Title: Report of the Conference on the Medical Services in Canada held at Ottawa, December 18, 19, 20, 1924
Author: Conference on the Medical Services in Canada (1924)
Date of first publication: 1925
Edition used as base for this ebook: Ottawa: F. A. Acland, Printer to the King's Most Excellent Majesty, 1925 (first edition)
Date first posted: 24 February 2009
Date last updated: 17 June 2014
Faded Page ebook#20090216

This ebook was produced by: Ian Deane, David T. Jones & the Online Distributed Proofreading Team at http://www.pgdpcanada.net

REPORT *of the* CONFERENCE

on the

MEDICAL SERVICES

HELD AT

OTTAWA, DECEMBER 18, 19, 20, 1924

Issued by

Department of Health, Canada

Ottawa

CONFERENCE *on the*

MEDICAL SERVICES IN CANADA

arranged by the

CANADIAN MEDICAL ASSOCIATION

and held under the patronage of

THE HONOURABLE HENRI BELAND, P.C., M.D., M.P.,

MINISTER OF HEALTH FOR CANADA

in the

HOUSE OF COMMONS, OTTAWA

on DECEMBER *18th, 19th, 20th,*

1924

ALEXANDER PRIMROSE, C.B., M.B., C.M., *Chairman*

T. C. ROUTLEY, M.B., *Secretary*

OTTAWA
F. A. ACLAND
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1925

REGISTRATION

December 18, 1924

Name	*Address*	*Body Represented*
Aikins, Dr. H. W.	Toronto, Ont.	College of P. and S., Ontario.
Amyot, Dr. J. A.	Ottawa, Ont.	Federal Department of Health.
Argue, Dr. J. F.	Ottawa, Ont.	Canadian Medical Association.
Arthur, Dr. R. H.	Sudbury, Ont.	College of P. and S., Ontario.
Austin, Dr. L. J.	Kingston, Ont.	O.M.A., Queen's University.
Bates, Dr. Gordon	Toronto, Ont.	Canadian Social Hygiene Council.
Bazin, Dr. A. T.	Montreal, Que.	Canadian Medical Association.
Blackader, Dr. A. D.	Montreal, Que.	Canadian Medical Association.

Carder, Dr. L. D.	Vancouver, B.C.	College of P. and S., British Columbia.
Chisholm, Dr. H. A.	Halifax, N.S.	Nova Scotia Health Department.
Clark, Dr. D. A.	Ottawa, Ont.	Federal Department of Health.
Connell, Dr. J. C.	Kingston, Ont.	Queen's University.
Connell, Dr. W. T.	Kingston, Ont.	Queen's University.
Cruikshank, Dr. G. R.	Windsor, Ont.	College of P. and S., Ontario.
Fitzgerald, Dr. J. G.	Toronto, Ont.	Dominion Council of Health.
Flatt, Mrs. C. L.	Wakaw, Sask.	Dominion Council of Health.
Gardner, Dr. W. A.	Winnipeg, Man.	Manitoba Medical Association.
Gauvreau, Dr.	Montreal, Que.	College of P. and S., Quebec.
Graham, Dr. Duncan	Toronto, Ont.	University of Toronto.
Grant, Dr. J. G.	Ottawa, Ont.	
Guerin, Dr. J. J.	Montreal, Que.	University of Montreal.
Hamilton, Dr. T. G.	Winnipeg, Man.	Canadian Medical Association.
Hattie, Dr. W. H.	Halifax, N.S.	Nova Scotia Medical Society.
Henderson, Dr. V. E.	Toronto, Ont.	Canadian Medical Association.
Hill, Dr. H. W.	London, Ont.	University of Western Ontario.
Houston, Dr. J. C.	Charlottetown, P.E.I.	Prince Edward Island Medical Society.
Irving, Dr. W.	Edmonton, Alta.	
Irving, Dr. J. F.	Yorkton, Sask.	College of P. and S., Saskatchewan.
Johnson, Dr. G. R.	Calgary, Alta.	College of P. and S., Alberta.
Jost, Dr. A. C.	Halifax, N.S.	Nova Scotia Health Department.
Kidd, Dr. J. F.	Ottawa, Ont.	Canadian Medical Association.
Laidlaw, Dr. W. A.	Edmonton, Alta.	Alberta Board of Health.
Leask, Dr. J. M.	Moose Jaw, Sask.	Saskatchewan Medical Association.
Low, Dr. David.	Regina, Sask.	Canadian Medical Association.
MacCallum, Dr. J. M.	Toronto, Ont.	Medical Council of Canada.
MacKay, Dr. D. S.	Winnipeg, Man.	University of Manitoba.
MacLaren, Dr. Murray	St. John, N.B.	Canadian Medical Association.
Macleod, Dr. J. J. R.	Toronto, Ont.	University of Toronto.
MacMurchy, Dr. Helen	Ottawa, Ont.	Division of Child Welfare, Dept. of Health.
Martin, Dr. C. F.	Montreal, Que.	McGill University.
McCalman, Dr. D. H.	Winnipeg, Man.	Manitoba Board of Health.
McCullough, Dr. J. W. S.	Toronto, Ont.	Department of Health, Ontario.
McDermot, Dr. J. H.	Vancouver, B.C.	British Columbia Medical Association.
McGill, Dr. H. W.	Calgary, Alta.	College of P. and S., Alberta.
McKibbon, Dr. P. S.	London, Ont.	University of Western Ontario.
McLaughlin, Dr. P.	Winchester, Ont.	
Melvin, Dr. G. G.	Fredericton, N.B.	Department of Health, New Brunswick.
Merson, Mr. Bert	Toronto, Ont.	Dominion Council of Health.
Noble, Dr. R. T.	Toronto, Ont.	Ontario Medical Association.
Normand, Dr. L. P.	Three Rivers, Que.	Canadian Medical Council.
Ower, Dr. J. J.	Edmonton, Alta.	University of Alberta.
Pelletier, Dr. E.	Montreal, Que.	Service Provincial d'hygiene de Quebec.
Poole, Dr. J. S.	Neepawa, Man.	College of P. and S., Manitoba.
Powell, Dr. R. W.	Ottawa, Ont.	Medical Council of Canada.

Primrose, Dr. A.	Toronto, Ont.	Canadian Medical Association.
Rehfuss, Dr. W. A.	Bridgewater, N.S.	Nova Scotia Medical Association.
Reilly, Dr. W. G.	Montreal, Que.	Canadian Medical Association.
Routley, Dr. F. W.	Toronto, Ont.	Red Cross.
Routley, Dr. T. C.	Toronto, Ont.	Canadian Medical Association.
Seymour, Dr. M. M.	Regina, Sask.	Department of Health, Saskatchewan.
Simpson, Dr. J. C.	Montreal, Que.	McGill University.
Small, Dr. H. B.	Ottawa, Ont.	Canadian Medical Association.
Starr, Dr. F. N. G.	Toronto, Ont.	Canadian Medical Association.
Stephen, Mr. W. F.	Huntingdon, Que.	Dominion Council of Health.
Tessier, Mme. Jules	Quebec, Que.	Dominion Council of Health.
Thornton, Dr. R. S.	Deloraine, Man.	Dominion Medical Council.
Wallace, Dr. W. G.	Ottawa, Ont.	
Walker, Dr. S. L.	Halifax, N.S.	Canadian Medical Association.
Wodehouse, Dr. R. E.	Ottawa, Ont.	Canadian Tuberculosis Association.
Wright, Dr. A. H.	Toronto, Ont.	Ontario Board of Health.
Young, Dr. George S.	Toronto, Ont.	Ontario Medical Association.
Young, Dr. H. L.	Victoria, B.C.	British Columbia Board of Health.
Young, Dr. A. M.	Saskatoon, Sask.	College of P. and S., Saskatchewan.

MEDICAL SERVICES IN CANADA

The Conference on the Medical Services in Canada, arranged by the Canadian Medical Association, met at Ottawa on December 18, 1924, under the chairmanship of Alexander Primrose, C.B., M.B., C.M.

The CHAIRMAN: Gentlemen, it is not necessary for me to indicate the reasons why this conference is called together. Those you all know, and the programme is in your hands. Before we begin our formal meeting, I have a very great deal of pleasure in asking the Hon. Mr. Graham, Minister of Railways and Canals, and Acting Minister of Health, to say a few words to us.

Hon. GEORGE P. GRAHAM (Acting Minister of Health): Mr. Chairman, ladies and gentlemen, I have tried a great many things in my life, but I never presumed to be a doctor of medicine until this morning. I could not diagnose a physical disability case, but I do try sometimes to diagnose the ills of the country, and some people have said that my prescriptions are not much good. I look upon the country's ills very much as you gentlemen do upon a physical disability; it is not so much medicine as care that is necessary. All the ills that are ascribed to the country are natural to all countries after the war, and the duty of Government and of Parliament is to endeavour to nurse the patient well, and give nature a chance to restore it.

I am glad to welcome you here. I regret that the Hon. Dr. Béland is not in the city at the present time, but on your behalf, and on behalf of the country, he has been doing excellent work at Geneva, and as you know, has been highly honoured there in being made chairman of the leading body in the world for the suppression of the opium traffic. That is a work in which you are interested, and it is one in which Dr. Béland is representing Canada and is taking a very prominent part there. I am sure he will regret not being here this morning.

Of the advances made in medical science you know much more than I do. Sometimes it is said that the health bodies, as I might call them, or the health departments of the various governments in the world, are running away from the profession and the profession is trying to catch up. I do not know how that may be, but this I do know, that your profession is perhaps the noblest of all in that it gets right at the hearts of the people and does what no other profession can do in meeting the wants of humanity, and after all that is what makes life worth living, that we may be of some assistance each to the other so that when we go those with whom we have been associated will believe that the world was better because we were allowed to come into it.

I welcome you all heartily, and trust that the effect of your deliberations may be such as, if I may say it, to bring the medical profession in all parts of the Dominion closer together if possible, for the promotion of that which you all have at heart, not only the further progress and enlargement of the usefulness of medical science, but the good of mankind in general. May I add that I trust the atmosphere that you will leave around the Parliament Buildings will be such as to ensure good health and long life to the Government.

The CHAIRMAN: I am sure we are very much indebted to the Minister for his words of welcome and inspiration. We regret that the Minister of Health is not present with us, but we are glad to hear from Hon. Mr. Graham that he is filling such an important function in the councils of the world at Geneva.

I have now pleasure in calling upon the President of the Canadian Medical Association, Dr. Kidd.

Dr. J. FRANKLIN KIDD: Mr. Chairman, ladies and gentlemen, as President of the Canadian Medical Association, under whose auspices you are assembled, it affords me great pleasure to welcome this large group representing medicine in the broadest sense of the term from the nine provinces of the Dominion of Canada.

This is the first time in the history of Canada that a meeting of this character has been held, and it would seem fitting that for this first national meeting of the Medical Services in Canada you should foregather in the capital of Canada, and under the distinguished patronage of the Acting Minister of Health. I understand that we have with us to-day representatives from the federal Department of Health, the provincial Departments of Health, Medical Colleges, the Dominion Medical Council, and provincial Councils, the Canadian Medical Association, and the provincial Medical Associations. I understand that for some years it has been customary for some of these groups to meet nationally, but never before have they met in a congress of this character.

In initiating this unique gathering the Canadian Medical Association is actuated by one motive, namely, the development

of an ever-increasing co-*operation on the part of all those charged with the medical responsibilities of this great Dominion, in the hope and to the end that such co-operation may bring about cohesion, foster harmony, and develop a higher type of service in keeping with the best traditions of our noble art.

It is not my purpose to go into details with regard to the programme, as Dr. Primrose, our chairman, and also chairman of this conference will no doubt deal with that matter presently. A year ago, in company with Dr. Routley, our general secretary, it was my privilege and pleasure to attend a medical conference in the city of Winnipeg, at which were gathered representatives from the four western provinces. Out of that conference there developed a plan of co-*operation which has worked during the last summer with most excellent results. I refer to the four splendid medical conventions which were held in sequence at Winnipeg, Vancouver, Edmonton and Moose Jaw, attended by over twelve hundred practitioners, and addressed by a travelling group of speakers. It was only because the provinces referred to worked together strongly that these splendid results were made possible, and with this knowledge in mind it seems to me that this larger conference, representing as it does the whole Dominion of Canada, should be productive of the greatest possible benefit to the public and ourselves.

On behalf of the Canadian Medical Association I desire to take this opportunity of thanking the Hon. George P. Graham, Acting Minister of Health, for placing at our disposal this splendid meeting room, and for the various services which have been so cheerfully performed by members of the staff of the Health Department in the way of assistance in making this meeting possible. As president of this association, and as a resident practitioner in this city, it gives me very great pleasure indeed to welcome you all to the city of Ottawa.

I am sure you are all as glad as I am that we have to-day with us the President-Elect of the Canadian Medical Association, Dr. David Low, of Regina. I will now introduce Dr. Low and ask him to address us.

Dr. David Low: Mr. Chairman, ladies and gentlemen, I find myself in a somewhat difficult position this morning, facing such a large gathering from all parts of the Dominion of the most prominent members of the profession. I realize that I myself am only an ordinary general practitioner from a small town in the west, but it gives me very great pleasure to be here and meet with you all, particularly so as to me it appears that this gathering is in one sense a culmination, and in another sense the opening of the gate to further progress towards unity, and the bringing about of closer co-operation between the profession in the different parts of this great country of ours.

As Dr. Kidd has mentioned, the medical men of the four western provinces have held national meetings, and there is no doubt whatever that great good has come from these conventions. You may not all agree, but it appeared to some of us on the outskirts looking in, and not actively engaged in the very heart of the profession, that there might be a possibility of some branches just getting a little ahead of the others, and we thought it would be a good thing for us all to get together and compare notes, so that we might go forward shoulder to shoulder without any possibility of a break in the ranks, and to eliminate any possible weak spots. It therefore gives me exceedingly great pleasure to be present at this meeting. I think we can confidently look forward to results that will probably be greater than any one conceived of at the inception of this Conference. I expect that it will only be the beginning of such meetings, which will be carried on each year in the future, and that we shall have as a result closer co-operation and less possibility of divergencies of opinion creeping in. I hope that the profession from Halifax to Vancouver will show a united front not only in advancing the science of medicine, but in developing our usefulness to the public at large.

The Chairman: I am glad we have heard from the President of the Canadian Medical Association and from the President-Elect. I think they have sounded the proper note for this conference when they suggest that the main thing we have in view is to unify the forces of the profession in Canada so that we may proceed with a common purpose and common ideals to great achievement. It is only by such unity, I think, that we can accomplish such a purpose. We are very much obliged to these two gentlemen, representing our national institution, for having addressed us this morning.

Before proceeding to the more formal work of the conference, I want to say that the press is present here to-day, and it is for you gentlemen to decide whether you wish the press present or not. It seems to me that at a national conference of this character we should welcome the press, but I want to know the pleasure of the meeting. Is it your pleasure that the press should be present? As there is no objection, we are glad to have the press representatives with us this morning.

ADDRESS BY ALEXANDER PRIMROSE, C.B., M.B., C.M., Edin.

Dr. PRIMROSE: At the meeting of the Canadian Medical Association held in Ottawa in June, 1924, it was determined to convene a conference in Ottawa for the purpose of discussing matters of interest common to all sections of the medical profession in this country. The various activities of the public health service; medical education; the role of the licensing bodies, the provincial licensing boards in their relation to the Dominion Medical Council, and the relation of all such bodies to the teaching universities, on the one hand, and the profession on the other; health Insurance; procedure in our law courts in the matter of expert evidence; these and other subjects may be discussed in the light of experience gained by different groups of medical practitioners from all parts of our vast Dominion. It seemed fitting that the Canadian Medical Association, which represents all sections of our country from the Atlantic to the Pacific, should inaugurate this movement; a conference so widely representative is capable of accomplishing much good. In Canada, where the large centres of population are so widely separated, we are apt to lack co-ordination in effort; we get self-centred, and we fail to understand that many of the problems which confront us are national and not merely provincial or sectional. This conference is convened for the purpose of uniting our forces. Instead of individual units, each seeking their own selfish interests, we hope to combine our forces and to present a solid front which will be effective in our determination to secure the highest ideals.

State control of public health and the enactment of laws for the prevention of disease are entirely of modern development. By the common law of England, "the only remedy for any act or omission dangerous to health was an action for damages or an indictment for nuisance." Following the plague, an Act was passed in 1603 making it a capital offence for an infected person to go abroad after being commanded by the proper authorities to keep his house. Then again, after the great fire, the Act for the rebuilding of London (1668) made provision for the height of houses, the breadth of streets, the construction of sewers, and the prohibition of noisome trades. Later, in the most important towns in England, local Acts provided the authorities with power to control public health. The first public health Act embracing the whole of England was passed in 1849; this did not include London which had its own health laws and regulations. The Act of 1858 extended the powers of the general board of health which had been created by the Act of 1848. The present controlling authority in England is the "Local Government Board," which was created by the Act of 1871.

In the latter part of the nineteenth century the economic value to the State of the health of the community was recognized in a manner which had not hitherto obtained. That famous British statesman Benjamin Disraeli, Earl of Beaconsfield, who was noted for his power to epitomize in concise and forcible language the importance of public questions of the day, said in a speech at Battersea Park in June, 1877,

> "The health of the people is really the foundation upon which all their happiness and all their powers as a State depend."

Numerous Acts dealing with public health have been passed in England since that date. It might be interesting, had one time and opportunity, to summarize these and to observe how various laws, bearing directly or indirectly on the health of the public, have been enacted in England, so that hardly any phase of human activity has been overlooked in the effort to regulate these activities in such fashion that they should not become a menace to health and for the prevention of disease. As an example of the minute detail observed in these regulations, one might cite "the cleansing of persons" Act of 1897, which "enables local authorities to permit persons who apply to them, on the ground that they are infected with vermin, to have the gratuitous use of cleansing apparatus." Then we have Acts regarding vaccination, the control of various infectious diseases, the Children's Act of 1908, Acts regarding factories, work shops, etc., etc., all of which are effective in preserving the health of the community.

The principal Acts which are at present operative in England have been summarized by a recent authority as follows: (1) the Education Act with the provision for meals Act, etc. (2) The Old-Age Pensions Acts. (3) The National Health Insurance Acts. (4) The Public Health Act; (a) as to hospitals and the treatment of disease, (b) as to maternity and child welfare. (5) War pensions and Ministry of Pensions Acts. (6) Housing of the working class Acts. (7) Acts relating to the relief of the Poor. (8) Unemployed Workmen's Act. (9) Unemployed Insurance Act.

England was the pioneer of all the nations in instituting effective legislation for the maintenance of public health and the prevention of disease.

In the United States of America the care of the public health has secured an ever increasing amount of attention in recent years from both Federal and State Governments. The federal public health service is a well organized body with wide powers; it has been freed from "political restrictions and petty annoyances" so that it is not hampered in rendering effective service to the State. As an illustration one might mention work accomplished in preserving the health of

children. To quote from a recent article on this subject one may mention that "as early as 1892 New York City provided for the inspection by health officers of school children, and by 1920 practically every city had organized some form of health examination for all pupils attending public schools." The work has extended, and in the late years qualified medical examiners have been employed to examine the eyes, throat, teeth, etc., and treatment is often given at the public expense where necessary. Schools in the open air have been opened for tuberculous children and means have been employed to secure fresh air, and suitable nourishment for such children. The extent of this work may be appreciated by the statement that "in 1919 cities having each a population of more than 30,000 expended an aggregate of $1,849,624 on medical work for school children, and an additional amount of $908,742 on other child conservation work, such as the employment of trained nurses to visit mothers in congested districts, and the establishment of infant welfare stations where mothers could obtain medical advice and free treatment for their babies."

In Canada we may congratulate ourselves that we are not one whit behind other countries in the solution of such questions. Our activities, federal, provincial and municipal, will compare favourably with those of other countries, and indeed in some respects we are in advance of others in our effective management of matters concerning public health.

In the various problems which we are to discuss in this Conference, including public health and the different ramifications of that important subject, we are confronted with conditions peculiar to the country in which we live. The extent of this Dominion, with widely scattered centres of population, the nature of our climate and in many instances the divergent interests of the people in different parts of Canada, make it difficult to combine effort and to establish effective measures which will have the whole hearted support of the entire population. The supreme purpose of the present Congress is to secure the co-operation of the entire country: we hope to be of assistance to the federal authorities, to strengthen their hands and inasmuch as we represent the whole of Canada from the Atlantic to the Pacific, we trust we may by combined effort provide something of real service in attaining ideals of the highest order in dealing with these questions for the betterment of our people.

It is difficult to overestimate the revolutionary effect of modern methods of transportation on our national life. Quick transportation by sea and land, more recently in the air, with added comfort in travel, has induced an ever increasing number of people to go abroad. A continuous stream of travellers pass from one country to another. Not only so, but there is a constant interchange of commodities including food stuffs and the transportation of cattle. The most potent factor to be considered, however, is produced by the movement of immigrants. It is no longer possible for any nation to remain isolated and self-contained: the destiny of each country is inevitably affected by its relations to other countries. This fact was demonstrated and forced upon the attention of the nations of the world during the great war and its aftermath. Among the many points of contact thus established, none have demanded greater attention than those which affect health. The preservation of public health and the prevention of disease has thus become an international problem.

Embodied in the Treaty of Versailles as an article of the Covenant of the League of Nations are these words: "Subject to, and in accordance with, the provision of international convention at present sitting, or hereafter to be agreed upon, the members of the league will endeavour to take steps in matters of international concern for the prevention and control of disease."

The Assembly of the League of Nations at its first meeting in Geneva in December, 1920, in accordance with the responsibilities placed upon it by the various Treaties of Peace, established a permanent international health organization as an important part of the activities of the league.

The health organization of the League of Nations as at present constituted is most comprehensive in its scope and activities. It is well for us in Canada to become familiar with its work and the method of its organization.

The central executive body is called the Health Committee, composed of sixteen members, namely, the Chairman of the Advisory Council, nine members chosen by the Advisory Council, and six members appointed by the Council of the League after consultation with the Health Committee. Four additional members may be appointed by the Council. The appointments extend over a period of three years.

MEMBERS

Dr. Th. Madsen, President, Director of the State Serum Institute, Copenhagen.
M. O. Velgne, Vice-President, Director-General of the Health Department of the Ministry of the Interior and of Health, Brussels.
Sir George Buchanan, C.B., M.D., Vice-President, Senior Medical Officer of the Ministry of Health, London.
Surgeon-General, H. S. Cumming, Vice-President, Director-General of the United States Public Health Service, Washington.
Professor Leon Bernard, Professor of Hygiene of the Faculty of Medicine, University of Paris.
Dr. H. Carriere, Director of the Federal Health Department, Berne.
Dr. Carlos Chagas, Director of the Instuto Osweldo Cruz, Rio de Janeiro.
Dr. Chodzko, Former Polish Minister of Health.
Dr. A. Granville, President of the Conseil Sanitaire Maritime et Quarantinaire, Alexandria.
Dr. Alice Hamilton, Associate Professor of Industrial Hygiene, Harvard Medical School, Boston.
Dr. Jitta, President of the Health Council of the Netherlands, The Hague.
Professor Ricardo Jorge, Director-General of Public Health, Lisbon.
Dr. A. Lutrario, Director-General of the Health Department of the Ministry of the Interior, Rome.
Dr. P. Mimbela, Professor of the Faculty of Medicine, Lima.
Dr. Nocht, Director of the Institute of Tropical Diseases, Hamburg.
Professor Donato Ottolenghi, Professor of Hygiene of the Royal University, Bologna.
Dr. L. Raynaud, Inspecteur-General des Services d'hygiene d'Algerie, Algiers.
Dr. Tsurumi, Japanese League of Nations Office, Paris.
Dr. Rajchman, The Medical Director acting as Secretary of the Committee.

The Health Committee directs through a Medical Director the health work of the League of Nations.

We had the great pleasure of meeting the chairman, Dr. Madsen, in Toronto recently.[1] He is a Dane: Director of the State Serum Institute in Copenhagen, an organization which has a world-wide reputation for its valuable contributions to scientific medicine.

There are a large number of sub-committees which have already accomplished much even in the few years of the committees' existence. Some of these we may refer to as an example of the type of work accomplished.

THE EPIDEMIOLOGICAL INTELLIGENCE SERVICE

The Epidemiological Intelligence Service of the League of Nations Health Section, organized with the financial assistance of the Rockefeller Foundation, gathers information on the prevalence of infectious diseases throughout the world and endeavours to promote collaboration between the National Statistical Services in order to co-ordinate their efforts.

Weekly or bi-monthly reports are issued from seventy-six countries or colonies with mortality and public health statistics. Statistical experts from various countries have been invited to Geneva. The Central Office is in Geneva, and a projected branch office in the Far East. Reports on health organizations in various countries have been published, and others are in preparation. Current reports have been published on such subjects as plague, cholera, yellow fever, typhus, relapsing fever, smallpox, enteric fever, cerebrospinal meningitis, acute poliomyelitis, encephalitis lethargica, influenza, scarlet fever and diphtheria. Then published every month in a form enabling comparison with previous periods, are data for malaria, dysentery, measles, trachoma, and other infectious diseases are presented when warranted by their prevalence.

For the first time official and contemporary records of epidemic movements in the greater part of the world are concentrated in easily accessible form.

Standardization of Sera, Serological Tests and Biological Products

On the proposal of Dr. Th. Madsen the provisional Health Committee initiated joint investigation of the principal medical research institutes of the world with the view of obtaining an agreement on the standards of potency of Therapeutic Sera.

The London Conference of December, 1921, fixed the general programme of laboratory investigations. The Danish State Serum Institute, Copenhagen, is acting for the purpose of this investigation as the Central Laboratory.

There was a special meeting at Geneva in September, 1922, to consider the agreement regarding the International Unit of Diphtheria Anti-toxin.

A Paris Conference in November, 1922, considered completed investigations re diphtheria anti-toxin and arranged that states might apply to the institute in Copenhagen for the retesting of their diphtheria standards gauged in accordance with the accepted international standard.

PERMANENT STANDARDS COMMITTEE

Dr. Th. Madsen, Chairman, Director of State Serological Institute, Copenhagen.
Dr. McCoy, Director of the Hygienic Laboratory, Washington, D.C.
Professor Calmette, Deputy Director of the Pasteur Institute, Paris.
Dr. H. H. Dale, Director of the National Medical Research Institute, London.
Professor Nocht, Director of the Institute of Tropical and Experimental Medicine, Hamburg.
Dr. L. Rajchman, Secretary, Medical Director, Health Section, League of Nations.
Director of Research, Dr. Th. Madsen.
Director of Biological Research, Dr. H. H. Dale.

Research in the Sero-Diagnosis of Syphilis.—Simultaneously in laboratories in Vienna, Brussels, Heidelburg, London and Warsaw.

Standardization of Biological Products.—During the International Congress of Physiology at Edinburgh, July, 1923, a technical conference convened by the Health Committee of the League of Nations was held. Dr. Dale was elected Director of Research.

Research on the Standardization of the following Products is being carried on: Digitalis extract, Pituitary extract, Thyroid extract, Insulin, Ergot, and Arsenobenzol.

Standardization of Anti-Dysentery Serum is being carried on in London, Paris, Warsaw, Basle, Moscow and Tokio.

Standardization of anti-tetanic serum is being carried on in Paris, Prague, Washington, and Frankfurt.

Standardization of anti-pneumococcus serum is being carried on in London, Paris, New York, and Berlin.

Standardization of anti-meningococcus serum is being carried on in London, Paris, New York, and Berlin.

A number of problems demanded solution in Eastern Europe. An investigation was made regarding typhus and relapsing fever in Eastern Europe.

An epidemic of typhus and relapsing fever of unparalleled severity visited Eastern Europe in 1919-20. In Russia there were 900,000 cases of typhus and 375,000 cases of relapsing fever.

It is noteworthy that no serious extension of the disease farther westward took place. The population in Russia in 1920 was 110,000,000.

In Poland in 1919 there were 34,000 cases of typhus.

The general mortality in Leningrad in 1919 rose to 80.7 per thousand, and in Moscow 40.5 per thousand.

Asiatic cholera in Eastern Europe has also been considered.

In 1848 there were 1,743,000 cases in Russia.
In 1892 there were 620,000 cases in Russia.

In 1921 there were 180,000 cases in Russia.

Anti-choleric vaccinations were performed by the Russian Health Administration in 1922.

Post-war Refugee Problems in Eastern Europe.

The number of returning emigrants and prisoners of war who passed westward across the Russo-Polish frontier during the four years 1919-22 exceeded three millions.

The mass movements of the population occasioned by the famine in Russia were of great importance in spreading infections of louseborne and other diseases.

Refugee Problems in Greece.

At the advance of the Turkish armies in the autumn of 1922, more than one million of the Greek population of Asia Minor and Eastern Thrace found a refuge in Greece. The continuous movements of the refugees and the unsanitary conditions under which they lived were favourable to the spread of epidemic diseases of many kinds and constituted a serious menace to the resident population of Greece as well as to the neighbouring countries.

Total number of refugees registered for assistance in May, 1923, 920,000.

Population of Greece, 4,970,000.

The epidemic diseases among refugees in 1922-23 included plague, smallpox, typhus, typhoid fever and dysentery.

The manner in which some of these problems have been tackled is evidenced by the activities of the Epidemic Commission.

The commission was created by the League of Nations in May, 1920, to assist the countries of Eastern Europe in their campaign against devastating epidemics of typhus fever and other communicable diseases, and an appeal for funds was issued.

Contributions were received from the Governments of Albania, Austria, Belgium, Bulgaria, Canada, China, Czecho-Slovakia, Denmark, Finland, France, Great Britain, Greece, Holland, Japan, Norway, Persia, Peru, Siam, Sweden, Switzerland, and the League of Red Cross Societies. The funds subscribed amounted to $800,000.

A subvention of the League of Red Cross Societies enabled the Epidemic Commission in collaboration with the Russian Soviet Health Services and the Polish Health Service to organize in Warsaw, Moscow, and Kherkov special courses for the training of public health officials in modern methods of combating epidemics.

Activities in Greece in 1923.

A vaccination campaign was carried on among refugees and the civil population. Total number performed:—

Tetra (typhoid, para-typhoid, cholera)	1,170,461
Smallpox	1,238,889
Anti-plague	93,243
Anti-dysenteric	28,880

Medical sanitary stores and laboratory equipment have been supplied to the Russian Health Administration to assist in the anti-epidemic campaign.

A survey of the health conditions of Persia is being undertaken at the request of the Persian Government.

It is hoped to co-operate with the local authorities in carrying out a plague investigation in the Russian Kirghiz Republic, and an epidemiological inquiry into typhus fever and cholera in Ukraina.

Activities in Eastern Europe, 1920-23.

Hospitals constructed by the Epidemic Commission.

Hospitals aided by the Epidemic Commission.
Newly erected bath-houses and delousing establishments.
Bath-houses and delousing establishments partly equipped.
Sanitary installation of quarantine stations.
Installation and equipment of a quarantine station at the port of Libau (Latvia).

The International Incomparability of Mortality Statistics.

The international list of causes of death prepared by the late Dr. Jacques Bertillon in 1886, and revised by international agreements in 1900, 1909, and 1920, constitutes the first practical advance towards international comparability of vital statistics. It is used in full detail only in a few signatory countries, and the utility of the statistics is further impaired by the absence of uniformity in registration methods, medical definitions and statistical procedure.

The gathering of medical statistics has advanced but slowly and with little international co-ordination, so that the quality and coherence of the data no longer correspond to the highly developed methods of statistical research. Recognizing this fundamental weakness of medico-statistical work, the epidemiological intelligence service was undertaken:—

1. To study, through groups of experts, the incomparability of mortality and notifiable disease statistics viewed internationally.

2. To publish hand books on the vital statistics of various countries.

3. To organize groups of medical statisticians to collectively study statistical procedures in various countries.

Gives examples such as: The fatal issue of an appendicitis is largely conditioned by the occurrence of peritonitis; the latter cause is accepted as sufficient in Italy and the Netherlands, while the primary cause is demanded in the United States and in England. The statistics are therefore not comparable.

Many of these points could be regulated by international agreement, but uniformity of procedure is, as yet, entirely lacking.

Interchange of Health Officers.

Aided by subventions received from the International Health Board of the Rockefeller Foundation, the League of Nations Health Organization has arranged a series of interchanges of health officers of forty-three countries, who have thus been able to study sanitary progress and administration in countries other than their own, accordingly promoting efficiency and international solidarity between health administrations.

From October, 1922, up to June, 1924, thirty-nine countries have taken part in interchanges, and some 230 individuals have profited by them.

Tuberculosis Specialists have interchanged, also School of Hygiene Specialists.

1922.—The first general interchange commenced in October 9th, 1922, with 23 Health Officers from 8 countries in Belgium and Italy.

1923.—A second interchange in England and Austria took place in which 29 participated; Malaria experts interchanged. In 1923, 12 senior Bacteriologists from Belgium, Denmark, England, Germany, Italy, Kingdom S. C. A., Poland and U.S.A. have been given grants to enable them to study at one or several Institutes of Public Health in foreign countries the laboratory methods and the administration of the Institute.

Third general interchange in the United States. On the Surgeon-General's invitation 24 health officers from 18 countries studied the public health practice of the United States. For two weeks they remained with the Federal Health Service in Washington. Divided into three groups, they visited during ten weeks, 3 southern and 3 northern States, studying state and local health activities.

1924.—Specialists interchange.

4th General interchange in Great Britain.

5th General interchange in Holland and Denmark.

6th General interchange in Switzerland.

Seventy-eight officials from 36 countries participated in the three general interchanges.

Statisticians from Brazil, Bulgaria, Czechoslovakia, Hungary, Italy, Norway, Poland, Russia and the Serbo Croat Slovene Kingdom met in October 1923, at Geneva, for six weeks collective study of vital statistics. They visited next the statistical offices in Berne, Interlaken (Switzerland), Paris, The Hague and London, and the National Research Institute in London.

1925.—Provisional Programme:—

Countries to be visited: Great Britain, Kingdom S.C.A. and Japan.

Interchange in the Far East limited to a few post medical officers.

Interchange of specialists in Child Welfare in France, Russia, Sweden, etc.

Sanitary Conventions.

As a result of the European Sanitary Conference held in Warsaw, March 1922, the following bi-lateral sanitary conventions and anti-epidemic agreements have been conducted:—

Bulgaria—Kingdom of the Serbs, Croats and Slovenes.
Czechoslovakia—Poland.
Germany—Poland.
Latvia—Poland.
Latvia—Russia.
Poland—Roumania.
Poland—Russia.
Austria—Kingdom of the Serbs, Croats and Slovenes.

In connection with the committee for communication and transit of the League of Nations, the Health Committee has prepared a model convention for the sanitary control of traffic on Waterways.

Inquiry in the Near East in 1922. A commission has examined the arrangements for the prevention of transmission of epidemic disease.

There are many other activities carried on by special sub-committees appointed to deal with special problems. These may be enumerated as follows:

Sub-committee on sanitary control of traffic and waterways.

Sub-committee on legitimate requirements of raw opium and its derivatives.

Sub-committee to study the health chapters of reports of the mandatory powers on the administration of the territories under the League of Nations mandates.

Sub-committee on anthrax.

Sub-committee on tropical diseases.

Sub-committee for the study of the cancer problem.

Sub-committee for the study of the malaria problem.

Sub-committee on the training of sanatarians in public health.

These various committees work in collaboration with the International Labour Office, the International Red Cross organizations, and other advisory and technical committees of the League of Nations.

It will thus be seen what a colossal amount of work is being undertaken by the Health Committee of the League of Nations.

Individual members of our Canadian profession have been active in International health work. In the summer of 1923 the late Dr. C. K. Clarke, Professor of Psychiatry in the University of Toronto, delivered the Maudsley lectures in England,

and aroused great interest among the health authorities of Great Britain by his fearless and able discussion of the question of the emigration of the mental defective. The public and professional Press of that country paid high tribute to the manner in which he handled the subject, and approved of the helpful suggestions he made.

The International Health Board of the Rockefeller Foundation.

Another of the International Health organizations of recent origin is that which has been inaugurated by the Rockefeller Foundation. The International Health Board of that Foundation has already accomplished much for the benefit of humanity. A vast amount of capital has been invested for international service. By a munificent bequest they have made it possible to establish in London what is known as the London School of Hygiene and Tropical Medicine, an institution which is truly international in its aim. It is inaugurated under the able direction of Dr. Andrew Balfour, and is unique in its organization, equipment and objective. More recently the Rockefeller Foundation through its International Health Board has made provision for the establishment of a School of Hygiene in Canada.

On May 20, 1924, the International Health Board of the Rockefeller Foundation approved of a proposal to assist financially in the creating and endowment of a School of Hygiene in the University of Toronto; and the following day the Rockefeller Foundation pledged $650,000 to the governors of the University of Toronto for that purpose. The governors of the university have accepted the proposals, and the above-mentioned sum will be utilized to provide a building to cost not more than $400,000; the remaining $250,000 will be used for the endowment of the school. While final details of organization remain to be perfected, the school will include the Departments of Hygiene and Preventive Medicine and Public Health Nursing, and the Connaught Laboratories. The operating or public-service divisions (namely, the anti-toxin and insulin units) of the Connaught Laboratories will be merged to constitute a public-service section of the school.

A Summary of the Activities of the International Health Board of the Rockefeller Foundation for 1923 is as follows:—

The creation of Departments of Rural Health Organizations:
In the United States and other countries

Hookworm diseases in South America, West Indies, Central America, China and the Far East.

Yellow Fever—Victories over such in South America, Central America and Mexico. It has been eradicated in many communities.

The board co-operated with State Services, not only in the United States, but in Australia, Philippine Islands and Czechoslovakia.

Co-operation with the League of Nations.
Interchange of public health personnel.
Epidemiological Intelligence Service.

Tuberculosis in France—Public health nursing in France, Philippine Islands and Brazil.

Public Health Laboratories in Honduras, Costa Rica, Nicaragua, Salvador, Guatemala and Manilla.

Malaria—in United States.

The pioneer work of the International Health Board in malaria control began in 1916 in tropical areas—Nicaragua, Palestine, Philippine Islands and Brazil.

Public health education in Sao Paulo, Brazil—Institute of Hygiene of the Faculty of Medicine.

Prague—Institute of Hygiene.

Warsaw, Poland—School of Hygiene.

London—London School of Hygiene and Tropical Medicine.

Fellowships.

For the year 1923 fellowships were provided for 130 men and women in 22 countries:—

Australia	4	France	2	Peru	1
Austria	3	Great Britain	1	Philippines	1
Brazil	13	Hungary	7	Poland	11
Canada	7	India	5	Salvador	1
China	2	Java	1	Spain	2
Columbia	1	Mauritius	1	Spain	3
Czechoslovakia	13	Mexico	1	United States	42
		Netherlands	3		

The year 1923 has seen the entry of ex-fellows into important public health positions in many countries.

In two countries, men who have studied on fellowships from the board now hold the position of Chief Health Officer.

Publications.

In 1923 many contributions to medical and public health literature have been made by staff members and others directly associated with projects in which the board participated.

Canadian Activities.

[Several courses regarding matters of public...] health have been available to graduates in medicine. These courses extended over one winter session of eight months and one summer session of three months. After passing a satisfactory examination the candidate received the Diploma of Public Health. These courses have undoubtedly served a useful purpose in the past, but adequate provision has not been made for the complete training of the specialist. We require better equipment and a special staff to meet the demand which is now made upon us. We congratulate ourselves that through the generosity of the Rockefeller Foundation a school is about to be established in Canada where facilities unsurpassed will be available for those who desire to take an intensive course of special study leading to a degree in public health. It is difficult to overestimate the value of this recent addition to our education institutions; it is a development of national importance, of which we in Canada may well be proud.

Schools for the Training of Specialists in Public Health.

We have already noted certain schools endowed by the Rockefeller Foundation, in Prague, Warsaw and London. We may refer to two other schools endowed by the foundation which are successfully accomplishing their object. *The Johns Hopkins University School of Hygiene and Public Health*: this was opened in October, 1918, with Dr. William H. Welch as Director; Dr. Wm. H. Howell assisting in the work of organization.

The school which was established in Baltimore by the Rockefeller Foundation instituted certain courses:—

1. A course leading to the Degree of Doctor of Public Health (two years).

2. A course leading to the Degree of Doctor of Science in Hygiene (three years).

3. A course leading to a certificate in Public Health (one year).

4. A course leading to the Degree of Bachelor of Science and Hygiene (two years).

5. Intensive course for Public Health Officers (three months).

6. Intensive course in Medical Zoology (three weeks).

The Harvard School of Public Health

For many years Harvard University has shown a very considerable amount of activity in Public Health work. In 1909 a Department of Preventive Medicine and Hygiene was established. The Degree of Doctor of Public Health was first conferred in 1911. In the same year a Department of Sanitary Engineering was inaugurated. In 1913 a Department of Tropical Medicine was formed, and in 1918 a Division of Industrial Hygiene with clinical and laboratory facilities was organized. There were other activities jointly with the Massachusetts Institute of Technology. Thus a substantial nucleus was formed in the university for the establishment of a School of Public Health of larger scope. This was founded in 1921 and endowed by the Rockefeller Foundation.

It constitutes one of the most comprehensive and complete schools in existence, where all the varied problems of public health may be studied effectively.

Another well-established school on this continent is the School of Hygiene and Public Health in connection with the University of Pennsylvania at Philadelphia. It is an independent institution in that regard.

Apart from the training of the specialist, we must not overlook the education of the general practitioner in matters of public health. No matter how efficient the medical health officer may be, he must ever be dependent upon the intelligent co-operation of the general practitioner. More particularly would we emphasize the importance of providing for preventive medicine, in the many phases of that subject, as a part of the curriculum in the under-graduate course in medicine. It is incumbent upon our Canadian universities to provide adequately for special study in a subject, which, of recent years, has become of ever-increasing importance as a progressive branch of medical science.

In recent years an increasing amount of attention has been paid to *the education of the public* regarding matters concerning public health. This has been carried on through various agencies. One might instance as an example of municipal activity, the excellent bulletin published monthly by Dr. Hastings, the Chief Medical Health Officer of the city of Toronto. This bulletin is issued to every ratepayer and discusses in simple language the best methods of preventing disease. It also contains suggestions for the care of the sick. Bulletins of a somewhat similar type are issued by the federal and provincial health authorities, either to physicians or to the lay public. The Bureau of Health and Public Instruction of the American Medical Association issues a magazine, "Hygeia," which first appeared in April, 1923. It is an attempt to educate the American people on matters of health and disease. Other methods are adopted for the purpose of reaching the public, such as health expositions, and broadcasting of talks on health by radio. Certain other organizations pay special heed to this type of publicity, such as the Canadian Social Hygiene Council in their effort to combat venereal disease, and the Anti-Tuberculosis League. The American Society for the Control of Cancer is in my opinion accomplishing good results both in the United States and Canada. An enormous amount of effort has been expended in the hope of solving the cancer problem, its etiology and effective treatment. The only practical result of clinical observation is to establish the fact that cancer is a curable disease if removed early. The public is being instructed as to the importance of this fact. The Society for the Control of Cancer began its work in the United States and Canada. More recently the Royal Society of Medicine has taken the matter up, and as a result in Great Britain a very active propaganda, with similar objects, has been inaugurated.

Turning now to *Canadian organizations in the Department of Public Health*, we find that these are federal, provincial and municipal.

The earliest recognition of public health in Canada was the enactment of the Quarantine Act, in 1794. Boards of Health were formed in 1832-1834 by the legislature of Upper Canada to combat an epidemic of cholera. In 1847 no less than 98,106 immigrants passed through the port of Quebec. Of these 8,691 were admitted to Grosse Ile hospital. Deaths from typhus fever among those admitted to hospital were 3,226; in addition 2,198 died on ships detained in quarantine. These victims of typhus were buried at Grosse Ile. There was a typhus epidemic in Canada in the years 1845-47, of cholera in 1849 and again in 1854-55. In 1849 a Central Board of Health was established in Canada. I am indebted to Dr. J. W. S.

McCullough for giving me these figures, which I abstracted from his recent monograph. "Ten Years Experience on the Provincial Board of Ontario."

Federal activities in connection with public health have thus been carried on in Canada for many years. For more than half a century (1865-1920) Dr. Frederick Montizambert, I.S.O., as Director General was responsible for safeguarding the health of the Dominion. Conspicuous in effective administration may be noted his development of the quarantine and marine hospital services both on the Atlantic and the Pacific coasts. He attained an international reputation as an authority on these matters. He was president successively of the American and the Canadian Public Health Associations. In the early days after Confederation he encountered many difficulties, such difficulties as are always attendant upon the initial development of a great public service in a new country. How splendidly he accomplished his purpose is universally acknowledged. We do well in Canada to pay tribute to a public health servant who has accomplished so much for the welfare of his fellow-countrymen.

In connection with *federal activities* we may note the formation of the Canadian Public Health Association, under the patronage of the Duke of Connaught, in 1911. Then again in 1919 a health ministry was established in the Dominion Parliament with Dr. John Amyot, C.M.G., as Deputy Minister. Under this ministry was established the Dominion Council of Health, in which the various provinces are represented by their chief executive health officer; these along with five members representing agriculture, labour, etc., including educational bodies, constitute the council.

The work of the council has included, among other activities, an effort to standardize the health regulations of the provinces, the publication of public health literature, the franking of vital statistics and public health returns, the study of public health questions, and securing federal aid in promoting such work as the clinics for the treatment and control of venereal disease.

