The . . .

BULLETIN

of the . . .

VANCOUVER MEDICAL ASSOCIATION

With Which Is Incorporated
Transactions of the

VICTORIA MEDICAL SOCIETY

the

VANCOUVER GENERAL HOSPITAL

and

ST. PAUL'S HOSPITAL

In This Issue:

VOL. XXI. NO. 2 NOVEMBER, 1944

Vitamin-Mineral Therapy

WITH

MINEROVITE

E.B.S.

VITAMINS *PLUS* MINERALS

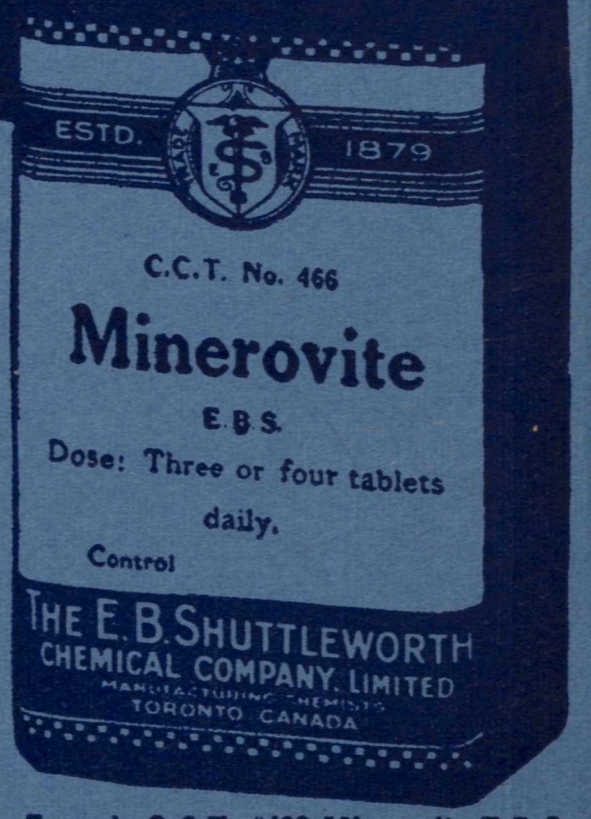
Only occasionally does one find clear-cut cases showing deficiency in only one vitamin. Generally, vitamin deficiencies are multiple and give rise to a confused clinical picture very difficult to diagnose. The skin, haemopoietic, digestive, nervous and cardiovascular systems may be involved. When confronted with a diagnosis suggestive of deficiency, but not clear-cut enough to indicate positively which vitamin is lacking, a multi-vitamin preparation is indicated.

***MINEROVITE, E.B.S.* is such a preparation, containing in each tablet about half the recommended daily minimum of each of the vitamins known to be essential to human health. For guidance in prescribing the proper dose, the accompanying table, showing the composition of Minerovite, appears on every bottle.**

INDICATED as a prophylactic vitamin and mineral supplement in cases of diets restricted for reasons of allergy, peptic ulcer or convalescence and a therapeutic remedy in cases of hypovitaminosis.

***TRACE ELEMENTS :** Some years ago, agricultural researchers began to track down the cause of deficiency diseases that affected livestock in some areas. It was found that the lack of minute amounts of certain elements ('trace elements' they have been called) was responsible, and several such elements have been found, small quantities of which are essential to healthy mammalian life. Such are the copper and manganese incorporated in Minerovite, 100 mgs. of each. per tablet.

**Oscar Baudisch, J.A.M.A., Vol. 123, Page 959*



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Each tablet contains:

Vitamin A	*2500 Int. Units*
Vitamin D	*400 Int. Units*
Vitamin C	*17.5 mgms. (350 Int. Units)*
Vitamin K	*.008 mgms. (200 Dam Units)*
Vitamin B_1 (Thiamin Chloride)	*.375 mgms. (125 Int. Units)*
Vitamin B_2 (Riboflavin)	*.50 mgms.*
Vitamin B_6 (Pyridoxine Hydrochloride)	*.125 mgms.*
Pantothentic Acid	*.125 mgms.*
Niacin	*5.0 mgms.*

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THE VANCOUVER MEDICAL ASSOCIATION

BULLETIN

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

Offices: 203 Medical-Dental Building, Georgia Street, Vancouver, B.C.

Vol. XXI. NOVEMBER, 1944 No. 2

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Moreover, chewing provides a gentle stimulation of surrounding muscles, helping to relieve local spasticity and stiffness, promoting tissue repair. The patient is more comfortable, willingly assumes a suitable diet earlier: convalescence is hastened.

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Ethically promoted—not advertised to the laity. In boxes of 16 and moisture-proof bottles of 250 tablets. Write for samples and literature to W. Lloyd Wood, Ltd., 64-66 Gerrard Street, East, Toronto, Ontario.

Dillard's **Aspergum**

VANCOUVER HEALTH DEPARTMENT

STATISTICS—SEPTEMBER, 1944

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

	Number	Rate per 1,000 Population
Total deaths	266	10.8
Japanese deaths	.....	Population Evacuated
Chinese deaths	14	29.8
Deaths—residents only	237	9.7
BIRTH REGISTRATIONS:		
Male, 318; Female, 300	618	25.1

INFANT MORTALITY:	Sept., 1944	Sept., 1943
Deaths under one year of age	22	13
Death rate—per 1,000 births	35.6	22.4
Stillbirths (not included above)	13	9

CASES OF COMMUNICABLE DISEASES REPORTED IN THE CITY

	August, 1944		Sept., 1944		Oct. 1-15, 1944	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
Scarlet Fever	19	0	20	0	10	0
Diphtheria	0	0	0	0	0	0
Diphtheria Carrier	0	0	0	0	0	0
Chicken Pox	9	0	19	0	10	0
Measles	5	0	21	0	56	0
Rubella	2	0	6	0	0	0
Mumps	17	0	14	0	5	0
Whooping Cough	7	0	20	1	15	0
Typhoid Fever	4	0	0	0	0	0
Undulant Fever	0	0	0	0	0	0
Poliomyelitis	0	0	0	0	0	0
Tuberculosis	46	8	87	7	25	–
Erysipelas	2	0	1	0	0	0
Meningococcus Meningitis	2	0	1	0	0	0
Paratyphoid Fever (Carrier)	1	0	0	0	0	0
Infectious Jaundice	0	0	0	0	0	0
Typhi-murium	0	0	6	0	4	0
Typhi-murium (Carrier)	0	0	2	0	0	0

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

	Vancouver	Rich-mond	North Vancouver	Burnaby	West Vancouver
Syphilis (September)	45	—	—	—	—	45
Gonorrhœa (September)	103	2	—	—	—	105

ALIKE IN APPEARANCE — *But-*

Tiny bodies, externally alike, may differ basically in their requirements of Vitamin D. That is why Squibb Cod Liver Oil comes in two potencies—Squibb Cod Liver Oil for normal babies and Squibb Cod Liver Oil with Viosterol 10D for premature or rapidly growing infants.

● Today, as in 1875, Squibb Cod Liver Oil is helping babies build strong, healthy bodies. They didn't know it then—but now most people realize that it isn't the oil itself—but the vitamin content of the oil that counts.

Squibb Cod Liver Oil is twice as rich in vitamins A and D as oils just meeting official pharmacopeia requirements. Therefore your patients have to give their babies one teaspoonful only of Squibb's daily as against two teaspoonfuls of these less potent oils.

The high quality of Squibb Cod Liver Oil is the result of careful rendering and refining of specially selected livers. Excessive heating and exposure to air is avoided and the final oil is carbonated and bottled under carbon dioxide to avoid oxidation of vitamin A.

Squibb Cod Liver Oil supplies, per gram, 1800 Int. units of vitamin A and 175 Int. units of vitamin D. It is available in 4 and 12 ounce bottles either plain or mint-flavoured. Premature or rapidly growing infants need extra vitamin D and should therefore receive Squibb Cod Liver Oil with Viosterol 10D, which contains 3000 Int. units of vitamin A and 400 Int. units of vitamin D per gram.

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VANCOUVER MEDICAL ASSOCIATION

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* * * *

PROGRAMME OF THE FORTY-SEVENTH ANNUAL SESSION

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

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

General meetings will conform to the following order:

8:00 p.m. Business as per agenda.
9:00 p.m. Paper of the evening.

January 2—GENERAL MEETING: Cancelled.

January 16—COMBINED CLINICAL MEETING AND STAFF MEETING AT VANCOUVER GENERAL HOSPITAL.

February 6—GENERAL MEETING:
Carcinoma of the Cervix—Dr. Ethlyn Trapp.
Late Manifestations—Urological—Dr. L. R. Williams.
Rectal—Dr. A. T. Henry.
Neurological—Dr. Frank Turnbull.

February 20—COMBINED CLINICAL MEETING AND STAFF MEETING AT ST. PAUL'S HOSPITAL.

March 6—OSLER LECTURE.

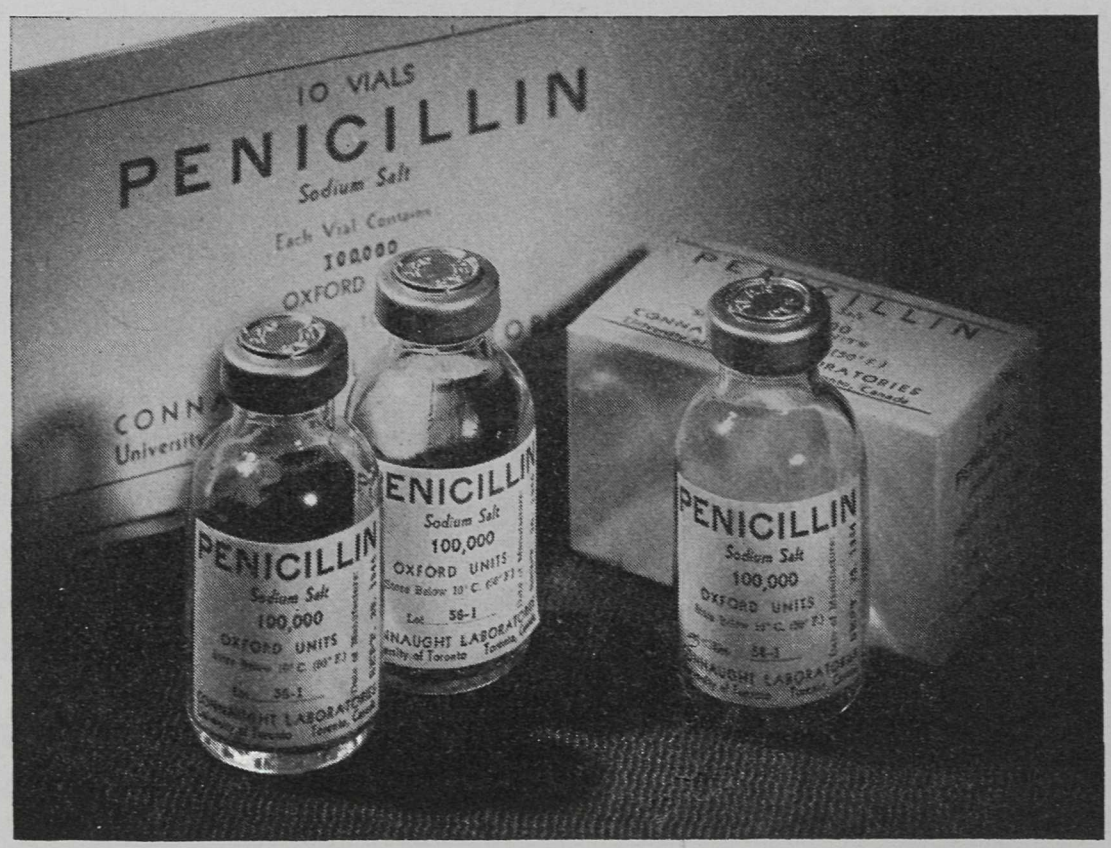
March 20—COMBINED CLINICAL MEETING AND STAFF MEETING AT VANCOUVER GENERAL HOSPITAL.

April 3—GENERAL MEETING: Penicillin Therapy.
Discussion to be led by Major W. W. Simpson, R.C.A.M.C.

April 17—COMBINED CLINICAL MEETING AND STAFF MEETING AT ST. PAUL'S HOSPITAL.

May 1—ANNUAL MEETING.

PENICILLIN . . .



To assure that Penicillin would be available for the needs of the Armed Services of Canada, the Dominion Government made possible, a year ago, the establishing of two production plants, one of which was in the Connaught Laboratories.

Production was commenced in the Connaught Laboratories within seven months and today large quantities of Penicillin of high quality are being produced.

The entire amount of Penicillin produced in the Connaught Laboratories is allocated to the Armed Services.

As soon as circumstances permit, Penicillin prepared by the Connaught Laboratories will be available for civilian distribution in Canada.

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THE EDITOR'S PAGE

At the last Annual Meeting of the British Columbia Medical Association, a most significant report was read by the Chairman of the Committee appointed to consider the question of a Medical School for British Columbia. The 1945 Session of the Legislature of the Province meets in January or February of next year, and we feel that something should be said about this, so that we may enlist as active workers towards this end, not only those who understand and appreciate the need for it, not only those medical men who live in or near Vancouver, but every medical man in the Province, every member of the Legislature, every educational leader, and last, but by no means least, the public at large, who will ultimately have to bear the cost—and who must be shown how great the need is, not only from our point of view, but even more from their own.

The urgency of the case is beyond question. We hear on every side of the plans that are being drawn up for social betterment, and we welcome and applaud these suggestions—we know, indeed, that they are long overdue. We know that the public is right in insisting on more and better medical service—on greater social security, on more efficient prevention of disease, mental hygiene measures ,and a more even distribution of our medical resources. And we know that if all this is to be accomplished on any reasonably satisfactory scale, the presently available number of doctors is altogether too far below the number that will be needed. Nor is it going to be possible to staff the positions necessary from any source of supply that we now have of medical men. The medical schools now in existence in Canada cannot begin to turn out medical graduates in sufficient number.

