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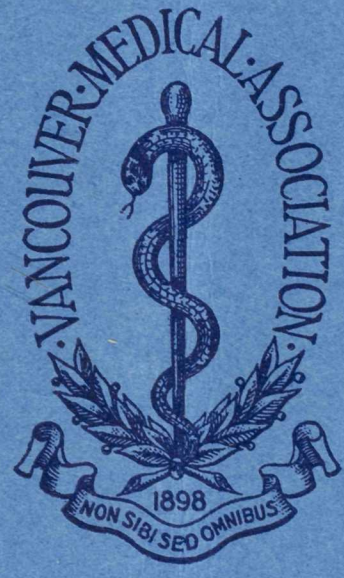
The BULLETIN
OF THE
VANCOUVER MEDICAL ASSOCIATION

Vol. XIII. OCTOBER, 1936 No. 1



In This Issue:

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SUMMER SCHOOL PAPERS

VANCOUVER GENERAL HOSPITAL PHARMACOPŒIA

BULKETTS

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THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

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203 Medical Dental Building, Georgia Street, Vancouver, B. C.

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DR. M. McC. BAIRD DR. D. E. H. CLEVELAND

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VOL. XIII. OCTOBER, 1936. NO. 1

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VANCOUVER HEALTH DEPARTMENT

STATISTICS—AUGUST, 1936

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

	Number	Rate per 1,000 Population
Total Deaths	189	9.0
Japanese Deaths	4	5.9
Chinese Deaths	8	12.0
Deaths—Residents only	160	7.6
BIRTH REGISTRATIONS—Male, 139; Female, 158	297	14.2

INFANTILE MORTALITY—	August, 1936	August, 1935
Deaths under one year of age	4	10
Death rate—per 1,000 births	13.4	32.8
Stillbirths (not included in above)	6	9

CASES OF COMMUNICABLE DISEASES REPORTED IN CITY

	July, 1936		August, 1936		September 1st to 15th, 1936	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Smallpox	0	0	0	0	0	0
Scarlet Fever	6	0	9	0	7	0
Diphtheria	0	0	0	0	0	0
Chicken Pox	8	0	6	0	4	0
Measles	4	0	1	0	0	0
Rubella	9	0	2	0	1	0
Mumps	13	0	12	0	1	0
Whooping Cough	4	0	4	0	1	0
Typhoid Fever	0	0	0	0	0	0
Undulant Fever	0	0	1	0	0	0
Poliomyelitis	1	0	3	0	0	0
Tuberculosis	27	16	14	13	13	--
Meningitis (Epidemic)	2	0	0	0	0	0
Erysipelas	5	1	2	0	0	0
Encephalitis Lethargica	0	0	0	0	0	0
Paratyphoid Fever	0	0	0	0	0	0

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VANCOUVER MEDICAL ASSOCIATION

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Programme of the 39th Annual Session

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

CLINICAL MEETINGS will be held on the third Tuesday of the month at 8 p.m.

Place of meeting will appear on the Agenda.

General Meetings will conform to the following order:

8:00 p.m.—Business as per Agenda.

9:00 p.m.—Papers of the evening.

1936.

October 6th—GENERAL MEETING.

DR. W. H. HATFIELD: "Programme of the Tuberculosis Division of the Provincial Board of Health."

DR. A. B. SCHINBEIN AND

DR. W. ELLIOTT HARRISON: "Surgical Treatment of Pulmonary Tuberculosis."

October 20th—CLINICAL MEETING.

November 3rd—GENERAL MEETING.

DR. E. J. CURTIS AND

DR. H. LAVELL LEESON: "Respiratory Infections of Childhood."

November 17th—CLINICAL MEETING.

December 1st—GENERAL MEETING.

DR. C. W. PROWD AND

DR. A. Y. MCNAIR: "Tumours of the Large Bowel."

December 15th—CLINICAL MEETING.

EDITOR'S PAGE

This is the first number of a new volume of the BULLETIN, and we enter upon our 13th year of existence. It is an appropriate thing once in a while to remember our beginnings: so much lies in a good start. Dr. Harry Milburn was the originator, really, of the BULLETIN, and it stands in some degree as a monument to him. It began its career under the Editorship of the late Dr. J. M. Pearson, who from all points was eminently fitted for the job. It was not in Pearson to be slack about anything, and he gave the BULLETIN a good start; its general makeup has changed little, if any, from what it was at the beginning.

We do not suppose it is possible to satisfy all tastes—but we should like to feel that the menu we provide has in it something for every guest. The BULLETIN is first and foremost an account of the Transactions of the Vancouver Medical Association, and secondarily a journal for the whole medical profession of British Columbia. As a matter of fact, it is very difficult to separate these two identities, and this is as it should be. Perhaps a better way of putting it would be that the BULLETIN is the contribution of the Vancouver members of the profession to the brotherhood throughout the province; it is given very gladly, and its columns are open for the contributions of any part of B. C.

There is a surprising lot of good, valuable work done in B. C. along medical lines, some of it quite original, some of it merely the extension of work already in train. It is our basic principle that this should have first place always in the BULLETIN. Thus from time to time have appeared papers, reviews of the work in the hospitals, and so on, and these have by no means been confined to Vancouver. We should like to emphasize the point that if any man anywhere in British Columbia has some original observation, some new technique, something that he feels should be passed on, we shall welcome it gladly and give it space.

An incident in the Summer School last month brought this forcibly to our mind. Dr. J. McF. Bergland of Johns Hopkins was speaking of puerperal infections, and of the danger from nurses and doctors suffering themselves from colds, infections of the hand, etc., who were engaged in the conduct of labour. We remember an excellent little article contributed some years ago by Dr. R. Coy of Windermere, on this very subject. He had noticed an undue amount of infection, and had traced it to a nurse who, while herself healthy to all appearances, was yet a carrier of virulent germs in her nose and throat, and had been the innocent cause of great mischief.

This sort of thing is of great value, and we shall always welcome it.

* * * *

Speaking of the Summer School of the Vancouver Medical Association: this year's School was indeed an excellent one, and we offer our sincere congratulations to the Committee which was responsible for it. The programme was a particularly good one from the general practitioner's point of view, we think; there was a great deal of common sense in the views expressed by the speakers. They stayed, most of them, on earth; one or two perhaps occasionally soared rather high, into the rarefied air of pH's and osmotic balances—we confess to a feeling of giddiness gradually blending into somnolence on one or two occasions—but these were rare.

Perhaps the thing that struck us most was the sanity and conservatism

of the speakers on the one hand, and their openness to new ideas on the other. Thus, Dr. Bergland cautioned us against fads and fancies in that most ancient division of medical practice, obstetrics, which fundamentally has changed so little, and which is so often a happy hunting-ground for the Athenians among us who always seek some new thing; while on the other hand, Dr. J. Evarts Graham, in the most ordinary language, told us of his daring voyages into seas yet uncharted and lands of adventure: with his removal of lungs, and subtotal resections of the pancreas, and other radical surgical manœuvres—yet we are told that Moynihan thought that surgery had gone about as far as it could go—surely that was not Moynihan speaking.

Then Dr. Farrar showed us in one-syllable words something of what we, as general medical practitioners, can do in understanding and helping the mentally and nervously afflicted among us—those poor victims who suffer so much from misunderstanding and misdirection.

We could say much about the others, but space is limited: the ingenuity and high degree of technical skill of Dr. Gordon B. New of the Mayo Clinic, whose work in plastic surgery, in carcinoma of the larynx, etc., is of such outstanding merit; the enthusiasm and keenness, on the biochemical side of medicine, of Dr. Irvine McQuarrie; the dry humour of Dr. Woodyatt, whose talks on diabetes and nephritis were so admirably adapted to his audience's needs; and last, and among the first in importance, the paper of Dr. C. E. Dolman on Undulant Fever. This is particularly timely just now, and its implications as regards the pasteurization of milk should be regarded as of the greatest importance. We trust that this matter will not be allowed to drop; Vancouver had been gradually acquiring a reputation for safe, good milk, and it is not the loss of reputation that matters so much, as the danger to our population, especially to the children, from milk-borne diseases.

Since we have the task of collecting this material for the BULLETIN, we repine, of course, at our ill-fortune, in that none of these papers were written, and most of them, being illustrated copiously by slides, are incapable of reproduction. Also, we could not attend all the meetings. But as far as was possible, we have reproduced the essence of many of the papers, and even from these poor sketches one can realise the wealth of material that was poured out before us. We can never be sufficiently grateful to these men, who give us so ungrudgingly and in such amounts all their best. This Summer School week is the best thing of its kind of the year, and we marvel frankly that any man can stay away from it. The only pity is that there is our daily routine to be got through, and it makes it hard to cover the whole programme.

* * * *

We commend especially to our readers the medical history of British Columbia which has been appearing in instalments in the BULLETIN. We owe much to Dr. M. W. Thomas, the Executive Secretary of the B.C.M.A. and B.C. Medical Council, for his admirable work in this. It is written in a delightfully racy narrative style. Many of the men referred to are but names to us, but they were well worth a memoir—they played their part in the building of the medical structure which we now inhabit.

* * * *

We would bring also to our readers' attention:—
The notes on the Vancouver General Hospital Pharmacopœia.
A warning note inserted at the request of a member of the Association.
A note from the offices of the College and the Library.

JOHN J. MASON, M.D.

