THE

BULLETIN

OF

The Vancouver Medical Association

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(1) Bach, F., Freedman, A., Bernstock, L., Br. Med. Jr., Sept. 13, 1952, pp. 582-86.

(2) Ichniowski, C. T. and Hueper, W. C., Sc. Ed., J. Am. Pharm. Assn., Vol. XXV, No. 8, pp. 225-30, Aug. 1946.

(3) Wieland, O., Med. Klin., 44: 1530-32, Dec. 2, 1949.

(4) Hart, R. E., Bull. Fed. Amer. Soc. Exp. Biol., Vol. 5, p. 182 (1946).

THE PAN PH

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HOSPITAL CLINICS

VANCOUVER GENERAL HOSPITAL

Regular Weekly Fixtures in the Lecture Hall

Monday, 8:00 a.m.—Orthopaedic Clinic.
Monday, 12:15 p.m.—Surgical Clinic.
Tuesday—9:00 a.m.—Obstetrics and Gynaecology Conference.
Wednesday, 9:00 a.m.—Clinicopathological Conference.
Thursday, 9:00 a.m.—Medical Clinic.
12:00 noon—Clinicopathological Conference on Newborns.
Friday, 9:00 a.m.—Paediatric Clinic.
Saturday, 9:00 a.m.—Neurosurgery Clinic.

ST. PAUL'S HOSPITAL

Regular Weekly Fixtures

2nd Monday of each month—2 p.m. ..... Tumour Clinic
Tuesday—9-10 a.m. ..... Paediatric Conference
Wednesday—9-10 a.m. ..... Medical Clinic
Wednesday—11-12 a.m. ..... Obstetrics and Gynaecology Clinic
Alternate Wednesdays—12 noon ..... Orthopaedic Clinic
Alernate Thursdays—11 a.m. ..... Pathological Conference (Specimens and Discussion)
Friday—8 a.m. ..... Clinico-Pathological Conference (Alternating with Surgery)
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Wednesday, 10:45 a.m.—General Medicine.
Wednesday, 12:30 p.m.—Pathology.
Monday, 11:00 a.m.—Psychiatry.
Friday, 8:30 a.m.—Chest Conference.
Friday, 1:15 p.m.—Surgery.

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SCHEDULE OF CLINICS—1953

MONDAY—9:00 a.m.-10:00 a.m.—Nose and Throat Clinic.

TUESDAY—9:00 a.m.-10:00 a.m.—Clinical Meeting.
10:30-12:00 noon—Lymphoma Clinic.

THURSDAY—11:00 a.m.-12:00 noon—Gynaecological Clinic.

DAILY—11:45 a.m.-12:45 p.m.—Therapy Conference.

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GREATER VANCOUVER PUBLIC HEALTH

Metropolitan Health Committee

Dr. Stewart Murray, Sr. Medical Health Officer, City Hall, Vancouver, B.C.

	Population (Estimated)
Vancouver	390,325
Burnaby Municipality	61,000
North Vancouver City	16,000
North Vancouver District Municipality	16,000
West Vancouver Municipality	14,250
Richmond	19,186
University Area	3,800
District Lot 172	1,469
TOTAL	522,030

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WHOOPING COUGH

Several babies with whooping cough have been admitted to hospital during recent months and the severity of symptoms has been in keeping with what might be expected at this early age. A study of the cases in all ages reported in the City of Vancouver during 1953 shows the following age incidence:

0-3 mos.	3-6 mos.	7-9 mos.	10-12 mos.	1-5 yrs.	6-14 yrs.	Over 14 yrs.
4	4	1	-	22	45	3

In our immunization program it is routine to start at 3 months of age with the administration of the triple antigen (pertussis vaccine, diphtheria toxoid, and tetanus toxoid). With the recommended intervals between doses the child is 8 months old before the series is completed and the peak of immunity is probably ot attained until perhaps a month or two later.

The comparatively large number of cases occurring in the 1 to 5 age group, suggests that these children are being neglected either in regard to their initial series or their reinforcing doses.

Since these are the ones who may be responsible for spreading the disease to their younger siblings, more concentrated effort should be devoted to their follow-up by the private physicians as well as the public health agencies.

Dr. Susan McMaster's article in the Canadian Public Health Journal of February 1953, shows that of the 242 cases of pertussis studied in 1950, no case occurred in any child who had received four doses of the vaccine and had followed up with the usual booster doses.

The highest number of cases found in the 6-14 age group is to be expected since the booster doses are not carried on customarily, beyond the age of five or six. These also may be the ones who are infecting the babies in the family.

This stresses the importance of warning parents to shield the babies from all those showing signs of a cold.

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MEDICAL-DENTAL BUILDING, VANCOUVER, B.C.

The Editor's Page

The recent developments in the matter of Hospital Insurance in B.C. have opened up a few vistas which it would seem worth our while to explore a bit. Just what changes will come about, we can only speculate—and most people's reaction to the plan outlined by the Premier of B. C. depends to some extent on the way it affects them personally—one can see that in the flood of comments, some favourable, and some exactly the opposite, that has been unloosed by Mr. Bennett's announcement of the changes that his Government proposes.

In the first place, one can hardly apply the word insurance to this new scheme, any more than one can apply it to the various functions of Government, of which the provision of hospital care has now become one. Our conception of insurance is a plan whereby a number of people together pay the total cost of any of a dozen different things that are bound to happen to a certain number of them each year—death, accident, sickness and so on. That is what we did when we paid our premiums before. But now it comes as a tax which everyone in the community must pay. Perhaps this is a mere splitting of hairs, but one feels that there is a difference.

The truth seems to be that sickness, hospital care, health matters and so on are in a different category to other calamities which beset mankind. In other cases, we are insuring against loss of money, by fire, accident and so on—and our payments are based on our ability to pay, and the value of the things we insure—and many people never pay for such insurance, because they have nothing to insure. But people are beginning to realize that if we are to insure against loss of health, everyone must come in, for several reasons—and during the last quarter of a century at least, the pressure has been increasing steadily, for the realization of this fact. That is why the demand for Health Insurance has grown so strong, and is growing stronger. The method by which this demand is to be met is a matter for discussion—but that it must and will be met is not in doubt.

The Government which introduced Hospital Insurance realized this, and made a bold move in the right direction. The medical profession of Canada itself, recognized this in the resolution passed by the C.M.A. in 1949, which we publish in this number of the Bulletin. Perhaps there have been mistakes made—but this does not alter the fact that the introduction of Hospital Insurance was a good and a statesmanlike step to have taken.

The years since it was instituted have proved two or three things. The first is that it has been a very great boon to a great many people, and to the country at large. We do not think anyone can reasonably deny this, and we do not think anyone seriously questions it. We all agree that it must be continued.

The second is, that there are some very big gaps which have to be filled. The first is simply the urgent need for more beds—we are desperately short of hospital beds. The next is the need for rearrangement of the beds according to the type of case—seriously acute, demanding all the resources of medicine, moderately acute, which could be handled more cheaply convalescent, still more cheaply, and lastly, chronic. One can envision many other needs—rehabilitation, etc.—but that is some way off. The third thing we have learned, is that compulsory payment is essential, and that it cannot be obtained under the present scheme of payment of premiums. For years, the responsible authorities have made honest and sincere efforts to compel payment. They have threatened, they have cajoled, they have cancelled old obligations—they have tried everything—and it has failed. So that great injustice has been done to those who do pay. We cannot fairly blame the Government for this—it is inherent in the present scheme, owing to the stubborn facts of human nature.

So that some other way must be found, and the increased sales tax is suggested. No doubt this has its disadvantages, though a great many of these, in our humble opinion, have been overstressed. But it has one great advantage—that everybody pays—and those who can best afford it pay the most. And if we are to believe the figures as put forward, the extra 2% will not be equal to the cost of Hospital Insurance for the great majority of people in the Province. We are not qualified to judge as to the correctness of this statement—but there are those in high places who are willing to stake their future (for it is nothing less) that this is so.

LIBRARY HOURS:

Monday to Friday ..... 9.00 a.m. to 9.00 p.m.

Saturday ..... 9.00 a.m. to 1.00 p.m.

RECENT ACCESSIONS:

Understanding Old Age by Jeanne G. Gilbert, 1953.

