THE BULLETIN

OF

The Vancouver Medical Association

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Monday, 8:00 a.m.—Orthopaedic Clinic.

Monday, 12:15 p.m.—Surgical Clinic.

Tuesday—9:00 a.m.—Obstetrics and Gynaecology Conference.

Wednesday, 9:00 a.m.—Clinicopathological Conference.

Thursday, 9:00 a.m.—Medical Clinic.
12:00 noon—Clinicopathological Conference on Newborns.

Friday, 9:00 a.m.—Paediatric Clinic.

Saturday, 9:00 a.m.—Neurosurgery Clinic.

ST. PAUL'S HOSPITAL

Regular Weekly Fixtures

2nd Monday of each month—2 p.m.—Tumour Clinic

Tuesday—9-10 a.m.—Paediatric Conference

Wednesday—9-10 a.m.—Medical Clinic

Wednesday—11-12 a.m.—Obstetrics and Gynaecology Clinic

Alternate Wednesdays—12 noon—Orthopaedic Clinic

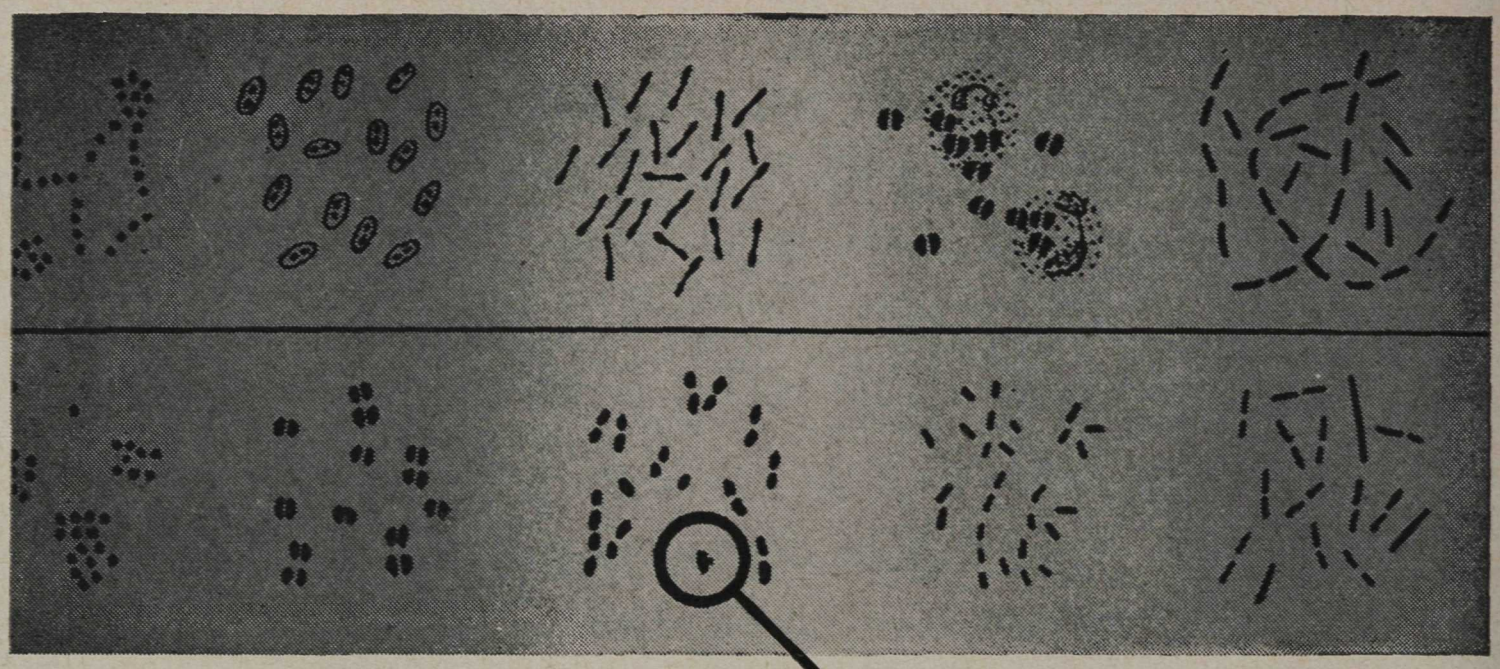
Alernate Thursdays—11 a.m.—Pathological Conference (Specimens and Discussion)

Friday—8 a.m.—Clinico-Pathological Conference (Alternating with Surgery)

Alternate Fridays—8 a.m.—Surgical Conference

Friday—9 a.m.—Dr. Appleby's Surgery Clinic

Friday—11 a.m.—Interesting Films Shown in X-ray Department



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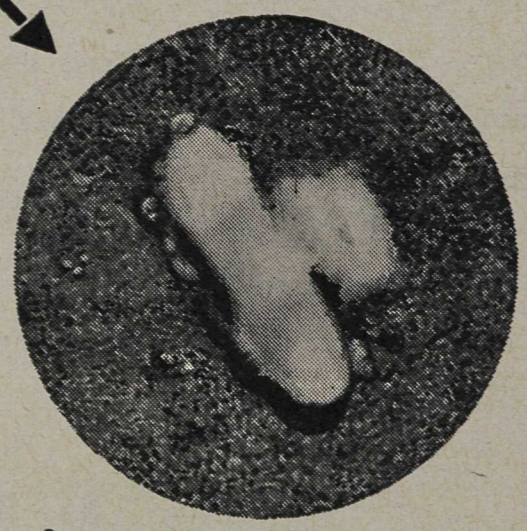

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Wednesday, 12:30 p.m.—Pathology.
Monday, 11:00 a.m.—Psychiatry.
Friday, 8:30 a.m.—Chest Conference.
Friday, 1:15 p.m.—Surgery.

BRITISH COLUMBIA CANCER INSTITUTE

685 West Eleventh Avenue,
Vancouver 9, B.C.

SCHEDULE OF WEEKLY CLINICAL MEETINGS

Monday—9 a.m. - 10 a.m.—Ear, Nose and Throat Clinic
Tuesday—9 a.m. - 10 a.m.—Weekly Clinical Meeting of Attending Medical Staff
Tuesday—10:30 a.m. - 11:30 a.m.—Lymphoma Clinic
Daily—11:45 a.m. - 12:15 p.m.—Therapy Conference

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Spring meeting—April 25th, 26th, 1952.

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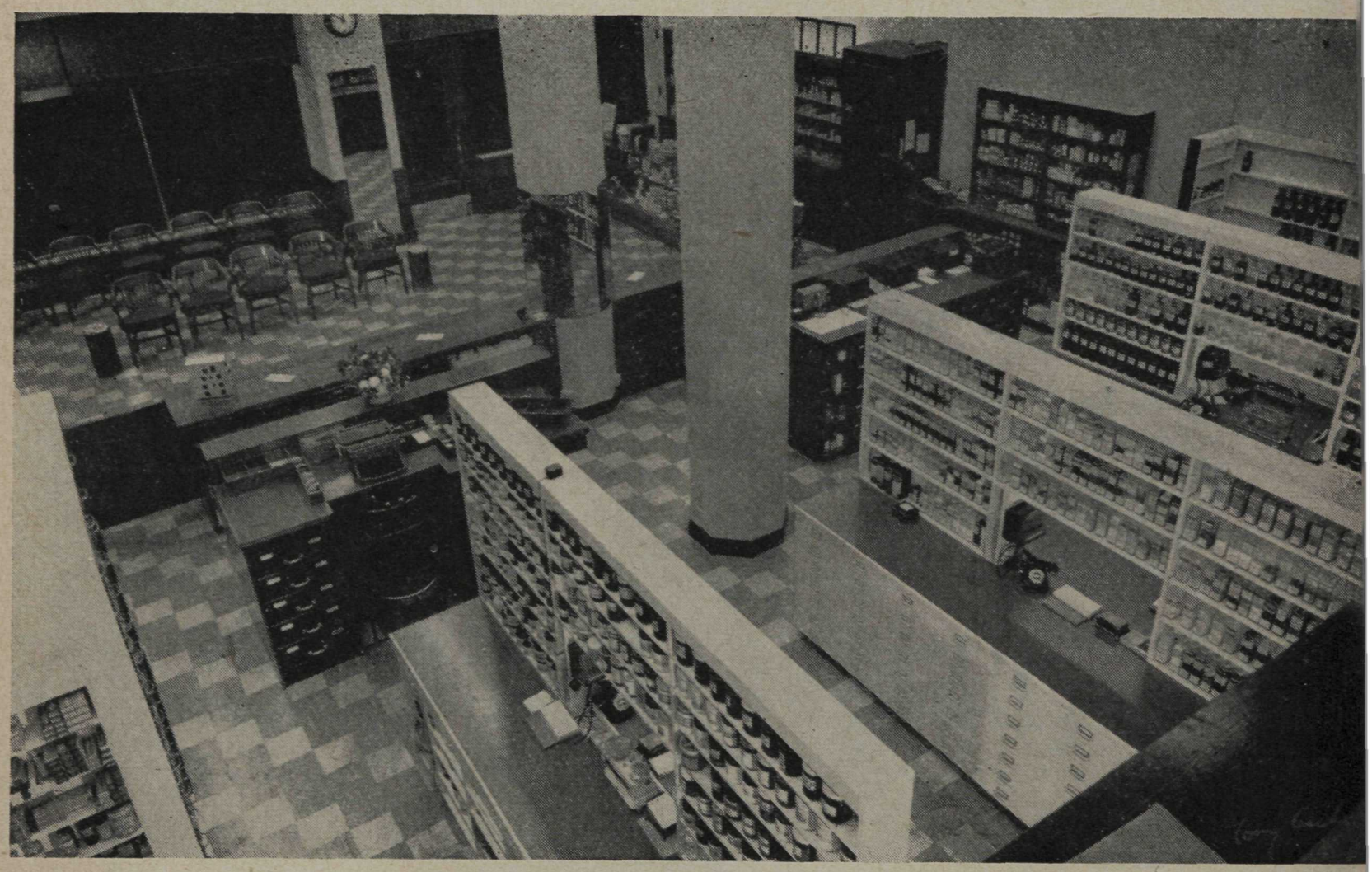

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VANCOUVER HEALTH DEPARTMENT

STATISTICS—JUNE, 1952

Total population—census figure (final) 344,833

Chinese population 7,117

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	June, 1952 Number	Rate per 1000 pop.
Total deaths (by occurrence)	371	12.9
Chinese deaths	15	15.3
Deaths, residents only	347	12.1

Birth Registrations—residents and non-residents (includes late registrations)

	June, 1952	
Male	427	
Female	401	
	828	28.8

Infant Mortality—residents only

	June, 1952
Deaths under 1 year of age	17
Death rate per 100 live births	28.7
Stillbirths (not included in above item)	6

CASES OF COMMUNICABLE DISEASES REPORTED IN CITY

	June, 1952 Cases	June, 1952 Deaths	Cases	Deaths
Scarlet Fever	101	—	66	—
Diphtheria	—	—	—	—
Diphtheria Carriers	—	—	—	—
Chicken Pox	145	—	95	—
Measles	82	—	169	—
Rubella	17	—	54	—
Mumps	98	—	38	—
Whooping Cough	5	—	16	—
Typhoid Fever	—	—	—	—
Typhoid Fever Carriers	—	—	—	—
Undulant Fever	—	—	—	—
Poliomyelitis	6	1	—	—
Tuberculosis	37	7	37	11
Erysipelas	1	—	2	—
Meningitis	—	—	—	—
Infectious Jaundice	—	—	—	—
Salmonellosis	—	—	17	—
Salmonellosis Carriers	—	—	—	—
Dysentery	—	—	—	—
Dysentery Carriers	—	—	—	—
Tetanus	—	—	—	—
Syphilis	11	1	8	2
Gonorrhoea	129	—	161	—
Cancer (Reportable Resident)	128	65	99	45

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In January of this year the Laboratories commenced distribution of ACTH direct to Canadian hospitals, physicians and research workers. The product was supplied as a stable, sterile powder, protein in nature and readily soluble in water or saline.

