THE BULLETIN

OF

The Vancouver Medical Association

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VOLUME XXVIII. SEPTEMBER, 1952 NUMBER 12

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*Literature and references on request

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VANCOUVER MEDICAL ASSOCIATION
PROGRAMME FOR THE FIFTY-THIRD ANNUAL SESSION

Founded 1898; Incorporated 1906

The Regular Monthly Meetings of the Vancouver Medical Association are discontinued for the summer months, but will be resumed in October.

VANCOUVER GENERAL HOSPITAL

Regular Weekly Fixtures in the Lecture Hall

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

SHAUGHNESSY HOSPITAL

Regular Weekly Fixtures

Tuesday, 8:30 a.m.—Dermatology.
Wednesday, 10:45 a.m.—General Medicine.
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

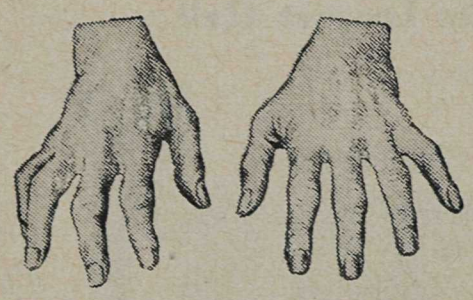
Monday—9 a.m. - 10 a.m.—Ear, Nose and Throat Clinic
Tuesday—9 a.m. - 10 a.m.—Weekly Clinical Meeting of Attending Medical Staff
Tuesday—10:30 a.m. - 11:30 a.m.—Lymphoma Clinic
Daily—11:45 a.m. - 12:15 p.m.—Therapy Conference

B.C. SURGICAL SOCIETY

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

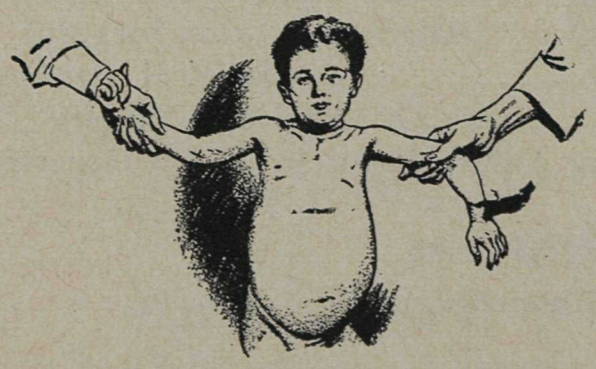
NEW *5-mg. Tablets of* Cortone*

For accurate adjustment of Maintenance Dosage and for therapy in conditions responding to Low Dosage



RHEUMATOID ARTHRITIS

ADDISON'S DISEASE



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FOLLOWING BILATERAL ADRENALECTOMY

Advantages of 5-mg. Tablets

FLEXIBILITY—

Used alone or in conjunction with the 25-mg. tablets, the new 5-mg. tablets afford greater flexibility in adjusting dosage to the individual patient's requirements. Fluctuations in the natural course of rheumatoid arthritis may be better controlled.

ACCURACY—

Permit more accurate establishment of minimum maintenance doses, thus controlling symptoms more closely and further minimizing the incidence of undesirable physiologic effects.

ECONOMY—

Prevent waste of CORTONE by more exact correlation between requirement and dosage.

Literature on Request

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ACETATE

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Part of a series on its everyday uses

Wyeth

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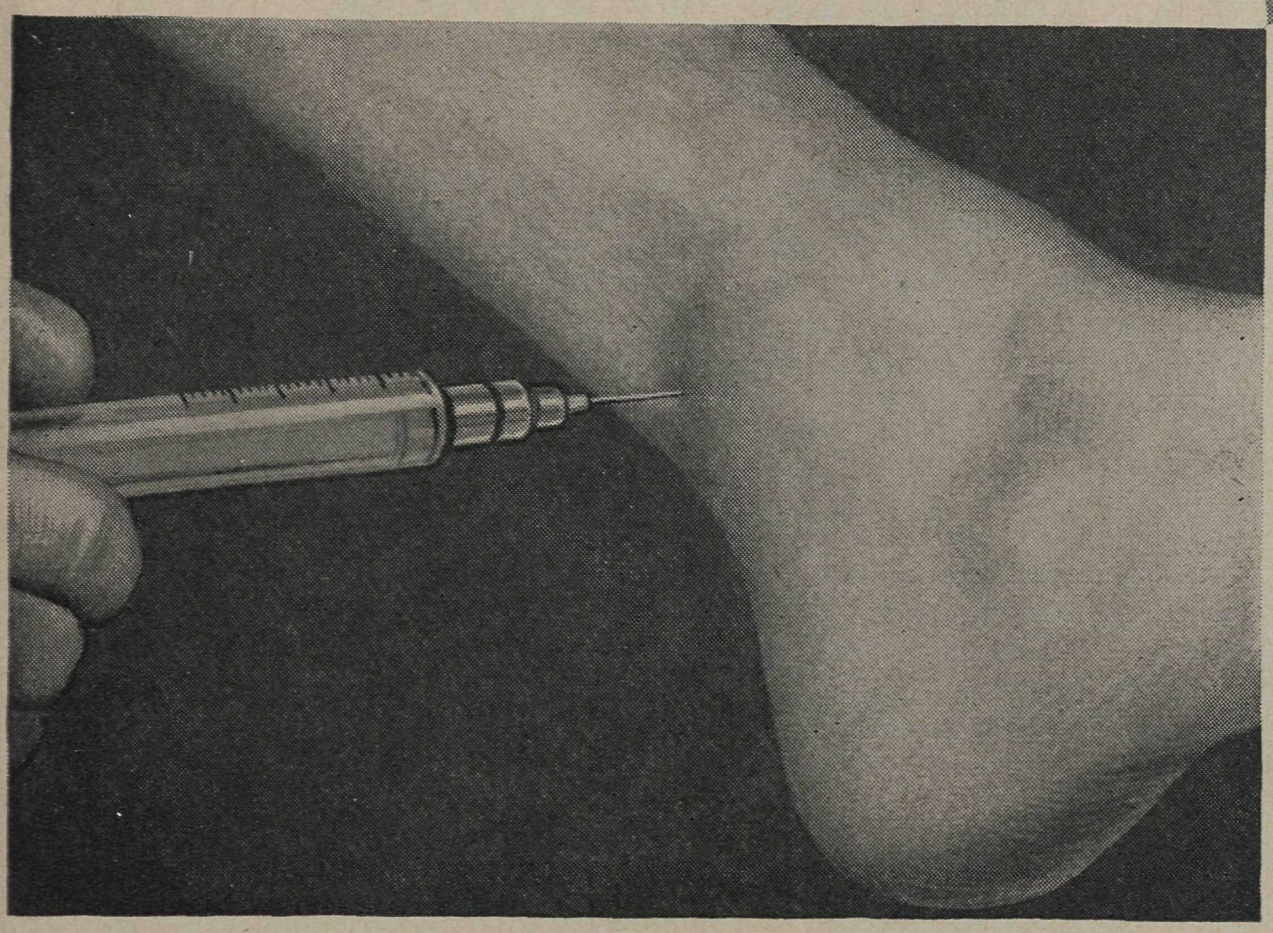

Treatment of Sprains

In the treatment of simple ankle sprains, Wydase added to procaine

1. facilitates adequate diffusion of anesthetic.
2. reduces the number of injections required and
3. promotes rapid absorption of edema fluid and blood from the site of injury.

Application of an elastic bandage maintains local pressure. Swelling subsides rapidly and early function is thus encouraged.[1]

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"The Spreading Factor" facilitates absorption of injected fluid . . . large clyses or small volumes of anesthetic or therapeutic solutions.

1 Britton, R. and Habif, D. V.: To be published.

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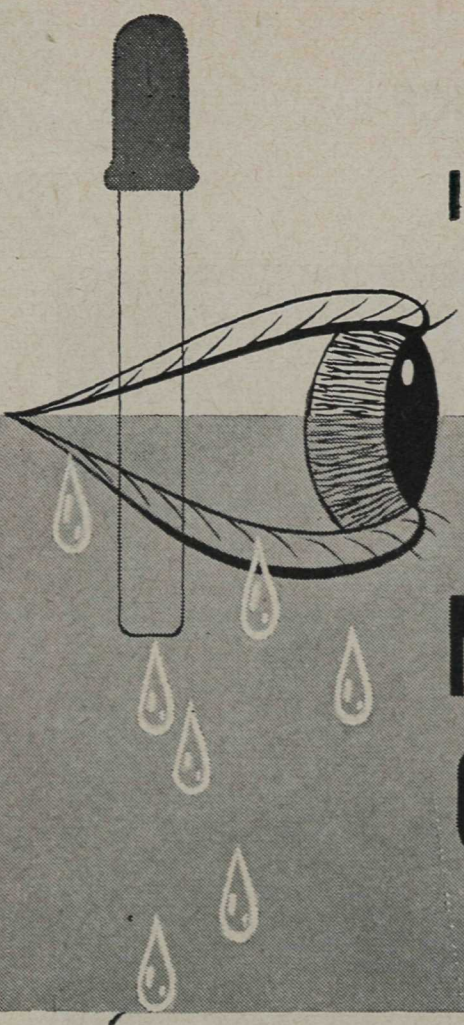

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OPHTHALMIC 1/8%

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Neo-Synephrine hydrochloride Ophthalmic 1/8% solution is available in 14.8 cc. (½ fl. oz.) bottles.