DIED SEPTEMBER, 1936.
Aet. 55.

PERHAPS the most striking thing about the passing of our colleague, Jack Mason, is the widespread regret of the community in which he lived and practised for so many years. Not only amongst his medical brethren, but from men and women of all ranks and all classes, one has been hearing every day expressions of sorrow at his death. There is a general feeling that our profession has lost one of its leading men, a man who represented the best we have to offer in the specialty in which he worked.

We cannot but agree with this popular estimate of his standing and of his worth. Mason stood loyally and unchangingly for a very high ideal in medicine. His standards of conduct, as of medical practice, were the highest possible, and he maintained them quietly and unostentatiously, but unswervingly and without compromise.

He was a very hard worker. One was constantly amazed at the volume of his work. One fears that perhaps he worked too hard and with not sufficient relaxation and interval for leisure. He always seemed to find work much easier and more natural than he did play and recreation.

He died younger than he should—but he was not so unhappy, perhaps, in his manner of dying: for he was working hard up till the very end. It is, we feel, the way he would have chosen, and the way most of us would choose.

Nor was he merely a slave to his work; as far as was in his power, he gave of his time and ability to the service of his profession; he was a past president of the Vancouver Medical Association and a former member of the Vancouver General Hospital Staff.

We extend to his wife and family our most sincere condolences in their bereavement.

DR. W. F. COY

DIED SEPTEMBER, 1936.
Aet. 73.

IN the death of Dr. W. F. Coy, another landmark has been quietly removed by the unrelenting hand of Time.

To those of us who are now coming into the "sere and yellow leaf" of life, Coy was a very well known and valued friend. He had been in practice a long time, as long as Vancouver was a city—since 1886, when he first registered in B. C. He was for a long time one of the leading men here in general practice, and had a very large maternity practice. He was a man of sound and ripened judgment, and particularly suited to family practice.

He has been much identified with general medical activities, and was formerly president of the Vancouver Medical Association. During the war, though over 50 years of age, he volunteered for overseas service, and served in the C.A.M.C.

Coy was always one of the friendliest, most genial men imaginable. He was liked by everybody, because he liked people himself, and got on well with people. Quiet and unassuming, he yet had a mind and a dignity of his own, and won respect as well as liking. We who knew him will miss him.

To his wife and family we extend our sincere sympathy in their loss.

NEWS AND NOTES

Dr. J. R. Naden and Dr. D. M. Meekison attended the meeting of the Pacific Orthopædic Association in Spokane.

* * * *

Dr. W. L. Pedlow entered the ranks of star golfers recently at Shaughnessy when he won two cups in one day. He captured the cup annually donated by Dr. George Worthington for the best low net score for one game, with a net score of 63. He also won Dr. D. McLellan's Ram's Horn Trophy for the best low net score for three games. With the Ram's Horn Trophy goes a silver cup which becomes the permanent property of the winner.

* * * *

Dr. Jack Wright defeated Dr. Leith Webster in the finals of the Doctors' Special Cup Competition at Shaughnessy Gold Club.

* * * *

Dr. Frank Turnbull has left for Honolulu, where he will spend the winter months. On his return he will remain in California for a few months, doing post-graduate work.

* * * *

Dr. A. C. Frost flew to New York on September 22nd, leaving Vancouver on the evening of the 22nd and arriving in New York the following evening. He will remain in New York about a month, doing post-graduate work.

* * * *

Dr. J. W. Arbuckle has returned from a hurried trip to Eastern Canada. He flew to Windsor, Ontario, to meet his son, Mr. William Arbuckle, who has been travelling on the Continent with Dr. and Mrs. Spohn. Dr. Arbuckle and his son motored back to Vancouver by way of Salt Lake City and Yellowstone Park.

* * * *

Dr. Howard Spohn is expected back in Vancouver early in October.

* * * *

Dr. W. A. Saunders has been appointed Public Health Officer in North Vancouver, to fill the vacancy caused by Dr. Amyot's departure for Victoria.

* * * *

Dr. M. H. Jones is going to Nelson to practice.

* * * *

Deepest sympathy is felt for Dr. B. B. Marr, whose wife, Mrs. Isabelle Drew Marr, died at her home at Murrayville on September 15th.

* * * *

Dr. and Mrs. Lavell Leeson have left on a motor trip to the Grand Canyon. Dr. Leeson will return about the 28th of September.

* * * *

Dr. W. H. Hatfield is making a tour of inspection of all the Health Centres in British Columbia. He will return to Vancouver about the first of October.

* * * *

Dr. H. H. Boucher has opened an office in the Medical-Dental Building. He is confining his practice to orthopædic and traumatic surgery.

* * * *

Dr. Stalker has left for Cleveland, Ohio, to attend a meeting of the American Hospital Association.

NOTE FROM OFFICES OF COLLEGE AND LIBRARY

The office staff in the offices of the College and in the Library report that very frequently doctors send to them applicants for positions of stenographers, doctors' attendants, etc., suggesting that they may be able to recommend these girls to some of the doctors who need office help. Mrs. Bender and Miss Choate would be very glad indeed to do this, if any doctor ever applied to them for help. But this rarely happens. Indeed it has been said that only twice in the past ten years has any doctor asked the Librarian to help him find a stenographer or office attendant. When girls come to the office or to the library asking if positions are available, whoever has to interview them has the discouraging task of taking their names, address, etc., but telling them at the same time that they can offer no encouragement, as none of the doctors ever come to this office when they are looking for office girls.

If the Doctors would co-operate in the matter and advise Mrs. Bender or the Librarian when they are in need of a stenographer or office girl, a register of the applicants could very easily be kept, but it is discouraging to all concerned under the present circumstances.

(Such a scheme would be of value in many ways: the medical man in search of an attendant would be saved much time and trouble, and would be more sure of getting exactly the kind of nurse he wanted, without the necessity of many interviews, and their attendant unpleasantness.—*Ed.*)

* * * *

WARNINGS

We note that a substance has been found in the Lost Lagoon, which experts at the U.B.C. think can be used in face powder. If a substance were found in the Lost Lagoon which could not be used in cosmetics or patent remedies, this would be real news.

A man has called upon us recently with a jar of miraculous ointment, composition not divulged beyond a statement that it contains "marvelous pine oil," of his own manufacture, which he states is a cure for ulcers, wounds, fistulas and of course every kind of skin disease. Upon being asked for evidence of its having been analysed, given a thorough clinical test and for literature containing reports to this effect, he displayed letters signed by two well-known Vancouver practitioners, each of whom testified quite warmly to the valuable properties of the preparation, but without giving any data of any value. Upon being told that the "testimonials were worthless and did not justify serious consideration," the man became hostile and insulting. Among other claims, it is interesting to note that he stated that a case, which has been diagnosed as acrodermatitis and which was seen in consultation by a number of physicians and surgeons in Vancouver and which was presented at a clinical meeting at the General Hospital about a year ago as having been cured by sympathectomy, had been cured by his ointment and in further substantiation of this asserted that he was supplying the ointment regularly at present to this patient.

There would seem to be no lack of satisfactory pharmacopœial preparations for use in the various injuries and diseases of the skin, and before adding another to the list it should have a modicum of scientific data behind it, such as chemical analysis, a thorough evaluation on an adequate series of

clinical tests, etc. Members of our profession who lightly lend their names to pushing the sale of nostrums and secret remedies are not doing a service to the public or their colleagues.

* * * *

BEWARE BOGUS SALESMAN!

The D. Appleton-Century Company has written the B. C. Medical Association stating that a salesman by the name of W. H. Patterson has been selling and collecting cash in the Company's name without authority, from physicians in Alberta, and is headed for Vancouver.

Attempts to check his activities by the Company have so far failed. *Surgery, Gynæcology and Obstetrics,* for whom he is also soliciting, state that they are "taking steps to see that he is brought to account for the monies he has collected and withheld covering subscriptions to our publications."

* * * *

MAYO FOUNDATION CLINICS

A special programme of lectures and demonstrations in medicine and surgery will be held under the direction of the Mayo Foundation from November 9 to 13, inclusive. Mornings will be devoted to surgical and medical clinics. In the afternoons and evenings symposiums will be conducted on neurology, gynæcology, diseases of the ear, nose and throat, laboratory procedures, emergency treatment, pædiatrics, and renal diseases. In addition a clinico-pathologic conference will be held. While this programme is arranged primarily for the Fellows of the Foundation, visiting physicians are invited to attend.

* * * *

DISTRICT MEDICAL ASSOCIATION ANNUAL MEETING, VERNON, B. C.

Dr. M. W. Thomas, Executive Secretary of the College of Physicians and Surgeons of B. C., and Dr. J. R. Naden, Secretary-Treasurer of the B. C. Medical Association, attended the Annual Meeting of the District Medical Association, held at Vernon on September 16th.

During the afternoon three papers were presented. The first, by Dr. A. G. Naismith of Kamloops, was entitled "Laboratory procedure, and the assistance which a laboratory at a distance could give to a general practitioner."

Dr. F. P. McNamee gave a very instructive and thoroughly well-worked-out paper on "The common disorders of the Eye, Ear, Nose and Throat, and their treatment, with special reference to the work of the general practitioner."

Dr. Naden used a number of X-ray plates to illustrate his paper on "The General Principles of the Treatment of Fractures."