More recently, the Laboratories developed a stable aqueous solution of ACTH (Corticotrophin). This readily injectable form of the product, which is now available in addition to the freeze-dried material, has a potency of 20 International Units per cc. Both forms of the product are free from other pituitary hormones or harmful impurities in clinically significant amounts.

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	—	25 International Units per vial
Sterile Solution (in 10-cc. vials)	—	20 International Units per cc.

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The Editor's Page

It is with great pleasure that The Bulletin has devoted this issue to Cancer. In the following pages our readers will see for themselves the great advances that have been made in this Province in dealing with this age-old problem.

The past twenty or thirty years have seen a great revolution in the attitude of medicine towards problems that for ages have been regarded as insoluble, and so have come to be accepted as necessary evils. Cancer is only one of these. Those of us who began the practice of medicine thirty or forty years ago can remember quite well when we accepted as inevitable such things as mental disease, heart disease, arthritis, diabetes, pernicious anaemia, even tuberculosis, though with the developing knowledge given us by bacteriological and epidemiological research, we were beginning to face this particular enemy with some degree of hope. But there was nothing we could do about the others, and the majority of the medical profession merely threw in their hands when the deal turned up that way.

Nowadays, the whole attitude of medicine has been radically altered. We are beginning to see that there is no such thing as an impossibility in medicine. Men of courage and foresight have accepted the challenge of "incurable" disease. We have only to look at the work being done in mental disease, at the results being achieved by research and study, to receive inspiration and stimulation. Heart disease, especially congenital heart disease and the degenerative diseases of the arterial system, are further examples of this. No longer do we sentence the sufferer from coronary disease, for example, to total incapacity and an early death, or what is worse, a long-drawn-out uselessness: we give him hope and help, so that often he may live a long and useful life. Countless babies with congenital heart disease are being cured and given a normal life.

And the same is true of cancer. The men and women who are leading us in the battle against this greatest of all captains of death, simply refuse to yield or accept defeat. Year by year, through research and study, through professional and public education, through the enlistment of the lay public, they are gaining in the fight—often overcome for a time, but never licked. And some day, nobody knows when, we shall find the chink in the enemy's armour, the loophole in his defences, when we find the cause of cancer. Meantime, countless lives are being saved, relief given to many more.

British Columbia has great reason to be proud of its Cancer Foundation. It has had and still has, magnificent leadership. It owes much to many men of vision and generous hearts. H. S. Foley, W. C. Ditmars, W. J. Twiss, E. W. Hamber, R. R. Arkell, N. Levin, W. H. Malkin, E. H. Brown, A. C. Turner and many others have given ungrudgingly of their time and money and executive ability—while among medical men G. F. Strong (now President of the Foundation), H. H. Milburn, R. J. Harrison, A. M. Evans, Ethlyn Trapp, H. H. Murphy and a score of others, have guided the project wisely and well, so that today British Columbia has an equipment second to none, to aid it in its fight against this mortal enemy. More, thanks to the long vision of all these men, we can look forward to steady development, and the keeping pace with modern discoveries in the line of therapy and research.

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Vancouver Medical Association

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CORRESPONDENCE

June 26th, 1952.

Dr. J. H. MacDermot,
Editor,
The Bulletin,
Vancouver Medical Association,
Vancouver, B.C.

Dear Dr. MacDermot:

I have been very much interested and impressed by the series of articles and editorials appearing in your Bulletin over the past while on Medical Economics. I felt that I should write to you to express my appreciation and to make a few comments of my own.

In your editorial in the May issue which reached my desk this morning, I note your argument that prepaid medical plans are the only answer we have to prevent, in part at least, a completely socialized form of medical care. Of course I am entirely in agreement with this thought and very vigorously made a statement to this effect at the main luncheon meeting of the Ontario Medical Association at which I was the guest speaker.

The longer I am connected with prepaid medical care, however, the more I am convinced that the statement you made that prepaid plans do not go far enough, is true. At the present time, although rapidly expanding, our Corporation is now offering care to only 265,000 people in this vast province—a mere drop in the bucket. I cannot visualize, even with maximum expansion, our reaching hundreds of thousands of people who need to be reached. It is here of course, that state subsidy must be brought in.

You raise a second point that medical men must play fair with prepaid plans. The conviction is growing stronger in my mind day by day that there are three types of medical people who are going to pull down the whole medical profession unless we can check their stupidity. In the first place there is the doctor who charges excessive fees; this applies of course, particularly to specialists, but the general practitioners are involved as well. We have had brought to our attention innumerable instances of gross over-charging by specialists—fees that were just out of all reason. We know that many of the exorbitant fees are levelled at people without any regard to their economic status. For example, we saw that other day accounts run up by two workmen in the U.S. for hospital and surgical fees and the total in one case was $15,000.00 and the other was $12,000.00. These bills were incurred in a period of less than a year. We were shown these accounts by the General Manager of one of the largest Corporations in Canada and he assuredly is no socialist, but his comment was, "How far does the Profession think it can get with this sort of thing?" Our own participating specialists in P.S.I. in general bill fairly, but there is a small percentage of them who persistently overbill everybody regardless of economic status. This of course, does only one thing—it just creates the most frightful type of public relations in this province.

The second type of doctor who worries me is the fellow who is against the entire principle of prepaid care and who refuses to look in the eye of reality. We have our share of them in this province. This fellow and people like him fortunately constitute

a minority, but unhappily a vociferous one. In many instances I suspect that this fellow is not so much opposed to the principle as he is to the fact that there is some control over his fee by somebody else.

The third type is the fellow who pays lip-service to the principle of prepaid care and who participates in the plan and then tries to steal the plan blind. Here again men of this ilk form a minority but a tremendously important one because we realize as we go along that unless we bring these fellows into line they will wreck any plan that ever operated.

I made mention of these matters in public in May in Hamilton and the repercussions have not been serious although we have had one specialist resign from P.S.I. because of my statements. It is time that the profession gets rid of those who are fouling our own nest.

I hope I have not burdened you with these matters but it is apparent to me that you are seeing along the lines that we are here and I thought that the least I could do was to acknowledge you for your recent letters and articles.

Yours sincerely,
R. M. ANDERSON, M.D.,
President,
Physicians' Services Incorporated.

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FOREWORD

BRITISH COLUMBIA CANCER FOUNDATION

G. F. STRONG, M.D., President

It is appropriate here to extend our sincere thanks to the Editor of the Vancouver Medical Association Bulletin for making possible this special Cancer Number to mark the opening of the new British Columbia Cancer Institute. The British Columbia Cancer Foundation is a lay-medical community enterprise organized to bring improved facilities for the diagnosis and treatment of cancer to this Province. The Foundation operates the British Columbia Cancer Institute and Boarding Home in Vancouver, the Victoria Cancer Clinic in Victoria, and Diagnostic Clinics throughout the Province.

In the early days of this organization the question was frequently raised as to why the Government should not carry out this programme. Under our present system of free enterprise the Government has assumed responsibility for certain aspects of public health. For example, the care of Tuberculosis and Venereal Disease and of Mental Disease is now an accepted Governmental responsibility. On the other hand if the diagnosis and treatment of cancer became the responsibility of Government there would be no reason for not extending that same service to diabetes, heart disease, and all the other common health problems.

The policy followed by the Directors of the Foundation from the start was that this effort should be a community one with Government aid. It is a great pleasure to acknowledge the assistance that has always been given to our activities by our Provincial Government. The Health Department of that Government has shown interest in these activities from the first. In addition to grants in aid for operating expenses, our first deep x-ray therapy machine was supplied by the Provincial Government. Since the establishment of the National Health Grants in 1948 the portion of our operating expenses not derived from patients' fees has been met from the Cancer Grant which is a matching grant made up in equal parts of contributions from the Dominion and Provincial Governments.

When the present Institute was originally planned bed accommodation was included. It may be a source of regret to many that beds are not provided in the new building. However, in view of the fact that the Institute is located across the street

from the General Hospital, and in view of the fact that satisfactory arrangements have been made with the Hospital for the accommodation of our bed patients, it was decided by our Directors to use the funds available to provide the best possible facilities for radiation therapy.

When the Cobalt 60 Beam Therapy Unit is installed our new Institute will have equipment second to none for the radiation therapy of malignancy. The tunnel under Heather Street with improved elevator service in both buildings will make the facilities of our Institute available to all patients in the General Hospital.

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THE BRITISH COLUMBIA CANCER FOUNDATION

The following brief history of the British Columbia Cancer Foundation will be of great interest to our readers. It has been supplied by the Public Relations Department of the B.C.C.F. through Mrs. M. Good, the head of this Department.

—Ed.

Readers of the Bulletin who were living in Vancouver in 1935 will recall a certain luncheon, held in the Italian Room of the old Vancouver Hotel. The date was June 12th, and invitations had gone out to more than sixty of the city's most representative citizens. The purpose of the meeting was to interest these people in the newly formed organisation—THE BRITISH COLUMBIA CANCER FOUNDATION.

For some time before this period the British Columbia Medical Association had expressed concern at the incidence of cancer in British Columbia, and was particularly perturbed by the fact that nobody appeared to be doing anything about it. A special cancer committee of the Association was set up to investigate the situation, and co-operation was sought from the Board of Trade Health Bureau and the Greater Vancouver Health League. Each of these groups appointed two representatives and the resulting committee of six—they were Dr. G. F. Strong, Dr. H. H. Milburn, Mr. Wm. C. Ditmars, Dr. B. J. Harrison, Mr. W. J. Twiss and Mr. Norman Levin—recommended that a province-wide organisation be formed to institute an intensive drive against cancer.