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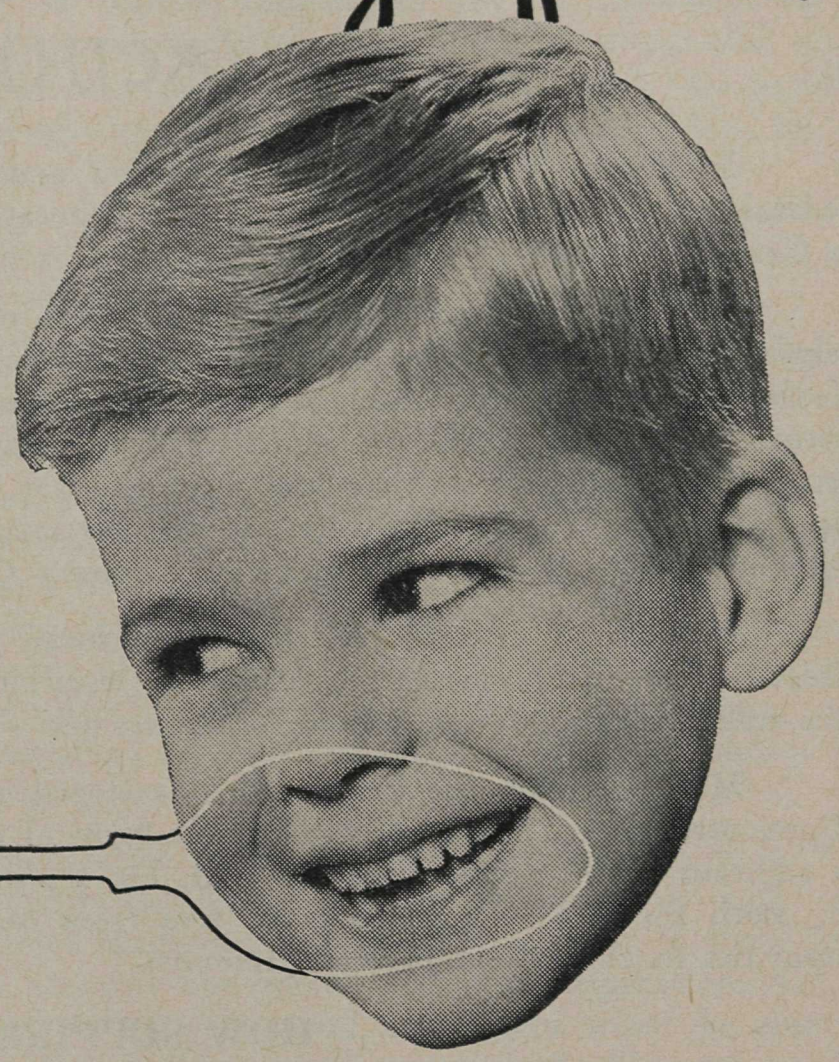
with its *natural orange flavor*

PUTS A *SMILE* IN

THE VITAMIN SPOON



The eager way that Mulcin® is taken, even by finicky children, solves one of the most common problems in prophylactic vitamin supplementation.

Already accustomed to the refreshing flavor of orange juice, children and adolescents welcome Mulcin as a daily "treat." The yellow color of this vitamin emulsion is appetizing too. And there is no unpleasant aroma or after-taste to detract from acceptability.

Mulcin's smooth, non-sticky texture makes it easy to pour. For infants, it mixes readily with formula, fruit juice or water. Clear and light, Mulcin does not separate on standing or shaking. It's stable at room temperatures.

Superior in every way . . . Mulcin is truly an achievement in pharmaceutical elegance.

EACH TEASPOON SUPPLIES:

Vitamin A	3000 units
Vitamin D	1000 units
Thiamine	1.0 mg.
Riboflavin	1.2 mg.
Niacinamide	8.0 mg.
Ascorbic acid	50 mg.

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CONNAUGHT

CORTICOTROPHIN
(ACTH)

In December 1949, at the invitation and with the financial support of the Federal and Provincial Governments, the Laboratories undertook to produce ACTH in Canada.

Specially collected pituitary glands were obtained across Canada through the helpful co-operation of the Canadian meat-packing industry. The facilities and staff of the Laboratories were applied to the development of methods of production and testing of ACTH, with the result that a product was prepared which met with favourable acceptance. Under the arrangements in effect during the initial period, supplies of ACTH were delivered to the National Research Council of Canada for distribution for research purposes by its Advisory Committee on ACTH and Cortisone.

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.

HOW SUPPLIED

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

Amounts of ACTH have been expressed in terms of International Units, Provisional U.S.P. Units, and milligrams (of an original house-standard). These various units represent equal amounts of activity as assayed in rats by the ascorbic acid depletion method.

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The Editor's Page

We have just been attending the Annual Meeting of the B.C. Division of the Canadian Medical Association in Victoria, and have been thinking about this whole question of Medical Associations, and why one should belong to them. One so often hears men complaining of the multiplicity of dues that are required of him by the various medical organizations which exist—and there do seem to be quite a few. The Canadian Medical, the B.C. Division of the C.M.A., the College of Physicians & Surgeons, and if one lives in Vancouver or Victoria, the fees set by the local Associations, looking at it casually, one is apt to feel that the calls on one's pocket never end.

Well, in this world we cannot escape paying for what we want. There are two questions that we must ask: what are we getting for what we pay—and how much does it cost?

If a man in Vancouver joins all these organisations, (and he must, of course, pay his College fees, if he wants to practice medicine), it will cost him about a hundred and fifteen dollars a year—next year a little less. That is less than ten dollars a month, considerably less than he pays for insurance on his car. Yet this money that he pays, most of it, is insurance on his means of livelihood. Compared with the sums that members of trade unions are called upon to pay, with strike assessments thrown in, it is very little, and no medical practitioner, we feel, can honestly complain that it is a serious drain on his pocketbook.

Take the Canadian Medical Association, which has recently been forced to raise its fee to $20 annually. (This includes the Journal.) Can anyone of us doubt that it would be a terrific blow to Canadian Medicine, and to each one of us, if the C.M.A. were to go out of existence? It is probably our greatest safeguard against the dangers that threaten Canadian medicine. It is our recognised mouthpiece when we come to deal with governments in Canada and abroad—it represents us, and represents us well, in the United Nations Organisation. Through the years of its existence, it has steadily grown in influence and power—and stands ready to fight for our rights and privileges as a profession. It has been responsible for the Royal College of Physicians and Surgeons of Canada—it has fought our battle (and this battle is by no means yet won) against ill-advised legislation, against uncontrolled immigration by unqualified medical graduates from other lands—it is organising the Trans-Canada Medical Organisation—it has assisted the general practitioner in organising—and more and more, year by year, its work has become an absolute necessity to every medical man in Canada. Its Journal is one of the best in the world, and has steadily grown in value. Everyone of us benefits by all this—every one of us should pay his share. Not only can we easily afford membership in the C.M.A.—but we cannot afford *not* to belong to this organisation. It provides us with *insurance*—it is helping to insure our very means of livelihood—and at twenty dollars a year it is very cheap insurance.

Then the B.C. Division of the C.M.A. Every medical man who attended this meeting must have been astounded and filled with pride, as we were, as he heard the reports given by the various Committees, notably the Economics Committee. Consider what this B.C. Division has already done, in less than a year of work. It has worked out a new Schedule of Fees, which has lifted the income of each one of us, till out of gratitude for this alone we should be glad to pay the paltry thirty dollars that membership costs. Their contacts with the Government over S.A.M.S. fees, and with the Workmen's Compensation Board, again mean a considerable increase in income for us. Their new Public Relations Committee is a most forward-looking piece of work. What sort of thinking is it that will accept all this, and make no acknowledgment? And

remember, this body, which has now practically reached the thousand mark in membership, is now our official spokesman, and what it does will govern our doings.

We dare not stay out of it. We have no voice in its deliberations, no influence on its actions, unless we are members. Some may say "One voice more or less is of no importance." That, of course, is wrong. Any voice is of importance, and if the speaker has something to say of value, never doubt he will be gladly heard and listened to. But quite apart from that, we frankly cannot see how all these hours of hard work (and one has only to listen to their reports to see what a stupendous job they have done) and take it all, benefit by it, and give nothing in return, do nothing to help.

And our local Associations, especially the Vancouver Medical Association, and the Victoria Medical Society. What do these give us? Perhaps, from an economic point of view, very little—though it is a fact that many men find that the libraries save them many dollars a year in books and journals which are readily available by this means, and which they would have to buy if they had not access to the libraries.

But these Associations have other functions, of untold value—they provide a means of scientific study and education, through the Library, with its study rooms, its huge supply of journals, through the Summer School, through business meetings, and so on. They provide a liaison between the provincial body and the large local groups of medical men, that is of great value to the latter, and so to everyone in the province. And finally, through its many years of existence the Vancouver Medical Association particularly, has contributed immensely to the unity of the profession.

More than mere mechanical union for defensive purposes, we need unity as a profession. We need to meet each other, to understand each other's problems, to work together. Only so can we grow in the fullest sense of the word. And this contact, this intercourse with each other, can not be obtained through economic conferences only. They can only be obtained through such organisations as the local Associations. The Library is, of course, the greatest single element in this achievement of unity—but meetings of the Association also provide, at frequent intervals, opportunities for contact that otherwise cannot be had. We must keep these societies strong, and active, and vocal.

Altogether, we think, ten dollars a month is not very much to pay for all this. We cannot afford not to pay it.

So much more could be said on this subject, but this is already overlong. But one thing is sure, the medical profession needs unity and strength as it never did before—and strength can only be bought by complete unity—by every member, not only a devoted few, doing his share. Some of us get off with just paying fees—others give uncounted hours of their time and energy, They give it gladly and ungrudgingly, but we must hold up their hands. And really, it costs very little!

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LIBRARY NOTES

Monday to Friday ..... 9:00 a.m. - 1:00 p.m.
Saturday ..... 9:00 a.m. - 1:00 p.m.

Library Hours beginning October 1st, 1952:

Monday to Friday ..... 9:00 a.m. - 9:30 p.m.
Saturday ..... 9:00 a.m. - 1:00 p.m.

Recent Accessions:

American Medical Association, Council on Pharmacy and Chemistry—New and Non-official Remedies, 1952.

Friedman, S. M., Visual Anatomy: Head and Neck, 1956

Grace, W. J., Wolf, S. and Wolff, H. G., The Human Colon, 1951.

Higgins, T. T., Williams, D. I. and Nash, D. F. E., Urology of Childhood, 1951.

Fletcher, E. T. D., Medical Disorders of the Locomotor System including the Rheumatic Diseases, 2nd edition, 1951.

Hewitt, R. M. (editor)—Collected Papers of the Mayo Clinic and Mayo Foundation, vol. 43, 1951.

Medical Research Council—The Estimation of Hæmoglobin, 1952.

Tidy, H. and Short, A. R. (editors)—The Medical Annual, 1952.

Surgical Clinics of North America—Symposium on Orthopedic Surgery and Neurosurgery, Lahey Clinic Number, June, 1952.

Veillon, E. (editor)—Medical Dictionary—English - French - German, 1950.

Wood, P., Diseases of the Heart and Circulation, 1950.

The following is a letter of thanks and appreciation sent by the Library Committee to Dr. H. A. McKechnie for his recent gift to the Library:

June 3rd, 1952.