Previous to the dinner, the visiting doctors were royally entertained at the home of Dr. and Mrs. Pettman. Dr. Pettman was past President of the Association. During the dinner Dr. M. W. Thomas gave a comprehensive account of the work of the Council of the College of Physicians and Surgeons of B. C., and also included in his talk the latest information on Health Insurance.

The General Meeting of the District Medical Association took place after

the dinner, when officers for the coming year were elected. There was an attendance at the meeting of about 25 doctors from the district.

THE VANCOUVER GENERAL HOSPITAL PHARMACOPŒIA

This little volume is rapidly making itself a necessity both in doctors' offices and behind druggists' counters. Up to date more than three hundred copies have been sold, and there is a steady demand for it. But we think that if everyone, hospitals, doctors and druggists, knew just what this little book contained, they would realise that it is an investment that none of them should miss.

It has an amazing amount of information in it, and an abundance of detail about preparations, diets, treatments, that is never found in similar publications, as far as we know.

Take *diets*. There are twenty-five pages on diets, giving samples and descriptions of all sorts of diets: diabetic, Sippy, reducing, ketogenic, ulcer diets, high calorie diets., etc. Not merely the diet is given, but accurate directions about its preparation and use, which are of great value from their condensed form and quickness of assimilation.

Again, in the chapter on Anæsthetics, the latest accounts of basal anæsthetics, preoperative medication, spinal anæsthesia, etc., are available.

A chapter on Clinical Standards—urine, gastric contents, blood chemistry, serology—gives a quick reference table which is always at hand.

The twenty-five pages on poisons and their treatment, on drugs in common use and their dosages, too, are very valuable.

But the real value of the book lies in its remarkably full list of pharmacopœial preparations, mixtures and pills and ointments and so on; these are all well-known, thoroughly tested prescriptions. Their use will save the patient a great deal of money, the doctor a great deal of time. We feel that one of the main advantages of this book is for the doctor who is constantly flooded with literature and samples of all sorts of most attractive-looking proprietary preparations. Most of these are merely our old friends of many years with a new dress and a fancy name, and they cost a great deal more than they would in their old clothes. A careful study of this pharmacopœia will show what we mean.

We think that every medical man should have a copy of this, should prescribe from it as often as he can, and should urge the druggist with whom he most often deals to have a copy. If the doctor is doing his own prescribing, he simply cannot afford to be without a copy. The book is absolutely up-to-date—not merely a rehash of old stuff. It has not some, but *all* the newest material.

It even has tables of height and weight in children, details regarding the incubation of infectious fevers, methods of making baths, of preparing lactic acid milk and other infant feedings, of the preparation of medicated gauzes, etc.

SUMMER SCHOOL PAPERS

In this number we include abstracts of some of these papers. Others will appear in subsequent numbers.

PUERPERAL INFECTIONS

Dr. J. McF. Bergland

The speaker began by a brief historical sketch. Puerperal fever, one of the puerperal infections, also known as "lying-in fever," was of course well known to the ancients. Galen and others described it, and perhaps the best account of it in those days was given by Soranus of Ephesus. This account is now in process of being translated, and Dr. Bergland has seen some of the translated parts. He pronounces them very interesting.

Soranus gives retention of lochia as the cause of puerperal fever. This has been so considered by many other writers, and there is undoubtedly some truth in it. Retention of secundines or infected secretions plays a considerable role, and removal of such toxic material is an essential part of treatment.

Soranus gives a picture of postpartum peritonitis which is very vivid, and very true to nature: the distended, tender abdomen, the dry tongue, the dry skin, all the symptoms and signs are there.

In 1793 Charles White described an epidemic in his neighbourhood, and his report includes a statement that he felt that he himself was responsible for some of it, that he spread the disease from one patient to another, thus showing that he recognized the infectious nature of the disease.

A little later Alexander Gordon of Edinburgh said the same thing, but the work of these two men attracted only sarcasm from their colleagues.

In 1843, Oliver Wendell Holmes, a noted anatomist and physiologist, as well as a writer whose name everyone recognizes, wrote his epoch-making treatise "On the contagiousness of puerperal infection." He pointed out that certain doctors were veritable angels of death, carrying his banner from house to house. More accurately, he showed that they were carrying it from post-mortem rooms to lying-in beds, and from cases of erysipelas which they visited immediately before seeing their maternity cases.

He suggested that they must be carrying around some poison with them, and suggested a rest from work for a few days, then a bath and a change of clothes. Naturally his suggestions were unpopular, and did not at once meet with general acceptance. But his pioneer work was to bear much fruit, nevertheless.

In 1847, Ignatz Semmelweiss, in the Vienna Lying-In Hospital, was impressed by the tremendous mortality due to lying-in fever in his hospital. Others had noticed this, but he worried about it, and made some observations. There were two divisions of the hospital, one in which the cases were handled exclusively by midwives, while in the other doctors and medical students were working. The second division's mortality from infection was just three times that of the first. He noticed the students coming straight from the postmortem rooms to the obstetric wards, and attending to labours. He made them wash in chlorine water, and—lost his job. He

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could get no other, and this man, whose service to humanity ranks with that of Pasteur and Harvey, died in obscurity of an infection contracted from post-mortem material. But at any rate there is a great monument which stands in Buda Pesth to his honour.

In later years a streptococcus was isolated, and recognized as one of the main *causæ morbi.* The staphylococcus is the other great cause.

The disease is a wound infection, caused by the entry of bacilli into the system through numerous "poor poor dumb mouths," as Shakespeare puts it. Other organisms than the pyogenic cocci have been held responsible in certain cases, gonococcus, b. coli, and, particularly in criminal abortions, the bacillus Welchii, the source of gas gangrene.

Pathology.—In the post-mortem birth canal we see evidences of entry of bacteria into wounds of various kinds, especially lacerations that have not been sutured. From this we derive the corollary that all wounds should be carefully closed.

The main portal of entry, however, is the endometrium, and the condition starts as an endometritis. A wall of leucocytes is thrown around the endometrium in the form of a leucocytic membrane, the lymphatics swarm with leucocytes.

Usually the process ends here. But if the infection passes these barriers, it reaches the parametrium, in the form of an acute parametritis, and this gradually spreads to the peritoneum. Here we get the dread puerperal peritonitis.

Occasionally the germs find their way to the blood stream and a septicæmia results, often with sudden death. But it is noteworthy, said Dr. Bergland, that a positive blood-culture is by no means necessarily the harbinger of a fatal ending. Many such cases recover.

There is, too, the pyæmic ytpe, with localised abscesses here, there and everywhere, and the thrombo-phlebitic type, localising in the broad ligament. Emboli or thrombi break off, and we may have sudden death; in any case, we have a long illness ahead of us, exhausting, and of doubtful prognosis.

Milk leg, or phlegmasia alba dolens, is a common sequel of such thrombophlebitis.

Etiology.—Usually infection by bacteria from without, through instruments, fingers, etc. There is, too, air infection by droplets from infected noses and throats in attendants. Hence the well-proven danger of infection from doctors or nurses with colds or influenzal attacks. (It is now a recognized part of good technique that all who enter the labour room should wear masks and caps.—*Ed.*)

Auto-infection.—This undoubtedly plays a very important part. Swartz of St. Louis isolated an anærobic streptococcus found at times in the upper part of the canal. This is found in negresses rather than whites, and so morbidity from this cause is greater in the coloured woman.

It is combatted (as are other forms of auto-infection—*Ed.*) by instillations of acriflavine, mercurochrome, etc.

Incidence of puerperal infection.—It used to be extremely common in hospitals, where it would sweep through whole wards, even the whole hospital, like a flame, destroying life wholesale. Now it is far less common in hospital practice, in fact as a cause of death it is probably of minimal importance here, but *outside of hospitals it is still the greatest cause of maternal deaths.*

In 1921 40% of all maternal deaths in the U.S.A. were due to puerperal infection: therefore were chiefly preventable, therefore *should have been prevented*.

What are we doing about it? asks Dr. Bergland, and the answer is "Very little."

Symptoms.—There are two main types, the putrid type and the septic type. There is not much need to enlarge on these; every practitioner knows them—their onset, course and symptoms.

Dr. Bergland, however, emphasized a fact that many must have noticed: that phlegmasia alba dolens will often develop in patients who have had a normal temperature and post-partum course for the preceding 10 or 14 days, and that this particular complication carries with it grave risk of embolism.

Treatment.—There is only one treatment of real value, *i.e., prophylactic*. Dr. Bergland emphasized the absolute necessity of keeping out of the birth-canal as much and as long as possible. There are often virulent bacteria lurking around labia, Skene's follicles, etc.

The accoucheur must be sure that he has not even the slightest infection on his own hands; a paronychia on the doctor's hand has proved fatal to a patient. He must guard his mouth and nose; avoid vaginal examinations, perfect himself in the technique of rectal examination.

Curative.—There is not much we can do; treatment is still largely expectant. Perhaps the very best treatment, Dr. Bergland thinks, is repeated small blood transfusions. Fluids by intravenous, glucose, etc., are of great value. Posture is important; ice to lower abdomen adds to the patient's comfort. *Ergot* is of great value in contracting the uterus and lessening lymphatic absorption.

One thing *we must not do* is curettage. Digital removal of fragments of infected tissue is permissible—but any sharp instrument lessens greatly the patient's slim chance of recovery.

Vaccines and serums he has found to be of no value, or very doubtful value.