This Conference would do well to use its influence to the utmost in urging the necessity of continuing the grant of $200,000 per annum which has been provided by the Dominion Government for the past five years for the purpose of combating venereal disease in Canada. We learn with concern that it is proposed to diminish this grant. It is true the grant was only guaranteed for five years, and the plea has been made that it was intended for the initial cost of organization. Let there be no misunderstanding on that count. It is easy to show that the expenditure was made not on organization, but on the actual cost of the conduct of these clinics. Those who know the situation recognize the splendid work which has been accomplished for our country under these grants in the last five years. We view with consternation the proposal of cutting them down, and in the interests of our fellow-citizens we would appeal to our federal Government to provide whatever financial aid is necessary for this purpose. It might easily be shown that an increase of the present grant would be justifiable for Canada. The problem is first an international one, as is recognized by the Health Committee of the League of Nations in establishing and maintaining researches in various countries in the sero-diagnosis of syphilis. Then it becomes a national problem in which our federal Government has already taken effective action, which we pray in the interest of the community will be continued with increasing effectiveness. The provinces and the municipalities are already doing their full share.

In addition to other matters the Federal Health Department has under supervision: Quarantine against other countries, the supervision of foods and drugs, patent medicines, narcotic drugs, child welfare, the superintendence of Marine Hospitals, the medical examination of immigrants, publications on public health, research laboratory work, and the organization of the Dominion Council of Health.

Provincial Health Organizations.

I am not in a position to speak historically of the Department of Public Health service in the various parts of the Dominion. We know the various provincial boards are doing effective work. The problems differ in different provinces. Those with an ocean seaboard, with ports open to the outside world, have problems peculiar to that situation. Others are concerned with an international boundary, on our Great Lakes, etc. The federal and provincial services must act in harmony in connection with problems arising from such conditions. The local provincial boards of health are under the control of the different provincial governments.

I happen to be in possession of some facts regarding the development in Ontario, which I may cite: [2]

After Confederation a Public Health Act was passed in Ontario in 1873, and local health committees were formed in various municipalities. These were the forerunners of the present local boards of health. In 1882 the Provincial Board of

Health was established as a permanent organization in Ontario. Dr. Peter H. Bryce became the permanent secretary. In 1890 the first public health laboratory was established under the direction of the late Dr. J. J. MacKenzie, subsequently Professor of Pathology and Bacteriology in the University of Toronto. This was the first public health laboratory to be established on this continent. Dr. John A. Amyot became director of the laboratory in 1900. Dr. George G. Nasmith was the first chemist on the staff; he was appointed in 1902. He continued to serve until 1910, when he became chief of the laboratories in the city of Toronto. From 1904-1910 Dr. C. A. Hodgetts served as Chief Officer of Health and Deputy Registrar-General. He was in turn succeeded by the present incumbent of that office, Dr. J. W. S. McCullough. He still is chairman of that board.

Doubtless the other provinces have had a somewhat similar evolution, from a small beginning up to the present standard of efficiency.

Municipal Health Organization

Once more I must plead your indulgence by citing as an example of efficiency, organizations with which I am familiar:—

In the city of Toronto the cost for public health service showed a remarkable increase in twenty-five years; 1909, $80,610; 1923, $835,132.

Under the regime of Dr. C. J. O. Hastings the death rate has diminished from 15.3 per thousand to 11.4 per thousand. Numerous tributes have been paid to the excellence of the public health service under Dr. Hastings, in Toronto, who has just passed through a somewhat critical illness, and, I am glad to hear, is improving. Of these activities, one might mention the following: Sanitary dwellings; pure milk and water supply, and pure food; control of communicable diseases; the work done by doctors, dentists and nurses; clinics and child welfare; work in the public schools; health examinations; infant mortality was almost cut in two in ten years; the practical wiping out of typhoid fever; the Toronto city nursing service is a pioneer service in many respects, with 114 nurses on the city pay-roll. These nurses are engaged in district nursing, pre-natal, infant and pre-school supervision; School service, physical examination, dental service, etc.

The Victorian Order of Nurses, engaged chiefly in bedside nursing, work in close harmony with the public health nurses of the city.

Once more we recognize that municipal activities in Canada are effectively organized and maintained in the different portions of our Dominion.

The Conference at present assembled is capable of accomplishing results of immense value. Representatives of all branches of the public health service, federal, provincial and municipal, are met for the purpose of studying problems of common interest. By the interchange of ideas, the demonstration of individual problems and the frank criticism of existing conditions we may be helpful to one another, and thus we hope to increase efficiency and to promote harmony and good will in our common endeavour.

MEDICAL EDUCATION

The advances which have been made in the standard of medical education in recent years are noteworthy. There is no branch of education in which more rapid and revolutionary changes have taken place. These changes have been forced upon us because of the ever increasing progress of scientific knowledge and in clinical observation. The present high status of medical education is not confined to a few centres, but is found in all progressive countries of the world. In Canada our progress has on the whole been satisfactory, and we have been accorded a position second to none in our achievements. This is a young country. While we perhaps lack the experience and prestige of older communities, we possibly have an advantage in being free from certain traditions and precedents which often frustrate the effort to make revolutionary and radical changes, even when these are obviously demanded by the changed conditions induced by progress in science and discovery.

The teaching faculties in medicine of our Canadian universities have evolved a course and curriculum of study peculiarly their own. In the earlier days, it is true, we modelled our curriculum largely on those of the Mother Country, in particular those of the Scotch universities. But of recent years we have evolved our own course, and in not a few instances we have been pioneers in the raising of standards and in the improvement of the course of study in medicine.

Looking abroad to-day we find we fulfil the requirements of the most exacting schools in other countries. If we take, for example, the exhaustive and illuminating report of Sir George Newman, entitled "Recent advances in Medical Education in England" (1923), we find we measure well up to the standards therein set forth as approved by the British universities and enforced by the General Medical Council of Great Britain. It is of interest to observe that in the report referred to, the distinguished educationalist, in his analytical study of medical education in its various branches, refers more than once in commendatory terms to the conditions which exist in Canadian universities.

Twenty-five years ago it was possible for a man to practise medicine and to attain success (measuring success by comparison with the results achieved by his fellows) without the application of more than the very rudiments of pure science in its application to medicine. I recall a personal experience of some thirty years ago when I approached one of the leaders of his profession of that time, and asked him to assist in the inauguration of a small club for the study of pathology. He told me he was "a practical man" and was not specially interested in the minute study of pathology. He was no exception among men of his class, men many of whom were able to produce results in practice well in advance of the large majority of practitioners. In the last quarter of a century the practice of medicine, using that term in its broadest sense to include all specialities, has thrown over empiricism and has now been established on a scientific basis. The effect is twofold as far as the curriculum of study is concerned. First it means a more intensive study in the fundamental sciences of physics, chemistry, biology, physiology and anatomy. These, together with the specialized training in these sciences such as biochemistry, pathological chemistry, pharmacology, hygiene, applied physiology, applied anatomy, etc., demand a great increase in the time allotted to their study. Secondly the student, having acquired this intensive training, must apply his knowledge clinically, and so in turn the clinical teaching demands a great accession to the time previously allotted to it. With his clinical work is linked up the minute study of pathology and bacteriology, which is now of such fundamental importance in his training in the clinical years. The inevitable result all along the line is a tremendous increase in the length of the curriculum.

We all deplore the increased length of the course in medicine. It is obvious to any one who studies the situation that it could not be avoided. If you take, for example, the English-speaking countries of the world, you will find in all schools of medicine there is an unanimity of opinion and of action in this regard. We may have different terminology as to the different years of the course; some may speak of "pre-medical years," others include such years in the complete course and call all years "medical years". But if you analyze the situation, you will find that the course embraces seven years of special study. Most men (over 90 per cent in one of our Canadian Universities) take an additional year as interne in a general hospital. Thus it comes about that a student entering medicine must look forward to a period of eight years before he is qualified to practise his profession. Any school that does not line up to this standard is courting disaster. Graduates of a school with inferior requirements will find themselves handicapped in practice; they will be unsuccessful competitors with their more highly trained fellows. The public are beginning to demand a knowledge of a man's credentials and are no longer satisfied with the mere fact that he is licensed to practise.

It is very interesting to study the gradual evolution in clinical training due to the introduction of so-called laboratory methods. At first there was an outcry that students were being taught technical methods with the use of scientific instruments and laboratory tests, to the exclusion of the essential study of the physical examination of the patient. We admit frankly the danger of such disastrous methods of instruction. We also admit that the discussion along these lines was advantageous. The danger, however, has been averted, and in every well organized clinic the methods of physical examination are taught more intensively, more persistently and effectively than has hitherto been the case. On the other hand, students are taught laboratory methods in the diagnosis and treatment of disease. It is absurd to condemn laboratory methods; they must hold their proper place in clinical teaching. A student to-day must be able to utilize the training he has had in the preliminary sciences in its application to disease.

A more recent phase in the evolution of clinical training has been the demand to have such subjects as physiology and anatomy carried over to the clinical years as applied subjects. More recently still is the suggestion that clinical subjects should be taught, in their elementary phases, along with the sciences in the preliminary years of the course. Lastly we have been urged to curtail the preliminary science course and restrict it to those parts of such subjects as physiology, chemistry and anatomy as apply in medical practice. As it appears to me the situation is at present confused and demands some clear thinking. I believe many of the suggestions are made without logical consideration of the actual problem in hand.

Everyone admits that a knowledge of physics, chemistry, biology, physiology and anatomy is essential in medical education. Obviously we do not require to train men as specialists in these subjects; therefore careful supervision and

restriction in the scope of these courses is demanded. I take it, however, that we wish a man to be trained in chemistry so that he can apply his knowledge of chemistry in the diagnosis and treatment of disease. Similarly he must be able to approach a clinical problem from the standpoint of physiology, biology, physics or anatomy.

To attempt to apply these sciences to medical practice at a time when the student is ignorant of clinical problems is waste of time. It must inevitably lead to confusion. In my opinion these subjects should be taught as pure science. There is, I believe, a great deal of nonsense talked about water-tight compartments now-a-days; the logical alternative would be a compartment filled with fragmentary material which has leaked in from neighbouring compartments causing a premature precipitation of false conclusions, and resulting in a conglomerate mixture which is hopelessly puzzling to the unfortunate student and impossible for him to digest and assimilate. Surely it is the part of wisdom to do one thing at a time. The student trained in pure science has, to my mind, the best possible equipment for the practical application of that science in the diagnosis and treatment of disease. The course in science, however, should be modelled and arranged by experts who realize that the ultimate goal of the student is that of a general practitioner in medicine. A common sense view of the situation will result in placing these preliminary science subjects in their proper relation to the other subjects of the curriculum of study. The student under such conditions will be better trained, capable of clear thinking and imbued with the scientific spirit, which is more essential to-day than ever before if we in the medical profession are to utilize the advances made in science from time to time in the relief of suffering humanity.

I would like to urge the undesirability of uniformity of curriculum in universities. It has been suggested, for example, that licensing bodies should issue schedules of study in each of these sciences, physiology, anatomy, etc. not only so, but to stipulate the method of instruction, e.g., so many didactic lectures and so many hours of laboratory work. There is a craze for standardizing everything, including industries and education. The inevitable result will be to kill initiative and to destroy individuality. If we take the subject of physiology, for example, it is surely conceivable that of two most effective and efficient teachers, one may cover ground and utilize methods of instruction of an entirely different character from the other. Both have the same ultimate goal, namely, to teach the student the principles of physiology in such fashion that he may later be able to approach a clinical problem fully equipped to use physiological methods in his bedside work. This end may be gained with equal success by very different methods of approach in the teaching of the particular science. The teacher should be free to use his own peculiar faculties for the attainment of the ideal result. Here again, in my opinion, the standardizing water-tight compartment of a fixed schedule is to be condemned outright.

I have touched on a few of the problems which are "live issues" in medical education to-day. We can never produce on a permanent basis an ideal curriculum. Progressive schools of medicine will change their curriculum of study from year to year. We hope to have discussions at this Congress which will assist us throughout Canada in meeting the requirements of to-day and if we continue, as I trust we will, to meet in annual session, we shall be able to stimulate one another to maintain high standards of medical education, constantly keeping pace with the requirements thrust upon us by ever advancing knowledge in all departments of medical science.

MEDICAL LICENSURE

Each province in Canada, under the British North America Act, controls educational matters; among other things it exercises its right to fix the standard of medical education required for a license to practice medicine. In each province there exists a provincial Medical Council operating under an Act of the legislature. This is the official licensing body. It accomplishes its purpose in two ways; first by insisting upon a certain curriculum of study, including matriculation standards, and secondly by examination. In some provinces the examinations conducted by the university are accepted by the provincial Medical Council: in other provinces the Council conducts the professional examinations in whole or in part.

In addition to the provincial Council we have a Dominion-wide body, the Medical Council of Canada which, under certain provincial restrictions, issues a license for practice in any part of Canada.

A general survey of the situation shows that no two provinces of Canada have agreed upon the requirements for license. In fact, the divergence in the regulations is extraordinarily, and one might add unnecessarily, great. The Dominion Medical Council as at present constituted under the federal Act is not concerned in curriculum of study. It conducts examinations and it accepts as suitable candidates for examination those who present what may be called an "enabling certificate," indicating that the requirements of the Medical Council of the province from which he comes have been fulfilled. These certificates are issued by the registrars of the individual provincial councils.

Canada is a vast country in area, with a population relatively small. We have common ideals in many things and perhaps in no sphere is this more evident than in educational matters. Effort is made from time to time to get the Educationalists together in order that each province may contribute towards the establishment of standards of education worthy of the country as a whole. One might instance, for example, the annual Conference of Canadian Universities, which is accomplishing much toward that end. Surely along similar lines it would be possible to improve the conditions under which we grant the license to practise medicine in Canada.

An effort has been made to secure representatives from each provincial Medical Council at this Conference to discuss medical licensure. Let us hope a beginning may be made to secure, if possible, something approaching a uniform standard of requirements for the various provinces. We as a profession in Canada would be greatly strengthened by uniting our forces in this respect. Is it too much to hope that one day the Dominion Medical Council, the federal body, may be the medium through which all the provinces, with something approaching uniformity will unite? Would it not be ideal that the various provincial councils should agree to accept the Dominion Medical Council as the sole examining body for license to practise medicine in Canada?

Why should Canada with a population of 8,350,000 require nine licensing bodies, when in Great Britain with a population of 45,000,000 there should be one such body only, the General Medical Council of Great Britain?

This is a national ideal for the attainment of which we might well sacrifice certain of our provincial rights and prejudices.

This Conference of individuals concerned in the administration of medical services in Canada is an experiment. The inevitable result of conditions which obtain in this country is to produce varied interests, often conflicting interests, which are difficult to unify. Everyone will concede the desirability of creating national ideals, which will unite the provinces for common effort. No great revolutionary effort of this kind can be brought about without sacrifice, and it is hoped the representatives of different provinces will be prepared to consider how far they can forego local considerations for the attainment of national ideals.

We hear a great deal now-a-days regarding the evolution of Canada as a nation. The union of the scattered provinces of Canada in national effort has presented many difficulties in varied activities of life. Success has been attained in many directions, but as yet the medical profession is divided with scattered provincial groups each operating without due consideration of the requirements of the other. We trust the beginning made at this Conference will result eventually in combined effort and the establishment of a national spirit which will greatly strengthen our hands. It is hoped the day is not far distant when the medical profession, in all its varied activities of public service, will be united in national organizations, second to none in efficiency and achievement among the great nations of the world.

The CHAIRMAN: I understand there are now some resolutions to be put.

Dr. W. T. CONNELL: The programme is necessarily incomplete, and as there are a number of matters of importance which gentlemen present wish to bring before the conference, I think it would be advisable for us to have a more detailed programme, and I would therefore move, Mr. Chairman, that you nominate a Programme Committee so that those members who have matters other than those which appear on the programme which they wish to discuss shall be given the opportunity.

Dr. AUSTIN: I second the motion.

Motion agreed to.

Dr. GEORGE YOUNG: I move that the chairman be empowered to nominate a Committee on Resolutions whose duty it will be to crystallize the results of our discussion in a series of resolutions to be presented before the close of the conference.

Dr. AIKINS: I second the motion.

Motion agreed to.

The CHAIRMAN: I will nominate the Committees after we have heard from Dr. Amyot, Deputy Minister of Health, whom I will now ask to address the conference.

HEALTH SURVEYS, HEALTH NURSES, AND THE RELATION OF THE MEDICAL PROFESSION THERETO

Dr. AMYOT (Deputy Minister of Health, Ottawa): Ladies and gentlemen, Dr. Primrose has given us food for thought. I did not know that anyone could compress as much information into such a small space, and he has finished his address right on schedule time. This all shows that there is a big ideal behind this medical profession in Canada; there is an attempt to make ourselves more useful to the public. It is a serious attempt. We are all thinking of it, and those of us who have had any university experience in drawing up a curriculum know well how earnest that endeavour has been.

Public health, that branch of medicine which looks towards the prevention of disease, has made immense progress in the last few years since we have had certain scientific facts upon which we can base our action. We owe the discovery of these scientific facts to the energy and efforts of the medical profession chiefly, with the one exception possibly of Pasteur, and after all we look upon him as part of ourselves. All these discoveries have been given to the world freely by the medical profession, have been put into the common pot. It is a principle, it is an ideal, it is something that is inground in us, that since we have learned from the experience of our predecessors, since they have without any reserve put all their knowledge into the common pot, it is for us when we find anything also to put it into the common pot for the benefit of all.

The medical profession has also this to its credit. Its work has been of an idealistic type. Did anyone of you ever in your practice in a city or in a town ever attempt to keep people sick in order to make your living out of them? You have made every effort that it was possible to make to prevent people getting sick. I do not know any other profession that does that. It is idealistic work when you get out and fight a condition that is resulting in typhoid, let us say, and as Mr. Graham remarked this morning, did any of you ever think of the practice that you were going to abandon when you were carrying on such work? You never did. You have gone out idealistically to try and stop human misery.

It is often said of us that we are a sort of a close corporation, that we are licensed, and licensed for our own protection very much as a labour union is. But is that so? We are licensed for the protection of the public. When we get into difficulties with reference to our property or our liberties are infringed, we go to somebody who knows what the law is, and the provinces and the Dominion that we live in see that these lawyers know the law sufficiently well not to leave us in jail, and not to allow our property to be wrongfully taken away from us. The lawyers are not licensed to make themselves a close corporation; it is simply that there shall be a degree of protection for the public, to ensure that they shall have a sufficient knowledge of the law to protect our property and our liberty. When we want our children educated we see that the teachers come up to a certain standard of qualifications, and the country also when it comes to deal with us demands that a certain standard of instruction and experience shall be required of us. We are not a close body. It is not for the protection of the medical profession that we are licensed; it is for the protection of the public, and wise legislators have provided for that. Experience has shown that it is necessary to have it so.

Now advances in public health have resulted out of that idealistic principle that is in every medical man's heart from the time he becomes a first year medical student until he goes out to practise. I do not know any college that teaches him selfishness. You try to teach him from the start that he is a peculiar type in the community. He is the type that of necessity becomes a sacrificer for the rest of the community.

The medical profession has advanced public health. The public have become interested in public health. The principles laid down by the medical profession, based on the scientific knowledge which they have evolved at the cost of great effort and sacrifice, have benefited the public, and the public is commencing to see the necessity of it. This knowledge of matters pertaining to public health is becoming common property. The public knows far more about public health to-day and the possibility and necessity of protecting their lives and their happiness than ever before, and who is responsible for that? The medical profession has taught it to them. You have only to look at the group of health officers in a province or municipality to know what efforts they have made to teach that public. And now the knowledge is becoming general: it is wider than it ever was before. Compare conditions to-day with conditions twenty-five years ago. Time has brought certain changes in the situation. The public has demanded men who knew more and who could spend more time on public health than it ever did before. The subject of public health has become a specialty just as much as neurology, internal medicine or surgery, and the men interested in public health, you must realize as medical men, have gone just as far in their special lines of work and done just as much hard work as you have done in your special lines of work. They have obtained what is really specialized knowledge. That is not always realized. I can take my own experience as an example. I quit the practice of medicine in 1900, after practising nine years. I had made as much effort as I could during

that time to make myself fit for that work. Since 1900 I have spent every hour of the twenty-four thinking of public health. I have, and the other public health men have done that kind of work; we think of public health day and night. A man one time questioned my right to say anything about a water system in a certain city. I said: "I have been at this thing now something like ten years. I have done all the work; at least, I have studied the water question as a bacteriologist and as a chemist; I have done it experimentally. I have seen all the water purification plants of this country and the United States. I have checked all my work bacteriologically and experimentally. I know intimately what they are doing. I have studied the physics of water filtration; I have studied the results of water filtration, and at the same time I have been studying why these filters and so on were necessary, and at the end of ten years of intensive study of that kind I think I have some right to a personal opinion on this subject. I think I am better qualified to speak on it than a man who has been doing work in medicine in other directions and has never been thinking about these questions." I give that as an example simply to show that public health men have gone out specializing in certain lines and you will excuse that personal, perhaps selfish note that I have sounded. But this you must realize, that we are doing a specialized line of work, and the men who are doing that work effectively have had to have a special kind of knowledge, and we have some right to our opinions. Sometimes we meet opposition in our endeavour to try and have things improved. Consider always that the public health men probably have some reason for the statements they make and the things they are advocating.

Public health men come more intimately into contact with the public; we have somewhat got away from the ordinary work of the medical profession. We are in the public's confidence and they are in ours, and we have points of view that the medical profession would do well to bear in mind, and reasons for the things we are advocating. I am not going to touch on that any further.

Certain developments have taken place. Sometimes we meet with opposition that we feel aggrieved at, particularly when we think of what the profession has done, and when we think we have sufficient basis for what we want to do. As to the great bulk of the profession, we know their heart is absolutely true. When you criticize, try and see our point of view.

There are certain points I have been put down on the programme to speak about this morning—health surveys and the public health nurses. We have got to the stage where we want to appraise and find out exactly what we have to do. We want to know the enemy we have to fight, and what are the possibilities of his putting up a real fight against us. Provincial bodies—of course, we have no right to step into any province except they ask our advice—have established what we know as health surveys. In the province of Quebec at the present time, in the City of Three Rivers, such a survey is being held by men skilled in their work. The object of that survey in the city of Three Rivers is to find out how much tuberculosis there is actually present there. Why is it there is such a large child mortality in that place? Why, if we can clear it up there, and make a demonstration in that one place, the knowledge that will be gathered there will be used in other places. The province has put into that place, with the help of the Anti-Tuberculosis League of Canada, officers who are specialists in tuberculosis and child diseases, and they are inviting the public to come and have themselves and their children examined. That is reaching people who did not get to the medical profession at all. The aim of the survey is not to treat the people. It is to find out whether they are sick, and if they are sick the officers send these people to the local doctors to be treated. They are attempting to make an examination of these people to find out just what should be done, and to wake up the public to the fact that there is an evil there that needs to be corrected. Public health men know just how much exists, but there must be a demonstration. Now they ask for the co-operation of the medical profession. I know that in some quarters this method is questioned. But it can be carried on without friction. It does no harm to the medical profession. These people are sick, and when they are found to be sick, they are treated by the local medical men. There cannot be any harm in that. We have to use public health nurses. The public health nurse has come to stay. It is not possible in the present state of things to employ full-time medical men for all the work that we need done in examining school children, and so on. We pick the most skilled ones we can get, and the ones we can get with the greatest economy, and we are using the nurses who have had experience with the people close at hand, and who have their own peculiar ways of getting information and gaining the confidence of the people. The public health nurse is developed to do that work, and is being used in the public health service to get where nobody else could get. They can get information about the people and win their confidence in a way that no one else could. They go into the families and find out what really is wrong. Often there are conditions that could very well be corrected if the people only knew, and the public health nurse is the one who can go and find that out. There is an endeavour always, and this is always at the back of the mind of the public health authorities, when they find out what is wrong to direct those who are sick to those who have the skill to treat them for their ills. In no place is the public health nurse taking the place of the physician. The nurses are directed in every well organized public health service to send the people who are sick to those who can treat them and look after them. Many laymen's associations want us to go further. The public health service is the buffer between you and the

public, and it is through the public health nurse that this work can be done. The public health nurse has come to stay; the health survey has come to stay; the public has demanded it, and you cannot get away from it. So co-operate with us to the best of your ability, and try and find out just what the object is, and do not obstruct it. When I say, do not obstruct it, I mean use your influence to keep those who do obstruct from doing so. Encourage us as much as you can. It is for the benefit of the public, and you can do it. I know that before this meeting is over there will be criticism of the public health service on both these grounds. We leave the matter until the criticism is made, and the situation can be clarified then. I know that the great heart of the medical profession is right, and is behind this movement, but there are those who are in opposition and criticize this method of dealing with sickness among the public and this attempt to discover their ills, but I think the criticism has come because of a lack of knowledge of what actually is taking place. The general profession knows, and it is for the general profession, for you gentlemen to try and smooth out that little opposition. Thank you.

The CHAIRMAN: I nominate the following gentlemen to the Programme Committee:—

Dr. A. Bazin,
Dr. J. F. Irving,
Dr. S. L. Walker,
Dr. G. R. Johnson,
Dr. H. W. Hill,
Dr. J. H. McDermot.
Dr. Glen Hamilton,

I nominate the following gentlemen to the Resolutions Committee:—

Dr. J. C. Connell,
Dr. W. A. Gardner,
Dr. W. H. Hattie,
Dr. MacG. Young,
Dr. G. G. Melvin,
Dr. J. J. Ower,
Dr. L. P. Normand,
Dr. L. D. Carder.
Dr. R. T. Noble,

Dr. ROUTLEY: It has been suggested from the floor that every member should rise in turn and announce his name and where he comes from, so that we may become better acquainted.

The CHAIRMAN: It is just an illustration of what I said before. We come from such a vast country that some of us are perhaps meeting one another here for the first time. I think there would be a certain advantage in doing as the secretary suggests.

A MEMBER: I was going to suggest that the roll be called this afternoon, not simply of individuals, but of the organizations as well, who are represented here. Those who are representing them could stand and give their names and say what body they were representing.

The CHAIRMAN: Then if there is no objection, the roll will be called this afternoon. If there is no further business we will now adjourn.

THURSDAY AFTERNOON SITTING

The Conference resumed at 2 p.m., with Dr. Primrose in the chair.

The CHAIRMAN: In order to keep the proceedings regular I propose to conduct the meeting under parliamentary rules unless any member of the conference wishes to move otherwise. Before proceeding with the programme I would ask if there is anyone who would wish to discuss the address that has been given by Dr. Amyot. If there is no discussion of that paper I would request Dr. Bazin, the chairman of the Programme Committee, to present his report.

Dr. A. BAZIN (Montreal): The Programme Committee desires to report as follows:

Any members of the conference desiring to submit papers which are not perhaps cognate to the papers already down on the programme are requested to communicate early with myself, the chairman of the Programme Committee, so that the committee will have an opportunity of placing his paper.

It has been decided that the rules governing the discussion should include a time limit of twenty minutes for papers, five minutes discussion by any individual, and ten minutes for reply.

On Friday forenoon a paper will be added to the programme, if time permits, "Maternal Mortality" by Dr. Helen MacMurchy, and on Friday afternoon a paper on "The Purity of Drugs," by Dr. V. E. Henderson.

The committee has considered the advisability of cutting short this conference in order to permit certain members getting away on Friday evening who are specially desirous of reaching home before Christmas Day. The committee feel, although they would like to meet the individual views of these members, that this conference has been arranged at a very considerable sacrifice of energy and time; we are all here at a considerable sacrifice of time, and it has been announced that this conference is to be a three-day conference. We have also plenty to occupy us during these three days and we therefore feel it would be inadvisable to, as it were, break faith with the majority of those present by in any way transposing the programme as printed, or by shortening the duration of the conference. I move the adoption of the report.

The report was adopted.

The CHAIRMAN: The first paper this afternoon is "Medical Licensure," By Dr. Jas. MacCallum, of Toronto.

MEDICAL LICENSURE

Dr. MACCALLUM (Toronto): Too often it is assumed that medical licensure is for the protection and benefit of the practitioners of medicine. Nothing can be farther from the fact. Protection of the profession is not the purpose of licensure—it is a result. Protection of the public is the real object of licensure. To discuss licensure on any other basis is not merely futile—but dangerous—dangerous both to the public and to the profession.

Medical licensure is a function of the individual province, not of the Dominion. Each province has, for administrative purposes, confided this function to some body, educational or professional. The action of the administrative body requires the consent or confirmation of the province, and may—and often does—come under its scrutiny, criticism and even revision.

In every province the governing body—the College of Physicians and Surgeons, commonly known as the Medical Council—has set forth certain requirements for the acquiring of a medical license: A. Preliminary education; B. A course of instruction, (i) in certain subjects, (ii) for a certain number of years; C. Passing of certain examinations.

A. As to Preliminary Education

It should not be forgotten that, by the British North America Act, education is a matter solely under provincial control—the Dominion has nothing to do with it. Those of us who have had experience in the Medical Council of Canada have learned that some of the provinces are very jealous indeed of their provincial rights, and that uniformity as to preliminary medical education is not the simple matter it may appear. Educational ideals are different in the several provinces. That one ideal is better or more desirable than another I leave you to decide.

The provinces do not even approximate uniformity in their matriculation requirements. The announcements of the several

provincial councils reveal a wide difference in the matriculations, dependent upon educational ideals, or upon the equipment of the primary schools. This difference is not to be wondered at, for education is not compulsory in all of the provinces. In some it is a matter of comparatively recent enactment. Because of this there must be a difference in the educational requirements of the public schools, and of the high schools—this in turn necessitates differences in matriculation. These differences are not irreconcilable. Time will probably bring an equality of preliminary education. If it is thought wise to discuss the requirements of preliminary education I would suggest that the minimum requirement that will enable a student to grasp the subject of medicine engage our attention. We can, without coming into conflict with educationalists, discuss the second requirement which is purely professional.

The second requirement is ***B. Courses of Instruction***, (*a*) for a given number of years, (*b*) in certain medical subjects.

There would seem to be but little difficulty in coming to an absolute uniformity of standard and yet there are serious variations. One practical difficulty is that the councils are not teaching bodies. Instruction is given, not by the Medical Councils, but by the universities which are independent of the councils, and each of which has ideas and ideals of its own—ideas and ideals which in the very nature of things must change more quickly than those of the Medical Councils, and which are not uninfluenced by financial and local conditions and even by political considerations.

The western provinces—Manitoba, Alberta and Saskatchewan—form a group which has recognized the value of the practical association of the licensing and the teaching functions and has confided the curriculum and examinations to the provincial universities. Other provinces have no provincial universities or have so many universities that it has been impossible to confide the examinations and curriculum to any one university, so that the Medical Council has been forced to keep these matters under its own control.

Number of Years

The number of years of professional studies demanded varies from five years of six months to six years of eight months of teaching. In other words, some provinces demand a course half as long again as others.

One province demands two years of pre-medical study followed by five years professional study. Other provinces do not demand any pre-medical study. The tendency of the universities is increasingly to demand the pre-medical years. This demand no doubt arises from dissatisfaction with preliminary education and from a knowledge that an adequate medical education requires an increasingly broad foundation of general education.

Medical Subjects Demanded

The provinces are at one as to the subjects regarded as essential, viz, anatomy, practical anatomy, chemistry, practical chemistry, physiology, materia medica and therapeutics, surgery, clinical surgery, medicine, clinical medicine, obstetrics, diseases of women and children, medical jurisprudence, hygiene and pathology.

How great a variation may exist is shown by the fact that in the syllabus of some of the provincial councils there is wanting one or more of such subjects as chemistry, physics, histology, embryology, pharmacy, toxicology, bacteriology, ophthalmology, diseases of the ear, nose and throat, psychology, psychiatry.

The requirements in practical subjects exhibit a like variation, especially in obstetrics and hospital attendance.

As to Obstetrics.

Some councils ignore all practical experience in this subject. Others demand ten or even twenty cases, and one demands in addition to ten cases eight months practice in a lying-in hospital.

In the Matter of Hospital Attendance.

The requirements vary from nothing to three years. The regulations reveal striking differences as to how many beds a hospital needs in order to afford proper and sufficient clinical opportunities. One province is satisfied with twelve months at a general hospital of fifty beds under the charge of not less than two qualified practitioners. Another demands eighteen months in a hospital of one hundred and fifty beds under charge of not less than four practitioners of whom two must be surgeons. Twenty-four months in an incorporated general hospital is the requirement of one, three years of another. One province demands not merely a certificate of hospital attendance, but goes a step further and requires six months service as an interne. This interne requirement is a dead letter, but so confident is that province of the necessity

of an interneship that it now proposes to demand it for one year.

C. In Examinations

At least four plans exist.

1. The provincial university conducts the examinations for the councils, or gives a certificate of university examination, which presented to the council, ensures registration.

2. The provincial council accepts the university examination in the primary subjects, but itself conducts the final examination for license.

3. Council conducts both primary and final examinations.

4. Council conducts examination at the end of each year with the aid of assessors. The percentage necessary to be obtained is in no case less than 50 per cent and goes up to 60 per cent.

From this analysis of the requirements and procedure of the various councils it appears that some provincial councils are too lax, or others are too severe in their requirements for licensure; or the needs of the various provinces differ, or the council has not given sufficient consideration to the question of what is needed by the practitioner who must possess at least "usual and reasonable skill."

If licensure is for the protection of the public, surely the people of one province have the right to protection of the same grade as those of another.

In this lies the argument for standardization of requirements for medical licensure.

You must consider the question whether standardization or uniformity is desirable. If desirable, is it feasible? If feasible, how is it to be accomplished? Is it to come from within each province or is it to come from without? What standard is desirable?

The problem has already been attacked from one standpoint—not the standpoint of uniformity of preliminary education, medical education, hospital and laboratory instruction, but of examination. Whether this is the most desirable way, whether it is grasping the shadow and losing the substance may be a moot question, but it seemed the only feasible way, and resulted in the Medical Council of Canada. The Medical Council of Canada was made possible only by the bold step of ignoring all questions of preliminary education, of medical education in all its details, and insisting only on a standard of examination. This is the strength of the Medical Council of Canada, and its weakness.

One must not lose sight of the fact that the license of the Medical Council of Canada exists only by the grace of the provincial councils which accept it without any question of curriculum, mutual reciprocity or standard—a courtesy which they deny to their sister provinces, of whom they demand both mutual reciprocity and an equality of standard and curriculum. As has already been said, by the British North America Act, education is a matter strictly within the jurisdiction of the individual provinces, so that standardization of medical education is a matter for individual action of each of the nine provinces.

Because of the British North America Act, the Medical Council of Canada is limited to examination in professional subjects only. The Canada Medical Act says that its "standard of examination shall not be lower than the highest for the like purpose (registration) in any province." So far no question has arisen as to the construction to be put upon the word "standard"—but what does it mean?—Is it percentage of examination marks, or character and number of professional subjects, or quality of the examination?

Sooner or later this question must arise. In Ontario, men rejected at the provincial examination have one week later procured the license of the Medical Council of Canada, and demanded registration in Ontario. Nova Scotia has provided for such cases (p. 11, paragraph 5) by enacting "no candidate shall be admissible to examination who has been rejected in the subjects of the examination by this or any other licensing board within the three preceding months."

In the working of the Canada Medical Act, the greatest source of trouble has been section 12 (*a*). "No candidate shall be eligible for any examination prescribed by the Council, unless he is the holder of a provincial license, or"—and I draw your attention to the word *or*—"unless he presents a certificate from the registrar of his own provincial Medical Council

that he holds a medical degree accepted and approved of by the Medical Council of the said province."

There are here two practical difficulties. Some of the provincial councils do not hold their examinations until after the date of that of the Medical Council of Canada. The results of the university examinations are often not known in time for the provincial council to give the enabling certificate. The difficulty has been met by the Councils giving a certificate that the candidate is eligible to take their examination and later forwarding a certificate of the medical degree having been obtained.

If the Medical Council of Canada were to postpone its examination until the results of the university and provincial council examinations are announced, it would not have any candidates, as the students at once scatter to their homes, rather than be put to the expense of waiting the announcement of results and then writing on another examination.

Quebec alone of the provinces has seen fit not to acquiesce in this modus vivendi, and refuses to give an enabling certificate unless the candidate has passed the provincial examination for license and has a medical degree, and has satisfied all the preliminary requirements for license.

Another difficulty is what construction is to be put on the words "his own provincial Medical Council." Is it the province in which his home is, that in which he matriculated, that in which he has pursued his medical studies, or that in which he intends to practise. A candidate may be a student of medicine *in* a given province and yet not be *of* that province.

It is not for the Medical Council of Canada to put an interpretation on these words; it leaves that to the provinces and accepts without question the enabling certificate of any province. This enabling certificate clause holds within it practically the same danger as will be pointed out in connection with British reciprocity. The student naturally seeks the line of least resistance and will present an enabling certificate from the province whose requirements are the least stringent. And there will spring up a money order business in enabling certificates.

Another problem productive of serious complications is that of British reciprocity. Since the onset of the Great War every province, with the exception of British Columbia, has had reciprocity with the General Council of Medical Education of Great Britain.

Provincial licentiates avoid the examination of the Medical Council of Canada. They send to Great Britain their certificate of provincial registration together with a fee, obtain British registration thus, and then register in any province. It is a real money order business in registration certificates, and is resented by many of the provinces. It works out practically as interprovincial registration without any equality of standard of preliminary education or of medical education. To close this back door Saskatchewan has had its Medical Act changed so that it grants registration only to those registered by passing the examinations of the General Medical Council of Great Britain. As the General Medical Council does not hold any examinations Saskatchewan has closed the door on the whole British register.

New Brunswick has sought to protect the Medical Council of Canada, by demanding proof of a bona fide residence in Great Britain from those possessed of a certificate of British registration.

The result—a result not foreseen—is that a graduate from Saskatchewan or New Brunswick can, through British registration enter any other province of Canada but graduates from the other provinces cannot register in Saskatchewan or New Brunswick.

The Medical Council of Canada has sought reciprocity with the General Council of Medical Education of Great Britain. The latter has done its best to bring this about, but has failed. Not merely has it failed—it has caused Saskatchewan, New Brunswick, and I believe, Manitoba to give up reciprocity. British Columbia has not had it for years.

Interprovincial reciprocity by the medium of the General Council of Medical Education of Great Britain is impossible so long as provincial pride exists, and there is any disparity in the requirements for medical licensure. Comparison and criticism of standards are inevitable and will always be heard, yet I do not despair of equality of preliminary and professional requirements being attained. Equality is not necessarily uniformity. Equality once attained, there can be no possible objection to interprovincial reciprocity, British reciprocity being given up entirely, and the provinces agreeing to accept the license of the Canada Medical Council.

This brief resumé of the requirements for licensure reveals a state of chaos which this conference may help to reduce to at least a semblance of order.

The CHAIRMAN: This address by Dr. MacCallum gives us food for thought. I fancy we all agree in the principle, that it would be exceedingly desirable, if possible, to come to some uniform standard of education in the various provinces of Canada. This subject will be up for discussion, and I hope the members of the conference will think over it and see if it is not possible for this conference to do what I, and I think all of us, would consider a splendid piece of work, that we should bring the provinces together in some way to consider this question and, if possible, solve the problem along what seem to be ideal and reasonable lines. However, I do not propose to say anything further on that point. I will now call on Dr. Glen Hamilton, of Winnipeg.

LICENSE INSPECTORS

Dr. HAMILTON: The subject that I have to present to you very briefly is one to which I am sure a great many of you, if not all of you, have given considerable study.

One of the greatest difficulties in the way of making certain and secure the aim and purpose of medical licensure is that of protecting the public against the presuming irregular. Our universities may efficiently educate, and our colleges license, but these do not and cannot protect an unsuspecting people, for whom the title "Doctor" or practitioner is a sufficient and satisfying guarantee of ability to treat.

All will agree with the opinion that much of our trouble with the irregular practitioner is due to the fact of there being no official whose duty it is to check up the licenses of those who practise medicine or any form of healing.

It is a matter of history that the medical Acts were passed in order to protect the public by licensing only those known to be scientifically trained and efficient. The feature of the Acts which assures to the public a properly qualified licensee is a valuable safeguard, but there is no safeguard which assures to the public that only those presuming to practise are so licensed.

A casual glance over the field of licensing in its application to many activities in our provincial, municipal and civic affairs shows that wherever license is issued, whether for the safeguarding of the public, the raising of revenue, or for any other purpose, there is in each case with the exception of the medical license, a close scrutiny of those so licensed; moreover the party, group or department most concerned in the license is the one usually assigned the duty of supervising such licenses. As medical licensure is on behalf of the public, the safeguarding of the public interest should be done by an officer acting on behalf of the public.

In provincial affairs, such as the automobile, the license is issued for two prime reasons, namely, revenue, and safety. The collection of money and issue of renewal license is smartly looked after by the provincial departments concerned with revenue and police order. In licenses issued by the city, revenue and tabulation of police information are reasons considered sufficient for a strict control. Here, too, the collection of the fee and the issue of the license annually are closely checked by a special official or department concerned. In the matter of a medical license, the prime reason for the issue of the same is educational efficiency in the interests of the public safety. The educational feature is guaranteed by the College of Physicians and Surgeons co-operating with the university—but what about the public safety? Why is there no annual check up of those practising medicine or healing of any kind, as there is of those who drive automobiles, or perform other activities in which the public safety is concerned?

When the College of Physicians and Surgeons Council has satisfied itself as to the educational equipment of an applicant, it issues license to practise. When the College of Physicians and Surgeons finds it necessary to exercise disciplinary power over those whom it has licensed, it is acting in accord with the clear intention of the Act; but the College of Physicians and Surgeons Council clearly cannot be called upon to exercise disciplinary effort upon all and sundry of the quacks and fakirs attempting to delude the public in the matter of treating disease. Surely here the question of public safety lies much nearer the Police Department of the Attorney General, and in the interests of public safety should be the particular charge of that department. A special officer appointed to scrutinize licenses of those who practise medicine or any form of healing would put an end to very many impositions perpetrated upon the public for many years with no authority to call them in question. It is true when the acts of these irregulars become the concern of the criminal authorities, the Attorney General's Department interposes, although its activities are exercised from the standpoint of criminality rather than from the standpoint as to whether the party under suspicion may or may not have been guilty of fraud upon the public in an unlicensed presumption.

In conclusion I would suggest, that in the interests of the public safety, the Attorney General's Department of each province should appoint officers to see that only those licensed to do so are permitted to practise medicine or any form of healing. The scrutiny of licenses could be readily assigned as a duty on officials already appointed and without extra expense.

The CHAIRMAN: Dr. Hamilton has brought up a very interesting point. The whole subject, including the paper by Dr. MacCallum and the paper which has just been read by Dr. Hamilton, is now open for discussion.

Dr. R. S. THORNTON (Dominion Medical Council): I rise for the purpose of supplementing in one or two points the statement which has been submitted by Dr. MacCallum.

Our Medical Council has been created since the 7th of November, 1912. It came into existence as a result of the final revision of the Act made in 1911, following a meeting of the Canadian Medical Association in Winnipeg in that year at which a resolution was passed asking Dr. Roddick to continue his efforts to get the law enacted. The reason why I go back into that little point of history is to point out that when the matter was under discussion in Winnipeg in 1911 at that meeting of the Canadian Medical Association, there was not at that time a Canadian medical man. We were provincial physicians only. There was no such individual as a Canadian Physician, meaning by that a man who had a standing which was nation-wide, and which would be recognized from the Atlantic to the Pacific. While we met as a Canadian Medical Association, there was not a Canadian medical man a member of that association. To-day there are 1,300 men with the Canadian license, one third of whom have obtained their Dominion diploma by reason of their ten years' standing, and the other two thirds by reason of taking the examination.

The point which was stressed at that time in the creation of the Dominion Council is still a point which I think we want to stress at this conference, namely, that of a national status for the practising physician. By that I do not mean that the Dominion Council should supersede or should in any way transgress upon the rights of the provincial Medical Councils, but that all of us as medical men, in the provincial Medical Councils, in the Dominion Council, and in the associations, should continually aim not merely for the point of co-ordination which we have been considering, but we should bear in mind that what we want to establish is a national standard of medical practice, and in whatever discussion may take place I would like to have that viewpoint in the minds of this conference.

There have been many little difficulties in carrying the Act into effect, and various questions arise at times between the Dominion Council on the one hand, and the provincial councils on the other, or, as it might happen, between provincial councils. But these have been overcome. Remember that our council was just being established when the war came. The war threw us out of four or five years of growth right at the very time when we were getting into our stride. So we would probably have had a much larger number than 1300 at the present time if it had not been for the war. We have ironed out these little difficulties that have arisen with us, but you will observe that it is not for the Dominion Council in any way to propagate its desires or wishes among the provincial councils. It would not be a proper thing to do, in the first instance; it would very naturally and rightly be resented in the second. So the Dominion Council has to wait for the removal of some of these difficulties, but any suggestions which are made from any outside body such as this conference in the way of recommendations to provincial councils, the Dominion Council would then be in a position to secure certain things being done which the provincial council might not be able to undertake.

Just one other point in conclusion. The province of British Columbia has accepted absolutely and entirely as the sole standard for qualification in that province the certificate of the Medical Council of Canada. They have no reciprocity with Great Britain; they have no reciprocity degrees of their own. A few years ago they surrendered their provincial examination, and accepted in place of it the license of the Medical Council of Canada, and that is the only way a man can go into the province of British Columbia and practise there to-day. An agreement has been made whereby the fee is divided to the mutual benefit of the Dominion and Provincial Councils, and to the benefit of the physician who takes the examination and saves $50 in the process. Is it possible that this conference might be able to help out an extension of this process of co-operation? As I say, the Dominion Medical Council cannot say to any province that they give up their examinations. There are local conditions too, which may make it difficult for them to be able to do that, but bit by bit, if each province could attain to the position of British Columbia, then you would have one standard from one end of the country to the other, and you would have established a national status for the practising physician in Canada.

The CHAIRMAN: We should like to hear from some members of the provincial councils who know the difficulties in their respective provinces. It is a very broad question, and I hope that this discussion will go on, and that everyone will express his mind freely and without any restraint. We want to know exactly what the objections are, and what support

may be given.

Dr. A. BAZIN (Montreal): If it is permissible I should like to read a letter from Dr. F. W. Marlow, who was detained by illness from attending this conference. He is chairman of the Committee of the Canadian Medical Association which has been studying for three or four years the question of higher degrees in Canada. No conclusion has been arrived at as yet by the committee, but a great deal of study has been given to the question. Dr. Marlow sends this communication:—

TORONTO, December 17, 1924.