Dr. H. A. McKechnie,
1541 West 29th Avenue,
Vancouver 9, B.C.

Dear Doctor McKechnie:

Your gift of two volumes to the Library—Angina Pectoris and Allied States by William Osler, 1897, and On Palsy and Apoplexy by J. Copland, 1850, were gratefully accepted at a recent meeting of the Library Committee. May I, on behalf of the Committee, thank you for your kindness and generosity in presenting these books.

Yours sincerely,
D. W. Moffatt, M.D.,
Secretary, Library Committee.

THE PACIFIC NORTHWEST BIBLIOGRAPHIC CENTRE

When members require books and periodicals not in the Vancouver Medical Association Library, every effort is made to obtain them either on loan or on microfilm, and one particularly good source for loans is the Pacific Northwest Bibliographic Centre housed in the University of Washington Library at Seattle. The Centre lists the holdings of some thirty-seven libraries in the Pacific Northwest including British Columbia, also the contents of the Library of Congress in Washington, D.C., and the John Crerar Library in Chicago, so members can see the vast resources that are available to them through this one channel. The Bibliographic Centre was established by the Pacific Northwest Library Association in 1940 and since that date the centre has grown and co-ordinates the library resources of the region in such a way as to increase the use of the collections for the furtherance of research and study.

BRITISH COLUMBIA CANCER INSTITUTE

TENTATIVE PROGRAMME FOR

REFRESHER COURSE — MALIGNANT DISEASE

OCTOBER 6-10, 1952

MONDAY, OCTOBER 6

Morning Session:

8:30 A.M. Registration.
9:00 A.M. Introduction by Dr. H. Rocke Robertson.
Chairman: Dr. A. M. Evans—Cancer of the Breast.
9:15 A.M. 1. Surgical Management—Sir Stanford Cade.
10:00 A.M. 2. The Role of Radiotherapy—Professor B. W. Windeyer.
10:45 A.M. 3. The Role of Hormones—Dr. L. G. Ellison.
11:15 A.M. 4. Discussion Period.
12:15 P.M. Surgical Ward Rounds, Vancouver General Hospital.

Afternoon Session:

Chairman: Dr. F. P. Patterson.
The Treatment of Bone Tumours.
2:00 P.M. Sir Stanford Cade.
2:30 P.M. Professor B. W. Windeyer.
3:00 P.M. Dr. Franz Buschke.
3:30 P.M. The Treatment of Cancer of the Lip—Dr. A. M. Evans.
4:00 P.M. The Treatment of Cancer of the Skin—Dr. S. T. Cantril.

Evening Session:

Chairman: Dr. G. F. Strong
8:15 P.M. Official Opening Ceremonies in the Ballroom, Hotel Vancouver.
The Rt. Hon. Paul Martin, Minister of National Health & Welfare.

TUESDAY, OCTOBER 7

Morning Session:

Chairman: Dr. A. Taylor Henry.
9:00 A.M. Clinical Meeting. Presentation of new cases of malignant diseases.
10:15 A.M. The Treatment of Cancer of the Tongue by Radiotherapy and by Surgery.
Sir Stanford Cade.
11:00 A.M. The Treatment of Cancer of the Maxillary Antrum.
Professor B. W. Windeyer.
11:30 A.M. Demonstration of Treated Cases—Lip, Tongue, Tonsil, Skin and Breast.

Afternoon Session:

Chairman: Dr. A. B. Nash.
2:00 P.M. The Treatment of Cancer of the Cerxix Uteri—Dr. S. T. Cantril.
2:45 P.M. British Columbia Cancer Institute results—Dr. Margaret Hardie.
3:00 P.M. The Treatment of Cancer of the Ovary.
1. Surgery—Dr. J. E. Harrison.
2. Radiotherapy—Dr. A. M. Evans.
3:40 P.M. The Treatment of Cancer of the Corpus Uteri—Dr. Ethlyn Trapp.

Evening Session:

Vancouver Medical Association.
9:00 P.M. "The Changes in the Treatment of Cancer"—Sir Stanford Cade.

WEDNESDAY, OCTOBER 8

Morning Session:

9:00 A.M. Clinico-Pathological Conference at Vancouver General Hospital.
Chairman: Dr. J. Balfour.
10:15 A.M. The Treatment of Cancer of the Bladder—Professor B. W. Windeyer.
11:00 A.M. The Treatment of Cancer of the Kidney—Dr. R. D. Nash.
11:30 A.M. Recent Advances in Surgery—Sir Stanford Cade.

Afternoon Session:

Chairman: Dr. R. B. Kerr.
The Management of the Lymphomas.
2:00 P.M. Professor B. W. Windeyer.
2:45 P.M. "Experience in the Treatment by Chemotherapy of One Hundred Cases of Leukaemia and Allied Diseases"—Dr. O. H. Warwick.
3:15 P.M. The Practice at the Britsih Columbia Cancer Institute.
Dr. D. M. Whitelaw, Dr. R. G. Moffat.
4:00 P.M. Discussion Period—Dr. Franz Buschke, Dr. H. H. Perry, Dr. H. K. Fidler.

THURSDAY, OCTOBER 9

Morning Session:

Chairman: Dr. H. Rocke Robertson.
9:00 A.M. The Role of Radiotherapy in the Treatment of Tumours of the Brain and Spinal Cord—Professor B. W. Windeyer.
9:45 A.M. The Treatment of Pain in Malignant Disease—Dr. Frank Turnbull.
10:30 A.M. Surgery and Radiotherapy in the Treatment of Cancer of the Oesophagus.
Dr. Franz Buschke.

Afternoon Session:

2:00 P.M. Conferring of Honorary Degrees at the University of British Columbia.
Sir Stanford Cade—Professor B. W. Windeyer.
4:00 P.M. Open House at the British Columbia Cancer Institute.
Tea by the Women's Auxiliary.

FRIDAY, OCTOBER 10

Morning Session:

Chairman: Dr. E. E. Day.
9:00 A.M. "Diagnosis, Choice of Method of Treatment and Surgery in Cancer of the Larynx"—Sir Stanford Cade.
9:45 A.M. "The Radiotherapeutic Treatment of Cancer of the Larynx".
Professor B. W. Windeyer.
10:30 A.M. The Treatment of Cancer of the Nasopharynx—Dr. S. T. Cantril.
11:15 A.M. The Spread of Tumours—Dr. William Boyd.

Afternoon Session:

Chairman: Dr. William Boyd.
2:00 P.M. "The Role of the Physicist in the Treatment of Cancer".
Dr. H. M. Parker.
2:30 P.M. The Use of Radioactive Isotopes—Dr. E. T. Feldsted.
3:00 P.M. Cobalt 60 Beam Therapy—Dr. H. F. Batho.
3:30 P.M. Clinical Experience in the Use of Radioactive Isotopes.
Dr. B. V. Low-Beer.
4:00 P.M. Diagnostic Uses of Radioactive Iodine—Dr. H. W. McIntosh.

THE LIFE AND WORK OF SIR JAMES MACKENZIE

By D. M. BAILLIE, M.D.

I feel it particularly fitting at this juncture in Canadian medical history to bring before you the life and achievements of the man whose memory we are honouring to-night. We have watched with a good deal of misgivings the rise of the specialists in the last fifty and especially in the last twenty years, until they include among their numbers a considerable proportion of the men and women who are actively engaged, in one form or another, in the practice of Medicine.

In this very City the number of men who specialize, and I include in this group the Radiologists, Pathologists and Public Health men, comprise at least 65% of all men and women actively engaged in medical work.

Quite recently the profession in Canada has realized this top heaviness and unnecessary disproportion, and I am glad to say that there is now a definite swing in the direction of general practice. There has been and still is a "Great Debate" going on in the profession about this problem and, no doubt, like many other difficulties, it will be resolved in time. It is a problem which exercised very much the mind of the man about whom I am going to talk to you to-night.

We are fortunate in having at our disposal a very remarkable biography of this man by a disciple and co-worker, Dr. R. MacNair Wilson. This biography is considered by those who should know, to be one of the finest in our literature. For purposes of this address I shall draw very freely upon it.

Sir James Mackenzie was born just 99 years ago in the farm of Pictonshill, Perthshire, just a stone's throw from the famous village of Scone, the legitimate home of the famous "Stone of Destiny." His parents were of old Perthshire farming stock, by no means well off, decent, God-fearing people in the Scotch tradition.

He went to the village school and later, at the age of 12, to the famous old Academy in Perth, a few miles from his home. Here he did not do too well and, so far as his school work was concerned, was rather unhappy. In later years he was heard to say—"The things that I remember most clearly about my school education were that I was considered a dunce at most of my classes, and that the subjects in which I did well were those in which my understanding, rather than my memory, was called into play."

He got tired of school and left at the age of 15 at his own request and with the reluctantly given consent of his father. Attracted one night by the play of colours that filtered through the large red, yellow and green jars that adorned the windows of a chemist's shop in Perth, he suddenly and quite impulsively made up his mind to be a chemist—synonymous in Scotland with druggist—and that he would enter that shop as an assistant. And so it was: he became the chemist's apprentice, on a four year contract—remuneration five pounds per annum. It was not long before disillusionment set in; he found he had exchanged the drudgery of school for the drurgery of the druggist's shop and the long hours—12 daily, 15 on Saturdays. He became very depressed, suffered from a sense of failure and wished he could be free. With the encouragement of his parents and especially of his mother, who must have been an admirable character, he finally made up his mind to see the job through to the end. He applied himself to the work and succeeded so well that at the end of his apprenticeship his employer offered him a partnership in the business, the largest and most lucrative in Perth, on the easiest of terms.

In the meantime he developed a taste for literature and in his spare time read extensively. He literally "devoured" the works of Scott, Thackery, Tyndall, Darwin, Huxley, Dickens and others. He even wrote a novel and collaborated in a play, both which are gone without trace.

All this undoubtedly must have stimulated his imagination and increased his self confidence, and it is not surprising that towards the end of his apprenticeship and no

doubt with the encouragement of the local doctors, he should have made up his mind to take up the profession of Medicine. However, he wanted to make sure and after he finished at Perth he worked as a druggist in Glasgow for one year before going to Edinburgh University at the relatively advanced age (for Scotland) of 21 years, to begin his medical studies. He must have been 4 to 5 years older than the majority of the men of his "year" and lived the frugal existance of most Scottish students; oatmeal porridge being an important article of diet.