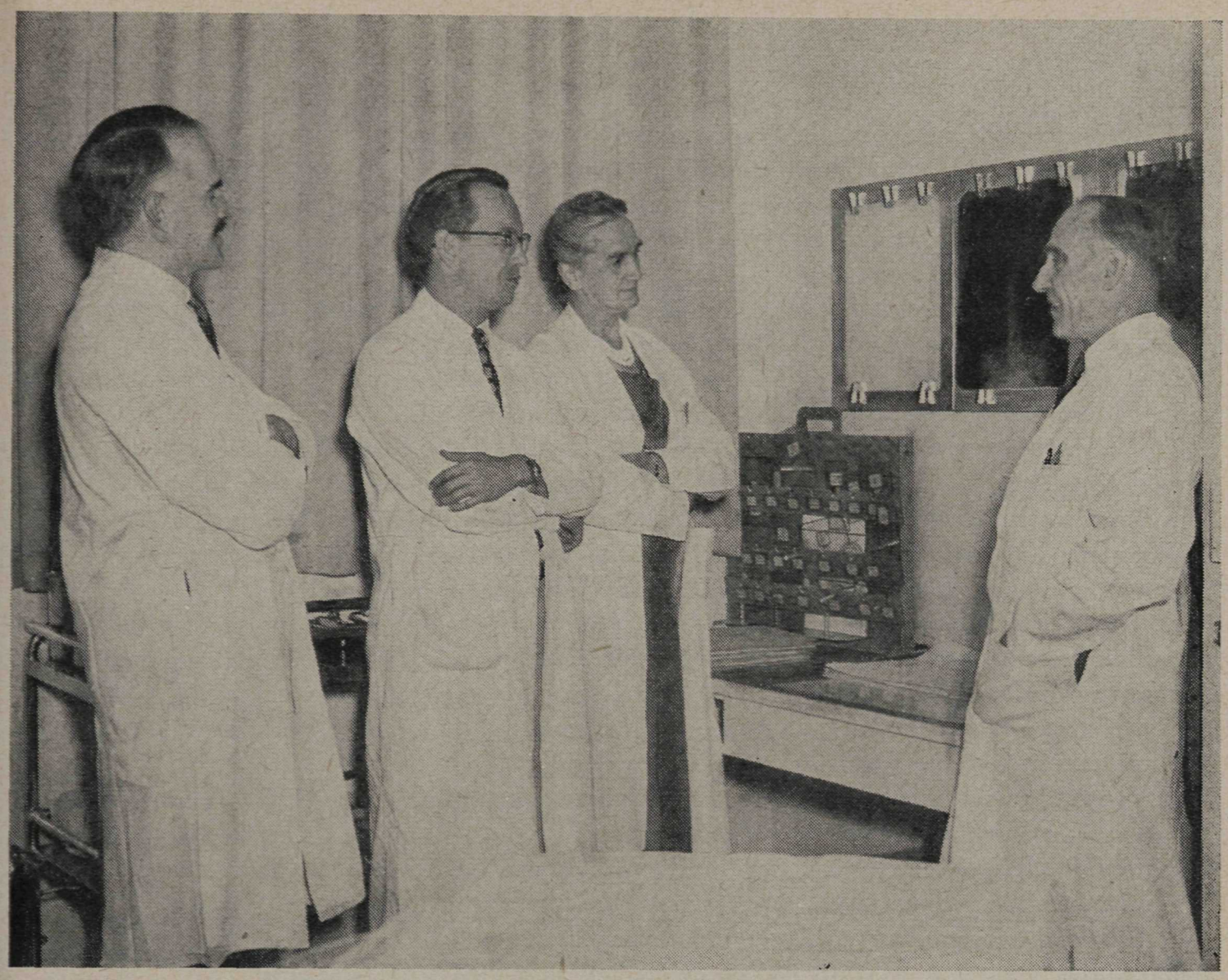
Thus the British Columbia Cancer Foundation was incorporated, on May 7th, 1935, and its objects were:

1. Collection and distribution of funds for the control of cancer in the Province of British Columbia;
2. To improve facilities for the diagnosis and treatment of cancer in the Province of British Columbia;
3. Education of the medical profession and laity in respect of cancer;
4. To give the necessary publicity to the cancer problem in the Province of British Columbia;
5. To engage in any research work that may seem desirable in dealing with the cancer problem in general.

These aims were comprehensive enough in their scope, and were an assertion of the Foundation's determination to tackle the problem systematically, and from all angles. The difficulties would no doubt begin with the transition from the theoretical stage to the practical.

The British Columbia Cancer Foundation was—and still is—composed of members of our lay citizens. Between them they have, through the years, decided policy, raised funds, formed the necessary standing committees to administer the Foundation's services, and generally accepted the responsibilities of providing for the people of this province the best means whereby cancer can be most vigorously combatted.

In 1935 the task ahead of them was not easy.



SOME OF THE STAFF

Dr. A. M. Evans, Dr. R. D. Nash, Dr. Margaret Hardie, Dr. R. G. Moffat.

The first step toward their goal was taken in the early part of 1936 when 3½ grammes of unprocessed radium were bought. This was made possible by a loan from the Provincial Government, and for a period of two years, in order to help the Foundation, the Honourable E. W. Hamber paid the interest on this loan. Eventually all but one gramme of radium was sold.

The First Clinic

As yet there was no building in which to begin the diagnosis and treatment of cancer patients. But in 1938 an anonymous benefactress left the Foundation $50,000. This was the first sizeable sum the Foundation had received and with it the Vancouver General Hospital Internes' Residence was converted into the first cancer clinic. At the same time the remaining gramme of radium was processed and a qualified radiotherapist and radiotherapy technician were engaged.

Many of us will remember the formal opening of the converted building, on November 5th, 1938, by the Lieutenant Governor of the Province, the Honourable E. W. Hamber. The first patient was admitted on Monday, November 7th, 1938.

During the war years progress was retarded. Dr. A. M. Evans, who was then Medical Director, and Miss Dorothy Findley, the radiotherapy technician, both went overseas with the Canadian forces, and Dr. Ethlyn Trapp took over the direction for the period of the war. When Dr. Evans returned she handed back to him an Institute which by that time was growing so rapidly that the need for X-ray facilities as well as radium was apparent.

The Provincial Government provided the first X-ray therapy machine, a 400 K.V., which went into operation in November, 1945, and its installation necessitated an increase in staff.

Departments of X-ray therapy and Social Service were set up, Medical Records were enlarged, and a part-time physicist came on to the staff.

In the meantime the British Columbia Division of the Canadian Cancer Society was growing active in the field of lay education, the promotion of research and the provision of welfare assistance.

In 1946 and 1947 the two organisations, the Foundation and the Society, arranged joint campaigns for funds. These drives, together with bequests and legacies from people who were sympathetic to the Foundation's ideals, made available a considerable sum of money which was set aside for capital expansion.

At this time the President of the Foundation was Mr. Harold S. Foley, of the Powell River Company. He was alert to the difficulties confronting the Foundation, and anxious that funds should be spent wisely, and it was at his insistence that Dr. Simeon T. Cantril, Director of the Tumour Institute at Seattle's Swedish Hospital, was invited to make a survey of the situation in British Columbia.

Dr. Cantril's recommendations bore out the original concept—the co-ordination of all radiation therapy in one main centre, and the advisability of having beds under the same direction if practicable. About the same time advice was sought from Dr. Ralston Paterson, of the Holt Radium Institute in Manchester and his reactions were a complete endorsement of Dr. Cantril's ideas.

Now that the Foundation had a blueprint from which to work it was able, in 1947, to ga ahead with plans for a temporary building with more therapy machines and a diagnostic X-ray Unit. This new building, at the corner of Heather Street and 11th Avenue, was opened in 1948, and at that time facilities included a 120 KV, a 220 KV and the original 400 KV therapy machines, a diagnostic X-ray Machine and a physics department with Dr. Harold Batho in charge as a full-time physicist.

In 1949 a 260 KV X-ray therapy machine was added with money donated by the B.C. Division of the Canadian Cancer Society. The same year a photographic department was developed and a Cytology laboratory, financed by the Society, was given space within the Institute building. A boarding home, furnished by the Society, was opened in 1949. This home is for patients, chiefly from out of town, who are undergoing diagnostic and/or treatment procedures.

Despite this constant expansion the Foundation could not keep pace with the demands made upon it and once again, in 1949, it had to face the fact that the building, which had been opened only the previous year, was no longer adequate.

A long-term expansion seemed the only solution.

Property adjoining the Institute at Tenth Avenue and Heather Street was bought and the old house next door demolished. The Foundation entered into an agreement with the Vancouver General Hospital to secure title to the property on which the original building stood, and the Hospital agreed also to make available to the Institute patients thirty beds within the hospital buildings. A tunnel running under Heather Street and connecting the two institutions was decided upon.

Construction of the new building started in May, 1951, and by June of this year most of it was ready for occupancy. The old building is in process of re-construction and will provide for expansion of the Physics, Medical Records and Diagnostic Department, a Nurses' Lounge, a Library, a Cystoscopic Room, an enlarged Radium Department, and a Mould Room.

The new building will also house a Cobalt 60 Beam Therapy Unit, the third in Canada.

Provincial Responsibilities

During these years of development the Foundation had not overlooked its responsibilities to the rest of the Province, and in January, 1948, the first Unit outside Vancouver was opened in Victoria at the Royal Jubilee Hospital—the Victoria Diagnostic

Clinc with Dr. H. H. Murphy as the Director. In 1951 this was expanded to include treatment facilities and the Unit is now known as the Victoria Cancer Clinic.

The Foundation's original plan foresaw the need for consultative services in other parts of the province and by the end of 1949 consultative clinics had been established at Penticton, Vernon, Kelowna and Kamloops. By July Nelson, Trail and Cranbrook were included. Prince George was added in 1951 and Prince Rupert in 1952.

Attending Medical Staff

The Attending Medical Staff of the Institute is appointed annually by the Executive Committee on the advice of the B.C. Medical Association and a weekly clinical conference is held where new cases are discussed and former ones re-assessed.

The British Columbia Cancer Institute is one of the most modern clinics in Canada. However, past experience has taught the Foundation to adopt a long-term view and the present building is so constructed that several floors can be added as and when required. One thing is certain however; just so long as we have the British Columbia Cancer Foundation, the people of this province will be assured of the best available treatment facilities for cancer patients. And the public is indebted to these visionary and far-sighted members of the laity and the profession whose industry has made this possible.