Briefly, may I state, that after studying the matter of a college I have concluded as follows:—

1. Majority of opinion throughout Canada is in favour of the ultimate establishment of a college.

2. Its establishment would stimulate post-graduate work, by providing possible recognition in Fellowship diplomas. The qualification of specialists would, in a measure, conform to its requirements. The general standard of medical and surgical practice would be elevated.

3. It would provide something distinctly Canadian for Canadians, and would soon be accorded due recognition throughout Canada and abroad.

4. An affiliation with the Royal College of England and London might be arranged.

5. No new organization is considered desirable or necessary.

6. If ultimately formed it should be in connection with the already existing Dominion-wide licensing body, Canadian Medical Council, which body, in the face of great difficulties, surmounted various obstacles as between the Dominion and its provinces.

7. It can only come as a matter of evolution. The process requires:—

(*a*) Abolition of provincial licensing examinations.
(*b*) One licensing body for Canada, namely, the Canadian Medical Council.
(*c*) License of Canadian Medical Council to be recognized in all the provinces.
(*d*) Intimate working relations between Provincial Medical Associations and Provincial Medical Councils.
(*e*) Intimate working relations between the Canadian Medical Association and the Canadian Medical Council.
(*f*) A united Canadian Medical Association and a general demand for a college.
(*g*) Canadian Medical Council to become the College of Physicians and Surgeons of Canada. Licentiates to become members.
(*h*) Establishment of Fellowship diplomas, with admission to Fellowship by examination only, except as provided for the admission to honorary Fellowship.
(*i*) Legislation covering (*g*) and (*h*).
(*j*) Selection of outstanding physicians and surgeons to conduct Fellowship examinations, until such time as there are sufficient Fellows in the college to do this work.

These conclusions are hastily put down and follow the line of my verbal report at the Ottawa meeting.

It would appear to me, that, an expression of opinion from the conference would be valuable, so that the committee may have some guidance in respect of further activity.

The CHAIRMAN: Was any action taken at that meeting by resolution or otherwise?

Dr. ROUTLEY: Yes. The annual meeting referred the matter to this conference, and Dr. Marlow, who was to be here but is ill, sends that communication on as chairman of the committee.

The CHAIRMAN: You have heard, the purport of the communication from Dr. Marlow, which has been sent on by him as chairman of that committee to this conference. It implies much of the argument already put forward as to the Dominion Medical Council controlling examinations for the entire country.

Dr. H. W. HILL (London): I am not intending to discuss licensure, but I wish to offer one bit of information to the conference which may be of some importance in the future.

Dr. MacCallum referred to the discrepancies in the requirements of the various councils of the various provinces. The universities conference has a Medical Section, which has taken up the question of discrepancies in the curriculum of the various universities, and reports have come in from nearly all the universities. I have the misfortune to be the secretary of that section and to have tabulated the results. They are quite interesting. I cannot report them here, but to illustrate just one point alone, and it is a very important subject, the school which gives the most gives three times the number of hours as the school which gives the least. I would lay before the conference the fact that this report will come out at the next universities conference, and it ought to contribute to the subject of medical education so far as showing what the actual status in Canada is.

Dr. G. R. Cruikshank (Windsor): As a member of the Ontario Medical Council I wish to state that anything that I say is not the voice of the council, but my own voice. Naturally we cannot say that we bind our councils, but this is a very important matter, and I am sure the Ontario Medical Council is willing to do anything reasonable, and if the universities will get together and submit something to us that is reasonable it will certainty receive our approval. We are here to protect the public, and all we ask is a reasonable knowledge of medical matters. A university may be idealistic and go much further than we do. In times past the Ontario Medical Council has done its best to raise some of the universities up to the general level, but in the last year or two the universities have taken such a spurt, that we do not need any longer to spur them along, but rather wait.

I was going to hold back a resolution I have here till later because five minutes is all I have and something may crop up later on which I want to speak, but I think it may clarify the issue if I present it now. I would move that the paper of Dr. MacCallum be referred to a committee composed of representatives from the various councils and the universities, with power to add to their number, for consideration. I think probably if we have a committee of this kind it can take Dr. MacCallum's address up clause by clause and have a report to submit that would be a step in the right direction.

The Chairman: Do you propose that they should submit a report at a future sitting of the present conference?

Dr. Cruikshank: I move that the address of Dr. MacCallum be referred to a committee composed of representatives of the universities and of the councils for consideration, and to report to-morrow to this meeting.

The Chairman: One thing occurs to me in connection with that. We are unfortunate in not having representatives from the provincial councils of the eastern provinces; there is no one here from Prince Edward Island, New Brunswick or Nova Scotia, who is a member of the Provincial Licensing Board. No one has responded to the roll call as officially representing those bodies. If Dr. Cruikshank would be good enough to write out his resolution, I can put it to the meeting later. In the meantime we can refer it to the Resolutions Committee, of which Dr. Connell is chairman. I am sure there is not a member present here who has not some very definite ideas on the subject before us, and before we get through I shall not be at all surprised if every individual in this room wishes to get on his feet and express his opinion. I hope there will be no time lost.

Dr. A. MacG. Young (Saskatoon): I wish to congratulate Dr. MacCallum on the paper he has just given us. We believe the subject which he has introduced is of very great importance. He made one reference to Saskatchewan regarding our relations with Great Britain which perhaps requires an explanation.

At the last meeting of the legislature, we had inserted in our Act the words, "after examination by said council." That is referring to the Medical Council of Great Britain. We were quite of the opinion that they did not conduct an examination, but had certain assessors or inspectors, and we said that so far as we were concerned we would accept that as coming within the meaning of our Act. In other words we did not exclude British practitioners from reciprocity, but we were not in favour of this method of interprovincial registration. That is the situation.

In Saskatchewan we are very much in favour of one portal of entry into the practice of medicine in Canada, and all we have done at any time has been along that line. I might state that we were the first in Canada who voluntarily did not hold provincial examinations. Then certain difficulties arose with regard to drugless practitioners, and a commission was appointed to inquire into the whole question. As a result of the investigation by that commission, the matter of holding examinations was turned over to the university. Again a means was opened up whereby provincial examinations would be held. At the last session of the legislature there was inserted in the Act these words, "or if deemed advisable may accept the examiners of the Medical Council of Canada appointed for a similar purpose." That means that if the university desires, it may accept the appointment of the Medical Council of Canada examiners. So we have left open the door again whereby this may become the sole portal of entry.

We believe absolutely in a national system of examination in Canada. Registration or license must be left to each province, but we believe the proper ideal is to have Canadian practitioners, rather than provincial practitioners, and our whole effort has been towards that end, and we will heartily support anything which will have for its effect the bringing of that into being.

The Chairman: As this discussion goes on it is getting more interesting. We have heard from Dr. Young as Registrar of the Council, and he has shown that so far as Saskatchewan is concerned there seems to be a sentiment in favour of some general standard for the whole Dominion. Whether or not that is to be the final opinion of this conference is left to be

seen, and therefore we will welcome any direct criticism or any antagonism against that idea. You have already heard my sentiments from the chair, and I would like to hear the opposite side, because we should all approach this question with an open mind. I think if the Registrars of any other councils would give us some technical points it might be of value. I see Dr. Aikens, of the Ontario Medical Council. Perhaps he might say something to us. It has been suggested to the chair that I should proceed in this way.

Dr. H. W. Aikens (Toronto): Five minutes, five hours, or five months would not suffice to enable me to compass the whole situation so far as licensure is concerned. If there are any difficulties in connection with matriculation or enabling certificates that we have not met with in our office already which call for solution, then I would say I would acquiesce in what Shakespeare says: "There are more things in heaven and earth than are dreamt of in our philosophy." We have had all sorts of difficulties, and we are at a loss from day to day to know how to proceed—difficulties which concern our council, concern other councils, concern the Canadian Medical Council, concern the British Council, and chiefly relating to the circumstances under which we should be free to give a qualifying or enabling certificate to those who come to us for them. It is a little difficult without specifying to indicate what our troubles are.

Matriculation we must handle as something which concerns not ourselves alone but other provinces, other countries under the British flag, and foreign countries, and we sometimes feel that it might be a wise thing to divide all those who come to us for the purpose of getting standing into two classes: those who will be allowed to matriculate with us, and those who will not. Those who will be allowed to matriculate with us will be naturally those who belong to our own province and have met all our requirements. To those who belong to other provinces and to foreign states we would say: "We will let you present your certificates for matriculation at the time you go up for final examination before us or before the Canada Medical, and we will say whether they are acceptable. If they are not acceptable, we will not give you a certificate. If you have not a certificate you cannot demand of us an enabling certificate; you will have to go to your own province for it." In that way we would meet a good deal of adverse criticism directed against our council on the ground that it has issued enabling certificates which should have been issued by other councils; but there are circumstances under which it is absolutely impossible to refuse students who come to our office on the last day before the one on which they must send in their certificate to the Canada Medical at Ottawa, and who say, "I come from a far distant province and want an enabling certificate." We say, "No, go to your own province." "I cannot do it," he says, "it is too far away and I am too late." Although we do not do so, we feel disposed to say, "Why did not your university five or six years ago advise you of the fact that at the end of your course you would have to have such a certificate, and prepare you in that way to obtain it at that time." We have been more than accommodating; we have been absolutely gracious with a great many to whom we felt we should not issue such certificates. But we are being pressed by our own graduates and our own licentiates, who say it is not fair to allow what is going on to continue any longer, that students should not be permitted, for instance, to go up for our Ontario matriculation examination and pass in seven subjects and fail in five, and then go to some neighbouring province and pass three or four more papers with the university of that province, and then come back to Ontario and ask to be allowed to go up for examination at the same time that a man who has passed all his twelve papers set by the Ontario Educational Department.

These are the difficulties we encounter every day, and personally I should be delighted to think that someone here had enough grey matter to tell us a solution of the problem, if for no other reason than to relieve us of the responsibility of meeting these unfortunate students whom we have to try and oblige, when we desire at the same time to play the game.

Dr. R. H. Arthur (Sudbury): I think probably we are all agreed on one thing, that is, that the ideal method of licensure in the Dominion would be to have but one examination, and that in the hands of some body that has power to govern the entrance to the medical profession throughout the whole Dominion.

Unfortunately, I think, at the time of Confederation the whole field of education was given to the provinces, each one to do as it saw fit, and that has probably been the great stumbling block in the matter of, I won't say medical education, but medical licensure. When the Dominion Medical Council was born, it was born with handicap; that is, they were only there on sufferance, and any province that did not choose to come in did not have to. I believe eventually they are all in now, but at the same time it does not give it the air of finality and power that I have always felt it should have, and it has always seemed to me, and I make the suggestion with great deference, not claiming any grey matter at all, that if the Medical Council of every province would signify their willingness to forego their examinations and place them in the hands of the Dominion Council, provided the Dominion Council would get legislation that would give them power to control the whole matter of entrance to the medical profession by examination, the present difficulties would be overcome. While the provinces have control of the matter of education, it does seem to me without any quibbling that it

does not necessarily follow they have control of the matter of examination, and if every one of the Medical Councils of the various provinces would signify not only their willingness but their desire for some such legislation along this line, in the form of an amendment to the British North America Act, that this power to control examinations, not necessarily education, but to control the examinations for the whole Dominion, should be got. If so, it would do away with the overlapping that now exists. It would make one standard throughout the country and we would then be one step further towards being a nation.

While these are my personal views, the body which I represent here I am satisfied at the present time would not under existing circumstances vote to forego their licensing power, but if they felt there was a finality to it I think they would agree.

Dr. L. D. Carder (Vancouver): Speaking on behalf of British Columbia, we have felt very keenly that there should be one licensing body for the Dominion of Canada. We, I think, were the first to delegate our examining powers to that central body absolutely. We hold no examinations; we delegate that to the Dominion Council, and we find it works very well. We have no reason to be dissatisfied with it, and we do not see any particular objection to the other provinces doing the same thing. We think we made a real sacrifice in doing that, because we do not have any twenty-five below zero weather out in British Columbia, and I never heard of anybody leaving British Columbia to practise in any other province, while others do leave other provinces to practise in British Columbia.

Dr. W. H. Hattie (Halifax): I certainly cannot speak in an official capacity at all. I am not a member of the Provincial Medical Board, but I am in such relationship to that board that I have some idea at any rate as to the attitude which the board takes on the proposal that the Medical Council should constitute a single portal of entry. As you may know, sir, Nova Scotia has not gained anything through uniting with the other provinces in Confederation, and we have learned to be very conservative there; we are not anxious to lose anything more than we have lost.

As far as our council in Nova Scotia is concerned we feel that the Provincial Medical Board is very fair and has, I think, a very good control of the situation. There is some dissatisfaction, but it is not very marked. I think I am giving you the attitude of the Board when I say they would hesitate very much indeed to depart from a procedure which has been satisfactory, in favour of another method which might not prove to be so satisfactory. As it is, the board has practically absolute control. We are very differently situated in that respect from the province of Saskatchewan. Dr. Young has told you that there the examinations are held by the university. With us the examinations are controlled absolutely by the board. We are possibly a little too meticulous about requirements. I know it has happened on several occasions that men whom we would not accept have been accepted by other provinces, and they have ultimately been able to get registration in Nova Scotia, either through the Medical Council of Canada, or through the General Medical Council; but we have entered into relationships with both the Medical Council of Canada and the General Medical Council with eyes fully opened to the possibilities. When in the first place we obtained reciprocal relations with the General Medical Council, it was with full knowledge of the possibilities that that would ultimately lead to an indirect system of interprovincial reciprocity. We have entered into these relationships with our eyes fully open, and we feel that we must abide by anything that might develop from these relations, and, as I say, we have had to admit men to registration who would not have been admitted had it not been for these relationships. The instances have been few, and we do not complain.

I do not like to introduce a discordant note, Mr. Chairman, but I think perhaps it is just as well that all should know that the chances are that the Provincial Medical Board of Nova Scotia would be rather loath to depart from its present practice. I think perhaps after all that is all I need say. There are arguments pro and con, but I do not know that I can add very much to the discussion.

The Chairman: That is the kind of criticism we want to hear. I am a Bluenose myself, and I know how difficult it is to get them into line, but once in line they are the best crowd I know of to fight for an ideal. We have not heard from Alberta yet.

Dr. G. R. Johnson (Calgary): I do not know that I can add very much to the discussion. I think many of the problems have already been stated. I thought at one time that Alberta had all the problems due to the fact that it was a new province and a great many medical men were coming in, not only from our own Canadian universities but from foreign countries as well. I thought our problems there were more acute than those anywhere else, but I find that that is not the case.

The general opinion in Alberta is in favour of, and I believe the council would be quite willing to stand behind any movement which would accept the Canadian Medical Council examination as being the one entrance into the province. It

is true that we would like to make sure that all applications received were bona fide in every sense of the term; that is, we would require from each man at least that he is a reputable citizen, that he has a good preliminary education, that he has taken a medical course and passed successfully. We accept the certificate of the Canadian Medical Council, and of the General Medical Council of Great Britain, but we would like to see one nation-wide standard, so that a registrant of Alberta could practise in any other part of the Dominion and the registrants of any other provinces come to Alberta and practise without further examination and without further test.

I will not mention any of the problems that we have had to meet in the last three or four years, as they are very similar to the ones mentioned by the Registrar of Ontario.

Dr. J. F. ARGUE (Ottawa): I want to look at this thing first of all from the standpoint of the medical student. I think one of the things we should consider here is whether there is not any possibility of the student getting away from dual examinations in his final year. In the majority of the provinces, in his final year he comes up for his university examinations, and if he wants to qualify to practise in the province he goes through another series of examinations. I think our ideal should be some method, either under the Medical Council of Canada or otherwise, if it ever comes to one licensing body for the Dominion, by which assessors should be appointed who would co-ordinate with the examinations that are held at the close of the University term, and in that way the student would be freed from one extra set of examinations.

There is another point. If we are to have any uniformity and prevent men slipping through into one province after being denied in another, we must have one standard matriculation. The universities of Canada should get together and provide one standard matriculation, and if a man passes that he should be able to go to the university. I think we have reached that in Ontario during the last year. We have one standard matriculation, and if a man wants to study medicine, law, science or any other subject that is taught at the university, that one examination qualifies him to enter the university.

Another point is that our provincial registrars or provincial medical councils should not allow anyone to get in by the back door. If a man is turned down by one province, if the registrar would take the trouble to notify the Medical Council and the provincial licensing bodies that this man had made application and that his qualifications were not what they should be, the other provinces would be warned. Probably most of you know that during the last session of the Ontario Legislature we had a man made a doctor practically by Act of Parliament. Things like that would be avoided. I do not hold the medical schools free from responsibility for some of the trouble. I can remember men of very meagre matriculation standards entering upon the study of medicine, and being told that if they would matriculate during their first or second year they could go on, and they would be kept on until finally they got a license to practise. This is simply a question of co-ordination, it seems to me, between the medical schools, the provincial Medical Councils, and the Medical Council of Canada. The ideal I have for the future is a license to practise anywhere in Canada after passing one examination, and that examination should be held during the time of the final examinations of the student's medical college, and should be conducted by a combined board appointed by the central licensing body and the university which the student attends.

Dr. A. T. BAZIN (Montreal): I do not represent any school or any licensing body, but I think Dr. Argue has struck a note which should command our sympathy when he spoke from the viewpoint of the student. I might cite one instance that occurred not so very long ago, where a student going through the strain of his final year and examinations, followed immediately afterwards by the strain of a provincial examination, and immediately thereafter by the further strain of the Dominion examination, committed suicide very shortly afterwards. There was no reason for it that we could discover except that his mental balance was upset due to the prolonged strain which he had undergone. That perhaps is an extreme case, but it shows what occasionally may happen.

There are other viewpoints that might be considered as affecting the student. Why after submitting a youth to a very prolonged system of education, with all the expense incident thereto, should he be penalized by the collection of a fee here and a fee there all for the gaining of one object? That applies not only to the licensing fees, but also to the matriculation fees. Matriculation in certain provinces, perhaps not in all, is by means of two paths: one the presentation of credentials which admit him, and the other by passing an examination. It is permissible to conceive that if a student desires to pass an examination, that there are special expenses incident to that examination which should be collected from the applicant; but if a man has followed a more or less prolonged course of preliminary instruction which necessarily involves expense, and does not actually form a demand for further expenses on the part of the provincial board in order to show his credentials, why should he be mulcted the expense of an examination fee? So much for certain

points in regard to the student's viewpoint.

As I say, I am not representing anybody but the executive of the Canadian Medical Association, and that Association felt that a conference of this kind, without necessarily arriving at any very definite conclusions, but simply talking back and forth, detailing the difficulties that present themselves, would certainly be of value. We have with us to-day one who has had a very extensive experience both on a provincial board, that of the province of Quebec, and on the Dominion Board, Dr. Normand, of Three Rivers. I am sure the conference would be very glad to get the benefit of his experience. There are many problems in the province of Quebec that are perhaps different from the problems presented in the other provinces, and we all of us in the province of Quebec appreciate the difficulties in relation to other provinces, and I do not think there is anyone who can clarify the situation better than Dr. Normand.

The CHAIRMAN: I am sure we shall all be delighted to hear from him if he will be good enough to give us his views.

Dr. L. P. NORMAND (Three Rivers): My situation is very peculiar, because I have not been appointed by the College of Physicians in the province of Quebec to represent it at this meeting. I am here as a representative of the Canadian Medical Council, but as my friend Dr. Bazin says, I have been associated for a very long time with the College of Physicians and Surgeons of the province of Quebec, having been for over twenty-five years a member of the college and for seven years president of that college.

The province of Quebec has been one of the first provinces of Canada to exchange with the British license. Since 1889 we have had an exchange of licenses between the province of Quebec and Great Britain, without any question. In connection with the Canadian Medical Council I was engaged for many years before 1912 studying the Roddick Bill, and I was one of the representatives of my province on the board, when that Act was finally drafted and put into effect.

The province of Quebec has never discussed the question of having one Dominion license. Any man from any province, Ontario, or western or eastern provinces, coming to the board of Quebec with a Dominion license has always been accepted and a license granted. In the province of Quebec we have two classes of students. We have those who comply with the requirements of our board, who are what we call regular students, and we have those who do not comply with our requirements but who come before our board and ask for a license to practise in the province of Quebec, but we refuse them. During the last twelve years many of them have been going to the other provinces and paying the sum of $25 or $50 to the registrar to be registered. They pass an examination of the Dominion Council, and get a license from the Dominion Board, and then come back to the province of Quebec and force a license from us when they have not proved themselves sufficiently qualified to be accepted by our own board in the first place. But we are now refusing to grant them a license. For the last three or four years we have decided not to license any man that we did not believe sufficiently competent to get our license in Quebec, and who simply went to some other province and then came back to us. In 1918, six years ago, Dr. Simard and myself asked for an amendment to the regulations of the Dominion Board by which the Quebec man who could not get a license from Quebec should not be accepted through any examination of the Dominion Board until he had satisfied every requirement in order to become a licensed doctor, or until he had got a certificate from the registrar of the province of Quebec. I was sorry to hear the other day that we have many men coming up before the board of Quebec, and instituting law suits against our Board on the ground that this amendment to the regulations of the Dominion board has not been subjected to the Governor in Council at Ottawa and given lawful effect. At the last session of the board of the province of Quebec in September—I was not present—they decided to ask that at its next meeting the Dominion Board find means to stop any incompetent man from passing via the Dominion Board, and if that is not done, I am sorry to tell you that the province of Quebec has decided to withdraw from the Dominion Board, if we cannot stop these incompetent men from forcing themselves on us.

I was very glad to hear representatives from other provinces tell you this afternoon that British Columbia, for one, has decided to put aside its own regulations and accept the examination of the Dominion Board. I have heard other gentlemen say that in the near future all provinces may accept the examination of the Dominion Board; but let me tell you, although I am not speaking for the board of the province of Quebec, I know French Canadians' ideas sufficiently well to be confident that never will the province of Quebec give away this right; never will it forego the regulations of its own board and accept only one Dominion license for all Canada. It is only a dream to think that such a thing will happen. Quebec will keep the same regulations, the same laws for the people who are willing to come before the Quebec Board, but we will always be very glad to help in trying to make the Dominion Medical Board the best of all boards in Canada.

The CHAIRMAN: We are very much interested in hearing Dr. Normand. It impresses me as an individual that he has made a splendid argument for the ideals we are trying to forward. It seems to me that if we had what has been suggested,

examinations of the same standard throughout Canada, it would not matter much whether the Quebec Board compelled its students to take its examinations in Quebec or elsewhere. It seems to me a uniform standard would solve a great many of the difficulties, and I am sure our colleagues from Quebec would welcome a condition which would permit a nation-wide scheme whereby that unification might be obtained without in the slightest degree infringing on the rights and privileges and ideals which our colleagues have in the province of Quebec and in the other provinces. I hope that this discussion will go on. This is the kind of thing we want to hear. We have just had a real difficulty presented, and I am sure there are many others.

Dr. YOUNG (Saskatoon): Suppose a man domiciled in the province of Saskatchewan and educated, we will say at McGill University in the province of Quebec, receives an enabling certificate from the registrar of Saskatchewan, and passes the examination of the Medical Council of Canada, receives his diploma and goes to the province of Quebec, will he be accepted in the province of Quebec for registration?

Dr. NORMAND: I am very glad that Dr. Young has put a specific case. If a man from Saskatchewan or any other province has received his preliminary education in such a way as to get his B.A. or some other degree, and is regularly admitted as a medical student of that province, if he has complied with all the requirements of that province, it does not matter if he has received his education in Quebec or elsewhere, if he gets his license from Saskatchewan and is a regular physician of the province, and then comes with a Dominion license to the board of Quebec, he will be accepted. But we do not want a man from Quebec who is not able to pass to get his B.A. or pass his preliminary examination, a man born and educated in the province of Quebec, to be allowed to practice in the province of Quebec when he is incompetent to pass our examination, just by paying a fee of $25 or $50 in Saskatchewan or any other province, and then come into Quebec with a medical license. We will not accept that man, because if he is incompetent to pass our own requirements he should not be allowed to practice in our province, for he has not proved himself competent simply by paying $25 or $50 in some other province. He is a man from our own province, and we have a right to refuse him even though he has a license from the Dominion Board, when he gets his license without any examination, just by paying a fee.

Dr. YOUNG (Saskatoon): I have in mind a gentleman in Saskatchewan who applied to me for an enabling certificate. I made full inquiry as to his domicile, and I was perfectly satisfied that he was domiciled in Saskatchewan. He complied with our preliminary requirements and received an enabling certificate from me, and did not have to pay $25 for it, either. Then he went to the Medical Council of Canada and passed their examination and received his diploma, and then went to the province of Quebec, but for some reason of which I am not aware he was refused. I understand that he went further. I have here a report from the province of Quebec, and apparently this man went to a lawyer; I presume that is one reason they keep lawyers, to keep men straight in the law. Apparently this man had a lot of difficulty, and I was wondering why that particular man had that difficulty, in view of what Dr. Normand has just told us, because this man was domiciled in Saskatchewan, and had complied with all the preliminary educational requirements of that province, and received from the registrar of that province an enabling certificate. He had met all our requirements as to preliminary education, had received his diploma from the Dominion Council and then went to the province of Quebec, but was not accepted without first going to a lawyer. I believe eventually he may have been accepted. I was wondering just what the regulation was with regard to that very case.

Dr. NORMAND: I do not know just what particular case Dr. Young is speaking of. I have not been a member of the executive for the last five years, and I cannot say what the reasons were in this particular case, but I know that before that we used to accept any man as long as he was a regular doctor and had graduated in any other province, and had received a license from the Dominion Board. Could Dr. Young give me the name of the man?

Dr. YOUNG (Saskatoon): Harold J. Steed.

The CHAIRMAN: This is a little bit irregular if we are to proceed by parliamentary rules. We cannot expect Dr. Normand to remember these individual cases. He has given the general principles and perhaps Professor MacCallum in replying will deal with some of these points in connection with licensure.

Dr. J. C. SIMPSON (Montreal): I happen to have come in rather close contact with students' problems in regard to education and licensure. Dr. Aikins very aptly said in the course of his remarks, referring to the student who comes at the last moment and asks for an enabling certificate that the question might very well be asked, "Why did not your university five years ago advise you that you would run up against this difficulty?" That, of course, is a very just criticism to make. It happens that in our own university less than fifty per cent of our students belong to our own province; less than fifty per

cent are students of the province of Quebec. The majority of them come from all the other provinces, from the United States and other countries. We are therefore brought into contact with the problems of students from all provinces. Certain of our students coming from other provinces and receiving their education in the province of Quebec, and living there five years, make contacts and for one reason or another wish to get a license to practise in the province of Quebec, so we are up against just such problems as Dr. Aikens has mentioned.

There are one or two practical points where I think great help could be given by registrars of the other provinces to their own men. During the last few years and particularly at the present time, we are taking up with the individual students when they come to us this problem of licensure which is five years away; we start with them when they enter the school. We are advising them as the sure way of keeping clear, to register with their own provincial council in their first year. We are telling the men from the province of Quebec that the way to get a license in the province of Quebec is to obey the regulations of the Quebec College of Physicians and Surgeons. We are advising the men from the other provinces to register with their home province. Now we are up against this difficulty. We find that one province, the province of Quebec, makes it obligatory on the student to register when he begins his medical study. The others do not. Ontario this year, and I think this is a splendid move, announced a policy of encouraging medical students to register with them when they begin their medical studies; they charge just a nominal fee for this registration. I have found from actual experience in the last month or two that some of our students who have tried to register in certain other provinces have not been encouraged, and in one case a student was told he could register but would have to pay $100. It seems to me that is a thing that just needs to be brought to the attention of the registrars of the different provinces. What are some of the advantages? Just one or two I want to reiterate: First, that the medical student from the beginning of his course is kept clear with his home province; secondly, if that student later on is for any reason influenced to practise in the province of Quebec, he has established from the very beginning of his medical course the fact that he does belong to the province of Alberta or Saskatchewan or wherever he happens to come from.

Dr. J. S. Poole (Neepawa): Dr. Thornton is a confrère of mine on the College of Physicians and Surgeons of Manitoba, but he spoke for the Canada medical. Speaking for the College of Physicians and Surgeons, but presenting rather my own views, we as a council feel that the Medical Council of Canada must either go forward or retreat. A number of anomalies have been presented to-day which must be rectified. An enabling certificate has been used by many men in a way in which it was not supposed to be used. Men who are not able to get a certificate from their own province go to another province, and it is to accommodate those students that an enabling certificate is given.

I think I am speaking for our own college in Manitoba when I say that if the rights of the provinces are safeguarded, if the Medical Council in a round-table conference of representatives of the provincial medical councils and of the universities can work out proper regulations as to matriculation and medical examination, our province, and in time I have no doubt the other provinces will get behind the Medical Council of Canada and give us the one door of entry. I have no doubt those Scotchmen in Nova Scotia will even see their way to come in as well. It is not the use but the abuse of the system that Dr. Normand is objecting to.

Dr. D. Low (Regina): I cannot speak with authority for anybody in Saskatchewan, but I think I can say something that will give you an idea of the general attitude of the profession in Saskatchewan in regard to this matter.

I think it was in 1920 that a representative went to the Vancouver meeting carrying a resolution asking the Council of the Canadian Medical Association to endeavour to have steps taken to establish a College of Physicians and Surgeons in Canada along lines similar to that in Great Britain, and if possible in conference with them. First I should say that we in Saskatchewan have not got a teaching body in medicine. Alberta, Manitoba and British Columbia have. We are the only province, I think, that does not undertake to manufacture doctors. We thought that in the working out of this resolution, it would come to the knowledge of the heads of the leading teaching bodies in the Dominion and those in close touch with the licensing process, and that we could safely leave it to them to maintain in Canada what we contend is as high a standard as is asked for anywhere of those who wish to practise medicine. We felt these men in due time would evolve a standard of requirements and education that would be satisfactory, and possibly beyond the requirements of most of those who set the standard for licensing at the present time.

I may say that the resolution was passed at the provincial meeting of the association. Some thought it had not received sufficient discussion, but the resolution was so acceptable to the association that they did not think it necessary to discuss it. But to make sure there would be no mistake, the resolution was brought up again next year and reaffirmed, and every one who spoke expressed his hearty concurrence in it. We still think that if our teachers, the men in the universities, and

those concerned with licensing in Canada, will get together in the spirit that we know exists, notwithstanding any disagreement that may appear on the top, we are confident that ultimately a system of examinations will be evolved that will be satisfactory even to Quebec.

Dealing with the question of what must be given up by the provinces, it seems to me, and I think to a number of others in Saskatchewan, that we do not have to give up anything in order to agree in this. We only have to say: If the standard is set where we think it should be set, and the applicant is shown to have a proper knowledge of medicine according to the standards of to-day (some of us might not be able to meet them), it will be acceptable.

The discussion to-day bears out what I have said. I do not think it is well to have all the sugar at the top when there is some salt hidden below. It reminds me of something Dr. Roddick said when he was endeavouring to have the Dominion Council established. I happened to have the honour of his acquaintance, and met him on one or two occasions during that time, and he told me, "Oh, it's a hell of a job. I get Quebec fixed up, and British Columbia breaks out. I get British Columbia fixed up, and Ontario breaks out." I am sure, gentlemen, we will get them all by and by. Notwithstanding the fact that we have a great number of extreme progressives in our Dominion no one will deny that we are a very conservative people. We do not like to take radical jumps; we do not like to swallow anything holus-bolus, but to thoroughly digest and assimilate it, and what Dr. Primrose has said about Bluenoses will apply pretty well all across Canada. Once we are satisfied a thing is right and really means a step forward, everybody gets in line. There is the statement of a man who was concerned with the formation of the Dominion Council, quite a prominent man in his province; "It's a splendid idea," he said, "a lovely thing, and we all like it; that is politically some of us do, but actually, you know, we don't want it." This discussion shows we are in just the same position we were in then, but notwithstanding all that, we have a Dominion Council. There may be some difficulties before us, but they can all be smoothed out. We have only to get together in a proper spirit to adjust the little difficulties, matters of detail rather, and I am satisfied that if we do that we shall achieve the ultimate result we are all aiming at.

Dr. J. J. Guerin (Montreal): The whole question, as I see it, is mixed up with the Roddick legislation from its very inception. I was a member of the Executive Council of the province of Quebec at that time, and I may say that the province of Quebec is exceedingly jealous and exceedingly conservative in so far as anything pertaining to the Dominion is concerned. They view with a great deal of anxiety any proposition that would militate in any way against the bill instituting the College of Physicians and Surgeons of the province of Quebec. They gave the College of Physicians and Surgeons certain rights, after very mature deliberation and they would not hear of any license that would deviate from the requirements enacted by that legislation.

We have, according to our law in Quebec, a standard of matriculation, and that is the rock on which the whole thing shatters—the matriculation. Our standard of matriculation is a B.A. degree of a university, and those who are not possessed of the B.A. have to pass before the College of Physicians and Surgeons, through professors chosen by them, an examination equivalent to the examination they would have passed had they obtained the B.A. degree, and until a student has got the B.A. degree or has passed an equivalent examination he cannot be registered in the province of Quebec. It is all very well for us to discuss the pros and cons. I believe myself that the standard of medical education throughout the Dominion of Canada is pretty well equalized, but it is to prevent the undesirable element from getting into the profession that we enacted those laws. We have had applications from all classes of people to study medicine, and before those laws were enacted many undesirable people were entering on the study of medicine, so it was finally decided that we would establish a standard of preliminary education, and that standard is established by the B.A. degree, or by a very severe examination equivalent to the B.A. degree, and a student is not supposed to commence his medical studies until he has satisfied the College of Physicians and Surgeons that he comes up to that standard.

It is all very well to speak about the final examination. I have no doubt but that many men are refused in the province of Quebec who are the peers of their fellow-practitioners in other provinces, so far as their medical training is concerned; but we are exceedingly conservative in Quebec. We want the preliminary training; we want to have men brought up in an atmosphere that will qualify them later on to occupy the exalted position of physician in our province. I do not know of any change in the British North America Act that could change this state of things, because education is essentially one of the prerogatives of the province, and the province, I may say, Mr. Chairman, is so exceedingly careful lest there should be any interference in the education of the youth that they would view with great suspicion any enactment that might in any way militate against the standard established to-day for the entry into the study of medicine.

In my own university, the University of Montreal, we have a matriculation examination; in McGill they have a

matriculation examination; many universities have a matriculation examination which qualify the youth to study medicine in these institutions, but neither matriculation nor examination by the University of Montreal, or McGill or Laval or of anything you please in the province of Quebec, will entitle a man to present himself for a license after five years unless he has previously qualified himself as the legislature requires in order to commence his study of medicine.

It is very well for us to discuss these questions and to listen to the arguments that are being made, but the primary trouble is the examination for the entry into the study of medicine, and unless you can find some method of co-operation which I cannot see at the moment, and I was very intimately concerned with the legislation in regard to this bill from the very beginning, I cannot see how you could ever pass any legislation over the head of the College of Physicians and Surgeons for the province of Quebec, and what is more I cannot see how the legislature could be convinced that it would be for the general advantage that we should deviate from the state of things that now exists. Our standard for the study of medicine is high; our standard is one that we do not wish to lower; and notwithstanding anything we may do, though I have no right or prerogative to speak for the College of Physicians and Surgeons, being here simply representing the University of Montreal—I have been on the board of the College of Physicians and Surgeons for many years; I am not on it now—but I am sure that if the representatives of the college were here they could not tell you anything different from what I am telling you.

From the discussion that has taken place it seems to me that the whole trouble arises over the preliminary education and examination for the study of medicine, and unless that difficulty can be overcome in some way that I cannot suggest, I think we will meet with failure in our efforts to bring about an understanding whereby the license of the Dominion Council would prevail in the province of Quebec.

Dr. J. C. Connell (Kingston): May I first express my great satisfaction and pleasure that I have been permitted to attend this first conference of the Medical Services in Canada. It realizes an idea, a dream perhaps, that has been in my mind more or less for the last twenty-five years, and I hope this will prove only the beginning of a permanent organization which will continue from year to year and contribute very greatly to the progress of the medical services and to the welfare of the people of Canada generally. We did not secure the Medical Act of Canada without dreaming about it for a long time. I was a medical student when I first heard Dr. Roddick speak on the subject of Dominion registration—I won't tell you just when that was, but it was a long time ago—and I considered it a great honour when later on I had the acquaintance and friendship of Sir Thomas Roddick. Certainly he dreamed about that Act for a long time, and finally his dreams came true. Even Quebec was reconciled and became a party to the Medical Act of Canada as it now stands. Of course, the Act is full of compromises, as is known to quite a number of gentlemen here who are familiar with the details leading up to the final acceptance of the Act. It is not a perfect Act by any means, but it has been working twelve years, and I think we have no reason to be dissatisfied with the results. There are now over 1,300 practitioners in Canada who have the license of the Medical Council of Canada. That represents a large body of medical opinion, and I think I can foresee in the next generation of the medical profession in Canada, that those who hold the license of the Medical Council of Canada will control medical opinion in Canada. I am quite sure there will be no going back; there will be progress, and continued progress all along the line. Of course, there are difficulties. Some of them are inherent in the Act itself. It has been suggested, for example, that the question of preliminary education, curriculum, and so on, should be in the hands of the Medical Council of Canada. There is no provision whatever for that in the Act. I myself, after working with it for some time, feel that that is not necessary, that we can work it out as it stands. That is one of the suggestions that have been made.

We have also been informed to-day that the province of Quebec will insist upon an amendment to the Act which will legalize what they have been doing for the last few years. I should like to emphasize that the Medical Act of Canada provides that a candidate must have either a provincial license, or that he must comply with all the regulations right up to the point of writing on the examinations of the provincial board. Now for several years the province of Quebec has not issued enabling certificates to such candidates. It will only issue certificates to those who actually hold a license. It has withheld that privilege, although that privilege is definitely provided for in the Canada Medical Act, and we are told that Quebec will withdraw unless that is legalized. Well, no amendment to the Medical Act of Canada can be presented to the House of Commons until every provincial council has consented; how are you going to get it? Not easily. I think it will be a long time before there is any amendment submitted to the House of Commons that will essentially change the provisions of the Medical Act of Canada. Perhaps that is one of the weaknesses of the Act; it may be it is one of its strengths. Personally I think it can be worked out as the Act stands.

There are one or two other points on which I would like to say a word: first of all, the reference made by Dr. Argue to

dual examinations by the council and the university and his suggestion of some system of assessors. After my experience of quite a few years now in connection with medical education, I am not in favour of such a system. I think it is not unreasonable that a candidate who has spent his years in a university and has now graduated should submit his qualifications for review by outside examiners. So far as I am concerned, I would say to any under-graduate who has come to the point of graduation, "It is quite reasonable that you should submit yourself to a board of examiners to see exactly where you stand." I think that is a very good thing for the school, a very good thing for the candidate, and I would be very sorry to see any departure from such a system. The system of assessors is not workable in a practical way. I do not think it amounts to anything. The other objection to it is this: We are likely for some time to educate quite a number of foreigners, and if you have a system of assessors practically every man who graduates from a Canadian school will have a Canadian license. I do not think that is good public policy; I do not think it is good from a professional standpoint. Just on that point I would like to point out what a good many of my provincial friends fail to see, that it is to the advantage of the profession in any province that all the men who are educated in that province should have a Dominion qualification rather than a provincial one. He should have the whole of Canada for his field, rather than be limited to one province. It is in the interests of the profession in the province that that should be the case. I say that because it applies particularly to my own province, and I have difficulty sometimes in persuading my colleagues that that is really the case.

In regard to the difficulty that Dr. Normand has raised with regard to Quebec, it seems to me the remedy lies with Quebec itself; it is a domestic problem. It appears there are two classes of students in Quebec, regulars and irregulars. The regulars—Dr. Normand will correct me if I misunderstood him—are those who have complied with the preliminary requirements of the Medical Council of Quebec in regard to matriculation. The irregulars are those who have not, and who with incomplete matriculation are admitted to the medical schools and receive a medical education. Why are they admitted? Is it not a matter of accommodation between the medical schools of the province and the Medical Council of Quebec? Should there be any irregulars? There are no irregulars in Ontario.

Dr. J. C. Simpson (Montreal): I think you misunderstood the statement of Dr. Normand. In his terminology irregulars are those men who do not fulfil the requirements of the province of Quebec but who fulfil the requirements of some other province. A man, for instance, who fulfils the requirements of Ontario, let us say, may not be a regular student from the point of view of the college of the province of Quebec, because he may not have the B.A. degree, which Quebec requires.

Dr. J. C. Connell (Kingston): If he is a resident of the province of Quebec, he is subject to the regulations of the council of the province of Quebec, and if he wants to get an enabling certificate—

Dr. J. C. Simpson: A student who has complied with the matriculation requirements for entrance to any university in Canada may still not be in a position to proceed to his license in the province of Quebec.

Dr. J. C. Connell: I cannot see but that it is a domestic question for Quebec, after all. If he wants to get an enabling certificate he cannot get it if he is not domiciled or a resident, and no other province will give him an enabling certificate.

Dr. J. C. Simpson: That is quite admitted.

Dr. J. C. Connell: No other province should give a man domiciled in the province of Quebec an enabling certificate. He must get it at home.

Dr. J. C. Simpson: That is obvious.

Dr. J. C. Connell: Then where are your regulations? There is no difficulty except between the council of Quebec, and the colleges. I may be dense, but I think after all it is a domestic question for Quebec, and I think I can safely say that Quebec will not withdraw from the Medical Council of Canada.

The Chairman: We have not heard from New Brunswick. I see my old friend Dr. MacLaren, whom the conference would be glad to hear from.

Dr. Murray MacLaren, M.P. (St. John, N.B.): I cannot speak for the council of the province of New Brunswick because I am not a member of it; I can only say something as an individual, and as a member of the council of the Canadian Medical Association.

We all recognize the fact that the British North America Act provides that education comes under the provinces. I think that also includes examinations, for I take it that education includes everything surrounding itself, and I think examinations would be included in the interpretation of education. Consequently both examinations and education are matters for the province to deal with. That being the case and the profession being unhappy under these circumstances, has led after many years to an attempt being made to arrive at some central method of examination. But there must always be difficulty in doing that. The British North America Act is there, and it is, I would consider, permanent, and I would say that so far as the Dominion is concerned we must always expect difficulty, and we are always limited in our procedure. I think up to the present we have endeavoured, as it were, to arrive at a method satisfactory to us and yet not in direct conflict with what is laid down in the British North America Act. I do not see any way of arriving at the object aimed at. I sympathize with those who desire it and would desire it if it were possible, but I have not any solution to offer. There may be, and I think there probably will be some way found of meeting the difficulties in the situation. Arriving at a uniform standard of matriculation and having a uniform standard of medical education throughout the Dominion is an entirely different thing from what is laid down in the British North America Act. There is clearly no reason why the various provinces, the various councils and the various universities should not among themselves agree upon a standard. It is a matter then for the councils and the universities, if they see fit, to grapple with the problem and arrive at a common standard. They are very far from it now. It was very interesting to note the disparities between the different provinces which Professor MacCallum outlined this afternoon, but there is no reason why an agreement should not be reached that would not in any way contravene the provisions of the British North America Act.

After all, our primary object is to elevate the medical status in the Dominion of Canada. That is the essential thing and to me is far more important than the question of one board of examination. All these other matters are, of course, important, but the primary thing is to arrive at as high a standard of matriculation and of education as we can reasonably expect and ask for. If we advance, we will advance, I believe, step by step. If we secure first a uniform matriculation, there will be here and there an improvement in matriculation requirements, because I am satisfied that those who have now a good standard will not be prepared to accept anything less. If we secure that first, an improvement in matriculation and through the curriculum of medical education, we will have accomplished a substantial good, and I think it may lead the way to something further in the way of Dominion registration. The whole scheme of registration will then be brought to a level throughout the Dominion, and by that time it may be there will be some method found of securing one examination.

British Columbia, it seems to me, has taken a wise course in handing over its examinations to the Dominion Board. There is nothing to prevent any other province from following its example, but no province need do so unless it chooses; and I take it there are several provinces that will not be prepared to do so. But even a few following that course will help in the formation of public opinion on this matter. I think the greatest good we can look forward to in the meantime, because it is possible, because it is reasonable, because it is desirable, is the obtaining of a uniform standard regarding entrance to the study of medicine, and in the subsequent course of medical education, that is, in the curriculum.

Dr. McGill: I wish to clarify one point about which there has been some misunderstanding, at least in my mind, and that is with regard to what is meant by an assessor. If it means a person who merely visits during an examination, without participating in it, then I would agree with Dr. Connell that it would be practically a useless procedure, but on the other hand, if in this country some system such as that adopted in Great Britain could be introduced, whereby the assessor is also a co-examiner, the system would be an admirable one when it is introduced to bring about reasonable uniformity in instruction, and there should be no great difficulty in working out some such scheme. One should remember, however, and I think the committee should remember, that such a scheme is necessarily expensive. It is expensive in Great Britain for the General Medical Council, and would be much more so here where the distances are so much greater. With regard to that examination, I may say I have had some personal experience, having been a co-examiner in the University of Aberdeen, for two years before I came to this country, and I know the influence of this system of co-examiners was very markedly felt in the standards that the local university authorities felt they had to maintain. It brought about a correlation of teaching which I think is what we are all aiming at in this country.

The Chairman: If there is no further discussion I will call upon Dr. MacCallum to reply.

Dr. Jas. M. MacCallum (Toronto): Others I am sure have succeeded very much better than I have in explaining the difficulties we had with matriculation, but I tried to make you understand that there were different ideals of education, different ideas about it, and I refused to say which was the best. When you tackle that job you have a very difficult thing to deal with, but do not forget, it is not merely a question of Quebec. We all have provincial pride. We in Ontario have, as I think you all know, but the fact is that the standard of matriculation can be improved in various places. It will be

improved, and that is my object in bringing the matter before you. We cannot do it ourselves, but reports will be made to the various Councils represented here, and I have no doubt it will lead to improvement.