J. EVARTS GRAHAM ON GALL BLADDER DISEASE

Some Reflections

It is hard to satisfy audiences of medical men nowadays by talks about gall bladder disease—most men know all about it.

Graham himself feels that there is still a great deal to learn: (1) *about the diagnosis* of conditions, the selection of cases, the evaluation of signs and symptoms; (2) *about results* of treatment.

Let us consider *the mortality in gall bladder surgery*.

It is a common experience that certain physical types of patients with gall-bladder disease stand operation worse, and succumb more readily, than do others.

The hyper-sthenic type, inclined to obesity, with short mesenteric attachments, with a short thick neck, is a dangerous subject: stands opera-

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tion badly, and shows a high mortality. He is more prone to contract pulmonary complications post-operatively.

So John Bull is a poorer risk than Uncle Sam.

In deciding on an operation, therefore, we must take these physical characteristics into account, and if the operation is one of election, we must stop, look and listen rather carefully.

Acute cholecystitis.—Dr. Graham feels that surgeons in the Atlantic area of the country are in favour of immediate operation, *as a rule,* in acute cholecystitis, and look upon it as an acute abdominal emergency. Their operation of choice is cholecystectomy.

In the middle West, he says, "we feel that this is erroneous and there are many reasons against it."

(The far West, at least as far as we know, entirely agrees with Dr. Graham in this matter.—*Ed.*)

One of the reasons urged for immediate operation is the danger of perforation. This, to Dr. Graham, is a very inadequate reason, since (1) it is a very rare accident, and (2) the gall bladder rarely perforates into the free abdominal cavity, but practically always into a well-walled-off abscess cavity, or into another viscus.

The protagonists of early operation insist that the younger the patient is, the more important is early operation. With this Graham completely disagrees. Studies and statistics have shown conclusively that perforation, especially into the free abdominal cavity, is far more likely to occur in the aged, in whom the circulation is poorer and ischæmia more likely.

The mortality rates in early operation (cholecystectomy) *on acute cholecystitis are much higher* than when conservative methods are in vogue. The best rate in early operation (cholecystectomy) is 10%, and it may run up to 20%. Where one waits for the acute condition to subside cholecystectomies show a much smaller mortality: as low as 2%.

It is occasionally necessary, of course, to operate on an acute gall bladder, but *drainage,* in Graham's opinion, *is the only wise and safe method,* and enormously reduces mortality.

In older patients often nothing else is necessary—but if cholecystectomy is deemed advisable, it should be done later at a secondary operation (three weeks or so later).

The leading surgeons in Great Britain also endorse this view.

We should keep the patient with acute cholecystitis under careful observation for some days, with appropriate treatment. This waiting should continue as long as toxæmia is subsiding, and patient is improving. If, however, after some days patient is not improving or is getting worse, and toxæmia is not subsiding, especially in patients of middle age, we must not wait, but *must drain.* This should be the first stage of a two-stage operation; the removal of the gall bladder being done later in three weeks or so. The mortality should not be more than 2% by this method.

A very important thing is the complete survey of the patient. Gall bladder disease is essentially a disease of middle life, and especially of the type subject to cardiac and cardio-renal disease—the overweight, sedentary, flabby type.

We should not be in a hurry to recommend operation in such a patient till we are sure that he or she is a fit subject. For this a thorough survey is necessary.

Our goal as surgeons should be to reduce mortality to zero. No mor-

tality, however small, is good enough. We can never be satisfied with our results.

There is a percentage of patients who die shortly after operation, within two days, showing hyperpyrexia, occasionally a subnormal temperature, stupor almost to the point of coma, and a very rapid pulse. These are what are more and more often referred to as "liver deaths."

There is some dysfunction of the liver here. The postmortem often shows no cause of death, beyond albuminoid degeneration and necroses of the liver, with, sometimes, similar changes in the liver.

The liver has a multitude of functions, and no one test can test them all; but for some years the degree of retention of dyes has been successfully used to show how much liver damage is present.

Persistence of symptoms after operation.

There is no more troublesome and trying complication than this.

We have removed a pathological gall-bladder, which may or may not have had in it a few stones; we made a very careful cholecystographic examination before operation, etc., but symptoms persist or recur.

Some years ago one Mr. Mackie of Glasgow started a search into old records of operations on gall-bladders; dug up some 160 cases operated on several years before, and had personal interviews with them. He found that the best results, as far as relief from symptoms goes, are obtained in patients who have stones.

Non-calculous cholecystitis does not give equally good results.

A priori one would think that the earlier an infected gall-bladder was removed, the better the results should be, but just the opposite turns out to be the case with gall-bladder disease.

If we remove a gall-bladder before calculi form, we do not get such good results.

Strawberry gall-bladder (cholesterosis) shows results not nearly so good when there are no stones as when these are present.

In patients who showed on examination by X-ray, evidence of disease, but at operation a fairly normal gall-bladder, when the bladder was removed on account of the X-ray findings: 50% were completely relieved; 20% in about a year; 30% no relief.

This is a very disappointing state of affairs, that in a series of cases of a major operation, only 70% considered themselves benefited. We must try and improve this.

When there were stones, 90% considered themselves as cured, or greatly improved.

Of the group not relieved, especially the non-calculous ones, a more careful re-examination will show that the symptoms complained of are coming only partly from the gall-bladder, partly or mainly from other viscera.

One very common condition is functional disturbance of the colon—constipation to wit.

Again, duodenal ulcer, renal stone, sometimes osteoarthritis of the spine, which frequently simulate gall-bladder disease, or Pott's disease.

The chief reason for the failure to relieve 30% of our patients is the *failure to give such patients a complete medical examination.*

We must consider our patient's pocketbook, but this is not an adequate excuse for such a failure.

Characteristic symptoms must be present.

Mackie's study showed that the best results are obtained not only where there are stones, but *where there is definite biliary colic*. The patients with vague symptoms are not so constantly relieved, especially where X-ray evidence is more or less inconclusive.

Then flatulent dyspepsia is not necessarily relieved by cholecystectomy.

Dr. Graham showed slides:

I.—Types (physical) of patients. The hypersthenic type and the asthenic type are the two extremes. The hypersthenic type is the one most commonly affected and the poorest risk. Between these two are the sthenic and the hyposthenic types.

II.—X-rays and pictures showing that in the hypersthenic, the mesenteric attachments are short, the gall-bladder round and high up and hard to reach, while in the asthenic type it is low and long, and pear-shaped.

III.—Microscopic slides of liver damage in acute cholecystitis, with infiltration round small ducts and capillaries, by polymorphs. An acute cholecystitis is always accompanied by an acute cholangitis.

IV.—A later slide showing that as process continues for a long time, fibrosis occurs, the walls of the little bile ducts are enormously thickened; the liver shrinks in size, becomes firm, owing to increase of scar tissue—hence we have the incurable condition of biliary cirrhosis.

V.—The lymphatic supply of the gall-bladder which anastomoses intimately with the lymphatics of the liver. Hence the danger of early operation, as lymphatics are wide open.

With regard to liver deaths. The excretion test of dye is found of value, in helping us to decide on the fitness of the patient to be operated upon. There is a large number of dyes excreted by the liver, which may be used as a test.

The Rosenthal test, by the use of iso-iodeikon, may be applied. This same dye will give X-ray opacity—and by a colorimetry test will give the degree of retention, using the bile as the object of our examination. Where retention is very high, the risk of operation is very great. Where jaundice is present, we may have as high as 50% retention, while with no jaundice, a cholecystitis may show only 27%. Alcoholic cases run as high as 70%; catarrhal jaundice up to 90%.

Slides were shown of liver tissue of two patients who died, with 90% and 70% retention respectively. These showed degeneration and cloudy swelling of nuclei. These two patients had been operated upon and had died.

The next patient that showed a high retention (90%) was put to bed for three weeks, fluids and glucose given till retention was reduced to 35% —he recovered.

Jaundice as a result of carcinoma shows only 12% retention, carcinoma without jaundice 7% up.

The test is therefore also of some value in differentiating jaundice of inflammatory origin, which is always high (up to 90%) from jaundice due to carcinoma which is always low.

The use of the dye test in Dr. Graham's clinic has led to a considerable reduction of mortality, when it is used as a guide before operation is decided on.

In the three years preceding its use there was an average mortality of 6%. Since 1928 it has been used with an average mortality of .5%. This is a very important and useful step, therefore.

RECONSTRUCTIVE SURGERY OF THE FACE

Dr. Gordon B. New

Dr. New reviewed briefly the anatomy of the nose. He showed some slides dealing with this, and showing various injuries to the nose.

There are three main ways in which injury to the nose shows itself: (1) Lateral displacement, the cartilages knocked off their attachments; (2) direct injury from in front, results in flattening of nasal bones inward; (3) S-shaped deformity, when there is more than one plane of displacement.

As regards the first of these, the old method used to be to try and hammer them back with a padded hammer. Now we chisel through bones from the inside, re-form the inside of the nose, refracture the bones, correct the position of the cartilages and hold them in place. We do not as a rule use cartilage or bone from any other part of body for this injury, but make use of the material already there. Most cases can be so adjusted. Possibly at a later date additional cartilage may be necessary.

Intratracheal gas-ether is the anæsthetic used.

Dr. New showed many slides illustrative of the methods used. A wax mask of the face is first made, then a model taken from this to see exact extent of deformity. On this additional wax is modelled to build up to a normal outline, then lead models are made and taken to the operating room.