Advances in Pediatrics edited by Samuel Levine, volume 6, 1953.

Rehabilitation by Walter S. Woods, 1953.

Pediatric Clinics of North America, Symposium on Cardiovascular Diseases, February, 1954.

Transaction of the Ophthalmological Society of the United Kingdom, 1953.

Surgical Clinics of North America, Symposium on Gastrointestinal Surgery, February, 1954.

Fifty Years of Medicine by Lord Horder, 1953.

Reason and Unreason in Psychological Medicine by E. B. Strauss, 1953.

The Homosexual Outlook, A Subjective Approach, by Donald Webster Cory, 1953.

History of the Second World War, Medicine and Pathology, edited by Sir Zachary Cope, 1952.

Modern Trends in Forensic Medicine by Keith Simpson, 1953.

The Knee and Related Structures by Philip Lewin, 1952.

The British Pharmacopoeia, 1953.

Stress and Disease by Harold G. Wolff, 1953.

Diseases of Muscle, A Study in Pathology by R. Dr Adams, D. Denny-Brown and C. M. Pearson, 1953.

The Biology of Mental Health and Disease, The 27th Annual Conference of the Milbank Memorial Fund, 1952.

MUTUAL MEDICAL AND LEGAL PROBLEMS AND RESPONSIBILITIES

By H. H. MURPHY, M.D., Victoria, B.C.

A paper presented before the Victoria Bar Association, October, 1953.

When your President honoured me by asking me to address this splendid gathering I was indeed pleased and keenly appreciative of the privilege and of the opportunity, and the errors of omission and commission which I may commit in the next few minutes I shall ask you all to blame on the head and not on the heart.

I came to British Columbia in 1912 and almost at once found that my name suggested to almost everyone I met that I was probably a relative of the distinguished native son and eminent jurist—the late Mr. Justice Murphy. I always felt that I deserved some commendation for being truthful and admitting that I could claim no such relationship. As the years passed and I came to know him personally I naturally developed the same high regard and respect for the man and for his work that was universal throughout the Province and the Dominion.

Your President left the choice of subject for discussion this evening to me—although he did, very tactfully, hint that perhaps it would be just as well NOT to talk about Cancer—so that subject, about which I know a little, was out, and I agree, quite properly out. So we decided upon a brief and of necessity a superficial consideration of some of our mutual problems and responsibilities.

The legal profession may well find amusement and perhaps some comfort when they hear the medical profession criticized, as it often is, for lack of understanding sympathy with their patients. As far as I know, this has been a good stick with which the profession could be beaten for centuries. A verse along these lines comes down to us from the twelfth century when the migration of organs in the human body was considered possible. All that remains of that quaint belief today is perhaps the expression —a "sinking of the heart":

"A certain doctor, known to have the stone,
Occasioned much alarm and consternation
Amongst his friends; the fact becoming known
Gave rise to much concern and conversation:

"How came he by this ailment?" someone cried.
"I scarcely know of aught that can be sadder."
"The explanation's plain," a wit replied,
"His heart has just slipped down into his bladder."

Perhaps the companion piece, but of more modern vintage, might emphasize a possible defect in the legal armour:

Two old friends meet—one Bill, on crutches and with a plaster of Paris cast on his leg. In answer to his friend's surprise, Bill explains that he broke his leg a year ago, and the friend says: "A year ago and you have your leg in a cast still?" "Oh, yes," replied Bill. "My doctor wanted to take it off eight months ago, but my lawyer advised me to keep it on." Just a difference in point of view and, allowing for this, perchance both physician and lawyer gave good advice.

It would be easy to multiply these differences in point of view, but they are trivial and on many, many occasions our interests are either identical or run so nearly parallel that I prefer, this evening, to direct your attention to what draws us together, as professions, rather than what separates us. It was Henry Clay who said: "It would not be very just or wise to arraign the honourable professions of law and physic because the one produces the pettifogger and the other the quack."

Some years ago an excellent article appeared in one of our leading professional journals. It was entitled "In Defence of Quarrelling" and was written by a prominent barrister in the United States, and over the years has remained fixed in my memory. Briefly, the point of the article was that the public, hearing in court the lawyers for one side tangle with the lawyers for the other, often classified it all as quarrelling — quite overlooking the fact that the lawyers in question might, on the adjournment of the court, be seen leaving happily together—this this opportunity to differ in court helped to maintain a healthy condition in the profession. Then he drew attention to the fact that the medical profession lacked this outlet and that very often one man decided on a procedure of major importance and that this was carried out without the pro and con discussion which might have resulted had another physician been present—shall we say for the moment "acting for the defendant." He then went on to discuss several cases with which he was quite familiar and which supported his contention.

At the time of publication—approximately thirty years ago—his position was more easily maintained than it would be now. This problem has been studied by organized medicine, by the Royal College of Surgeons of Canada, the American College of Surgeons, by the Canadian Medical Protective Association and by hospital boards across the country. In addition, during these thirty years there has been spectacular growth in technical procedures to aid in proving or disproving clinical findings.—these include all the usual studies made in our Radiological and Clinical Pathological laboratories. Thus we have developed a measure of teamwork unthought of in the early twenties. Another result of these advances has been that diagnosis on the spot—except in emergencies—serves only to direct further investigation and the final opinion given to the patient is what I think your profession would dignify with the designation of a "considered opinion."

As an example of the type of concrete problem common to both our professions where, in my opinion, much might be accomplished by studied and combined action, I might mention the fact that neither barrister nor physician is allowed by the Federal Government to make any deduction in his annual income tax payment to cover what we might call "obsolescence of plant," to keep to some semblance of income tax return phraseology. The business man is allowed each year to make certain deductions to take care of the replacement of his capital investment. The barrister and the physician have each made a large investment of time and money in their education before they obtain a licence to practise. This investment is constantly being added to during the years of active work and yet it disappears with the individual. In my profession we feel that there should be a fund built up over the years through similar income tax deductions to replace this investment for the estate. A prominent, retired physician from the United States recently told me that his son, now carrying on a large orthopaedic practice, pays annually in income tax approximately the same amount as his father saved each year to make possible his retirement. I believe that a joint committee drawn from the Canadian Bar Association and from the Canadian Medical Association might accomplish much if entrusted with the study of this problem.

There are, at the present time, several unfortunately highly controversial problems which I submit call for careful study, and I suggest to you this evening that these problems, too, could be advantageously studied by such a joint committee. Under this heading I would include:

1. Capital punishment.

2. Castration for certain sex crimes such as rape. I am quite aware that sterilization alone will not solve that problem, but I believe that the existence of that penalty would serve as something of a deterrent. In spite of all the quasi-scientific talk we hear today about uncontrollable impulses, I believe that if a policeman were standing by when the act was under consideration the impulse might be controlled. I am sure you will agree.

3. Use of the lash.

4. Care of drug addicts.

5. Control of crime comics.

6. Dissolution of marriage when one partner is incurably insane.

7. The right of the individual to die when suffering from incurable, painful or grossly disabling illness. Today the patient suffering from severe blood loss may refuse a life-saving blood transfusion and so die gloriously and honourably in defence of his liberty—but he has no such liberty when hopelessly and incurably ill.

The public is thinking along these lines and leadership from the learned professions is, I believe, indicated. A joint committee such as I have mentioned might study these problems for a couple of years and then make a report. That report would, I feel sure, be welcomed by our legislators and would be of great assistance to the individual members of our professions when faced with one of these difficult problems. I feel free to make this suggestion to you this evening because your Canadian Bar Association has already shown its courage and its readiness to give leadership in the recent discussion of certain labour problems. The fact that such action aroused some outspoken antagonism, in my opinion, rather proves the soundness of judgment shown by the Bar Association in making a pronouncement.