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THE NEW BUILDING

By The Editor

A short while ago, in our editorial capacity, we visited the new buildings of the Foundation: Mrs. Robertson, the Secretary, received us very kindly, and interrupted a busy period of work to show us around, and explain everything to us.

It was a memorable voyage of discovery. We had watched the building going up, and in a general way knew what it was for—but had no idea at all of what really had been accomplished. The Foundation will, we understand, be holding Open House in October, when it is formally opened, and the citizens of Vancouver will be able to see for themselves what a magnificent piece of work this institute is. Everyone should make an effort to go and see what has been done here.

The first thing that strikes one is the atmosphere of calm—nobody is in a hurry, yet at every corner one sees someone working—a nurse giving a deep-therapy treatment, a crowd of outpatients sitting reading magazines or chatting, as they wait for their hour: administrative offices in full swing. There is a feeling of spaciousness here, as if each department had plenty of room. There is, too, lots of light and fresh air.

The Outpatients' Clinic is, of course, the biggest single department: as most people who come here come on an outpatient basis: what beds are occupied for treatment are in the main building of the V.G.H. and are reached by a tunnel, one of the many that connect the various buildings. On the main floor there are eight examining rooms, fully equipped—where patients are examined or checked. These occupy one corridor. Another at right angles to this houses the therapy rooms: all the machines are on this floor—and I saw the room which is being prepared for the new cobalt 60 bomb: a massive floor of concrete with a great gutter in it, ready for the installation of this, the third in Canada.

Then we went upstairs where on the first floor is the Conference Room, a long, well-equipped room with comfortable chairs, where medical clinics and conferences will be held. Some 250 or 300 can be seated here. Arrangements are made too, for bringing in patients—with rest rooms for them and suitable nursing care.

The Medical Records room is on this floor too, and is a hive of busyness. It is in a sense the brain of the establishment, or at least its memory centre.

The floor above has a beautiful lounge or solarium, some thirty or forty feet long and wide in proportion. This is a place where patients may rest and read and bring

their friends. It has been equipped by the I.O.D.E., and is a thing of beauty. On the other side of the hall are rooms where dressings are made to be sent out, according to the Foundation's plan for home nursing of cancer cases.

And so it went—one finely organised and equipped department after another. We visited the old building, which now looks so small and out-of-date, but where so much splendid work has been done. We saw the "boarding home" with its fourteen beds, where out of town patients can be housed, who need examination and treatment in the Clinic, but do not need hospital beds.

As we went through all this, we thonght of the old days, when to merely mention the word "cancer" to a patient was the equivalent of a sentence of death. To-day we use the word, in talking to patients, almost as freely as we say "tuberculosis" to another group of sufferers. And it is institutions like the B.C. Cancer Foundation, who had the courage and wisdom to use the word frankly themselves, that have brought about this change in the public attitude, Slowly, the panic that used to be the inevitable result of diagnosis is being dispelled. People are getting less afraid—more hopeful, more confident that much can be done for them. And this means earlier diagnosis and earlier treatment—and this means more lives saved, less suffering and agony and some day, please God, the end of Cancer.

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SOME OF THE PROBLEMS OF LARYNGEAL CANCER

By DR. L. E. WOOD, Vancouver, B. C.

Malignant tumours of the upper respiratory tract are common, and whilst most of them occur in sites other than the larynx, growths in the latter situation are all too frequently seen. Indeed, something like 5 per cent of all malignancies of the body occur in the larynx.[1]

The larynx is an ideal situation for the growth to cause maximum discomfort and distress and often to necessitate radical forms of treatment, each of which adds its own contribution to the misery which all too often precedes death.

On the other hand providing diagnosis and treatment are early, the larynx can be a very favourable site in which to have a malignant growth, since treatment is very successful and there are great possibilities from the point of view of a cure.

The first real problem of laryngeal cancer then is one of early diagnosis.

Chiefly for the purpose of description laryngeal growths are thought of as being either intrinsic or extrinsic. Intrinsic growths are those situated within the area outlined by the thyroid cartilage, i.e., within the voice box. If it extends outside this area it is said to have become extrinsic. Growths also occur primarily in an extrinsic position, but these are not regarded as true laryngeal growths.

This arbitrary placement of the growth is not entirely without clinical significance, since intrinsic and extrinsic growth differ in their natural history, treatment and prognosis.

*Intrinsic lesions*s occur anywhere in the larynx, but the common sites are:

1. Anterior part of one vocal cord.
2. Middle part of one vocal cord.
3. Anterior commissure—where the cords meet.

Intrinsic lesions derange the function of the larynx and so produce voice changes and respiratory obstruction. Hoarseness in well over 95 per cent of cases is the earliest and often for a long time the only symptom. Dyspnoea, on the other hand, is a late symptom usually and is encountered far less often.

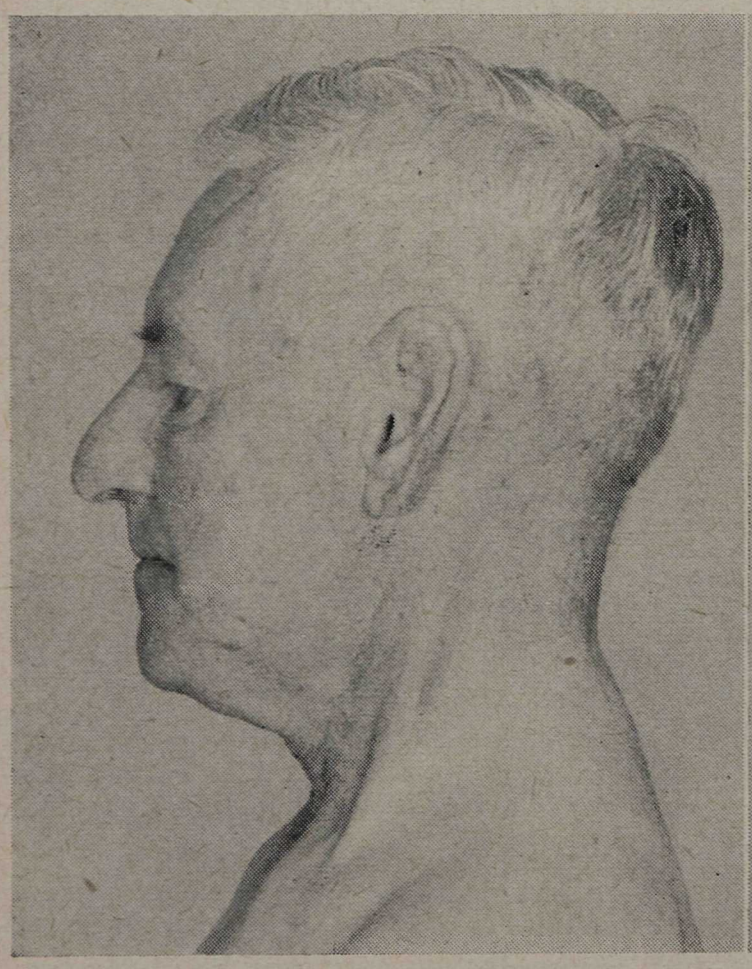
Now hoarseness is not much of a symptom. Patients too often ignore it and indeed there are far commoner causes of hoarseness than cancer. Not infrequently the hoarseness of cancer becomes manifest at the time of a head cold, which itself is

a prime producer of hoarseness and voice change. The lesson here is to examine every larynx in every patient who is hoarse, no matter whether or not the symptom would obviously seem due to a cold or sore throat. If on examination there is nothing seen to arouse suspicion such treatments as are necessary may be instituted and the patient watched. If the hoarseness does not clear up rapidly further examination should be made, and if it has lasted for more than two weeks one should be most suspicious. This is true no matter what the age of the patient may be. Laryngeal cancer has its greatest incidence after 40 years of age; Figi and New in a report on 380 cases found that 84 per cent occurred in 40-70 age group and 9 per cent in those under 40. They report a case of 15 and another of 28 years of age.[2]

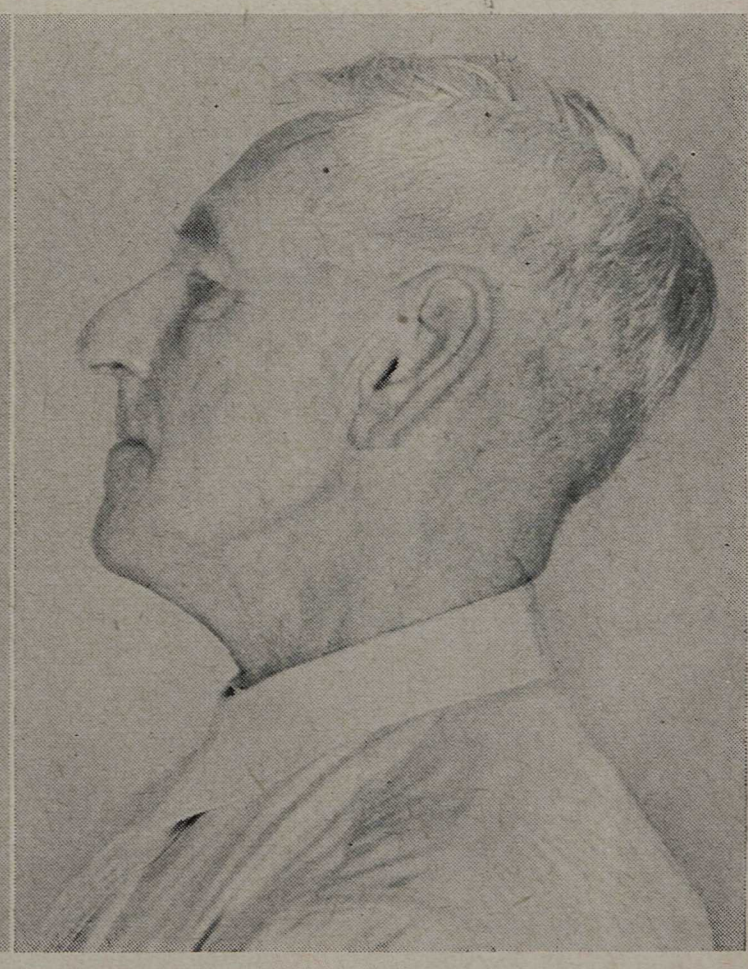
It is also accepted that men are more prone to the disease than women, about 10 to 1.

No matter what the sex or age of the patient may be, cancer should be kept in mind as a possible diagnosis until this is proved wrong.