When cartilage and bone are necessary they are taken from the rib.

Dr. New then showed numerous slides illustrating the methods of dealing with various deformities—the saddle-nose of congenital syphilis, for instance, the deformities caused by serious injury and disease were shown.

Rhinophyma, for instance, with its huge disfiguring craggy growth, is fairly readily cured by paring. The open ends of the ducts must be left, and gradually it heals, till a condition is reached immensely superior to the original. Where the tip of the nose has been cut off, or where it has had to be removed on account of cancer, flaps are brought down from the forehead. Slides here showed remarkably good cosmetic results. When carcinoma has been present, however, it is best to wait for a year before the flap is turned down, to make sure about recurrence, etc.

Another serious cause of deformity is fracture of the malar bones, of the zygoma. The malar bone is often pushed in, and Dr. New showed pictures of a special hook he uses to pull them out into place. The zygoma may be built up with cartilage and the original contour recovered.

At times in facial surgery it is necessary to immobilize the jaw to obtain healing. This may be done by wiring the teeth together, and feeding through the nose.

In fractures of the jaw, a plaster cast is applied to the head, like a cap, coming down to edge of forehead. Various bolts, slings, etc., can be attached to this, and adjustments of the fractured ends made in this way. The crest of the ilium can be used as a source of bone for grafts.

A number of slides showing the procedure with regard to harelip were also shown.

Angiomas of the face, even extensive ones, can be dealt with. In adults, diathermy or electric coagulation is the best procedure, while radium gives better results in children.

Hairy and pigmented moles can also be dealt with in the same way, and so removed. Large raw areas may be left and full thickness grafts applied.

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MEDICAL PIONEERING IN BRITISH COLUMBIA

By M. W. THOMAS, M.D.
Vancouver, B. C.

(PART 2—Continued)

Dr. Helmcken told of a woman who did not like doctors. Her husband came to the surgery and brought him to the house. As they entered the sick-room the husband confided in the doctor that his wife felt she would prefer to get on without a doctor. "But my wife is so ill, she would be glad to see the devil himself if he came." "Yes," the wife added, "that is why I sent for you, Doctor."

Often in the old days some posts ran short of medicine. The Hudson's Bay Company's Factor at Bella Coola had run out of physic and had nothing left to give the Indians but seidlitz powders. He would rather not give those to the Indians, as he wanted them for himself. But this Indian was a valuable Indian, a faithful man who could be trusted inside the Fort, and such men were rare and valued in those days. This Indian believed that he had been bewitched by Indians of a neighboring tribe. He pined and pined, so the story goes, and had used all the salts, peppermint and other old-time remedies without effect other than to exhaust the supply. The Factor finally decided to use his favourite seidlitz powders. He seated the Indian and he took two tumblers and mixed the powders. When the water fizzed and bubbled and hissed the Indian was astonished. "Here, drink this," shouted the Factor. The Indian was afraid. The Factor was annoyed—these powders were too valued to be wasted. "Drink it, dash you!" screamed the Factor, and grabbed the Indian and forced him to gulp down the draught. It acted as an emetic and the Factor shouted, "There, that finished the witchcraft." It did. From that day, the Indian never stopped getting well. He entirely recovered.

The honourable gentleman was always known to be a strongly humane, benevolent man going about among the people doing good, dispensing his services and his remedies with an admixture of generous goodwill and sound common sense. At times he was abrupt and could give a scolding or a censure and a brusque bit of advice, its succinct tang making either linger long in the memory of the recipient.

Dr. Helmcken possessed a retentive memory and took an active interest in the large family connection in and about Victoria. Many were the visits to the old home in those declining years, especially after he had passed the 90th milestone. He often told them of the old days. He was a sober man, but used to take a night-cap or a bit of toddy, and when asked by the family as to why he so imbibed he would tell of his having had typhoid fever many years before and of how Dr. Davie, who had attended him at that time, had ordered whiskey for him and that for some reason this Doctor (he had since died) had never countermanded the order.

Dr. Helmcken was married in 1852 to Cecilia Douglas, daughter of Sir James Douglas, the Governor of Vancouver Island. He was always very active in all important developments in the new country. In 1855 he was first Speaker of the first Legislative Assembly (this without remuneration). From 1864 to 1871 he was a member of the Executive Council of British Columbia. In those stormy days, before Confederation was accomplished, there was considerable controversy in the western province which delayed its union with the Eastern provinces until 1871.

In that year Dr. Helmcken, accompanied by Dr. Carroll (late Senator Carroll) and Mr. Joseph Trutch (afterwards Sir Joseph Trutch), went to Ottawa to confer on terms of Confederation and brought back the "terms" in his pocket.

The Honourable Doctor J. S. Helmcken died in 1920 in his 97th year, respected and honoured by all. A real pioneer and a fine medical gentleman had passed,—a doctor who had served and one of whom much more could be written. His funeral service was a suitable benediction and was largely attended by the Victoria profession.

The Victoria Medical Society has a gavel and gavel block which was carved from a piece of a tree which was grown from a cherry-stone which Dr. Helmcken had planted in his garden, and so we hope the story of the "first doctor" will ever live even in these hectic days of speed and stress.

In the library of the Victoria Medical Society a gallery of portraits of all the pioneer practitioners has provided a stimulus to a sustained interest in early medical history.

While no written history of medical pioneering in British Columbia could be complete without reference to each and all those men who came to these shores to practise the healing art, time will not permit that I should more than mention many of them. However, we none the less revere their memory and pay tribute to them, not only because of noble work done but in many cases for what they have done for us who follow, in establishing the practice of medicine up to the passing of the Medical Act in 1886, when the College of Physicians and Surgeons of British Columbia was organized. (Licensure and Registration have served to regulate medical practice in this Province during 50 years.)

In passing I would mention Dr. Alfred Benson, who came to Victoria in 1849, remained a short time and moved to Fort Vancouver and practised there.

Dr. James Trimble, born in Tyrone, Ireland, in 1818, came to Victoria in 1858 and practised until 1885. In 1886 he was elected to the Colonial Legislature, was Mayor of Victoria for two years and served as speaker of the first Provincial Parliament after Confederation from 1871 to 1878. He died in 1885. In appearance he might have been the subject of the picture "The Doctor."

Dr. Joseph Beauchamp Matthews came to Victoria in 1860 and practised for twenty years or more. His photograph shows his side-whiskers well supported by the high-cut collar of an Inverness cape.

Dr. William MacNaughton Jones, born in Cork, Ireland, came to British Columbia in 1861, practised in various parts of the Province—New Westminster, Nanaimo, Barkerville and Victoria. He died in 1896 at William Head while Superintendent of the Quarantine Station.

Dr. John Ash arrived from England in 1862 and took up practice in Victoria. He was an able man and was recognized as such by the profession as well as the public. He, too, was a member of the Legislature.

Dr. Israel Wood Powell, a graduate of McGill, in 1860. He was born in Port Dover, Ontario, 1837; commenced practice in Victoria in 1862, and was a member of the Legislative Assembly of Vancouver Island 1863 to 1866. It is stated that he was responsible for the drafting of the School Bill, which established free schools for British Columbia, and was selected as chairman of the first Board of Education.

He made the first speech in Victoria on behalf of Confederation. He was one of the founders of the Grand Lodge of Free Masons in British Columbia, and was the first Grand Master in the Province from 1867 to 1871. He was for years the Indian Commissioner and was interested in a very intimate way in all phases of public life and development of the Province. Dr. Powell was the first president of the first Medical Council following the passing of the B. C. Medical Act, holding office in 1886 and 1887.

Dr. G. L. Milne, who has recently been removed from us by death, was most interested always in the affairs of the profession. He was a member of the Provincial Parliament and it was largely due to his efforts and organization work that the Medical Act came into being. He was a member of the Medical Council and Secretary and Registrar from 1886 to 1896. While Dr. Milne did not come to Victoria until 1880, I think it fitting that he be mentioned in association with the first president of the Medical Council.

The story of medical practice in British Columbia would be incomplete without a long chapter devoted to those men who went to the Cariboo in the good old days, which might be defined as the Mining Period.

While there was little sickness among those hardy mining pioneers, yet with 15,000 to 20,000 people in Cariboo in those days from 1860 to 1867, the Government established a hospital at Barkerville about 1862 under Dr. Thomas Bell. He is described as an English surgeon, well qualified, one who attended to his practice and left mining alone. He was recognised as skillful and was very popular. He was the outstanding medical man of that time in the Cariboo. He stuck to his work and was always sober. A miner had the end of his nose bitten off in a fight in 1866. Dr. Bell did a perfect plastic operation, using tissue of the forearm for a pedicle graft. He worked in the Cariboo until 1873-74, when he was succeeded by Dr. Watt, who, when the population of those parts had fallen off, was subsidized to serve the country from Yale to the north end of the Cariboo, a distance of four hundred miles. Dr. Bell died in Barkerville in 1880 and is buried there.

On one occasion when a Dr. Black, who was in charge of the Barkerville Hospital, was absent, Dr. Bell served for five months. When he rendered an account to the Hospital Committee his bill was disallowed and he was so informed in a carefully drafted letter:—"The profession of which you are so worthy a member has ever been distinguished by its unselfish and sacrificing devotion at the shrine of mercy. With pleasure the Committee record on their minutes the fact that in your person the Hospital found a kind friend and its patients a skillful adviser."