A few minutes ago I mentioned the Canadian Medical Protective Association which is a mutual aid organization developed in association with organized medicine in Canada —to give advice and aid to its members in time of trouble—when some patient is considering medico-legal action. It was started about fifty years ago and was patterned after the British Medical Defence Union which was established about twenty years earlier. It is not an insurance organization in the ordinary sense of the word. In case of suit it stands ready to advise and help its members in those cases where it seems reasonable—the case is defended but the Association does not exist to condone poor work in any way. Membership now comprises about 50% of the total medical population of Canada. We recognize that from the purely medical point of view some of the suits against our members are entirely justifiable, since the unfortunate result has been due in part at least to carelessness or incompetence, thoughtlessness or undue hurry, and in such cases the public should have redress. But in all cases, except those involving gross carelessness or incompetence we wish to have the case adjudicated by the courts—to give the physician or surgeon a chance to defend himself and to avoid the payment of excessive damages. After half a century of this work I think it worthy of note that our Council feels that only a very few members are doing poor work. We have appraised, over the years, the type of work which may result in dissatisfaction and our members are constantly advised and directed in such matters. Some suits result from an unwise or ill considered word from another physician, and it is possible that an equivocal, blundering word from one of your profession might have the same effect. But here I hasten to add that we know very well that thoughtful, wise consideration by your profession may and does prevent many of these possible but frivolous actions. The great majority of these unfortunate cases are due to misunderstandings between patient and physician—perhaps undue optimism on the part of a surgeon—and yet the physician or surgeon who has not the God-given gift of optimism will accomplish little, and will lead a life of worry and disappointment.

Perhaps the most urgent problem in connection with the organization of Medical Services in Canada is the question which has been before us for many years and which becomes more and more imperative of solution as each new scientific discovery increases the efficiency of medical practice and automatically, I might say, makes the cost more and more prohibitive for the ordinary citizen. The medical profession of Canada has had this under consideration for many years—the first whisperings began about twenty-five years ago. Our position is this—we are prepared for such changes provided that the management remains under our control—in other words we do not want to be a part of a purely governmental service which we cannot direct. At the same time we must remember that all three major political parties have approved of the principle involved

and in a survey made by the Canadian Institute of Public Opinion in 1949, 80% of those consulted favoured some form of health insurance to include hospital and medical care under Federal control. Frankly in a project so vast and so expensive, if it is sponsored by the Federal Government I, personally, expect that it will be directed by the Federal Government. However as yet Ottawa has not acted, and under the aegis of the Canadian Medical Association the Trans-Canada Medical Services is already functioning in every province of Canada except Newfoundland, and we expect that that new province will shortly be included. Briefly this organization provides for pre-payment of medical services for industrial groups. At the moment details are under consideration which may enable individuals to be enrolled. The Head Office is in Toronto and co-ordinates the work of the various provincial units—all of which operate under the aegis of the Canadian Medical Association.

For several years the Federal Government has had a Committee working on this problem of supplying a National Health Service and their first step was the establishment of large grants to the provinces. In certain instances the grants are the so-called "matching grants" which means that for every dollar put up by Ottawa another dollar must be supplied by the Provincial Government. These grants have been made now for some years to aid in the care of Tuberculosis, Public Health, Crippled Children, Venereal Disease and Cancer. When these grants were brought before the house initially by Mr. King, the then Prime Minister, and Mr. Martin, the then Minister of Health—a portfolio which he still holds—the members were advised that the Government was making the initial step towards some measure of national health service. When that time comes your profession will undoubtedly be asked to advise on the terms and extent of the enabling legislation. It is beyond the realm of possibility that if this proves to function satisfactorily you too might find yourselves caught up in a new social development? So far the Government seems to be proceeding wisely if somewhat slowly. In the March issue of the Atlantic Monthly there was a valuable article by Dr. James Howard Means, Professor of Clinical Medicine at Harvard, on Governmental Medicine in the United States. In this article Dr. Means stresses that in 1953 the Federal Government provides some measure of medical and hospital care for twenty-five millions of the population—actually one-sixth—and that is done in spite of the opposition of organized medicine. He then reviews briefly what is being done in Canada and closes with this paragraph:

"Planning at all levels, national, state and local—is absolutely necessary and it is hoped that the medical profession of the United States may see fit to co-operate with the Government along some such lines as that which he Canadians are following at the present time."

So much for examples of those developments of the moment where it seems to me we have mutual interests which are our special concern because we are physicians or barristers. We have further mutual interests because we are first Canadian citizens and secondarily professional men and women. If we accept, as I do, the old adage "The decisive events of the world take place in the intellect"—then we must concern ourselves with current trends in education. We have been fortunate, in this Province, in the calibre of the men who have been directing our educational programme and at this point I would congratulate your Association in that one of your members held the important position of Minister of Education in our local Government for many years and gave to that Department distinguished leadership with obvious tangible results in the problem of mass education. In the last troubled quarter of a century Canada has embarked on a vast educational programme—constantly breaking new ground in the attempt to give our citizens what, for lack of a better name, I shall term a "minimum standard of education". There have been errors but there has also been progress, and no matter how impatient you and I may have been when we tried to dictate a letter to a stenographer who could type but could not spell—who could file material but had little knowledge of the glorious inheritance she had overlooked in her mother tongue—yet we cannot condemn unqualifiedly without due consideration of the times and the complexity of the problem. My own personal feeling is that if we cannot afford the latest and best

in housing and equipment of schools as well as the best possible teachers then we should see to it that the rewards offered to the teaching profession should be increased sufficiently that those who have the gift of teaching and who feel the sense of dedication to this work may be able to make it their life's work without undue personal financial sacrifice. You will recall the definition of a college as a log with the student sitting on one end and Mark Hopkins on the other.

I have just referred to "mass" education very briefly because I believe that we should all be perhaps even more interested in what I might call "selective" education—and by that I mean the development of the outstanding, clever intellectual students of each generation. They should, in my opinion, be segregated early and given every opportunity—you may say that they are in the minority and probably they are, but they will leaven the whole lump, and if we arranged to educate them to think rather than to memorize, then we might find that we had a much greater number of potential prospects for a liberal education than we had realized. For a few minutes I would like to direct your attention to an interesting experiment now being conducted in a small college—St. John's—at Annapolis, Maryland. This small college, for its enrollment last year was only 233, was founded as King William's School in 1696—in the pre-revolutionary days and chartered as St. John's College in 1784. It had a distinguished tradition of scholarship until the turn of the present century when the elective system, then being tried out in both the United States and in Canada, was adopted and students were allowed so much latitude in selecting their courses that more and more a student decided early in his school days—just what he wished as his life's work and his whole Arts course was directed along these lines as pre-medical, pre-legal, pre-commercial, pre-educational or pre-earning a living. In other words he or she did not start out with the idea of getting a balanced liberal education but rather to secure special training. The decline in scholarship continued until 1937, when it became apparent that the system must be changed or a new system adopted. At that time the College was reorganized under two outstanding educators, Stringfellow Barr and Scott Buchanan. The College now emphasizes two Latin aphorisms in their calendar—the first is "No way is impossible to courage" and the second is "We are making free men out of children by books and balances" and by the word 'children' they mean men and women who are capable of liberal learning. Briefly the system is this. Enrollment is limited to young men and women of outstanding ability and the classes are small enough to permit the tutorial method in the interpretation of The Hundred Best Books (the same hundred books considered last session at Victoria College in the extension courses for adults). For example, if the group is reading Carlyle's French Revolution the discussion periods will consider and analyse the history of revolution—what it has accomplished—when it is justifiable—when it occurred in France, what was happening in Russia, in England or in what was later to be the United States. In other words this course is largely modelled on the British system—apart from seminars there is a formal lecture to the student body as a whole once a week—about half of the lectures are given by members of the College staff and the balance by outside guest speakers. Scientific training is classified under mathematics, physics, chemistry and biology so that the graduate will have sufficient knowledge to understand the world in which he will live and work and also to understand how that world has evolved mentally. The degree given is the usual B.A. but it is divided into three and if I read to you from the Calendar just what these three divisions mean I think you will grasp what the College means by their degree:

"B.A. *Magna cum laude*—to be awarded to those students, who in the opinion of the Faculty, are judged satisfactory both in attainments and progress and capable of pursuing their work in law, medicine and theology or in the graduate schools of language and literature, the natural sciences and logic and metaphysics.

B.A. *Cum laude*—a less eminent case of the first.

B.A. *Rite*—to be awarded to those students, who in the opinion of the Faculty have made sufficient progress in the intellectual virtues to warrant recognition by the

College, but on whose actual powers in the several arts and sciences and therefore on whose actual capacity for advancing further in the professional or graduate schools, the Faculty declines to make a final judgment."