Laryngeal examination is of cardinal importance in making a diagnosis of any laryngeal condition, for how else can you be sure what is wrong unless you look and see. Indirect examination by means of a mirror is not difficult. To accomplish it a little skill is needed and a lot of patience. True, there are several snags, but most of these can be overcome if the examination is carried out in an orderly fashion. The first step is to get the patient seated properly. Most people for some unknown reason adopt the wrong position and the examiner fails to correct it. The patient should sit well back on the chair and sit straight up with a little forward lean. The examiner should be seated and should be lower than the patient. The standing examiner trying to visualise the larynx in a patient slouched backward in a disorderly manner is doomed to disappointment. The light should be well focussed and the examiner confident that his headmirror can throw this light into the oral cavity and move it from place to place



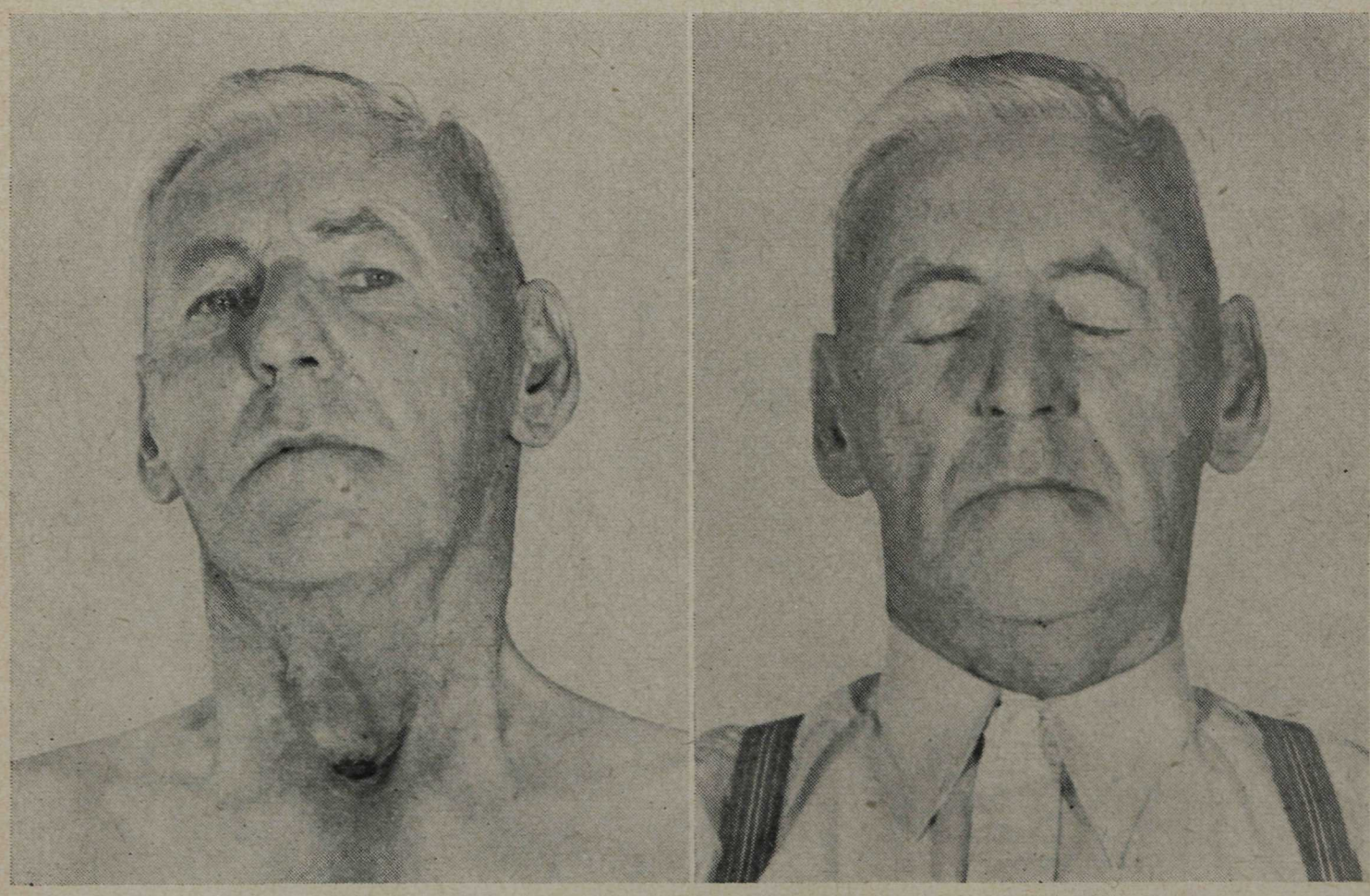
Faulty Position.



Good Position.

until all the structures to be examined have been illuminated and well visualised. The patient is then instructed to put out the tongue as far as possible and at the same time to breathe slowly and deeply through the mouth. It is useful to get the patient to breathe noisily, for then you know that he is not breath holding. The tongue is grasped with a dry cloth and should not be pulled, but rather rolled over a finger placed undeneath it. This rolling movement causes a greater excursion of the upper surface of the tongue than the lower, which is shorter and fixed, with the result that the epiglottis which is attached to the back part of the dorsum is raised up. The tongue should not be squeezed so as to cause discomfort nor should it be pushed down on the incisor teeth. The light should be focussed on the base of the uvula and upon this point the mirror should be placed. The mirror should be warmed to prevent steaming, but not hot enough to burn the patient. The patient is told to breathe deeply with the result that the soft palate moves upwards and backwards and the mirror follows this movement and is then held firmly but gently in this new position. The larynx should now be exposed.

Gagging is one of the common pitfalls. Too often this is due to attempted examination in a bad position. Often it is due to pulling on the tongue, touching the dorsum of the tongue or the posterior pharyngeal wall with the mirror or moving the latter in its position on the uvula. If the tongue is forcibly pulled the patient gets a desire to swallow. The majority of patients can be examined by this means but there remain a few who defy even the gentlest handling. Here it is necessary to render the throat insensitive by spraying the soft palate and dorsum of tongue with an anaesthetic (10 per cent cocaine).



The Stoma *Completely Covered When Dressed*

Another snag is often presented by the epiglottis. Sometimes the epiglottis overlies and obscures the anterior part of the larynx and manipulation may not be sufficient to obtain a satisfactory exposure. Some of this can be eliminated by correct rolling of the tongue instead of pulling, and some of it be getting the patient to say "eh".

In obstinate cases it may be necessary to raise the epiglottis with a probe whilst the patient rolls out his own tongue. Sometimes this fails either because of the intolerance of the patient or from lack of gentleness on the part of the examiner. In this event examination by other means (direct) is imperative since failure to visualise the anterior part of the larynx because of an overlying epiglottis means failure to see that part of the larynx where cancer is commonest.

Another snag is that no matter how well the larynx may be visualised a growth may be missed because it is out of sight—this applies particularly to those lesions under the cords or in the ventricles. In this case where you are suspicious or where you cannot properly see because of the epiglottis overhand direct examination by a laryngoscope should be done.

There is nothing terrible about direct laryngoscopy; it is an easy procedure, given good preparation, and very informative. If no preparation were needed we might find it to be a standard office procedure such as proctoscopy or vaginoscopy and in that event probably far less cancers would be missed.

Appearances:

There are three classes of things to look for:

1. The tumour itself which may be:
   a. A slight thickening or roughening of one card.
   b. A fungating cauliflower growth.
   c. Whitish red ulceration.
2. Impairment in mobility of or fixation of the vocal cord.
3. Oedema.

Spread:

Direct surface or tissue extension is the early method of spread. The lymphatic system in the larynx is peculiar and is called a closed system and a growth may remain for a considerable period of time without dissemination. Glands are usually involved late and not until the growth has become extrinsic. This factor greatly influences the prospects of treatment and the prognosis, and it is a generally accepted fact that patients with an intrinsic lesion have great possibilities with regard to a cure and the longer the condition goes undiagnosed the more these possibilities decrease.

Extrinsic Growths:

Spread of the growth beyond the confines of the larynx may be in any direction and depending on this are the symptoms produced:

1. Posteriorly—over the arytenoid area into the hypopharynx and upper oesophagus.
2. Laterally—along the ary-epiglottic folds to the pyriform fossae or base of the tongue.
3. Anteriorly—into the base of the epiglottis or tissues of the neck.
4. Superiorly—into the epiglottis or tongue.
5. Inferiorly—into the subglottic region or upper trachea.
6. Into the lymph glands.

The early symptoms of extrinsic spread are mild and misleading. Patients complain of sensations of tickling and pricking or discomfort in the throat, of a feeling of a lump in the throat and pain in talking or pain in swallowing. All these symptoms have much commoner causes than malignant disease. The later symptoms are dysphagia, local pain in the throat, earache (referred pain), dyspnoea, cough and haemoptysis and neck swellings (glands).

The early symptoms should never be overlooked for they do have a definite cause. If this cause be not obvious, if there is no improvement on treatment, or if one's suspicions are aroused, further investigation is imperative (direct laryngoscopy and œsophagoscopy). Early diagnosis in the stage wherein these mild symptoms are manifest will very often ensure amenability to treatment, but beyond this stage, the possibility of successful treatment declines rapidly.

Outside the larynx the lymphatics are abundant and extrinsic growths disseminate quickly—therefore the prospect of treatment is not good and the prognosis bad.

Everything then depends on getting at the growth before it spreads outside of the larynx, i.e., before the above symptoms have made their appearance.

Treatment:

The problem of therapy is essentially one for the specialist, but it is important for patient and doctor alike to know something of the possibility of treatment. Early treatment of intrinsic growth is highly successful. When a lesion is confined to one vocal cord, the cure rate is around 90 per cent. The voice remains, but may vary from being harsh and husky (if surgery is performed) to more or less normal (with certain types of irradiation).

In certain intrinsic growths and some of the extrinsic ones radical surgery may be the treatment of choice. This consists of total excision of the larynx. The trachea is brought to the skin surface low down in the neck and the continuity of the pharynx and esophagus preserved. This procedure in select cases gives excellent results although it has received much criticism from certain quarters. The main points of criticism seem to be 1, That it is unnecessarily mutilating, and 2, the patient is robbed of his voice.

It would seem timely to answer these criticisms.

No procedure designed to preserve life would seem unnecessary. The absence of the larynx causes the outline of the neck to be depressed and the operation scars are conspicuous only for a few months. Apart from this the only other evidence of mutilation is the stoma. This tracheostoma is small and lies low in the neck, being out of sight when the shirt collar is fastened. Breathing is not objectionable and indeed hardly noticeable to the patient or his friends. Swallowing is natural and the patient can smoke as much as he likes and enjoy it.

Speech does not depend upon the larynx but upon the supralaryngeal structures—pharynx, palate, tongue and lips. Nor is the larynx necessary for the whispered voice for normal people. Laryngectomy then only robs the patient of his power to make a noise which noise is used by the other structures to develop speech. Therefore if the patient can learn to make a substitute noise he will be able to speak loudly and clearly. Experience bears this out.