It takes years to make a doctor, and we cannot get started too soon. Even if several medical schools opened their doors tomorrow, it would be a long time before the effect would be felt. Therefore time is "of the essence of the contract," and we should be thinking in terms of speed.

British Columbia is especially in need of a school. We need not at this juncture labour the point so clearly made by our Committee, that Eastern schools are finding it impossible to allot enough vacancies to candidates from British Columbia, that our young men are losing opportunities that should be theirs. Both Canada and British Columbia suffer from this fact. The only remedy is to start one of our own.

It would seem, in view of the physical conditions, that Vancouver is the logical place, in fact the only place at present, where a medical school can be built at present, which would offer facilities of training. This is not to say that only in Vancouver should there ever be a medical school. British Columbia is growing, and there would seem to be no reason why ultimately another excellent school should not be built elsewhere—e.g., Victoria, with its good hospitals and its steadily developing medical facilities. When that day comes, we should give it our utmost support.

Meantime, Vancouver must be regarded in this matter, not as the City of Vancouver, but as a suitable site for the British Columbia Medical School. This will, of course, be best attached to the University of British Columbia, not necessarily entirely situated within the campus of that institution as at present—for obvious reasons of clinical teaching—but under the jurisdiction, and within the corporate structure, of the University.

We shall be told, *ad nauseam,* of the difficulties that exist, of the needs of other faculties, of the desirability of a law school, of the lack of money to satisfy everybody.

In this matter we do not think any of the arguments are sound. Is there a crying need for a Medical School? There is. Have we the facilities and the material and personnel to establish a first class Medical School? We have, as nobody could doubt who sees the excellent hospital facilities and possible material in the way of lecturers, teachers,

which are already available to be drawn on, and which could easily be supplemented from other sources if the opportunity were given.

We are apt to be too much impressed by size. Vancouver is not in the million-population class, but we may do well to remember that Montreal and Toronto were turning out excellently trained doctors when they were not nearly as big, and had nothing like the hospital sources of clinical materials that we have—that Winnipeg, which is not as big as we are, has for a generation and more been giving a training in medicine second to none; that Edmonton, with less than half our population, is doing the same. We should have had a school here twenty years ago.

The need is urgent, and the money can and must be found. But we must make the need plain, and the medical men of the province are the ones who can and must do this. Every medical man in British Columbia should be behind this, should preach it in and out of season, should importune those in authority, and "wear out the doorsteps of their houses" doing this.

We quoted Dr. McPhedran of the Canadian Medical Association in this matter, when he told us that we must ourselves sell this scheme to the public, and be propagandists and teachers. We may also quote Dr. Herman L. Kretschmer, President of the American Medical Association, who stressed the fact, in addressing the House of Delegates at the A.M.A. meeting that "*practising physicians*" (not, mark you, Committees, or the Council of the College, or the Secretaries of the various Associations) "should devote at least two hours a day to educating the public. . . ." "The physician should serve as his own public relations man within the profession."

Dr. Eben J. Carey, Dean of Marquette University School of Medicine, says, "The medical education of the public is not the responsibility of the politician, but of the members of the medical profession."

With all this we thoroughly agree. THE BULLETIN hopes at an early date to go more deeply into this matter. In the meantime, we urge our readers to read and reread the parable of the Importunate Widow and to remember that homely proverb, "The hinge that squeaks gets the grease."

LIBRARY NOTES

RECENT ACCESSIONS TO LIBRARY—

Surgical Clinics of North America, Symposium on Cancer, Barnard Hospital Number, St. Louis, October, 1944.

Manual of Military Neuropsychiatry, 1944, by Harry C. Solomon and Paul I. Yakovlev.

Transactions of the Ophthalmological Society of the United Kingdom, Vol. 63, Session, 1943.

Autonomic Regulations, 1943, by Ernest Gellhorn.

Gastro-Enterology, Vols. 1 and 2, 1943, by Henry L. Bockus.

Text-Book of Ophthalmology, Vol. 2, by Sir W. Stewart Duke-Elder.

Intravenous Anæsthesia, 1944, by Richard C. Adams.

SPECIAL SUPPLEMENTS—

Special issues of two well-known journals will be received with much interest. *The British Journal of Surgery* has published an extra number, devoted to Penicillin in Warfare. A wide range of cases is reported by members of the British and U. S. Army Medical Staffs, and these are taken from experiences in various theatres of war. The introductory articles include one on "The Principles of Penicillin Therapy," by H. W. Florey and M. A. Jennings, and one on "Bacteriological Methods in Connection with Penicillin Treatment," by L. P. Garrod and N. G. Heatley. The two concluding articles cover penicillin therapy in gonorrhœa and syphilis.

The American Journal of Ophthalmology has issued a second section to their October number, which contains the sixth de Schweinitz Lecture of the College of Physicians of

Philadelphia, Section on Ophthalmology, given by Henry C. Haden. The title is, "Concerning the Relations of the Developing Optic Nerve to the Recessus Opticus and the Hypophysis in Young Fœtuses: A Study of Seven Human Fœtuses 4 M. M. to 40 M. M., Inclusive." Forty-one illustrations, which compose the major part of the publication, were made from unretouched photographs of sections of human embryos and fœtuses in Dr. Haden's private collection.

DOCTOR BAGNALL AND THE MEDICAL LIBRARY

In 1920 the Library of the Vancouver Medical Association was in its early adolescence when an event that was to mould its future for twenty-five years occurred. Wallace Bagnall was elected to the Committee in charge of the Library.

The greatest event in the development of the Library prior to this had been the donational benediction of Sir William Osler, with his fervent insistence on the importance of a library in the medical community. Doctor Bagnall believed in this almost to the point of fanaticism and gave of his time, energy and ability more than most physicians realized. It would surprise most of us to know that at least every other book in our library had been chosen by Doctor Bagnall; it would amaze us still more to know that he believed our library to be wholly inadequate for the cultural needs of a medical fraternity; but it would not astound those of us who worked with him that he envisaged a scientific library that would give British Columbia an access to all branches of science. His views on the development of our library were such that physicians were wont to dismiss him as a visionary. He deplored the inadequate physical accommodation, the popular or democratic election of men often little interested in, or qualified to be a judge of, the upkeep or growth of a library, and the lack of general appreciation of the influence of a library on the quality of medical practice. He dreamed of a general medical library serving not only our Association but the University, our medical school and the province at large—a physicians' club with lunch and tea rooms, a common meeting place dominated by the intellectual influence of an eclectic library.

His help to the library was not only advisory or theoretical. He rarely missed a meeting of the committee, even in the last year when he might well have rested to advantage, he spent evenings in sorting out and discarding the dross and superfluous from the huge numbers of books that have long been gathering dust in the cellar of the library. With a tenacity that at times could become a downright annoyance, he insisted on buying books in research, in the auxiliary sciences, and in cultural subjects. His cutting retort to any objections would be that, even if older ones were not reading these books, younger and better men were coming along and the material must be here for them.

Osler has said, "In the continual remembrance of a glorious past, individuals as well as nations find their noblest inspiration." One of the greatest legacies of our profession is the memory of great physicians in each community. For sustained interest, continuity of effort, idealism and realism nicely balanced, and avoidance of all personal publicity, this was one of our community's greatest physicians. His "understanding was keen, skeptical, inexhaustibly fertile in distinctions and objections; his taste refined; his temper placid and forgiving, but fastidious, and by no means prone to malevolence or to enthusiastic admiration."

This is a poor expression of the affection and respect in which the Committee of your Library held Doctor Bagnall, but in the near future, we shall give you the opportunity to participate in a development in your library which will commemorate the Bagnallian tradition and hopes in such a manner that, were Doctor Bagnall here, he would say, "Well done."

—THE LIBRARY COMMITTEE.

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(Canadian Medical Association, British Columbia Division)

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PSYCHIATRY IN GENERAL PRACTICE

By Dr. G. H. Stevenson (Toronto)

Read at British Columbia Medical Association Annual Meeting.

Perhaps a slight change of one letter should be made in the title of this paper to make it read—"Psychiatry Is General Practice" rather than "Psychiatry in General Practice."

I offer this suggestion seriously because of the growing appreciation that general practice is not limited only to the physical abnormalities that afflict us, those caused by physical etiology, bacteria, toxæmias, degeneration, etc. The physical field is no small field and a thorough training in these aspects is no small achievement, but its boundaries have been extended by a new dimension—the emotional factors in disease and health. True, physicians have perhaps always recognized that there were mental elements in physical disease, such as the effect of the attitude of the patient to his disease as affecting its outcome. He knew that worry often seemed to have an adverse effect on the well-being of the individual. He remembered that Crile thirty years ago demonstrated that certain hyperthyroid cases recovered without operation when relieved of their domestic or economic problems. He knew that his own psychological approach to a patient was important in maintaining the confidence of the patient in him and helping the patient toward recovery. It may sometimes have facetiously been referred to by others as "the bedside manner" but actually he was including a form of psychotherapy in his treatment programme.

In 1920 Professor Walter B. Cannon of Harvard published his monumental work "Bodily Changes in Pain, Hunger, Fear and Rage," in which he showed how stormy emotions, operating through the sympathetic nervous system, produced in experimental animals the effects of increased blood sugar, rapid hearts, elevation of blood pressure, decreased production of digestive juices, arrested digestion and inhibition of peristalsis. Valuable as these effects may be to us and to lower animals in times of great danger, to enable the animal to fight better or to run faster, tney nevertheless become a handicap and an interference to the welfare of the animal if they continue when the need no longer exists. And yet so many of our patients come to us with sleeplessness, digestive disorders, cardiac complaints, which if analyzed thoroughly, may prove to be due to continued emotional conflicts and disturbances, rather than to any disease of the body itself.

In 1935 Helen Dunbar brought together in one volume, "Emotions and Bodily Change," practically everything that had been published on this subject. It is still the basic reference work in this field.

In the intervening years much additional work has been published showing the interplay of the mental and physical, leading to the coining of a new word to express this body-mind relationship, the word "psychosomatic." An organization for research in psychosomatic medicine has been formed, the *Journal of Psychosomatic Medicine* is

published regularly. Since 1939, Weiss and English have published the first edition of a textbook on psychosomatic medicine. A new volume by Dunbar entitled "Psychosomatic Diagnosis" has been published within the past year.

The present war as well as World War I enlarged our knowledge of psychosomatic medicine. World War I emphasized in great numbers of cases what we already knew less frequently in civilian life, that conflicting emotions of fear for one's safety and desire to be a brave soldier, produced so-called shell-shock in predisposed individuals. The present war has shown the effect of anxiety, homesickness and discontent in producing peptic ulcer as at least a large part of the etiology. Neurocirculatory asthenia with its multiform physical symptoms is now recognized as a neurosis with somewhat similar emotional origin. Perhaps psychosomatic medicine is beng overworked, perhaps too much is being claimed for it, but at least the general practitioner, to be fair to his patients and himself, must in many cases weigh the contribution of emotional factors in the causation of disease. Even such a general condition as fatigue may well be the expression of discouragement with the problems and responsibilities of life, indefinite pains, pelvic or elsewhere, may represent a psychic pain, as so commonly expressed in such phrases as "he gets under my skin" or "he gives me a pain in the neck." Nausea and vomiting may be the somatic equivalent of psychic repulsion to distasteful life situations. Some of these symptoms, referable to the abdomen, can simulate gall-bladder or appendicial disease and lead to unnecessary surgery.

A good general rule in the neuroses and the psychoses is to avoid surgery unless you have good reason to believe that the morbid condition is causing the mental illness and only then if other means have failed. Neuroses cannot be removed surgically but can be made worse by surgery. While focal infections, readily accessible, should be cleaned up by minor surgery, such as infected teeth, tonsils and sinuses, it is often definitely hazardous to open an abdomen without clear evidence of definite inflammation or other definite morbid process. Unless a retroverted uterus is definitely producing physical distress it may be much better to leave it surgically undisturbed; even hernias are best left unoperated, especially in middle life, unless they are more of a hazard and handicap to the patient than they commonly are. Within the past year I have seen a doctor with a history of two previous manic attacks develop a third attack immediately after herniotomy, and a bank manager, mildly neurasthenic, enter a deep depression and attempt suicide after the same operation. The mental changes accompanying hyperthyroidism may be rendered still more severe by surgical removal of the thyroid rather than by mdical treatment and psychotherapy.

Before leaving the matter of surgery in mental medicine I should like to refer to a surgical procedure of fairly recent development known as prefrontal lobotomy or leucotomy. Originated in France by Moniz some ten years ago, it was brought to this continent by Freeman and Watts, who have performed this operation frequently and published a volume concerning it by the title of "Psychosurgery." The operation is of special value in the agitated depressions of middle or later life which have failed to benefit by more conservative treatment. It consists in a trephine bilateral in the line of the coronal suture, and a severance of the tracts between the hypothalamus and the prefrontal areas of the brain. It does not appear to affect the intellectual capacity of the individual, but in selected cases the disappearance of worry and agitation are phenomenal, with good gain in weight and varying degrees of return to a good social and occupational adjustment. Dr. K. C. McKenzie of Toronto has operated on approximately 25 cases, 5 of whom have been patients of the hospital to which I am attached. Only one of our five is unimproved, a case of schizophrenia; four, suffering from involution melancholia, were able to return to their homes immediately after convalescence, in spite of several years of previous mental hospitalization and all four continue at home.

To return more closely to general medicine and psychiatry, I should like to caution practitioners as to the dangers of bromide administration in the actual causation of psychoses. The bromides have won a valued place in our pharmaceutical treatment of many conditions, but in addition to the gastric and skin conditions they sometimes

cause, they may also produce a state of cerebral intoxication. Given to relieve sleeplessness, so-called "nervousness" and other psychic disturbances, they may actually increase the symptoms to the degree of marked mental confusion and hallucinosis. Every mental hospital admits patients who would not have become admitted or become psychotic had the bromide tolerance and blood concentration of bromides been closely watched. Some patients may of their own accord take larger doses than prescribed and others may get their bromides through drug store purchase, but only too frequently the patient has taken the drug under medical direction. Commonly the people who develop a bromide delirium have kidney damage which inhibits the usual excretion rate and permits the bromides to accumulate in the bloodstream. Treatment depends on early diagnosis, immediate discontinuance of bromides, and the administration of common salt, 30-grain capsules, thrice daily until the bromide concentration is reduced well below the toxic level, which is usually 150 milligrams per cent.