I said I was a man of peace, and yet I may say I regret very much there was no gentleman here who would get up and break a spear on behalf of British reciprocity. Some of my friends say I love a fight. Candidly I confess I do, but I do not see why something has not been said on that question. I would ask Dr. Carder this. He tells us they have accepted the Medical Council of Canada examination as their own. Now in the event of that becoming the practice in all of the provinces, or in the event, which will happen long before that, of the license of the Canada Medical Council becoming Dominion-wide, has British Columbia got any objection to our also having British reciprocity? What will be the attitude of British Columbia?

Dr. L. D. CARDER (Vancouver): They would not do it.

Dr. MACCALLUM: All right; that settles that for all time, gentlemen. I knew that long ago. I thought you might just as well recognize the fact that these problems are complicated by political considerations. I am not going to say what they are, but just buttonhole Carder outside. He did not tell me, but I got it from another source.

Dr. Normand told you Quebec was going to withdraw. I have had later advices. The last advice I got was that Dr. Normand was suffering from nightmare. Every once in a while he falls to sleep and is wakened by some such nightmare. I am quite convinced had Dr. Normand, the Nestor of the Quebec Medical Council, been present at that council, he would never for one moment have joined in it. Dr. Normand, like myself, is a man of peace. Like myself, so my friends tell me, he is a man of consideration and courtesy. This is all a misunderstanding, gentlemen. I am not going to get up here for one moment and contend anything else. Dr. Normand and I may possibly go over to Hull, and in a quiet chat get a great many things cleared up. I had taken the trouble to read the proceedings of the Quebec Medical Council, and there seems to have been in this account of that nightmare some sort of an idea that the other provinces were trying to force Quebec. Now I know Dr. Normand will never think that for one moment. It is all a misunderstanding. The College of Physicians and Surgeons of Quebec has no quarrel with the Canada Medical Council. The Canada Medical Council is placed in a most invidious position. The province says: This man was born in this province; he matriculated here; his domicile is here; he lives here; this is his home; he belongs to us. Surely Dr. Normand would not be so discourteous; I am sure he would not be lacking in the courtesy so characteristic of all the French-speaking people, as to say, "We demand that man." That is where the whole trouble is. The Dominion Medical Council cannot interfere. What right has it to say to my quiet and serene friend there, Dr. Aikins, "You cannot give a certificate to this man?" He says, "This man is mine." Saskatchewan says, "He is not your man, he is ours." Quebec says, "That man belongs to us." I hope that will show to Quebec that we really are at one and I have not any doubt that Dr. Normand will join the league.

Dr. G. R. CRUIKSHANKS (Windsor): I am sure we are all agreed that this has been a most profitable discussion. We have touched on some knotty problems, but the end is not yet. It won't do to get drawn into a controversy in this discussion, or then nothing will be done. I move, seconded by Dr. Poole, that Dr. MacCallum's paper be referred to a committee composed of representatives from the universities and licensing bodies for consideration and report to this conference to-morrow, the committee to be named by the chair.

The CHAIRMAN: What is your pleasure? Shall the motion carry?

The motion was agreed to.

The CHAIRMAN: Then I nominate the committee as follows:—

Dr. D. S. MacKay (chairman)
Dr. W. H. Hattie
Dr. J. C. Simpson
Dr. L. P. Normand
Dr. Duncan Graham
Dr. P. S. McKibbon
Dr. W. T. Connell
Dr. W. A. Laidlaw
Dr. W. A. Rehfuss
Dr. G. R. Cruikshank

Dr. J. S. Poole
Dr. G. R. Johnson
Dr. A. M. Young
Dr. L. D. Carder
Dr. R. H. Arthur
Dr. J. M. MacCallum
Dr. R. S. Thornton
Dr. J. J. Guerin

May I ask every member of this committee to be present to meet Dr. MacKay in the Tudor room of the Chateau promptly at eight o'clock to-night. Is there any further business? If not, we will now adjourn.

The conference adjourned.

FRIDAY MORNING SITTING

The conference met, Dr. Primrose in the chair.

The CHAIRMAN: I shall first of all call upon Dr. Seymour, Deputy Minister of Health of Saskatchewan, to read to the conference his address on public health work in that province.

HEALTH WORK IN SASKATCHEWAN

Dr. M. M. SEYMOUR, Deputy Minister, Department of Public Health, Province of Saskatchewan: It is almost two decades since the province of Saskatchewan was constituted, but in order to trace the groundwork of public health activities initiated by the early pioneers, it is essential to give credit and honour to those who legislated and administered the affairs of what was then a part of that large area known as the Northwest Territories.

As remote as 1898 we find a Public Health Ordinance in force for the prevention of contagious diseases, with provisions for appointing medical officers of health and sanitary inspectors in cities and towns. Although, at this early period of western civilization, the cities in what is now the province of Saskatchewan, had not attained to any great importance in population, we find that they, with several of the more populous towns, had complied with the law in having the services of medical health officers. In common with all newly-settled sections of land recently opened for homesteaders, little attention was paid to affairs affecting the general health. The natural freedom from law and order found all settlers who entered the virgin prairies become almost licensed to neglect or pay attention even to the rudiments necessary to healthy life. The well-balanced discipline of the members of the Royal Northwest Mounted Police was employed to meet and advise settlers that all matters of law for the order, health, and general wellbeing of residents must be respected, and to this splendidly equipped and judicial force much credit is due for the administration of early health measures.

The Public Health Ordinance, amended in 1902, was adopted at the first session of the legislature of the province of Saskatchewan in 1905, and was further amended in 1907 and continued to be the health law until December, 1908.

Early in 1906 the Government appointed Dr. M. M. Seymour as Provincial Medical Health Officer, who, for three years, was the only official, and who, with occasional help from the Royal Northwest Mounted Police, carried out such preventive measures as were necessary in controlling outbreaks of disease of a communicable nature. At this period, when settlers were flocking in from all quarters, such diseases as smallpox and typhoid fever were introduced, becoming endemic, owing to the then practice of settling in communities. Many of the outbreaks reached epidemic proportions, showing the necessity for a more organized and delegated method of control by health districts, instructed, supervised and made responsible to a central governing authority for all affairs affecting the people's health.

Up to this stage the administration of health matters was under the Department of Agriculture, and the correspondence of the period shows the amount of work required of the deputy minister and the provincial medical health officer in attending to all matters relating to the public health and welfare of residents.

With the passing by the legislature in 1909 of the first Public Health Act, being chapter 8 of the Revised Statutes of Saskatchewan, a new and improved method of public health administration was inaugurated, a permanent bureau was created under one of the ministers of the Government, with the chief officer called the Commissioner of Public Health to perform the duties prescribed by the Act, and such other duties as might be assigned to him by the Lieutenant-Governor in Council under any other Act.

A Council of Public Health was established to act with the commissioner in considering and revising rules and regulations made under the provisions of the Act and to report thereon to the Lieutenant-Governor in Council. The commissioner immediately set about to the collecting of a staff of permanent officials as a nucleus around which centre would collect all matters relating to the public health, requiring legal, technical and executive decision. Early in 1910 the following officials were appointed, namely: T. Aird Murray, C.E., Consulting Engineer and Assistant Commissioner of Health; Medical Inspector and Provincial Sanitary Engineer in the person of Thomas Watson, a member of the Royal Sanitary Institute.

The appointment of a consulting engineer to this new province proved to be a wise and advanced step in the work of

prevention of disease, as the provision of means for sewage disposal and the preserving of safe water supplies to the larger centres of population was of the utmost importance in a prairie province like Saskatchewan. The new Public Health Act provided that before any scheme for establishing a water supply or sewage disposal works could be undertaken, it was first necessary to obtain from the commissioner a certificate to the effect that the plans and specifications had been approved of. This was made mandatory by the inclusion in the Act that no by-law for raising money for such a construction could be submitted to the electors without the preamble to the by-law stating that the proposed work had received the approval of the Commissioner of Public Health. This type of advanced public health legislation was very favourably commented upon at a conference held in Ottawa, called by the public health section of the Conservation Committee in 1910. At this early period, sewage disposal plants were designed and constructed in Regina, Moose Jaw, Swift Current, Yorkton and Maple Creek, most of which were completed and in operation in the year 1910.

The Public Health Act, in defining the functions of the commissioner, specified matters for which rules and regulations could be made for the guidance of all whose duties it would be to carry out health provisions. Regulations dealing with contagious and infectious diseases, prevention and removal of nuisances, dairy and milk supplies, tenement houses, hotels and restaurants, were treated and passed as being the essential matters requiring early attention.

As a preparatory step towards efficient administration, it was imperative to organize the province into health districts in order to utilize local governing bodies and make them responsible to the Bureau of Public Health for carrying out the regulations dealing with sanitary and health affairs. Although in every city and many towns there existed health boards, in the numerous rural municipalities and villages no such provision obtained. Therefore, it was necessary to create all organized centres as health districts. This was easily accomplished by making every municipal board a unit of the bureau with a qualified medical practitioner as medical health officer.

With the distribution to health units of copies of the Public Health Act and Regulations, together with the powers and responsibilities they directly implied, the councils of health districts especially, and also the general public, became interested, with the result that the correspondence on all subjects relating to health became voluminous. This desire to acquire information was met as far as possible by the commissioner and other officials of the bureau, by visiting centres and holding public meetings to educate not only members of health boards but also the general public on ways and means of co-operating with their local health authorities in efforts to carry out the provisions of the regulations. Year by year has shown that the regulations issued by the bureau have engaged the attention of the local health board, as well as interested residents to give personal attention to matters affecting community life, until the Bureau became the clearing-house for all complaints relating to hygiene.

In 1923 the Public Health Act was amended, creating the Department of Public Health, with Hon. J. M. Uhrich as the first Minister of Public Health. The responsibility for the administration of the activities of the Department of Public Health in Saskatchewan is vested in the Minister of Public Health, and he has under his jurisdiction the following Acts: —

(1) The Public Health Act;
(2) The Vital Statistics Act;
(3) The Union Hospital Act;
(4) An Act to Regulate Public Aid to Hospitals;
(5) The Venereal Disease Act.

The Council of Public Health, created by previous legislation, was continued under the new Public Health Act. It consists of the deputy minister, as ex-officio chairman, three duly qualified medical practitioners, one qualified Veterinary Surgeon, and at this session the Act has been amended by adding a civil engineer to the Council of Public Health. This council is required to meet at least once a year to consider and review all orders, rules and regulations, and to make a report to the minister, with such suggestions and recommendations as may be deemed necessary in the interests of public health. This Council may also consider matters referred to it by the minister and submit a report upon the same to the Lieutenant-Governor in Council. The members of the Council are appointed to hold office for two years and receive remuneration from public funds.

The members of the Council of Public Health at the present time are, in addition to the Deputy Minister, Dr. T. W. Walker of Saskatoon, President-Elect of the Saskatchewan Medical Association; Dr. T. M. Leask of Moose Jaw, President of the Saskatchewan Medical Association for the year 1924; Dr. W. A. Thomson, former President of the Saskatchewan Medical Association; and Dr. Chasmer, Secretary-Treasurer of the Saskatchewan Veterinary Association.

The provisions regarding health districts and boards of health, as well as requiring health districts to appoint legally qualified medical men as health officers, are being continued in the new Public Health Act. The power is also given for the appointment of sanitary officials. In order to provide for the increased work of the Department of Public Health, it has been divided into the following divisions:—

(1) Administration;
(2) Child Welfare and Hospital Management;
(3) Communicable Disease;
(4) Sanitation and Hospital Organization;
(5) Venereal Disease Control;
(6) Vital Statistics;
(7) Laboratory.

ADMINISTRATION

The administration under the minister has full responsibility regarding all matters pertaining to the department and formulates the general policies and suggestions in connection with the various divisions. The department operates the general supervision of all boards of health of the province, as well as the carrying into effect of the Health Act and Regulations. Public health propaganda and publicity work receives a lot of attention from the department.

CHILD WELFARE AND HOSPITAL MANAGEMENT

The Division of Child Welfare and Hospital Management, which is presided over by a physician, has the supervision of the organization and holding of child welfare conferences and baby clinics, home nursing, maternity grants, and the relief of destitutes, who are for certain reasons unable to obtain aid from any municipality.

Within the last few years all parts of Saskatchewan have been well covered by baby clinics, special attention being given to outlying districts far from qualified medical assistance. This work has been very much appreciated, with the result that a number of districts now have child welfare clinics held regularly under the supervision of the local physician. Children of pre-school age are given a thorough physical examination, parents are advised as to defects, if found, and are advised to see their physicians regarding the same. The importance and necessity of an examination by a medical man, at least once a year, is strongly recommended to the parents. The growth of this work may be judged by the fact that the number of children examined has grown from two hundred and ninety-two (292) in 1906 to three thousand four hundred (3,400) in 1924. It may be noted that the latter figure does not include the number examined in connection with local clinics, of which there are now a number being held regularly. Films, pictures, posters and exhibits are made use of for the spreading of baby welfare, and information is given at fairs and other community gatherings.

In addition to these clinics, three nurses are employed to give further instructions in the care of children, one nurse devoting her time among the new Canadians. This work is meeting with great success, and through the enthusiastic co-operation of women's organizations, the number of women reached is growing rapidly. The course includes instructions in the general care of children, first aid, and what to do before the doctor arrives.

MATERNITY GRANTS

The province of Saskatchewan makes a grant of twenty-five dollars ($25) to assist any expectant mother who lives where there is no medical attendance readily available to obtain the required medical aid. This sum is usually divided by making a grant of ten dollars ($10) at once to the mother for obtaining the necessaries for the event, and fifteen dollars ($15) is paid to the doctor who attends her. This sum of $25, however, may be paid entirely to the physician, or may be paid to the hospital that the mother goes to, upon her request. That this grant has fulfilled, to a great extent, its purpose, may be judged from the following figures:—

Year	Number of mothers receiving the grant
1920	17
1921	125
1922	253

1923	286
1924	427

HOSPITALS

Upon the formation of the province of Saskatchewan in 1905, there were six hospitals received financial aid from the public funds:—

Regina—Victoria Hospital.
Prince Albert—Victoria Hospital.
Yorkton—Queen Victoria Cottage Hospital.
Moosomin—General Hospital.
Battleford—Victorian Order.
Indian Head—Victorian Order.

UNION MUNICIPAL HOSPITALS

In order to ensure better hospital care for the rural districts of the province, and especially to provide for maternity and emergency cases, in the year 1917 an Act was passed providing for the formation of rural municipal hospitals by which two or more municipalities could combine to form a hospital district. By this means it is possible to raise money to build and equip a hospital, and this union hospital plan has worked very satisfactorily.

There are at present forty-three (43) hospitals receiving aid in the province, not including ten (10) Red Cross Nursing Outposts. Saskatchewan is now fairly well equipped with hospital facilities. Fifty-six per cent (56%) of the total bed capacity is available in the cities, while forty-four per cent (44%) serve the rural districts and the population of the smaller centres. For the treatment of tubercular cases there is one bed now available for every nineteen hundred (1,900) of the population, while isolation accommodation is at the ratio of one bed for every thirty-three hundred (3,300) of the population. The sum of three hundred and twenty-thousand dollars ($320,000) was voted to the aid of hospitals last year from public funds. The per capita investments in hospital buildings and equipment in the province now amounts to five dollars and ten cents ($5.10). In September, 1923, the hospital regulations, which have been enforced for a great many years, were amended for the purpose of assisting the hospitals in obtaining for their patients the best possible service.

The Department of Public Health, which administers the Hospital Act, makes it clear that the responsibility for the management and control of the hospital, as well as the results obtained in so far as the patients are concerned, rests with the Board of Management. It is pointed out that the board has a duty to perform in seeing that the hospital is properly staffed and furnished with the necessary X-ray and laboratory facilities. Among the regulations are included:—

(1) The interpretation of practising medicine in hospitals, which is limited to those registered under the Medical Profession Act.

(2) All plans and specifications of the building or addition to hospitals, or alterations in hospitals, shall, before such work is begun, be submitted to the Minister of Public Health for approval.

(3) Provision shall be made for at least eight hundred (800) cubic feet of space for each patient, and twenty-four hundred (2,400) cubic feet of air per hour, with at least one window for every two beds.

(4) Fire protection must be provided.

(5) City hospitals are required to have an Advisory Medical Board of three doctors.

(6) Each hospital is required to have a medical staff, which staff is to meet monthly for the purpose of reviewing and analyzing the clinical experiences of the staff, discussing cases ending fatally or unimproved, and any notifications or applications which may occur in the hospital.

(7) A report of the meeting is to be sent to the minister.

(8) Hospitals are required to make provision for the care and treatment of maternity cases, as well as for cases of tuberculosis, to the extent of one-tenth of their authorized bed capacity.

(9) Case records are required to be written up for every patient admitted to the hospital, as soon as possible after the admission. Where no case record has been written up, the hospital is to note this fact in red ink on the form which is sent to the Department every six months.

(10) Anaesthetics are to be administered in the operating room, and by a physician, unless permission is otherwise given by the superintendent.

(11) Two qualified practitioners are required to be present at major operations, except in cases of emergency, to be approved of by the superintendent.

(12) Nurses and employees shall show proof of vaccination against smallpox, and shall take typhoid vaccine every two years. Those showing a positive Schick test shall be given toxin-anti-toxin. Those giving positive Dick test shall be immunized against scarlet fever.

In the training school for nurses provision is made for nurses receiving at least three months in a sanatorium. In the year 1923 the hospitals had two thousand two hundred and fifty-three (2,253) beds, and treated thirty-two thousand six hundred and sixty-three (32,663) patients, of which three thousand four hundred and forty-eight (3,448) were emergency cases. In 1912 only one birth in twenty was attended in hospitals; in 1923 one out of every six births took place in the hospital. Five hundred and thirty-one thousand and seven (531,007) hospital days were accounted for, which was an average of 12.7 days for each patient. During the year twelve thousand four hundred and thirty-six (12,436) operations were performed, with two hundred and eight (208) deaths following. Infections developing in hospitals were: Medical, 22; surgical, 22; obstetrical, 16. The average cost per patient per day for maintenance was three dollars and nineteen cents ($3.19).

In the year 1909 an active anti-tuberculosis campaign was started by the author. The Anti-Tuberculosis League was established, with the result that to-day Saskatchewan has a first-class, modern, up-to-date institution for the treatment of tuberculosis. Another similar institution will be opened in the beginning of the year 1925, providing accommodation then for over four hundred (400) patients.

DIVISION OF COMMUNICABLE DISEASE

The Division of Communicable Disease, under the direction of a physician, includes:—

(1) Epidemiology and statistics;
(2) Distribution of vaccines and sera;
(3) Supervision of trachoma;
(4) Supervision of tuberculosis;
(5) Care of the dead.

This division co-operates with local health authorities and physicians generally, in the carrying out of the regulations for the control of communicable diseases, as well as distributing propaganda and literature regarding the same.

There are forty-four (44) diseases classified as communicable, which the law requires to be reported to the local health officer, within twenty-four hours. This officer in turn submits a report to the division, weekly, of all cases he has had reported, or has knowledge of. Cases of tuberculosis not receiving sanatorium treatment are visited by a nurse of the Department, who, in co-operation with the attending physician, gives instructions in the care and preventive measures relating to the disease. A full-time nurse is also employed regarding cases of trachoma. This nurse acts under the direction of the division Director, and co-operates in the closest possible way with the local physician.

It is found that approximately 49.4 per cent of deaths from diphtheria occur in children under six years of age, and 44 per cent occur between the ages of six and sixteen. A special effort for the locating of this disease in children up to the age of fourteen is made by the use of the Schick test and anti-toxin. Vaccines and sera are distributed free and doctors in hospitals, during the year 1923, distributed a sufficient amount of toxin and anti-toxin to immunize thirty-three thousand one hundred and fifty-nine (33,159) persons at a cost of six thousand two hundred and ninety dollars and twenty cents

($6,290.20). Smallpox vaccine was issued sufficient to vaccinate nearly twenty thousand (20,000) people. Sixteen thousand five hundred and seventy-three dollars ($16,573) was expended in vaccines and sera in this year.

The following figures are of extreme importance, showing the rapid increase in the death rate from cancer. These rates are per 100,000 population:—

1914	18.0
1915	18.4
1916	27.8
1917	28.8
1918	29.6
1919	28.5
1920	30.1
1921	39.3
1922	42.2
1923	42.6

Last year there was one more death reported from cancer than from tuberculosis.

I wish to acknowledge the very great assistance which has been received from the Dominion Council of Health in improving the legislation and regulations regarding health matters, thereby making them, in so far as possible, uniform with the Health Acts and Regulations of the other provinces of the Dominion.

Much help has also been received from the Federal Department of Health. The literature sent from the Department, as well as the advice, counsel and visits of officials have been of very great aid.

DIVISION OF VENEREAL DISEASE

The division for the examination and treatment of venereal diseases operates three full-time dispensaries and clinics in the larger cities, and two part-time clinics in the smaller ones. Since the beginning of this work in 1920 the number of patients receiving treatment has increased from two hundred and seventy-eight (278) in 1920 to one thousand four hundred and thirty-one (1,431) at the end of 1923. Venereal diseases are classed as communicable, and every person so infected is required to report either to a registered medical practitioner or a public health dispensary, and undergo a course of treatment for the cure and prevention of the spread of the infection. Physicians giving treatment for these diseases, syphilis and gonorrhœa, are required to report all such cases with particulars, within three (3) days of the first visit of the patient. For this purpose all registered medical practitioners are supplied with suitable forms for so reporting. These forms do not require the sending in of the name of the patient as long as the patient continues treatment, which he is required to do by law. Prisoners at the two provincial jails are examined, and, where necessary, receive treatment, the cost being borne by the Department of Public Health. Neo-arsphenamine and mercury are supplied free to physicians for the treatment of patients who are not able to pay for the same, or who are unable to report at a dispensary. These dispensaries are located in the largest office buildings in each city and everything is arranged so as to minimize undue publicity, which might otherwise be attracted.

Follow-up work is done as far as is possible, by the two nurses employed, male and female. Sources of infection are strongly emphasized and attempts are made to clear this up. Educational work in connection with syphilis and gonorrhœa occupies a very important place in the work of this division. First-class wax models, illustrating various stages of syphilis and gonorrhœa, are used, and exhibited at fairs and exhibitions, and frequent public addresses are made relating to these diseases, by the deputy minister. Pamphlets, etc., are distributed, so that thousands of people are being reached through these different agencies. As a result of a recent survey undertaken by the division, it was found that only nine per cent (9 per cent) of those attending might have been able to pay something for treatment.

I might mention that one hundred and five (105) patients received treatment at the Regina dispensary on one day recently; five of these patients being children suffering from hereditary syphilis, the remaining hundred being about equally

divided between syphilis and gonorrhœa in men and women.

Upon the termination of the Great War, health representatives of the different provinces were invited to come to Ottawa to confer with the federal authorities as to what measures could be taken for the prevention and treatment of syphilis and gonorrhœa.

Conditions arising out of the Great War gave much publicity to the fact that these diseases were common in civil life, as was shown by the statement that for every six cases of syphilis and gonorrhœa among the soldiers of the United States Army, five of them had the disease when they entered the army.

At the Ottawa conference it was stated that there was a sufficient amount of these diseases in Canada, in addition to any that might be brought back by returning soldiers, to justify these diseases being dealt with as a national problem, assistance for which should be supplied to the provinces from federal sources. This principle was acknowledged and agreed to at the time, and the sum of two hundred thousand dollars ($200,000) was voted by the Federal House to be divided among the different provinces, upon the basis of population, and that each province would furnish an equal amount to that given by the Dominion, and that provision would be made by each province to provide such facilities for the continuance and treatment of syphilis and gonorrhœa as would be approved of by the Federal Department of Health.

This the provinces have done, and having seen how these diseases are being dealt with in some of the principal centres of the United States and Europe, and hearing what is being done in Canada, through being a member of the Dominion Council of Health, I must decidedly state that the measures being carried out at the present time in the different provinces of Canada, regarding syphilis and gonorrhœa, are the best being done anywhere.

All interested in this question were very much disappointed this year when it was learned that a reduction of twenty-five per cent (25%) had been made in the Dominion grant, especially so after a deputation from the Federal Council of Health had received the most positive assurance that the best would be done to prevent any reduction being made. I heartily approve of the recommendation made in the very able address of the chairman of this conference, that a resolution be sent urging that the grant be continued.

DIVISION OF SANITATION

The Division of Sanitation, under the direction of a civil engineer, gives information concerning the organization of Union Hospital districts, prepares plans and specifications for the construction of up-to-date hospital buildings, and co-operates with municipal boards of health for the prevention of diseases caused by pollution of air, water, milk and food. Public water supplies, sewage and sewage drainage systems are under constant observation, and new installations or extensions to existing systems cannot be undertaken until the plans and specifications have been approved of by the department. It might be noted that the sum of two hundred and sixty-four thousand four hundred and sixty-eight dollars ($264,468) was expended by municipalities during 1923 for the development of the water and sewage works, this sum being more than three times the amount spent in any previous year, which would indicate a tendency towards more active development in municipal sanitary works.

There was in Saskatchewan last year some four hundred and fifty-six thousand (456,000) dairy cattle. The authorities have been shown that about eighteen per cent (18 per cent) of these are tuberculous. It has also been shown that twenty-five per cent (25%) of the deaths from this disease in children are caused by bovine tuberculosis. Seventy per cent (70%) of all milk sold in the cities of Saskatchewan is now pasteurized. Four years ago this process was a commercial one which offered practically no protection from the disease. To-day the city pasteurization plants are all under careful bacteriological supervision, and ninety-eight per cent (98%) of the total bacteria has been eliminated, thus ensuring almost complete protection from milk bovine diseases.

This division devotes a lot of attention to giving advice towards private sources of water supply. For sanitary purposes, the province is divided into four districts under the supervision of a sanitary officer, who devotes his whole time of visiting, inspecting, giving advice and instructions to medical officials, regarding the responsibility and the protection of the health of their respective communities. This work is helping to raise the health standards of the smaller urbane centres, and having also a marked effect in improving the health ensurement of the people in the rural districts. Slaughter houses receive attention, as well as do summer resorts, and considerable amount of time is devoted to the organization and consideration of Union Hospitals throughout the province.

LABORATORY DIVISION

The Laboratory Division of the Department of Public Health is maintained for the benefit of the public, and the assistance of the medical profession and the hospitals of the province. All work is done free of charge. The work of this division is increasing very rapidly. In the year 1923 over seventeen thousand (17,000) examinations were made. Culture media, containers for different specimens are supplied to doctors, hospitals and any one requiring same. Twenty thousand (20,000) of these were distributed during the past year. The scope of examinations included five thousand three hundred (5,300) examinations for syphilis and gonnorhœa, four thousand (4,000) for other communicable diseases, and in addition, over four thousand (4,000) examinations for the Liquor Commission, and other departments. The director also performs autopsies and attends inquests when required.

DIVISION OF VITAL STATISTICS

The Division of Vital Statistics compiles records of births, marriages, dissolution of marriages, and deaths occurring within the province. It also classifies and tabulates these statistics, in order to provide some satisfactory means to show the result of public health activities. It is the channel whereby the efforts of the other divisions may be traced year by year. Thus the Health Department is enabled to set a goal of attainment, and the degree of approach to that goal may be taken as a measure of success of the work done.

Each municipality in the province is considered as a registration division, although any such district may be enlarged or diminished at the discretion of the Lieutenant-Governor in Council. The Secretary-Treasurers of the towns, villages or rural municipalities constitute the local registrars. City registrars are appointed usually from members of the Health Department. In unorganized territories the Lieutenant-Governor in Council may appoint any person to act in that capacity.

In conclusion it can be claimed that some results have been obtained in health work in the province of Saskatchewan.

Beginning with one official, and with an appropriation in 1906 of twenty-seven thousand dollars ($27,000) for all health work, including aid to hospitals, the sum a year ago had been increased to five hundred and forty thousand dollars ($540,000).

In 1905 the six hospitals with their equipment were valued at $63,084.53.

In 1924 the forty-three (43) hospitals with their equipment have a valuation of $700,000.

In 1905 one thousand and seventy-eight (1,078) patients received twenty-one thousand, three hundred and sixty-nine (21,369) days' treatment.

In 1924 thirty-two thousand seven hundred and sixty-three (32,763) patients received five hundred and thirty-one thousand five hundred (531,500) days' treatment.

From a hospital bed capacity of about seventy-five (75) in 1905 it has been increased to two thousand three hundred and fifty-three (2,353) in 1924, or one hospital bed for every three hundred (300) of the population.

For the treatment of tuberculosis seven hundred (700) beds are now available in Saskatchewan, and between two and three million dollars have been spent in providing up-to-date sanatoria.

In the year 1912 one birth in every twenty (20) took place in hospitals.

In the year 1923 one birth in every six (6) took place in hospitals.

The report of the Registrar-General of Great Britain recently published stated that the general death rate of Saskatchewan of 7.4 was the lowest of any portion of the British Empire.

The Dominion Bureau of Statistics, commenting on the mortality rate of Saskatchewan, stated it was not only the lowest of any of the provinces of Canada, but the lowest for any country in which vital statistics are available.

For these results credit is due to the splendid work done by medical officers of health in the cities, towns and rural districts, as well as to the assistance received from the members of the medical profession.

Last year I had the honour of being named by the Federal Government to represent Canada upon the Interchange of Health Officials of the Health Section of the League of Nations. There were twenty-four (24) delegates, representing eighteen (18) different countries. We met in Washington, spent four months making a thorough survey of conditions in the United States, after which we went to Europe and spent a few months in looking over health conditions there, having a final conference in Geneva.

Time does not permit me to go into details regarding this trip. I must, however, say that from what I have seen on this side of the water and in Europe, it is not at all necessary to go outside of Canada to see the most up-to-date health work being done at the present day.

The Chairman: We are all interested in the address which we have heard from Dr. Seymour, and it might be just as well before any discussion is had on his paper that we first hear from Dr. Jost. Both addresses might then be discussed at the same time.

THE NOTIFICATION OF DISEASES

Dr. A. C. Jost (Halifax): The paper which I shall offer to the conference has at least the merit of brevity. Necessarily it was written from the point of view of the province of Nova Scotia, so that ladies and gentlemen will bear in mind that the illustrations are of course Nova Scotian.

"No Health Department, federal or local, can effectively prevent or control a disease, without knowing when where or under what circumstances cases are occurring". This is the heading which for many years has stood at the top of the page commencing the reports on the disease prevelance in the United States Weekly Public Health Reports. The motto is something more than a justification of the elaborate and valuable portion of the report which follows, if indeed any dictum so obvious requires justification.

THE NEED

The knowledge sought after is vital to the organization whose duty is the control of disease. It is essential for the local board or unit, whose duty is that of self-protection against the individuals who may have been in actual contact with the infection. Little less important is it for the larger—the provincial or state—organization, whose responsibility is in the larger area made up a number of local subdivisions; for though the central organization must go to the areas not infected, the information is vital, that in one or more of the units making up the whole there are present diseases which it would be well for the remainder to prevent gaining a foothold. And finally, since disease recognizes no political or state boundaries, since these are days of rapid travel and constant intercourse between countries not nationally connected, it is most advisable that the larger areas be able to acquaint themselves of the presence of disease in the countries surrounding them. Each of these statements may be regarded as a truism, so far at least as infections are concerned, a truism which requires no elaboration or excuse.

Furthermore, the motto outlines for us a synopsis of the information it is most desired to collect. When has the disease occurred? This is a matter of the most vital importance. Was it present at the time the report was being made or has it burnt itself out? Is the information being sent at a time when there is possible the institution of measures to prevent spread, or have already the seeds of contagion been scattered far and wide? Control necessitates the early and active commencement of suitable protective measures. It is not historical data which it is desired to collect merely as a matter of interest and record; it is rather the information on which instant action is to be taken, if life is to be saved, or if the community is to be protected. It must therefore be obtainable at the earliest date after recognition, if it is to be of value, for otherwise exposures may have been made, a short incubation period may have been passed, and already an outbreak have so far gained headway that speedy arrest or control is impossible. Exact information of the "when, where and under what conditions" the disease is occurring is therefore essential.

On these points there is practical unanimity of opinion, concurred in by every organization formed for public health protection. In respect to other information, or programme of effort, there may be differences of opinion, but of the fact that a health organization or department is seriously hampered or hopelessly crippled if it cannot secure this so needed information there is no difference of opinion. As well expect the banker to devise an adequate banking system without a knowledge of the monetary demands of a country or his facilities for meeting them, as to expect a health organization to

protect community or country without a knowledge of the conditions against which it must be prepared to guard. "You do not know where you are going, but be on your way" are as faulty instructions to the mariner leaving port as, "You do not know what amount of disease is present, but function" is to a health organization.

DIFFICULTIES OF COLLECTION

But it is doubtful if any health organization has yet devised a means of procuring the information it requires, in a way which is satisfactory to itself, or which justifies the opinion that the figures it presents are really representative of the health conditions of the community in which it is interested. One must admit that there are a certain number of cases of almost any infectious disease the recognition of which is an impossibility or which do not at any time in their courses come under the observation of a person or organization who might be supposed to be interested in them for the purpose of reporting. There are the mild or ambulent cases of the infections, large numbers of which at no time come under the notice of any controlling agency. There are certain infections in which the almost universal procedure is to arrange for their care in the home, no physician being called except for the purpose of diagnosis with respect to the initial case occurring in the home or the community. These are well known facts, so well known as to admit of no denial nor while the disease itself preserves its usual characteristics or while society is constituted as it is can the difficulty be surmounted. But letting these cases go, admitting that these must remain, to prevent such accuracy as would delight the heart of a statistician, there are I believe few health authorities who have devised any scheme or who have succeeded in so carrying out or perfecting any scheme devised by others that they will accept without a well marked degree of hesitancy the numerical data of disease prevalence which may from time to time be secured.

METHODS

In all the schemes for the collection of the information sought after there is a quite marked similarity of procedure. In order the better to secure the reports, in order to have more than one route by which the necessary information may pass, practically all regulations provide for the dual responsibility of both physician and householder, with respect to reporting, once an infectious disease has been recognized. Furthermore, there is quite marked unanimity in there being made provision for the disease being recorded, not to one individual or organization only, but to both a medical health officer, if one be appointed, and to the local board of health. The report once received by the medical health officer, the route is a well marked one, the report going thence to the central authority for noting and tabulation. There is too, practical unanimity in the provision that, after the occurrence in the household of the initial case, with each separate or additional case, in the event of the disease having spread, the same procedure must be followed. Not however in all the regulations is the time the same in which any or all of the diseases must be reported. With respect to our own law for instance, while for some a time limit of twenty-four hours has been set, in other diseases one of a longer time is permissible.

These provisions apply to the reporting of the disease at its initial onset. In order to be assured that no cases have been missed by this procedure, endeavour has been made to procure information from altogether different sources (as for example the death reports), information by which it may be determined if diseases on the notifiable list have gone on to death, not having been reported. Checking up the mortality lists, a note is made of all deaths occurring from such. The medical health officer or the physician in attendance is then requested to examine his records, for the purpose of ascertaining that the necessary reporting had been carried out in these particular cases. This procedure is the one on which most reliance is placed in the state of New York.

These then are the various steps of the process, advised and followed out in practically all instances. They are simple, checked whenever possible, and provision is made by passage along an alternate route if for one reason or another one has not functioned. This provision applies especially however to the first steps in the process, where suppression is the most urgent, and where it is necessary that the board of health as well as the medical health officer must be made aware of the emergency, in order that measures may immediately be taken to safeguard other members of the community. The objection to it all is that only in a very moderate number of cases do the results obtained merit the opinion that there has not been somewhere along the route a very serious breaking down. As has been stated, many cases are not reported at all, and many more are reported to the medical health officer or to the local board of health and disappear before another point in their destination has been reached.

NOVA SCOTIA'S EXPERIENCE

While it may be asserted that some progress has been achieved towards accuracy in the years which have elapsed since the attempt was first made to collect data, this province cannot be said to have progressed so far towards a satisfactory result as have others of the Dominion. It is somewhat difficult to determine how far short we are falling. If we take the number of deaths caused by certain of the notifiable diseases in the course of the year, a computation may be made showing approximately the total number of cases which have been present if the ordinary case fatality was met with. An attempt has been made along this line and the results are herewith presented:—

Disease	Deaths 1922-1923	Average Mortality	Probable number of cases present	Cases reported 1922-1923
Diptheria	25	16%	160	187
		1 out of 6		
Cerebro-spinal meningitis	12	25%	50	17
		1 out of 4		
Pneumonia all forms	819	10%	8,000	344
Measles	49	1%	4,900	1,570
		1 out of 100		
Scarlet fever	14	2 to 8%	150-700	641
		1 out of 12 to 50		
Tuberculosis all forms	651	14%	4,500	347
		1 d. to 7 cases		
Typhoid fever	21	10%	200	113
Whooping cough	60	1%	6,000	716

These are, it must be admitted, perilously of the nature of guesses, but they indicate, respecting some of the diseases at least, how far we are from getting the reports we should have. Apparently, and this is something which is quite commonly conceded to be the case, the presence of diphtheria is made known to the medical health officer and by him to the department, with a quite commendable degree of accuracy. Possibly the same may be said of scarlet fever, since the wide range observable in the fatality rate may be sufficient to explain the discrepancy. We ought to have as great accuracy in respect to typhoid fever, but whether we have it or not cannot be stated. But there is such a difference in respect of the other diseases between the number of cases reported and the number we believe to have been present that the conclusion is obvious that but a small portion of the reports find their way to the department.

IS MORE ACCURATE REPORTING POSSIBLE?

The question will at once be asked, if some diseases are being reported with a fair degree of accuracy, why are not all? Does not the success with respect to some indicate that there is a possibility of success with respect to all? Is it that the pressure of public opinion is more urgent and will not permit laxity, or is it that the natural dread inspired by some disease encourages their being brought into the limelight? If the latter is the case why cannot this attitude of mind be encouraged in respect to all diseases? Should any disease be played as a favourite? Should any be protected by having conjured up for its benefit the shelter of professional inertia or secrecy, and permitted to continue its ravages? The medical profession should lead, not follow public opinion in this respect.

THE PAYMENT OF FEES

Shall a fee be asked for in connection with the collection of reports? There is no question which in any group of physicians will more quickly precipitate an argument. In favour of it are those whose opinion is that there are now too

many demands being made on a physician for which little compensation is provided. This service is largely, it is claimed, a service in which the public only benefits. If the public are to benefit it is but fair that the information, being valuable, shall be paid for, at least to the extent of reimbursing the physician the amount of his outlay. But has the physician no responsibility as a member of his community or of society as a whole? Is he not protecting himself and his own family when he protects the community? How many physicians are there who could enjoy their present standing if society, through government, municipal, provincial or federal aid or some organization had not provided the hospitals, schools or colleges where his education was obtained, or had not protected him from opposition even to the extent of placing themselves liable to the criticism of having established a closed profession? In Utah this protection of the state may be withdrawn and the practitioner's name be removed from among those eligible to practise in the state if reports of notifiable diseases are not communicated to the proper authorities. So here at least is one community which is disposed to question the assumption that there is no community responsibility from which a physician may not escape.

RESULTS OBTAINED FROM REPORTING ON PAYMENT BASIS

Has the payment of a fee been productive of more accurate returns? This is very questionable. There are countries where this system is in vogue and apparently is meeting with favour, and where there is a disposition to think that the results obtained justify the expense. There are others where payment is provided for, and presumably the fees collected in some cases, but which countries by no means favourably impress one as being among those whose records are of value. There is at least one where for years provision for the fee has been on the statute books but where within the past five years no instance of its collection has been known. In the state last referred to the health authorities attach no significance to this provision, but are apparently satisfied with the results obtained, to all intents on a purely voluntary basis. Only one conclusion seems possible, that success in the collection of the statistics does not depend wholly on the provision or otherwise of a fee.

WHO SHALL PAY THE FEE?

And who shall pay the fee, if a fee is to be charged? Is it to be a provincial responsibility? Has any organization of medical men sufficient influence with their provincial governments to induce them to accept the expenditure? If not the provincial organization, can they do this with the municipal authorities? Of all the ways in which the small amount of money which it is possible to obtain for health purposes can be spent, does this method of spending it offer the prospect of the most satisfactory returns? In the province of Nova Scotia the Health Act specifically states that certain diseases must be reported. Can it be represented to the government or the municipality that the legislation now on the statute books has been unfair in its demands on the medical profession and that the profession has thereby suffered and will continue to suffer until some other provision has been made? Remember that it is the medical profession as a whole on whom the burden of establishing proof of this must fall. No matter how anxious a health department may be to bring about a change it must have the support of the whole profession behind it if these demands for payment are to meet with a favourable result.

THE PRESENT URGENCY

This matter is being brought before you because about this time it is forcing itself on the attention of all the provincial health departments. The nearly national status which the Dominion now has as a signatory participant in the League of Nations compact has brought added duties and responsibilities. One of these is that Canadian statistics of the presence of disease shall be prepared and forwarded for publication with those of the other signatory powers. A duty has thus been imposed on the Federal Health Department or the Census Bureau which these departments unaided cannot perform. Only through the assistance they are given by the provincial departments can the scheme be carried out, or can the results obtained be other than a commentary on lack of provincial organization or support. It cannot be considered that this article in any way fully covers the ground. If it has had the effect of bringing this important matter before you in some of its most striking aspects it shall have served its purpose.

The CHAIRMAN: The papers which we have had from Drs. Seymour and Jost are now open for discussion.

Dr. H. W. HILL (London, Ont.): Dr. Seymour spoke of a Minister and a Deputy Minister of Health and he also referred to a Commissioner. Perhaps it would be well if he would explain the respective functions of these various officers. I do not

know whether I was right in gathering that the Health Department of the province of Saskatchewan administers certain hospitals. If that is the case, I might ask Dr. Seymour to what extent the department is engaged in this work. To my mind the fundamental distinction between the practising medical profession and boards of health is the fact that heretofore boards of health have been supposed not to do any therapeutics. I wonder what has been done in Saskatchewan in this respect? With regard to the excellent paper which we have had from Dr. Jost concerning the reporting of communicable diseases, it seems to me that men who are engaged in public health affairs should realize unreservedly that it is altogether unfair to charge the physician, who does not report all cases that occur, with the responsibility of any neglect in this matter. It must be borne in mind that the physician fails to have any cognizance of an enormous number of cases, and we shall never properly control communicable diseases so long as health departments depend entirely upon the reporting of these diseases by physicians. I am sure that the physician does not see 40 per cent of the total number, and we are trying too often to control the spread of communicable diseases on a 40 per cent basis. This of course is impossible. We have made an intensive investigation in the city of London in connection with 8,000 school children and the figures disclose an astounding state of affairs in comparison with the records of the health department, which do not begin to touch the actual numbers of communicable diseases that exist. When we remember that 74 per cent of the population who die between the ages of one and thirty-nine succumb to infectious diseases of one kind or another, we can easily realize that the problem of controlling communicable diseases is one in regard to which boards of health have so far merely scratched the surface. This is true of medicine in general, because 60 to 70 per cent of the population require medical attention and of this number only some 20 per cent receive it. The possibilities have not yet been exploited, either from the therapeutic or the public health standpoint. The whole thing remains to be done on an enormous scale which would stagger most of us, particularly when we realize what has to be done in both these directions. For myself I am convinced that until the board of health discovers cases of infection and reports back what it finds we shall never get anywhere; certainly I do not think that any progress will be made merely by trusting to what the members of the medical profession may report to us, no matter how conscientiously they may do so.

Dr. J. W. S. McCullough (Toronto): The question of reporting communicable diseases is one that is constantly coming up and in my opinion the duty which now devolves on the medical profession in connection with the reporting of these diseases is a proper one to which they should respond. On the other hand, however, seeing that the measure is something which is intended to benefit the general public, I think it is only fair that the public should be expected to pay for the service they receive. In England the physician is paid 2s. 6d. for reporting communicable cases, and this system has worked well there. I think the point has been well taken by Dr. Hill, that even if some enactment had the effect of increasing the number of reports made by physicians there would still be a large proportion of communicable diseases in Canada which would remain unreported, inasmuch as a considerable percentage of these cases are not attended by doctors. This I think will be admitted readily enough. If we could improve the situation to the extent of having the physicians report all cases with which they have to do, so much would be gained. It is important that reports of this kind should be given to the health authorities, for only by knowing of the existence of tuberculosis, for example, can the problem in relation to that disease be adequately dealt with. The same is true in regard to other infectious diseases. In the obtaining of reports of communicable diseases I do not think that any measure will give altogether satisfactory results. In this matter the solution is to be found in a full-time organization, with well-trained nurses going into the houses of people from day to day. They can find out what cases of communicable disease exist and report them. I am strongly of the view that physicians should be paid for these reports, and in my opinion the local unit of government and not the central government should be held liable in this regard.