The older method of voice training depends on the regurgitation of air, but oesophageal speech of this type has several disadvantages although it is fairly easy to learn. Harder to acquire but of much better quality is pharyngeal speech. The basis of this is the taking in of air at the mouth and nose (by suction) holding it in the pharynx by a trigger-like action of the tongue and releasing it slowly, allowing it to vibrate against the palate and pharynx. Our patients start smoking on the first post-operative day; there is a little hesitancy at first but progress is quick, and we show them that if they can suck smoke in at the mouth and hold it and then blow it out of the nose and mouth they can do the same with air, and if they can do that they will learn to talk again.

The fact that laryngectomy does not materially affect the whispered voice gives a good background for rehabilitation. Given a whisper, a well functioning pharyngeal suction pump and a psychologically attuned patient, in time that patient will develop an excellent voice.

The psychological attitude both toward the cancer and the proposed method of treatment is terribly important and presents quite a problem.

There are those who are spiritually defeated on learning the diagnosis, and again there are those who accept it and enquire into what is to be done. There are those who in spite of explaining to the contrary are sure they will be left speechless, some, the very old, are not temperamentally suited to the procedure. Many snatch at the prospects of a cure without fully realizing all that is involved. I believe that all candidates should observe the results for themselves and it is my practice to get them to meet a patient recently laryngectomized. They see and hear. They look at the

neck and the stoma, they see the patient smoke, eat and drink and they hear his voice, however poor. If they can accept this and make up their minds to be every bit as good only then do I consider laryngectomy. For laryngectomy is only the method of choice for a few select sufferers. Imagine for a moment the hypothetical case of a foreigner with poor command of English, an older person perhaps, and one who cannot write: probably he is bewildered and does not fully appreciate what it is all about. This man I suggest is the worst possible candidate for operation, for no matter how successful the operation may be from a surgical point of view, he will be left excommunicated, unable to express himself, useless and pitiable.

But if the patient fully realizes that he can and will talk again, eat, drink and smoke normally and with enjoyment, be able to work and live a fairly normal life, if he makes up his mind to do just this, then and only then does laryngectomy become not only necessary and justifiable but also imperative and is by way of being one of the most satisfying things that one man can do for another.

REFERENCES

1., 2.—Histopathology of Ear, Nose and Throat, EGGSTON & WOLFF, page 1015.

PUBLIC HEALTH AND MENTAL HEALTH NEWS

G. F. AMYOT, M.D., D.P.H.,
Deputy Minister of Health, Province of British Columbia

A. M. GEE, M.D.,
Director, Mental Health Services, Province of British Columbia

THE RELATIONSHIP BETWEEN THE PROVINCIAL HEALTH BRANCH AND THE B.C. CANCER FOUNDATION

The B.C. Cancer Foundation has for many years been the organization taking the major interest in the control of cancer in B. C. Through the B. C. Cancer Institute in Vancouver, the Foundation has conducted a programme of diagnosis and treatment of those suffering from this disease.

Prior to the inception of the National Health Grants in 1948, considerable discussion had taken place regarding ways and means of expanding the programme and stabilizing its financial status. However, no final decision had been made at the time the National Health Grants were announced. In view of the large amounts of funds which would become available through the National Health Grant for cancer, Dr. O. H. Warwick, executive director, National Cancer Institute of Canada and Canadian Cancer Society, agreed to in the fall of 1948, to carry out a survey on all phases of the cancer problem in this province.

A logical outcome of the recommendations made by Dr. Warwick in his report, "The Care of the Cancer Patient—With Special Reference to the Province of British Columbia," was the decision to name the B. C. Cancer Foundation agent of the Province of British Columbia in the provision of diagnostic and treatment services for cancer. In effect, therefore, the programme of the B.C. Cancer Foundation is the cancer control programme in this province.

After the B. C. Cancer Foundation had been named as the agent of the province, it was agreed that the Provincial Health Branch would assume responsibility for the operating expenses of the B. C. Cancer Institute, although one-half of these expenses are reclaimed from the National Cancer Control Grant. Prior to this time the Provincial Health Branch had made annual grants to the B. C. Cancer Institute, but there had been no fixed policy. The new arrangement also applies to the operating expenses of the services which have since been added, namely, the nursing home, consultative

cancer clinics and the Victoria cancer clinic. Assistance from the Cancer Control Grant and the matching provincial funds has also been given to the B. C. Cancer Foundation for the purchase of equipment.

The importance of cancer control is readily acknowledged. Progress undoubtedly is being made through a sound programme in British Columbia which is a co-operative effort between the Provincial Health Branch, the Canadian Medical Association, B. C. Division, and our voluntary agencies, the B. C. Cancer Foundation and the Canadian Cancer Society, B. C. Division.

The programme must be geared to the problem, and the problem is known only as the result of adequate reporting of cases. The accompanying tables and comments, prepared by the Division of Vital Statistics, Provincial Health Branch, reveal the importance of the problem which would undoubtedly be much greater if all cases were reported.

The most frequently used measure of the extent of the problem of malignant tumours is the count of deaths ascribed to this cause. However, for obvious reasons, mortality statistics give an incomplete picture of the incidence and prevalence of the disease. Yet in planning treatment facilities, it is most important to have this later information. In an attempt to obtain more useful information, the Provincial Health Branch has maintained a reporting system and his obtained certain data from the malignancy reports received. The following tables present a brief summary of the number of new cases reported during 1951 and also the number of deaths registered from this cause. It will be seen that the number of new cases reported is only slightly in excess of the total number of deaths. The number of new cases would undoubtedly be considerably greater if complete reporting were achieved. More extensive analyses and cross-classifications of the reported morbidity and the mortality, including age-specific rates, have been made, and are available upon request.

Although cancer was made a notifiable disease in this province at the request of the B. C. Medical Association, less than twenty per cent of the new cases have been reported directly by the physicians. The other eighty per cent have been located by checking biopsy reports, reports from the B. C. Cancer Institute, and reports from general hospitals. The attention of all physicians is directed to the importance of reporting all new diagnoses of malignancies, in order that a true assessment of the problem may be made.

MALIGNANT NEOPLASMS

New Cases Reported* and Deaths Registered.

By site and sex—1951

SITE	Male		Female		Total	
	New Cases	Deaths	New Cases	Deaths	New Cases	Deaths
Skin	241	13	176	5	417	18
Digestive System	190	442	161	266	351	708
Genital System	121	102	234	132	355	234
Breast	6	2	278	159	284	161
Respiratory System	93	166	19	34	112	200
Buccal Cavity	122	30	31	9	153	39
Blood and Lymphatic System	38	82	19	56	57	138
Urinary System	71	67	31	25	102	92
Brain	4	30	4	20	8	50
Endocrine Glands	5	4	14	12	19	16
Other	37	31	23	20	60	51
Total	928	969	990	738	1,918	1,707

*Reported prior to death.

MALIGNANT NEOPLASMS
New Cases reported* and Deaths registered
By Age-group and sex, 1951

AGE-GROUP	Male		Female		Total	
	New Cases	Deaths	New Cases	Deaths	New Cases	Deaths
0 - 9	1	11	8	10	9	21
10 - 19	5	5	5	4	10	9
20 - 29	7	10	23	7	30	17
30 - 39	27	19	85	24	112	43
40 - 49	69	48	141	73	210	121
50 - 59	171	130	243	148	414	278
60 - 69	276	296	223	204	499	500
70 - 79	254	339	171	204	425	543
80 and over	89	111	57	64	146	175
Not stated	29	—	34	—	63	—
Total	928	969	990	738	1,918	1,707

*Reported prior to death.

BIOPSY SERVICE

The Provincial Biopsy Service, which was inaugurated in February, 1950, provides for free biopsy services relating to cancer to be carried out by those hospitals employing certified pathologists. The service is available to anyone in the province either as an in-patient or out-patient at a hospital or phyisician's office. The physician may refer the tissue specimen to any one of the following approved hospitals for examination without charge to the patient providing the specimen is accompanied by the Biopsy Request Form:

Royal Jubilee Hospital, Victoria.
St. Joseph's Hospital, Victoria.
Vancouver General Hospital, Vancouver.
St. Paul's Hospital, Vancouver,
North Vancouver General Hospital.
Royal Columbian Hospital, New Westminster.
Royal Inland Hospital, Kamloops.

During the nine months ending December, 1950, 6,965 examinations were carried out under this service. For the corresponding period in 1951, 8,983 examinations were done, or an increase of 20 per cent. The percentage of specimens examined, which were found to be malignant, increased from 12 per cent in 1950 to 14 per cent in 1951. Although the increase in the number of specimens examined is no doubt due in part to the fact that this is a new service, the large volume of examinations done, as well as the increase in the percentage of specimens found to be malignant, indicates that the need for this type of service is being met.

In addition, these hospitals continued the examination of specimens originating in their own hospitals. The total number of examinations done on specimens originating in the hospitals was 14,986 for the nine months ended December, 1950, and 16,440 for the same period in 1951, or an increase of 9.7 per cent. The percentage of these specimens found to be malignant was 6.8 per cent in 1950 and 9.1 per cent in 1951. The main factor contributing to the lower ratio of malignancy found in this group as compared to the specimens referred under the Biopsy Request Form is the policy of the routine examination of large numbers of specimens from hospital in-patients regardless of whether or not malignancy is suspected.

In the two-year period ending March, 1952, the total number of specimens examined, including those originating in the hospital as well as those referred under the Biopsy Request Form, was 61,021, of which 6,033, or practically 10 per cent were found to be malignant.

COLLEGE OF PHYSICIANS & SURGEONS INCORPORATED 1886
VIRTUTE ET VERITATE
BRITISH COLUMBIA

REQUIREMENTS FOR MEDICAL REGISTRATION IN BRITISH COLUMBIA

The following information is submitted by the Council of the C.P.S., in full, for the guidance of:

A. *Doctors* who intend making application for registration in this province.
B. *Internes* who intend applying for hospital positions.
C. *Hospitals* in British Columbia who employ internes.
D. *Applicants for Enabling Certificates* to write the examination of the Medical Council of Canada (L.M.C.C.).

A. *REGISTRATION.*

A doctor who is applying for registration shall complete the prescribed form and fulfil the following requirements;

1. An applicant must be a graduate of a medical school approved by the Council of the College of Physicians and Surgeons of British Columbia.
2. An applicant must be a Licentiate of the Medical Council of Canada (L.M.C.C.).
3. An applicant shall present a certificate of having completed twelve months interneship in a hospital approved by Council.
4. An applicant, not being a Canadian or a British subject, shall have filed intention of becoming a Canadian citizen, and produce documentary evidence of having done so.
5. An applicant must be able to read, write and speak the English language.
6. An applicant shall be required to make a personal appearance before the Committee on Registration and produce original documents regarding his qualifications (including passport and visa).