In the early years he made heavy weather—finding it difficult to know how to study and having an indifferent memory. He applied himself with diligence and by working hard managed to obtain passes in his prescribed subjects. In the latter part of his medical course, however, the clinical years, he found his feet, forged ahead and in the final year actually won three medals. Even this success did not unduly elate him, or fill him with any idea that the was more than a rather inferior kind of student. It was hard for him to forget the humiliation and disappointment of the Perth Academy days. Years later, with this experience in mind he wrote—"There are two very distinct qualities of the human mind: memory and the power of reasoning. The earliest to be developed is that of memorizing, and this can be cultivated with great ease. The power of reasoning is quite different although, no doubt, memory plays a part. When we look at a great number of students, we discover that this power of memory is greatly developed in a few, and that all our educational methods are devoted to its cultivation. Examinations are specially contrived for the purpose of discriminating those with the best memories, and to them all the honours and prizes are given.

"The individuals, who, on the contrary, possess more of the power of reasoning than their fellows, receive no consideration. There are minds which have a difficulty in remembering isolated facts, but, if these facts are related in some consecutive manner, they can not only remember them, but also appreciate their bearing on one another. This type of mind is slow in acquiring knowledge, and in our present-day methods of education less and less encouragement is given to this type of student. His peculiar powers are never developed and their presence is never suspected."

The recognition that he himself was one of those people endowed with this particular type of mind was his first, and perhaps the most important if his discoveries, for it set the whole course of his future, and enabled him to garner a rich harvest of achievement.

He graduated in 1878, at a time when Pasteur and Lister were beginning to revolutionize the thinking and practice of the medical world and opening up new vistas and horizons for aspiring young men. The call was not for him for he felt that the height of his ambition was the lot of most of his fellows—namely general practice. Urged by the insistent persuasion of a friend, Dr. John Brown, he applied for a Resident post at the Edinburgh Royal Infirmary and to his surprise got the appointment. A year later, in 1879, he was invited to take up an Assistant-ship in Burnley—an industrial and coal mining town in North East Lancashire, with the firm of Dr. Wm. Briggs and Dr. John Brown. He accepted and settled down to work in a practice which had been founded some 80 years previously by Dr. Howarth. It was a practice of what we would call a mixed type—working people preponderating but it included the business people of the city and the gentry of the surrounding district—in fact a typical cross section of society.

Mackenzie was quick to find, as we all have done, that there is a world of difference between the "learning" of Medicine and its practice. He was surprised to find that the great majority of the complaints brought to him, day by day, were quite beyond his diagnostic powers. Especially so was this from the point of view of prognosis. Questions crowded in upon him, such as—"How long is this trouble going to last?" "Is this going to prevent me working?" "What are the chances of my boy's recovery?"—and so on. To most of these he had no answer and this trobuled and worried him immensely. He turned to his lecture notes, his textbooks and even to the thick tomes of a

Medical Encyclopædia, which he bought, but all in vain, for this knowledge, apparently, was not available. He discovered later, in consultation with other men, that they, too, were experiencing the same difficulties. Unlike these others, however, he could not accept and put up with these deficiencies with equanimity. They worried him as he went about his daily work—and he made up his mind to do something about it.

From the material point of view he was obviously doing well, for a year after he started he was offered and accepted a third share of this lucrative practice. This made him work and think all the harder. He kept copious case notes with the idea of following up these conditions to see how they developed. As he stated later—"The only way to find out what a symptom betokened was to wait and see what happened to the person with that symptom." As a matter of fact we all, sooner or later, adopt this procedure, which eventuates in what we call "accumulated experience." It is the clinical sense which so many of he older men possess that enables them to make a diagnosis by a glance at a patient's face or by the wistful look in a woman's eyes.

"About 1883 or 1884" Mackenzie wrote—"I resolved to begin a series of careful observations entirely for my own improvement, never dreaming of research, for I was under the prevalent belief that medical research could only be undertaken in a laboratory, or, at least, in a hospital with all the appurtenances. I merely sought to find out something about the nature of my patient's complaints. I had recognized that when the patient had some physical sign, and when disease had made considerable ravages in the body, a moderately accurate diagnosis could be made; but in the vast majority of my patients there was no physical sign, or, if there was a physical sign, I was not sure of its relationship to the patient's ill-health. The ill-health was chiefly recognized because of the patient's consciousness that he was not well, and this was made known to him by his own sensations. Sometimes these sensations were accompanied by phenomena of a certain kind, such as increased pulse-rate, a rise in temperature or a slight pallor—I put to myself the question—'What is the mechanism by which these symptoms and signs are produced?' and to my astonishment I found that nowhere in literature could be found a satisfactory explanation of the mechanism of a single one of them."

"So I set before myself the task of finding out the nature of the symptoms and signs which I met in the course of my practice. I had thus placed before me two definite objects, at which to aim:

(1) Understanding of the mechanism of symptoms, and

(2) Understanding of their prognostic significance.

When at this date, forty years after, I look back upon my work, I can recognize that it was this simple resolution and these definite aims which guided me to such success as I have achieved . . . . I may point out that the necessity for such an investigation, with these aims, could only be found by one who had, in his daily work, found the need of them."

It is seldom, if ever, that a doctor goes through life without meeting some soul-shattering experience. Mackenzie was no exception. Early in his Burnley career he was attending a young woman in her first confinement and everything seemed to be going on quite normally. He had just assured the husband and attending relatives to this effect when to his dismay and consternation the patient suddenly collapsed and died with her babe unborn. We can all appreciate what his feelings were in this extremity, but the incident had an important bearing upon his future career because it determined the particular line of work to be followed. While doing the usual day by day work of a general practitioner—doing most of his own surgery and all of his obstetrics, he particularly devoted detailed study to Circulatory Diseases, a course which culminated in his becoming, in the later years, the leading authority in Heart Diseases of his time.

He had to start almost from scratch. The available knowledge of heart conditions and their prognosis was pitifully inadequate. The whole emphasis in teaching was on heart murmurs and pulse irregularities. These, according to authoritative teaching

in the early eighties of last century were evidences of heart disease. Rheumatic Fever was very common in England at that time, treatment was most unsatisfactory and the number of subsequent damaged hearts was legion. Information regarding the management of pregnancy complicated by post-rheumatic heart conditions was sketchy and unhelpful. Mackenzie soon realized that if he had to have this information he would have to find it out himself in daily experience over a term of years. This involved a careful annotation and following-up of cases. In this way he accumulated thousands of case histories, over the years.

About this time he started using a Dudgeon's Sphygmograph to take tracings of the radial pulse on smoked paper. He had noticed that there were different types of pulse irregularities and that pulse irregularity was common in pregnancy and in children. These irregularities were regarded by Authority as signs of ill omen, but Mackenzie noticed that many patients with irregular pulses were obviously in good health. How could he differentiate the good from the bad. The pulse tracings were confusing and baffling and he spent many hours in what spare time he had, pondering over them, but they did not seem to get him anywhere. He then turned his attention to the pulsation in the veins of the neck. In his student dyas he had been told that this phenomenon was simply a "back wash" from the heart, but he felt that, perhaps, some information could be gleaned here. After many difficulties he re-invented a modified form of Mary's Tambour to obtain tracings of this pulsation and later combined this apparatus with the Dudgeon Sphygmograph to produce a most convenient and ingenious instrument to obtain synchronous tracings of the apex beat, neck veins and radial pulsations. This became known as the Mackenzie Ink Polygraph and enabled him to demonstrate new and very important discoveries in cardiac function and pathology.

In the midst of all this he fell in love and soon thereafter married. The lady was Miss Frances Jackson and the marriage took place at Haslemere on September 13th, 1887. Mackenzie at that time must have been a most attractive man. He was 34 years of age, and as his biographer says—"A splendid looking man, tall, broad-shouldered, with massive brows and the clear, masterful features of physical and mental strength. Courage radiated from his eyes, and not courage only; humour and kindness also, and a native gentleness of disposition which was in keeping with his robust vigour. This man was incapable of being "small" even to the extent of being petulent; but he was exquisitely simple, as simple as a child.

Such men are made or marred by the women they marry. Mackenzie was most fortunate. Theirs was a long and very happy married life and she was ever a source of encouragement and help to him in his work.

His practice by this time had become exceedingly heavy and onerous but he never lost sight of his quest. In what spare time he had he mulled over the "Mysteries of the Waves" in his tracings. In the early days of 1890 he suddenly thought of trying his polygraph on a case of pulse irregularity to see if he could get any information as to what the different chambers of the heart were doing. To his astonishment and delight the tracings showed a transposition of the auricular and ventricular waves. The ventricles had prematurely contracted while the auricles maintained their normal rhythm as plainly shown on the tracing. For the first time in history he had demonstrated that the chambers of the human heart might fail to keep step with one another: that they might beat out of their correct and proper order.

"I can remember," wrote Mackezie, thirty years later, "the excitement which filled me when I fully appeciated this discovery . To-day, of course, the idea of getting excited about the discovery of an extra-systole will seem absurd: but it must be borne in mind that, at that time, no one had the remotest idea of how this commonplace form of irregularity was produced. To the investigator, no delight is equal to that which comes when nature's curtain is drawn aside for a moment, however brief that moment might be."

What was equally important was that reviewing his notes on those cases of extra systole irregularity for the preceding six years, he found that they were all alive and

well—many of them doing strenuous work. He could, therefore, conclude that this form of heart irregularity did not appear to be of serious account over a comparatively prolonged period of time.

His next achievement was the demonstration and elucidation of Sinus Arrhythmia—or what he called the "Youthful Type of Irregularity" and his conclusion that it was an innocuous type of symptom or physical sign.

He had, however, the utmost difficulty in getting the significance of these discoveries over to the medical profession. His articles were not accepted by the well known medical journals of that time—he was only a general practitioner and who was he to tilt against the big authorities in London and other teaching centres?

Sinus arrhythmia and extra systole have been and are commonplace terms, are daily used in our work, and accepted as part of the knowledge of the medical profession. We must remember, however, that at the time of Mackenzie's discoveries, thousands, nay hundreds of thousands, of adults and children were being subjected to anxiety and lives of invalidism by our profession, because they had irregular hearts and were therefore suspect. Mackenzie's first case, when he started practice in London was a girl with Sinus Arryhthmia, who had been undergoing Nauheim Treatment. Very soon afterwards a boy was brought to see him with the same type of irregularity. This lad had been forbidden to play games—had had three months in bed. Thereafter his parents had taken him to a celebrated Continental Clinic—where he had been treated for months, with no improvement. The boy was next taken to a well known Continental specialist and given hypodermic injections. Finally his parents were told that the disease was incurable—that the boy should not play games or undertake strenuous activities.