Dr. H. L. Young (Victoria, B.C.): We came here—at least I did—fully expecting that there would be a rather intimate discussion of that aspect of the question touching the relationships of the health authorities to the medical profession and the public. Speaking as a health officer, I think there is a feeling of hostility on the part of the medical profession towards the health authorities, but I want to qualify that statement at once to the extent of expressing my agreement with Dr. Amyot who yesterday said that the opposition came rather from a clamorous minority and not from the profession as a whole. The profession as a whole is, I think, satisfied to lend its influence and power to the advancement not only of the interests of the profession itself but as well of those of the community at large. Since the war there has been a material change in the relations between the public on the one hand and the medical profession and governments on the other. In all these questions we must remember that three elements are involved—the profession, the public and the government. Ultimately, the views of any one of these must prevail where the majority exists, and the people are conscious of the fact that there is something radically wanting in the attitude towards themselves of both the profession and governments. They are demanding more and more that something shall be done in regard to diseases that can be controlled and they are appealing to the profession to whom they have been accustomed to look for guidance in emergency. They are determined

that the government shall give them such protection for themselves and their families as they feel that they are entitled to. The public consciousness is becoming alive not only to its rights but as well to its power, and it is for the profession to see to it that nothing shall be done which will endanger its own interests. The government looks at these questions not from the humanitarian but from the economic point of view. Let us not forget that. If we consult the budgets of the different provinces over a period of years, we shall find that in the last ten years the votes for charities and hospitals have more than doubled, from the point of view of maintenance alone. In British Columbia during the last ten years we have doubled our expenditure, and we are spending this year upwards of $1,500,000 for the maintenance of our institutions. This does not include an enormous expenditure in the way of capital charges. Governments are becoming seriously alarmed and are determined to see that diseases shall be controlled as far as possible in order that the taxpayers may be relieved of the burden which they are at present bearing for the upkeep of these institutions. The hospitals are obliged to carry an accommodation for thirty per cent more than they should have to take care of. Proper preventive measures are being demanded by the people, and governments are supporting this demand. We have now reached the stage where preventive methods are encroaching on curative methods, and if the medical profession does not take proper steps to meet the situation they may find the people demanding something which they do not understand, which has not been thoroughly worked out, and which will end detrimentally to the profession itself. At present the public have enormous organizations—this is especially so in the United States—which are reaching out and extending their energies, and they are demanding more and more that proper measures be adopted to safeguard the health of the people. There are a great many fanatics who expect to cure all the ills of the world by means of legislation. We have these people on the one hand. On the other hand, we have in the profession the ultra-conservative element who are content to go along following the traditions of the past, giving their services freely wherever they can, but accomplishing little in the way of prevention. Between these two extremes the public health authorities are rapidly having to assume a position of control, restraining the one and trying to stimulate the other.

Now, in years gone by we have been wont to look upon the sick person as an individual who had been visited by Providence and who might look after himself if he was able to pay, but who, in any case, was usually taken care of by the profession. Since the war we have been gradually coming to the view that the individual must be considered from a different standpoint; he is not to be regarded merely as an individual but rather as a member of the community, and his case must be treated from the point of view of the public welfare. It seems to me that unless the profession itself takes matters in hand, the public will force something upon the government which will be unsatisfactory both to themselves and to the profession. The profession, recognizing that governments respect it and are asking for its advice, will do well to come forward and take the initiative in this forward movement with a view to preventing chaos and to advancing the general welfare of the public. In British Columbia we have tried to provide some measure of co-operation, and in regard to this Dr. MacDermot will have something to say. The public health officers, let me say, are not the originators of the present forward movement; it is due to the awakening consciousness of the public, and it is a mistake for the profession to assume any attitude of antagonism to the health authorities.

The Chairman: The present conference affords a splendid opportunity for experts to get together, and the subjects which are being discussed this morning are undoubtedly of sufficient interest to elicit further discussion. I might call upon Dr. Laidlaw, of Edmonton, who no doubt has something of interest to contribute to the subject.

Dr. W. A. Laidlaw (Edmonton, Alberta): There is no question as to the need of these reports being made by physicians; such a need is I think apparent to all. The experience of the province of Alberta, based on morbidity and mortality statistics, is somewhat similar to that of Nova Scotia. Diseases of any severe type are well reported; practically all cases of smallpox for example are notified. The people themselves have a dread of smallpox and they will report, and see that their neighbours report, every occurrence that takes place. In regard to the milder diseases, however, no reports come from the country districts. In the municipalities and cities where there are full-time officers and an organized staff we get fairly complete reports, but in a province like Alberta, where the municipal unit comprises some nine townships, or eighteen square miles, where there is not the means of providing an organized staff or a medical officer we are not getting the reports that we should. We get no reports from the small municipalities except where the disease is severe, and often we get such reports after the damage is done. The solution lies in grouping together all these small municipalities into one unit large enough in population to pay a full-time staff. Dr. McCullough will, I think, bring that question up later. Our population in that province is, I think, about 600,000. The forms for reporting these diseases should I think be concise and simple, and the Department of Public Health through the local boards should be charged with the onus of following up and getting the information from the physicians. In Maryland there is a follow-up system, a form being sent every week to physicians on which they state the number of diseases that have occurred of which they

have cognizance. This system, I believe, is proving valuable. As regards the question of fees, I agree it is the duty of the provincial or local boards to pay for the reports which the doctors send in. In the last analysis we can get no reports unless we are assured of the hearty co-operation of the medical profession, and it does seem to me that the boards should pay for these reports.

Dr. G. G. Melvin (Fredericton, N.B.): I should like to make just a few remarks touching Dr. Jost's paper. No doubt members of conference will understand that we in New Brunswick are late comers in the field of public health, having passed the present Health Act only in 1918. In the province of New Brunswick we do not place the whole burden of reporting communicable diseases on the medical man. True, we do place upon the medical man the responsibility of reporting communicable diseases whenever it is possible for him to do so, in other words, in all those cases in which his attendance is required. I hardly think that anyone would be so unreasonable as to suppose that the responsibility of reporting communicable diseases should be placed upon a physician in any case in which he is not interested and in regard to which he can therefore have no knowledge. In New Brunswick, however, we put upon the lay population some share of responsibility; we place upon the householder the burden of reporting what he suspects to be a communicable disease when any such occurs in his household. Every householder suspecting a disease of a communicable nature is expected to report it to the local health authority, and it then becomes the bounden duty of that authority—and there is one such authority in each county—to transmit the information to the central departmental authority. The matter is then investigated, and as matters work out in New Brunswick we are generally able to investigate these cases of supposed contagious disease through our own officers. We have adopted in New Brunswick the principle of all-time medical officers, and I may say that this is by no means a dead letter. Scarcely a week passes but I have had investigated cases of suspected communicable diseases to which no doctor had been called. Some of these upon investigation have proved negative, but that does not discourage us. Others have been positive and by such means we have been able more than once to check what was apparently the beginning of an epidemic. I thought it worth while to call the attention of conference to this point, as it agrees to some degree with Dr. Hill's view that the public health authorities should investigate these cases themselves and report back to the physician in order to relieve the medical profession of the necessity of reporting their own cases. It would cost an enormous amount of money to investigate every single case, and in any event a good many of the diseases would not reach us. As I say, we are laying upon the lay population themselves as well as on the medical profession the responsibility of reporting communicable diseases; that is to say, we expect the householder to report such cases as he suspects himself. We do not of course hold him responsible if, acting upon a suspicion which afterwards proves to be ill-founded, we find that the disease which he thought to exist does not really exist at all. We cannot blame him for a false diagnosis, but we expect him to report whenever he has reasonable grounds on which to base a suspicion. The population of New Brunswick, I may say for the information of gentlemen who may desire to know, is about 400,000.

Dr. H. W. McGill (Calgary, Alberta): I desire to say a word in behalf of the man in private practice. I am afraid the private practitioner has been put in a false position this morning, and Dr. Young, I have no doubt quite unintentionally, helped to do that. I do not think there is a clamorous minority among the profession opposed to public health matters. The duty of the state is clearly defined, and Dr. Hill a moment ago referred to the responsibilities which should fall respectively to the country and to the individual. The field of prevention is one of the duties that appertain to the state, but how far the public health bodies and the state should go in adopting remedial measures is a question which is giving the profession some concern. The public child welfare movements, public health units, and so forth, are ideal, and necessary and good in their way, but to what extent should they adopt remedial measures? In the matter of infectious diseases, that might be desirable, but certainly preventive health measures form part of the scope of the state. I would refer particularly to one such measure, which I regard as one of the most efficient of the preventive means which we have adopted. I mean vaccination. In many parts of the country vaccination is more or less neglected, and in this connection there is room for greater attention on the part of public health bodies. I rose, mainly for the purpose of putting myself on record in regard to the suggestion that private practitioners are opposed to measures of public health. I do not think that this is the case at all, nor do I think that any such inference can be substantiated for a moment.

Dr. George Young (Toronto): The thought occurs to me, Mr. Chairman, that possibly there is a danger of paternalism in the public being treated as children, without any sense of responsibility on their part to the state. It seems to me that governments do not pay enough attention to the education of the individual regarding his duties to the state, and in my opinion the regulations in the province of New Brunswick have a good deal to be said in their favour.

Dr. R. E. Wodehouse (Ottawa): In Manchester the wage earner is reimbursed for any loss suffered as a result of

quarantine and it is claimed that satisfactory results are obtained through this system. The authorities get to know of cases of infection, inasmuch as the householder has no fear of reporting the disease; he knows that he will not suffer any financial loss. Where this is not done there is naturally a reluctance on the part of people to report diseases. We must have the co-operation of the people in the reporting of diseases and in Los Angeles, in the case of the plague, those who are affected hesitate to report.

The CHAIRMAN: If there is no further discussion, Dr. Jost and Dr. Seymour will close the discussion.

Dr. JOST: Referring to Dr. Hill's comment, I have no doubt whatever that he is perfectly right; a great deal of the responsibility rests with the householder, and that I think is practically universally recognized with all health organizations. Not only is the physician supposed to report any case with which he is dealing, but the householder as well is expected to play his part. I drew attention in my paper to the fact that there were several channels through which this information might eventually pass on its way to the central authority. One difficulty which we have had to contend against is this: we are not getting any reports from the doctors in a good many cases, and if we do not get them from the doctors how can we in reason take the matter up with the householder? Undoubtedly a great many doctors do everything they possibly can; we have proof of that in our own experience in the province of Nova Scotia. Some of our physicians report, but unfortunately there are many cases that are not reported, and if the doctors do not report it is impossible to do anything with the householder. My paper dealt with the pros and cons, the various arguments for and against, the practice, and I mentioned the fact of pay. I referred to one state in which, although there was provision for pay the physicians never requested it. Our own experience in Canada is not very favourable so far as the value of payment for reports is concerned. I believe that some years ago in British Columbia there was offered for reports on tuberculosis a fee as high as a dollar, and if I mistake not, Dr. Young will bear me out that the results were not very satisfactory. Even after that offer was made there was no improvement. The same thing has been true in a great many states in the American union. Some states adopted the practice of paying a fee and eventually, struck the provision off the statute books. So far as this particular question of a fee is concerned my own opinion has not crystallized; I am doubtful whether by such a provision you could get better results. I do not think there is much more I can add at the present moment by way of closing the discussion on my own paper.

Dr. SEYMOUR: Replying to a question asked by Dr. Hill regarding the respective positions of Minister of Health and Commissioner, I may say that by the enactment of certain amendments to the Public Health Act in 1923 a minister of health was provided for and the position of commissioner was done away with. There are no hospitals in Saskatchewan administered by the Government. A grant of fifty cents per day is made to hospitals for both pay and non-pay patients and one dollar a day is paid to the sanitoria for tuberculous cases. The Department of Health takes a special interest in hospitals and provides regulations for the reason that the administration of the Hospitals Act comes under the Minister of Public Health; and when the question of providing aid for hospitals was under consideration, and the sum of $320,000 was asked for in that province, some of the members of the legislative assembly wanted to know what was being done with a view to ensuring that the money was spent to the best advantage. The minister replied that the amounts were carefully checked and that every effort was made to see that the best possible treatment was given patients. The Department of Health is trying to make good that statement and the regulations provide that the best possible work shall be done in the hospitals and necessary facilities afforded. The clinics are for inspection and diagnostic purposes only; no treatment is made in connection with any of the clinics. The nurses are distinctly instructed that their work is merely that of inspection and that examinations should be made by medical men alone. We try to differentiate between these two.

With respect to the reporting of diseases, I am in accord with remarks made by Dr. McCullough, that the profession should not be asked to do this extra work without remuneration. The onus of reporting is placed on the householder in practically all health acts of the province. That however does not amount to anything; the householder does not report and no effort is made to make it compulsory. It is a mistake to assume, as I think some may assume, that Dr. Hill was in favour of householders reporting.

We have done away with terminal disinfecting; we rely more on bedside disinfection. I believe that public health education carried on by men like Dr. Amyot and Dr. Hill in Canada has done an immense amount of good, and we are trying to have our health regulations based on the definite information they supply us. I may observe that we do not quarantine now for smallpox. The patient is isolated and if any objection is raised to vaccination we keep him isolated long enough to ensure the public safety, or until he sees the wisdom of being vaccinated. I think it is unfair to lock up a whole family because of the illness of one member. This year we supplied anti-toxin free and a sufficient quantity of material to deal with 40,000 cases of different kinds, while sufficient smallpox material was provided for 20,000

persons. There is a large amount of trachoma in the province of Saskatchewan and we have provided the services of nurses to care for these cases under the direct supervision of a local medical attendant. By employing full time nurses for trachoma we have secured good results. In conclusion, I may say that the Department of Health does not do any therapeutic work.

The CHAIRMAN: I have now pleasure in calling upon Dr. McCullough to address the conference on the subject he has undertaken,

"THE GREATEST PUBLIC HEALTH NEED OF CANADA"

Dr. JOHN W. S. MCCULLOUGH, M.D., D.P.H. (Chief officer of Health, Department of Health, Ontario): Before I begin the discussion of the subject on which I have undertaken to address the conference, I beg to be allowed to congratulate the executive committee on the success that has so far attended this gathering. It is a rare opportunity to public health men to be able to meet and discuss such problems as have so far come before this conference, with the general profession and I am sure that the committee having this matter in charge have discharged their duties well and to the satisfaction of all who are present. The subject of my address, as the chairman has announced, is "The Greatest Public Health Need of Canada," and that your suspense may be relieved at once I shall say that the greatest need of public health in Canada is a full time local health organization.

In my opinion the most pressing public health need in Canada to-day is the establishment at the earliest possible date of some system of full time local health organization. Most of the provinces have excellent government organizations, supported as a rule by active voluntary associations, but in the municipalities, particularly in the rural areas and small towns, the machinery for carrying on public health work is not as effective as one would desire. A study of the municipal health organizations of the United States, Great Britain and Canada shows that outside of the large cities there is no completely satisfactory organization for carrying on public health work in an efficient and economical way. The part time health officer in these countries, with some notable exceptions, has proved a failure as might be expected. The business in life of the practising physician is the practice of his profession. The work of the part time medical officer of health necessarily interferes with and injures the professional work of the practising physician and consequently both suffer. I have in mind two small cities in Ontario close together, each with a population of about 30,000. The people in each of these cities are of much the same character. Both of these cities are largely industrial and are smart up-to-date places, from a business point of view. The assessed values and the debenture debts are much the same. The one has had a full time health organization for about five years. This city has pasteurized milk, medical inspection of schools, ante-natal clinics, tuberculosis clinics, and public health nurses, and spends on public health work upwards of $20,000 a year. The latter has always had a part time medical officer of health. There, loose milk is sold, there are no clinics, no medical inspection and no public health nurses. The yearly public health expenditure is $6,500. But in the former the infant mortality rate has dropped in five years from 101 per thousand births to 38, in the latter, this rate has actually increased in late years and is now 71 per thousand births.

In the care of tuberculosis, most of the provinces of Canada show a remarkable decrease in mortality in the last twenty years, but the public expense in the care of existing cases shows that a great deal requires to be done to lessen the financial burden in this regard. For example, let me point out that in Ontario, the institutional care of some 3,000 tuberculous cases last year cost the provincial government $315,290. This represents about one-third of the actual cost of maintenance of these cases, and takes no account of interest on investment, nor cost of administration. In addition, the last report of the Mother's Allowance Board (1923) shows that there was paid in allowances on account of tuberculosis $214,578. This sum is 13 per cent of all disbursements made by that body. Thus it will be seen that the large sum of about one and a half millions of dollars is spent by the public of Ontario on the care of the indigent tuberculous. This bill will gradually increase from year to year unless satisfactory means are provided whereby the infection may be controlled.

The cardinal principle in the control of tuberculosis is the discovery and treatment of early cases and segregation of advanced ones. This is a task beyond the power of any provincial government and must, to be effective and economical, be the duty of competent local authorities. The part time system provides no satisfactory solution of this, or indeed of any public health problem. On the other hand, the experience of full time health organizations shows that under such control public health work is advanced in a remarkable degree. Public utilities such as pure water, sewage disposal, satisfactory disposal of waste and garbage, and clean milk are soon provided; the infant mortality, the tuberculosis and typhoid

mortality are rapidly diminished; inspection of school children is satisfactorily carried on and the entire community under such control benefits to a large degree both physically and financially. In provinces where the rural areas are divided into small municipalities like townships, and in the small towns, such units are financially unable to bear the burden of a full time health service. Under such circumstances the logical course is to consolidate a number of such units for public health work, taking for this purpose the county or part of a county with its small urban municipalities. This is exactly what is being done in Great Britain and in the United States. In England the consolidated communities are called combined areas. In the United States the county is the usual unit. In the former country considerable advance has been made in this direction, and in the United States the number of counties organized in this manner has increased from four in 1914 to over 250. By means of an organization of this kind direct results have been obtained in connection with the control of the smallpox situation. There was a smallpox outbreak in the Essex border cities last winter which was confined to this area and only 67 cases were reported. You may form some opinion as to the nature of the outbreak when I say that of the 67 cases, 32 died, and of the latter none had ever been vaccinated. While I am on the subject of smallpox, I should like to emphasize the great value of vaccination in this particular instance. On the occasion of which I speak the medical men and the population of the particular city concerned got together; about 98 per cent of the population were vaccinated in two or three weeks and the result was that the total cases were but 67. This could not have been accomplished if the seven municipalities combined had each a part time health officer.

Reference has been made to the question how far remedial measures should extend on the part of a department of health. In my opinion the Department of Health should confine its attention to communicable diseases, while the treatment of all other diseases should be in the hands of practising physicians.

More is necessary for the successful operation of a county or combined area scheme than a full time properly qualified medical officer, although this attainment is a long step in advance. There must be a satisfactory budget for expenses so that public health nurses may be employed in the follow-up work of medical inspection of schools and general community service. Sanitary inspectors are needed for the supervision of milk supplies and for other purposes, and certain clerical assistance is necessary. The basis for the determination of a budget is usually placed at 71 cents per head of population. In order that the county or "combined area" may be assured of the proper qualifications of the medical officer of health, the central authority should contribute towards his salary and make the qualifications of the medical officer of health a condition of such contribution, and further, some security of tenure in his office should be guaranteed. In England the Ministry of Health pays one-half the salary of full time medical officers of health.

There is little hope of any but the larger cities voluntarily adopting a plan of this kind. Where the scheme of municipal health organization is in operation, as it is in Ontario, the local authorities are apparently satisfied with it for the reason that they know of nothing better. They regard the quarantine of communicable disease as the beginning and end of the duties of the medical officer of health. The only way to instruct local governments in the value of a competent health organization is by practical demonstration extending over a period of three or five years in suitable counties or combined areas. Ordinarily such demonstrations for a chiefly rural area will cost $10,000 a year. The funds might be secured from the joint contribution of central government, local area and perhaps some private source. There is nothing like successful demonstration of work of the kind to convince the public of its value.

Whether or not these remarks apply with equal force to provinces other than Ontario, other members of the Conference will be more competent to say, but there is no doubt that in respect to my own province, the weakest spot in our public health organization is the part time plan, and our greatest need is to have that plan replaced by a full time service. The matter is brought to the attention of this Conference for the reason that in the inauguration of such a plan enabling legislation is required to consolidate municipal units into county or combined areas for public health purposes. This being done, public opinion and the assistance of the medical profession are necessary in its successful operation. It is hoped therefore that the conference will fully discuss this question, and if the subject meets with the approval of the members that they will give it their valued assistance. As a further example of the value of a full time health organization it is of interest to point out that the advance report of the results of the work of the Massachusetts Health Commission in Halifax, Nova Scotia, shows that the death rate of that city has dropped in five years from 20.01 per thousand in 1919 to 11.7 per thousand in 1923, and that the work of the commission has resulted in the saving of 550 baby lives and 1,700 adult lives in the five year period. In Ontario last year, through the co-operation of the Canadian Anti-Tuberculosis Society and the Red Cross, the Department of Health was able to carry on a survey. I need not burden you with the results of that survey, but they amply show the great need that exists in urban and rural areas for proper surveys to discover defects among children. We carried on the work among pre-school and school children and were splendidly

assisted by the local practitioners. I trust that the conference will discuss this question and that we shall have the views of gentlemen upon it.

Dr. J. G. FITZGERALD (Toronto): This interesting and significant contribution does not inaugurate any fundamentally new principle, nor does it propose anything radical. For over 80 years local medical officers of health and health authorities have been co-operating in the larger communities. The first full time local authority was appointed eighty years ago, and since then there has been a rapid extension, so that the application of this principle is now general throughout the world. It was in Liverpool that this radical movement was inaugurated and now in all countries it is regarded as essential and is accepted as a matter of course. What Dr. McCullough in essence advocates is its extension to less populous and smaller communities, either in the shape of counties or in the form of combined areas. The extension of the principle has taken two forms: in the United Kingdom there is what is known as the combined area while in the United States the country is divided for this purpose into counties. It was in 1908 in Jefferson county, Kentucky, that a full time service was inaugurated and last year in the United States there were 230 such county services. That gives an idea of the rapid extension of the movement there. Since 1911, under the direction of the Minister of Health, of the Scottish Board of Health, and of the Health Department of Northern Ireland, there has been a similar extension of the movement in the British Isles. The most important consideration, and the one to which I would especially direct the attention of the conference, is the question of ways and means. There are many other important aspects of the problem, and while I do not think we should consider the question of policy, as to what the department should undertake it does seem to me that the matter of ways and means is of vital importance. Dr. McCullough intimated at the close of his address that in some countries the central authority contributed a considerable part of the cost of maintenance. That is true in the United Kingdom; there the local authority contributes a small proportion of the cost while the contribution of the central authority is substantial. In the United States the federal service, the state health department and the local county each contribute, in addition to what is received from the Rockefeller Foundation, which is the successor to the Rockefeller Sanitary Commission. In 1923, through the co-operative support of this one voluntary agency alone there was contributed the sum of $216,000 in twenty-two states. Three other countries besides the United States benefited from that institution, Canada being one of the three. The province of New Brunswick was assisted to some extent. It is interesting to know that in the new countries of Europe, in Jugo-Slavia and in Czecho-Slovakia, this method is spreading; these countries are being now aided by more than one body. The same is true in South America, notably in Brazil. The question of ways and means is a very important aspect of the subject, and until there is some definite assurance that there will be an adequate financial support to warrant the inauguration and to ensure the proper maintenance of this work, we cannot hope for the best results. There is a conspicuously successful example in the Essex Board of Municipalities: in my humble opinion the work there has been extraordinarily successful.

Dr. MELVIN: I shall offer just a few observations upon Dr. McCullough's interesting paper. Had I discussed this subject six years ago, at the inauguration of our present health system in New Brunswick, I would have said that all time medical health officers were absolutely essential. Members of the conference will pardon me if I refer for a moment or two to our little province; I know it is obscure, especially to people in the West. However, I may observe that we have put into practice and have continued in operation the principle of all time medical health officers. While I am in agreement with Dr. McCullough as to the superiority of the system of all time medical health officers, at the same time I have one or two reservations to make. The word reservations, by the way, has come very much into use of late years; but that is by the way. The all time medical health officer is certainly the ideal condition; a trained all time medical officer is of considerable advantage. And by "trained" I mean a man who is educated in the science and art of public health work. There can be no question, therefore, of the superiority of that system. But in the province of New Brunswick—and this is what I meant when I said that I had a reservation to make—we have found that all time medical health officers are not very easily had; by reason of the necessity of paying an adequate salary to an all time man we have been able to secure few such officials. That is the only fly in the ointment. If we had financial aid enough to increase the pay by 50 per cent there would be no obstacle at all in the way of having all time medical officers in New Brunswick, but owing to financial restrictions we have rather too few medical health officers in that province to cover the districts which they are supposed to take care of. We have three officers, each of whom has a territory of about six thousand square miles to cover, that is to say, three or four counties. I must say on behalf of these men that their work is a great success; their duties are efficiently discharged and they are performing a great service to the community. They are indeed the standby, the corner-stone of our health system, and they are by far the most important officers we have on our staff. The point I want to emphasize in this matter is this: in public health promptness is everything—promptness in responding to complaints of every kind where contagious diseases appear. One can understand that other things being equal, the more promptly a complaint is responded to the more efficient will be the administration of public health. Indeed, promptness

is of such importance that it is hard for one to overestimate it. The only point in favour of part time officers is the relatively greater number of these officers who may be obtained, with a consequent added promptness with which complaints may be taken up. On the other hand, however, part time medical officers are almost of necessity untrained men, inasmuch as you cannot expect to get a man skilled in public health to undertake this work on such a basis. You cannot expect a man to go to the expense of properly fitting himself for the discharge of the duties involved in public health administration if you are to pay him $500 or even $1,000 a year. I say therefore that part time medical men are almost necessarily untrained, and this of course is a great disadvantage. I thought I would bring this point to the attention of the conference, but I do not want to be misunderstood at all. I am heartily in favour of Dr. McCullough's proposition, but it seems to me that medical health officers should be not only trained men but all time men as well. We have a system of public school inspection in which we have medical school inspectors who partly make up for the paucity of the district medical officers. They are all time men, and in addition to that fact they have had the benefit of a short course—the only instance in Canada of a short course in training in medical school inspection. This helps to a considerable degree so far as our province is concerned in supplementing the duties of the district medical health officers. In conclusion, let me once more express my hearty approval of the principle contained in Dr. McCullough's paper.

Dr. A. H. Wright (Toronto): I want to say just a word or two in regard to Dr. McCullough's paper, and I am entirely in accord with him. That, I suppose, is an old story with me, so far as my relations with him are concerned. I cannot add much to what he has said in reference to the two cities which he mentioned as spending $20,000 and $6,000 respectively. His mention of that fact however, brought to my mind a paper read in Detroit at the last meeting of the American Public Health Association by Dr. Rumsden, of the United States Health Department, at Washington. He put the matter on a business basis, which is something that is not altogether new. Dr. McCullough's paper also put it on a business basis to a certain extent. But Dr. Rumsden went rather farther back; he did not take the father or the mother of the family but he went to the central power: he went back to the government and through the government to the taxpayer. His paper was published in the December number of the *Journal* and it is an admirable one which I can recommend to any member of the conference. He said that to withhold one dollar on the ground of economy and to lose one hundred dollars in consequence was not good business, and he gave certain figures to substantiate the position he took. The last appropriation by Congress, he pointed out, was $3,400,000,000; and as he stated, the taxpayer has a right to know what becomes of that money. He looks around and finds that so much is given to agriculture, so much to stock-raising, so much is devoted to roads, so much to harbours, and a large sum is spent in the enforcement of a prohibition act which is not enforced. In short, the taxpayer finds that money is wasted on every hand, and when he sees so much disease around him he naturally asks himself how much, either directly or indirectly is spent on the prevention of disease. As this doctor asked, would it be too much to ask that five per cent be spent on the public health? Perhaps five per cent might be a great deal; but there is not spent five per cent. Would one per cent be reasonable? That might be fair; but they do not even give one per cent to public health, or even one-half of one per cent. No, according to the figures they spend just two-tenths of one per cent of the whole appropriation for the purpose of safeguarding the public health.

I think that Dr. McCullough has the right idea; and when he gets hold of a good idea it is hard to knock it out of his head. Now, what is the best way of dealing with this subject? Dr. McCullough, I think, has put the matter in a way that will be effective. But a great deal depends of course on the way in which you put things, and the important thing is that we should get on the right path. Once we are sure that we are in the right direction we may safely go ahead. I am strongly tempted to tell an old story, and although members of the Conference may be quite familiar with it I think I shall venture it. Two Cockneys were discussing politics and one of them wanted to know what was meant by the slogan, "One man, one vote". "Well," said the other, "it means just what it says—one man, one vote." But the first fellow would not be put off in this way; he could not understand the significance of this political phrase. "What does one man, one vote mean, though?" he asked. "Well," the other fellow replied, "it means one vote to one man". His friend still could not understand it and the other fellow to make it plain said, "One vote, one man. One vote means simply this—one bloody man, one bloody vote". "Oh," exclaimed the other fellow, "I understand what it means now, but why the bloody 'ell didn't you tell me that in the first place?".

Dr. McCullough: It is impossible for a man to carry on intensive health work in six counties, and it is just a question whether he can do so in one county. All I am suggesting is that there should be a suitable area, from the point of view of extent of territory as well as from the financial standpoint, so that one organization can satisfactorily do the work there. I do not think it would be in the interest of public health, however, that any scheme of this kind should be foisted on the public too rapidly; I should prefer to see it introduced gradually and with the consent of the public. And there is no better way to begin than by establishing in a province like Ontario a few demonstration areas where an organization may be

started and this work carried on for three or five years so that the people might see the value of it. Our people are intelligent enough to appreciate the value of an organization of this kind and I am sure that they would adopt it after adequate demonstration.

Dr. BLACKADER (Montreal): This is an all-Canadian conference, embracing as it does representatives from Halifax to Vancouver, and I think it would be well if the proceedings were placed before the general profession of Canada through the medium of our *Journal*. I would suggest therefore the advisability of having all addresses edited as far as possible by the speakers themselves. The whole February number might be devoted to the report of the proceedings of this conference, and if this were done it would be wise I think to have the speeches edited in the way I have suggested. The January number is already in the press, but if all those who have spoken will kindly edit their papers and their speeches we can have the February number of the *Journal* carry a complete report of the conference for the benefit of every member of the profession.

The CHAIRMAN: It is exceedingly important that the proceedings of the conference be reported in detail for the information of the entire profession in the Dominion, and undoubtedly the proper channel for this would be the *Journal*.

FRIDAY AFTERNOON SITTING

The conference resumed, Dr. Primrose in the chair.

The CHAIRMAN: I call upon Dr. MacDermot to address the conference on the subject of

HEALTH INSURANCE

Dr. J. H. MACDERMOT (Vancouver, B.C.): I do not know how much of what I am about to say is old ground, because I do not know just what has been done in other provinces in this regard, but I thought that the best way in which one might deal with a subject of this kind would be to treat it rather on the assumption that nobody had ever heard anything of health insurance.

In British Columbia we have been conducting a somewhat intensive study of the question. By health insurance I mean any plan or scheme whereby a certain group in society, roughly determined by earning power, is insured against the cost of sickness, wholly or in part. A specimen of such a plan is the National Health Insurance of Great Britain, commonly known as the Panel system. The history of our connection with the problem is briefly as follows:

Some eight or nine years ago the Government of British Columbia appointed a commission to go into the question of workmen's compensation for industrial accidents. Prior to that time industrial companies or other employers of labour insured themselves against accident to their workmen. When a workman was hurt he usually had to employ a lawyer to fight his claim for damages, or accept a sum which was often unfair. His fight, be it noted, was with the insurance company, not with his employer. He had no wage allowance coming in whilst he was ill, and often he had to wait a long time for his money. The legal fees were high, and very often the final result was that the workman obtained very little.

The attitude of the employer towards an injured workman was hostile. What about the doctor? He usually did his work for little or nothing unless he protected himself very carefully, and on the whole this class of work was exceedingly ill-paid and unsatisfactory to the medical man. In the first bill drafted no mention was made of medical aid at all. When the commission held its sessions the Vancouver Medical Association appointed a committee which met the commission and gave evidence. This committee also approached Labour, through its leaders, and urged on them the necessity for a medical aid clause from the point of view of the workman. Together we were successful in having such a clause added.

Next came the question of medical fees and method of administration. At first, there can be no doubt, the commission had at least a bias towards salaried medical men, from the standpoint of economy, both from money and trouble, as it appeared to them. We were able to persuade them that the principles of free choice of doctor, and payment of the latter, by a schedule of fees were fairer and more satisfactory than the other. As a result we obtained our present Workmen's Compensation Act, which works on the whole very well and with satisfaction to all those who are party to it. The workman gets all that is his due without deduction; he gets allowances for the time he is away from work, and his bills are paid. The doctor is fairly paid for his work, and except for minor details I think it is fair to say that we have little or no criticism of the act. The employer's attitude towards the injured workman is entirely changed. He works now with the workman and for him, to secure as good a settlement as can be obtained.

Great strides have been made in the direction of safety appliances, etc., designed to prevent accidents.

This is all a matter of economic efficiency; everybody concerned, the Government, the employer of labour and the workman has realized that the prevention of accidents saves money. They have realized too that by giving prompt and adequate care to the injured man, they save money and save the human material of industry. The workman is satisfied that he and his family will be able to get three meals a day even when the breadwinner is hurt. It is a sound piece of legislation and is well administered. Our experiences in this regard taught us several lessons, and other provinces will no doubt have seen the same thing.

We learnt first as regards the Government, that we cannot expect, indeed we have no right to expect, the Government to look after our interests. It is true, as we know, that the surest way to secure a good and efficient act is to have competent medical aid, and that this can only be secured from adequately paid medical men. But we must remember that the government is always subject to tremendous pressure from two sides, first, from those who want the legislation which will protect them, and secondly, from those who have to pay for it. The burden of financing these acts is a heavy one. In

the end, we believe, it is lighter than the original burden of cost attached to the old methods; but it is difficult to convince those who have to pay that this is so. Under this dual pressure the Government seeks escape and finds it naturally in keeping the medical fees that have to be paid down as low as possible. The moral is that we must fight our own battle. We must be ready and organized to meet any such situation. That is the first and perhaps the greatest lesson we learnt.

Next, we learnt that we must educate our own members. One cannot accuse labour of greed and selfishness, nor can we accuse the Government of meanness any more justly than we can some of our own members. The medical man is willing to be exploited and to do any amount of work for nothing; but when it comes to making an arrangement whereby he can be sure of being paid he wants the earth; at least, some of them do. This is one point that has to be noted.

Next, as regards labour. We learnt that labour is our best ally and that we should keep it so. Labour's interests in this matter are ours and we should realize this fact and work with labour.

Lastly, we found that this method of dealing with industrial accidents is an extremely good one and very satisfactory in every way to the workman, for the reason that the evils outlined above have been mainly removed, and for us, because we receive fair remuneration for this class of work. Next came the question of sickness. The V.M.A. took this up next and spent some time deliberating on it. Our trouble was that we had no facts to work on, and the conclusions we drew were hypothetical only and subject to attack for that reason. We felt that something ought to be done but we had not the basic facts at our disposal on which to base any conclusion. Accordingly we decided to call in outside help and pay for it. Two years ago the British Columbia Medical Association set aside a sum to be devoted to this purpose and employed a statistician to go into the whole matter and dig out the facts of the case. He spent some four months over this task and accumulated a great deal of material which I shall present to you in a brief digest. The following questions present themselves for answer:

1. Is there any demand for health insurance, and from whom?

2. Is there any need for health insurance? And why is our present system not adequate?

3. What form should health insurance take? What would be the advantages of it and the dangers?

4. What will it cost?

5. How will this cost be distributed?

6. How would it be administered?

6a. How would it affect the medical profession?

7. What attitude should the medical profession take?

8. How can the interests of the medical profession be safeguarded?

Questions 1 and 2 may be considered together: 1. Is there any demand for it, and 2. is there any need for it?

Our researches into the economic conditions of British Columbia revealed the following facts:

The average income of the industrial worker in British Columbia is $1,000 a year or a little less.

The average duration of illness for each individual is about seven days yearly.

The average working man's family in British Columbia has about one week's supply of money in case of illness attacking the wage earner; when this is spent they must run into debt.

Less than five per cent of the working population has any insurance of any kind against illness, accident or death. This includes lodge or club insurance, or benefit from fraternal organizations, as well as ordinary sickness and accident insurance. Speaking to a statistician of the Sun Life Company yesterday, I was informed that only about four per cent of the population at large carries life insurance.

The cost of insurance is prohibitive to the working man.

Sickness means to the working man loss of earning power, absorption of his savings, incurring of medical bills, and

hardship to his family. It means more; it means that he cannot get adequate medical attention, and therefore he does not recover as quickly as he should. A working man with pneumonia needs hospital care, trained nursing and skilled medical attention just as much as does a millionaire; but unless he becomes a charity patient how can he afford it?

Sickness and poverty react on one another, and the worry, insufficient food and so on aggravate the sickness.

He does not seek medical attention as early as he should for himself or his family. Much avoidable illness is thereby caused.

Our inquiry covered most of the states of the union, many of which have been studying this question closely. Summarizing their replies we found that they tallied quite closely with ours, their time loss varying from six to nine days yearly. The Metropolitan Life has also conducted an investigation with approximately the same results. In British Columbia the economic loss to industry from sickness, in wages alone, was placed at $4,165,000. To this must be added medical and hospital care. This has been worked out on various bases, but the smallest estimate is somewhere over $2,000,000. This when added to the wage loss is rather more than three times the cost of industrial accidents alone. It is the consensus of opinion, we find, that this ratio of three to one is correct, and we will do well to bear it in mind.

Another great disadvantage of our present system is the impossibility of preventing sickness, especially amongst children and women. Except for a small amount done through voluntary subscription and in free clinics, preventive medicine is almost an impossibility, though we admit its necessity and would gladly practise it. Labour, as a section of society, recognizes all these things and is pressing for relief. It is labour that is hardest hit. They have adopted health insurance as a plank in their platform. The demand is there, and the facts I have cited seem to show that the need exists. And I have of course only dealt briefly with the matter. A very much stronger case could be made out, and it seems to be the uniform opinion of all the states who have gone into the question that under our present system of treatment of the sick there is a great and unnecessary loss of life, of time (that is, wage earning time and wages) and of health apart from life.

It is coming to be recognized that sickness affects a whole community, not merely the sufferer, and that this is true not only of infectious disease but of any sickness. It constitutes a definite loss and in one way or another the whole community pays for it.

Before leaving Vancouver, I had an interview with Mr. E. S. H. Winn, Chairman of the Workmen's Compensation Board, who has authorized me to quote him in several references which I may make. He is also Chairman of the Mother's Pension Board. His work in these two capacities has given him an unusual opportunity to observe industrial conditions. I asked him if he felt there was any need for a system of health insurance and he stated most emphatically that it is one of our greatest needs to-day. The question, "Who should be beneficiaries?" he answered by saying that he would place the upper limit of income at $3,000 annually. This may appear high to many of you and we had arrived at a somewhat lower figure; but a great many authorities on the subject state that there should be no upper limit. Three thousand annually would include all wage earners, including railway engineers and conductors.

As to the method of administration of such a scheme, it might I think be done only in certain ways:—

1. By a voluntary organization, somewhat similar to club and contract practice, only on a larger scale and with larger fees.

2. By a compulsory scheme under which every member of the class affected must pay.

Again, it may involve only medical aid; or on the other hand sick benefits may be added.

Lastly, as to the payment of medical men and their employment. It may be done by a capitation fee (the Panel system) or patients may be given free choice of a physician, who will then be paid according to a fee schedule for the work done. As regards the voluntary scheme, we do not think that anything can be said in its favour. It would not work. The only people the act was designed to help, the shiftless and improvident ones, would refuse to take advantage of it. The five per cent who now take out insurance in one form or another would be the only ones who would join. It would cost at least twice as much as a compulsory scheme. During our investigations we found that the insurance companies insuring against sickness return less than fifty per cent in the form of paid claims. This does not of course mean that they make fifty per cent profit, but their cost of operation is from twenty-eight to thirty-five per cent of the premiums. The cost of the Medical Association in British Columbia (that is to say, the cost of administration) is less than four per cent of the total cost.

There are many other objections; and all the states consulted agree that any scheme instituted must be compulsory and must function through an extra-political board.

As regards sick benefits, there can be no question that unless these were included the act would only be partially adequate. If it is true that the average working man's family is only one or two weeks ahead of the wolf, sick benefits are necessary. It was the opinion of Mr. Winn that these might be left out at first and added afterwards, but he expressed himself as being of the opinion that they were an integral part of any complete scheme.

We come now to the question of the method of payment of doctors. We came to a unanimous conclusion, so far as our various committees were concerned, that we should utterly reject the Panel system or any system involving salaried medical men except in cases such as X-ray or other laboratory workers. We regard the Panel system as pernicious. It introduces the element of speculation into the relations between doctor and patient, which is so demoralizing and leads to such unsatisfactory results in contract and lodge practice with certain exceptions.

There is a continual struggle between the doctor and the source of his salary, the commission governing the administration of the act. The competitive element in the practice of medicine, which is so valuable and salutary is removed when the practicing physician is paid a salary. The only room for competition left in such a case is the possession of the job itself. There are other undesirable features of the Panel system but they are merely a matter of cost.

The question of cost must come next. The cost, apart from sick benefits would amount to about three cents a day to the workman himself. For his wife and family it would be increased in proportion but not equally. It is suggested by many who have gone deeply into the subject that there should be no distinction between single and married men but that they should pay equally. The estimates of cost vary to a considerable extent in various localities, but Mr. Winn, who has access to accurate figures in affairs relating to the Workmen's Compensation Act, estimates that the proportion of cost would work out somewhat as follows:—

Wage-earner	$1	monthly
Government	50 cents	monthly
Employer	$1	monthly

Making a total of $2.50 in all. This is very nearly our estimate, though we allowed a little more. Three dollars would pretty nearly cover medical aid and sick benefits.

What should be the attitude of the medical profession towards health insurance? In the first place, the medical profession should conduct an organized and thorough investigation into this whole matter. If one talks to twenty medical men about health insurance, one is apt to get twenty different opinions, varying with the status and special interests of each man, but utterly useless because they do not know the facts. And without a thorough knowledge of these one cannot work out any plan.

May I quote from Dr. Cabot, of Boston, who wrote about this matter some years ago:—

> "When sickness insurance gets a footing in the country I hope that it will be planned and led by those who know most about it, namely, the physicians themselves. Nothing would be worse for the reputation and dignity of the profession than to become engaged, like the English medical profession, in an unseemly scuffle with the government, to lose in the fight, and finally to be dragged, kicking and struggling into the enemy's camp and forced to do what they had previously angrily refused. Let us make our experiments and gain competence before the state tries to take over so difficult and dangerous a task."

This seems to sum up what our attitude should be, and it sums it up in my opinion fairly well. We should study the problem thoroughly and have every man in the profession acquainted with the facts, and be ready to take a definite stand when the question is mooted, as it certainly will be.

In British Columbia we have prepared a brief summary of the facts as far as we have ascertained them and are sending this to every member of the profession. We contemplate having a round table conference with representatives of labour and getting their views. I would repeat here that medicine has no better friend than labour in this connection. Their interests are ours, and it is just as important for them that any system of medical aid shall be planned along the right lines as it is for us. To this end, I should like to see this matter taken up by the Canadian Medical Association with a central committee and by every province with local committees. I have not dwelt much on the side that concerns us, but is it not

true that there is room for improvement in our present system or for a change of some kind?

The really enormous amount of work done for nothing or for trifling fees, the fact that we are handicapped in our work at every turn because our patients simply cannot afford the tests and special examinations that they should have; the huge free clinics in every city, composed of people who could pay a little but who cannot possibly afford regular fees; the impossibility of doing preventive work—all these arise out of our present system of practice. Undoubtedly too the prevalence of quackery is due to our present system, and nobody can suppose that any intelligent commission administering an act would allow patients to go to practitioners of cult medicine; this would be not from any love of us particularly but from simple economic reasons.

Again, we know that certain evils have crept into the practice of medicine. Over specialization, and specialization by men who are not fit to be called specialists, would be checked, because results are tabulated, and results count. The medical man who lets himself slump, who gets rustier and rustier, could not get by under any system that kept comparative records. The operation of the Workmen's Compensation Act has shown that men are on their mettle, are kept up to the mark, are checked up sharply if they do bad work; and again, cheap contract work and lodge practice would be eliminated.

Lastly, there is considerable economic gain from such a scheme. Certainty of payment, of fair fees for work done, would be a tremendous boon to a profession which has suffered too much from uncertainty in these things. I am not claiming that such an act would immediately bring about a complete surcease of all our troubles. There are several problems that arise.

First, the difficulty of preventing some men from getting more than their fair share—and this has been a real problem with the Workmen's Compensation Act. Perhaps limitation of quota might help here.

Next, the young man beginning practice: how can we help him?

Then there is the specialist, the legitimate specialist, not the college bred one, who needs elimination rather than help. We must be very careful not to remove incentive and not to try for a standardized product. Our experience of the Workmen's Compensation Act shows that this is not a very serious problem. Besides, there will always be private practice.

Then there is the problem of the indigent. Mr. Winn suggested in this regard that some scheme might be formed whereby people out of work might be carried for three months. Again what about such matters as venereal disease, and diseases requiring institutional treatment? Then we must remember that if we adopt any such scheme we must to some extent surrender our independence. Therefore, we must make very sure of our ground before we do endorse any scheme of the kind. We must prepare ourselves before the scheme is put into operation. We must also be prepared at any time in the near future to be called upon to implement some sort of health insurance scheme.

Mr. Winn, whom I have quoted, was some two or three years ago appointed chairman of a commission to inquire into health insurance in British Columbia. The report of this commission has not yet been made public, but from conversation with Mr. Winn, I do not think there is any doubt that he personally thinks health insurance should be inaugurated, that it should be administered by an extra political commission, as is workmen's compensation; that patients should have free choice of a physician; that medical and hospital care should be paid for by our present method, that is to say, for work done according to a schedule of fees; and that all treatment should be provided for. Sanitorium and institutional treatment, he thinks, should be left as they are, under salaried medical officials, and he is most probably right in this.

We in British Columbia do not think that the medical profession should strive to inaugurate any scheme, but that we should educate ourselves thoroughly about it and remain receptive, but ready to meet any situation that may arise.

The first essential for this is complete organization of the profession. We found this in the Compensation Act matter; our salvation lay in the fact that we were at that time thoroughly organized. Every man in the province was lined up and we spoke as one voice. In England, on the other hand the profession was caught napping, and we know the result. We have no fear, so far as we are concerned, of a fair and reasonable Health Insurance Act. I am quite sure that many men would welcome it. There are endless details to be worked out, but our clear duty at present is, first, to organize; secondly, to study the question; thirdly, to meet those other interests that are involved—labour, the government, the employer—and obtain their views and impress ours upon them. Our first duty is to the sick. If we can devise, or help to devise any plan which will improve health conditions there is no section of the profession that will hesitate, so soon as it realizes the

facts of the case.