   General Information—The fee for registration is $200.00. Temporary permits to practice are not granted. Under no circumstances can interim certificates be added for purposes of locum tenens.
7. Applicants are advised that it may require sixty days for completion of registration procedure outlined herewith.

B. *INTERNES.*

Medical graduates who are accepted by a hospital in British Columbia should complete their registration in this province or be covered by an Interim Certificate. Interim Certificates cannot be granted to undergraduate internes or for purposes of locum tenens.

Applications for "Interim Certificates" are submitted to the Registrar of the College of Physicians and Surgeons of B.C., by the hospital concerned. An applicant is required to complete the prescribed form, and appear *in person* before the Committee on Registration. *He must be a graduate of a medical school approved by the Council of the College of Physicians and Surgeons of B.C.* Interim Certificates are issued without charge.

C. *HOSPITALS.*

Hospitals approved for interne training are requested to apply to the College of Physicians and Surgeons of B.C. for the necessary application forms for graduate internes not registered in this Province. This Certificate may only be granted to graduates of Universities approved by the Council, as provided under Section 38 of the Medical Act. They shall forward a list of graduate internes employed, showing medical degrees and where obtained. The necessary application forms will then be forwarded to the hospital together with the advice that these applicants must appear in person before the Committee on Registration. On receipt of these completed forms the Registrar will advise the hospital the date of meeting of Committee on Registration at which applicants are to appear.

The following general hospitals in British Columbia are approved for Interne training:

Vancouver General Hospital, Vancouver
St. Paul's Hospital, Vancouver
Shaughnessy Hospital, Vancouver
Royal Columbian Hospital, New Westminster
Royal Jubilee Hospital, Victoria
St. Joseph's Hospital, Victoria
Veterans Hospital, Victoria

In the case of *foreign graduates* it is recommended that their qualifications be submitted to the Registrar for inspection prior to their appointment as an Interne. The Registrar may only issue an Interim Certificate to a graduate of a medical school approved by the Council of the College of Physicians and Surgeons of B.C.

D. *ENABLING CERTIFICATES.*

The Medical Council of Canada requires an Enabling Certificate from all applicants who wish to take their examinations. This certificate may be obtained from the licensing body of any Canadian province, provided that the applicant fulfils the requirements of the province concerned.

In order to be granted an Enabling Certificate from the College of Physicians and Surgeons of B.C., the applicant must complete the prescribed form and fulfil the following requirements;

1. An applicant must be a graduate of a medical school approved by the Council of the College of Physicians and Surgeons of British Columbia.
2. An applicant must be able to read, write and speak the English language.
3. An applicant shall be required to make a personal appearance before the Committee on Registration and produce original documents regarding his qualifications.
4. The applicant shall present a certificate of having completed twelve months interneship in a hospital approved by Council.
5. Applications must be submitted to the Registrar of the College of Physicians and Surgeons of B.C. not later than ninety days prior to the date of examination of the Medical Council of Canada.

General Information—If there is any doubt as to the experience and qualifications of the applicant, he may be required to take an examination in basic sciences.

Particulars regarding the examination of the Medical Council of Canada may be obtained from—

The Registrar,
Medical Council of Canada,
150 Metcalfe Street,
Ottawa, Ontario.

Fee applicable for an Enabling Certificate.

Any person who,

1. In the opinion of the Council has been for a period of not less than five years a *bona fide* resident of British Columbia; or

2. Has taken his pre-medical course in the University of British Columbia; shall be granted an Enabling Certificate for Five Dollars ($5.00). For all other applicants the fee shall be Twenty-five Dollars ($25.00).

Inquiries and requests for application forms should be addressed to:

The Registrar,
College of Physicians and Surgeons of B.C.,
1807 West Tenth Avenue,
Vancouver 9, B.C.

CANADIAN MEDICAL ASSOCIATION—B. C. DIVISION

October, 1951 — September, 1952

OFFICERS

President	Dr. H. A. L. Mooney, Courtenay, B.C.
President-Elect	Dr. J. A. Ganshorn, Vancouver, B.C.
Vice-President	Dr. R. G. Large, Prince Rupert, B.C.
Honorary Secretary-Treasurer	Dr. W. R. Brewster, New Westminster, B.C.
Chairman, General Assembly	Dr. F. A. Turnbull, Vancouver, B.C.

STANDING COMMITTEES	CHAIRMEN
Constitution and By-Laws	Dr. R. A. Stanley, Vancouver, B.C.
Finance	Dr. W. R. Brewster, New Westminster, B.C.
Legislation	Dr. J. C. Thomas, Vancouver, B.C.
Medical Economics	Dr. R. A. Palmer, Vancouver, B.C.
Medical Education	Dr. G. O. Matthews, Vancouver, B.C.
Nominations	Dr. H. A. L. Mooney, Courtenay, B.C.
Programme and Arrangements	Dr. R. C. Newby, Victoria, B.C.
Public Health	Dr. G. F. Kincade, Vancouver, B.C.

SPECIAL COMMITTEES	CHAIRMEN
Arthritis and Rheumatism	Dr. A. W. Bagnall, Vancouver, B.C.
Cancer	Dr. A. M. Evans, Vancouver, B.C.
Civil Defence	Dr. L. H. A. R. Huggard, Vancouver, B.C.
Emergent Epidemics	Dr. G. F. Amyot, Victoria, B.C.
Hospital Service	Dr. J. C. Moscovich, Vancouver, B.C.
Industrial Medicine	Dr. E. W. Boak, Victoria, B.C.
Maternal Welfare	Dr. A. M. Agnew, Vancouver, B.C.
Membership	Dr. L. H. Leeson, Vancouver, B.C.
Pharmacy	Dr. D. M. Whitelaw, Vancouver, B.C.

Those who read the following articles may be struck by the fact that the subject matter is mostly devoted to the activities of a local medical association. A word of explanation may therefore be in order. It will be apparent that the affairs of regional societies are not the concern of the B.C. Division as a rule. The Vancouver Medical Association is, however, to a certain degree an exception, in that some of its most important activities very definitely affect the profession in this Province as a whole. When we recall that this Association has served the Profession in British Columbia for about half a century, through its Library, its Summer School and its Bulletin, and that "The Bulletin" has become the official organ of the B.C. Division, it will be obvious that its future is the concern of every doctor in British Columbia. For this reason we have had the temerity to discuss its affairs in the following paragraphs.

When the B.C. Division began to conduct the business of the Profession, space was allotted in "The Bulletin" for the presentation of its activities. In effect, this publication became the official organ of the B.C. Division and it is hoped that this portion of the journal may be greatly improved and expanded. In the mean time, the editor of this section would welcome questions, comments, suggestions and criticisms from members of the C.M.A.—B.C. Division. In this way the "Cloakroom" discussions may be the means of bringing enlightment and enjoyment to the entire Profession.

—G.C.J.

THE DOCTOR AND THE MEDICAL SOCIETIES

Don't worry, this is not going to be a learned treatise, but just a few thoughts that come to mind in considering this subject.

Medical men have always felt the need of an association where they could get together, and discuss their mutual problems. For example, in 1898, the doctors of Vancouver appreciated this, and so was formed the Vancouver Medical Association. This society has had quite a saga, and as the wants of the doctors expanded, it responded with the formation of a library, which is one of the best medical libraries to be found; a publication for the dissemination of medical and other news to all the doctors in the province; a forum for discussion of medical, economic and any other problems that might arise; a benevolent fund, now merged with the provincial fund under the council of the college; a most effective public relations committee, who get results, though perhaps not always in the way some of the doctors might have thought best; the annual Summer School, a very excellent refresher course open to everyone in B.C.; regular monthly business and clinical meetings. These are but a few of the achievements of the Vancouver Medical Association.

Gradually, there arose a need for a province wide organization, so the British Columbia Medical Association came into being. This has recently been revitalized and reorganized as the B.C. Division of the C.M.A. As you know, the Council of the College of Physicians and Surgeons has handed over to this body all functions, except those specifically the property of the council. So, the economic affairs of the profession in B.C. are under the guidance of this group. With the modern trends in affairs, including the growing tendency for governments to intervene in our lives, this has become a most important organization to which we must all give our support, for the effectiveness of the society in dealing with any other group is in direct proportion to the number of doctors belonging.

To return tothe V.M.A., though some of its functions may have been taken over by other groups, it is now becoming even more important than ever. It retains its value in the clinical field, but even more necessary are the business meetings. For while it is important that we all belong to the provincial association, yet, owing to size and geography, it is obviously impossible to have too frequent meetings of the entire organization, or even the smaller Assembly, and we must leave the management of our affairs to the elected representatives in the executive. However, the monthly business meetings of the V.M.A. give us all an opportunity to bring up any subject on which we feel some discussion will be of benefit. And one can be certain that any important points raised there will rapidly find the ear of the provincial executive. This is the best method of communication to that executive, and is of great help to them, in that they are most anxious to have our views on various problems which arise, so by belonging to and attending regularly at the meetings of the V.M.A., one is in a position to have some say on what goes on. Don't do your crabbing in the doctor's room at the hospital, but bring it out into the open at these meetings, and let some action be considered to improve those things to which you object.

So, the reluctant conclusion to which I am forced is, that in one's own selfish interests it is wise to belong to both the V.M.A. and the B.C. Division of the C.M.A.

—F. L. SKINNER.

The Library

The Vancouver Medical Association Library had its beginning at a meeting held in October, 1902. At that time Dr. Brydone-Jack gave a notice of motion as follows: "That this Association form a medical club, for the purpose of renting a suitable room, furnishing the same, and providing medical periodicals for the use of its members; also starting a Medical Library and Reading Room."

The library had a small beginning and the first amount of money collected for the start of the library was two hundred and fifty dollars. It was not, however, until March of 1906 that the Library actually had a home of its own, and this was in a house at the corner of Hastings and Granville streets, where a suitable room was found to house the library at a rental of twelve dollars a month. From this very modest beginning, the Library gradually grew and extended its activities until at the present time we have the library housed in the Academy of Medicine Building on the corner of Burrard and Tenth avenue.

Between 1906 and 1952 the library has had many financial struggles but it has gradually grown until at the present time we have about eleven thousand volumes. In addition to this, the medical and surgical journals received are one hundred and sixty-seven. The more important ones of these are well bound. There is a good section on the history of medicine together with the section on medical biographies, etc. The librarian and her assistant perform many functions and bibliographies are prepared upon request. Any references that the Doctors may desire or any other information are looked up and given as soon as possible to the inquirer.

The library maintains a messenger service for members living in the city and books are mailed to members in and out of the city, postage being paid both ways by the library. There is a microfilm service and photostats are requested for those articles not in the library and there is an inter-library loan service for books not in the library.