It took Mackenzie 15 to 20 years and the compilation of thousands of case histories to establish the true facts of these heart irregularity conditions, but all this enabled him to talk with an authority that could not be refuted.

These studies led him on to the consideration of another kind of irregularity—which at the time he called the "Dangerous Type"—which we now know as Auricular Fibrillation. He had followed the course of a woman whom he had first seen in 1880—soon after he had started practice. She had Rheumatic Fever and was then thirty-one years of age; she had a previous attack nine years previously. At the time he saw her she had a well marked mitral stenotic murmur. She had a relapse three years later and again the following year in 1884. She was kept under observation for another fourteen years until in 1898 she suddenly developed what he had expected—the so-called "Dangerous Type of Irregularity." She displayed a rapid and very irregular pulse—but to his surprise the presystolic murmur of the mitral stenosis had disappeared. Repeated polygraph tracings all showed the same thing—an absence of the "A" or auricular waves and very irregular ventricular waves. So auricular waves—no presystolic murmur: the only conclusion—the auricles had ceased to beat. So he reasoned and called the condition Paralysis of the Auricles—later to be known as Auricular Fibrillation, although Mackenzie, himself, still later, resumed the former terminology.

He went still further and rationalized for the first time the use in this condition of Digitalis, a drug previously given in a very haphazard way, He, also, showed that there were two kinds of Auricular Paralysis or Fibrillation—the one associated with heart failure, the other without heart failure. He showed that cases of the latter were associated with a pulse of normal or nearly normal rate and could continue at work for years, while the former were likely to die within a short time of heart exhaustion.

He, also, at this time, pointed out that the first and most important evidence of heart failure was respiratory distress, and pain in response to an effort that otherwise should be normal—a symptom we now know as "Effort Syndrone." He apparently was the first to correlate the presence or absence of this symptom with the physical findings, and so was enabled to assess the pathological significance of cardiac murmurs present. In other words he maintained that the true test of heart efficiency was the amount or work or effort it was able to produce without distress. He was able to

demonstrate that many presystolic and other murmurs were without serious significance and that the usually prescribed restrictions were not necessary. This principle was another notable advance in cardiological knowledge, because it made for a more exact and valuable prognosis—particularly so in cases of pregnancy. This contribution alone is probably his most valuable gift to medical science.

By this time Mackenzie was about 45 years of age, and had acquired considerable recognition in Lancashire and the North of England as a very able clinician; and was doing a great deal of consultative work in the surrounding district—as well as his general practice. Otherwise, to all intents and purposes all this valuable work and knowledge were unknown. Years afterwards he said to McNair Wilson, "There are three stages in the history of every medical discovery. When it is first announced, people say it is not true. Then, a little later, when its truth has been borne in on them,, so that it can no longer be denied, they say it is not important. After that, if its importance becomes sufficiently obvious they say that anyhow it is not 'new'." He added, after a moment—"All my early papers and writings were refused by the leading medical journals. Years passed before I could even obtain a hearing." All this is of course, not unusual. Lister had the same trouble to put up with in getting his ideas accepted by the profession in England.

Baffled by this resistance, Mackenzie, at the age of 49, published his first book in 1902—"The Study of the Pulse" which contained reproductions of over 300 carefully analysed tracings that he had made in cases in private practice. These consisted of records of the arterial, venous and hepatic pulses and many cardiograms. The book was almost a complete "flop" in England but created some interest abroad—particularly in Germany, so much so that visitors from abroad started to come to Burnley to interview him about his work. There is a story to the effect that at a meeting of the British Medical Association in the South of England, four medical men from Germany presented themselves and said they had come to meet and talk with Dr. Mackenzie of Burnley. They were informed there was no such person. "But we have read and studied his book." The answer—"We have never heard of him." The foreign visitors at once left the Conference and betook themselves to Burnley.

It is interesting to note that one of the first to recognize Mackenzie's work was Dr. William Osler, who in 1905 visited and conferred with him at Burnley. In 1906 Mackenzie attended the Toronto meeting of the Canadian Medical Association and read two papers—a notable distinction. But progress in England was dreadfully slow, and finally he decided to give up his work in Burnley and move to London.

The move was accomplished in December, 1907, and he and his family settled down at 17 Bentinck Street. He was far from being well off and had saved very little money. There were no influential friends to back him up. But he felt very strongly that this was the only way to get his message across. His first year must have been a grim one: patients were few and far between and his income in that time was only £114. However, his leisure enabled him to get on with the preparation of his great work "Diseases of the Heart," published the following year in 1908. This book burst like a bomb-shell in medical circles—had a phenomenal sale for a book of this kind, so that a second edition had to be published the following year. It revolutionized and rationalized the diagnosis, prognosis and treatment of heart diseases throughout the world and was of immediate practical value especially to the general practitioner. The subject matter and its presentation were so overwhelmingly convincing that contradiction and rebuttal were alike, useless and inadequate. One can quite fairly say that this book firmly laid the foundations of modern cardiology.

Mackenzie became famous almost overnight. Honours and the friendship of many of the leaders of the profession were showered upon him. He was accepted after examination as a member of the Royal College of Physicians and elected a Fellow of the Royal Society. He was given opportunities for teaching—as head of a specially created

heart department at the London Hospital and as physician to the Mount Vernon Hospital for Chest Diseases. Soon thereafter he was given a knighthood by the King.

The material benefits, also, crowded in upon him. Through the good offices of Dr. Frederick Price he acquired consulting rooms in Harley Street, where he conducted a large and lucrative consultant practice, and for the next ten years he was one of the busiest men in London.

But his battle to get his ideas and teaching across was not yet won. He soon realized that his chief claim to fame in the eyes of his confreres was that he was the inventor of a machine—his polygraph—a so-called symbol of scientific medicine, and that the main theme of his teaching about heart function and prognosis was being overlooked. He found, too, that Harley Street was not the place to advocate he theory that the best instrument for medical research was the general pracitioner.

In one of his lectures at this time he pointed out that there are four stages in disease—"the predisposing stage, the early stage, the advanced stage and the final stage," and remarked "that the history of medicine showed that disease could best be studied by starting at the end and working backwards." "It can be said," he declared facetiously, "that ample provision has been made for the study of disease after it has killed its victim." He continued "If the conditions which predispose to or provoke disease are to be recognized, the investigator must have the opportunity for seeing the circumstances which led up to the invasion of the disease. It is manifest that neither the laboratory worker nor the hospital physician, who are the persons mainly concerned with research, have this opportunity. The early stages of disease, are, as a rule, insidious and are indicated mainly by subjective sensations. The patient, becoming conscious that there is something amiss with him, does not as a rule, seek help from the hospital physician, but from his family doctor. The bulk of patients in the early stage of disease are never seen by those who are systematically engaged in its investigation." He further suggested that the most experienced physicians should conduct their teaching and investigations in the Out-Patient Departments of the hospitals where patients could be seen in the earliest stages of disease. On another occasion he said to McNair Wilson—"I have no quarrel with Harley Street except that it is Harley Street. It is concerned so much with those who are stricken to death, so little with those who have just begun to be ill, that as a rule there is nothing to foresee. Thus the vital and tremendous importance of the power to foresee is overlooked." The enunciation of ideas like these did not serve to make him very popular with his contemporaries. Some of them must have thought he was mentally unbalanced. He devoted a good deal of his teaching time to the younger men and soon had an active group of disciples around him—one of the most notable being John Parkinson.

About this time the Electrocardiagraph appeared in England and was enthusiastically taken up. Its findings confirmed many of Mackenzie's observations, but he never became very dependent upon this instrument as he claimed it tended, so often, to confuse and complicate conclusions that should otherwise be basically simple to arrive at. In this connection McNair Wilson narrates an amusing incident — when a distinguished American doctor asked him to introduce him to "the Great Mackenzie." This devoted admirer talked to him about the electrocardiograph and the meaning of the waves produced by it. He spoke a good deal about the "Q" wave and then, finally, demanded of his silent and unresponsive auditor: "What line of research would you advise me to take up when I return home?" Mackenzie's reply came in accents of some weariness: "I would advise you to go into general practice and stay there for ten years." The American doctor controlled himself with an effort. "Do you mean that, Sir James Mackenzie?" he asked incredulously. "Absolutely." "But why?" "Why? Because it is only in general practice that a man can learn how to foresee danger to his patient and how to prevent it." That doctor left Harley Street in utter bewilderment and he was not the only one thus to suffer. The idea of commending general practice as a

medium of experience and research was not by any means acceptable advice to the young aspiring physicians in London at that time.

The Great War of 1914-1918 threw a further strain upon Mackenzie's time and activities. At that time when hundreds of thousands of men and women were joining the Services there was a great deal of confusion in the medical assessment of heart conditions. Perfectly fit people were being rejected because of heart murmurs while others, who were unfit were being acceptd. For practical purposes, as the older men will remember, there were two basis heart conditions acknowledged. V.D.H. (Vulvular Heart Disease) and D.A.H. (Disorderly Action of the Heart). The latter, as we now know, was not a heart condition at all, but Neuro Circulatory Asthenia. The confusion became so bad that it amounted to a national scandal. The Government was forced to take action and appointed a Special Committee including Mackenzie, Lewis and others, to investigate and report. Later a special hospital was established at Hampstead for the study of these cases.

During these London years Mackenzie contributed many articles to the Medical Journals and also published a number of very important books. The most practical perhaps was "Principals of Diagnosis and Treatment in Heart Affections." It is a smallish book, full of medical wisdom, and I would recommend it, even although it is nearly 35 years since it was published, as a necessary book for the young practitioner. Another book was "Symptoms and Their Interpretation"—a review of his work on pain and the nervious phenomena which accompany it. This covered the results of a study of over 20 years and pointed out its importance in the diagnosis of many diseased conditions, especially in the early stages.

Yet another book was "The Future of Medicine"—published in 1919, in which he criticized the methods of medical education at that time—especially as it applied to those students who were going to be general practitioners. He pointed out the redundancy of attention paid to unimportant details to the detriment of the basic essentials, to the emphasis laid upon mechanical aids to diagnosis at the expense of training in the fundamental clinical procedures. Can we deny that the same strictures apply even to-day? He particularly emphasized the importance of training students in the art of interrogation of patients, explaining its importance and its difficulties. He was, also, concerned about the rapid growth in the number of specialists and the preponderance of their influence on medical education. He felt that they were not the right people for training the future general practitioner.