This might be a good place to interject the suggestion that we drop the old term insanity and replace it, not by mental illness or psychosis, but delirium. As long as we think of the term insanity we are apt to think of something outside the field of general medicine. These terms all mean that the individual has experienced a mental change, from whatever cause or causes, of such an extent that he is unable to think clearly and coherently, he may have delusions and hallucinations and is unable to govern his conduct in a socially satisfactory manner. The common practice has been to think of delirium as of short duration and due to toxic or traumatic factors, and insanity as of long duration. This is not a very logical differentiation and I suggest no differentiation is indicated. So-called insanity or psychosis is merely a longer than usual delirium, a still unrecovered delirium, and is still within the province of the general practitioner.

A case in point might be the so-called puerperal psychoses. These distressing conditions following some confinements are due chiefly to toxic and debilitating factors on the one hand, or to emotional factors on the other, perhaps a combination of the two. The patient is delirious. If toxic she may clear up quickly under treatment, but it may not be a toxic delirium. It may be a manic-depressive delirium, which will last longer but will terminate in recovery, or it will be a schizophrenic delirium, which only too frequently runs a malignantly deteriorative course, to chronic dementia. But even in this last case the patient is still delirious perhaps years after the birth of her child and still a challenge to our research and our best and untiring therapeutic efforts.

While criticizing the use of the words insanity or psychosis, might I also suggest we discontinue use of the term "nervous breakdown." This is usually applied to the non-delirious mental disorders, the neuroses. But there is no nervous tissue pathology in these cases and certainly it is not broken down. People sometimes like to hide behind their "nervous-breakdowns," so-called, or take pride in them, aided and abetted at times by their medical practitioner. I suggest we call them by their correct name, emotional disturbances or disorders, which immediately puts some responsibility on the patient for controlling or regulating his emotional reactions to make them less likely to cause invalidism.

Distturbances of sleep are common in emotional disturbances, often being the early symptoms. While we do have to treat symptoms as they arise, I would suggest we not pay too much attention to the control of this particular symptom but concern outselves more with the underlying factors which have produced it. The patient doubtless will be greatly worried about his poor sleep and will insist on "sleeping medicine." His preoccupation with his sleep difficulty may be screening his real emotional conflict, and it is much easier to prescribe a hypnotic than to find the time in these busy days to thoroughly analyze his psychological problem. The administration of hypnotics by themselves, however, will not solve the problem, although affording temporary symptomatic relief. The danger of a bromide delirium I have already referred to. The patient may become addicted to hypnotics and we may find we then have an addiction problem also to treat. Some of them lose their ability to produce sleep except in increasing dosage with the possibility of damage to kidneys and also interfere with the clarity of

the patient's thinking. Remember, too, and tell your sleepless patient that nature will see that we get enough sleep, even though it may be light and frequently broken. Patients often claim they have not "slept a wink" but the observant nurse will record the fact that the patient perhaps did sleep for varying periods of time. The patient is not telling a falsehood, but the sleep being light and broken gives him the impression that he has been awake all night. Hypnotics should be exhibited only in the face of real need and if used should be discontinued speedily. A warm bath at bedtime, a light easily digested lunch, a quiet comfortable bed, persuasion and perseverance, with more attention to the underlying psychopathology might be thought of as a general regime in such cases.

Some of these symptoms of sleeplessness may be a part of the menopausal syndrome. I do not propose to enter this field except to refer to those cases of serious menopausal depression commonly known as involution melancholia. Although progress is being made with endocrine therapy we all know its results are none too satisfactory as yet. We still have a lot to learn and many improvements and refinements yet to be made in it.

I imagine, however, that the symptom of "depression" can cause a great deal of anxiety to the physician in general practice. Normal depressions can be sufficiently worrying, but the patient depressed and on the borderline between normalcy and a psychosis, presents a very difficult problem. You will urge constant nursing care, of course, twenty-four hours a day, the secure locking or removal of poisons, antiseptics, guns, sharp-pointed instruments, ropes, etc. But there are always wells and cisterns or nearby streams, or a person can jump from a window or rooftop. She can tie belts or sheeting around her neck. If you advise immediate removal to a mental hospital the relatives may feel you are too hasty. If you delay, you may have a suicide and be blamed for not having taken such action. The welfare of the patient is, of course, the only criterion which should guide us, and removal to a mental hospital should not be delayed if constant skilled supervision is not available or if the patient does not show good response to treatment. A family history of suicidal attempts or of depressive psychotic reactions may be a valuable help to us in making our decision.

I have just spoken as if there was no alternative between home nursing and the mental hospital in such cases, but there should be an intermediate facility, namely the psychiatric ward in the general hospital. This has been a development of the last twenty years in the United States, more particularly in the last ten, and we are making a slow beginning in Canada. True, you have had the psychopathic division of the Winnipeg General under the able direction of Dr. Mathers for many years. Toronto has had the Psychiatric Hospital. But every general hospital of fifty beds should have a small well-equipped psychiatric section, not only for observation but for protection of the patient and for at least preliminary treatment. A general hospital is not doing its full duty to the sick public if it refuses the delirious patient. Even the smallest general hospital should have a room or two (not in the basement or in a corner off the laundry) but close enough to the other wards for good nursing, treatment and availability of consultants. Victoria General Hospital in London has recently opened a 13-bed psychomedical ward with continuous hydrotherapy, electrotherapy, occupational therapy, dietetic facilities and skilled nursing. The ward is under the direction of the Chief in Medicine as one of his medical wards, treatment being directed by the psychiatrist on his staff. I cannot urge too strongly the importance of such a ward for the welfare not only of depressed patients but of any other psychiatric or psychosomatic problems occur ring in general practice.

I have referred to electrotherapy as one of the facilities on this ward and it is now a standard in most mental hospitals. Time does not permit an extended review of "shock" therapy, but I think "shock" therapy has been the most useful and promising therapy in psychiatric practice in the last twenty years. Beginning with insulin hypoglycæmic shock, then metrazol convulsive therapy, we have now come to favour electric shock as able to do therapeutically what these others did, and with fewer complications and much greater ease of administration. The rationale is still unknown but the effects,

particularly in involution melancholia, at times verge on the miraculous. In those patients who may not respond to this therapy, prefrontal lobotomy, referred to earlier in this paper, still offers one more valuable therapeutic prospect.

Before leaving involutional melancholia it might be noted that men may also go through an involution, usually later than in women, at fifty to fifty-five, with feelings of depression, discouragement, fear of psychosis, sexual impotence or reduced virility, insomnia and gastric disturbances. This may be called neurasthenia, but it might just as well be called the male climacteric and treated accordingly.

The largest psychiatric field is of courses the neuroses. Freud has said that the neurosis is the price we pay for civilization, and as it is a poor sort of civilization we have, it hardly seems worth the price. But the great mass of us have our neurotic tendencies and your offices have many people coming for help for these conditions. They are the greatest problem of Army psychiatrists as selection problems, and constitute the largest group of neuropsychiatric casualties. At one time many doctors, after examining a patient who complained of cardiac or gastric symptoms, and finding no organic pathology, might say he had nothing wrong with him, or he only imagines he is sick, or he is only a neurotic. None of these three statements would be a correct statement. If a person has symptoms which interfere with his adjustment to life he is sick, but the etiology may be psychic and environmental and not organic or bacterial, or, as indicated at the beginning of this paper, it may be a combination of the two. The symptomatology may be variable depending on the type of stress and the make-up of the individual, but each case calls for complete study of the family history, the life history of the individual, his problems, conflicts and adjustment difficulties and a careful physical examination. Correction of the psychic and environmental aspects of his life may yield high dividends in better health. The general practitioner may well be his own psychiatrist.

This presupposes some knowledge of psychotherapy, which means the use of mental influence in treatment. Although whole textbooks have been written on psychotherapy, and although some specialists concentrate on one form of psychotherapy, and scorn others, for those of us who take a middle of the road position, such extremes need not alarm us. Billings in his excellent little book "Elementary Psychobiology and Psychiatry" has a good outline which might be summarized as follows:

Symptomatic palliative measures, a building up physically by rest, diet, correction of physical handicaps, cultivation of new interests. In a more direct way an attempt is made to manage both the external environment and correct personality weaknesses. Careful analysis of all factors, positive suggestion, direction and re-education of the personality are then attempted. These general principles should also apply to the treatment of alcoholism, a neurosis not uncommon in men. Compulsive drinking (alcoholism) and drug addiction if viewed as psychoneurotic illnesses rather than as moral lapses, fall definitely within the scope of the practitioner. There is as yet no pharmacological or surgical treatment for these conditions but careful psychotherapy and adequate after-care yield better results than commonly thought.

I have suggested that psychiatry is not a specialty but rather a new dimension to general practice. Whether or not it is correct to say that psychiatry is general practice, at least I believe it is true to say that general practice certainly should include psychiatry.

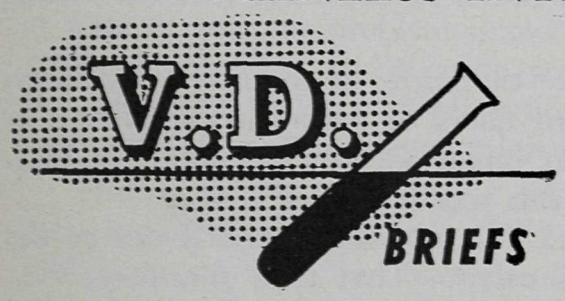
Preventive psychiatry or mental hygiene is the positive aspect of health education, the prevention of mental ill health and the preservation of good mental health. Here again the general practitioner has a similar responsibility as he has in the physical field for keeping the child or adult physically fit and warding off smallpox, diphtheria and typhoid by immunization. Perhaps practitioners generally may not feel too confident of their ability in the mental hygiene field, but I suggest they should familiarize themselves with it, so that they may give leadership to teachers and the general public in building up a more mentally healthy public than now exists. Time does not permit a discussion of mental hygiene principles here but I am prepared to review them with you if and when a suitable hour can be found. There are many good texts on the subject, some of

them by Canadians. The Canadian National Committee for Mental Hygiene, 111 St. George Street, Toronto, is prepared to supply lists of reading material on request.

The general practitioner might also engage in research in psychiatry. One remembers that Sir James Mackenzie made his studies in cardiology while in general practice. All the people who enter mental hospitals have been under your care before coming to the mental hospital. Nearly 30% of our admissions are the result of cerebral arteriosclerosis and so-called senility. Why should this be? Why should our brains wear out so much sooner than our hearts? You might have some observations over a period of years that would establish another mental hygiene principle and enable many more people to maintain good mental health until their hearts stop beating. Your experience with endocrines and other chemical agents if carefully noted should also be helpful. Nor should you send your early deliria to the mental hospital (unless too acute to care for safely locally), until you have attempted treatment (perhaps with the consulting service of the Provincial mental health clinic service).

It is worth noting that with the exception of senile and cerebral arteriosclerotic psychoses, all other psychoses are either declining or maintaining the same level as for many years past. The general practitioner has a large place in the treatment of psychosomatic disorders and the improvement of good mental health.

PAINLESS INTRAVENOUS TECHNIQUE



Try the use of an intradermal wheel of novocaine administered with a fine needle, as a prelude to removing blood specimens or administering arsenicals. Patients will be grateful. This technique will permit you to prod around for difficult veins. Patients won't disappear after the first "shot"—never to return.

* * * *

LATENT SYPHILIS—AN "EXCLUSION" DIAGNOSIS

All syphilis is *latent* at some time in its course. Most syphilis is *latent* at any given time. Diagnosis is established by:

(1) Repeated positive blood tests.
(2) No clinical evidence of disease.
(3) C.S.F. negative.
(4) X-ray heart and great vessels negative.
(5) Supportive historical evidence of syphilis.
(6) Supportive epidemiological evidence of syphilis.
(7) Exclusion of conditions causing False Positive tests!

* * * *

CONTACT INVESTIGATION

Somewhere in the community there is at least one contact associated with each V.D. patient's infection.

The physician's *most important* duty is to arrange for this contact to be examined.

The physician and his patient may determine the fate of many.

Where possible, the patient should arrange to bring his or her contact in for investigation.

If this is not feasible, identifying information concerning the contact should be passed to the Health Department for discreet, confidential investigation by specially qualified workers.

* * * *

"FIND V.D. CONTACTS — REPORT V.D. CASES."

Vancouver Medical Association

"FRACTURES OF THE OS CALCIS: IMPROVED METHODS OF TREATMENT"

By Lt.-Col. R. I. Harris

Read at Vancouver Medical Association Summer School.

The management of fractures of the os calcis is difficult. There are several reasons for this. First, the damage to the os calcis varies within the widest limits from an insignificant fissure without displacement to the most extreme degree of comminution with gross deformity. Such variation of injury makes standardization of treatment impossible. Secondly, the technical problems involved in reduction of the fracture are complex and difficult to solve. Thirdly, involvement of the subastragaloid joint is frequent. When this occurs, late disability from pain is inevitable even though a reasonably good reduction is obtained.

In so difficult and complex a problem it is not surprising that much difference of opinion exists regarding the best form of treatment, nor is it surprising that the results are often unsatisfactory.

In civil life, fractures of the os calcis are mostly the result of industrial accidents, falls from a height, from jumping down on to hard floors or pavements, resulting in fractures. But the fracture has become one of great importance in this war. In fact, it has become almost the characteristic fracture of this war.