We owe a duty too, to ourselves, not to allow ourselves to be exploited or to be forced into a humiliating condition of underpayment, of scrambling for positions, of incompetent and skimped work. This is not only for our sakes, but because such a state of affairs is utterly injurious to the very people it is designed to serve. By maintaining our right to adequate payment for honest work we shall be showing our honesty and our sincerity as workmen.

I am presenting herewith the report of our committee brought up-to-date showing figures and statistics as regards the financial effect of illness on the working man, and going into the question of costs.

The CHAIRMAN: This is one of the most important questions that have come before the conference and we are indebted to Dr. MacDermot for the splendid paper which we have heard and which seems to me to be the logical and analytical type of address which calls for careful study. Dr. MacDermot's paper is now open for discussion.

Dr. GEORGE YOUNG (Toronto): The question which Dr. MacDermot has so ably discussed in the address we have just heard is one of considerable importance to the medical profession in this country. It seems to me that the profession should wake up to the importance of this matter, for it would be rather a serious thing for us in Canada if we were faced with the same difficulty that confronted the medical profession in the Old Country in 1911 when Lloyd George launched on the public, complete in all its details, a bill which proved altogether intolerable to the profession. At that time the medical profession in Great Britain was not organized to deal with the matter and it cost them some $300,000—to say nothing of the money that came in from outside sources—to make the details of the bill such as would be at all tolerable to the medical fraternity. It seems to me that now that this question is in the air and that labour is behind it in certain provinces the matter is one of some importance. We should carefully study it, we should get at the facts as far as we possibly can, and altogether make ourselves acquainted with the details of the subject, so that in the event of legislation being mooted we should be able to protect ourselves as well as the public against any ill-considered measure that might be undesirable, either from our own point of view or from the standpoint of the community at large. The matter, I think, is one for the association to deal with.

The SECRETARY: Might I ask Dr. MacDermot whether the British Columbia Association proposes to acquaint the other eight provinces with the work which has been done in that province in connection with the study of this problem.

Dr. MACDERMOT: I suppose that, as this matter is one for the association, it is possible that this conference might, through the Resolutions Committee recommend that the association take up the subject.

The CHAIRMAN: It might be well for the conference to appoint a committee to go into the subject and report to the next conference and then to the Association. Having heard Dr. MacDermot's address, I am of the opinion that the matter should go to the Association eventually.

Dr. GEORGE YOUNG: Perhaps that would be the best course to adopt. I would move that the chairman be empowered to appoint a committee to study the matter, in the light of the remarks which we have heard, and that the said committee report to the conference.

Dr. LOW: I second that motion.

The CHAIRMAN: I shall ask Dr. MacDermot to close the discussion.

Dr. MACDERMOT: I am not quite clear as to just what scope the Dominion would have as a whole in a question of this kind. The matter, I am inclined to think, is rather of a provincial character and it will probably be for each province to inaugurate its own system. Later on there might be national co-ordination of provincial activities. As regards Dr. Routley's question, I may undertake to say that British Columbia will be glad to inform any of the other provinces as to just what has been done; we will furnish the facts.

The CHAIRMAN: It has been moved by Dr. Young, of Toronto, and seconded by Dr. Low, of Regina, that this matter be referred to the Executive Committee of the Canadian Medical Association. Is it the pleasure of the meeting to adopt the motion?

Motion agreed to.

The SECRETARY: I have a few announcements to make. Members of the conference will be interested to know that seventy-

three delegates have registered on the present occasion, which is about twenty-three more than we expected. This evening, following the dinner at the Chateau Laurier, I should like to have the pleasure of meeting the members of conference representing the four western provinces, of Manitoba, Saskatchewan, Alberta and British Columbia. As members of conference know, the next annual meeting of the association is to be held in Regina during the week of June 22 next. It is well known that the western provinces are behind that annual meeting and intend to lend their co-operation to the end that the gathering may be a successful one. Last November a year ago I had the pleasure of meeting representatives of the four western provinces in conference and following that very excellent meeting there was prepared for the ensuing year a programme which was quite beneficial to the provinces concerned. It seems an opportune time, now that so many are gathered together here that we should get together for the purposes of an informal round table talk on plans for next year. If the eastern provinces desire to inaugurate a co-operative movement the Secretary will be charmed to meet a delegation from those provinces at any time to discuss a scheme similar to that which has worked so successfully in the West.

The CHAIRMAN: I shall now call upon Dr. MacMurchy, of Ottawa, to address the conference on the subject which she has undertaken to discuss.

MATERNAL MORTALITY

Dr. HELEN MACMURCHY, Department of Health, Ottawa: A memorandum upon the present state of affairs in regard to maternal mortality in Canada was prepared by direction of the Deputy Minister of Health and laid before the Dominion Council of Health on December 16, 1924.

At the request of the Council the following summary of this memorandum has been made for the conference on the Medical Services in Canada.

DEBATE IN THE HOUSE OF COMMONS

In the course of a debate upon another subject in the House of Commons on July 17, 1924,[3] Mr. Davies, M.P. for North Battleford, made a reference to maternal mortality, quoting from the pamphlet "Issued by the Meeting Lake Development Association. Representing Rural Municipalities Numbers 466, 467, 497, 498."

The following is the paragraph in which the quotation made by Mr. Davies occurs:—

> "There is no doctor living in this whole area. The nearest doctors available in cases of great need live in the towns along the lines of railway to the south and west a distance of 30 to 70 miles. The same applies to hospital provision. With an estimated population within the four municipal areas of 4,500 it is easy to imagine the amount of distress and suffering that exists through lack of medical attention. Owing to the costs of obtaining medical advice, in most cases running from $30 to $70 a visit, it is only in extreme cases that medical aid is brought in and when this occurs in the winter months the suffering is increased tenfold. During the last five years there have been over 800 births in these four municipal areas and out of these only 60, or approximately 7 per cent, had medical attention. In many of our little cemeteries there is a mound that covers the remains of some pioneer mother who has paid a penalty that would have been avoided had medical aid been obtainable."

A letter was addressed to the Minister of Health by Mrs. J. A. Wilson of Rockcliffe, President of the Local Council of Women, Ottawa, April 8, 1924, making enquiry as to how many women are confined without medical attendance in Canada.

At the Annual Meeting of the National Council of Women of Canada, a resolution was passed, referring to the statement that twenty-four mothers died in childbirth every week in Canada in 1922 and inquiring whether these mothers were given sufficient or any medical and nursing care.

Many letters in regard to maternal mortality and maternal welfare have been received by the Division of Child Welfare in the Department of Health of Canada since 1920. A few extracts are here given:—

> "We are a farming community of about three hundred people, have no resident doctor, neither have we a nurse. Our nearest doctor is three and a half miles distant, and he is the only one within a radius of fifteen miles. We country people need help for our farm women at childbirth...."
>
> "I hope some day we'll see every mother cared for as good as we care for our thoroughbred stock at least. It seems a pity that at this most important event we do not know that mothers have everything easy and comfortable. Wouldn't it be worth Canada's best efforts to make sure Canada's rural mothers fared well at the time their children were born? I think it would, and any one who cared enough would work with that result in view. We Canadian women must pull together for the benefit of women all over Canada especially farm women...."
>
> "If you could see the conditions here with regard to mothers and children it would make your heart ache. Expectant mothers performing tasks fit

for men's strength and then when their hour comes often having to go through the ordeal without any assistance except that of a neighbouring woman and sometimes not even that; poor, ignorant, faithful, hard-working women—used worse than dumb beasts. They certainly need some person to befriend them and teach them. I often wish I had the power to rouse the women of Canada to an understanding of what these poor women and babies have to endure and I am sure they would devise means to help them. I have tried to do a little and it seems such a little for them. But I have determined that every baby arriving in my district shall have something more than a flour sack to wear...."

"We have so many new babies and unfortunately so many deaths. Last week a mother died having her eighth baby in ten years and now we are faced with the problem of looking after these poor children—so thin and pale—it makes my heart ache to go into the house and the hardest part is this, Doctor, she wanted to die—so tired and worn out and weary...."

"Perhaps the day will come when people will look back and wonder why mothers have been held so cheap. It seems to me that the present day could solve the problem in such a way that no woman would have to take the risks of twenty years ago. I know two neighbours about to be confined. Both have already large families, neither one expects to have a doctor as they feel the expense will be hard to bear even if one decides to take the cold fifteen-mile-drive in winter. Each has lost her mother within the last three years. I can't refuse them help yet I do not feel equal to the task, deeply as I sympathize with their need. They might get assistance if they claimed to be paupers. But being self-respecting, hard-working young Canadians trying to make a home and raise a family they and their families have to face danger. This is the normal state of affairs all through Western Canada except close in to towns or cities. Even if limited means is not the difficulty, few mothers care to go far from their dear ones in times of sickness...."

The questions raised by the foregoing may be summarized as follows:—

I. What is our maternal mortality in Canada?

II. How does it compare with the maternal mortality of other countries?

III. Is it excessive?

IV. What proportion of births occur with no medical or nursing care for mother and child?

V. Are medical fees too high?

VI. What recent enquiries or investigations have been made into maternal mortality and related subjects, such as puerperal sepsis, and with what results?

I.—What is our Maternal Mortality.

The figures quoted above are in accordance with those reported by the Dominion Bureau of Statistics for the year 1922.

The total number of deaths in childbirth was 1,248, which is at the rate of 24 every week, or 3.4 every day.

The maternal mortality rate per 1,000 living births was 4.9 for all the provinces of Canada, including the figures supplied by the provincial authorities in Quebec and transmitted by the Dominion Bureau of Statistics.

For the eight provinces of Canada which form the Registration Area the maternal mortality rate was 5.5 per 1,000 living births.

The following table gives the rate for each province:—

DOMINION BUREAU OF STATISTICS

	Population		Births		Birth-Rate		Infant Mortality				Maternal Mortali		
Provinces	Total population Census 1921	Total population estimated 1922	Total No. of Births 1921	Total No. of Births 1922	Rate per 1,000, 1921	Rate per 1,000, 1922	Deaths under 1 year, 1921	Deaths under 1 year, 1922	Rate per 1,000, 1921	Rate per 1,000, 1922	Total Maternal Deaths in C.B., 1921	Total Maternal Deaths in C.B., 1922	Rate per 1,00 192
Alberta	588,454	611,281	16,561	16,153	28.1	26.4	1,391	1,475	84.0	91.3	111	111	6.
British Columbia	524,582	539,036	10,653	10,166	20.3	18.9	602	692	56.5	68.1	51	63	4.

Manitoba	610,118	626,436	18,478	17,079	30.3	28.2	1,533	1,669	83.0	94.4	81	99	4.
New Brunswick	387,876	392,381	11,465	11,564	29.6	29.5	1,299	1,194	113.3	103.3	47	59	4.
Nova Scotia	523,837	528,207	13,021	12,693	24.9	24.0	1,311	1,239	100.7	97.6	56	70	4.
Ontario	2,933,662	2,981,182	74,152	71,430	25.3	24.0	6,763	5,921	91.2	82.9	387	370	5.
Prince Edward Island	88,615	88,307	2,156	2,160	24.3	24.5	180	153	83.5	70.8	7	8	3.
Saskatchewan	757,510	785,832	22,493	22,339	29.7	28.4	1,814	1,913	80.6	85.6	128	127	5.
Quebec[4]	2,361,199	2,402,287	88,749	88,377	37.6	36.7	11,387	11,297	128.0	127.8	338	341	3.
CANADA	8,775,853	8,954,949	257,728	252,571	29.4	28.2	26,280	25,553	102.0	101.2	1,206	1,248	3.8

DEATHS IN CHILDBIRTH—RURAL AND URBAN

At the request of the department the following table has been prepared by the Dominion Bureau of Statistics. It is noted that in every province, such urban death-rate is considerably in excess of such rural death-rate. All villages under 1,000 population are classified as rural.

In England and Wales the rural maternal mortality is the greater.

MATERNAL MORTALITY RATES BY RURAL AND URBAN FOR THE REGISTRATION AREA, 1922

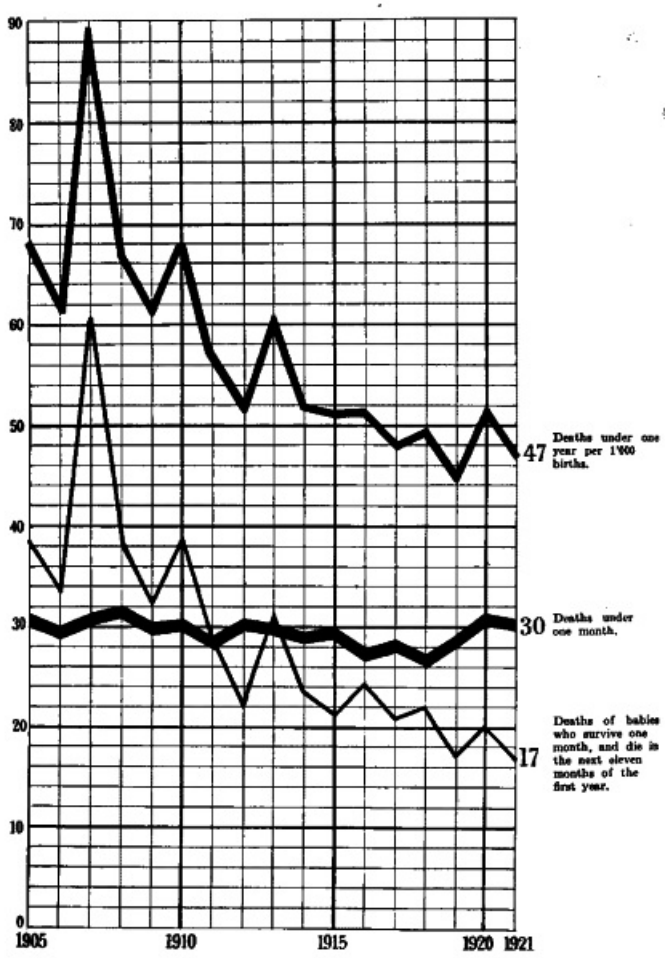
	Rural			Urban			Total		
Province	Births	Maternal Deaths	Rate per 1,000 living Births	Births	Maternal Deaths	Rate per 1,000 living Births	Births	Maternal Deaths	Rate per 1,000 living Births
Prince Edward Island	1,751	5	2.9	409	3	7.3	2,160	8	3.7
Nova Scotia	6,914	36	5.2	5,779	34	5.9	12,693	70	5.5
New Brunswick	7,874	25	3.2	3,690	34	9.2	11,564	50	5.1
Ontario	29,343	121	4.1	42,087	249	5.9	71,430	370	5.2
Manitoba	9,554	42	4.4	8,125	57	7.0	17,679	99	5.6
Saskatchewan	17,497	74	4.2	4,842	53	10.9	22,339	127	5.7
Alberta	9,483	60	6.3	6,670	51	7.6	16,163	111	6.9
British Columbia	3,217	16	5.0	6,949	47	6.8	10,166	63	6.2
Total	85,637	379	4.4	78,557	528	6.7	164,194	907	5.5

It is, however, probable that our maternal mortality is larger than these figures indicate. An important inquiry further referred to below on maternal mortality in Ontario, by the Provincial Department of Health, under the direction of Dr. J. W. S. McCullough, Deputy Minister, and Dr. W. J. Bell, Pediatrician to the department, shows that in 1921 there were approximately 483 deaths in childbirth in Ontario instead of 387 and 465 in 1922 instead of 370, or an increase of about 25 per cent in the above figures.

SIGNIFICANCE

No words are needed to express the national importance of this subject. The death of the mother means often the death of the children.

Research studies in maternal mortality now in progress in the Vital Statistics Division of the New York State Department of Health show that for every 1,000 women who die in the state from causes connected with childbirth, 500 of their babies die within the first year of life. These studies throw light upon the problem of the motherless child. The statistics show that each mother who dies from a cause connected with childbirth leaves on the average two or three living children. Careful inquiries made by the division have brought out the fact that in the opinion of the attending physicians from one-third to one-half of these mothers were neglected or given poor care at some time before their confinement.—(*Health News*, New York State Department of Health, Albany, February 4, 1924).



From Report of Sir F. Truby King, M.D., Director of Child Welfare, Department of Health, New Zealand, 1921-22

INFANT MORTALITY.

We cannot hope for much improvement in the infant mortality rate shown in the above tables until we give the mother better care.

The great reduction in infant mortality which has taken place since 1900 in England and Wales, Canada, New Zealand, the United States and other countries has almost all been in the second to the twelfth months of the first year of the baby's life. This is shown in the accompanying graph from page 3 of the Annual Report of the Director of Child Welfare in New Zealand, Dr. F. Truby King, 1921-22.

It is the same in other countries. The child dies in its first month because the mother did not receive proper pre-natal

care.

Make Canada safe for the mother and she will make Canada safe for the baby.

II.—MATERNAL MORTALITY IN CANADA AND OTHER COUNTRIES

Year	Country	Number of Maternal Deaths	Rate per 1,000 Births
1922	Denmark	146	2.0
1922	Netherlands	454	2.5
1918	Sweden	304	2.5
1916	Italy	2,351	2.5
1920	Switzerland	235	2.9
1923	England and Wales	2,892	3.8
1922	Australia	621	4.5
1923	Spain	3,010	4.6
1923	Irish Free State	297	4.8
1923	North Ireland	148	4.9
1920	Germany	7,865	4.9
1922	New Zealand	146	2.0
1922	Denmark	149	5.1
1922	Belgium	827	5.4
1922	Canada (Registration Area)	907	5.5
1916	France	1,895	6.0
1923	Newfoundland	46	6.2
1923	Scotland	718	6.4
1922	United States (Registration Area)	14,657	6.6

III.—IS IT EXCESSIVE?

It has always been recognized that maternal mortality in childbirth is preventable.

In spite of this fact, maternal mortality has not declined or has declined very slowly.

In England and Wales[5] the maternal mortality rate in 1900 was 4.81 per 1,000 living births and in 1922 it was 3.58.

"The high child-bed mortality in England is one of the darkest blots on our health record; it can be removed only on condition that mothers and those who attend them understand the character of the risks involved."—(*London Times*, 2.7.24.)

Maternal mortality in Canada in 1922 was 45 per cent higher than in England.

"Lying-in is neither a disease nor an accident, and any fatality attending it is not to be counted as so much per cent of inevitable loss. On the contrary, a death in child-bed is almost a subject for an inquest. It is nothing short of a calamity which it is right we should all know about, to avoid it in the future."—(*Florence Nightingale*.)

"The case stands strongly against us—the mother in the prime of life—the most valuable citizen in the community—dying often from a preventable disease."—(*Prof. W. W. Chipman*, McGill University, Montreal.)

What should we regard as a satisfactory maternal mortality rate? Major Moss, R.A.M.C., stated at the discussion of this subject at the British Medical Association meeting, Section of Obstetrics and Gynaecology, 1924, that he had found it to be not over one in 2,000 with ante-natal care.

NOT ONE MOTHER DIED IN TEN YEARS

From 1894 to 1903—not one baby died in Villiers-le-Duc in France, not one mother died in childbirth and only one stillbirth occurred.

The Mayor, a doctor, was M. Morel.

The same thing once happened in Quebec, in a rural parish, through the exertions of the curé, the parish priest. Not one mother died in childbirth in that parish for a whole year. I saw the reference probably in "The Canadian Journal of Medicine and Surgery," perhaps about 1904, but I have been unable to find it again.

At the meeting of the Academy of Medicine, Toronto, December 5, 1922, Dr. C. J. Hastings, Medical Officer of Health, stated that the number of deaths in Toronto in 1921 of women between the ages of 15 to 45 was 610. Of these 14.3 per cent died of diseases of pregnancy, 50 per cent being septic cases. The other chief causes are in percentages—Cardiac, 12.1; tuberculosis, 12.1; cancer, 8.4; pneumonia, 7.0, etc.

Prof. W. B. Hendry stated that from 1914 to 1922 there were cared for in the Burnside Maternity Department of Toronto General Hospital 6,982 maternity cases, of whom 86 died—a mortality rate of 12.4 per 1,000.

PRE-NATAL CARE

The good results of pre-natal care are shown by figures quoted by Dr. J. W. S. McCullough and others in 1920, from the records of the Burnside Maternity Department of Toronto General Hospital.

MATERNAL MORTALITY PER 1,000 LIVING BIRTHS

Maternity patients in public wards, not supervised	35
Maternity patients in semi-private wards	8
Maternity patients in public wards, supervised	4

HELP NEEDED IN THE HOME

Information received by the department seems to show that, in addition to the great need of better medical and nursing care, ante-natal, obstetrical and post-natal, the difficulty, often the impossibility, of getting any help in the house even during the first ten days after the birth of the baby is a cause of maternal morbidity and mortality in Canada.

At the request of certain provincial authorities an outline has been drafted intended to assist in organizing "Home Helps" for mothers. This help is necessary for the home and the children, even if the mother goes to the hospital at this time, and it is also necessary for a short time after she returns from the hospital.

RURAL ANTE-NATAL CARE

Dr. E. K. MacKenzie, Tain, Rossshire, who travels 11,200 miles and has 3,700 visits and 2,400 consultations per year, states that since 1915 he has had 680 confinements, 224 primiparae, with 11 stillbirths and no maternal deaths and no puerperal fever.

He says, "The contention that in general practice there is no time for ante-natal care is baseless, as I have also found the statement that patients resent such attention."

"Ante-natal care not only removes the anxieties of my practice but simplifies my procedure and in the end makes my actual work less."

Dr. Janet Campbell says that without pre-natal care "a comparatively simple event becomes one of dangerous urgency."—(Discussion at British Medical Association, Section of Obstetrics, B.M.J., 16.8.24.)

It was in 1900 that the late Prof. J. W. Ballantyne, of Edinburgh, proposed that ante-natal care should form a special and separate department of the work of a maternity hospital. The first ante-natal hospital ward was established by Dr. Ballantyne in the Maternity Department of the Edinburgh Royal Infirmary in 1901.

"The advocacy of Ballantyne and his tardy followers has not been in vain. The profession has at last universally acknowledged the urgency of the teaching and practice of preventive midwifery."—(*British Medical Journal*, 16-8-24.)

"England was fortunate in having as the father of English midwifery, Harvey, who introduced into that branch of medicine the wide view, the scientific spirit, and the conservative practice which have been its characteristics. It was Harvey's inculcation of patience and gentleness in imitation of nature, adopted by Smellie and Hunter, which made such a strong impression on Boer, the founder of the great Viennese School of Midwifery, who, after studying in France and England, adopted the British practice 'having learnt in France what Art, in England what Nature, could do.'"—(Page 1056, *The Lancet*, November 22, 1924. The Lloyd Roberts lecture on The Renaissance of Midwifery, by Herbert R. Spencer, M.D., B.S., London, F.R.C.P., Obstetric Physician to University College Hospital.)

IV.—What Proportion of Births Occur with no Medical or Nursing Care for Mother and Child

The most complete statistics received are those from the Province of Saskatchewan:—

Total births for 1922	22,815
Total births attended by a physician, 15,001, or	66 per cent
Total births attended by a nurse only, 182, or	1 per cent
Total births attended by neither physician nor nurse, 7,632, or	33 per cent

It is stated that in other provinces the number of mothers who receive no medical care at childbirth varies from 10 per cent to 50 per cent.

In the United States Registration Area the corresponding figure is said to be 30 per cent.

An inquiry into the matter of Medical Service was begun in Ontario on April 3, 1924, and is now almost complete.

The following is the form of the inquiry.

Secretary,
Local Board of Health.
Re Medical and Hospital Services

DEAR SIR,—The Minister of Health and the Provincial Board of Health desire to obtain accurate information as to the distribution of legally qualified medical practitioners and of hospitals in the province of Ontario. The questionnaire on the reverse side of this letter is sent to you with the request that you will be good enough to furnish the information asked for. When the facts are known it will then be possible to determine just what districts or municipalities need further medical assistance or hospital accommodation.

It is suggested that you confer with the local authorities and others interested in your municipality in order that the information furnished may be as accurate as possible.

Please complete the questionnaire and forward it to the Chief Officer of Health, Spadina House, Toronto, before May 15, 1924.

JOHN W. MCCULLOUGH,
Chief Officer of Health.

QUESTIONNAIRE

*R*e medical and hospital services

Municipality.....County.....

1. Population of municipality (1921 census).....

2. Names (of legally qualified medical practitioners in the municipality) Addresses

.....

.....

3. Is there, in your opinion, any lack of medical service to the people in the municipality?

.....

4. (*a*) Number of hospitals in the municipality (give names).....

.....

(*b*) Number of hospital beds.....

(*c*) How are hospitals operated and maintained?.....

(*d*) Is there enough hospital accommodation in the municipality?.....

(*e*) If not, how many more beds are required?.....

Date .....

.....
Secretary, Local Board of Health.

If there should not be enough room under any of the sections a separate sheet may be used.

NUMBER OF HOSPITALS IN CANADA

Prince Edward Island	3
New Brunswick	25
Nova Scotia	3
Quebec	18
Ontario	150
Manitoba	47
Saskatchewan	60
Alberta	50
British Columbia	100
Total	479

RED CROSS NURSING OUTPOSTS, NURSING STATIONS AND HOSPITALS

Prince Edward Island	1
New Brunswick	0

Nova Scotia	1
Quebec	0
Ontario	9
Manitoba	8
Saskatchewan	9
Alberta	2
British Columbia	0
Total	30
Total	509

V. Are Medical Fees Too High

From the point of view of the patient there is some reason to think that this may sometimes be the case.

A good many letters have been received on this subject, such as the following:—

> "Do you know the terrible rates the doctors can charge here and sometimes do charge as high as $65 to go a few miles out in the country to a common maternity case (not more than seven or eight miles). Is it any wonder people take long chances these hard times? Of course we have some splendid big doctors who can see farther than their pocket, but don't you think their charges should be fixed a great deal lower than they are?"

VI. What Recent Inquiries or Investigations Have Been Made into

There is a great change, especially in the last three years, in the general attitude in regard to maternal mortality.

At the Eighty-eighth Annual Meeting, British Medical Association, 1920, Section of Obstetrics and Gynaecology, Herbert Williamson, M.B., F.R.C.P., President, the following were the introductory remarks by the president:—

> "Our meeting this year is one of peculiar importance, for we see on the horizon the dawn of a new era in obstetrics. We have realized that in the interests of the State—nay, in the interests of humanity itself—it is desirable to amend and to amplify the training of those who are to succeed us in the practice of obstetrics. The State is awakening also to the fact that in the past it has failed to discharge its debt to the mothers of the race and has grossly neglected the things which make for their safety and happiness; there is to-day a sincere desire to correct these errors, and the questions involved are receiving an earnest and disinterested consideration such as has never been accorded them before.
>
> "We have come to realize more and more that obstetrics is essentially a branch of preventive medicine. I do not think it is speaking too strongly to say that it is the most important branch of preventive medicine. The dangers of childbirth are to a great extent preventable, and the more clearly this idea is grasped and acted upon by the medical profession and the general public the lower will be puerperal mortality and morbidity."

Maternal Mortality in New Zealand.

A report by the Special Committee set up by the New Zealand Board of Health, July 27, 1921, appeared on October 7, 1921. The Committee, who had the assistance of Dr. Jellett and others, made twelve recommendations which are of great value.

Maternal Mortality in England.

In the reports of Sir George Newman, especially in "Recent Advances in Medical Education in England" much attention is devoted to the prevention of maternal mortality. The following reference is made to Prof. B. P. Watson's paper in the British Medical Journal of October 21, 1922:—

> "Professor Watson, of Edinburgh, has rightly pointed out that if we in Britain are to keep abreast with other nations in regard to obstetrics and gynaecology we must be prepared to give a fuller and more intensive training in midwifery to our medical students. Such training cannot be given by making attendance on a certain number of confinements at the patient's house the chief feature. Clinical medicine and surgery could never be taught in such a way, nor can clinical obstetrics. What is necessary, as Professor Watson claims, is more intensive training, so that the student may

concentrate his study and live, as it were, in its atmosphere, seeing all the work of a maternity hospital, an ante-natal clinic, the technique of the labour room, the care of the newly-born infant, and the aftercare of both mother and child. This is what he says:—

> 'Ante-natal care implies a thorough general examination of the patient as early in pregnancy as possible, and a special examination to make sure that she has the physical configuration necessary for a normal labour. It implies a careful watch on the patient at regular intervals throughout the pregnancy, and the immediate institution of appropriate treatment whenever the least departure from normal is detected....
>
> 'The problem which faces us is to convince women generally of the necessity for ante-natal care. This, as I have said before, can only be done by the efforts and example of the whole body of medical practitioners. An isolated ante-natal clinic here and there will benefit the community which it serves, and public opinion will be educated to a certain extent, but it will not be until the consulting-room of every practitioner is an ante-natal clinic for his district that the maximum of benefit will be obtained'."

Sir George Newman adds:—

"The most significant educational advance which has recently occurred is, however, instruction in regard to the application of the principles of preventive medicine to obstetrics in four respects, namely, ante-natal work, the conduct of labour, the prevention of congenital syphilis and the care of the infant. The two last subjects are referred to elsewhere in the present report."

ONTARIO

Special Investigation.

A special investigation has been carried on for the last three years on Maternal Mortality in Ontario, by the Provincial Department of Health, under the direction of Dr. J. W. S. McCullough, Deputy Minister, and Dr. W. J. Bell, Pediatrician to the department. The plan adopted has been to issue the subjoined letter to the physician whose name is signed to the death certificate of any woman between 15 and 50 years of age at the time of death.

The results of this investigation show an additional number of deaths which were really deaths in childbirth, though not returned as such on the certificate of death. The increase amounts to about 25 per cent—in other words—there were, in 1921, 483 deaths in childbirth in Ontario instead of 387, and 465 in 1922 instead of 370.

Dr. Bell received replies from about 95 per cent of the physicians concerned.

SPADINA HOUSE,,

DEAR DOCTOR,—The Provincial Board of Health in conjunction with the Department of the Registrar-General is making a special study of the subject of maternal mortality.

For this reason and in order to make the investigation as complete as possible, it has been decided to inquire into the death of every female between the ages of 16 and 49 years inclusive. Your co-operation in this investigation is earnestly solicited and will be much appreciated.

Your name appears as the physician who attended the deceased named below, will you therefore be good enough to furnish the information requested in the form and return at earliest convenience.

Yours very truly,
JOHN W. S. McCULLOUGH,
Chief Health Officer and Deputy Registrar-General.

Name.....

Age..... Date of Death.....

Nationality..... Married or Single.....

Was deceased pregnant at time of death? Yes or No.....

If so, was pregnancy or parturition a factor in connection therewith, or had pregnancy or parturition any relation, contributory or otherwise, to the woman's death?.....

Was the deceased a primipara or a multipara?.....

What was the length of the primary stage of labour?.....

Were instruments used?.....

Was pituitrin used?.....

Was the baby born alive?.....

Was the labour full term?.....

If not, what was the age of the foetus?.....

Did the labour occur in hospital or at home?.....

Signature.....

Address.....

MIDWIVES.

By request, the following official information has been made available:

No regulations or official recognition in the following Provinces:—Alberta, British Columbia, Manitoba, New Brunswick, Ontario, Prince Edward Island, Saskatchewan.

Quebec.—Midwives are licensed by the College of Physicians and Surgeons of Quebec.

Nova Scotia.—"The only regulations respecting midwives, so far as this province is concerned, are those contained in the Medical Act. The Act states that nothing shall prevent any competent female from practising midwifery in this province, except in the city of Halifax. In the city of Halifax no female shall practice midwifery unless and until she fulfils such conditions as the Medical Board by regulations or by-law appoints, and satisfies the examiners appointed by the board. A diploma or certificate from a recognized hospital may be accepted in lieu of an examination."

ENGLAND AND WALES

The following reports on public health and medical subjects by Dame Janet M. Campbell, M.D., M.S., Senior Medical Officer for Maternity and Child Welfare, Ministry of Health, have been issued in 1923 and 1924.

No. 15—Teaching Obstetrics and Gynaecology in the Medical Schools.
No. 21—The training of midwives.
No. 25—Maternal Mortality.

On page 57 of report No. 15, Dr. Campbell states eight conclusions which have received general support.

On page 44, report No. 21, she recommends an extension of time of training for unqualified women from six months to twelve months and for trained nurses from four months to six months.

On pages 90 and 91 of report No. 25, Dr. Campbell states that the maternal mortality rate is unnecessarily high, that it is highest in rural counties and that "We can, however, with some confidence, assign responsibility primarily to the adequacy or otherwise of the professional attention during pregnancy, and at the time of birth. A careful midwife and a skilful doctor rarely lose a patient, given a reasonable chance for the exercise of their competency."

A summary of Dr. Campbell's recommendations re securing a reduction in puerperal mortality and morbidity is given on pages 92 and 93.

These three reports are of outstanding importance and influence. This is illustrated by the following inquiry:—

Puerperal Sepsis

At the request of the Ministry of Health, the Royal Society of Medicine have taken up this subject. [6] The combined Sections of Obstetrics and Gynaecology and State Medicine, and the Society of Medical Officers of Health met on November 6, 1924, to consider this matter.

The following report was presented:—

Report of Committee representing the Sections of Obstetrics and Gynaecology, and Epidemiology and State Medicine, and the Society of Medical Officers of Health:—

"Any case in which there is a rigor or a temperature of 102° or higher for 24 hours, during the first ten days after a confinement or abortion, must be notified.

"Get rid of the official term 'puerperal fever,' and use in its place the term 'puerperal sepsis'.

"Puerperal sepsis is a febrile condition of the nature of wound infection, arising after labour or abortion, due to bacterial invasion from, or absorption of, products of bacterial action from some portion of the genital tract."

A recommendation brought forward by Dr. Bourne at this meeting was that the services of specially-qualified obstetricians should be available through the Department of the Medical Officer of Health or otherwise, to help the general practitioner in difficult cases of midwifery.

This proposal had already been made by Professor Louise McElroy, in a letter to the British Medical Journal of October 4, 1924. Professor McElroy pointed out the importance of having a medical inspector of midwives who is especially qualified in obstetrics and who is also a full-time officer, as consultant.

"The President, Dr. Russell Andrews, considered that the discussion had been very useful. It now remained for the sub-committee to meet and to consider the reply to be sent to the Ministry of Health. It could be anticipated that there would be a demand for a comprehensive inquiry."

It will be noted that the standard proposed by the committee is somewhat different from previous standards.

STANDARDS OF MORBIDITY.

1. The British Medical Association include within the term, "Puerperal Morbidity," all conditions in which the temperature reaches a height of 100° Fahr. on two occasions from the end of the first to the end of the eighth day after delivery.—(B.M.J. 1906, 1 Suppl. p. 264, May 19).

2. *Congress of Puerperal Fever, Strassbourg, August, 1923—Resolutions:—*

(1) The congress considers that precise rules should be established for determining the temperature in labour and the puerperium, and for interpreting the results.

(2) The temperature should be taken morning and evening during the hours preceding the meal and also on each occasion when any symptom indicates that there may be a rise of temperature.

(3) The record should show whether the temperature has been taken in the armpit or internally, and in the latter case the locality chosen. The congress urges the advantages of the rectal temperature.

(4) Excluding the temperature within the twenty-four hours following delivery, every temperature exceeding 38° (100.4° F.) on one occasion and persisting more than twelve hours should be considered pathological during the puerperium.

SCOTLAND

Notes from "The Report of the Scottish Departmental Committee on Puerperal Morbidity and Mortality."

The highest rate recorded for a single year was 7.0 per 1,000 births in 1918, the year of the great influenza epidemic. Of the four years, between 1855 and 1913, in which a mortality of 6.0 was reached, two (1874 and 1875) were associated with the severest epidemic of scarlet fever recorded in Scotland.

The most important avenue to the prevention of maternal mortality and morbidity is through ante-natal care.

Every pregnant woman should be encouraged at an early date to put herself under the supervision of a medical attendant. If necessary this supervision should be provided by the public health authority.

We recommend that legislation be considered to make the conduct of maternity homes illegal unless they are registered by the local authority and conducted to their satisfaction.

We recommend that every death occurring within four weeks after the termination of pregnancy should be fully investigated by a person designated by the local authority, and the facts communicated to the Scottish Board of Health.

Increased ante-natal care of the mother and due training and co-operation of her professional attendants will together include most of the remedial measures which are at present applicable to the prevention of maternal mortality and morbidity.

RETURNS RE PUERPERAL SEPSIS

An effort is now being made in England and in the United States to increase the accuracy of returns reporting puerperal septicemia. Dr. Reginald Dudfield, Medical Officer of Health for Paddington, and others have pointed out that this disease is not being satisfactorily reported.

In the state of New York during 1920-23 there were 1,148 deaths from puerperal sepsis recorded, but only 877 cases of the disease reported.

Dr. Harmon of the School of Medicine of Western Reserve University deals with the variations in the United States death rates of puerperal septicemia and makes the following statements:—

> "According to the published figures of the Census Bureau for 1920 for the United States registration area for deaths, it was the largest single cause of maternal mortality and was responsible for about 34 per cent of all such deaths.
>
> "All rates therefore in this paper are expressed as the number of deaths from puerperal septicemia occurring in an indicated area during a year per 100,000 married females, age fifteen to forty-four, credited to that registration unit."

The following are among Dr. Harmon's conclusions:—

> "For the whole period, when all the states are considered as a unit there is no evidence of a significant downward tendency in the rates from puerperal septicemia."
>
> "The high rates, the lack of a consistent downward trend, and the variability of the rates for the states studied demand that greater attention be given to the prevention of puerperal infections and that efforts to accomplish this end be organized as soon as possible."

AMERICAN ASSOCIATION OF OBSTETRICIANS, GYNAECOLOGISTS AND ABDOMINAL SURGEONS

Another important American report is the Report of the Committee on Maternal Welfare to the American Association of Obstetricians, Gynaecologists and Abdominal Surgeons, 1923.

The following is the conclusion of the report of this committee:—

> "Women will never escape what must be designated as the accidents of pregnancy and labour, but they may be spared much of the danger, which is now accepted as being of preventable origin. It is this phase of preventive obstetrics in which organizations, self-constituted and enthusiastic to do welfare work, can find a proper field for their activities. This cannot be successfully accomplished, however, in any community without a lay interest being manifested by persons who will, by a generous philanthropy, provide the means of financial support; and, also, by an interest on the part of semi-professional organizations, such as associations of trained nurses, as well as women's clubs; and finally by an interested medical profession, willing and ready to lend its aid. All such elements of the lay, the semi-professional and the professional people, if they co-operate, can bring about an organization powerful for good; and also elastic enough to recognize the responsibility of each class and to accept by agreement that each shall function as an entity, neither invading the prerogative of the other, and thus to impress upon the community its value as a factor in upholding the public health."
>
> (Signed) HENRY SCHWARZ, M.D.,
> GEORGE W. KOSMAK, M.D.,
> GEORGE CLARK MOSHER, M.D.,
> *Chairman*.

STANDARDS OF MATERNITY CARE

It may be noted that the standards for maternity care have been raised.

The following are the standards of maternity care adopted by Regional Consultants in Obstetrics for the New York State Department of Health, Albany, N.Y.

Prenatal

Continuous medical supervision should begin as soon as the mother suspects pregnancy.

Hospital care should be advised when indicated and available, for all parturients (particularly primiparae) and should be insisted upon for all abnormal cases.

First visit should include:—Histories of previous pregnancies and labours. Determination of expected date of confinement. Instruction in the hygiene of pregnancy, including diet, elimination, exercise, rest clothing, care of the breasts preparatory to breast feeding, marital relationship, and provision of literature on pre-natal and infant care.

Physical examination should be made as early in pregnancy as practicable. Special attention should be directed to determination of blood pressure. Urinalysis. Heart, lungs and kidneys. Thighs, legs and vulva for varicosities. General nutrition. Posture with examination for spinal curvature, subluxation of sacro-iliac joints or other abnormality. Blood Wassermann when indicated. Pelvic examination. Palpation of bony pelvis. Pelvimetry, the following measurements being suggested: interspinous, intercristal, external conjugate, external obliques, internal conjugate (estimated), transverse of the outlet, posterior sagittal.

Classification as to type of pelvis.

Vaginal examination preferably after the first six weeks if there are no indications of abnormalities.

Instruction of the patient to report promptly the following symptoms: headache, nausea, dizziness, visual disturbance, epigastric pains, bleeding, constipation, edema.

Frequency of visits. The patient should visit her physician at least once a month until the sixth month, then every two weeks or oftener as indicated, preferably every week in the last four weeks. Local nurses and social workers could be utilized to follow up patients if they do not return at the appointed time.

Subsequent visits should include: Determination of blood pressure. Urinalysis. Examination for fetal heart. Any other examination that may be indicated. Determination of presentation and engagement and probable position of the fetus after the seventh month. Vaginal examinations should not be made after the seventh month unless indicated. If made they should be conducted under the same aseptic precautions as for delivery. Rectal examinations will usually furnish necessary information.

Instruction of the patient in: preparation of person, room, outfit for confinement and for the baby. This may often be given by the patient's nurse or by the local visiting or community nurse at the physician's request.

Delivery

Time should be given freely.

Consultant facilities should be available. As any abnormality requires more than average experience it should not be handled without the advice of a consultant obstetrician.

Nursing care should be adequate.

Equipment sufficient to meet emergencies should be accessible.

Surgical cleanliness. Rubber gloves, sterilized by boiling or steam pressure should be used for examinations and delivery.

The vulva should be shaved and the entire field cleaned and made and kept aseptic.

Vaginal examinations should be avoided if possible. Usually confirmation of previous findings can be made and progress satisfactorily followed by rectal and abdominal examinations.

Indications for interference, the cervix being fully dilated or dilatable and no other abnormality being present.

Failure of labour to progress.

Fetal heart rate below 100 or above 170.

Should radical interference become necessary, the same careful surgical technique should be used as when entering the

peritoneal cavity.

Examination after delivery should include: the perineum and vaginal outlet for evidence of lacerations, which should be repaired immediately.

The placenta and membranes to see if they are complete. The uterus by external palpation to see if it is empty and firm. Time should be taken to examine the baby thoroughly and to give full directions for the care of both patients.

Hemorrhage: Normal contractions of uterus, determined by abdominal palpation should be maintained for at least one hour after it is emptied. In event of persisting hemorrhage immediately after delivery which does not yield to ordinary measures the fundus should be massaged through the abdominal wall. If bleeding continues the cervix may be examined for lacerations and necessary repairs made.

Freshly sterilized gauze for packing should be available.

Puerperium or postpartum period

The patient should be seen by the obstetric attendant as often as may be needed.

Postpartum visits should be made at least, on first day, to determine uterine contraction, bladder tone, to establish breast feeding and note general conditions of the patients.

Third and fifth days, to determine possible evidence of infection and not involution.

Tenth day, to determine involution, general condition of patients and to fix the time when mother may sit up.

A final bimanual examination should be made about six weeks after delivery or before the patient resumes usual activities to determine displacements, subinvolution, cervicitus, resolution of lacerations with correction of defects.

The patient should remain in bed at least ten days after delivery.

She should not resume full activities for six weeks after delivery as it takes six to eight weeks for complete involution to take place.

The services of a visiting or community nurse may be secured if available for the aftercare of patients if such service is desired.

GENERAL CONGRESS OF OBSTETRICS AND GYNAECOLOGY, 1925

"At the General Congress of Obstetrics and Gynaecology to be held next year, 1925, at the Royal Society of Medicine, Dr. Russell Andrews will preside over a reunion of the various British and Irish societies devoted to the subjects of gynaecology and obstetrics, when one of the subjects set for discussion is the treatment of puerperal sepsis. To this discussion two whole sessions will be devoted, and it will be introduced by reports from two special committees in London and the North of England, when the grave interest of the matter will secure widespread attention for the conclusions of the Congress. From all that has been written above it will be seen that now at least the medical profession is alive to the supreme importance of a scientific service of midwifery, and the status of work along all its lines is thereby indefinitely raised."—(The Status of Midwifery, November 22, 1924, page 1075, *The Lancet*.)

The CHAIRMAN: Dr. MacMurchy has interested every member of the conference in the excellent paper she has given us. The subject she has discussed is obviously one that must be tackled by the profession or the state, or by whatever authority can best deal with it. Certainly we cannot afford to have mortality statistics in this class of cases greater in this country than they are elsewhere. It does seem to me that the subject, which is of such great importance, is one that should be grappled with. The paper is now open for discussion.

Dr. JOST: If I am in order, I would move that there be submitted to the Resolutions Committee for consideration the following question: "Should a comprehensive investigation be made into maternal mortality in Canada, and if so by whom?" I think that this conference might suggest to the Canadian Medical Association the advisability of calling the attention of the provincial societies to the importance of this question with a view to the adoption by each society of such

action as it may deem advisable.

The CHAIRMAN: The question might be handed to the Resolutions Committee for consideration.

Dr. J. C. CONNELL (Queen's University): Medical science is cosmopolitan; it has no geographical boundaries, inasmuch as we are concerned only in the extension of the frontiers of knowledge. At the same time, I think it is acknowledged that matters relating to medical education fall within the province of each country and appertain to that country itself. In Canada such matters are provincial rather than national. I propose to submit for your consideration, Mr. Chairman, as well as for the consideration of members of the conference, a matter which I consider of very great importance and which I think should be carefully considered by this national meeting—a matter which may be regarded not only from a sentimental aspect but, as well, from a practical point of view.

About fourteen or fifteen years ago the American Medical Association appointed a council on medical education, at a time when there were some 200 medical schools in the United States. The primary duty of that council appeared to be to inspect the medical schools of the United States and to report on their condition. Following that inspection, this council on medical education—on what authority I do not know; I am quite sure it was not on the invitation of any representative Canadian body—proceeded to inspect the medical schools of Canada and to prepare a report upon them. To those of us who concerned ourselves with these reports, it was from the beginning quite evident that whatever criteria were adopted to determine the standing of the various schools they were not applied in Canada in just the same way as they were in the United States. This is not the time to refer to the nature of some of the criteria, but one cannot help observing that some of them were extremely artificial. As a result of these inspections there has been published from time to time in the annual reports of the council on medical education a classification of the American medical schools together with one in regard to the schools in Canada.