His remarks on this subject are worth quoting. "There should be in every school of medicine one or more teachers who have been in general practice for 10 to 20 years. Indeed, it would be well if a young man were encouraged to enter general practice with the expectation that if he proved himself fit he should be qualified to become a teacher, and have the opportunity in a well equipped hospital of solving the problems he has had to face in his practice. . . . He would see every phase of the more common diseases and have to practise every branch of medicine. In saying that he would have to practise branches of medicine which are generally considered so important that it is necessary for men to spend their whole time at that special work, I am but stating what actualy happens in practice, and the majority of patients have to be satisfied with the general practitioner's knowledge. And after all it is not very difficult for the general practitioner to become fairly efficient in these special branches. Many general practitioners are very efficient obstetricians and surgeons and it is easy to acquire a very practical knowledge of eye, ear and throat diseases. If it was recognized that the posts of physicians to teaching hospitals, and consulting practice, were open to men who would train themselves in the field of general practice, a greater incentive would be given to general practitioners to utilize their opportunities. No teacher of medicine should be appointed until he had demonstarted that he had abundance of experience, and the ability to advance medicine, so that a qualification for a teacher would be from 10 to 20 years' practice of his profession, in actual contact with patients. This length of

time is absolutely necessary for a man to acquire, not only the power of detecting the manifestations of disease, but of assessing their value, for it is evident that no one can attain this latter power unless he has himself followed individual cases a sufficient length of time."

All this, of course, is very interesting in view of the discussion going on in Canada to-day about the status and educational needs of the general practitioner, and it looks as if we, at last, are swinging round to Mackenzie's view. I feel, too, that much would be gained if individual practitioners could slough off some of their robust individualism and combine into small partnership groups. This would enable them to have some much needed rest and leisure time for study and recreation and prevent them getting Coronaries at an untimely age. Also, it would afford them opportunities for brief and informal consultations with their immediate colleagues in the course of the daily work.

Two other books I will briefly mention. "Angina Pectoris" and the "Basis of Vital Activity"—the latter published a few days before his death in January, 1925: in reality a review of his work at St. Andrews. For towards the end of 1918, the urge to get back to research work became clamorous and to everyone's surprise he decided to give up his very lucrative practice in London and go to an environment suited to this purpose. He wanted to have the opportunity of associating himself with some general practitioners in some small, semi-isolated town in which many cases could be followed "from the cradle to the grave" their ailments studied and careful records kept, especially of their early symptoms. He chase St. Andrews on the coast of Scotland, as a place with a relatively static population, which was in close association with its medical school at Dundee. Some say that an important factor in his decision was the presence of the famous golf course, for he was an inveterate golfer.

So at the age of 65 and towards the end of 1918 he quietly took his departure from Harley Street and a practice yielding him some £8000 per annum and settled down at St. Andrews. He called upon the doctors there, explained his plans and asked for their help and co-operation. He became consulting physician to the St. Andrews Cottage Hospital and later in 1919 bought, largely at his own expense, what was later to be the St. Andrews Institute of Clinical Research—a large house fitted with consulting rooms, Laboratory and X-Ray equipment. Here, in collaboration with the local doctors he worked for several years trying to assess the value of early symptoms, their mode of production and their significance. Some important discoveries were made which are discussed in this previously mentioned book.

Soon after he arrived in St. Andrews he became aware that he was a victim of Angina Pectoris. This gradually increased in severity through the years, but he would not allow it to interfere with his medical activities. Finally, however, the walls closed in upon him until in August, 1924, he was compelled to slow up and accept a life of invalidism. In this environment he completed the revision of his big book "Diseases of the Heart" and finished the "Basis of Vital Activity"—despite the miseries of anginal pain. Finally and mercifully he died in his sleep of coronary occlusion in the evening hours of January 25th, 1925.

What lessons can we learn from the life of this remarkable man? There are several which I would like to suggest:

(1) A return to an attitude of greater simplicity in our approach to our daily work among our patients. Medicine has become such an exceedingly complicated business—with a legion of serological, bacteriological and radiological tests and techniques that the fundamental and all important perceptive and reasoning faculties tend to be pushed into the background. I do not wish to decry the great advances and benefits that have come to mankind from biochemistry, bacteriology and radiology, but I sometimes feel that we have come to depend too heavily upon them. All these very important "Aids to Diagnosis" considerably increase the cost of medical care and there is a limit to the tolerance of the public in this respect. There is no finer diagnostic

instrument than a well trained and experienced brain which has at its command well developed faculties of perception.

(2) Increased emphasis upon the humanitarian side of Medicine. The urge towards so-called "Scientific Medicine" may have the tendency to make us forget the human personality in cases where kindness, cheerfulness and thoughtfulness can do far more than any therapy or surgical procedures we can do for them. Mackenzie was loved by his patients—for his skill, yes, but certainly much more for these other qualities.

(3) The need for a receptive and enquiring attitude to our daily work. The opportunities for Medical Research especially in the field of general practice are still with us and should not be overlooked—especially by the younger men.

(4) The ever pressing need for early diagnosis, particularly to cite one example, in the field of Mental Diseases. If we could only more readily recognize and act upon the early signs of nervous and mental breakdown what a sum of misery and unhappiness we could save our patients and their families.

In conclusion I can not do better than present an eloquent memorial tribute to this great man than appeared in the British Medical Journal from the pen of Sir Thomas Lewis:

"It was in 1908 and shortly after he migrated to London from his old home and practice at Burnley that I first came to know Mackenzie personally. While it was never my privilege to work under his supervision, yet he extended to me, though many years his junior, a friendship that soon became intimate and highly prized. I found in him during these years, before the War, when we were in almost daily and personal communication, a man whole-heartedly devoted to the search for the knowledge of disease, and eager, most eager to impart his spirit and conceptions. He was an exceptionally vigorous and strong personality, intolerant of statements founded on tradition, trenchant and acute in criticism, rich in personal experience, combative in argument, but open nevertheless to conviction on all questions without reserve. He saw, as few or none of his day saw, where clinical knowledge ends and ignorance begins, and never hesitated to define the limits of his knowledge: and he was the first authority in clinical medicine on whose lips I frequently heard the words—"I don't know." To him diagnosis, the affixing of a temporary label, gave little satisfaction: his patient still contained his problem or problems. Mackenzie's mind could not rest on the known, but turned incessantly each and every hour of the day to the unknown, and in perceiving and defining the unknown he displayed a masterly power. To know Mackenzie intimately was to imbibe independency of thought: none could go to him seriously to discuss, and surviving the brusque shocks of that first interview, return without a growing inspiration and stimulus. For he possessed the gift of stimulating others in unusual degree. As a man he was hard headed and warm hearted, quick in temper and in sentiment—genial and hospitable, possessed of an invigorating, blunt humour, schooled by long experience in the sensibilities, reservations, obstinacies and frailties of patients, he was an astute and shrewd physician, who rarely failed to inspire an unlimited and merited confidence. This briefly of his practical work as I knew it; as a bedside investigator he ranks in my judgment as the first of his time; he has gone from us to hold a place in the history of British Medicine by the side of Sydenham, Graves, Addison and Bright, and he will live in memory as not the least of such men.

1. "The Beloved Physician", R. Macnair Wilson.

2. "Recollections and Letters of Sir James Mackenzie", J. H. Pratt. New Eng. Journal of Medicine, Jan. 2nd, 1941.

3. "Obituary", Sir Thos. Lewis. Brit. Med. Journal, Jan. 31, 1925.

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

PROGRESS IN VENEREAL DISEASE CONTROL

Few physicians these days would deny the fact that the therapeutic armamentarium has been considerably enriched since the advent of penicillin. Indeed, it is not too much to say that the treatment of acute infections due to susceptible organisms (including in this category, early infectious syphilis and acute gonococcal infection) has been revolutionized, and largely solved, since the discovery of this antibiotic.

To the private physician concerned with the care of his patient, and to the specialist venereologist charged with the public health control of venereal disease, penicillin has proven a real boon. Its known efficacy in treatment, ease of administration, safety, lack of toxicity, inexpensiveness, and in particular, its ability to rapidly clear the infectious lesions of early syphilis of virulent treponemata, have established its place in the control of venereal disease. These manifold advantages, together with the fact that the incidence of venereal disease is known to be declining at the present time, have engendered an optomistic feeling that the control of these infections is at hand.

VENEREAL DISEASE REPORTED, BRITISH COLUMBIA, 1947-1951‡

	All Syphilis		Early Syphilis		Gonorrhœa	
Year	No.	Rate*	No.	Rate*	No.	Rate*
1947	1,775	170.0	578	55.4	4,039	386.9
1948	984	90.9	252	23.3	3,617	334.3
1949	807	72.4	157	14.1	3,833	344.1
1950	572	50.3	58	5.2	3,653	321.0
1951	467	40.1	34	2.9	3,301	283.3

*per 100,000 population.

‡Source: Quarterly Statistical Reports on the Incidence of Venereal Disease in Canada, Department of National Health and Welfare, Ottawa.

From these figures it will be seen that much has been achieved in the past five years. British Columbia entered the post-war era (1947) with the highest reported syphilis rates in Canada—170.0 per 100,000 population for all syphilis reported, and 55.4 per 100,000 for early infectious (primary and secondary) syphilis. By the end of 1951, these rates had been reduced to 40.1 and 2.9 respectively, which represents a 76% reduction in rate for all syphilis and a 95% reduction in the infectious syphilis rate. It is apparent, therefore, that within a short period of five years, a particularly successful focal attack has been made upon the problem of infectious syphilis, and it is with some pride that we can say that British Columbia has now attained virtually the lowest rate for infectious syphilis amongst the provinces in Canada.

In analyzing the reasons for this spectacular decline in incidence, there can be little doubt but that it represents the accumulative achievement of a focal attack proceeding on several fronts simultaneously, thus:

(1) The advent of penicillin into the field of treatment, which has made available a drug not only curative of early syphils, but also having the ability to render infectious lesions, non-infectious, within a matter of hours.

(2) The application of the principles of epidemiology to the elicitation and follow-up of contacts known to have been exposed to infection.