At this point I will show you some slides. Here, for instance, is the X-ray of the heel of an airman who received this injury to his os calcis. That type of injury; viz., a powerful force applied from below, has in this war produced innumerable fractures of the os calcis. Sailors on board ship, whose ship has been torpedoed or mined, sustain the injury by reason of the fact that the deck of the ship is forced up against their heels and this produces fractures of the os calcis. Soldiers, driving vehicles over recently captured fields, run into land mines and the floor of the vehicle is driven against their heels, or sailors sliding down the sloping sides of a sinking ship go up hard against the bilge of the ship and suffer a fracture of the os calcis.

Not infrequently in these war casualties, the fracture of the os calcis is combined with compression fractures of the vertebral column, so we have, at this particular moment, ample reason for devoting a little time to this subject.

I must say that in war casualties the problem has not been very satisfactory there, the chief reason being that in the forward area the facilities for dealing with this fracture in an adequate fashion all too often don't exist. It requires some equipment which is not standard in army hospitals and which will demand the ingenuity of the surgeon to improvise what he can. More important, it requires the interest of someone who knows something about fractures of the os calcis. By the time the man gets back to the general hospital where we may find instruments and staff capable of handling the problem, it is too late because union of some sort has already begun. And all too often this problem of organization of treatment for specialized problems, of which fractures of the os calcis are one, leads to that kind of imperfect result. The other kind of thing is that in the management of fractures, particularly difficult complex problems, there is a moment early in their course when skilled treatment by those who are experienced can do the most for the fracture, but if that moment passes, then the improvement which could have been obtained by skilled treatment cannot be gained even though the patient later is placed in the hands of those experienced with it. We must remember that not only are there certain problems which need expert help, but in order to gain the best from their skill they must be able to deal with them before it is too late.

In civil life, the Workmen's Compensation Board knows perhaps as much about this injury as anybody else. Here, for instance, are records supplied me by Dr. Bell of the W.C.B. in Ontario of some sixty consecutive cases of fractures of the os calcis, indicating the duration of total disability, which meant the time lost from the moment of the accident until the man returned to work, and you will notice how long is the period of disability. It ranged from a month in an insignificant case, to a large group, the majority of which were from 7, 8, 9, 10 to 12 months away from work. The great majority of cases were back to work within 15 months, but that is a long period of disablement for this rather simple fracture. Of these 60 cases, most of them were left with some partial permanent disability, necessitating compensation. Thirty-five were placed on pensions varying from 3% to 50%. The remainder received compensation. Not one case reached a finality with no disability at all. The average cost was great—$1350 per patient.

The most important landmark in our treatment of fractures of the os calcis has been Boehler's contribution and his work has done more than anything else to improve our management of fractures of the os calcis. His emphasis upon the multiplicity of fractures, each of which requires individual treatment, and his emphasis on the need for restoration of the bone to its normal shape, and of the value of traction in securing this, has greatly advanced our knowledge of treatment. Perhaps most important of all has been the stimulus he has given to the thought and study of this particular problem, but in spite of this the problem is too often poorly managed. Many cases are still treated with simple plaster and fixation without any plan of restoration of he bone. His plan of treatment falls shrt of perfection, though, and on several points. First, his assumption that fractures of the os calcis can be dealt with by traction alone.

The traction is applied by a pin through the crest of the tibia and a pin through the posterior-superior corner of the heel, and is applied first in a certain direction and with a certain force and then the direction of the pull is changed and the pull is applied again and again with a certain amount of force, and having pulled in these two directions, a plaster is applied incorporating the bones in the plaster. The assumption is that if we apply this traction in two directions and with a predetermined force, that we can expect any fracture of the os calcis to be reduced. The second difficulty in Boehler's management is that there is no provision for determining as we go along how we are getting along with the fracture. No X-ray is taken and the fluoroscope is not used. Like any other fracture, these fractures need the assistance that we can obtain during the process of reduction. Fractures of the os calcis vary from one another so much that it is impossible to areat them with a rigidly formulated plan without X-ray.

The third shortcoming is the assumption that the deformity of the fractured bone can be corrected by traction alone. It has been my experience that while traction, applied as Boehler recommends, or better still applied somewhat differently, is a very important agent in the management of fractures of the os calcis, there are certain types of fracture in which no amount of traction applied with whatever force you wish and in whatever direction you wish, will completely reduce the fracture, and this is particularly true when a large fragment carrying the posterior facet of the subastragaloid joint is depressed into the body of the bone. The traction which is applied does not often elevate that fragment. It needs something more than this to do it.

Finally, I think that Boehler has not laid sufficient stress upon the necessity for fusion of the subastragaloid joint in certain types of fractures of the os calcis. There are important reasons why this fusion should be undertaken. To begin with, the fracture often results in extensive comminution of the bone, and this frequently involves the articular facet of the os calcis, and when that is so it is seldom that we achieve the perfection of reduction that will restore that and make it perfectly smooth. The second reason why fusion is important is one which has not been sufficiently stressed. Not infrequently the fracture lines of the os calcis are so disposed that a portion of the bone which carries the articular surface for the posterior facet of the subastragaloid joint is entirely separated from the bone in the fracture line. In other words, not only

is the bone fractured but that piece of bone is separated completely from its blood supply, or in a large part from its blood supply. But in a certain proportion of cases such a fragment is deprived of its blood supply and undergoes aseptic necrosis. It loses the articular cartilage and, though it may become revascularized, its articular surface has been damaged and this results in late osteoarthritis. Such cases are irreparably damaged, and if they have any late disability, it can only be overcome with fusion of the joint. Here is another illustration of this point, showing an X-ray of one of these cases. This is a fragment which is likely to undergo aseptic necrosis. It is such facts as these which make more frequent use of subastragaloid fusion wise and good treatment.

In order to provide a more flexible means of treating fractures of the os calcis by traction, we have found it necessary to apply traction in more than two directions and, in particular, that there is need for traction in the direction of the long axis of the foot in order to overcome the shortening that so often occurs. There is need for a pin through the head of the metatarsals which can lengthen the foot when traction is applied. It is of advantage that this traction be applied by an instrument which will enable one to modify the direction of its pull within as wide limits as possible, and also that it be applied by an instrument which will enable us to modify the force of the traction. This traction ring which you see illustrated here has been devised for that purpose. The man's leg is thrust through that ring there and to these hooks are applied spreaders on Kirschner's wires through the heads of the first and fifth metatarsals. Now, this being a circle, it is possible to shift these tractors around the circle in any way you wish, so that the direction of the traction may be modified within wide limits. Of course, the force can be modified by the amount of screwing up of this traction which is applied. Now, here is an example of what can be accomplished by such tri-radiate traction. We have here two or three sets of X-rays. Here is a very severe fracture of the os calcis. This is the result of the application of tri-radiate traction,—much improvement in the fracture, but this fragment is not yet perfectly reduced. One must realize that when you put traction on that os calcis, it is resisted by the tendo-achillis. This becomes a fulcrum against which it is difficult to tilt up the anterior end of the bone. This is a point which I said was overlooked by Boehler in his treatment. I think his point of view is a very good one—if I seem to point out the difficulties of the treatment it is only to emphasize the great strides made in his treatment. That problem is a very real one and it occurs reasonably often (in about one-third of the cases), and it is not overcome by traction of any kind or in any direction or with any force. It can, however, be overcome if one drives in a stiff pin and uses that pin as a handle, by means of which this fragment is drawn into position. You can see that pin applied here.

If we are going to restore the subastragaloid joint we can rely on traction to add much more towards that objective, but a certain proportion of cases will need something more than traction, and most commonly they need to have that fragment tilted up at the anterior end. Here is another example of the problem—a severe fracture of the os calcis with gross comminution and gross compression of the articular surface. The articular surface is impacted into the body of the bone. This is the result obtained by tri-radiate traction—a very nice reduction of the fracture. Now, this one was one of the early cases in which we were carrying out our method of treatment. We obtained a good reduction and this is the result three months later. The man went back to work and he worked as a moulder and the results have not been perfect because he still has pain in his subastragaloid joint and you can see why that is. We would have done better to have fused that joint, as he now has aseptic necrosis.

At this moment I should like to emphasize the problem of subastragaloid fusion. If what I have told you is right, then we should take fusion as part of our treatment. If we agree that certain cases need fusion, then the sooner we fuse them the better, in order to save time for the patient and in order to take advantage of the early period of osteogenesis. Now, here is a case in point—a severe fracture to the os calcis—and this is the result obtained by traction. It is very easy to apply great force on this tractor. Actually, the amount of force needed is not very much—there is a tendency to over-pull.

At this moment I should like to discuss the aspect of fusion of this subastragaloid joint as applied to the particular problem that we have in mind. All of us have been faced with the necessity of fusion because of disability which follows fractures of the os calcis and most of us have approached the joint from the lateral side of the foot. Now, such lateral exposures are difficult. Subastragaloid fusion in a joint which has not been damaged is a nice bit of technique and not done easily unless it is done in a very precise fashion, but when the joint has been severely damaged then the exposure of the joint is extremely difficult and cannot be accomplished without at the same time exposing the mid-tarsal joint, and that necessitates fusion of the mid-tarsal joint.

Some time ago Dr. Gallie devised an operation for mid fusions of the subastragaloid joint which overcame some of these problems, the chief point being an encroachment from behind and the insertion of bone grafts between the os calcis and the astragalus. I may say that it is one of the simplest of procedures and is effective. When you think a fracture of the os calcis is going to give late trouble and you think it should be fused, then do it early for the best bony union. Having decided that the fracture of the os calcis is of such a nature that late trouble is going to occur, there is no reason at all why fusion should not at once be proceeded with, even though the plaster is still on, because it is possible to do the operation from behind through a window in the cast and that is what we have been doing quite satisfactorily.

This drawing represents a fracture of the os calcis which has been reduced by tri-radiate traction. Ten days after reduction a window was cut in the plaster and a fusion was performed. It is a simple exposure and through that exposure a rectangular tunnel is cut in the subastragaloid joint. That is quite easy to do. This tunnel is cut with a chisel. This slide illustrates the procedure. A double graft is then thrust into this tunnel and we have the joint bridged by these two grafts. This is the type of fracture in which we think this aspect of treatment should be considered—a very gross comminution of the fragments. This is the result obtained by traction. You can readily see that there is still tremendous crushing and comminution of the central portions of the bone. It was our judgment that it was the best reduction that we could obtain so ten days afterwards an operation was preformed and a graft was placed in the subastragaloid joint. This is a photograph of the apparatus in use. We use heavy Kirschner wire instead of Steinman pins. This is another picture of the same patient, showing the tri-radiate traction apparatus. Having reduced the fracture to our satisfaction and having checked it by X-ray, a plaster is applied incorporating the steel wire and the pins. Here is another case in which the tractor has been applied.

Now, this picture illustrates a number of problems. Here is a moderately severe fracture of the os calcis with moderate compression of the posterior half of the subastragaloid joint. Here are a series of X-rays which illustrate the steps in the reduction of the fracture. Here you see the effect of traction alone and it has lengthened the bone and it has improved the position and restored the critical angle but it has not reduced that articular portion of the os calcis adequately. An attempt was made to do that with a heavy Kirschner wire but it was not strong enough, so a Steinman pin was put in place and this improved the condition considerably though there is still room for improvement.

Now, here are a number of X-rays of patients, illustrating a number of the problems. Here are the X-rays of a man who had a double fracture to the os calcis and we treated both his fractures in this manner. There was no operative fusion of his joint as his trauma was so great. This series shows a moderately severe fracture. This shows the result of reduction by traction.

In conclusion, I would say that it is well to regard fractures of the os calcis as a major problem in fracture surgery. It is necessary to appreciate that fractures of the os calcis vary greatly from one to the other. Therefore, we must individualize each problem. We must study the fracture and the X-ray and decide what is necessary in this particular case. We must make up our minds at the beginning whether a fracture of the os calcis presents a major problem or whether it is a simple problem in fracture

treatment. If it is a major problem then we must find the means of dealing with it adequately right away at the beginning. The procedures which will do most to give a good result are:

(1) Traction, especially if it is tri-radiate traction and especially if it is sufficiently flexible that its direction can be changed and its force can be changed. When traction is used we should have some means of checking the result by X-rays during the procedure.

(2) We should appreciate that some other measure than traction may be necessary in certain cases to restore the bone to something like its normal shape, and this is our objective. We should appreciate that in a considerable proportion of our cases, no matter how skillfully we handle the fracture, there will be gross damage to the subastragaloid joint and late disability will be inevitable. These should be treated with subastragaloid fusion and the sooner the fusion is done the sooner the man will be back at work. Posterior fusion has given the most satisfactory results. The freedom of the mid-tarsal joint to move has not proved a disability when the subastragaloid joint is fused. On the contrary, it has been an asset.

DR. A. W. BAGNALL

Obiit Nov. 22, 1944

The medical profession of Vancouver has sustained many blows lately by the loss of some of its older and most valued members—and the loss of Dr. Wallace Bagnall is by no means the least of these. He had been in practice in Vancouver for many years and had reached the top of his profession, as an internist of rare skill and ripened judgment, whose work was regarded as being of the best. His integrity of character and his sincerity of mind, gave to his opinions a soundness and maturity that made him a valued consultant to his colleagues, and a practitioner of assured worth, to the public at large.

Bagnall was always a student, and had the critical faculty of mind. This is a very valuable quality in the man of medicine, and not as commonly possessed as it should be. His bump of credulity was poorly developed, and he examined each new thing with critical care. He was not easily made enthusiastic about new things—and in all his doings, not merely professional, he preserved an open mind, and had to be shown. But when he did become interested in a subject he explored it exhaustively—and mastered it thoroughly. He was especially interested in Rheumatism and Arthritis, and made himself one of the foremost authorities on these subjects in Canada. His work on the gold therapy of Arthritis was of the pioneer order—and one remembers a most complete report made by him on the subject many years ago. Even here, however, enthusiastic as he was on the subject, he did not lose his head or become fanatic at all, and rather offended some of the ultra-enthusiasts by his conservative attitude towards the matter.