Among the men who came to Cariboo was Dr. Arthur Walter Shaw Black, surgeon at Williams Creek. He was elected member of the Legislature for Cariboo West in 1863.

Dr. Trevor, a clever young Englishman, practised in the Cariboo from 1863 to 1868. Dr. Wilkinson, a Canadian, practised from 1864 to 1866, when he died at Cottonwood.

Dr. John Chipp, English surgeon, went to Barkerville in 1864. He was reputed a good practitioner and was liked by all and was one of the men who kept sober at times.

Dr. T. M. Foster arrived in 1863 and is recorded as a Scotch gentleman who seldom charged for his services—did very little practice and was more interested in mining.

Dr. Siddall, an American Homeopathic physician, remained there from 1864 to 1868 and also interested himself in mining.

Dr. Robert Carroll came to Cariboo in 1867. It was he who accompanied Dr. Helmcken to Ottawa to arrange the terms of entry into Confederation. He was made a Senator.

In 1870 Dr. Brouse came to Yale; a son born there later became a doctor, graduated from McGill, practised in New Denver in the late nineties and came to Vancouver after the war, limiting his practice to skin diseases, and died in Vancouver a few years ago. A son of his is a graduate in medicine, became a house surgeon at the Vancouver General Hospital and is now reported to be practising in Saskatchewan.

There are many more men whose names will be recorded and should be, for the medical pioneer who served in the Good Old Days without the comforts of modern practice deserves not only a mention, but our recorded recognition of the respect in which we shall ever hold him. Those men held no parley with unmanly fears.

In looking over the history of our Medical Council one finds the names of Simon J. Tunstall of Kamloops, W. J. McGuigan of Vancouver, Dr. C. N. Trew of New Westminster, Dr. E. B. C. Hanington of Victoria, who came to British Columbia in 1878 and, with headquarters at Yale, was chief surgeon on construction from Port Moody to Spences Bridge, with Dr. J. W. Lefevre of Vancouver and Dr. S. J. Tunstall at either end of this line. Dr. Hanington later practiced in Victoria and was the first president of the Victoria Medical Society. His son, Dr. D. B. Hanington, is now practising in Ladysmith.

The name of Dr. J. C. Davie appears on the first Medical Council. Dr. Davie came to Victoria from England with his father, Dr. John Chapman Davie, Sr., in 1862. He had already commenced his medical training and went to California and graduated from what was then Cooper Medical College in 1865. He returned to practise in Victoria and rapidly became the outstanding physician and surgeon of his time in this province.

Dr. Davie did much to develop the hospitals in Victoria and was not only a bold surgeon but a skillful one, a good diagnostician with a keen scientific mind, and might almost be described as the father of surgery in British Columbia. Now that I have told you somewhat of his qualifications, I feel that I shall not be censured if I attempt to describe his quality. We shall see a well-dressed, incisive, neatly formed man with an energy which endures the stress of hard and long hours. His language at times was superb —one wonders where he learned some of the words—possibly a mixture of his medical schools in England and California. He possessed a strong urge for large checked plaid suits and wore a largish diamond in his scarf-pin.

On the occasion of one of his many visits to California, he had the misfortune to travel at a time when an English absconder was wanted. The description of this gentleman-at-large tallied with the loud-checked suit and diamond. On the arrival of the ship at San Francisco, two detectives surprised Dr. Davie into profanity by escorting him to the local lock-up. After twenty-four hours he was able to establish his identity and I rather suspect that the authorities were glad to release this pepper-pot from Victoria.

On another occasion a younger doctor had a male patient on the operating table. He was showing marked signs of suffocation from a laryngeal obstruction. Dr. Davie knew this patient, with whose family there had been some long-standing differences. He picked out a scalpel, and as he

deftly plunged it into the trachea, said, "Now, breathe, damn you." The patient breathed freely.

When Dr. O. M. Jones came to Victoria, he was associated with Dr. Davie, but they were each possessed of much the same forcefulness of character, possibly shown in different ways, but they parted largely because of differences growing out of their similarities. Dr. Jones had, after one of his trips to Europe, adopted a chlorine scrub and was using the lime and washing soda when Dr. Davie passed and enquired as to the origin of the new smell. On being told that Dr. Jones was scrubbing for his next operation, he remarked, "My God, he must be dirty!"

Much more could be written of these early practitioners, and in the near future I feel that some attention should be given to those men who have survived those early days and to those who laboured in the 80's and 90's. As time passes it becomes increasingly difficult to secure the facts. I would urge that the profession throughout Canada set itself the task of compiling its history. Much profit and pleasure attaches itself to such an effort. The study of the past is a stimulus we all need and builds up a reverence and respect which will redound to the benefit of the individual and the whole profession.

We owe it to those grand men who have anteceded us,—we owe it to ourselves and to those who will follow, to inscribe a background for the Canadian profession. There have been many names, some of men who have passed, some of those who are still with us, which I have been tempted to include in this paper, but I have left that pleasure to one with a more able pen.

Whatever I have said of those with whom I have dealt will in no way detract from the glory of those who followed later. Those who practised the art of healing in the Province in the nineties and in the early years of this century are known to us, and many who are still with us we but partly appreciate, and Kipling's lines might be applied in their particular cases:

"We are too close to appraise what manner of men they are."
"They are too near to be great, but our children shall understand."

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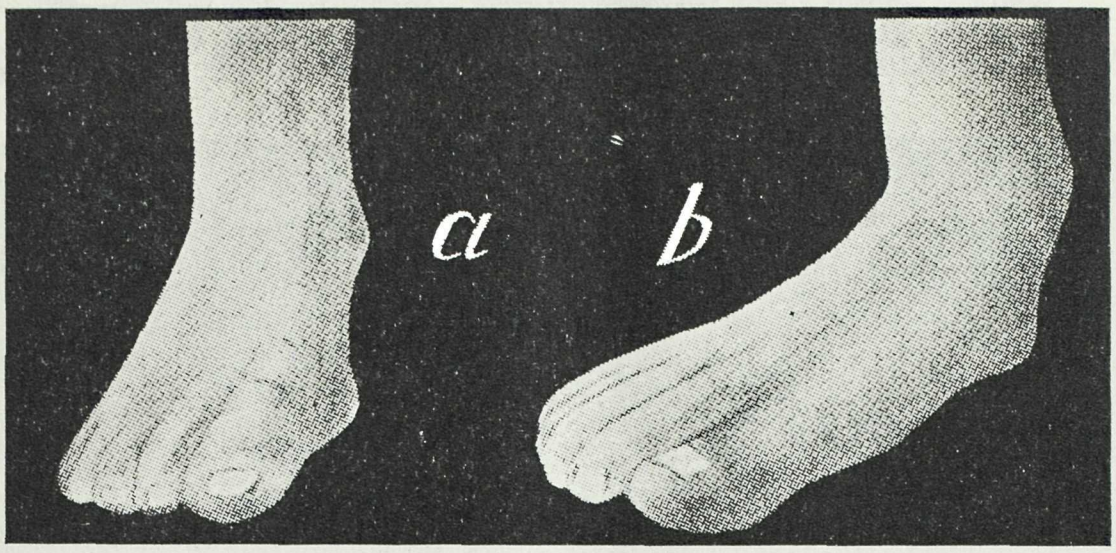

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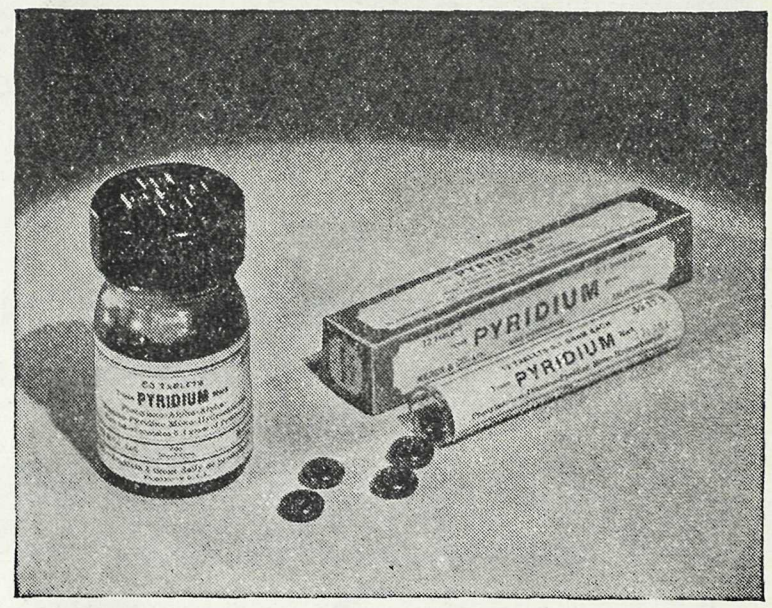