(3) The recognition that gonorrhœa may be used as a signpost to indicate the potential locus of a fresh syphilitic infection, since it is known that approximately 3% of patients with gonorrhœa acquire syphilis at the same exposure; together with application of "over-treatment" methods aimed at not only curing the gonorrhœa, but also aborting the concomitantly-acquired incubation syphilis, and

(4) Effective law enforcement aimed at the suppression of third party facilitation, and particularly of prostitution—community conditions which play a large part in the spread of these infections.

While the figures for syphilis give optimism in regard to the future control of that disease, in reviewing the trend in gonnorhœa, there is less cause for satisfaction. In this Province, cases of gonorrhœa were reported in 1947 at the rate of 386.9 per 100,000 population: in 1951, the rate stood at 283.3 which represents only a 26% reduction in rate over the quinquennial period, despite the fact that the war against gonorrhœa has been pushed with equal vigour and no less effective weapons as that against syphilis.

Accepting the figures for 1951 at their face value, the rate for that year, namely, 283.3 per 100,000 represents an annual attack rate of somewhat over one-fourth of one percent, or about one in four hundred per year—a fairly high figure for a predominantly civilian population.

Further light is shed upon this problem by figures obtained from the routine examination of prisoners passing through the Vancouver City Gaol Examination Centre. For the same year, 1951, of a total of 901 females examined, 163 (or 18%) were found infected with gonorrhœa, while a further 87 (10%), were given treatment for gonorrhœa on epidemiological grounds upon the basis of being known to be promiscuous or having been named as a source of infection by another party.

So far as British Columbia is concerned, it would appear therefore, that while a successful focal attack has been made upon the problem of infectious syphilis and thereby the reservoir of latent and late syphilis can be expected to shrink in time because of the reduction in the number of new infections occurring, and will be still further reduced by present case-finding methods, gonorrhœa remains a problem of major importance requiring more intensive efforts directed towards its eradication.

In the light of the known efficacy of penicillin in the treatment of gonococcal infections, this appears a paradoxical situation. Theoretically, such efficacy should effect a reduction in the number of persons in the infectious stage of the disease. If the epidemiology of gonorrhœa follows the usual pattern, the mathematical decrease in opportunities for transmission should ensure a high rate of decline in the incidence of this disease. To date, and for reasons which are not fully understood at present, such a decline has not materialized.

The apparent failure to develop any protective response following infection, and the readiness with which a patient may be re-infected after apparent clinical and bacteriological cure, are probably factors of considerable importance in this regard.

ADMISSION X-RAY PROGRAMME IN GENERAL HOSPITALS

Beginning in 1950 a programme of chest x-ray surveys for all patients admitted to the general hospitals was adopted, and 31 hospitals have been provided with miniature x-ray equipment for this work through the National Tuberculosis Health Grant. At the present time 4 other hospitals have had these facilities installed or are in the process of being provided with them.

Figures for the first six months of 1952 show that 35.8% of hospital admissions had miniature chest x-rays. In comparison with the last six months of 1951, when 33.6% of all admissions were x-rayed, this represents a slight improvement.

As will be noted from the figures below, several hospitals achieved excellent coverage of the cases admitted, while others fell far below normal expectancy which should be about 75% of all cases admitted. Aside from the fact that chest x-ray of

hospital admissions is an excellent case-finding programme, there is the fact that in those hospitals where adequate coverage of the admissions is not being maintained, there must be a number of cases of tuberculosis undetected which constitute a hazard for the staff. A wider application of this programme could reduce the tuberculosis hazard in hospitals to a minimum.

LOCATION	HOSPITAL	Admissions Adults and	Children Number	X-Rayed Percentages
Campbell River	Lourdes	746	145	19.22
Chilliwack	Chilliwack General	1928	622	32.26
Cranbrook	St. Eugene's	1042	647	62.09
Comox (2)	St. Joseph's	469	71	15.11
Creston	Creston	439	255	58.08
Duncan	King's Daughters	1928	241	12.50
Fernie (2)	Fernie	231	23	9.95
Kamloops	Royal Inland	2564	1584	61.77
Kelowna	Kelowna	1496	91	6.08
Kimberley	MacDougall	977	385	39.40
Nanaimo	Nanaimo	1832	593	32.36
Nelson	Kootenay Lake	1653	498	30.12
New Westminster	Royal Columbian	6723	1943	28.90
New Westminster	St. Mary's	1334	770	57.72
Ocean Falls	Ocean Falls	383	106	28.09
Penticton	Penticton	1107	332	29.99
Port Alberni	West Coast General	1429	436	30.51
Powell River	Powell River	1156	547	47.31
Prince George (2)	Prince George	692	163	23.55
Prince Rupert	Prince Rupert	1784	363	20.34
Rossland	Mater Misericordiae	743	537	72.27
Trail	Trail Tadanac	2043	1327	64.95
Vancouver	Grace	1821	1615	88.68
Vancouver (North)	North Vancouver General	1558	1036	66.48
Vancouver	Mount St. Joseph's	1154	862	74.69
Vancouver (1)	Vancouver General	15886	370	2.32
Vancouver	St. Paul's	7671	6202	80.85
Vancouver	St. Vincent's	1827	971	53.14
Vernon	Vernon	1541	534	34.65
Victoria	Royal Jubilee	5528	1525	27.58
Victoria	St. Joseph's	4327	1745	40.14
	TOTAL	74032	26539	(Av) 35.84

(1) X-rays were taken in Private Ward Pavilion only for this period due to renovation of the Main Building.

(2) Figures for January, February and March (1952) only.

NOTICE

The new R.C.A.M.C. Officers' Mess at 963 West 27th Avenue has been in operation now for about three months. An invitation to an Open House in June was extended to as many ex-medical officers as could be traced through the College of Physicians and Surgeons. These records are probably incomplete and it is our wish that anyone who was not contacted at that time, and is interested in associate membership in the Mess, will not hesitate in getting in touch with us. The Mess is open Saturday evenings after 8 p.m.

C. E. ROBINSON, Major
Mess President

W. H. SUTHERLAND, Lt. Col.
O.C.

British Columbia Division
Canadian Medical Association

1807 West 10th Ave., Vancouver, B.C. Dr. G. Gordon Ferguson, Exec. Secy

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For Your Information

The Economics Committee

A regular meeting of the Committee was held on August 13th. The first important subject that came under discussion was the principle involved in payment for S.A.M.S. cases for services rendered by the Staff of organized teaching hospitals. It did not take long to recognize that not only the care of pensioners was involved but also the system of medicine as practised in these hospitals and hospital organization itself. It was decided that this problem was too large and concerned hospitals too intimately for the Committee to come to any reasonable solution in a regular session. The Economics Committee would require a special session to deal solely with this subject.

Accordingly, on September 4th the Committee along with the sub-committee on S.A.M.S., met with representatives of the Medical Staff from the Vancouver General Hospital, St. Paul's Hospital and the Children's Hospital. A very serious discussion on all aspects of S.A.M.S. work by hospital staffs took place for a full three hours. No decisions were reached at this time, but the frank discussion was fruitful and at the next meeting a policy will no doubt be formed to recommend to the Board of Directors.

* * * * *

Acting on instructions from the Board of Directors, the Executive Committee established a sub-committee for liaison with the Workmen's Compensation Board and also a sub-committee to study contract practice and doctors salaries. Dr. F. P. Patterson will chair the committee to work with the Workmen's Compensation Board and Dr. J. Ross Davidson has consented to conduct the study on contract practice and salaried doctors.

* * * * *

Another subject that occupied the Economics Committee was "Terms of Service" for physicians with M.S.A. and the conditions under which extra billing might be practiced. Medical members of the Board of M.S.A. were present by invitation to assist the Committeee. As a result of this meeting, the Terms of Service for physicians and information to M.S.A. subscribers were reviewed and recommended to the Board of Directors for approval.

* * * * *

On August 22nd the President, Dr. H. A. L. Mooney, and the Executive Secretary called on the Honourable Eric Martin, Minister of Health and Welfare, at his office in Victoria. No specific problems were discussed with the Minister, but rather the opportunity was taken to acquaint him with medical organization in the Province of British Columbia and to offer the cooperation of the Association to him. It is felt that an effective relationship can be established for the well-being of all.

* * * * *

The Executive of the Board of Directors met on Saturday, August 23rd, at 11 o'clock in the forenoon. One of the first orders of business was to receive from the Economics Committee their recommendations concerning the Terms of Service and extra billing in respect to the M.S.A. This was debated once more and the Directors ordered that the draft as considered, together with a short explanatory statement on the recommendations of the Economics Committee in respect to extra billing, be prepared and sent to all members of the General Assembly. This subject will be debated by the General Assembly in full expectation of a firm policy to follow.

* * * * *

The Benevolent Fund was considered at the last meeting of the General Assembly in May. It was decided that for several reasons it would be better for the Benevolent Fund to be administered by the Council of the College of Physicians and Surgeons. It has not been possible, however, to complete the changeover as the Fund is set up under the Constitution of the B.C.M.A. and our Constitution will have to be changed to accommodate the transfer. The Board of Directors have instructed that an extraordinary resolution be framed for consideration by the General Assembly and the Annual Meeting to make possible this transfer to the College.

* * * * *

The Association was informed that physicians were given an accounting code number when working with organizations which use I.B.M. machinery. Each physician may have a multiplicity of numbers, one for each organization. M.S.A. now keep the largest and most effective code list. Since the code number is used solely for the identification of the doctor in mechanical accounting, the Executive agreed that a single number to each doctor would make things easier for him. They have asked M.S.A. to consider enlarging their present code list to make it possible for all registered physicians to have a code account number. Thus, any other organization which uses

code numbers would be able to get a master copy from M.S.A. and each physician, we hope, will be spared the problem of keeping track of several numbers.

* * * * *

Some members of the Executive and committee chairmen had the pleasure of dining on August 19th with Dr. Malcolm Taylor, PhD., a visitor from Toronto. Dr. Taylor is on the staff of the School of Hygiene, University of Toronto, teaching business administration. He is a well-trained instructor with considerable practical experience in problems of administration of medical schemes. At the present time he is touring Canada under the auspices of the Rockefeller Foundation to study problems in the administration of prepaid medical care plans. After a pleasant dinner in the Reception Room of the Academy, the group sat comfortably and exchanged ideas on these very important problems that physicians meet in day to day practice.

* * * * *

The Committee on Public Relations sent a message to the newspapers in Vancouver offering to their editors the facilities of the Medical Association with any problem they might have when dealing with medical news. As a result of this letter, the Association office has been able to render some assistance to the newspapers on the phone. It is hoped that the newspapers will learn to seek authoritative medical opinions and advice through the Association and thus make their task of reporting medical and health affairs not only an easier one but make the results more authentic.