Bagnall was a quiet, almost austere man, who made no fuss and did not apparently go out of his way to assert himself—but he was very warmly respected and liked by all who knew him. It is very pleasant to reflect on the occasion at the last Medical Dinner when the Degree of Prince of Good Fellows, the Vancouver Medical Association's *cachet* of worth and true fellowship, was conferred on Wallace Bagnall. It warmed the hearts of all his legion of friends, and we rejoice that he knew, before he left us, that we loved him, as well as respecting and liking him.

The Vancouver Medical Association owes a special debt to Dr. Bagnall. He served on the Library Committee for many years, and no member of that

Committee ever gave more generously and freely of his time and energy. It is not too much to say that a great deal of the present excellence and efficiency of the Library is due to the work that he did year after year, and to his constructive interest and mature experience. His place will be hard to fill.

We offer to his family our sincerest sympathy in their loss.

DR. M. W. THOMAS

Obiit Nov. 11, 1944

The grievous and untimely death by drowning of Dr. Morris Thomas, Executive Secretary of the College of Physicians and Surgeons of B. C. and the B. C. Medical Association, brought a profound sense of shock to every medical man in British Columbia, and to scores outside this province, who had come to know and respect him as one of the leaders in the medical organization of Canada. The shock was followed by a deep sense of personal loss, as of a dear friend, whose passing has left a gap in one's more intimate life.

Thomas had, more than most men, a genius for friendship and a great affection for his friends. He knew men personally—he took a keen interest in all that befell them—in their family relationships and their professional doings —he knew what their hobbies and recreations were—he rejoiced with them in their happier moments—and sorrowed with them in times of trouble. One felt that he knew intimately every man in the Province, and the further the man lived from the centres of population, the more anxious was our Secretary to do all he could for him. He was always working for the men in practice. Perhaps this was his duty—but Thomas brought to this duty a devotion and a loyalty that made him the friend, as well as the willing servant, of all that it was his duty to serve.

He was a good fighter, too—and the medical profession owes much to his courageous battling for their interests. Many a man in B. C. will testify to the help and support that he received from our Secretary, in his dealings with employers of labour, and groups of employees seeking medical service. The Medical Services Association, so successfully operating in our midst, owes an uncountable debt to his work and indomitable support—and his refusal to allow inferior schemes to compete unjustly and unfairly with it.

Organized medicine in B. C. can never repay its debt to Dr. Thomas. He was an almost ideal man for the work he carried on for so many years—and it is very hard to see how he can be replaced. It may be that no man is indispensable: that even the lòss of a Moses need not mean irreparable disaster—that the thing for us to do is, as Joshua had to do, to get up and go on—but we have lost a very valuable and badly-needed guide, counsellor and friend—and it will be long before we shall see his like again.

We feel that we speak for every medical man in British Columbia when we extend to Mrs. Thomas and his family our deepest sympathy in their bereavement.

THE DIAGNOSIS OF A NEUROSIS

GEO. A. DAVIDSON, M.D.

Presented at the North Pacific Society of Internal Medicine, Vancouver, B.C., September 16, 1944.

More and more it is being stressed that the diagnosis of the Neuroses is ont made by excluding organic disease. A neurosis is a definite disorder and the diagnosis calls for certain findings as much as the diagnosis of pneumonia, hyperthyroidism or any such diseases. It is because it is felt that so many neglect this basic fact that it is thought wise to discuss the question of the diagnosis. We are told that 30 to 50% of the discharges and rejects from our armies are due to mental, emotional and educational faults. It takes but a short time in medical practice to make one realize that he has had little training to make him feel at ease in dealing with this type of disorder if he comes from an average medical school. While this paper will contain little that is new, it is hoped that it will bring those interested in Internal Medicine a better understanding of what the term Neurosis actually means.

A few months ago a 42-year-old male was referred because of complaints that were suggestive more of a neurosis than of organic disease, *e.g.*, he had spells of feeling faint, his stomach was unsettled and his heart palpitated. He had been off work for one year but had been undergoing examinations for two months prior to that. He had been in one hospital, had seen two physicians and had gone "through" three clinics. He had had X-rays taken of his chest, stomach and colon. He had had three different electrocardiograms and at least three basal metabolic ratings, and had had various blood and other tests. This work had cost him more than $300 and he had lost about $3500 because of unearned wages (salary $85 per week). With the exception of one medical man all eventually reached the conclusion that it was "nothing but nerves" and he was told to "go ahead and don't worry." He stated that one well-known clinic had told him that there was nothing that a physician could do. My suggestion is that had a more careful history been taken with a view to understanding the man rather than his individual organs, he would have been saved much worry, expense, and much of the time spent by the various physicians would have been saved. Another point of great importance is that during the fourteen months on treatment he had developed many bad habits of thought, and had reached a point where it was much more difficult to deal with him than it would have been at first. The easiest time to deal with these cases is when the symptoms are new, when the patient must be studied carefully and given an understanding of the meaning of his symptoms. His problem will be returned to later.

WHO DEVELOP NEUROSES?

I. *The Insecure Background.*

In studying an individual with symptoms the logical method is to deal with the patient as a whole and not to think only in terms of how the heart, stomach and other organs are behaving. The whole life situation must be seen as clearly as possible so that the various influences that have played on this individual from his childhood can be properly evaluated. It is suggested that the most necessary single point for the diagnosis of a neurosis is to decide whether or not the individual had felt secure in his childhood. The child deserves security and the child who is secure is most likely to become a stable and confident adult. It has been recognized that home situations have much to do with the development of neurotic states. Death of a parent or divorce of parents are tragedies that reach far into the future of the child's life. This is probably largely due to the fact that the child feels so often that he is left in an insecure position. Too often when

the father dies the mother is left with an inadequate income and in addition to having to worry over the bodily needs there is no longer the partner to help absorb and modify the emotional situations that develop. Too frequently the mother pours out her grief on the eldest child so that he must face problems of both economic and emotional natures that he is not yet ready to face. Instead of continuing his life of play and gradually accepting adult responsibilities these are suddenly thrust on him so that he develops a habit of reacting in an anxious way to difficult situations—a habit that often persists with him throughout life.

Strife in the home will also produce a feeling of insecurity and uncertainty in the child and cause him anxieties too early in life.

Another point that should be stressed is the effect of the over-anxious, over-solicitous mother on the child. There is too much fear expressed that the child will catch a cold, get his feet wet or meet with an accident so that often the child looks upon life as a dangerous business and full of hazards rather than taking new experiences in his stride and with ease.

In a group of pension cases suffering from so-called Neurocirculatory Asthenia there were nine cases that had been under observation for 15 years or more. Six of the nine patients had lost one parent before he was 15 years of age, ono had lived in an atmosphere of over-protection and one had a father who had been an invalid for years. In this same group where figures were available for 18 of the group, nine who developed the disorder were first children although the group as a whole averaged seven children per family.

Those things in a home situation that make the child feel insecure and afraid have been discussed at some length as it is felt that the neuroses have their setting well back in the life of the individual.

II. *The Necessity for Adjustments in Life.*

With this picture in mind the adjustments that the individual has to make may be considered. Kraines[1] has put this nicely when he says: "If one disregards all hair-splitting phrases and obscure terminology, it may be generally agreed that all psychologic reactions are built up, pyramided on two fundamental drives—the drive for self-preservation (ego-maintenance) and the drive for race preservation (predominantly sexual). In other words, man seeks security and satisfactions." Note the term "security"! Put otherwise, if one is happy and contented in his efforts at self-preservation, be they satisfaction in his school work, his office or labours, and if one is satisfied with his relationship to the opposite sex, be it puppy love or a satisfactory marital adjustment, "all's right with the world." Probably this might be extended a little to include his relationship to people generally, i.e., the making of a satisfactory social adjustment.

If, then, the initial complaints are of a nature that suggest emotional trouble rather than organic disease, it is felt that it is the duty of physicians to enquire into these adjustments. Physicians often are timid about asking such personal questions and yet the patient is usually anxious to discuss them and unburden himself.

III. *The Physical Findings Expected.*

Broadly speaking, psychoneurotic symptoms and signs may be divided into two groups, (a) those expressed by tension, and (b) those expressed by conversion. In the tension states one sees the type of case produced by autonomic overactivity, *i.e.*, definite physiological activity is produced.

According to Fulton[2], stimulation of the hypothalamus indicates that the posterior and lateral hypothalamic nuclei are concerned primarily with the sympathetic outflow, the following responses being seen: (a) Cardiac acceleration, (b) elevation of the blood pressure, (c) dilatation of the pupil, (d) retraction of the nictitating membrane, (e) piloerection, and (f) inhibition of the gut. He says further that these hypothalamic nuclei also have connections with the cerebral cortex, generally through secondary neurons via the zona incerta, septum pellucidum and mamillo-thalamic tract.

Bodily changes as a result of emotional reactions have long been recognized although the cortico-hypothalamic connections have only recently been worked out, and these not entirely as yet. The names of Pavlov[3], Cannon[4], Wolf and Wolff[5] at once bring to mind some of the important work that has been done and more recently have the roles of emotion been stressed in such diseases as peptic ulcer and hyperthyroidism. If the symptoms associated with sympathetic stimulation are kept in mind many of the symptoms and signs seen in the neurosis are evident, *e.g.*, dilated pupils, increased heart rate, increased systolic pressure, disturbances in the secretion and motility of the stomach and bowel, urinary disturbances, disturbances of sweating, etc. The neurosurgeons with their attacks on the frontal areas have clearly demonstrated that definite change can be produced in the personality with a decrease in the general tension.

Keeping in mind the type of background expected in the neuroses, the difficulties in adjusting to certain life situations and the physiological changes resulting from cortical-hypothalamic disturbances, the history of the man who was off work for over a year because of his so-called "nervous state" may be reviewed.

When the patient was 12 years of age his father died as a result of an accident. His mother had quite a struggle to raise the family after her husband's death and she was regarded as nervous, suffered with certain "spells" and was said to have overworked. The eldest brother did not accept much responsibility for the family although he was 20 years of age when the father died. The next two children were girls. Each had suffered from breakdowns and appear to have been badly adjusted. The patient was quite aware of all the family troubles. From the age of 12 years he worked after school and turned his earnings over to his mother. He left school entirely at 13 years of age and has always been sensitive because of his lack of formal education. Although he changed positions fairly frequently he did very well until, due to the war, he was forced to change his occupation. He started work in a shipyard, where the pressure was quite sustained. At the same time he was doing a certain amount of gambling at cards and at horse and dog races. The excitement of this probably gave him symptoms referable to his autonomic nervous system. He did well in the shipyards but did not like the responsibility, had some fear of his boss and got the idea that this man might welcome an opportunity to show his authority. He began to have spells in which he would feel faint, his stomach felt unsettled, his heart palpitated and he was constipated. He was advised to stay off work to see how he felt and from that time on did not return to the shipyards and actually did not get back to any kind of work until about July 1, 1944, that is, more than one year from the time he stopped work.

Physically he showed fine tremors to the fingers, brisk jerks, moderately enlarged tonsils, a coated tongue, a pulse rate that varied between 88-120 and a blood pressure of 140/88. The hands were decidedly moist and cool.

This is regarded as a fairly typical neurosis (tension state) because of the (a) insecure childhood, (b) the difficulty in adjusting to the change of work with the increased pressure, and (c) because of some of the physical signs which are common in neurosis.

I am particularly interested in your reactions as to the amount of work that should be done in ruling out organic disease and especially in the laboratory work. In such a case as has been described, would we be justified in reaching the diagnosis of a neurosis without the extensive laboratory work being done? From the history, would we not be reasonably justified in omitting much of this work? Interestingly enough, it was at one time suggested that the man suffered from hyperthyroidism, and yet when he visited a man who confines himself largely to the diagnosis and treatment of diseases of the thyroid gland this man did not think that it was necessary to do a basal metabolic estimation—a test, incidentally, in which I believe we place altogether too much faith, as in about 98% of tests it is within our accepted range of normal, and that is a wide range.

Some internists believe that any man who presents himself with complaints referable to the stomach should have a series of stomach and bowel pictures. Should these be insisted upon, and will an injustice be done to a large number of our patients if we do

not demand it? True it is that the trend today appears to be to believe that emotional instability is a forerunner of peptic ulcer. Many men feel that they are running too great a chance of missing structural change and yet this is doubted.

I have reached the conclusion, and it is felt that you will agree, that many patients are not convinced by negative reports and they believe that the physician must be overlooking something or that his disorder is beyond the knowledge of medical men. How often the patient will insist that we do not understand, and whether he says so or not the fact that he drifts from one physician to another is proof that he has not entire confidence in our findings and reports.

Many physicians believe that a lot of tests impress the patient and make him feel more confident in his physician. This is doubtful. It is felt that care should be taken in obtaining the history with an attempt to understand the man and his problems, and a physical examination should be done to confirm or make you doubt your diagnosis. If the other course is followed, how frequently do we hear patients say, "Well, Doctor, if there is nothing wrong with me but an emotional condition, why did Dr. X make all those tests on me and put me to so much expense? Surely he must have felt differently."

This, of course, is about the same as saying that your patient feels justified in doubting your diagnosis when Dr. X, who undoubtedly was a good man, was not certain of the condition. In other words, he feels that the doctors are in doubt and it is felt that this would not occur if the first man who saw the case treated it with understanding and confidence.

While it is not my intention to discuss the treatment of the neurosis, it is felt that it is our duty to give the patient some understanding of the physiological responses of the body to emotional factors.

It is agreed that not all cases of neuroses are as typical as the one described, and yet he was examined and re-examined and still left in doubt and without relief.

Briefly, my contention is this: (a) Having in mind the structure of the neurosis and (b) being familiar with the "ring" of the symptoms described, our attentions should be directed towards a better understanding of the man and his problems and less attention should be paid to the study of his individual organs.