There are many other facets to this gem of educational training which might well occupy us for a considerable time but I think what I have already said will direct your attention to certain changes which are occurring in our ideas of education—in other words to be literate in the pre-atomic age and to be literate today are not necessarily one and the same thing.

The question of adult education becomes increasingly important in view of changing conditions in industry, business and professional life in ths country. I have in mind the increasing incidence of early retirement—by early, I mean retirement for women at 60 and for men at 65. It probably concerns your group less than almost any other comparable group, numerically speaking, because of the very nature of your work—but even for you it does come into the picture to some extent—even if unfortunately only through illness. This is of course something on which I am inclined to think and talk with the enthusiasm of a proselyte, having retired two years ago, and incidentally I am finding the new chapter interesting and enjoyable. However, while it is a subject which might serve well for an evening's discussion, I merely mention it now to stress the need for mental as well as financial preparation if the individual is going to enjoy the leisure to which he has looked forward for so long. He must have interests or hobbies which will take the place of his regular work—and these must be of such a character that he may be able to carry them on in spite of advancing years. Adult training becomes increasingly imperative when on every hand Canadian citizens, as a group, are asking for and securing an ever-increasing amount of leisure time. Valuable as the radio is and entertaining as television may be, we need more and more lectures of the type given as extension lectures by Victoria College. Training in the details of his work the citizen will get and with ever increasing improved mechanical devices he may be able to do the nation's work in an eight hour day and a five day week but if he is to be a happy man, if he is to understand at all the ever changing currents in the world in which he lives today, he must have the day's events translated for him in the light of history by those who by training and intellectual flair are able to do so. For example, I have in mind some part of our educational system which, when Hitler burned the books, would draw our attention to the fact that this has been done many times before—by the Chinese in the third century B.C.—by the Arabs at Alexandria in 642 A.D. And of course in war great libraries have been destroyed many times—for instance the library at Louvain in the first World War. And yet whether by design or the accident of war, knowledge survives. The books burned in one place turn up in another. And of course if such wanton destruction could not destroy knowledge when books were laboriously copied by hand on vellum the futility of such an act in the world today with its multitude of printing presses is at once apparent. Again when Stalin died and a triumvirate succeeded we think at once of the first triumvirate in Rome—Caesar, Crassus and Pompey. Crassus quickly disappeared from the scene—even as Beria has done in Russia. On Caesar's death the second triumvirate—Anthony, Lepidus and Octavius was formed and again, as in Russia, Lepidus soon disappeared—and history records practically the same in the French Revolution at the time of Robespierre.

I have recently been enjoying the Holmes—Laski letters. It is the record of a most unusual friendship between the youthful Laski, twenty-two, and Mr. Justice Holmes of the American Supreme Court, then in his seventy-fifth year. Both men educated in the classical tradition and reading not only in their mother tongue but French and German as well. The correspondence began in 1916 and lasted until within a few weeks of the death of Mr. Justice Holmes in 1935—and it was not a matter of an occasional letter but scarcely a week passed without an interchange of letters. There are few subjects which were not discussed—usually more or less in agreement but often not. You will recall that Mr. Justice Holmes was known as "The Great Dissenter". You find him always reviewing Greek, Roman, French and German basic ideas of liberty and

freedom and correlating them with the problems before him in his daily work in the Supreme Court—always concerned that the rights of the individual should not be overlooked in the maze of legal tradition, requirements and precedent. To quote Sydney Smith—"Great men hallow a whole people, and lift up all who live in their time." His position always reminded me of the prayer for social justice in the Book of Common Prayer.

"Grant us grace fearlessly to contend against evil and to make no peace with oppression; and that we may reverently use our freedom, help us to employ it in the maintenance of justice among men and nations."

It is not just the power which your profession holds in the interpretation of the laws of the country but it is also the devotion of great men of the type of Mr. Justice Holmes which has made the profession of law the great and honourable one that it is. I like to associate this idea with the following quotation which justifies the use of the same adjectives in describing my own profession:

"An American soldier, wounded on the battle field in the far East, owes his life to the Japanese scientist Kitasato, who isolated the bacillus of tetanus. A Russian soldier, saved by a blood transfusion, is indebted to Landsteiner, an Austrian. A German is shielded from typhoid fever with the help of a Russian, Metchnikoff. A Dutch marine in the East Indies is protected from malaria because of the experiments of an Italian, Grassi, while a British aviator in North Africa escapes death from a surgical infection because, through the discoveries of a Frenchman, Pasteur, and a German, Koch, a new technique was elaborated. In peace as in war we are the beneficiaries of knowledge contributed by men of every nationality. Our children are protected from diphtheria by what a Japanese and a German did; they are protected from small pox by the work of an Englishman; they are saved from rabies because of a Frenchman; they are cured of pellagra through the researches of an Austrian. From birth to death they are surrounded by an invisable host, the spirits of men who never thought in terms of flags and boundary lines, and who never served a lesser loyalty than the welfare of mankind." (W. R. Wallace).

In conclusion, Mr. President, you and your members may perhaps feel that to some extent I have been day dreaming—and perhaps I have—but in the words of Dana Burnet:

"The Dreamer dies; but never dies the dream
Though Death shall call the whirlwind to his aid
Enlist men's passions, trick their hearts with hate—
Still shall the vision live—say nevermore
That dreams are fragile things—what else endures
Of all this broken world save dreams alone."

You will also recall the closing lines of Tennyson's "Ulysses":

"Come, my friends,
'Tis not too late to seek a newer world.
Push off, and sitting well in order, smite
The sounding furrows; for my purpose holds
To sail beyond the sunset, and the paths
Of all the western stars, until I die.
It may be that the gulfs will wash us down:
It may be we shall touch the Happy Isles
And see the great Achilles, whom we knew.
Though much is taken, much abides; and tho'
We are not now that strength which in old days
Moved earth and heaven; that which we are, we are;
One equal temper of heroic hearts,
Made weak by time and fate, but strong in will
To strive, to seek, to find and not to yield."

CANADIAN MEDICAL ASSOCIATION
BRITISH COLUMBIA DIVISION

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

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In view of the constant references in the press to plans of National Health Insurance, and the fact that a public forum on this subject to contemplated during the Convention of the Canadian Medical Association in June, it is felt that a republication of this statement of the C.M.A. at Saskatoon in June, 1949, would be timely.

—STATEMENT OF POLICY—

Adopted by the General Council of the Canadian Medical Association, June 14, 1949.

1. The Canadian Medical Association, recognizing that health is an important element in human happiness, reaffirms its willingness in the public interest to consider any proposals, official or unofficial, which are genuinely aimed at the improvement of the health of the people.

2. Among the factors essential to the people's health are adequate nutrition, good housing and environmental conditions generally, facilities for education, exercise and leisure; and not least, wise and sensible conduct of the individual and his acceptance of personal responsibility.

3. It is recognized and accepted that the community's responsibility in the field of health includes responsibility not only for a high level of environmental conditions

and an efficient preventive service, but a responsibility for ensuring that adequate medical facilities are available to every member of the community, whether or not he can afford the full cost.

4. Accordingly, the Canadian Medical Association will gladly co-operate in the preparation of detailed schemes which have as their object the removal of any barriers which exist between the people and the medical services they need and which respect the essential principles of the profession.

5. The Canadian Medical Association hopes that the provincial surveys now being conducted will provide information likely to be of value in the elaboration of detailed schemes.

6. The Canadian Medical Association, having approved the adoption of the principle of health insurance, and having seen demonstrated the practical application of this principle in the establishment of voluntary prepaid medical care plans, now proposes:

(a) The establishment and/or extension of these Plans to cover Canada.

(b) The right of every Canadian citizen to insure under these plans.

(c) The provision by the State of the Health Insurance premium, in whole or in part, for those persons who are adjudged to be unable to provide these premiums for themselves.

7. Additional services should come into existence by stages, the first and most urgent stage being the meeting of the costs of hospitalization for every citizen of Canada. The basic part of the cost should be met by individual contribution, the responsible governmental body bearing, in whole or in part, the cost for those persons who are unable to provide the contribution for themselves.

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The Section of Physicians in Public Service
Message from the Executive

The Executive of this Section of the C.M.A., B.C. Division, met February 22 and March 1 to discuss a program for the meeting of the Canadian Medical Association in Vancouver this coming June.