I shall not go into any detail except to say that as a result of the last inspection of which I had any knowledge, which was made in 1921, a report was submitted by the inspectors which, as it related to one of our Canadian universities particularly, was so untrue in many respects, and so absolutely unfair in many more, that the Senate of the University and the Board of Trustees took the matter up and entered a vigorous protest against the action of the inspectors of the council. In consequence of that protest—at least following upon that protest, whether in consequence of it or not—the classification of Canadian schools was discontinued. For the years 1921, 1922, and 1923, in the reports of the council on medical education no classification of Canadian schools was included. In the report of the council published in the American Medical Journal in August of this year there appears again a classification of Canadian medical schools, and apparently, at least so far as I know, that classification has been made without any re-inspection. Certainly there was no general re-inspection.

Now, let me point out just what this means. First of all, I want to note that in the United States there are now about 80 medical schools, of which only four are placed in Class B by this report. So far as Canada is concerned five schools are placed in Class B, namely, Dalhousie, Queen's, the Western University, Montreal, and Laval. On the other hand, I would point out that the report includes in Class A in the United States such institutions as the College of Medical Evangelists, Loyola School, Chicago, Boston University, Boston, and others of a similar standing. I know something of these institutions, and it is quite evident that the criteria are not applied in the same way to Canadian schools as to those in the United States.

There is another point to which I would call attention, and that is that the judgment of this council on medical education is not universally accepted in its own domain. The state of New York does not accept its judgment in regard to Canadian schools nor even in regard to the schools of the United States. One of the American schools included in Class A in this report is not accepted in that category by the Board of Regents of the state of New York, who have made their own classification of Canadian schools. And the classification made by that body in regard to Canadian schools is different from that which appears in the report of the council. The state of Pennsylvania has also made its own inspection with a different result. So that obviously the judgment of the Council on Medical Education is not to be accepted as finally authoritative.

Now, there are two aspects to this question: There is the sentimental side of it, and there is also the practical point of view to be considered. It is a humiliation that those connected with certain Canadian schools should find themselves in the company indicated in this report. Of course, after all, it does not concern us in Canada very much as to what our neighbours think about us, and they have a perfect right to adopt their own policy. That policy is one of antagonism to the admission of Canadian students to their qualifying examinations; one is constantly made aware of such an objection

throughout the United States. Objection is taken to Canadian certificates and difficulties are put in the way of Canadian graduates who are seeking state examination. We need not find fault with them in this regard; as I say, it is a matter of policy. When, however, a foreign corporation undertakes to classify Canadian schools without invitation, although they may consider their results confidential, without exception being taken to them, the matter assumes a different aspect when those results are published throughout the world. I think it is rather a serious matter, as it puts a grave disability on every Canadian graduate from every one of these so-called Class B schools who may happen to be in practice anywhere in the United States. Such a man has not the same standing if he is called into court; it is pointed out before his evidence is taken that he is a graduate of a Class B school, and this prejudices him immediately in the eyes of the court. That is the practical side of the matter: every Canadian graduate who is in the United States, or who proposes to practice there is under a serious disability as a result of this published classification.

Now, it seems to me that it would be very proper for this conference to take some action in the matter. All we want is to be left alone to work out our own ideals in our own way, and in my judgment at any rate there never was a medical school in Canada which was justly included among the Class B schools of the United States. There never was a school in Canada that gave a degree with less than four years work. I am unwilling to take the point of view that medical education in Canada has benefited in any way by the inspections of this particular council. I move therefore that the matter of the classification of Canadian medical schools by the Council on Medical Education of the American Medical Association be referred to the Resolutions Committee in order that a suitable resolution be drafted for the consideration of the conference.

The CHAIRMAN: What is the opinion of members of the conference regarding this question?

Dr. J. J. GUERIN (Montreal): I think we are all united on the question of the advisability of having reports of our standing from our own centres. These reports that have been submitted by the American authorities have been gathered, I am afraid, in a haphazard manner, and I am satisfied that whoever the gentlemen were who carried on the investigation, they did not put themselves en rapport with the authorities of the different schools; otherwise, I cannot see how they could make any such classification as is indicated. Speaking for my own school, I can state that there is nothing in the medical curriculum to be found in any other school that is not covered in the University of Montreal, where the course is of the same duration as it is in other universities. We have two pre-medical years and five years of medical study. I had heard before about this classification having been made, but I am at a loss to know where the information was acquired and through the medium of whom. I think it would be a very excellent thing to pass such a resolution as has been proposed, and I am sure that if we inspected our own schools we should find altogether different results.

The CHAIRMAN: Did these inspectors investigate the Canadian schools on their own initiative?

Dr. CONNELL: The inspectors were not invited to come, but they were accorded every consideration. They come without notice and introduce themselves, and whenever they have done so we have informed them of the condition of affairs. Usually we have had pleasant assurances from them that things were going along pretty well, but when the printed reports came in we found that we were just where we were before. The last visit was made in January, 1921. One of the statements made at the time in regard to Queen's had reference to the location of the institution; they thought that a medical school ought not to be in that situation. It was quite evident that many artificial considerations were taken into account in determining the standing of the schools, but we did everything we could to accommodate them. I do not suggest that we ever responded to the apparent proposal to make our courses agree with theirs. At the time of the last inspection we pointed out to the inspector that we had just made two appointments of whole time men, and we were immediately informed that that was not one of the standards required and that they could not put it to our credit. I feel that we have been harshly dealt with, and it is absolutely unfair that we should be prejudiced in the eyes of the world by these reports, for which there is no justification. So far as the situation of the school is concerned, we are not responsible for its location, but there was every justification for its coming into existence, and it need not apologize for its continuance. Let me repeat that all Canadian graduates from these schools are constantly prejudiced in the eyes of the public in the United States by means of these reports, which cannot be justified on any ground.

Dr. THORNTON: I second the motion that the matter be referred to the Resolutions Committee for consideration.

Dr. YOUNG (Saskatoon): Perhaps the Resolutions Committee would be glad to have some expression of opinion from representatives of the other universities as to what they think of the matter.

The CHAIRMAN: Further discussion, I am afraid, would be out of order, seeing that Dr. Connell has closed the debate.

Dr. MACLEOD: I did not understand that Dr. Connell was summing up the discussion when he last spoke a moment ago. Certainly it did not occur to me that the matter had been closed, for I intended offering a word or two on the question.

The CHAIRMAN: I do not think Professor MacLeod may proceed unless it is the pleasure of the conference that he be allowed to do so. I am afraid I must declare the discussion closed at this juncture, and Professor MacLeod will have an opportunity to speak after the Resolutions Committee has reported. I do not want to close the debate precipitately, but it does seem to me that this has already been done, and therefore any further discussion would necessarily be out of order.

Dr. REHFUSS: In the circumstances, I move that the subject be reopened for further discussion. In this motion I am seconded by Dr. Low.

The CHAIRMAN: Is it the pleasure of the conference to adopt that motion?

Motion agreed to.

Dr. J. J. R. MACLEOD (University of Toronto):—I do not intend to discuss this question at any length, but I want to point out that the American Medical Association has done such excellent work in its inspection of medical schools in the United States that the fact that it should have applied this method in Canada should not be taken by us too seriously. It is a fact that by means of this classification it has been able very largely to discipline a number of schools in the United States which were distinctly detrimental to the interests of medical education. The usefulness of the classification is now possibly coming to an end, and I think I am correct in saying that a great many of those who have been interested in this work are now prepared to drop the whole question of classification. It would therefore, it seems to me, be a very unfortunate thing if we in Canada, in taking the initial step in the co-ordination of our own medical educational affairs should do anything that might cause misunderstanding on the part of our colleagues in the United States. We must work with them in harmony; we must remember that from many of our medical schools as instanced by Dr. Connell of Kingston, graduates are compelled to go to the United States. And they ought to go. Canada has been a breeding place for medical practitioners, scientists and teachers, and has supplied many of the leaders in the medical profession in that country. So that in any resolution framed by this body expressing any sense of criticism of the methods which the American Association has applied, the language should be extremely cautious and should be only suggestive of the possibility of Canadian schools being omitted from any future published classification. What I really want to point out is that we are prepared now as a country to mind our own medical affairs without assistance directly from the United States, and this sense might be conveyed by a tactfully worded resolution. It does seem to me however, important to bear in mind that we must work in close harmony with them and not do anything that will prejudice the relationship.

Dr. A. F. BAZIN (Montreal): Perhaps it might be well if we could get some information from other universities as to the accuracy of the statement that in 1924 a classification of Canadian schools was made without any inspection, the last inspection having been made in 1921. If that is the case, the matter would seem to be very serious. Let me offer one thought while I am on this subject. I sometimes think that the word harmony is very much misused, and it is sometimes interpreted by a strong and powerful party as signifying, on the part of a weaker party, an absolute lying down to be stepped on. I am perfectly willing and shall always be prepared to live in harmony with everyone as far as I can possibly do so, but I certainly am not prepared to purchase harmony at any such price as this. I am not ready for harmony under any such unequal conditions.

Dr. W. H. HATTIE (Halifax): In substantiation of Dr. Connell's remarks, I can say that while at Dalhousie we have been waiting for more than two years for a re-inspection by the Council on Medical Education, we have not had it, although such an inspection has been promised us.

Dr. J. C. SIMPSON (Montreal): I ask for information only. I am not aware that during the last two years the reports of the Council on Medical Education of the American Medical Association contained any classification of Canadian schools. The list of schools on the continent during the last two years has given a classification of all American schools, but so far as I am aware the nine Canadian schools have been omitted.

Dr. J. C. CONNELL: The classification was discontinued in 1921, and reappeared in 1924 exactly as in 1920.

Dr. OWER: The University of Alberta expected an inspection in 1919 and was inspected in 1923.

Dr. D. S. MACKAY (Winnipeg): As a result of the first inspection carried out at our school the institution was classified as an A school but later on, upon a further inspection, we were demoted. We were told that along certain lines we must

improve. The inspectors based their classification on what appeared to us to have no reference to the quality of teaching but rather to the square feet of space occupied in laboratory accommodation. We pointed out, however, that we had sufficient laboratory accommodation and equipment for the students, as well as an adequate teaching staff; but it seemed that the kind of room we had did not appeal to the inspectors. Our buildings were in course of construction and when we got into our new quarters we expected that the unfavourable classification which had been made would be rectified. It is true that we did not have a full-time paid physiologist, but that was merely a temporary want. We have had our university in Manitoba since 1906 and when our man left us we were at a loss to find a substitute. At last we secured one and we reported that fact to the inspectors, but I do not know whether any inspection was made with that fact in view. This occurred in the fall of 1923, and early in January of the present year we were notified that we had again been placed in Class A. No doubt there is a bit of sentiment in this matter so far as we are concerned, because I know that we do claim to have good results.

I must concur in the remarks of Dr. Bazin so far as the word "harmony" is concerned. I for one am absolutely sick of and fed up with this advocacy of harmony, and we do not intend to lie down and take things quietly when we have principles at stake. We are going to stand by those principles. Our schools are founded on the best medical system and are suited to the conditions in the West. We are prepared at all times to put into effect all the good points that may strike us in any system and we will give them a fair trial and endeavour to carry them out to the best of our ability with a view to giving the students the best possible instruction. But, I repeat, we refuse to lie down and take things submissively; we will retain the right to decide for ourselves such questions as intimately affect our own welfare.

The CHAIRMAN: As Dr. MacKay has remarked, our schools are modelled after the best universities and we propose to stick to our own methods. At the same time, however, I think we can do all that and work in harmony with others. I am not at all taking issue with Professor MacLeod, for there does not seem to me to be any reason why we should not continue in harmonious relations with the United States or any other country for that matter. A large percentage of our graduates practice in the United States and we are closely related to the people there in many ways. A very large percentage of Canadians, too, belong to special societies in the United States and we cannot, on inadequate grounds, do anything else than work in harmony with them. I do not think there is any misapprehension in regard to that term; I think we all understand pretty well what we mean by it. We must however insist on fair play, and we do not mind telling the United States that we will not take dictation from anybody but are quite capable of pursuing our own course. That I think is the sentiment of the Canadian generally, and this is a matter that requires the best consideration possible. I hope the Resolutions Committee will consider it carefully and take the matter up again to-morrow.

Dr. V. E. HENDERSON (Toronto): I am glad that the Programme Committee accepted my suggestion that I should be allowed to preach the gospel to which I am called by the Canadian Medical Association on this occasion. I may meet the chairman of the new Committee on Pharmacy, which is a committee that has functioned in the Ontario society and which, through the Canadian association approached the Government two years ago in regard to the difficulty of getting pure drugs. The particular type of pure drugs in connection with which we approached the government comprised such medicinals arsphenamine, pituitary extract, digitalis, adrenalin, thyroid, and acetyl salicylic acid. The proposal we made to the government was that they should undertake to standardize all these drug stuffs for the manufacturer and that no drug stuff should be sold that did not comply with the regulations which the Dominion government would lay down. That plan has been adopted by the United States government so far as arsphenamine drugs are concerned. The American Government standardizes them and if the drug stuff submitted for analysis comes up to the requirements that particular batch is given an official number and is sold to the public under that number, so that any sample seized by a food and drug inspector may be identified.

Now, Canada is a small country from the point of view of population and is widely scattered. The medical profession is working in the interests of the public and the idea is that we should aid the manufacturers in Canada in overcoming certain handicaps by getting the government to undertake this standardization. We found that the government, through the foresight of the Deputy Minister of Health, had already gone so far as to interest themselves in the appointment of a pharmacologist. After about a year they found one and he underwent a period of training. He should be able, I have no doubt, to carry on the work efficiently; but if the mills of the gods are said to grind slowly, it would seem that the mills of the government are just as tardy. We are not sure that the time may not come when it will be necessary, for the medical profession, if they are interested in getting pure drugs for their use, to bring pressure to bear upon the government to move a little more quickly. I do not think that the department is entirely convinced yet that the step proposed is the right one. In the United States a number of drugs are standardized by the manufacturers, and a great many of these drug stuffs

sold in Canada by American firms are marked "physiologically standardized." Most of the manufacturers, however, are careful to say that the drugs are not standardized in compliance with the Pharmacopœia of the United States. There is some question as to whether a manufacturer falling down on his standardization should be severely dealt with. I understand that under the new regulations which will be in effect in a year this matter will be made compulsory. The standardization laid down by the United States Pharmacopœia is in some cases not the best that could be devised, and I know that the chairman of the Committee on Standardization is now convinced that in one or two respects they might be altered to great advantage. This has become apparent as a result of the international congress which was held in Edinburgh last summer under the League of Nations and which I had the honour to attend as an observer. The Canadian Association urged the Government to undertake a standardization not only from the standpoint of the manufacturer but because our experience has convinced us that the result which we have in view can be obtained in no other way. Under the Food and Drugs Act the Department of Health is charged with the duty from time to time of making inspections, taking samples from druggists' stocks or from other sources and submitting them to analysis, and instituting prosecutions wherever drug stuffs are found to be deficient. We have no official knowledge of what the results of these analyses have been; that information is not made public now as it was in the past. It may be that the Department is exceedingly well advised in this matter, and to a certain extent it may be said that when the information was published it was not of very great value to the physician. It was, however, of value to him in this respect, that it showed what a large percentage of our medicaments can be standardized and which were by no means up to the standard required. The figures in days gone by were appalling; seventy-three per cent of a certain drug analysed on one occasion was far from being what it should have been. If that is the case with drug stuffs that are easily handled it surely will be true also in regard to things which are difficult to deal with and where it is necessary to have an expert with trained judgment to carry out the tests. We therefore came to the conclusion that in order to get some positive assurance in this matter the method of government standardization was the only satisfactory one to be followed. The chief duty of the Committee on Pharmacy lies in this direction, and we want to have the medical profession throughout the country apprised of the situation and prepared to use their best endeavours to see that pure drug stuffs are obtainable.

If I may, I should like to mention one or two instances that occurred to me in recent experiences. As regards pituitary there is one extract sold in this country which we have assayed on many occasions and we have not found it better than one-twenty-fifth of the strength it should be for medicinal purposes; and it has been as low as one-thirtieth. I have had only one or two samples recently, of drug stuffs susceptible of chemical analysis, examined in my laboratory. And in passing, I might observe that we should have a laboratory to do this sort of work properly. I have looked at several samples of salicylic acid in double form and in no instance did it contain the quantity of acetyl salicylic gases indicated. We were convinced that it was exclusively sodium salicylic. These examples are enough to show what we are driving at. We are in a difficult position. Suppose I undertook at the present time a careful study of acetyl salicylic acid: how am I to get the information contained in that examination to the members of the medical profession? I can understand that the department, perhaps rightly, is not in the position to publish the names of the manufacturers and of the deficiencies found in their products. Possibly the position of the department is quite sound in that regard. In the United States the medical profession is largely in the same predicament, but they subject drug stuffs from any source to analysis themselves and in that case they are able to make use of their findings for the information of the profession. The question is a difficult one and I am continually asked why that information cannot be got to the public. Of course, no one can make any public statement in regard to the products examined from any particular source; one has to be safeguarded before he can make any statement in public. But the Committee on Pharmacy is bound to be interested in the question. The profession, it seems to me, are rather at fault in the matter of the growth of patent medicines. I am sure it is highly detrimental to our own pockets as well as to those of our allies the druggists. In the post-war rush I had occasion to make use of drug stores as a means of giving to my students some knowledge of dispensing. I required them to bring me forty prescriptions, filled in at any drug store or in any hospital pharmacy, for inspection, to assure me that they had done the work. I was astonished to find the number of proprietary substances of various kinds, ranging from flavours to so-called remedies, which were employed by the profession. And I was still more horrified to find that my students could not make up these prescriptions without including such things as Frost's 127. One student in great distress reported from a small town that he had been unable to make up forty prescriptions in the time he had spent there and could not see any possibility of being able to do so, inasmuch as the whole business consisted in dispensing Frost's 127 or some other medicament for the patients. This sort of thing is absolutely unsound, and the doctors lay themselves open to criticism in that type of dispensing. It seems to me that we contribute in that way to the use of patent medicines, so that the people of the country are led to believe that they can buy ready made preparations that will serve their purpose just as well as the prescriptions of the doctors. Thus we tend to destroy the confidence of the people in the profession. One might speak

with fervour and enthusiasm on this particular point, but I do not think that it is necessary to dwell upon it at any length. There is one point on which I desire to appeal to members. The Committee on Pharmacy constitutes a small nucleus of men doing pharmalogical work. It would be well I think if we could get a physician or two in each province to make a hobby of the thing and seriously to think about this matter. Something of this kind might serve to advance the interests of medicine in this particular respect. I can only promise that anything I can do in supplying any such individual with information, and furnishing him with the necessary ammunition, I shall be glad to do.

Dr. AMYOT: The department has a limited control over such things as food and drugs. For the last two years a serious effort has been made to set up standards for these very drugs of which Dr. Henderson has spoken. For various reasons we have been held up, but we are on the verge of being able to launch out. We are making every effort possible and in a short time shall be able to do something in that direction. So far as publication is concerned, we have had many prescriptions that were below standard, and these things were published in the newspapers, or at least in some of them. Both in the United States and in Canada, however, it is rather difficult to secure publicity on any large scale, and this for various reasons. Many of those concerned are large advertisers and to have the facts published in regard to these people is a matter of extreme difficulty. This is one of the difficulties that are encountered in Great Britain, in the United States and in Canada as well. If the facts are published they are more or less camouflaged, and in some cases they are not published at all, so that we have to depend on the little local knowledge which people have that druggist so-and-so has been caught and found guilty. And the druggist endeavours to suppress the news as quickly as possible.

Dr. H. W. MCGILL (Calgary): One fact has often struck me and I think it must have been apparent to most gentlemen of the medical profession, and that is the terrific propaganda of a high pressure nature which is made on medical men by the agents of proprietary medicine manufacturers. Every morning my desk is piled up with literature advertising these preparations. To those of us who have been in practice for some years this is not a matter of any great concern; we simply throw all this literature into the waste paper basket. But in my opinion this practice on the part of proprietary medicine agents constitutes a distinct danger to scientific medicine, and in any case it is an intolerable nuisance. I know of young physicians who have received many visits from these high pressure salesmen who attempt to exploit their products. Every discovery that is made is immediately exploited for all it is worth, and altogether this practice is quite overdone. A tremendous campaign of advertising is instituted to create a demand for some product that could not normally exist. Vitamines is one thing in point; certain pharmaceutical houses attempt by means of advertising to create a demand for this article, of which there is no need whatever. A young man starting out in practice may happen to be rather weak on prescription writing, and this literature is apt to tempt him to find an easy substitute for proper prescriptions. These suggestions coming in day after day might indicate to him an easy road to the writing of prescriptions, and this is a distinct menace. In the old days the manufacturers of patent medicines used to get out almanacs which they would leave at the country grocers'. These almanacs contained notices of preparations which it was claimed would cure all the ills of mankind; and in addition information of various kinds was given together with recipes and so on. Now, instead of distributing these almanacs, the proprietary medicine manufacturers send out literature to the medical practitioners and every few weeks they dispatch a detail man to explain the virtues of these products. This is something which might be looked into.

Dr. BAZIN: Dr. Henderson, I gather, represents the Committee on Pharmacy of the Canadian Medical Association, which made representations to the Government urging the adoption of some system of standardizing drugs. Does Dr. Henderson wish the conference to take up this matter with the association with a view to securing some action on the part of the department?

Dr. AMYOT: The matter is under consideration.

Dr. HENDERSON: I do not think it would do any harm if a resolution were passed on the question. Quite apart from anything that we might do, I think that such a resolution from the conference would have a good effect on the profession throughout the country. I should be glad to move that the Resolutions Committee be instructed to draw up such a resolution. With reference to Dr. McGill's remarks, I can only say again what I indicated in my address, that I think the medical profession is itself largely responsible for the amount of high pressure literature and the canvassing with which medical men are assailed. It seems to me that if members of the profession would do what a friend of mine did in one instance it would tend to diminish this practice on the part of agents. He was visited on one occasion by one of these men and he showed the agent that the essential drugs in a certain preparation had never been adopted by the American Pharmacopœia, which is a liberal one. That sort of thing would discourage this type of propaganda. The opinion is held by some that the medical profession as a whole is easily gullible.

The CHAIRMAN: We shall now receive the report of the Resolutions Committee.

Dr. J. C. CONNELL (Kingston): With your permission, I shall move the resolutions clause by clause and they can be adopted or otherwise disposed of as we proceed. The first resolution is as follows:—

> "That in the opinion of this meeting the conference has been productive of much benefit, and arrangements should be completed for its establishment upon a permanent annual basis."

Resolution agreed to.

Dr. *Connell*: The next resolution is this:—

> "That the conference of 1925 be held early in the month of December, in Ottawa, and under arrangement and auspices similar to those of the present conference."

Dr. MACDERMOT: Would that be early in December? From the point of view of members from the East, December may be an ideal month, but for the West it is not a very favourable time of the year. This year we could have had a better representation from the province of British Columbia had the conference been convened at an earlier date.

Dr. MCCULLOUGH: It is important that the meeting should be held next fall, or either before or subsequent to the meeting of the Dominion Council of Health. This year the Dominion Council of Health met previous to this conference. It might be advisable to have a similar arrangement next year.

The CHAIRMAN: Why not omit the words "early in December"?

Dr. YOUNG (Saskatoon): There is a meeting of another body in Ottawa every year, the Medical Council of Canada. It is composed of two representatives from each college or medical board in Canada and a representative from each university. Those of us who come long distances appreciate the fact that travelling costs money and takes a lot of time. If the conference could be called immediately after the meeting I have mentioned we should get a better representation than would be possible otherwise. If the colleges agreed to be represented by those who were on the Medical Council of Canada a great deal of time and expense could be saved. That body meets in September next year. I would ask that due consideration be given the fact that the council meets next September.

Dr. *Connell*: I move that the resolution be adopted, amended as follows:—

> "That the conference of 1925 be held in Ottawa, and under arrangement and auspices similar to those of the present conference."

Motion agreed to and resolution concurred in.

Dr. CONNELL: I move the following resolution:—

> "That the 1925 conference shall occupy four days, to permit of one or more sessions being devoted to sectional meetings of the various organizations represented, that is, Licensure, Education, Public Health."

Dr. MACKAY: I think we are making a mistake in this. We have 75 delegates on the present occasion; there are some of us from the medical schools and we should like to carry away as many ideas as possible. Licensure, education and public health are three important subjects and I am afraid that we shall miss some important points in connection with these subjects. We are carrying the practice of specializing too far. Specialization is all right as far as it goes, but I think we would do better by having open meetings rather than by dividing them into sections.

Dr. HILL: The great point of the conference is that medical men in different branches have an opportunity to hear the point of view of others.

Dr. CONNELL: I withdraw the resolution.

Resolution withdrawn.

Dr. CONNELL: I beg to move the following:—

> "That the same organizations represented at this conference shall be called to the 1925 conference."

Resolution concurred in.

Dr. CONNELL: I move the following resolution:—

> "That this conference gladly accepts the offer of the Editor of the Canadian Medical Association Journal to publish in the February issue a full report of the transactions of this meeting."

Resolution concurred in.

Dr. CONNELL: I move the following resolution:—

> "This conference approves the principle of combating venereal disease by community efforts; appreciates the value of the work accomplished during the past five years; realizes the necessity of maintaining and augmenting the work of the clinics which should be closely supervised to avoid abuse; and strongly urges upon the federal and provincial governments the need of continuous and increasing financial support."

Resolution concurred in.

Dr. CONNELL: I move the following resolution:—

> "That we recommend a five-year period of medical study, each of thirty-two teaching weeks as a minimum requirement of which three years should be devoted largely to clinical subjects."

Dr. MACLEOD: How many schools in Canada at the present time have a thirty-two week session? Does that include the examination period? Most of the Canadian schools give no more than thirty weeks.

Dr. MACKAY: I understand, from information given us yesterday that this thirty-two week period is exclusive of examinations.

Dr. HILL: It seems to me that a recommendation of this kind, made with the weight of this Conference behind it, and providing no alternative, will bind the hands of the medical section of the universities very materially. I think it might be well to offer a tentative suggestion rather than to recommend something definite such as is now proposed. I have no doubt that the medical section of the universities wishes to meet us on this point, but it is hardly advisable to pass such a resolution as this in its present form.

The CHAIRMAN: If I might be allowed to do so, I would suggest omitting the words "each of thirty-two teaching weeks." It would be a pity for us to put ourselves on record in any such binding form, for I am sure there would be a considerable difference of opinion on the question. It seems to me rather unwise for us to commit ourselves on a question in regard to which we know there will be a lot of discussion. I would advise deleting the objectionable words.

Dr. CONNELL: I must explain that I am not responsible for this particular resolution.

Dr. AMYOT: I move that this particular resolution be held over until to-morrow.

Dr. MACKAY: I think we should accept the suggestion of the chairman. I would therefore move that the resolution be adopted, amended in the way proposed by the chair.

Dr. CRUIKSHANK: I second that motion. I do not think that the committee had any idea, when it drafted this resolution, of laying down any hard and fast rule. We simply wanted to equalize the various teaching bodies in the different provinces.

The CHAIRMAN: Is it the pleasure of the meeting to adopt the resolution as amended?

Dr. GRAHAM (Toronto): This resolution is based upon the paper which we had from Dr. McCallum yesterday. The requirements in certain provinces provide a period of five years and six months, but this varies. The question the committee had under consideration last night was what might be suggested as a minimum requirement which would be satisfactory to all provinces, and it seemed that that minimum should be at least five years. I think the condition of things would be worse than it is at present if we left any room for misinterpretation of the requirement; obviously it would not do to leave the thing in such a way as to make it possible for someone to interpret the requirement as meaning five years of two months each. I do not know that such an interpretation is altogether an impossibility. We must have a reasonable length of academic year, and simply to say five years would seem to be inadequate. Most of the schools give thirty weeks of teaching, with two weeks for examinations. To leave the matter in an indefinite state is not advisable.

The CHAIRMAN: I would suggest, to make the resolution definite, that we substitute the word "thirty" for the word "thirty-two" in accordance with Dr. Graham's views.

Dr. Connell: I was not a member of the committee that drafted this particular resolution, but I know that thirty teaching weeks is about all that you can get in unless you begin early in September or carry on your examinations into a period when the council examinations are held. I move that the resolution be adopted, amended as follows:—

> "That we recommend a five-year period of medical study, each of thirty teaching weeks, as a minimum requirement of which three years should be devoted largely to clinical subjects."

Resolution as amended concurred in.

Dr. Connell: I move the following resolution:—

> "That we recommend that students have instruction in pre-natal and post-natal care of patients, and attendance on at least ten maternity cases under instruction."

Resolution concurred in.

Dr. Connell: I move the following resolution:—

> "That the Provincial Council and the medical schools be asked to encourage students to register at the beginning of their medical course and that for such registration a nominal fee only be exacted."

Resolution concurred in.

The conference adjourned.

SATURDAY MORNING SITTING

The conference resumed, with Dr. Primrose in the chair.

The CHAIRMAN: As it is the desire of most of us to get away shortly after noon, we shall have to adhere strictly to the time limit rules this morning for speakers, and make a prompt start. I will now call on Professor Macleod to present his paper on Medical Education.

MEDICAL EDUCATION

Dr. MACLEOD (Toronto): It is obviously impossible in twenty minutes to consider in any adequate detail the principles involved in an education for the medical practitioner.

The fundamental principles which must guide us in framing a course of study for medicine are, first, to train the student to grasp the known laws of science so that they may be applied in the detection, prevention and treatment of disease, and secondly, to give him sufficient practice so that he may apply such facts and procedures as experience has shown are the most efficacious for these purposes.

It is essential that these principles be lived up to, and yet it is impossible that the method of working them out can be the same in different places. I cannot attempt to give review of the methods in vogue in different medical schools in different communities, but must confine my remarks pretty strictly to the type of medical education which I believe most adequately prepares the youth in a Canadian community for the practice of his or her profession.

There are several aspects of the problem which demand attention, and the first is with regard to entrance requirements. There are two purposes for these requirements: The first is that the student may have a suitable general education so that the mind may be prepared and trained to assimilate new knowledge; and, secondly, he must have had some preparation for the study of medicine, some special training in the fundamental sciences upon which the practice of medicine and surgery depend.

Now with regard to general education, this must necessarily vary greatly in different communities. The ideals of these communities vary; the facilities for education vary; the traditions vary. It is, I think, an accepted principle that you cannot have exactly the same educational system in different countries, even although these may be very closely related. In most countries of the English-speaking world there are two examinations which are given to test the efficiency of school education. These are generally the junior and the senior leaving certificates. They go by various names in different countries. Sometimes they are called leaving certificates, as in the Scottish Education Department; sometimes they are called the certificates of the schools examination board, as in Oxford and Cambridge; sometimes they are matriculation certificates, as in London and the English provincial universities; sometimes they are the High School graduation certificates, as in the United States. In most places in Canada they are known as matriculation certificates and are of the junior, and the honour or senior standard. It is a very difficult thing to equate the standards demanded by these various certificates; almost impossible to do so exactly. I have compared as closely as I could the two with which I am most familiar, the entrance requirements for the Scotch universities and for the Canadian universities, and as a result of the investigation, which I made with the aid of registrars and other experts in education, I found that there is as close a similarity as there could possibly be between the junior leaving certificate of Scotland and the junior matriculation of Ontario. The senior certificates—although I am not quite so sure of these—very nearly correspond also. It comes to be important then, in equating the value of preliminary education, to have some simple method by which this can be done, and in my belief there is probably no one better than to take the average age of the students.

Granted that the educational system of a country is sound, and is based on established pedagogical principles, then I think we can take the age on graduation from the high school or similar institution as a fair standard of the attainment reached. I have taken the ages of students on entry to the University of Toronto Medical Department, and have tabulated them for each of the years, with very interesting results. There are 780 students concerned, and the largest number entered at the age of 19; the next largest number at 18, and the next at 20. The peak is at 19; that is for all the students of the six years' course. Three years ago the entrance requirements to the Medical Faculty of the University of Toronto were raised in a manner which I will explain in a moment, so that it is interesting to compare these figures for the total six years with those for the first three years during which the new entrance requirements have their effect. The results work out pretty nearly the same: 31 per cent of the students of the first three years entered at 19; 26.5 at 18, and 14 per cent at

20, which means that in the three years during which the standard has been raised, the school authorities have so adjusted their schedules so as to make it possible for the youth even in face of these increased entrance requirements to get through his school education in a somewhat shorter period of time than previously obtained. Two-thirds of all the students in the first three years in the University of Toronto entered at or below 19 years of age, which means that on graduation after completion of a six years' course the age of the students varies between 23 and 25, which, I think it will be admitted by most medical educators, is about the age at which a student should be graduated from his medical college.

Now with regard to the junior certificates. Junior certificates include English, Latin, mathematics, history, experimental science, and usually one other language. Some other subjects are usually added, but the student has a certain option with regard to the choice. The junior certificates are all pretty well standardized, as it were, except perhaps with regard to the sciences. The sciences which can be most advantageously taught in schools are mathematics, physics and chemistry, and it is extremely important in the high school training in these subjects that the heuristic method should be adopted and encouraged as much as possible; that is the method by which the student is taught to think out experiments for himself. He is given the problem, and simple physical apparatus—it need be only very simple, a piece of string and a weight will do a great deal,—and he is made to work out the experiment for himself. And similarly in chemistry; the apparatus and materials need not be elaborate. Teaching by the heuristic method is of course applicable only in physics and chemistry and not in biology.

With regard to the honour certificate, as a rule the requirements are, I think, about equivalent to the high school certificate in the United States, that is a graduating certificate from a high school. As a rule this is considered a fair education. In the United States, and also in Great Britain, it has been considered that for the medical profession there ought to be further preparation; it has been considered there should be further cultural training. In Scotland it has recently been enacted that besides the junior certificate there shall also be required a senior certificate in three subjects at least, and in the University of Toronto the same principle has been adopted. We require one further year at high school or collegiate institute, and we require that the subjects taken in this extra year shall be English, mathematics and one language. It is agreed by most educators, I think, that this extra year at high school or collegiate institute is equal to the first year in the Arts course in most colleges, and by requiring an honour certificate we are really requiring one year of college education besides the ordinary high school education.

We have chosen English as one of the obligatory subjects for obvious reasons I need not take time to cite. We have chosen mathematics for reasons which it may be well to explain. In preparing the student for the profession of medicine, we have to remember that its principles depend upon the application of the laws of physics and chemistry in the study of animal function and in the investigation of disease. Therefore a man must be trained to think in these fundamental sciences. The schools, we believe, cannot carry the training further than the junior certificate in physics and chemistry. Some schools can, no doubt, but most schools cannot. All schools, however, are capable of giving an adequate training in a science upon which both these sciences depend, mathematics. There is no high school or collegiate institute in which an adequate training in honours mathematics cannot be given; and it is well to remember it is not that the man may acquire the technique of mathematics that this training is required, but rather that he may be taught to think scientifically, and no training for this purpose is better than a course of mathematics.

There are many other aspects of the entrance requirements that I should like to dwell on as I consider them a very important part of education, but time will not permit. I hasten on to the curriculum.

The first year of the curriculum in most places is known as a pre-medical year. It is a training in physics, biology and chemistry. It is obviously the foundation of medical knowledge, and unless this foundation be well built the superstructure cannot be satisfactorily added. The main thing in the course in these subjects is the training in principles. Facts are not so important. Facts in physics are not very important to medical men: the principles are. The mind must be trained so that in after years, when it is necessary to do so, the physician or surgeon may be able to grasp the significance of new principles in the sciences and apply them in the treatment of diseases. I need cite only as instances the application of X-rays, the application of heat rays, and the application of the fundamental principle of hydrodynamics in the measurement of blood pressure. Many mistakes were made by the profession in the earlier years of blood pressure measurement because so few comprehended the principle of hydrodynamics. It is not facts, it is principles that should be taught, and that is why a grounding in the pre-medical sciences, is necessary.

The fundamental medical sciences I would subdivide into anatomy and the institutes of medicine. Of anatomy I need say

very little, only perhaps it is well to emphasize that in its modern aspects this subject should include the study of X-ray plates and their interpretation, and some surface anatomy. Repetition is most important in the teaching of anatomy. Anatomy is a science based on observation. It is a science demanding a very retentive memory, and it is only possible to learn this science on the principle of summation of stimuli—repeat, repeat, repeat, until the subject sinks in and becomes part of the automatic mental mechanism, as it were.

With regard to the institutes of medicine, this comprehends the sciences of physiology, biochemistry, bacteriology, pharmacology and pathology. It is really the part of the course in which the pre-medical sciences are brought together, and their application in the study of animal function, and in the interpretation of disease, is worked out. It is the junction point in medical education. The whole of medical education depends upon a thorough study in these sciences.

I will speak of physiology, and of that only for a moment. The training in physiology, like the training in physics, should be based on the principle that it is not facts so much as principles that you endeavour to convey to the student's mind, and in this training therefore the laboratory must play an essential role. In the laboratory the student creates, by the experimental method, conditions which are strictly analogous with those which are met with in the clinic, where, however, they are created by disease. If, therefore, you train the student properly in the physiological laboratory to interpret the changes in function, and to investigate the changes of function which result from these experimental lesions, you are necessarily training him also in the symptoms of disease, and I think there is no part of the course in physiology that is more important for this purpose than the part that is often called the Frog and Turtle course, where the student is required to go through experiments of an apparently trivial nature on isolated muscles and isolated heart. Now, gentlemen, I know that the value of this course is often put at far too low a level, and that I think, is because, most people do not understand its object. This is to train the student first of all to formulate a problem, secondly, to simplify it to within his limits of investigation, thirdly, to study it experimentally by the physical and chemical means that are available, and fourthly, to draw conclusions and test them by further experiments so that he may know whether the hypothesis with which he started can be sustained or must be dismissed. Diagnosis is the formulation of a hypothesis which is then put to the test of observation or experiment. It is exactly the same in the physiological problem, and to train a man properly in this method, one must begin with the simplest conceivable experiment. These are afforded in the so-called Frog and Turtle experimental course. I, for one, as a teacher of physiology would never give up this course, I consider it the most important part of the whole training. From the simple the student proceeds to the more complex. He goes on to experiment on mammals, and then finally ends up with experiments on man, and in the course given in most physiological laboratories now-a-days from one third to one half of all experiments are on man himself. That has developed very much in recent years. I cannot say more about the other courses as time will not permit.

I wish to say one word with regard to options. Besides the obligatory courses in the medical curriculum a certain amount of time should be set aside for options. These options may be either in cultural subjects or in scientific subjects. In cultural subjects they should be given with the point in view that the student may carry forward the training he has had in high school into the medical curriculum. It does seem a pity that a student who has had a course of four years in High school in French should on going to the medical faculty drop the whole thing so that he forgets it. It seems to me it is obligatory on all medical educational organizations to afford the student a chance during his medical course to apply his knowledge in French or other school subject so that he may use it profitably in his profession. It is easy to do it; it works out; it has worked out in the University of Toronto. Finally let me read to you the number of students who have elected to take the various options that we have offered. The details as to the working out of these you will find in the University Calendar; I need not take time to explain them here. In the first year the students elected options as follows:—

Scientific French	54
Scientific German	3
English	27
Mathematics	21
Exempt	1

In the second year there are two groups of options, one group cultural and the other scientific, and every student must take one subject from each group. In the cultural options students took courses as follows:—

French	18

English	5
Psychology lectures	72
Mathematics	2
History	2
Exempt	1

You will notice that 18 students took French again in their second year. They are keeping up the study and can possibly now use French in a practical way. We know how important a knowledge of French is in Canada, and here a chance is given to the medical student of keeping up what he has learned, and carrying forward his studies in the language. An excellent course of psychology lectures is given in the cultural options, preparing the medical man for the study of the psychological aspects of disease, not that they may become psychiatrists, but apply the principles of psychology in the practice of their profession. I will now give the number of students taking scientific options in the second and third years.

SECOND YEAR

Scientific Options—

Chemistry	48
Biology	45
Physics	3

THIRD YEAR

Scientific Options—

Cytology	12
Com. Neurology	6
Parasitology	6
Embryology	7
Anatomy joints	40
Anatomy cross sections	19
Mathematics	3
Physics	3

You will notice that the student is given the chance in the second year to repeat some of the things in chemistry he learned in the first year. Why drop it? Let the subject spread over the years, and do that partly by means of options. The psychology lectures, as well as the cultural options in the second year, only take four hours a week, and yet that is enough to give a man a certain experience in these subjects. In the option of cytology the student is taught the principles of microscopic technique more adequately than he could in a big class. He is made to prepare slides for himself from the beginning and study them.

In the moments that remain I will not give the numbers for the fourth and fifth years, but will take the time to read, if I may, from an article that appeared in the *University of Toronto Monthly* some years ago, and in which I think the principles upon which the medical schedule should depend are summed up:

> "These principles have been stated in what I believe to be the order of their importance. For if the mind be properly trained, the acquisition of knowledge will unconsciously follow, and the graduate will enter upon his professional career prepared not merely to apply the already established practice of others, but as a critical thinker and investigator. Every graduate in medicine, whatever his particular sphere of activity, should be an original investigator. If he is engaged in general practice he must consider every one of his patients as furnishing a separate problem to be investigated by the application of scientific methods reinforced by a knowledge of the experiences recorded by others. If he is engaged in any of the other branches of medical science, originality in thought is equally essential to success."

And with regard to raising the entrance requirements to the extent to which they have been raised, and that is not very far, let me add that this standard which we require now is practically the same as that required for most students of engineering. The student of engineering has to deal

> "with measurable factors, with calculable forces, and with known magnitudes of error. But the physician must deal with a much more complicated type of problem, one which embraces elements of vastly differing categories, chemical, physical, biological and psychological. Surely to do this properly the medical student, before he enters upon his more strictly professional studies, must be at least as highly trained in the sciences as the technical student. And he should besides have a broader education in the humanities, for his science must be tempered by a sympathetic understanding of human nature if he is to apply it successfully in the relief of suffering."

The CHAIRMAN: Perhaps we had better take all the papers first this morning. I will now call on Dr. Martin.

Dr. C. F. MARTIN (McGill University): To the very lucid explanation of the point of view of medical education that Professor Macleod has given I think there is very little, perhaps, to add in a general way because he has covered the essential points, most of which may be more or less covered in the remarks I have to make.

There is one point I would like to make, however, with reference to the very wise procedure that is taken in Toronto University with reference to cultural requirements. As most of you know, the course in Toronto University is a six-year course in one sense, and in McGill University and some others it is a five-year course, but the difference is really only on paper. The plan that we have adopted in the last year of making the medical course a five-year instead of a six-year course was merely for the purpose of making a very definite division between what we call the purely medical subjects, in contradistinction to the pre-medical or cultural subjects. As Professor Macleod has explained, it is very wise, to give a very broad cultural touch to the pre-medical sciences, so we have adopted the principle of relegating rather to the Arts Faculty than to the Medical Faculty the sciences of physics, chemistry and biology. Chemistry, for instance, is taught to the pre-medical students by a teacher who is a graduate in medicine. The physicist and the biologist realize that there are a number of students in their group who are going to enter medicine, and so a medical "twist," so to speak, is given to these courses—but not very much, because the principle that is held is that the broad cultural value of these subjects and their power to make one think in terms of scientific principles is more important than the medical twist which may be given to them.

In medicine we have two pre-medical years, and a five-year course, and in Toronto it is practically the same, with one pre-medical year and a six-year course, both being thus seven years' courses. We have recently had the pleasure of going over with our Toronto colleagues the entrance requirements, and have discussed the benefit of various changes, as to the cultural value of these subjects; the differences are essentially very slight. I was extremely interested in hearing Professor MacLeod's remarks upon the cultural value of the pre-medical sciences, because I think that is a very striking feature of the fundamentals that should underlie the early education of those who are preparing themselves for medicine.

I will now proceed with the paper.

MEDICAL EDUCATION

Dr. MARTIN (McGill University): The extraordinary development of scientific medicine within recent years, as shown by the epoch-making discoveries in methods of diagnosis and treatment, the improvements in technical equipment, and the advance in public health administration, have been one of the cardinal features in the world's progress. Simultaneously, however, it has all enormously increased the complexity of medical education—so much so that any effort to gain a comprehensive view of its details leaves us in a state of intellectual ataxia.

The attempt to overcome the errors and prejudices attached to older methods of education has not entirely succeeded, and tradition still guides our activities, and, not infrequently, dominates them. The many unsolved problems that face us indicate all too clearly the confusion that still exists as to the real purpose of medical education in our schools. Is it any wonder then, that a year ago the Association of American Medical Colleges deliberated for two long days to bring some kind of order out of chaos? By the time these deliberations ended, little progress had been made, and finally a commission was appointed to investigate the whole field anew and, when ready, to bring before the Association a summary of the most enlightened views obtainable. So great were the divergencies of opinions as to standards that no unity of plan up to that time could be attained.

Far be it from me, then, to offer to-day any solution of the many problems that confront us! Let it be my function merely to present to you a few suggestions as a basis for discussion with the hope that thereby a better mutual understanding may

be obtained with reference to the needs of medical education in this vast country.

UNIVERSITY AND TEACHER

I take it that the dual function of a medical school is to *teach* and *investigate*—two very different and yet two very closely-related functions. Every teacher of scientific medicine must needs be an investigator in its broadest sense—while in the atmosphere that he creates about him, the investigator stimulates thought upon all those under his influence.