It is realized that these suggestions will be received with antagonism and criticism by many of the organically-minded men present, and yet it is felt that as a group we are open to criticism for the way in which we deal with this group of patients and for the way in which we go through with our rituals and end up by telling the man to "Forget it. It's nothing but nerves."

Summary

1. The diagnosis of a neurosis is not made by exclusion but this disorder has a definite symptom complex; a definite background of insecurity, a history of difficulty in adjusting to some problems and certain physical findings indicative of (a) tension or (b) conversion.
2. The physiological effects of emotion are discussed especially as they affect the cortico-hypothalamic-autonomic system.
3. It is argued that much unnecessary investigation and laboratory work is done on this group of patients without value being received.
4. And finally in having reached our conclusion that the condition is a neurosis it is felt that we owe the patient an explanation as to why he develops his symptoms and why they persist, rather than leaving him with a diagnosis of "just nerves."

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EMOTIONAL PROBLEMS OF DEMOBILIZATION

MAJ.-GEN. CHISHOLM

Read before the B. C. Medical Association, September, 1944

The process of changing oneself from a soldier to a civilian is in very many cases at least just as difficult psychologically as the change from civilian to soldier. In a typically successful soldier the total environment has been oriented towards successfully fighting the enemy for a period of anything from one to five years, or more. Every pressure directly influencing the soldier has been formulated and exerted in this direction. His whole value is judged by his efficiency as a fighter or in giving support to other fighters. The whole object of his existence and the focus of all endeavour about him is killing. Effective and wholesale killing has been for years given precedence as the highest moral value and the most admirable of all virtues.

The soldier has become accustomed to living in a very close knit community which in relation to its main preoccupation is completely reliable and dependable. Its reactions in relation to any important question are completely predictable. All its moral values are quite clear and all friends and enemies are known.

There is little real psychological preparation for the cessation of hostilities during the closing weeks of any campaign. Emotional tension runs very high; there is great preoccupation with the events of the moment which are almost invariably new and strange and exciting. Soldiers generally do not allow themselves to count too surely on surviving a war, at least without severe crippling. In long continued warfare it tends to become evident to soldiers that only major wounds leaving permanent crippling are likely to ensure their survival. Even repeated minor wounds keep men away from fighting only short periods and there is a high degree of mathematical likelihood of the soldier being killed if he does not receive major wounds. Very many soldiers, showing a degree of superstition which because of its almost universal presence in our civilization must be regarded as normal, feel that it is dangerous to count on survival, that this is in some way a defiance of some Power which may be annoyed at such presumption. It is true that soldiers generally indulge in much fantasy about living conditions "after the war," but these are kept clearly in the realm of fantasy and are heavily discounted as a precautionary measure.

The cessation of hostilities is experienced as a major emotional shock by soldiers generally. There is a very extensive loss of orientation, a feeling of being lost and bewildered, a groping, turning towards the things of civilian life and all its very different values. During this period, soldiers tend to be highly labile in mood, unstable and unpredictable. Typically they can hardly be induced to concentrate on anything for very long at a time. The sudden release from the years-old fear of imminent death with the release of all the consequent tensions, leaves soldiers disorganized and uncertain. These states may be expressed in quarrelling, defiance, drunkenness, even rioting and insurrection. Aggressive urges which have been carefully nurtured and developed over a period of years are supposed to disappear overnight, leaving a peaceful civilian with no such pressures and consequently no need of outlet. The soldier is expected overnight to give up what in very many cases at least is a consuming hatred, and in all cases the object of aggressive antagonism and to become protective and friendly towards the very people whom he has been hating for years. With the memory of all this, of his friends or relatimes who have been killed or maimed or even tortured by the enemy, fresh in his experience and kept alive as a spur to his aggressions, this changeover in attitude may be very difficult indeed. It may be successful on the surface but at the expense of extensive repressions and conflict within himself.

The cessation of hostilities, in the mind of a soldier, renders his continuing as a soldier completely pointless. He has lost his reason for being a soldier and the period during which he must be kept in the Army with no fighting to do either in the present or future feels to him unreasonable and persecutory. All these considerations point to the difficulty in the early stages of the period after the cessation of hostilities.

In addition to the disturbed relationship with his immediate environment, he must undergo a reorientation towards civilian life, employment, family and friends. In very

many cases the separation between husband and wife has been far more than geographical. Each has been developing along different lines. This is not to indicate that there will necessarily be any loss of love between husband and wife. The tendency is rather for each to idealize the other and to maintain a picture of the other which may be too difficult to live up to. On the other hand, suspicion about sexual fidelity is very common and may cause much trouble, whether justified or not. The relationship of the returning father with his children may also be difficult. The ease of the establishment of such a relationship depends largely on the truth of the picture which the mother has presented to the children, of the father. If she has over a period of several years painted a picutre which is rather her idealization of him than himself as he is, the children and the father will inevitably be in difficulties when he returns. There is a tendency in many women to use the absent father as authoritative backing for all their own ideas about desirable behaviour in children and to represent the father as having attitudes which in fact are their own and not his at all. When the father returns and persists in talking and behaving as himself rather than as the idealized picture, the children may become bewildered, and the mother resentful of her husband's letting down her ideal of him.

Commonly too the wife has for some years been relatively independent, with the family's money in her own purse to be spent entirely as she sees fit. This circumstance has produced in most women a much greater sense of financial responsibility. A few have become, of course, more irresponsible. The return of the husband will in almost every case affect the financial independence of the wife, so that the spending of family resources becomes at best a matter for consultation between husband and wife, and at worst an absolute dominance by the husband or by the wife in this field. Either of these latter situations will complicate the re-establishment of the family and the development of the children.

A further possible complication is the greatly enhanced group value of many women, who have devoted themselves to canteens, Red Cross, and many other services, including war work of all kinds, whether in factories or in committees. It will require a major readjustment for these women if it becomes necessary for them in effect to retire to their homes and become again "only" housewives. It is to be hoped that at least a large part of this enormous amount of potentially valuable effort can be redirected into channels which will continue to be useful during peacetime.

In relation to civilian employment, there is also a major job of reorientation to be done. There are large numbers of men in the Armed Forces who have never had any really stable civilian employment. Many thousands have come directly out of schools and colleges. The transition from a closely knit group whose major virtues have been bravery, self-sacrifice and value to the group, to a society whose values are most usually measured in monetary terms, may be very difficult indeed. Transition from the long continued state of devotion to one's friends and to a cause, to the self-seeking attitude which is so common in civilian life, has always been confusing and difficult for demobilizing soldiers. The emotional need of the soldier after years of conditioning, is not just for monetary reward but for emotional status even more importantly. He needs more to feel valuable and important than he does to feel wealthy. This typical need of the returned soldier to feel important to the group, if appreciated and used, can be of the greatest importance to the future of any country. If it is not satisfied the inevitable tendency will be for the returned soldier to segregate himself with those of his kind from the mass of the people and to insist on his rights and privileges.

The detailing of all these potential difficulties may indicate a pessimistic atttude about the rehabilitation of the soldier. Actually all these difficulties can be avoided or overcome by intelligent understanding and determination. It is, however, very important that there should not be a general attitude about rehabilitation like the Victorian novelist's idea of marriage, "And then they were married and lived happily ever after." "And then he returned from the wars and they lived happily ever after" can be true but will be so only if the inherent problems in this major adjustment are tackled with wisdom

and forbearance. Much can be done to increase the understanding of both soldier and civilian in this field so that it should be possible to develop general understanding of the problems involved, and a much greater degree of tolerance and helpfulness on the part of both.

In the Army it is proposed to prepare soldiers for demobilization by courses of lectures and discussions in small groups in an attempt to make the transition to civilian life less uncomfortable and, as so often happens, disillusioning. The newspapers, magazines and the radio can do much along the same lines for civilians. It should never be taken for granted that all the adjustment has to be done by the returning soldier. Civilians may well find certain aspects of the philosophy of the good soldier which could with value be incorporated into their own thinking and feeling patterns.

NEWS AND NOTES

We regret to record the passing of: Dr. M. W. Thomas, Executive Secretary of the College of Physicians and Surgeons, on November 11th; Dr. A. W. Bagnall, of Vancouver, on November 22nd; Dr. G. A. McCurdy, of Victoria, on November 21st; Dr. Wm. Buchanan, of Peachland, on December 5th, and Dr. A. McK. Stewart of Haney.

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Of interest to the profession is the marriage of Major A. Maxwell Evans, R.C.A.M.C., Radiologist with No. 1 Canadian General Hospital in Italy, to Miss Eleanor Mionr, Red Cross Welfare Officer of Windsor, Ont. The wedding took place in Italy.

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Congratulations on the birth of daughters are being received by Dr. and Mrs. Neil A. Stewart of Vancouver, and Surg.-Lieut. F. E. Kinsey and Mrs. Kinsey.

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Sons were born to Dr. and Mrs. H. Dumont of Vancouver, Dr. and Mrs. H. Emanuele of Penticton, and Dr. and Mrs. John Piters of Vancouver.

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Lieut.-Col. A. L. Cornish, Victoria; Lieut.-Col. S. A. Wallace, formerly of Kamloops, and Major J. E. Walker of Vancouver are on the staff of the newly commissioned hospital ship *Letitia,* which has just completed her maiden voyage.

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S/Ldr. J. L. Parnell, formerly of Vancouver, is now with the R.C.A.F. headquarters in the Middle East.

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Capt. W. S. Huckvale, R.C.A.M.C., who was wounded overseas, is back in Vancouver.

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The following are the officers of the Fraser Valley Medical Association for the year 1944-45: President, Dr. H. H. MacKenzie; Vice-President, Dr. G. H. Manchester; Secretary-Treasurer, Dr. J. G. Robertson. The representative on the Board of Directors of the British Columbia Medical Association is Dr. Bruce Cannon.

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The Board of Directors of the British Columbia Medical Association held a meeting on November 29th. Those members present from out of town included: Doctors D. M. Baillie and P. A. C. Cousland of Victoria; Dr. F. M. Auld, Nelson; Dr. C. H. Hankinson, Prince Rupert; Drs. A. H. Meneely and E. D. Emery of Nanaimo, and Dr. G. S. Purvis, New Westminster.

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Doctors F. M. Bryant and Thomas McPherson of Victoria; F. M. Auld, Nelson; G. S. Purvis of New Westminster, and E. J. Lyon of Prince George, attended the meeting of the Council of the College of Physicians and Surgeons held in Vancouver on November 30th.

NOTICE

It has been brought to our attention that some medical men fail to write prescriptions for narcotics in INK and also fail to DATE prescriptions as required by law. Druggists may refuse at any time to fill prescriptions not written in ink or not dated. Medical men must adhere to the rules.

A. J. McLachlan,
Registrar.

Capt. W. H. S. Stockton, R.C.A.M.C., has returned to Vancouver. Capt. Stockton was injured in an automobile accident in Italy.

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Flight-Lieut. G. A. Lawson, R.C.A.F., who has returned to civilian life, is at present in the East taking a post-graduate course.

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Doctors C. W. Duck, R. A. Hunter, T. M. JoJnes and R. B. Robertson of Victoria were recently on short hunting trips on the mainland.

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Dr. W. E. Baker has opened an office in Victoria, confining his work to Ear, Nose and Throat. Dr. Baker served with the R.C.A.M.C.

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Flight-Lieut. H. B. McGregor, R.C.A.F., has returned to civilian life, and is resuming practice in Penticton.

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Dr. F. R. G. Langston and his wife, Dr. Kathleen Woods Langston, have returned to the Province, after several years spent in England.

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Capt. P. S. Tennant, R.C.A.M.C., has returned to civilian life, and is practising at Kamloops.

EAST KOOTENAY MEDICAL ASSOCIATION

On October 29th, a meeting of the East Kootenay Medical Society was held in Cranbrook.

During the afternoon, in the St. Eugene Hospital School of Nursing, the scientific sessions were heard. Dr. G. O. Matthews gave a talk on "Some Pædiatric Conditions and their Treatment" and Dr. Murray Meekison spoke on "Common Problems met with in dealing with Fractures." These papers were well received and thoroughly appreciated.

During the short intermission between papers the Sisters of St. Eugene Hospital provided refreshments.

In the evening a dinner was held in the Cranbrook Hotel. Following dinner, Dr. G. O. Matthews, President of the British Columbia Medical Association, addressed the members. Among other matters he discussed the formation of a Faculty of Medicine in B. C.

Dr. M. W. Thomas, Executive Secretary of the College of Physicians and Surgeons, spoke briefly on medical economics, and on the subject of a revised schedule of fees.

Dr. F. M. Auld of Nelson, member of the Council of the College for the Kootenays, gave a short address on the activities of the Council.

Dr. H. H. Milburn, President of the College of Physicians and Surgeons, described various health plans, and brought up the subject of a Medical Faculty.

Dr. F. W. Green spoke briefly on medical practice in East Kootenay. As M.L.A. for the District he would be pleased to place before the Provincial Legislature any subjects which the College of Physicians and Surgeons wished to bring to its attention.

After a short address by Dr. W. O. Green, in which he thanked the visiting doctors for devoting so much time in attending the meeting in Cranbrook, the officers for the coming year were chosen:

President: Dr. J. Vernon Murray, Creston; Vice-President: Dr. T. J. Sullivan, Cranbrook; Secretary: Dr. W. O. Green, Cranbrook.

Those members present at the meeting included: Drs. G. O. Matthews, D. M. Meekison, H. H. Milburn, M. W. Thomas, from Vancouver; Dr. F. M. Auld, Nelson; Dr. G. W. Leroux, Fernie; Dr. J. Vernon Murray, Creston; Dr. A. E. Kydd, Michel; Dr. J. M. Tedford, Kimberley; Drs. F. W. Green, W. O. Green and T. J. Sullivan, Cranbrook.

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DISTRICT No. 4 MEDICAL ASSOCIATION ANNUAL MEETING

The annual meeting of District No. 4 Medical Association was held in Kelowna on Thursday, October 26th, at the Royal Anne Hotel. Dr. L. A. C. Panton, President, presided over the sessions, and was ably assisted by Dr. W. F. Anderson, Secretary.