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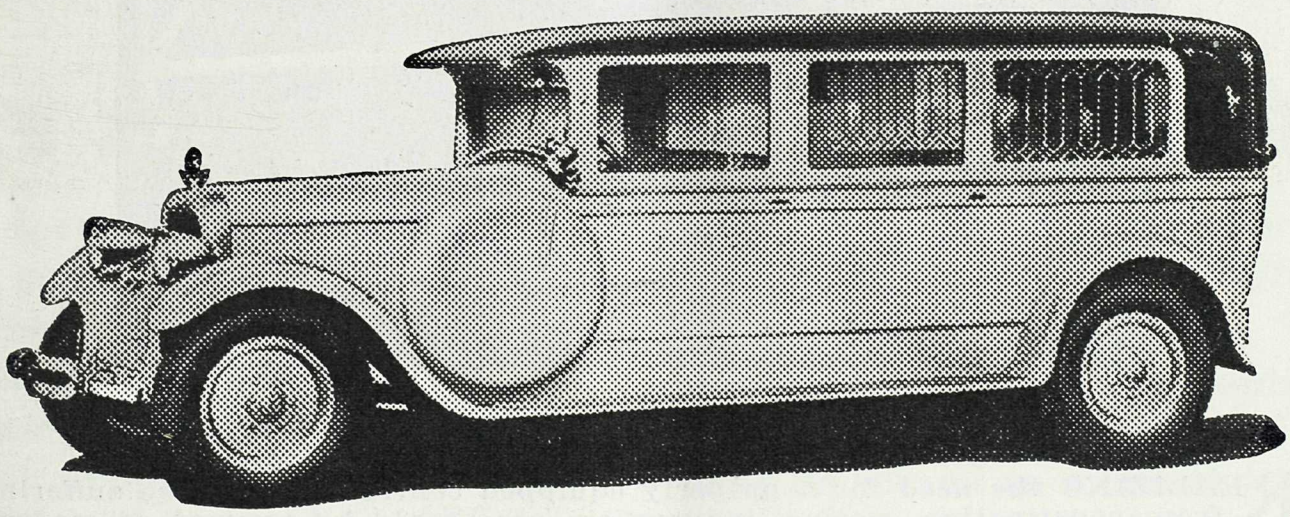

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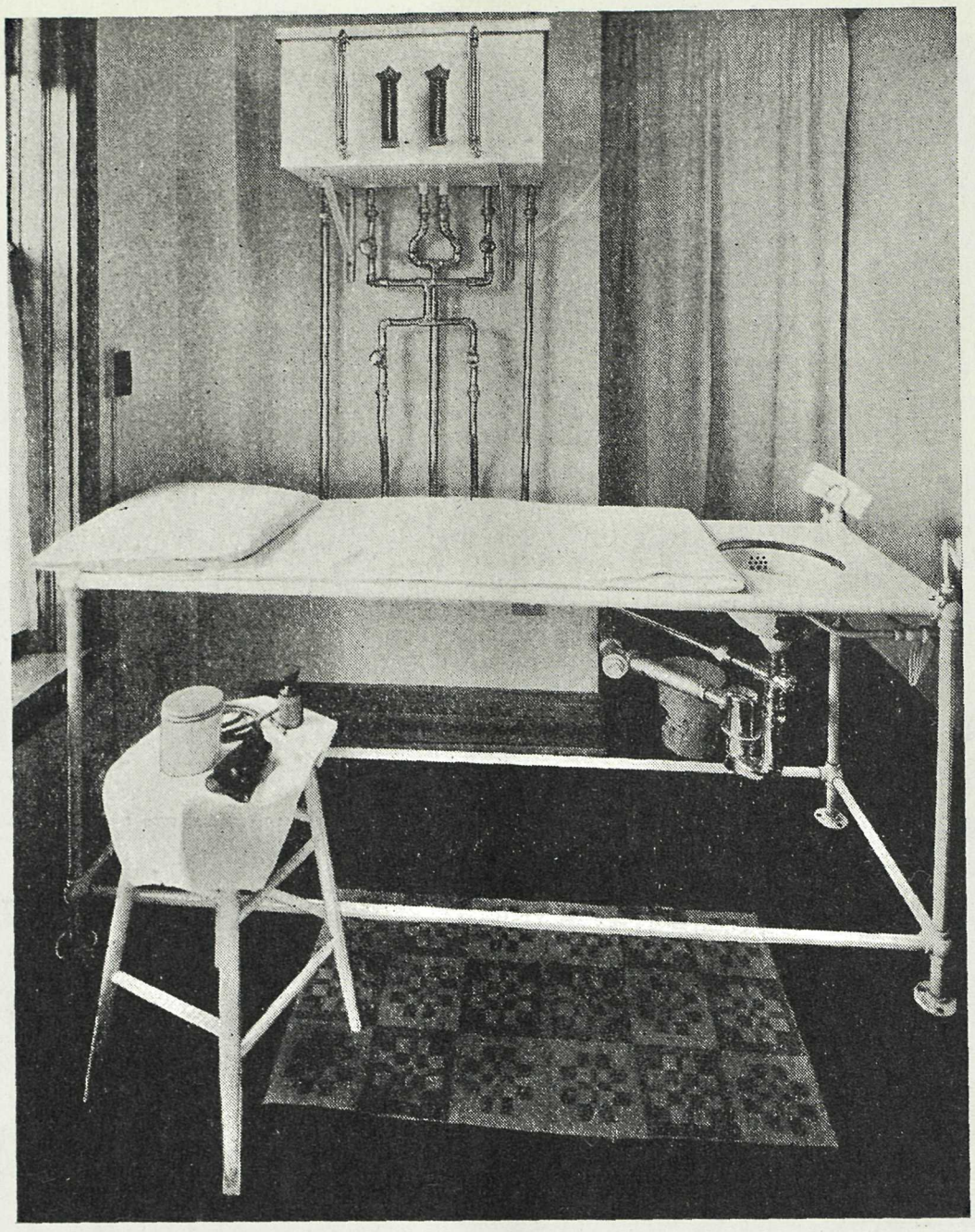

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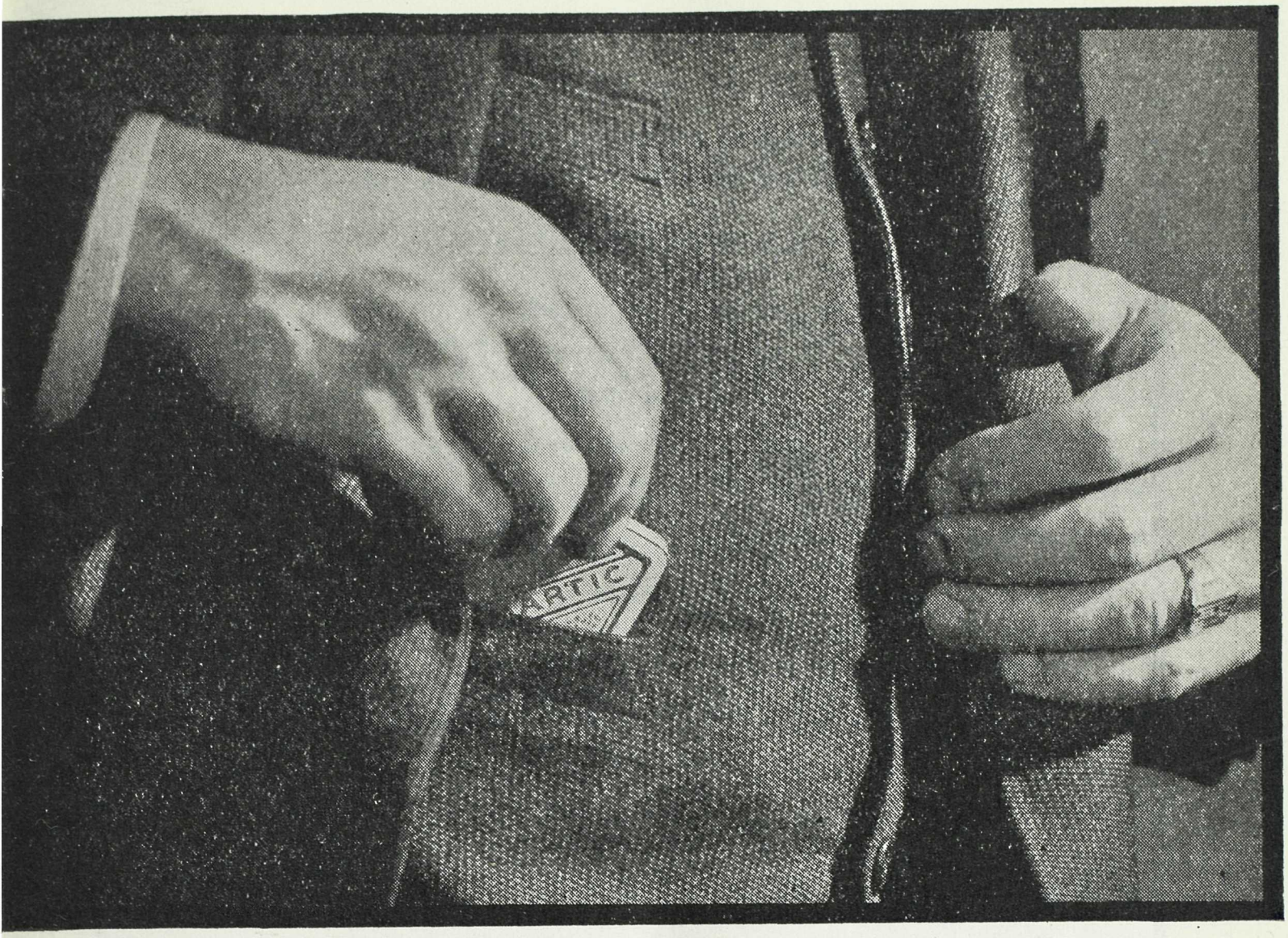