Dr. Harrison presented a circular letter to be sent to people employed as salaried physicians in positions supported directly or indirectly by public funds across the Dominion of Canada. This large body of medical personnel includes a considerable number of physicians presently outside the activities of the Canadian Medical Association and they are invited to contribute in an organized way, their special experience in the field of public health—using the term in its largest sense. They are asked to participate in directing the expanding public medical programme by the influence of their united opinions on the various functions of the Dominion and Provncial governments. As the status and well-beng of the salaried physician is an integral part of an adequate medical program, they are asked to come prepared to discuss the report of the subcommittee on salaries of the Economic Committee of the B.C. Division.

Reports on salaries, holidays and pensions of those employed in B.C. were presented and discussed. The question of extra risk involved in the treatment of communicable disease and the exposure to radiation during employment with relation to extra holidays was discussed.

An intense program of activity to organize for the June meeting is foreseen. Members with ideas regarding this program are urged to come forward.

PUBLIC HEALTH AND MENTAL HEALTH NEWS

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

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

PHYSICAL CONDITION OF MOTOR VEHICLE DRIVERS

For some time both the Motor Vehicle Branch and the Health Branch have been viewing with increasing concern the number of licensed automobile drivers suffering from a physical disability which renders them incapable of safe driving under normal conditions in all areas of the Province.

At the time of initial and periodic drivers' examinations by the Motor Vehicle Branch, clearly defined cases of defective vision, hearing, co-ordination, loss of limbs and other similar observable deficiencies are apparent. However, cardiac, diabetic and epileptic conditions cannot be assessed by the Motor Vehicle Branch without prior notification and recommendation by an examining physician.

At the present time, recommendations by physicians are not readily available, except through completion of the standard medical certificate for those drivers apply for class A or B chauffeur's licence. Here the profession well recognizes its responsibility in providing the Motor Vehicle Branch with an opinion as to whether a driver's physical or mental condition might interfere with his ability to drive.

Current certificates of medical examination for passenger car drivers are not required for those under the age of 70, unless the Motor Vehicle Branch has reason to suspect a debilitating condition.

Furthermore, the medical certificates which are now required for all drivers aged 70 and over do not always indicate to the Motor Vehicle Branch that such a condition exists. In many cases this is due to a natural reluctance on the part of the examining physician to report an individual who may be a close friend, or whose only enjoyment lies in the occasional Sunday drive to the country. However, in some cases, failure to report is due to a physician's lack of awareness that his patient is potentially a dangerous hazard to himself, his passengers and to others on the road in the event of sudden death or loss of consciousness resulting from his condition.

This misunderstanding has been exemplified in a few cases in which the examining physician has display marked resentment towards the Motor Vehicle Branch when requested for an opinion as to the individual's ability to drive efficiently under ALL conditions and at ALL times, believing that the Motor Vehicle Branch was attempting to assess the case from a medical viewpoint and as a result was questioning the physician's qualifications.

At no time, of course, does the Motor Vehicle Branch assess a medical examination that requires a physician's professional recommendation. Furthermore, this Branch has no intention of revoking the licences of elderly people unless they are incapable of efficient driving.

Both the Motor Vehicle Branch and the Health Branch do feel, however, that the medical profession can materially assist in determining whether or not a driver—young, middle-aged or elderly—shall be allowed to remain on the road.

At the request of the Health Branch and the Motor Vehicle Branch the problem of drivers who are subject to temporary impairment of neuro-muscular function is now before the British Columbia Division of the Canadian Medical Association for review and recommendation.

Whatever the outcome of this review may be, it is to be hoped that the profession will assume the same responsibility with respect to the medical fitness of the passenger car driver as it has so commendably done in the case of class A and B chauffeurs whose fitness is already recognized to be imperative to public safety.

BRITISH COLUMBIA CANCER FOUNDATION

Its Functions and Activities

I. THE BRITISH COLUMBIA CANCER FOUNDATION, incorporated under the Societies Act in 1935, operates the British Columbia Cancer Institute and its adjoining Boarding Home, the Victoria Cancer Clinic and ten Consultative Cancer Clinics throughout the province.

In 1948 when Federal Health Grants for Cancer were first made available, the British Columbia Cancer Foundation was asked to outline a programme for the diagnosis and treatment of cancer in this province. The plan drawn up was approved by the Provincial Committee appointed to administer the Health Grants and thereupon, the British Columbia Cancer Foundation was officially designated by the Province of British Columbia as the agency through which the cancer programme for British Columbia would be implemented.

The finances of the British Columbia Cancer Foundation are obtained from different sources. Capital funds, a responsibility of the Foundation, are derived through joint campaigns with the B.C. Division, Canadian Cancer Society, from bequests and from legacies. Grants-in-aid are available from Health Grants for the purchase of equipment. Operating expense is met from two sources. Approximately twenty percent comes from patients' fees and the remaining eighty percent comes from Health Grants which are matching grants from Provincial and Federal funds.

II. THE BRITISH COLUMBIA CANCER INSTITUTE, 2656 Heather Street, Vancouver 9, is the main treatment centre under the auspices of the British Columbia Cancer Foundation.

The Medical Staff consists of:

The permanent medical staff composed of four fully qualified radiotherapists, one full-time and two half-time physicians, one part-time diagnostic radiologist and an assistant resident from the Vancouver General Hospital; and *the Attending Medical Staff* of 117 specialists which is appointed annually by the Executive Committee of the British Columbia Cancer Foundation to assist the permanent Medical Staff in consultation regarding diagnosis and treatment. Clinics are held at which the appropriate specialists of the Attending Medical Staff are present:

Clinics:

Ear, Nose and Throat Clinic	Monday,	9:00 - 10:00 a.m.
Clinical Meeting	Tuesday,	9:00 - 10:00 a.m.
Lymphoma Clinic	Tuesday,	10:30 - 12:00 noon
Pain Clinic	Wednesday,	10:00 - 12:00 noon
Head and Neck Clinic	Wednesday,	10:30 - 12:00 noon
Gynaecological Clinic	Thursday,	11:00 - 12:00 noon
Therapy Conference (held by permanent Medical Staff for the purpose of reviewing new and old patients and of outlining treatment).	Daily,	12:00 - 1:00 p.m.

All the above meetings are open to any member of the medical profession who wishes to attend.

Other Profession Staff:

The Physics Department has two fully-qualified radiological physicists on a full time basis.

Technical Staff:

One Director of Nursing and Chief Radiotherapy Technician.

Eleven qualified radiological technicians, all registered nurses, who operate the X-ray therapy and cobalt machines, assist the radiotherapists in radium therapy and the radiologist in the Diagnostic X-ray Department.

The Outpatient Department has five registered nurses and the Boarding Home has four on its staff.

Facilities to be found at the Cancer Institute include:

Outpatient Department for the examination of new and old patients;

Radiotherapy Department with one gramme radium; the following X-ray therapy machines: 1 - 400 KV, 1 - 270 KV, 1 - 260 KV, 1 - 220 KV, 1 - 120 KV, 1 - Cobalt 60 Beam Therapy Unit; radio-active isotopes laboratory;

Diagnostic X-ray Department;

Physics Department;

Clinical Photographic Department;

Cytological and Clinical Laboratories;

Medical Records and Statistical Departments;

Social Service Department;

Business Office and

Boarding Home with 14 beds.

Cooperation with the referring doctor is essential in the best interests of the patient. To this end, the Institute and the Victoria Cancer Clinic staffs attempt at all times to keep him informed of the condition of the patient while undergoing diagnosis and active treatment. On the day of the patient's first visit, a letter is sent to the referring doctor informing him that the patient has been seen. Further letters are sent when plans for treatment have been arrived at and when treatment is finished. Subsequent letters are sent when the need arises and at the anniversary visit of the patient.

Similarly, it is essential for the purposes of accurate medical records and statistics that the referring doctor inform the Institute and/or the Victoria Clinic regarding the general condition of his patient from time to time.

III. THE VICTORIA CANCER CLINIC at the Royal Jubilee Hospital, Victoria, B.C., is the second treatment centre under the auspices of the British Columbia Cancer Foundation. The referral of patients and the procedures carried out are similar to those at the British Columbia Cancer Institute. Radiotherapy equipment consists of a 400 KV, a 260 KV and a 140 KV X-ray therapy machine and 300 milligrammes of radium. All the facilities of the Royal Jubilee Hospital are available to the Cancer Clinic. These include beds, operating theatre, pathological department, social service department and clinical laboratory, etc. Close co-operation exists between the Victoria Cancer Clinic and the British Columbia Cancer Institute.