Dr. Gordon O. Matthews and Dr. D. Murray Meekison, both of Vancouver, gave scientific papers, the former dealing with pædiatrics and the latter orthopædic surgery.

The election placed the following in office:

President: Dr. R. W. Irving, Kamloops; Vice-President: Dr. J. R. Parmley, Penticton; Secretary-Treasurer: Dr. C. J. M. Willoughby, Kamloops; Representative on the Board of Directors of the British Columbia Medical Association: Dr. R. W. Irving.

It was decided that the next annual meeting would be held in Kamloops.

Those present at the meeting included: Dr. G. O. Matthews, Vancouver, President of the British Columbia Medical Association; Dr. H. H. Milburn, Vancouver, President of the College of Physicians and Surgeons of B. C.; Dr. M. W. Thomas, Executive Secretary of the College of Physicians and Surgeons; Dr. E. J. Lyon, Prince George, District Representative on the Council of the College of Physicians and Surgeons; Dr. D. Murray Meekison, Vancouver; Drs. J. S. Burris, R. W. Irving, H. F. P. Grafton of Kamloops; Dr. A. F. Gillis, Merritt; Drs. R. H. Irish, E. A. Gee, W. G. Trapp Tranquille; Dr. W. A. Drummond, Salmon Arm; Dr. J. H. Kope, Enderby; Dr. R. Haugen, Armstrong; Drs. J. E. Harvey, A. J. Wright, F. E. Pettman, H. I. Campbell-Brown, J. A. Taylor, Vernon; Dr. W. H. B. Munn, Flight-Lieut. A. W. Vanderburgh, Summerland; Drs. J. R. Parmley, L. F. Brogden, Penticton; Dr. G. W. Cope, Oliver; Drs. W. J. Knox, B. de F. Boyce, L. A. C. Panton, W. F. Anderson, A. S. Underhill, D. M. Black, J. A. Urquhart, G. McL. Wilson, J. S. Henderson and D. B. Avison of Kelowna.

* * * *

WEST KOOTENAY MEDICAL ASSOCIATION ANNUAL MEETING

The West Kootenay Medical Association held its annual meeting in Rossland on Saturday, October 28th, at the Rossland Hospital. The meeting was under the able chairmanship of Dr. E. E. Topliff, President.

The team from Vancouver included Dr. Gordon O. Matthews, Pædiatrician, and President of the British Columbia Medical Association; Dr. D. Murray Meekison, Orthopædist; Dr. H. H. Milburn, President of the College of Physicians and Surgeons, and Dr. M. W. Thomas, Executive Secretary of the College. Dr. Matthews and Dr. Meekison contributed papers of a scientific nature to the meeting, while Dr. Milburn and Dr. Thomas addressed the gathering at the banquet which followed.

The following were elected to office:

Honorary President: Dr. G. M. Kingston, Grand Forks; President, Dr. G. R. Barrett, Nelson; Vice-President: Dr. Arnold Francis, New Denver; Secretary-Treasurer: Dr. Wilfrid Laishley, Nelson; Representative on the Board of Directors of the British Columbia Medical Association: Dr. G. R. Barrett.

The meeting was well attended and among those present were: Drs. E. E. Topliff, and L. B. Wrinch, Rossland; Drs. W. A. Coghlin, M. R. Basted, D. J. M. Crawford, J. S. Daly, E. S. Hoare, M. E. Krause, Wm. Leonard of Trail; W. H. Ormond, Slocan; Dr. Arnold Francis, New Denver; Drs. F. M. Auld, W. Laishley, N. E. Morrison, G. R. Barrett, R. B. Brummitt of Nelson; Captain Gordon, and Drs. G. O. Matthews, D. M. Meekison, H. H. Milburn and M. W. Thomas, Vancouver.

REMUNERATION TO PRIVATE PHYSICIANS FOR INDIGENT V.D. CASES

The Division of Venereal Disease Control of the Provincial Board of Health is pleased to announce that as from December 1, 1944, there will be an increase in the rate of payment to private physicians for treating venereal disease cases who are unable to make any payment for such treatment. Payment is made only to private physicians practising in areas where no clinic is operated by the Division. The usual reasonable fee charged will be paid for the initial examination, including smear, pelvic examination in women and blood tests. For the treatment of syphilitic cases, the rate will be $2.00 per injection, and for additional visits for the treatment of gonorrhœa the rate will be $2.00 per visit. Physicians practising in those areas where there is a full time health unit are asked to submit their accounts to the Director of the Health Unit, otherwise the accounts should be sent to the Division of V.D. Control, 2700 Laurel Street, Vancouver. All accounts must be in triplicate.

DR. GORDON ALEXANDER McCURDY

1907: Born Sydney, Nova Scotia. Died: Victoria, British Columbia, 1944.

In the death, at the early age of 37, of Dr. Gordon McCurdy, the medical profession and the citizens of British Columbia have suffered a serious loss.

Dr. McCurdy was a graduate of Dalhousie University in both Arts and Medicine. On completion of his University course in 1933, he did post-graduate work in Pathology at Glasgow University and returned to Halifax as Assistant to Dr. Ralph Smith, Provincial Pathologist. In 1937 he was appointed Director of of the Pathological Department of The Royal Jubilee Hospital in Victoria. During the next seven years, in spite of impaired health, he was enthusiastic in building up his own Department, organizing Pathological Conferences and assisting in the scientific work of the Victoria Medical Society. He qualified for membership in the American Board of Pathologists and as a fellow of the American Society of Chemical Pathology. His professional work was characterized by a very high degree of intellectual integrity and in demanding a high standard of scientific work from himself he predicated the same in his associates. In addition to his his special training, Dr. McCurdy had an unusual aptitude in correlating clinical medicine with the Pathological and Bacteriological findings.

However skill and judgment in his own work, important as they were, would not alone have accounted for his success. He had an exceptional facility in making lasting friendships. He had early learned to follow the advice of Polonius:

> "Those friends thou hast and their adoption tried,
> Grapple them to thy soul with hooks of steel."

and the friends of college days remained steadfast and loyal in spite of passing years and separation.

Dr. McCurdy had few outside interests but those privileged to know him in his own home quickly realized how deep was the satisfaction he found in the world of music opened to him by his gifted wife.

We shall all miss Dr. McCurdy in our daily work and wish for his guidance and enthusiasm.

—H. H. Murphy.

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Mersalyl (described in the Addendum 1936 to the B.P. 1932) is accepted as the standard mercurial diuertic. In common with all potent drugs, it has some toxic properties, but these are of little significance as compared with the benefits associated with its controlled use. A few cases of idiosyncrasy have been reported, but, as has been stated in a report upon the use of intravenous mercurial diuretics (Lancet, May 8th, 1943, p. 576), *'The occurrence of a few unfortunate reactions is not an indication to withhold the drug but rather to use care in administering it'.*

Mersalyl is indicated principally for the treatment of ascites and œdema of cardiac and cardio-renal origin and ascites due to hepatic cirrhosis.

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Stocks of Mersalyl B.D.H. are held by leading druggists throughout the Dominion, and full particulars are obtainable from . . . .

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†WOLDMAN, E.E., and POLAN, C.G.: The value of Colloidal Aluminum Hydroxide in the Treatment of Peptic Ulcer; A Review of 407 Consecutive Cases, Am. J. M. Sc. 198: 155-164 (Aug.) 1939.

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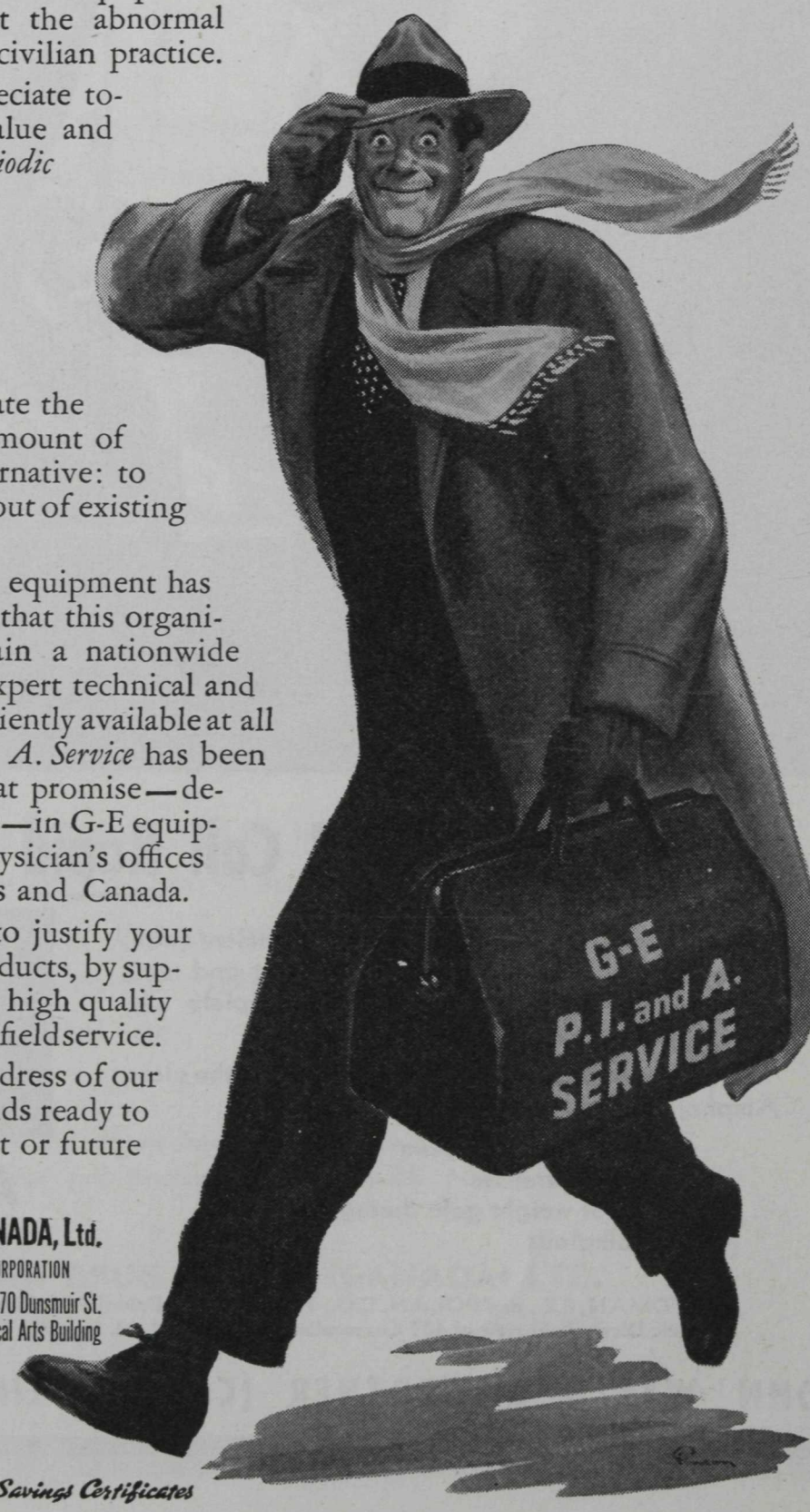

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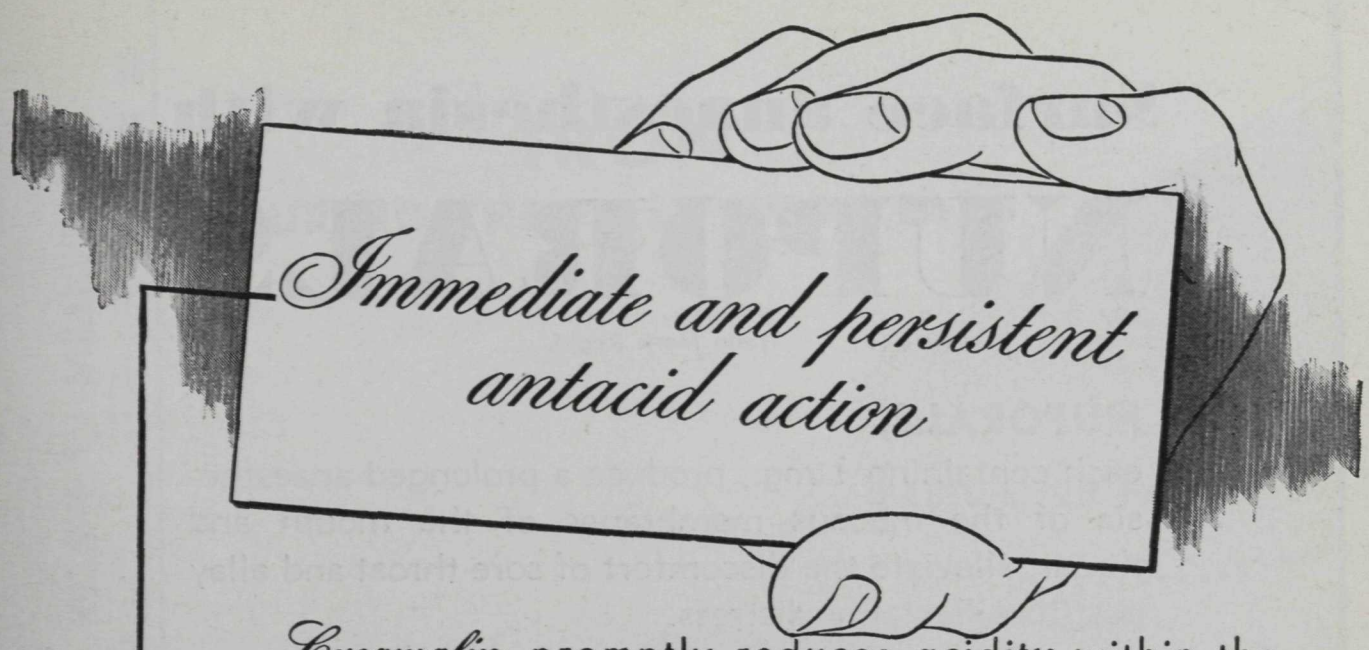

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Creamalin often induces healing of peptic ulcer when employed with an ulcer regimen.