* * * * *

During the past ten days the Association has received no less than six phone calls and two written letters on the subject of misunderstandings concerning doctors' accounts. The majority of these misunderstandings stem from ignorance on the part of the patient as to exactly what is a schedule of fees and whether or not a consultation can be bought at a fixed sum in the same manner as a piece of furniture. In the belief that each physician will prefer to solve his problem directly with his patient, these enquiries have been redirected to the doctor in question. It is only when these preliminary attempts at solution fail that any problem will be taken to the Executive of the Board who may act in their capacity as a Mediation Committee. It is surprising, though, to find what small omissions of detail lead to these misunderstandings. Probably the most outstanding one was when a physician called a consultant without telling the patient and the patient was shocked to receive a second doctor's account. Courtesy and consideration are sound principles in business as well as ordinary personal relationships.

PRACTICAL PUBLIC RELATIONS

We sometimes hear the comment that the medical profession is a heartless, poorly principled and grasping group of people, and then, "But, of course, I don't mean my doctor. I think he is perfect." There are several reasons for this strange reaction, including the psychological one of loyalty to the individual physician of personal choice. However, some reasons are unnecessary and something can and should be done to remove them. The following letter was recently received in the Association office.

Canadian Medical Association, B.C. Division,
Vancouver, B.C.

Dear Sir:

I recently visited the specialist who has looked after my eyes for many years, ever since I first started wearing glasses, to have my eyes tested for changing my glasses. For this, which was a very short process, I received a bill for $10. Up to now it has always been less for having the eyes tested than for a first visit, which is natural, but now his fees for this have been doubled and are the same in both cases.

Upon taking the matter up with him, he said that he could not charge any less because the fees have just been raised by the Medical Association and he has to charge according to the rates set by them.

I did not know that the Medical Association could prevent a doctor from making things a little easier for a patient with small means, which also have to cover dental and other medical expenses. It means that people in my position will not be able to afford proper medical attention for their eyes and will be forced to go to opticians in future.

I am making this protest on behalf of others as well as myself who cannot afford to pay such exorbitant charges.

Yours truly,

(signed)

In this instance, the physician either does not know his relationship to the Association in respect to the schedule of fees or has deliberately evaded his personal responsibilities and directed criticism to his colleagues and away from himself. Unfortunately, the Association is entirely unaware of the situation for which it is being criticized.

What is the position of the Schedule of Fees in relation to the individual doctor and how should a doctor respond in a situation such as this?

Each individual physician is master of his own destiny and in becoming a member of the Association and taking part in all its activities surrenders no prerogatives. Through group action, a schedule of minimum fees applicable as a guide for persons of average means is decided through study and disseminated to all members. The principles are outlined in the Introduction.

The relationship between the individual physician and his Association in respect to the schedule of fees is vastly different to that which applies to a union of tradespeople. In the union the individual surrenders his personal freedom of action to the Executive Body and what comes up as a schedule of rates is a positive commitment signed on his behalf, which may not be varied and is not a guide.

Since this personal freedom is retained by the individual physician the Association fully expects that the individual physician will also recognize that any fee charged is his own for services rendered. ("This is my fee.") If the individual feels that his services are not worth the fee in the schedule and he cannot with justice charge his patient that fee, he is at perfect liberty to reduce the account, and as a responsible member of the Association should make representation through the Executive Secretary to the Tariff Committe to reconsider the fee as published in the schedule.

When does the Association actively frown on reduction from the Minimum Schedule of Fees?

Only under the circumstance when a physician enters into an agreement to render services to a group of normally employed people for a general reduction. When this is done, the principles underlying the schedule are nullified. It no longer is a question of the individual doctor in relation to the circumstances of an individual patient. Such reductions place one physician in competition for livelihood against another solely for economic reasons rather than purely professional ability, and the Association believes this is not in the interests of a good medical service to the population. When a physician is faced with a request for group reduction, it would be proper for him to present the problem to his own colleagues and have his Association assist him in any necessary solution.

The quoted letter was answered in the following manner.

August 7, 1952.

Dear - - - - - - -:

I have your letter of August 5 containing your protest in the matter of your doctor's account. Despite what your physician told you I can assure you that the

Medical Association cannot prevent a doctor from making things a little easier for one of his patients, and does not wish to attempt to prevent him from doing so.

You have been misinformed on this subject and on behalf of the Medical Association I cannot accept the protest you have sent to us.

GORDON FERGUSION.

OFFICE OF THE FIRE MARSHALL
Vancouver

VANCOUVER B.C.

August 27th, 1952.

411 Dunsmuir St.,
Vancouver 3, B.C.
The College of Physicians & Surgeons of B.C.,
1807 West 10th Avenue,
Vancouver, B.C.

Gentlemen:

In the past few years we have had a few deaths by fire of children through the use of open-flame and electric hot plates in the steam treatment of colds and bronchitis.

We are writing to our representatives throughout the Province that they recommend the use of electrical steam equipment. We have checked on it and find it reasonably priced and free from fire hazard.

We would appreciate it very much if your members, when recommending steam treatment, would suggest the use of electric steamers.

Thanking you,

Yours very truly,

M. A. WALKER,
Fire Marshal.

News and Notes

Dr. C. J. Coady has given up his private practice, and is now with the Department of Pathology at St. Paul's Hospital.

Dr. P. W. Hudson is now residing in Vancouver from Trail, B.C., where he is in the Department of Pathology at Vancouver General Hospital.

Dr. C. C. Jackson has returned to Vancouver from Philadelphia where he has been taking post graduate studies in Proctology at the Temple University Hospital.

Dr. W. N. Kemp has opened a new office in Vancouver. Practice is limited to occupational diseases and industrial injuries and also general medical and surgical consultations.

Dr. E. J. P. Badre has returned to Vancouver after spending some time in Durham, North Carolina and Cleveland, Ohio, taking post graduate studies in Plastic Surgery and has opened a practice in this specialty.

Dr. G. A. Badger has returned to Vancouver from Toronto, where he has been taking post graduate studies at the Sunnybrook Hospital and Toronto General Hospital.

Dr. James Ed. Musgrove is now associated with *Dr. B. T. H. Marteinsson* of Vancouver.

Dr. E. W. Skwarok has returned to Vancouver from Boston, where he has been taking post graduate studies.

Dr. Wm. D. Stewart has moved to Kansas City to take studies in Pathology at the University of Kansas Medical Centre.

Dr. W. S. Wilson has given up his practice in Vancouver and is now residing in New Westminster, B.C.

Dr. C. H. Hemmings is now practising in Victoria.

Dr. W. B. Hich is now in Stewart.

Dr. D. Klassen is now in practice with *Dr. P. J. Doyle* of Vancouver Cambie district.

Dr. J. A. McDougall is now employed by the B.C. Cancer Institute.

Dr. Roderick McLeod has joined the Burris Clinic in Kamloops.

Dr. P. H. Melville is now practising at Bella Coola.

Dr. Peter Purcheson is now anesthetist with the Moose Jaw Clinic in Saskatchewan.

Dr. W. D. Watt is now practising in Queen Charlotte City in the Islands.

BIRTHS

To *Dr. and Mrs. G. P. Skelhorn,* of Vancouver, a son.

To *Dr. and Mrs. J. A. Porter,* of Vancouver, a son.

To *Dr. and Mrs. Hamish McIntosh,* of Vancouver, a daughter.

To *Dr. and Mrs. M. Wall,* of Vancouver, a daughter.

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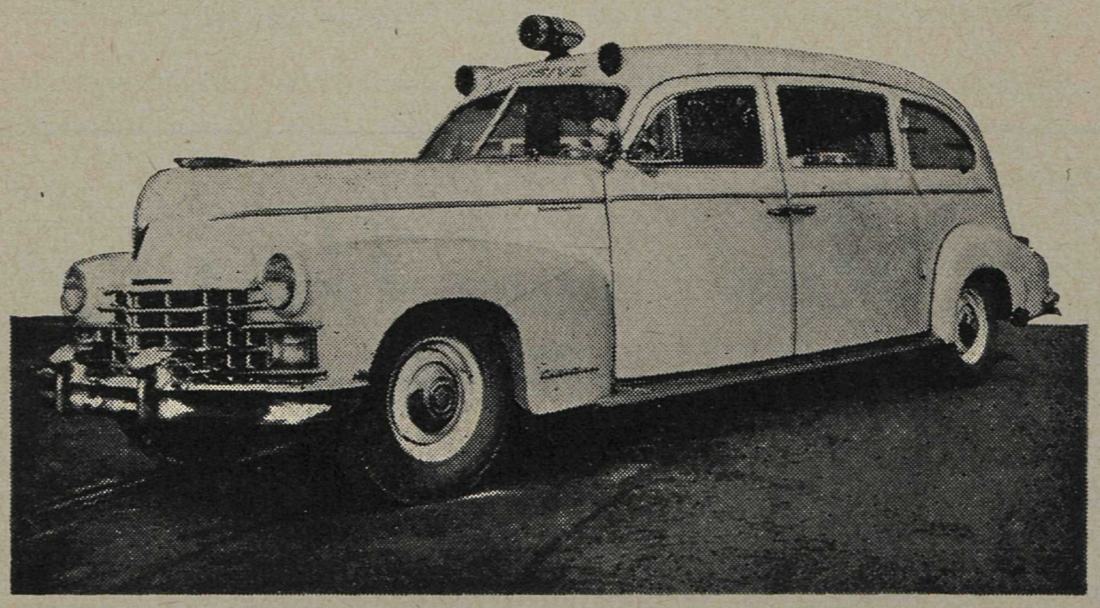

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INDEX TO VOLUME XXVIII—1951-1952

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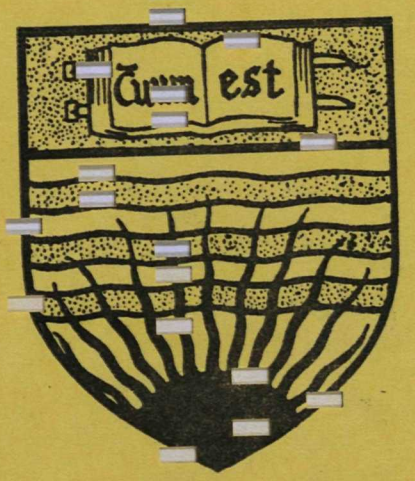

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