IV. CONSULTATIVE CANCER SERVICES have been established at various centres throughout the provinces in co-operation with the local Health Services of the Provincial Department of Health and Welfare.

The purpose of these services is to assist in the diagnosis of patients referred by the medical profession in the areas concerned, to make recommendations concerning treatment and to re-examine patients from these centres who have had treatment at the British Columbia Cancer Institute and the Victoria Cancer Clinic. Radiotherapists from the permanent staff of the Cancer Institute make regular visits to the following centres:

Penticton, Kelowna, Vernon, Nanaimo	Every month
Kamloops, Trail, Nelson, Cranbrook	Every two months
Prince George	Every four months
Prince Rupert	Every six months

Doctors wishing to have patients seen at these clinics are advised to contact the Director of the local Health Unit for further information. The Cancer Foundation offers this service to the physicians of British Columbia in the hope that it may assist in early diagnosis and may prove of some educational value to the medical profession.

V. THE CANCER PATIENT.

For the general information of the referring doctor, the following data may be helpful in explaining to the patient what he may expect from the services offered:

(a) *Referral*: Patients are accepted for diagnosis and treatment only when referred by a practicing physician or dentist. Correspondence should be addressed to the Director of the Institute or Victoria Cancer Clinic. The initial appointment should be made by the patient's doctor and all pertinent data forwarded to the Institute or Cancer Clinic before the patient present himself. This is particularly important for patients from out of town. If boarding home accommodation is required or if the patient is in need of hospitalization, the referring doctor is requested to inform the Cancer Institute or Victoria Clinic before sending the patient to Vancouver or Victoria.

(b) *Financial status*: Upon admission, the patient is interviewed by a social worker who assesses the patient's financial and social status. All patients receive diagnosis and treatment regardless of ability to pay. However, in those cases where a patient is in a position to pay all or part of the cost of services, he is expected to do so. If the patient is not able to pay for these services, he receives this free of charge. There is no fee for follow-up examinations.

(c) *Routine of admission*: After the patient has been received at the reception desk and preliminary data has been checked, he goes to the Social Service Department where a social and financial history is taken. The patient is next seen by a doctor in the Outpatient Department who takes a complete medical history and does a complete physical examination. One of the members of the permanent Medical Staff sees the patient and a consultation is arranged with the Attending Medical Staff for discussion regarding diagnosis and treatment. As noted above, the referring doctor is informed of the progress of his patient by letter.

(d) *Treatment*: In those cases which are referred for treatment, arrangements to have this carried out, whether by radiotherapy or surgery, will be made and the referring doctor will be informed of the recommendation. In those cases which are referred for opinion only, no treatment will be carried out until the doctor's approval is obtained.

(e) *Follow-up examination*: On completion of treatment, the patient is referred back to his own doctor, but is expected to return to the Institute or Victoria Clinic for follow-up examinations at stated intervals. If the patient is from out of town, he will be seen by an Institute radiotherapist at one of the Consultative Cancer Clinics.

(f) *Hospitalization*: At the present time, the Cancer Institute has at its disposal twenty beds in he Vancouver General Hospital for patients who require a hospital bed while undergoing radiotherapy. Patients requiring surgery are admitted to the Vancouver General Hospital or any other hospital which the referring doctor may specify.

(g) *Boarding Home care*: The fourteen-bed Boarding Home attached to the Cancer Institute is available for patients undergoing radiotherapy and diagnostic procedures. This Home is primarily for out-of-town patients. All arrangements for placement of out-of-town patients should be completed before the patients leave home.

(h) *Transportation*:

Vancouver patients who are unable to come to the Cancer Institute by any other means may be driven in by the Institute car during active treatment. Arrangements for this service are made through the Social Service Department.

Out-of-town patients on Social Allowances should have all arrangements made for their transportation and board through the local Welfare Officer at the nearest Social Welfare Branch. A medical report should accompany the request for assistance. In the event that there is no Social Welfare Branch in the vicinity, application may be made directly to the Director of Provincial Medical Services, 635 Burrard Street, Vancouver 1, B.C.

Out-of-town patients NOT on Social Allowances who find themselves unable to finance transportation to the Cancer Institute or Victoria Cancer Clinic may be assisted through the Cancer Aid Fund of the Canadian Cancer Society. (See below.)

(i) *Other services available for cancer patients*:

Cancer Aid Fund of the B.C. Division, Canadian Cancer Society—The Canadian Cancer Society is a national lay organization, the primary objectives of which are education, welfare and the promotion of research. The B.C. Division of the Society

provides the Cancer Aid Fund previously mentioned to help needy cancer sufferers who are not eligible for assistance from any other source. It should be noted that the Fund does NOT pay for medical services and is NOT available for any person in receipt of Social Allowances.

The provisions of the Fund are these:

Transportation costs within the Province of British Columbia, with meals and taxis if necessary and the expenses of an escort where indicated.

Funds for boarding or nursing home care not to exceed the going rate in the community.

Funds for drugs prescribed by a registered medical practitioner up to a monthly limit of $25.

Funds for housekeeping services up to $60 per month.

Services of Victorian Order of Nurses if requested by a doctor by the British Columbia Cancer Institute or Victoria Cancer Clinic.

Aid is given for a period of three calendar months and is subject to review at the end of that time.

Application for assistance should be made by the patient's doctor through the local Unit of the Canadian Cancer Society or by writing to the offices of the B.C. Division, Canadian Cancer Society, 686 West Tenth Avenue, Vancouver 9, B.C.

Cancer dressings are made to specifications by members of the Order of the Eastern Star at Dressing Stations throughout the province under the direction of Grand Chapter of the Order for British Columbia. These dressings are available without cost to any patient for whom the purchase of such dressings would be a financial burden. The main workroom is located at the British Columbia Cancer Institute and similar stations serving their communities are established in thirty-three other centres.

VI. SUMMARY.

The referring doctor can facilitate the work of the Cancer Institute and the Victoria Cancer Clinic by making his patient aware of the following:

(1) THAT a social and financial history will be taken upon admission.
THAT no charge will be made for those persons who cannot pay, but that anyone able to pay part or all of the cost of services will be expected to do so.
THAT the information taken at this time may assist the patient substantially at a later date.

(2) THAT a complete medical history and physical examination will be done by a member of the Institute Medical Staff. Certain diagnostic procedures may be required, such as biopsies, X-rays, etc. The private doctor, knowing his patient, can often gain co-operation to the benefit of all.

(3) THAT in those cases which the doctor refers for treatment, arrangements to carry this out, whether by radiotherapy or by surgery, will be made, and that the doctor will be informed of the recommendation by letter or telephone.
THAT in those cases which the doctor refers for opinion only, no treatment will be carried out until the doctor's approval has been obtained.

(4) THAT after completion of treatment, the patient will be asked to return at periodic intervals for re-examination, either at the Cancer Institute, Victoria Cancer Clinic or at one of the consultative cancer clinics. This does not mean that he shall not consult his own doctor as usual. HE IS AT ALL TIMES THE PATIENT OF THE REFERRING DOCTOR. The Cancer Institute and the Victoria Clinic will co-operate in after-treatment care in any way possible.

The question is often raised as to whether the patient should be told that he has cancer. It has been found by experience at the Cancer Institute that it is usually better to give the patient the diagnosis at the beginning. It often makes for a more co-operative patient—one who has faced the problem and who starts his course of treatment with the knowledge that everything possible is being done for him.

However, there are some patients who may be unable to accept such a verdict, or whose families are apprehensive on their behalf. In these cases, the wishes of the referring doctor or the patient's family will be respected.

EXPERIENCES WITH CHILDHOOD ASTHMA

JOHN PITERS, M.D. (Vancouver)

With the opening of the Health Centre for Children at the Vancouver General Hospital in 1948, one of the first clinics to be set up was the Allergy Clinic. Since that time we have followed some 250 patients at the clinic, many of whom still attend actively. Out of the closed and inactive files we have drawn the first 74 cases for review, with particular reference to the respiratory group, and these will serve as a basis for discussion.