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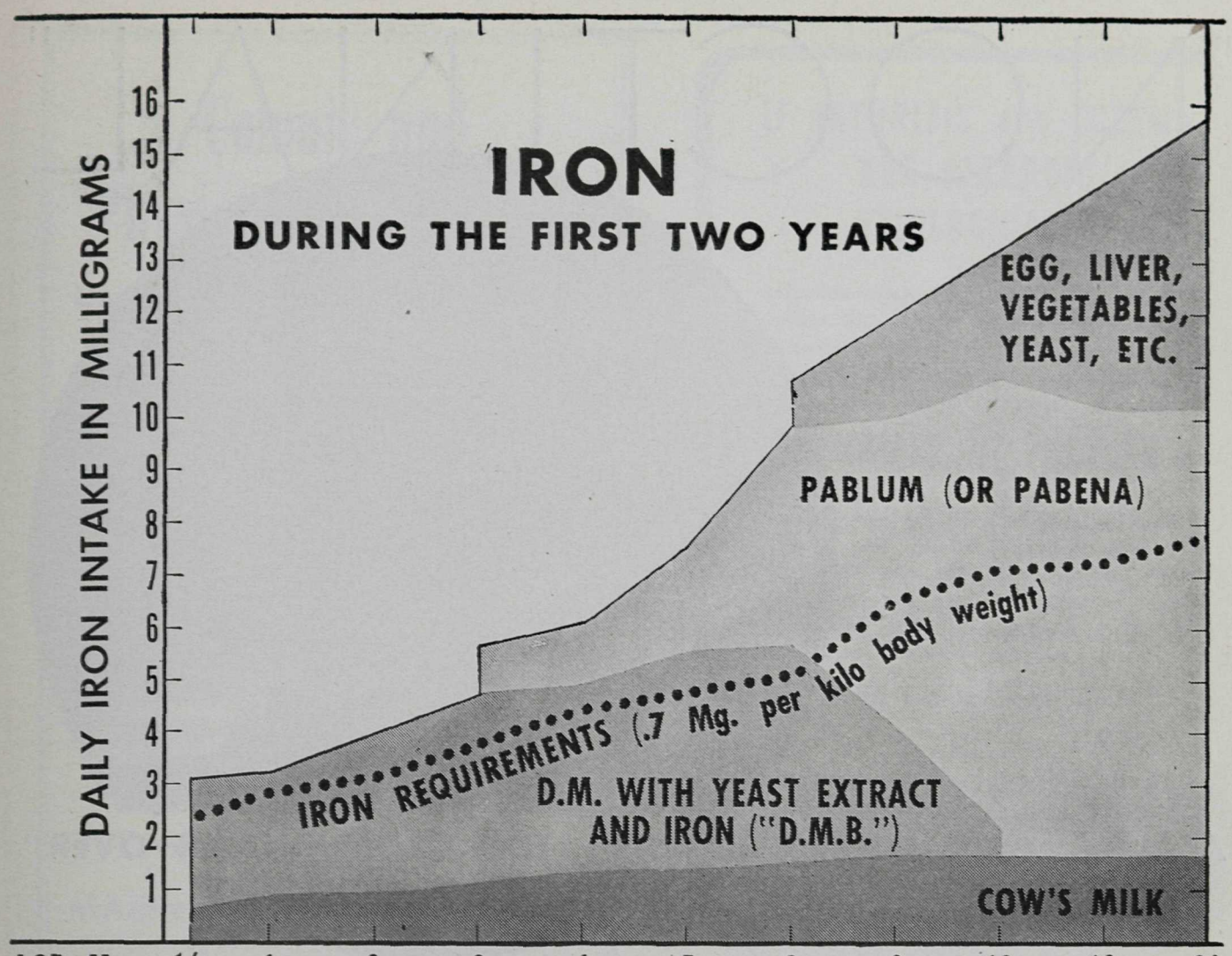

AGE, Mos.	¼	1	2	3	4	5	6	9	12	18	24
WEIGHT, Lbs.	7	9	10	12	14	15	16	19	22	23	25
MILK, Oz.	10	16	18	21	24	26	28	32	32	32	32
"D.M.B.," Oz.	1	1	1¼	1½	1½	1¾	1¾	1	¼	0	0
PABLUM, Oz.	0	0	0	⅛	¼	¼	½	¾	1	1	1

IRON DURING THE FIRST TWO YEARS

During foetal life iron accumulates (in the form of haemoglobin) in the infant's body. After birth the haemoglobin frequently drops to 50% by the third month, especially in prematures. Neither breast milk nor cow's milk is capable of offsetting this loss, as they are deficient in iron. This chart shows that when the carbohydrate and cereal supplements contain iron, a sizeable margin of safety over the requirements can be maintained, not only during the important first six months, but throughout the first two years of life.

More iron than the calculated requirement is needed because some iron is not utilized. In rapidly growing, or poorly nourished infants, and in the presence of infection, the need for iron may be even greater than is indicated in this chart for normal infants.

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"NOCTINAL"

(SODIUM ETHYL SEC.
BUTYL BARBITURATE
"Frosst")

A SAFE QUICK ACTING SEDATIVE, FREE FROM "HANG-OVER"

For sedation, hypnosis and to augment the action of analgesics.

"Noctinal" is intermediate between the very short acting barbiturates, such as Pentobarbital, and the long acting, like Phenobarbital. It is effective in 30 minutes and lasts 4 to 6 hours. The patient awakes refreshed after a sound, restful sleep, with no "hang-over" of depression.

"Noctinal" is safe. Even in excess of full therapeutic doses, it has practically no toxic effect on heart, blood pressure, respiration or kidneys. It is easily soluble in water and is quickly eliminated.

DOSAGE

TABLETS:

When mild continuous sedation is required: ½ to 1 grain two to three times daily.
In insomnia: 1½ grains about one-half hour before retiring.
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Best results are obtained if followed by a warm drink.

LIQUID:

Average dose for adults: Two to three fluid drachms (7 to 11 cc.) in a wine glass of water.
Maximum daily dose for adults: Two fluid ounces (57 cc.).

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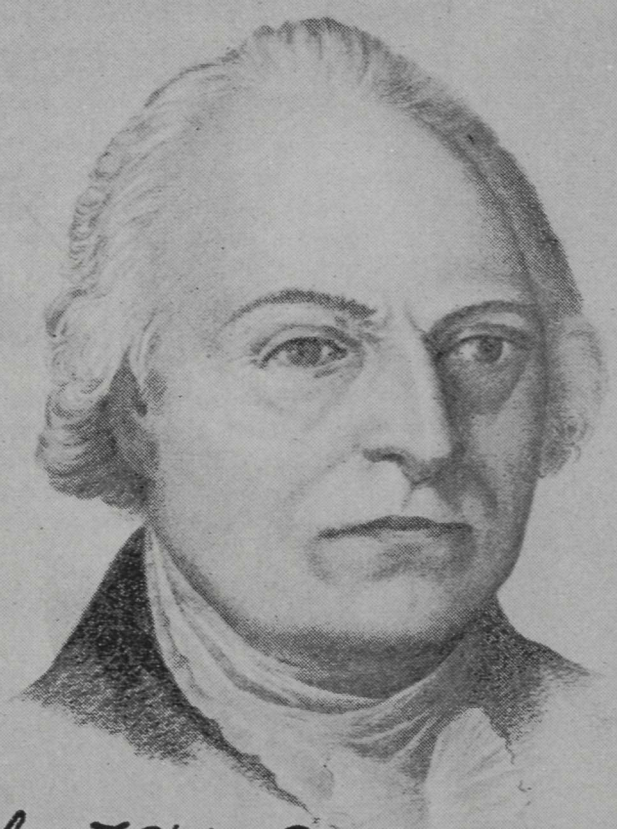
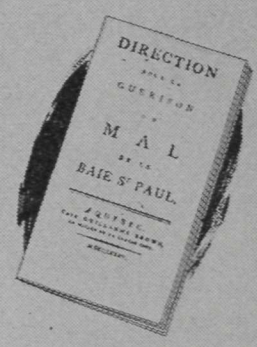




This pamphlet, written by Badelard, is thought to be the first Canadian publication of a medical nature.

Louis F. Philippe Badelard PHYSICIAN AND SURGEON (1730-1802)

BORN in 1730, in Picardy, Badelard obtained his medical degree in France and came to Canada as surgeon to the French troops. During the Battle of the Plains of Abraham he was made prisoner by a Scot named Fraser. They became life-long friends. After the Conquest he settled in Quebec where he won recognition as a skilful surgeon.

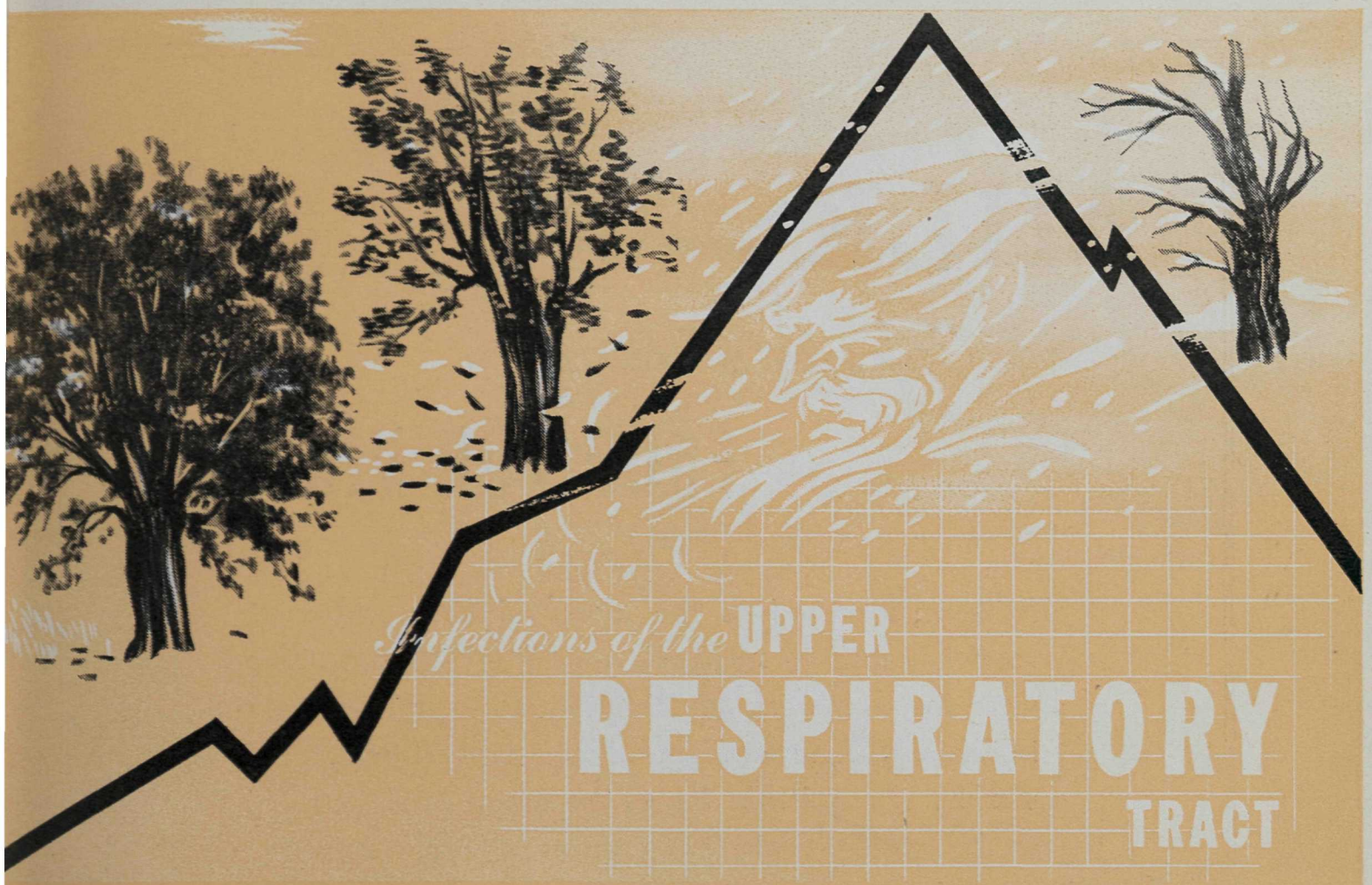
He enrolled in the Canadian Militia in 1775 and the following year was commissioned as Surgeon to the Quebec Garrison. At the request of Governor Haldimand, he investigated an outbreak of disease at Baie St. Paul. Badelard continued this investigation until 1782. He diagnosed the disease as syphilis and prescribed various forms of mercury in treating it.

In 1785, a pamphlet giving detailed instructions for the treatment of the malady and the dosage of mercurial remedies prescribed was written by Badelard and circulated by the Government to all parishes for the instruction of the people. (See illustration above.)

In 1788, Badelard was conspicuous in supporting a legislative measure to compel anyone wishing to practise Physic, Surgery or Midwifery in Quebec to undergo examinations and obtain a qualifying Diploma.

Of a somewhat irascible temperament, Badelard seems later to have gained universal respect and affection, for at the time of his death, in 1802, he was followed to his family burial place at Ancienne Lorette "in spite of intense cold" by a great throng of clergy and citizens of all classes. He bequeathed 12,000 livres (Foundation Badelard) to L'Hôpital Général for the purpose of "wintering, lodging and feeding two poor people". His obituary describes him as of "a nature faithful, zealous, charitable, gay and frank . . . the declared enemy of hypocrisy".

The example set by men like Badelard in helping to establish a sound foundation for the practice of medicine in Canada inspires this organization to maintain with unceasing vigilance its policy—Therapeutic Exactness and Pharmaceutical Excellence.



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* Values Variable.

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