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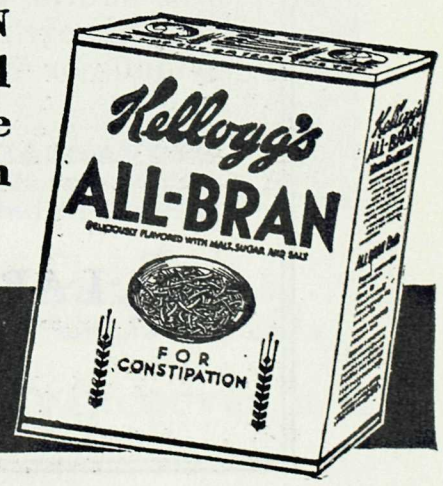

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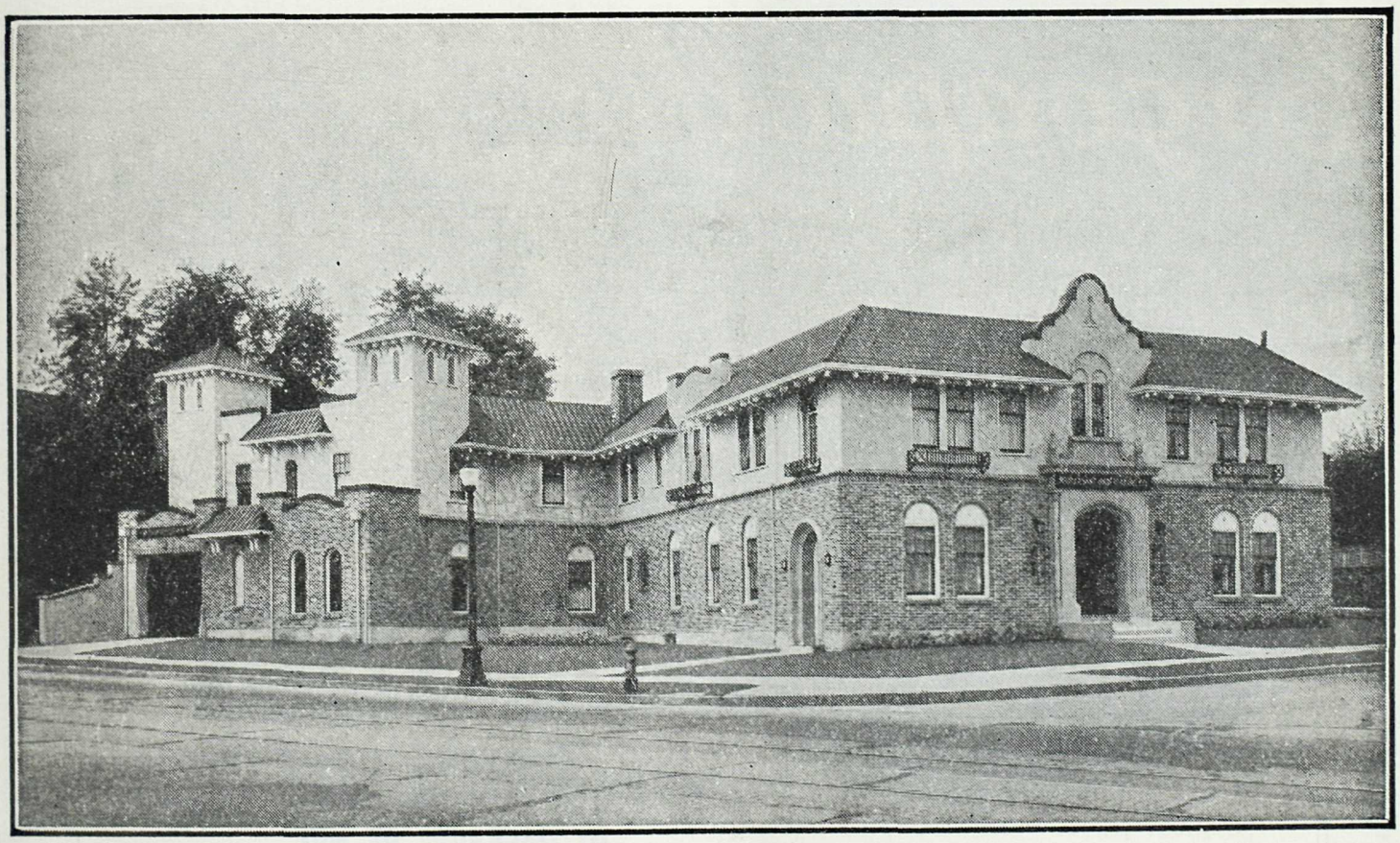

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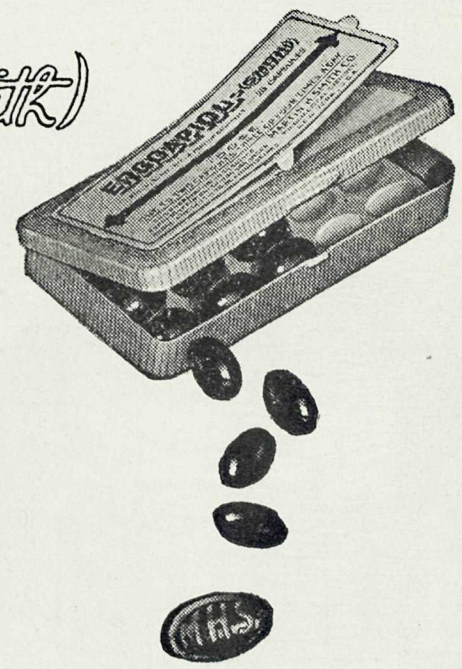

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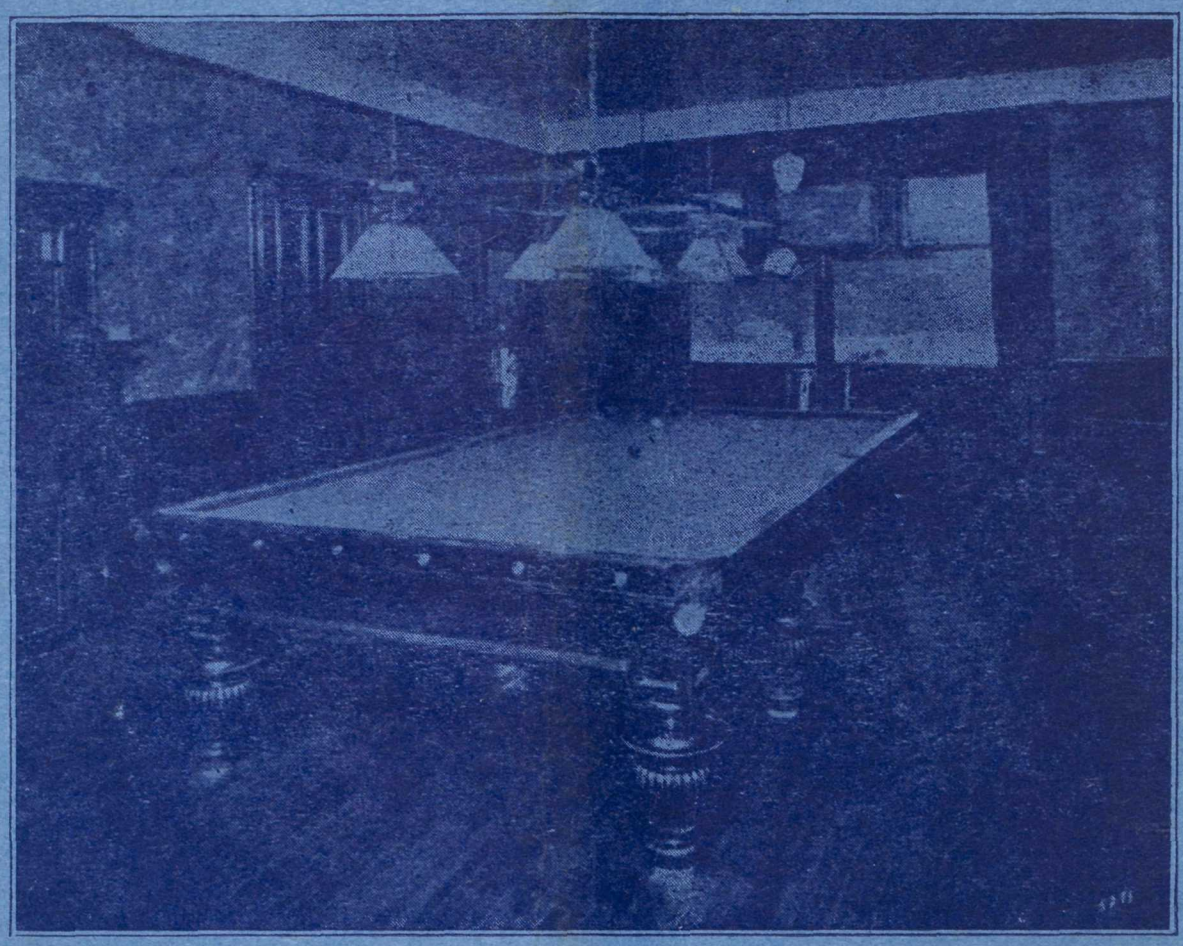

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