Out of these 74 cases, 58 were seen with asthma as the chief complaint, with or without other associated allergies. In reviewing the 58 asthma cases, 10 cases were excluded on the grounds of insufficient attendance and study, leaving a total of 48 cases for more detailed consideration.

Admittedly, this is too small a group to have statistical importance, but out of our mental threshing a few gleanings may appear, to be augmented by our experiences in private practice.

Boys exceeded girls by more than two to one, a rather common but unimportant finding, since it has no bearing on the severity, course, or ultimate prognosis of the disease. It parallels roughly the two to one finding reported in larger series.

The family background is instructive in asthmatic children. Bowen, reviewing a large series of cases in the Lancet (68: 169, 1948) demonstrated that 20% of asthmatic children give a history of previous infantile eczema, and that 50% of a group of eczematous children developed asthma. A hereditary factor was present in 90% of his cases. When derived from one parent 30% of the children developed asthma in their first 10 years. When the allergic heritage was derived from both parents, nearly 90% of the patients developed asthma in their first 10 years. Our own statistics are too meager to quote, but our impressions agree with the above figures. In some patients the allergy was clearly traced back for 4 generations.

The following is a brief account of the procedure followed in studying these cases:

All cases first pass through the medical clinic and receive a preliminary work-up and general examination. Here other medical illness is excluded or treated, so that the allergist usually can deal solely with the problem of allergy.

The allergic investigation of these patients begins with the taking of a detailed allergic history. A special form has been developed which has made the histories more uniformly complete, and which serves as a guide for the new residents when they first come on the service. Great stress is placed upon the details of the single asthmatic attack in an effort to discover its relation to infection or other etiological factors. The home environment is carefully gone into, with special reference to the bedroom, overcrowding, social background and animal pets. We have learned that overcrowding of bedrooms, and poor housing, aggravated by poverty, usually means predictable clinical failure in a patient sensitive to dust unless the patient can be moved to another environment. At times the parent is aware of the more obvious or more severe sensitivities, particularly if animals or foods are the offenders. With animal sensitivity the eyes and face are frequently involved. Where foods are involved the asthma is usually accompanied by skin and intestinal symptoms. Again, we cannot over stress the importance and value of careful, detailed history taking.

On physical examination the appearance of the turbinates, the presence or absence of emphysema, and the patient's general condition are noted. Of some diagnostic importance is the fact that in a first or early attack in a young child, dyspnoea, wheezing and a prolongation of expiration are usually less marked than in an adult. In an established case of asthma the physical findings are comparable to the finding in adults. In chronic asthma of several years duration, our patients frequently showed obvious and marked emphysema, with increasing fixation of the thorax. A notable feature was the frequency with which an allergic rhinitis was found in our asthmatic patients. This frequently antedates the asthma, and persists even when the asthma is under reasonably

good control. The pale, swollen, boggy turbinates, the nasal obstruction, and the nasal itching are characteristic findings.

A tuberculin test and X-ray of the chest are considered routinely necessary. Blood counts, nasal smears for eosinophilia, or blood sedimentation rate are performed where indicated. Blood smears have shown eosinophilia in most patients at some time or other, but never as a constant finding. The eosinophilia has ranged from 5 to 25%. An occasional case may require bronchoscopy or lipiodol studies to demonstrate or rule out bronchiectasis.

All study cases then receive skin testing by the scratch method, followed by a few intradermal tests where specially indicated. This is followed by an attempt to classify the case as to etiology.

On the basis of skin testing, the 48 cases of asthma under discussion can be divided into 3 etiological groups.

38 cases or 80%, had positive skin tests of the immediate wheal type, having clinical significance. These were all of the inhalant variety. House dust easily headed the list, followed by feathers, cat dander, dog dander, kapok, timothy and plantain. In addition four of these cases gave a positive delayed reaction to the intradermal injection of a stock respiratory vaccine. In none of our cases was food clearly or unequivocally shown to be responsible for the asthma, in spite of occasional positive tests. Outside the clinic we have occasionally seen cases of asthma due to food. But such cases are extremely rare, and usually of a high order of sensitivity. Frequently the parents are aware of them, and they offer no real problem in diagnosis. Food allergy producing asthma should not be diagnosed on the skin test alone. In any case, food allergies tend to be outgrown. We mention this because of the hardships imposed by restrictive diets in sick children who may already be malnourished and underweight. The animal group of skin tests is important because of the excellent result which usually follows the removal of an offending cat or dog.

It becomes obvious then, that most cases of asthma in children could be successfully investigated by intelligent history taking and a mere 10 or 12 skin tests. These tests can be performed by an assistant or technician; but they should be read and interpreted by the physician in relation to the history.

The second group of cases, 10 in number and roughly 12% of the total, gave completely negative skin tests of the immediate wheal type, but gave a positive delayed reaction to stock respiratory vaccine intradermally. This group is extremely interesting. The family background was frequently, but not necessarily, negative for allergy. Respiratory infections were frequent and repeated. A respiratory infection, perhaps with fever, often preceded the onset of asthma. Wheezing tended to appear early in life, sometimes at 4 to 6 weeks of age. The first few episodes were usually diagnosed as bronchitis or bronchiolitis, later attacks being more typically asthmatic. We feel very strongly that these cases are on an infective basis and that their prevention and cure depends upon successful prevention and treatment of their respiratory infections. In general, their prognosis is better and they often clear spontaneously. More work needs to be done on this group of cases, as to the allergic mechanism. As over 50% of respiratory infections in children are on a viral basis, perhaps the word infective should be used to describe them rather than bacterial. We have used stock respiratory vaccines and occasionally autogenous vaccines on these patients, on an empirical basis, and at times they have seemed helpful.

Of the 38 cases showing positive scratch tests, 14 gave histories strongly suggesting that infection was also a factor, and of these, 4 gave positive tests to respiratory vaccine. These 14 cases appear to be of mixed etiology, with infection at least occasionally initiating an attack, and frequently aggravating an attack set off initially by an inhalent mechanism.

Before making a final diagnosis it is well to bear in mind the possibility of other conditions such as croup, laryngotracheobronchitis, bronchiolitis, foreign body, bronchial

stenosis and enlarged tracheobronchial glands. The last two can produce almost constant wheezing and an almost intractable cough.

When a satisfactory working diagnosis has been established the question of treatment has to be considered. This can be discussed under the headings of symptomatic relief and general management. Symptomatic relief must of course be provided, but if nothing else is done for the patient the relief will be short lived. Of prime importance is the over all, intelligently directed, allergic management of the case for an adequate period of time. Asthma is usually a continuing problem.

Space will permit us to barely mention some of the innumerable drugs available today for symptomatic therapy. Epinephrine and ephedrine have not been displaced for the relaxing of bronchial spasm, but have been reinforced by newer sympathomimetic drugs available under the trade names of Vaponephrin, Isuprel, Neoepinine, Aludrine, Norisodrine and Orthoxine. Some of these are identical chemically. They may be administered by oral, sublingual or inhalent route. Aminophylline can be used as a rectal suppository. The related theophylline is effective by mouth. The antihistamines have proven disappointing in asthma, particularly in the severe and chronic cases where help is most needed. Where infection appears to be a factor the antibiotic agents have been very valuable. The iodides are still used for their expectorant value. We have found that a combination of some of these drugs has often been effective, where each drug, by itself, was not. A tablet containing theophylline, ephedrine and phenobarbital, together with a suitable antihistamine has given many of our patients relief. Finally, we have the new hormones A.C.T.H. and Cortisone. Their effect is often dramatic but they too offer temporary relief and not cure. In the present state of our knowledge we would like to see these hormones used as a brief and temporary measure to tide the patient over an unusually severe and intractable episode.

Between attacks, the general management and care of the patient continues. A knowledge of the patient's social background and environment can be very helpful. In the clinic, a social worker visits the homes of the more severe cases to give aid and to bring back a report on the home. A personal visit by the physician can also pay big dividends.