During the winter months the library is open until 9:30 p.m. from Monday to Friday for the benefit of those people who are not able to go to the library during the day time.

In our present library there are two good reading rooms and five study rooms together with a dark room for reading microfilms available for all members.

The librarian and her assistant are always on hand to give personal service to any members who visit the library.

During the past several years medical libraries have been started in the various hospitals in the city; namely at St. Paul's Hospital, The Vancouver General Hospital and at the Shaughnessy Military Hospital. Libraries within the hospital are maintained by the hospitals themselves and they are to serve the members of the hospital staff. The predominant library in B.C. is that of the Vancouver Medical Association which is available to all members and associate members. The Committee in charge of the library are very active and they endeavour with the money allotted to them to give the most valuable service possible.

On going over the history of our library, I find that from a small beginning in 1902, until its present status, that the finances required to bring it to this size have always been provided by the members of this association. The library is supported entirely by the funds collected as dues from the Vancouver Medical Association and this library has always been in the past a major educational influence with the Association. To allow anything to interfere with the development and progress of the library would directly detract from the value of the Vancouver Medical Association.

The library is an essential part of any strong medical association, and the members of the profession in Vancouver will wish to maintain the present standards and high degree of usefulness, for with the increasing perplexities of medicine, it is more necessary than ever to have a proper place for reference. The library has in the past served Vancouver medical men well, and it will continue to do so in the future.

—W.J.D.

A SPECIAL LETTER—REPRINTED

July 15th, 1952.

Nineteen hundred and nineteen people who journeyed to the Banff Springs Hotel and the Chateau Lake Louise during the week of June 9th, 1952, made the Eighty-third Annual Meeting of the Canadian Medical Association one of the most notable in its history.

With superb setting, a well-balanced programme and a kindly disposed weatherman, the Convention just had to be a success.

But there were other happenings, too, which, in retrospect, make this meeting not only memorable but something which should give every member a sense of pride and satisfaction.

Your General Council, with one hundred and ten delegates present from the ten Divisions, came to grips with the medical problems of Canada in a statesmanlike manner.

We all know—perhaps some of us vaguely—that such things as medical economics, public relations, hospital accreditation, voluntary plans for medical care, undergraduate and postgraduate medical education, national and international obligations—are of much concern to Canadian doctors.

We also know that Canadian citizens, including politicians, are, in increasing numbers, taking more than a casual interest in what we have been pleased to call "our business". We cannot, and should not, ignore these facts. And your General Council, with full appreciation of its obligations to every one of our nine thousand members, determined that all of the problems which face us must be met intelligently and effectively.

We have an excellent Journal which reflects the best efforts of Canadian doctors, but with constantly rising costs we find that the Journal will cost $125,000 to produce in the coming year.

The hospitals of Canada require inspection and accreditation. A Joint Commission of the Canadian Medical Association, the Canadian Hospital Council and the Royal College of Physicians and Surgeons of Canada is being set up to help every hospital in Canada to improve its standards and usefulness. There is every likelihood that this will cost the C.M.A. between $15,000 and $20,000 next year.

One year ago your Association founded the Trans-Canada Medical Services—a Federation of the Voluntary Prepaid Medical Care plans sponsored by our Divisions. The movement was commended in the House of Commons by the Prime Minister of Canada. Our hope is that this may prove to be the answer to National Health Insurance. Our contribution to the effort is $8,000 for this coming year—a small price to pay for a very worthy purpose.

Medical economics, the study of our economic and social welfare, will cost us $10,000 next year. And there is every possibility of this sum being considerably increased.

The truth of the matter is that new projects demanding more staff, and increased costs of our many activities call for a budget in the coming year of $75,000 more than our present revenue from members' fees and advertising would produce.

What is the answer? Your General Council, without a dissenting vote (there were a few abstentions), decided that our annual fee would have to be increased to $20.00, effective January 1st, 1953.

Our present fee of $10.00 a year is exactly what it was in 1922—thirty-two years ago. A look at National Medical Association fees around the world discloses that they have in most instances increased 100 per cent or more in the last few years.

But your General Council didn't increase the fee because we were out of date or out of line—not at all. Your General Council, after long and careful debate, decided that the fee simply had to be increased if the Association is to do the job which every member expects it to do. And we must not fail.

Your General Council is confident that you and all other members will recognize that the Canadian Medical Association is the voice of Canadian Medicine. The Association belongs to you and you to it. We send you this letter now in order that you may be fully informed of the vital necessity of increasing the Association's revenue. We hope that, when your Provincial Division a few months hence, approaches you for annual dues for 1953, we will have your contained support.

Yours sincerely,

Harold Orr, President — Edward S. Mills, Honorary Treasurer

Norman H. Gosse, Chairman of General Council

T. C. Routley, General Secretary

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CANADIAN MEDICAL ASSOCIATION—B. C. DIVISION
1952—CONVENTION
EMPRESS HOTEL, VICTORIA, SEPTEMBER 15-18 Inclusive

SUNDAY **September 14**	**10:00 a.m.**	Board of Director.
MONDAY **September 15**	**8:00 a.m.**	Nominating Committee. Louise Private Dining Room.
	8:30	REGISTRATION—Hotel Lobby.
	9:00	General Assembly—BALLROOM.
	10:30	Official Opening of Medical Exhibits.
	11:00	General Assembly reconvenes till noon.
	2:00 p.m.	General Assembly reconvenes for the whole afternoon.
	8:00	Meetings of Sections.
TUESDAY **September 16**	**8:30 a.m.**	REGISTRATION.
	9:30	College of Physicians and Surgeons—Annual Meeting.
	12:00 noon	Annual Luncheon—Crystal Gardens. Guest Speaker: Dr. Harold Orr, President, C.M.A.
	2:30 p.m.	Surgical Round Table Conference. "Emergency Surgery of the Newborn." Chairman: Dr. J. Stenstrom. Moderator: Dr. Rocke Robertson. Members: Dr. H. Richard, Dr. A. H. Bill Jr., Dr. J. R. Neilson.
	8:00	ANNUAL GENERAL MEETING— C.M.A.—B.C. Division.
WEDNESDAY **September 17**	**8:45 a.m.**	REGISTRATION.
	9:00 a.m.	Clinical Session. Chairman—Dr. R. Burns.
	9:00	"Carbon Tetrachloride poisoning. A health hazard of fire extinguishers." Dr. K. Hamilton—Edmonton.

	9:30	"Irreducible Intussusception in infants." Dr. H. Richard—Edmonton.
	10:00	"Treatment of inguinal and umbilical herniae in infants and children." Dr. A. H. Bill, Jr.—Seattle.
	10:30	INTERMISSION.
	10:50	"Systematic Lupus Erythematosus." Dr. H. Orr—Edmonton.
	11:30	"Medical Economics." Dr. R. W. Richardson—Winnipeg. Chairman—C.M.A. Economics Committee.
	1:00 p.m.	Golf—Victoria Golf Club.
	8:00	Supper Dance—Crystal Gardens.
THURSDAY	8:45 a.m.	REGISTRATION.
September 18	9:00	Clinical Session. Chairman—Dr. M. Mitchell.
	9:00	"The Traumatised Hand." Dr. H. Richard—Edmonton.
	9:30	"Depressive Reactions in W.C.B. Settings." Dr. K. Hamilton—Edmonton.
	10:00	"Management of Obstruction of the Intestinal Tract in Infants and Children." Dr. A. H. Bill, Jr.—Seattle.
	10:30	INTERMISSION.
	11:00	"Congenital Abnormalities of the Rectum and Anus." Dr. A. H. Bill, Jr.—Seattle.
	12:00 noon	New Board of Directors—Luncheon. Private Dining Room—Empress Hotel.
	2:30 p.m.	Medical Round Table Conference. "Care of the Aging." Chairman: Dr. S. G. Kenning. Moderator: Dr. R. B. Kerr. Members: Dr. R. A. Hunter, Dr. K. A. Hamilton, Dr. M. M. Baird, Dr. B. M. Fahrni.
	6:30	Cocktails—Lower Lounge.
	7:30	ANNUAL DINNER—Ballroom. Guest Speaker—Mr. S. Keate.

CANADIAN MEDICAL ASSOCIATION—B.C. DIVISION
ELECTION RESULTS

District	Principal Delegates	Vice-Delegates	Members Nominating Committee	Alternates
No. 1 Victoria	Gavin Chisholm, Victoria Eric W. Boak, Victoria	J. Elison Dalton, Victoria Raymond C. Newby, Victoria	Fred H. Bonnell, Victoria Donald A. Hewitt, Victoria Gordon H. Grant, Victoria	T. F. Rose, Victoria John U. Coleman, Duncan
No. 2 Nanaimo	Carmen C. Browne, Nanaimo	G. B. Helem, Port Alberni	Norman H. Jones, Port Alberni Alan B. Hall, Nanaimo	
No. 3 Vancouver	*A. W. Bagnall, Vancouver *F. A. Turnbull, Vancouver *F. P. Patterson, Vancouver *P. O. Lehmann, Vancouver *Completing 2nd year. †G. C. Johnston, Vancouver †Ross Robertson, Vancouver †R. A. Gilchrist †J. Ross Davidson, Vancouver †R. A. Palmer, Vancouver †Elected for 2-year term	R. A. Stanley, Vancouver W. H. Sutherland, Vancouver A. S. McConkey, Vancouver G. H. Francis, Vancouver Keith MacLean, Vancouver Leslie R. Williams, Vancouver George Elliot, Vancouver D. W. Moffatt, Vancouver G. A. McLaughlin, N. Vancouver	J. H. Black, Vancouver E. C. McCoy, Vancouver W. E. Austin, Vancouver Boyd Story, Vancouver E. B. Trowbridge, Vancouver D. M. King, Vancouver	G. L. Watson, Vancouver A. W. Wallace, Vancouver
No. 4 Prince Rupert	R. G. Large, Prince Rupert	L. M. Greene, Prince Rupert	L. W. Kergin, Prince Rupert W. S. Kergin, Prince Rupert	J. G. McKenzie, Prince George Gordon M. Fierheller, Prince George
No. 5 New Westminster	J. A. Sinclair, New Westminster (completing 2nd year) W. R. Brewster, New Westminster (elected for 2-year term)	R. W. Patton, Chilliwack C. A. Cawker, New Westminster	J. R. Ireland, New Westminster D. G. B. Mathias, New Westminster	
No. 6 Yale Kootenay	A. S. Underhill, Kelowna C. J. M. Willoughby, Kamloops J. McMurchy, Nelson	F. L. Wilson, Trail	H. F. P. Grafton, Kamloops A. F. McRoberts, Kelowna J. V. Murray, Creston	
No. 7	(All Completing 2nd Year)			

*These elected officers serve for the year 1952-53 and take office following the Annual Meeting September 16, 1952.