The removal of offending allergens from the environment is obviously the first principle of allergic management. We are convinced that it is right in the home that most of our allergic battles are won or lost. The parents who fail to cooperate because of laziness, a rejecting attitude, or mere lack of intelligence, can defeat all our efforts. Poverty, poor housing, overcrowding and family strife are behind many of our failures. In one family the father was an abusive, chronic alcoholic, the mother a deteriorating post encephalitic. In another family, the father was an epileptic, the mother of rather meagre intelligence. The two patients involved were never free of severe asthma. One of these patients was sent to the Solarium. Here, in a period of 7 months, she gained 16 pounds, recovered from an anemia, and never wheezed once. Four other patients were similarly completely free of asthma for months at a time at the Preventorium, the Solarium or in a foster home. Their asthma promptly recurred as soon as they returned home. Parents can be trained to watch for provocative factors. Occasionally these factors are psychogenic. One patient cried herself into an attack, another was upset by a scolding and promptly wheezed. Skin testing is a valuable diagnostic aid. Positive tests not corroborated by the history must be ignored, as they are at best only potential allergies. On the contrary, a clear cut history of sensitivity to an allergen requires no skin test. Wherever possible the offending allergen is removed or avoided. In the case of house dust, the most important single offender and a composite of many substances, the problem is difficult. In the bedroom, the mattress is changed or encased, the rugs and drapes removed, upholstered furniture removed, dry dusting and sweeping are replaced by vacuum cleaning, and the room kept scrupulously clean. If possible the whole house is similarly treated.

Where the removal of the antigen is obviously incomplete, hyposensitization by injection must be carried out. For most of our cases House Dust, Kapok, Mixed

Feathers, Pollens and Mixed Respiratory Vaccine were the only allergens used, either singly or in combination. Used alone the results are rarely spectacular, but combined with other effective means of control, hyposensitization is a useful procedure.

In infective asthma, foci of infection such as tonsils or adenoids are removed if clearly involved. Several patients were treated by irradiation of the pharynx, with questionable results, and we remain skeptical as well as afraid of this method of treatment. Antibiotic therapy is used freely where indicated. Several patients did well on small prophylactic doses of sulfadiazine through the winter months. Respiratory vaccine is given in graded injections.

All patients with persistent asthma, showing signs of emphysema, are given special breathing exercises. These are demonstrated and later controlled by the physiotherapy department. This re-education in the matter of proper breathing is very important for the chronic cases, and is definitely helpful. It should not be overlooked as an auxiliary form of therapy.

On this routine a great number of our patients have been helped. Some of the patients seem almost cured. A few of the worst cases have been abject failures, yet they clear up when taken out of their home. Our cases did not lend themselves well to statistical analysis.

Finally, a few words as to prognosis. It is obvious from the records that as outpatients approached puberty their symptoms cleared entirely or lessened considerably. What is their ultimate prognosis? Francis Rackemann of Boston has recently reported an amazing follow-up study of 668 cases of asthma after an interval of 20 years. All the cases were under 13 years when first seen. About one-third of all children outgrew their symptoms at an average age of 13 years. Another 20% were relieved but knew they were still sensitive. A further 20% were free of asthma but had developed some other manifestation of allergy, usually hay fever. About 25% of the children continued to have asthma after 15 years but the trouble was severe in less than half of this group. Recurrences due to new allergies sometimes appeared after an interval as long as 15 years, showing that the essential lesion is not the particular allergy but the capacity to develop sensitiveness. The cases with negative skin tests showed the best results of all: two-thirds were cured at 15 years, again indicating that this group is different from other groups, and suggesting that in infective asthma, allergy may eventually be replaced by true immunity.

Presented to the North Pacific Pediatric Society in 1953.

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WORKMEN'S COMPENSATION BOARD

To the Members,

College of Phycisians and Surgeons of British Columbia.

Dear Fellow Members:

Our letter of February 1954, presented some problems in relation to dependency claims. Since the letter was written we have run into further problems in relation to the lack of post-mortem examinations or coroner's inquests in cases where a dependency claim has been submitted. I have on my desk at this time a non-fatal and a fatal claim on the same workman submitted within a few weeks. The workman died on January 2nd, 1954, and the first information thereto, received at the Head Office of the Board was on January 28th and by that time the workman was well and truly buried.

We make every possible effort to justly handle such a claim but the problems are almost insurmountable if we do not have adequate information on which to adjudicate.

It might, at this time, be of some value to quote a decision given by Lord Maughan, Lord Chancellor of Great Britain in 1941 and I quote "the burden of proof in any particular case depends on the circumstance in which the claim arises. In general the rule which applies is that upon him who affirms not him who denies rests the burden of proof. It is an ancient rule founded upon considerations of good sense and should not be departed from without strong reason." This quotation emphasizes the necessity of the workman or his dependents submitting adequate information to the Board in relation to any claim.

I hope you will bear with us in the necessity at imes of requests being sent to you for extra information. A great many of these problems arise because the information on the workman's form, the employer's form and the doctor's form do not coincide and we have to determine the true facts before we can adjudicate intelligently on the information on file. We are many times criticized for these requests but it is essential if the information is not the same.

For some time we have been working on the problem of closer checking of x-rays in relation to the accuracy of interpretation and diagnosis and the treatment which has been instituted as a result of the x-ray reports.

We are disturbed by difficulties we are encountering in relation to adequate supervision of claims and are seriously considering the question of having all x-rays brought into the Head Office of the Board for review. No immediate plans have been set up but the problem is under consideration and we will be communicating with you at a later date when our plans have been finalized.

Your cooperation in our mutual problems is appreciated and we hope our attempts to improve relations will result in more efficient handling of workmen's claims.

We appreciate your suggestions and criticisms and hope that you will continue with your letters.

Very kindest of personal regards, I remain,

Sincerely yours,

J. R. Naden, M.D.,

Chief Medical Officer.

News and Notes

The Doctors Wives' Club invites new members to their monthly meetings in the Academy of Medicine. Phone *Mrs. R. W. Lamont Havers* at ALma 2494.

Dr. Henry Farish is now taking Post Graduate training in Memphis, Tennessee.

Dr. D. M. Ekman is now in Obstetrics at the Mercy Hospital in San Diego.

Dr. Murray G. Williams is studying Dermatology at the University of Pennsylvania.

Dr. Chris West has been posted to Toronto with the Canadian Navy.

Dr. N. T. McPhedran is now studying surgery at the University of Toronto.

B.C. Doctors who recently gained their certifications are *C. L. Aszkanazy, J. S. Campbell, Margaret Hardie, Donald Hollinger, J. A. Leroux, Anson McKim, Darrell Osborne, W. D. McKinlay, Peter Percheson, V. W. Pepper, Cyrus Pow, A. K. Ronan, Eugene Skwarok, George Wakefield, Donald Whitley.*

Dr. Julius Danto and Dr. Stuart Madden have occupied a new building one block from the Vancouver General Hospital. With them is *Dr. Colin Campbell*, doing proctology.

Dr. F. W. Arber is now practising general surgery on the North Shore of Vancouver.

Dr. J. A. McDonnell is now in medicine at the Montreal General Hospital.

Dr. A. D. McKenzie of the Vancouver General Hospital Surgical Staff was married this month in Montreal to June Bowen, a Science graduate of McGill.

BIRTHS

To Dr. and Mrs. *F. E. McNair* of Vancouver, a son.
To Dr. and Mrs. *F. W. Hurlburt* of Vancouver, a daughter.

☆ ☆ ☆

NEW REGISTRANTS:

February 10th, 1954 ..... NORWELL, David Millar,
Langley Prairie, B.C. (Assoc. with Dr. A. O. Rose).

February 12th, 1954 ..... RITCH, Elsie,
3779 Blenheim St., Vancouver, B.C.

February 17th, 1954 ..... GLASS, Major Leslie Stuart,
4965 College High Road, Vancouver, B.C.

February 17th, 1954 ..... JONES, Robert Arthur,
St. Vincent's Hosp., 33rd and Heather St., Vancouver, B.C.

February 23rd, 1954 ..... STEVENSON, George Herbert,
Apt. 110, 1222 Harwood Street, Vancouver, B.C.

February 24th, 1954 ..... EDEN, John,
Vancouver General Hospital, Vancouver, B.C.

February 25th, 1954 ..... WOOLLACOTT, Paul James Victor,
987 Roosevelt Crescent, North Vancouver, B.C.

February 26th, 1954 ..... BUCHAN, William Robertson,
R.C.A.F. Station,
4050 West 4th Avenue, Vancouver, B.C.