I should like to emphasize at the outset that the university standard of teaching differs essentially from that of the high school. It is not merely the impartation of accepted knowledge, nor the rehearsal of facts at the bedside, in the theatre or the laboratory. In other words, a university is not there to make of the mind merely an encyclopaedia, but rather to train a working instrument for use in the profession of medicine,—not to stuff students with an accumulation of facts, but to teach them how and what to assimilate. Routine instruction there always must be—the presenting of facts, methods, principles—calling for no great skill on the part of the teacher and requiring little effort or intelligence on the part of the student to absorb. Too often this performance *seems* adequate, and the student is dismissed without a single stimulus to engender a live interest or enthusiastic thrill. But modern scientific teaching has long since outgrown the idea of carrying students through without at the same time developing them. The successful teacher, realizing that it is waste of time to rehearse mere facts (there are textbooks for that purpose), inspires his students with higher ideals of service and research, propagates an interest in scientific progress, stimulates new ideas and surrounds himself wherever he may be with an atmosphere of intellectual achievement—this is an ambition worthy of a university chair, and otherwise the teacher is not fulfilling the qualification for which he is appointed.

The teacher of medicine, then, must be something more than a mere pedagogue. He must be a man with power to infuse enthusiasm and love in the work, a capacity to open up new vistas even in the daily routine.

And, so, the *purpose* of medical education would seem to be primarily to reflect the state of medical knowledge in general; to indicate the method of approach to medical problems; to have the windows wide open to the unknown, and to create an atmosphere of investigation—not research for research's sake but because every individual patient and every individual malady is a problem in itself for special investigation and individual treatment. It is not a question of how much or how many scientific subjects are in the calendar but what is the quality of the instruction.

The broader the conception of medical education, the better. The more philosophical the training the more the critical faculties develop. Observe the recent tendency to include in the general university curriculum subjects which hitherto have been allotted only to the medical school—hygiene, general pathology, general physiology and even anatomy, and at McGill we have already opened the way.

While it may be granted that a medical school must maintain a high university standard to differentiate it from the methods of the high school, it may be contended that in this new country, the main business of the medical school is chiefly to turn out general practitioners who are able to meet every ordinary emergency with a ready wit and a skilled hand. Surely this is so—and let no one underestimate the importance of the general practitioner, but obviously this very importance it is, that, to my mind, makes the duty of the medical schools all the more serious. Students must be trained to be not merely good ordinary general practitioners, but *better*—men not only with good commonsense and familiar through spoon-feeding with the essentials of theory and practice, but men who, fired with the spirit of inquiry, gain through their training the attitude of the investigator and original thinker. Therein should lie the difference between the practitioner of two decades ago and the excellently trained man of to-day. Will anyone question as to which of these two will make the better and safer practitioner of medicine?

Some of you may be aware that a few years ago an effort was made to create a substandard type of physician—one who in two or three years could perchance learn to meet requirements for the rural districts. Was it any wonder that the plan met with failure, lacking as it did, the fundamentals of sound pedagogic principles!

TIME-TABLE

It is obvious that every curriculum must have its frame-work—an outline as it were of the various paths along which the student must go, to attain power to be of service. There can be no difference of opinion as to the need of a definitely prescribed training, but never should this be so all-absorbing as to destroy initiative or an interested enthusiasm.

On the other hand, there are always more subjects in the curriculum than students can ever hope to master, and the rise of specialism has not lessened the burden. A student can hardly hope to reach more than the threshold, rarely indeed to enter into the outer courtyard of medical knowledge, and even at best, he does not attain a very intimate knowledge of any one of the subjects. There is, in consequence, the urgent need of stressing the major subjects in their essentials only and their general principles, while minor subjects and the specialties may only be so treated as they relate to the general problems of medical practice.

The specialist, unless unusually broad in his conception of education, may not grasp relative values nor distinguish the essentials from the non-essentials in the general plan. Specialism has, verily, gone to the extreme—in dentistry, perhaps, even more so than in medicine. The existence in St. Louis of a specialist on extraction of the unerupted third upper molar tooth may be an extreme example of this!

Standardization, then, is necessary—not a standardization of hours spent in effort to accumulate facts, nor even in the total number of subjects, but a standardization which will furnish evidence of attainment, a proof of the student's ability to approach the many problems of practice, of his initiative and of his ability to convert facts into power.

The time-table must, above all things, not be overloaded. The amount of information required should be reduced, and the student's capacity to understand principles must be increased. We at McGill reserve two afternoons weekly for the students' leisure; no lectures are given after five o'clock in the afternoon. It is recognized that the curriculum is far too rigid, that there must be more latitude, more flexibility in the time-table, with opportunity to read, observe, think and breathe freely. Edsall has emphasized the fact that independent judgment and enthusiastic interest grow with exercise and atrophy with disuse, and unless there be some intellectual freedom, there can never be proper mental development.

For the most part, in all our curricula, the time and effort required to accumulate facts is far greater than that afforded for their intelligent contemplation—and for the comprehension of the principles underlying them.

Elimination, then, of unnecessary knowledge is an essential, and it is well to substitute in place thereof free scope for independent work, or a choice of optional subjects along whatever lines the taste may be.

The month of April in McGill, during which post-graduate courses are now given, has been rearranged so far as student activities are concerned. The worthier students are allowed free scope to study as they will, and to attach themselves to whatever service or teachers they so desire. Post-graduate courses are open to them, as are also the laboratories and wards for independent observation, and for a leisurely contemplation and summary of the year's work.

THE PRE-CLINICAL SUBJECTS

The marked changes which scientific teaching in anatomy and physiology have undergone at McGill University during recent years form an apt illustration of the need to correlate more closely together not only the preliminary sciences with clinical subjects, but likewise the purely medical subjects studied in the early years of the course. Anatomy has long ceased to be a study of structure only: to the isolated work of the dissecting-room and lecture theatre has been added the practical study of the living subject. The study of function of anatomical structure has taken the place of mere study of form; the why and wherefore of structure is explained by exhibition in the living body; the normal living individual is exhibited, and when occasion arises, perversions of the normal are presented to the student class in the theatre or in the wards. In other words, the living anatomical subject is made to demonstrate what formerly was only done on the inanimate body in the dissecting-room.

So, too, in our study of physiology. Ward classes form part of the teaching in physiology. The Professor of Physiology is the Director of Experimental Medicine; he make rounds with the students in the wards; he associates himself and his work with the attending physicians. Nay, more, a course is given to clinical teachers on physiology in its application to clinical medicine in order that he may better inculcate physiological principles in clinical teaching.

Thus is brought to pass another great change in medical education. The early contact of the student with patients is more and more stressed, even in the so-called pre-clinical years. In the first clinical year, moreover, students who only recently have been given some instruction in physical examination are now brought into the out-patient departments and wards in groups to learn by direct observation and intimate contact the problems of internal medicine and surgery. In the ward rounds, members of the senior class are called upon to instruct the junior students by discussion of cases under their charge. Correlation of all the preliminary sciences and the pre-clinical subjects is emphasized in the later years, for

it is our firm conviction that the methods of the laboratory must ever be closely linked with the clinic.

No more successful course is given in our school than that of the clinical pathological conferences, which stimulate the investigating spirit and a keener search for truth.

Fundamentally, these are the principles upon which medical education should be based, for thereby the student is enabled to gain by experience greater powers of observation, of interpretation, of forming sound conclusions, and of trying them out in the light of his constantly-increasing experience.

THE STUDENT

We have dealt with the teacher and the time-table. One word about the student himself.

Next to the inspiring teacher, the student is, after all, the most important asset of the school. The better the type, the greater will be the reputation of the school. A poor type of student tends to lower the standard.

It is for that reason I would like to emphasize here the need of better early school training—better educators—and the misgivings that one feels at the unfulfilled requirements that lead to entrance on a professional career. Fortunately, the popularity of the medical profession permits of a limitation of the number and a selection of the fittest. How often does a candidate mistake his calling! How often does his application form show that he lacks the essential qualities of heart and head and breeding which are so necessary to the making of a physician! Not infrequently, too, the unprepared student may succeed in passing his matriculation, only to find later on that some other calling should have been his choice. Verily, many are called but few chosen, and of the few that are chosen, still fewer attain the goal.

Following upon a good school education, the prospective physician needs a sound general cultural knowledge, such as is afforded by a year or two in the Faculty of Arts. With this knowledge should naturally go an elementary acquaintance with the simple technique and principles of the preliminary sciences. Any effort to compel the student to delve too deeply into these sciences, however, during his pre-medical years is often liable to divert his interest from the broader conception of his profession. On the other hand, to those with a taste for such special lines every facility should be afforded.

As in other countries, in other states and provinces, so here—there is a need—a very great need of better and more harmonious co-operation between the Universities and the State Boards. Were it but possible to achieve more success along these lines, Canada would have no need to fear competition from any other country in the world.

To summarize—I would urge for medical education in Canada the following suggestions:—

1. Improvement in education in the primary schools, and better trained teachers.

2. A broader cultural training in the pre-medical years, with sufficient teaching of physics, chemistry and biology to illustrate the broad principles of the subjects and the elementary technique.

3. A better standard of English expression and composition.

4. Early contact of the student and patient as illustrated in the teaching of function in anatomy and the teaching of physiology in the wards as well as in the laboratories.

5. Better efforts at correlation of preliminary sciences with the living patient.

6. Still more intimate contact of student and patient in the early clinical years, with special reference to the out-patient department for the study of the beginnings of disease and minor ailments.

7. Emphasis of the three major clinical subjects, and a frank recognition of the fact that the specialties should be taught chiefly in relation to these three subjects.

8. A better programme in the teaching of the specialties as regards quantity and quality.

9. Less overloading of the curriculum and elimination of the non-essentials.

10. Greater intellectual freedom for the student throughout his course and examinations.

11. Insistence on adequate material for clinical work and laboratory facilities in hospitals.

12. More careful selection of medical teachers in respect of their power to stimulate the investigative spirit, while at the same time exciting sufficient interest by disclosing the utility of the knowledge imparted.

13. Limitation of students, and greater care in their selection.

14. The retention of some didactic teaching, with insistence, however, on the importance of group instruction.

All that has been said in rambling fashion here represents but a few of my own personal beliefs—subject to revision, and, no doubt, very open to criticism. The somewhat chaotic state of medical education to-day lends itself readily to discussion. After all, how few there are with sufficient knowledge and experience to dictate a policy? Let us hope that in our conferences here, our main motive will be an honest desire to aim at raising the Canadian medical profession to higher and ever higher levels of concerted, harmonious effort. Divergence of opinion there will be—how, indeed, could it be otherwise, most of all with the problems of medical education.

> "Now, who shall arbitrate?
> Ten men love what I hate:
> Shun what I follow—slight what I receive.
> Ten men who in ears and eyes
> Match me: we all surmise
> They this thing, and I that—whom shall my soul believe?"

The CHAIRMAN: I am sure we all are very much interested in these two most important contributions to our proceedings. We have had contributions on preliminary education entrance requirements, degrees and the curriculum of study, and I think we had better hear from Dr. Young now on post-graduate medical education before the whole matter is open for discussion.

POST-GRADUATE MEDICAL EDUCATION IN CANADA

Dr. GEO. S. YOUNG (Toronto): At the present time medical post-graduate work in Canada is being carried on in two ways:—

(1) By what may be called Intramural courses, conducted within the teaching centres.

(2) By Extramural, or so-called Extension lectures and clinics.

INTRAMURAL COURSES

Of the former some lead to a degree, and with one or two exceptions are intended to develop specialists. At least five of the Canadian universities give courses, lasting a little less than a year, in public health for the degree of D.P.H. One grants the degree of Master of Science after a year of "residence as a graduate student" and an approved "thesis embodying the results of original investigation." Another grants a D.Sc. two years after graduation for original after examination and an approved thesis. One at least gives a Diploma in Radiology after an eight months' course. Two schools give post-graduate degrees in surgery and one in medicine, after courses lasting from two to three years.

For those of us who believe that no one should become a specialist until he has had experience in general practice the question naturally arises: Is there any recognition of this principle in the planning of the courses mentioned? The answer is to some extent, yes. All the courses in public health are open to the general practitioner. One university goes so far (in the right direction) as to require a year in general practice before entrance. This is a wise provision. The man who intends to devote his life to public health work should at the very outset, by personal experience acquire the viewpoints of the public and of the family physician. It is with them that his future career lies.

Of the remaining courses leading directly to specialism, one in surgery rather effectually shuts the door on the great majority of general practitioners, since it demands a year of interneship on a rotating service in hospital as an entrance requirement. The other post-graduate course in surgery, and also the one in medicine, both admit the general practitioner, but the selection of students for these courses does not favour the man who has been in general practice.

It will be noted that the schools in Canada have made a fair beginning in the training of specialists. The task is not an

easy one. To carry on post-graduate work concurrently with under-graduate teaching is a tax on the staff, the resources, and the clinical material of the universities. Perhaps that is the reason why it is easier to accept or select as post-graduate students those who have just finished their under-graduate course. They fit in better with the established order of things. One cannot escape the fear, however, that the trend of higher medical education in Canada, as in the United States, is toward the selection by the Faculties of certain promising students whose future will be shaped in such a way that they will receive a long intensive training and will in time become the teachers of our colleges without any experience in general practice. If this policy should be carried too far it would close the door to the general practitioner for teaching positions. There would come a time when the future general practitioners would be taught entirely by men who had never had experience in general practice. This, surely, would not be desirable. Not only should the door to post-graduate education be open wide to the general practitioner, but there should be a "Welcome" sign on the door. It is this "Welcome" sign that attracts nearly one hundred of our graduates to the United States every year, and too often the best of them do not come back.

In addition to the training of specialists, several Universities give short or indeterminate courses for graduates. In one instance post-graduate lectures are given throughout the university session. In at least two schools advanced laboratory courses are given to recent graduates who wish to engage in research. One gives special courses in industrial hygiene and school hygiene. Two schools at least give the general practitioner an opportunity to spend as much time as he chooses in following up the under-graduate clinics during the college sessions. Several of the schools have short post-graduate courses annually open to all graduates in medicine. The announcement of one of these is so attractively phrased that I take the liberty of quoting it:—

> "The object is in nowise to train specialists in any branch of medicine or surgery, but to afford an annual opportunity to the general practitioner to witness with a minimum expenditure of time and energy the practical and clinical application of those methods of diagnosis and treatment which have come into use since his own graduation, or which on account of local conditions he may have hesitated to adopt in his own practice."

The difficulty of combining post-graduate and under-graduate work has suggested the idea of organizing separate post-graduate schools having their own teaching hospitals. Obviously, such a scheme could only be carried on in the large centres and would require university or private financial backing, or both. It could utilize the university teachers who were nearing the age limit to the advantage perhaps of both university and teacher. In this connection I may quote a very valuable paragraph from a recent letter from Dr. Hattie of Halifax. He writes:—

> "I am strongly of the opinion that the Canadian colleges should co-operate in the endeavour to concentrate post-graduate teaching, where the greatest amount of clinical material is available, *and that exchange of teachers should be effected* when practicable, *in order to give a national colour to the courses*. It seems to me that with real effort we should be able to so organize post-graduate teaching that few of our men would feel it necessary to go across the line in order to get what they want in this particular."

I am sorry that Dr. Hattie is not present, but I may remark that he is a firm and ardent believer in a closer union of the provinces than Confederation has yet brought about, and I do not think that one can over-emphasize the point he stresses. To proceed.

POST-GRADUATE EDUCATION IN CANADA: EXTRA-MURAL WORK

It is now some years since extension lectures in medicine were undertaken by Canadian universities. In Ontario until June, 1921, these lectures were given on request, and beyond simple announcement no special effort was made to secure audiences. At this time the Ontario Medical Association entered the field as impressario and advertising agent. Briefly the plan adopted was as follows:—

Lists of subjects and lecturers were submitted by all the universities, and in a few instances by medical societies. From these a schedule of over three hundred subjects was compiled and sent out to all the county medical societies in Ontario. The societies were asked to choose subjects on which they desired lectures and to notify the central office of the Ontario Medical Association. The names of the men who were prepared to lecture on these subjects were then sent to the societies and from them a choice was made, dates set and the details finally carried out through the central office. At first each society was given the privilege of having four lectures annually. This number was increased to six and finally to eight.

These lectures have been delivered without expense to the county societies. All travelling expenses and a small honorarium have been paid through the Ontario Medical Association. Fortunately, at an early stage of the movement, the leaders of the Ontario division of the Red Cross took an interest. They saw in it better medical service to the public and

made a grant of $5,000 a year for three years. This has taken care of about two-thirds of the expense, while the balance has been paid by the Medical Association. As already stated the universities have borne the chief part in the providing of lectures. The lecturers themselves have been willing at all times and have gone to almost every nook and corner of the province. It was the business of the Ontario Medical Association to create the demand, and you will realize how successful its efforts have been when I tell you that in three and a half years 750 extension lectures have been given in the province.

You will notice that extra-mural work as it is being carried out in Ontario does not wait for the individual to apply but goes out to seek physicians everywhere. It is an organized effort to influence educationally the whole medical profession. It is being conducted on a large scale and involves the expenditure of time and money. The doctors in Ontario ask that it be continued. The Canadian Medical Association would like to extend it from coast to coast. The American Medical Association has been keenly interested and proposes now to inaugurate a similar movement embracing every state of the union. One may well ask whether all this is worth while. The answer must take into account the effect of environment on those who practise medicine.

With a few notable exceptions the men who attain eminence in medicine are dwellers in cities, and yet a close acquaintance with the medical profession outside of the larger places will reveal here and there men of outstanding ability. They may not be able to discuss the scientific aspects of modern medicine; they may be ignorant of the more refined methods of diagnosis; but they can use the tools of knowledge which they have, with unerring precision. They have learned to use these tools under the drive of a personal responsibility to patients whose lives may depend on their judgment. But they have been hampered in their development by their environment. They have lacked the stimulus of daily contact with their fellow practitioners. They have had to learn from books rather than from men. They have missed that greatest of all incentives to reading, namely, association with students. Too often they have had to work without the aid of the laboratory and too often, but naturally, they have gradually become skeptical as to its value as an aid in diagnosis.

Now the object of the extra-mural work already described is to organize or to stimulate into activity county medical societies, to bring together frequently groups of doctors living within reasonable distance of one another, to provide speakers who would not only give information in regard to the latest things in medicine, but who would bring a new interest and enthusiasm to the work of the rural practitioner. In other words, the aim has been to give to him so far as possible the advantages which surround the doctors in the teaching centres.

It has been interesting to watch the development and results of this movement. Sometimes at first there was a good deal of local inertia and the attendance at meetings was small. This was considered a strong reason for urging more meetings, and sooner or later out of the original failure there grew a strong and enthusiastic society. At first speakers reported that there was little or no discussion of their papers; local men were diffident about discussing questions which they were accustomed to approach from the standpoint of experience rather than of scientific knowledge. To-day discussion is generally free and the meetings are more profitable, not only to the local men but also to the visiting speakers.

It has been the aim of the Committee on Education of the Ontario Medical Association to have the programme of the county society meetings supplied in part at least by local members, and this has been strongly urged from time to time. An effort has also been made to substitute clinics for lectures and papers wherever possible. Both of these objectives have been realized to some extent. Recently at a district meeting the excellent programme was almost entirely provided by men from the smaller places, and one came away with the conviction that country and small town practice offers a rich field for clinical research.

After all, the ultimate test of the value of this intensive extra-mural work must be this: Is it for the public good? If through this educational influence on the whole medical profession it should lead here and there to earlier diagnosis and more effective treatment the public will gain. It is scarcely necessary to add that the doctor's income will not increase but rather diminish. If it makes the country more attractive to the recent graduate it will help to solve the serious problem of inadequate medical service in the outlying districts. If it should stimulate some men here and there to cultivate the hitherto scarcely touched fields for medical research in general practice, it might benefit not only our own Canadian people but the world at large. Extramural post-graduate education as carried on during the last three and one half years costs money. If it is to be extended throughout Canada, it will mean an expenditure of $30,000 a year. It is a movement for the people. *From where will the money come?*

Dr. L. J. Austin (Kingston): I feel somewhat diffident about offering any criticism or any observations on medical

education in Canada, having had only three and a half years in which to study the matter. I should like, however, to point out certain things in connection with medical education in England, because we sometimes get comparisons, between conditions in England and those in Canada, which are unfair. Ordinary medical education in London covers a five year period, and the boys come to medical school later in London than they do in Canada, many of them coming from Oxford and Cambridge, where they start their true medical studies, as old as 22 or 23. In the ordinary course of things medical education in England—I do not know about Scotland—is based on three years of clinical study. This is not purely clinical, because a certain amount of anatomy is still carried on as well as some physiology. The point I want to make is that the two systems are really incomparable, inasmuch as the clinical year in London is one of fifty weeks and not thirty-two. Once the student has begun his work in the wards he is lucky if he gets a fortnight's holiday in the year, and therefore, during the time they put in, the students must necessarily get a broader view than they do here. The amount of didactic lecturing is quite negligible, and all clinical teaching is done in the wards and by means of out patients. The consequence of this is very grave: no man can go into medicine in London unless he has a father to pay for him because there is no opportunity, and absolutely no arrangement is made to render it possible, for the student in any way to make his own living and thus to help himself through college. This of course has resulted in medicine becoming a much more closed thing in London than it is in this country. I am speaking from the point of view of what I have seen at Queen's University, where many men in the summer months have been able to make enough money very nearly to put themselves through university. As I say, therefore, the two systems are really incomparable. I personally am a specialist; I want that understood. And I might say that I am in an impossible position, for I am supposed to be a specialist in all branches of surgery. We know that that is impossible in a way, although it is perfectly good enough for teaching surgery up to the time of graduation, because anyone can pretend to be a specialist in any one branch of surgery without post-graduate work. The amount of post-graduate work done by a student in the Old Country is vastly greater than it is here; the student must put in three or four years in a big hospital, and it is absolutely necessary for him to pass a fellowship examination if he means to get an appointment. That means that a man who does surgery in the Old Country must undergo a long period of special training. The pros and cons of what one might call the closed class of surgeons as produced by the Fellowship examination in the Old Country I will not argue. There are many points of view to be taken on both sides; the system has its advantages as well as its disadvantages. I want to make an appeal on behalf of the student, for whom a word has been said by Dr. Bazin and Dr. Martin. Where shall we stop? We have seven years now and then a period of eight years is being required, so that the strain is enormous not only financially but mentally as well. Where are we going to stop? We passed a resolution yesterday providing that pre-natal and post-natal hygiene should be added to the curriculum. What next are we going to have? I do not know, but I venture the opinion that something else will be suggested next year. We have embraced in the curriculum now the major subjects in surgery and we have got to the stage where we are trying to turn out men who will not be actively dangerous to the public. We are also insisting, and rightly, that they must put in another year in hospital. I find with my students that in the intensive thirty weeks given them they reach a stage in which every new fact inculcated drives out some other. So that it all gives one furiously to think as to how to control the curriculum. I agree with everything that has been said about not attempting to make specialists; but what are we to do? It is hard enough to make a uniform man with broad principles who can apply them with his patients afterwards; but this increase in the number of subjects I look upon as a grave danger. I could make allowance for physiologists, but it is not my intention to do so.

Dr. J. C. Connell (Kingston): It strikes me that what we need is something to stabilize medical education rather than to standardize it. The condition of flux in which we find ourselves is apparently becoming aggravated, so that we hardly know where we are. During the twenty years that I have been on the medical faculty this tendency seems to have been increasing. When I took charge we had a four year course; we have passed into a five year course, and about the time the war came a movement was introduced to have a six-year course, and that is in process of development. Now there is a movement in regard to an interne year. What is to be the attitude of the medical school towards this interne year, which in Ontario is now taken by 97 per cent of the graduates? What is to be the attitude of the schools and licensing bodies towards making this a permanent requirement? That is something we must consider. My attitude at the present time—and it is constantly changing in the light of experience—is definitely against options in the medical course and against the introduction of cultural subjects in a purely medical course, that is to say, of cultural subjects in a five-year medical term. That is my attitude at the present time.

I think that something may result from this conference, continued from year to year. If the Programme Committee, or something like an educational committee, studied this question carefully we might be able to succeed in having a definite minimum standard preliminary education which the conference could unanimously support as a recommendation to the medical schools. What I have in mind is a definite minimum, leaving the universities and medical schools to develop for

themselves beyond that point, and to work out the details in their own way.

Dr. Houston (Charlottetown): I should like to refer briefly to Professor MacLeod's excellent paper, in which there is food for thought for us in Prince Edward Island. Those of you who are connected with the universities know that our Prince of Wales College enjoys a certain reputation by reason of the graduates whom it turns out. But we have at the head of the college now a man who seems to think that mathematics and science generally should have very little place in the curriculum. If a student knows his Latin, French, English and history, especially the history of Rome and Greece, apparently that is about all he requires, in the opinion of the principal of the college. I feel that we are going behind in the scientific subjects and I do not know how the conference can help us. I was wondering whether a resolution or some recommendation could be made from the Medical Council to the educational authorities of Prince Edward Island on this subject. It seems to me that a very useful purpose would be served, from our point of view, if the Prince Edward Island Government could be made aware of the facts which have been so forcibly presented to us this morning by Professor MacLeod, so far as they relate to the requirements for entrance to medical school. I feel strongly on this point because I have a boy going through Prince of Wales College and I am positive that the course lacks in the respects I have mentioned. I have talked to the board as well as to the principal of the college, Dr. Robertson, about this matter, but Dr. Robertson seems to think that medicine is only a sort of course leading up to insurance or something of that kind.

Dr. G. R. Cruikshank (Windsor): Quite naturally the discussion so far has come from the teachers, as it should, and I want to congratulate the conference on the very excellent papers which we have had and to express as far as I can, as an ordinary every-day practitioner, the appreciation which I am sure the medical profession as a whole has for what we have heard. However, I want to give the conference a point of view from the other end of the line, so to speak; I want to refer to the practical aspect of the matter. In the border cities we have about one hundred practitioners, 90 per cent of whom do anything that comes along in the way of labarotomy. I am not saying that this is as it should be, but it is the fact nevertheless, and this will continue. The graduates will go into practice and keep on doing this. If we could devise some means of increasing their education along these lines, if we could increase their dexterity, we should be doing something for the general public. It has been stated that the medical profession is harassed by manufacturers' agents who try to sell their products and who, in order to dispose of their goods, resort to all sorts of pestilential methods. Well, it seems that a lot of practitioners are handicapped in other ways; they object to the fact that some irregulars carry on a thriving business to their detriment. I have asked some young graduates how often they have seen tonsils treated with electricity, and to what extent they have seen the ultra violet used, and invariably they reply that they have seen very little done in this direction. The practitioner must consider not only the curative effect of remedies, but as well the comforting influences on the patient. I believe that this is really the only active agency in all these things, and I hope that this method will not only be taught but will be applied as well. One of the most successful post-graduate schools I know of is that of Vienna. The teachers have nothing to say about the course they teach. The students get together and discuss what they want, and I believe that is why Vienna is as popular as it is. One of the duties of the council is to protect the public. Some man calls himself a specialist and claims to have had a little more experience and to possess somewhat more skill along certain lines than the ordinary practitioner. That may or may not be true, and I think it is the duty of the Medical Council to see to it that any man who calls himself a specialist should have something entitling him to the distinction. I have been urging upon my council for the last fifteen years the advisability of holding an examination for specialists and I hope the principle will be adopted. There is a tremendous amount of operative surgery being practised and those who undertake this work should undoubtedly be possessed of the necessary qualifications, the dexterity and deftness which are essential. And I do not believe that our medical schools are doing enough in the way of teaching physical therapeutics.

Dr. T. S. McKibben (London, Ont.): I believe that some of our universities could do more than they have done in the past or are doing now in the granting of diplomas not only on the basis of academic excellence but also from the point of view of personality. Those who are connected with licensing bodies will catch the drift of my remarks because not only the graduates of our schools but others too run amuck. Whenever we are considering matters of curriculum we should be careful not to overlook the importance of ethical standards.

Dr. W. A. Rehfuss (Bridgewater, N.S.): As a country practitioner I cannot fail to take this opportunity of expressing myself as being absolutely in agreement with what Dr. Cruikshank has said. I think it is the duty of every practitioner to cultivate a sympathetic understanding of his patients. I do not think there is any profession which comes more in contact with things that are heart-rending than do medical men, and this is especially true of the country practitioner. Personally, I believe that all universities should strive to fit every student to handle emergency surgery. Often a doctor in the country

is confronted with a ruptured appendix or something of the kind and is placed in a position in which any treatment other than radical surgery must of necessity fail. If in the country districts immediate surgical aid were available, even though from a hand not quite as deft as one might expect, a great many more patients would be saved; certainly it would be a great advantage over waiting for four or five hours before assistance could be had from a so-called specialist. An attempt should be made by the universities to see that every graduate has sufficient skill to be able at least to take care of emergency surgery with some degree of success. I agree with what has been said on the subject of specialists. I think that there are a great many men who, if the test of an examination were applied to them, would not describe themselves as specialists. If they advertised themselves as general practitioners it would be more nearly true. Certainly in very many cases so-called specialists do not know much more about their particular subjects than does the ordinary practitioner.

Dr. R. H. Arthur (Sudbury, Ont.): I was rather struck with Dr. Cruikshank's statement concerning the equipment of graduates. It reminded me of an incident that is related in one of the American textbooks on obstetrics. The author tells of a very old practitioner somewhere on the Pacific coast who was called upon before he died to give his opinion of the new doctors who were coming into the place. The old gentleman said that in his experience he had found that the young doctor was all right but that he had one fault—he knew too damned much that was not true. According to Dr. Cruikshank, however, we are at present turning out young men who do not know enough. Dr. Austin, perhaps unwittingly, in the course of his remarks said a word for dad. I have educated one son in medicine and it seems to me that from dad's point of view the extension of the course, and the post-graduate years that are piled on, certainly make it difficult.

In the course of his remarks Professor Martin spoke of the limitation of the number of students. For some years now we in Canada have been manufacturing doctors for export, and no doubt there is a good deal to be said on this point. But I wish Professor Martin would tell us what means are being adopted to limit the number of students. This is a very important question and the method of this limitation is one that we hear discussed in the country a good deal. The opinion is held by many that the determining factor in the long run, owing to length of course and other considerations, will be one of finance.

Dr. S. L. Walker (Halifax, N.S.): My lack of special knowledge has kept me silent before the wisdom of so many who are specially qualified to speak on the various subjects that have been presented to the conference. However, there is one question which has been brought up this morning that appeals to me strongly, and it is this: the object of all our medical education, and all this talk that is carried on in connection with it, no doubt is that we may better serve the public in preparing medical men for their work. What is it that the public needs? It is medical service. And where does that service come from? From the general practitioner. And the general practitioner is to be found in the rural and urban sections of the country. We are turning out a large number of graduates who are looking to the United Stales, and the crying need in Canada to-day is to turn out men who will satisfy the needs of the scattered rural sections of this great country. From what the western men say, one would imagine that only in western Canada were scattered rural districts to be found, but the little province of Nova Scotia presents a considerable problem in this regard; for in that province there are stretches of country of 30, 40 and 50 miles that are served by one medical man without a trained nurse to assist him in his work. I think our medical schools should turn out general practitioners who can safely be permitted to go and take up the burden that confronts them in the scattered rural sections where at present there is very little possibility of affording the people the care and attention they need. Perhaps the Conference might be able to think of some method—perhaps by means of a bonus or an honorarium, or possibly a scholarship—of encouraging students to take their course and in return guarantee that for two or three years they would serve those sections of the country which at present are not being looked after. We need general practitioners above all, and after they have been in practice they can then become specialists.

Dr. H. W. Hill (London, Ont.): I want to call the attention of the conference to an academic point, and that is, the classification of subjects into cultural and non-cultural. I do not think this is a wise classification. It does not strike me that French, English, history and philosophy are in themselves cultural subjects. I have seen them so taught that they had an effect quite the opposite of cultivating the student. In my opinion the classification of subjects into cultural and non-cultural is a matter of method of teaching altogether. As a matter of fact I have known physics to be taught in such a way that it constituted a course of culture; the moment the professor of physics decided to teach this subject with that idea in mind he found the principle a sound one. Men can get just as much culture from anatomy, taught as it should be taught, as from philosophy or ancient Greek history, taught as these subjects frequently are.

Dr. D. S. MacKay (Winnipeg): I must express my appreciation of the papers which have been contributed by Professor MacLeod and Professor Martin. I think the time has come when this subject must be more seriously considered, and this

conference opens the way. We believe in a sound preliminary education followed by a thorough medical course. I heartily concur in the view that the period now allotted for a young man going into university for graduation in medicine has about reached the limit. I think the economic limit has been reached. I agree with Dr. Martin that the young man in a university to-day is faced with a problem which only the strong will survive. He works from eight or half-past eight in the morning until five or six at night and in his final years he must attend obstetrical clinics—and obstetrics come on in hours over which he has no control. The student, then, is working at high pressure and has no time for consideration of the subjects he is taught in the day. As a matter of fact he has no time to think for himself, and the consequence is that he must come out of the university more or less as a sort of stuffed fowl rather than a human being who can tackle a question and analyse it. We have found this not only with our own students but with students from elsewhere. So far as the question of curriculum is concerned, I think we in Manitoba are now arriving at a fairly satisfactory solution. We have a two-year pre-medical course and five years of an actual medical term, with a final interne year. That is seven years altogether. We have no intention of increasing the period; to do so would be economically unsound. We have very little difficulty at present in increasing the number of our students, although the question may arise as to the placing of them. There is a large hospital in Winnipeg which can accommodate a good many of them. The hospitals in which our students are placed are carefully selected and the system is working out satisfactorily. I think that the limitation of the number of students is an important point, and the problem of finding hospital appointments for them will no doubt to a certain extent control this situation. We are up against a problem in that regard. It is claimed that all British subjects resident in Manitoba are entitled to education if they are capable of fulfilling the requirements. That may be right, and we do not dispute it. At the same time the facilities for giving a man a good sound education must be limited by economic considerations, and we can I think satisfactorily take care of fifty men in the graduating year. At the present time we have sixty-four working over capacity, and if there were some means of having such a conference as this pass some form of resolution it would strengthen our hands materially. We are endeavouring to deal with the situation ourselves, but it is always well to have outside help. I greatly appreciate the stand taken by Professor MacLeod and Professor Martin and I am sure that their addresses provide a great deal of food for reflection.

Dr. F. W. Routley (Toronto): I rise as a general practitioner to make one simple statement regarding the present day graduate of our universities. It has been my privilege in practice during the past ten years to have associated with me a considerable number of graduates from our Canadian universities. They have usually been of high standing in their year and I have greatly admired their academic training. But I have sometimes wondered whether the present-day university was not falling down in regard to some other things than the simple study of scientific medicine. You know, the old Canadian doctor of the last generation was in the habit of telling his patients, or the family of his patients, when he arrived on a case, that he was called just in time, and that half an hour in the difference would have meant the death of the sick one. He would also tell the patient how long he would be sick and when he might expect to be out of bed. This was a point with him. In the present day, on the other hand, I have found among recent students too great a tendency to consider their patients as cases rather than as sick persons requiring medical aid. I make this statement, because after all our duty is to the public and in order to obtain the best results we should make the best possible impression on the people with whom we have to deal. You cannot possibly expect to get the best results in any department of labour unless the people with whom you deal have absolute confidence in your ability. While there never was a time in the history of Canadian medicine when the graduate was as well qualified to practice his profession as he is to-day, at the same time I think that some attention should be paid by universities to the attitude of the young doctor towards his patient and his patient's family. In this regard, I think there has been something remiss in the universities in the last few years.

Dr. W. H. Hattie (Halifax): Dr. Routley's remarks have stimulated me. One of the things that have impressed me at Dalhousie is the fact that most of our students have been taught medicine as practised in the hospitals and not in the homes, and our endeavour now is to make such arrangements as will enable students in their five years to get some opportunity of going into the homes of people and learning something of social conditions which will have a bearing on their practice afterwards. We are endeavouring also to let the students see as far as possible the way in which various organizations that are interested in public health are carrying on their activities. The work of the Halifax Dispensary, the work of the Victorian Order of Nurses, and the welfare work of the Massachusetts Health Commission are all being carried on from offices in the public health buildings, and the students, while not having their attention particularly directed to these organizations, nevertheless have an opportunity of seeing the way in which the work is done and the way it may be co-ordinated with their future activities. One of the things I noticed immediately upon taking over the duties which I have recently been endeavouring to discharge, is the fact that students of the first year do not realize that they are medical students at all. They are unable to see the particular bearing of the subjects of that first year on the medical course. We have been able to get over that difficulty to a large extent by arranging for a weekly conference with

members of faculty. Practically speaking, only our full-time staff has been able to attend these conferences, but we have learned as a result that there has been a good deal of overlapping in teaching and there have been rather serious omissions. However, we have been able to rectify these things. We have succeeded in interesting members of the faculty of arts, who are also members of the faculty of medicine, in the particular points in connection with their teaching that apply to medical students. This has worked out in an unexpected way. They have discovered that if they pause long enough to call the attention of a medical student to some point which they are demonstrating it intensifies the interest of the art student, so that in consequence not only the medical student is benefited, but the other students as well.

Dr. H. W. McGill (Calgary): I should like to pay a tribute of appreciation to the three papers that have been delivered this morning, and I am sure that had I been two days late my trip would still have been worth while. I am not in a position to discuss the subject matter of the papers, but Dr. McKibben has, I think, brought out an important point. It is essential that a high standard of ethics should be observed. The licensing body of Alberta has had some experience in this regard. We have had men applying for registration whose conduct in certain respects was not what one would expect. It is quite evident that they have not the most rudimentary ideas of honour and honesty and it gives us great misgiving as to what their character will be later on when they become practitioners; there is reason to fear that in very many instances they will not reflect credit upon the profession. What the solution of this difficulty is I do not know, but undoubtedly all licensing bodies will have to face the question. I do not think that the misfortune is to be attributed to any defect in university training, because I believe that when a man comes to the university with such a mental twist no amount of training will eradicate it. The careful selection of students might prove a way of meeting the difficulty, but there is no doubt whatever that the difficulty exists. Certain it is that the methods which some of these students pursue are not very promising and would seem to afford some reason for misgiving concerning their future honour.

Dr. Ower: I should like to emphasize this particular point which I think is one that might come up for discussion at the next conference.

The Chairman: I fear further discussion will have to be deferred until the conference meets again unless it is the desire of the meeting that we should continue this afternoon.

Dr. Geo. S. Young: If I am in order I would like to say this: I am very glad that Dr. Martin, and I think Dr. Hattie, stressed the importance of early correlation of the scientific subjects with the clinical problems that come after. We have swung too far away from the old apprentice system, and the result is that medical education is not a superstructure based on a solid foundation, but a house in which the scientific subjects are packed away in the cellar, and when the application of these subjects is required in later years the student has forgotten where to find them. It seems to me that early correlation of the scientific subjects with the application of the science in later problems is a very important matter. I am sorry that the extreme importance of this subject of medical education has somewhat overshadowed the question of post-graduate education. I was just about to move:

> That this conference heartily approves of the Extramural post-graduate work as carried out in Ontario during the last three and a half years, and urges that every legitimate effort be made by the Canadian Medical Association to secure funds whereby this work may be extended to all the provinces in Canada.

Dr. A. T. Bazin: I second that.

Motion agreed to.

Dr. C. F. Martin: I will try briefly to answer the various points that have cropped up since the papers have been read.

First of all, in response to Dr. Arthur's inquiry with reference to the selection of students, I may say we stop really at nothing in the way of selection of students. We do not allow any written law to dominate our selection. Of course, every candidate who comes to McGill University for the medical course must fulfil certain preliminary requirements. As to his knowledge of the preliminary sciences, in that too we make fairly high demands. A man who was exceptionally good in two of the three preliminary sciences might be admitted if deficient in the third, provided his attainments in the other two were of a very high order. I am merely giving that for example. That is one thing, his knowledge.

Second, there are the cultural requirements. Every man must write a letter of application in his own handwriting; we do not accept typewritten letters of application. He must also send his photograph or have a personal interview, and we prefer the personal interview. If a man has the qualities of heart and head and breeding, as I said in the paper I read those are the three requirements above all others that concern us in the selection and admission of students. In order to

illustrate that point I have just got figures from Dr. Simpson. In the course towards the study of medicine, 54 students were already in course in the pre-medical years. That left 46 vacancies in the first year of medicine—we accept 100 only. In order to fill those 46 vacancies we had to select from 285 applicants coming from all over the United States and all over Canada. That selection might seem to be a little difficult, but as a matter of fact so many factors can come into it that we are able through consideration of the various things to eliminate without very much difficulty. Dr. Simpson is a past master of that, and he undertakes the responsibility of selection almost entirely; only now and then in special problems is there a consultation of the committee.

I would just like to combine one answer to Dr. Cruikshank and Dr. Fred Routley. I had anticipated the remarks that have been made with reference to the general practitioner and the service he renders to the community. The teacher in a university should always in his class work stress the importance of service. That is an obvious thing; it may not be done enough. I think the success of the work of the practitioner depends almost entirely upon his knowledge of the fact that the first thing to do is to make his patient comfortable—not to make a blood chemistry test, not to make a diagnosis of his immediate need or a diagnosis of his ultimate scientific condition. Perhaps in our universities we fail to inculcate that principle sufficiently; I will admit it, but the effort is made, and more and more stress is being laid in all our universities on the importance of it.

I would like to ask Dr. Aikins, privately, by what methods the university can teach the student before he graduates to do a lobectomy operation with skill. We are supposed to teach the men how to study that after they become doctors.

I would like just to thank Dr. Hill for what he said about cultural training, because practically every subject can be so treated as to impart cultural training; I think his interpretation of that is correct.

Dr. J. J. R. Macleod: Dr. Martin's reply to several questions is in exactly the same terms as I believe the Medical Faculty in Toronto would have used.

With regard to the use of the terms cultural and non-cultural, I am sorry there has been perhaps a misunderstanding here. They are merely convenient labels for the division of the subjects, and I would be the very last to subscribe to the principle that there is not as much cultural training in anatomy and physiology and the medical subjects strictly as in Latin, or Greek, or Divinity or anything else. The terms are used only for convenience.

With regard to the suggestion as to the advisability of teaching elementary science and mathematics in the schools, I believe the result of the extended debates that have taken place all over the English-speaking world on this question has been to show that it is advisable to give a certain amount of training in these subjects in our high schools. Unless the young mind is trained to think in terms of science early, it is very difficult afterwards to make successful progress in these fields.

With regard to the importance of psychology—which I think has been indirectly stressed in the discussion—I would point out that one cannot teach the student to deal even with his normal fellow man, much less to deal with his diseased fellow man, in a humanistic way by systematic courses in psychology alone, but these do give him a basis; they give him something to think about, and they stress for him the importance of dealing with the human mind according to the same principles as those with which he deals with any other academic subject that can be systematized.

Lastly, Dr. Connell has asked the question, or rather he has done more than that, he has given the negative to the question whether cultural options should be a part of the medical curriculum. Let me explain: These cultural options as given in the University of Toronto do not take more at a maximum than five hours a week for the first three years of the course, and they are designed merely for the purpose of enabling the student to appreciate the value of what he has learned in these subjects in the school. It does seem to me a shame that a student should be brought to a large university merely to be taught the technique of his profession. He should be given the opportunity at least of seeing what a college course in the subjects of his high school means, what the difference is between the university outlook with regard to these subjects, and the school outlook. For these reasons, therefore, I believe where it is possible to do so, a limited, a very limited amount of so-called cultural study should be offered to the medical student.

The Chairman: I think it is obvious to all members of this conference that we have simply touched the very fringe of this question. I think the discussion so far has been most useful, because it has been presented by men who are engaged in education, and enlarged upon by men who are in general practice, and I think that is a splendid thing, both for the practitioner to know the viewpoint of the men engaged in teaching, and on the other hand, for those engaged in teaching to

know the viewpoint of the general practitioner. That in itself, I think, would justify this conference. Of course, the discussion has not been as full or complete as we would like, but no doubt this subject will take a very prominent place in the next annual conference.

REPORT OF THE RESOLUTIONS COMMITTEE

Dr. J. C. Connell (Kingston): I beg to present the following report on behalf of the Resolutions Committee:—

> *Resolution No. 1* Whereas the attention of the Conference of Canadian Medical Services has been directed to the classification of Canadian medical schools by the Council on Medical Education of the American Medical Association, as published in the Educational number of the Journal A.M.A., August 16, 1924;
>
> Resolved that in the opinion of the conference it is desirable that the publication of this classification be discontinued, and be it further resolved that the secretary of this conference be instructed to communicate with the Council on Medical Education of the A.M.A., stating the desire of this conference in reference to Canadian medical schools as expressed in this resolution.

The Chairman: Is it your pleasure that this report be received. I understand you to move that, Dr. Connell?

Dr. J. C. Connell: I move that the report be received.

Dr. C. F. Martin: Before that question is put, I wanted to speak.

The Chairman: The report must be received before it can be discussed, obviously.

Dr. C. F. Martin: It is the reception of the report I would like to discuss, but that would involve a discussion of the case. I do not quite know how to deal with it.

The Chairman: I am afraid I shall have to rule there is no harm in simply receiving the report. Once received it is open for discussion. Shall the report be received?

The motion was agreed to, and the report received.

The Chairman: Now the report is open for discussion.

Dr. C. F. Martin: I had the pleasure of coming down here with Dr. Connell this morning, and asked him what conclusions had been arrived at last night in connection with this resolution, and he kindly told me what the resolution was, as just read. It seemed to me at the moment quite a harmless thing, which I think I said, but on going into breakfast I purchased the valuable morning paper published in Ottawa, and that has given me reason to think more seriously about this matter, and also to reconsider my view that the thing is as harmless as at first seemed. May I just read the headlines, in case some of you have not seen the report? In large type appears this: "*Strong protest against report of U.S. Doctors—Dr. Connell hotly resents uninvited act of foreign body's classification of Canadian Schools.*" Of course, Dr. Connell never hotly resented it. I am going to move an amendment, if necessary, but I want to say this, for the sake of the Canadian medical profession, and for the sake of the importance of this conference being properly recognized. I hope nobody is so small-minded or unkind as to think that I, happening to belong to a school which was classed in Class A, would want to ignore that a sister school, very worthy, has been treated perhaps unfairly, no doubt unfairly, inasmuch as no proper supervision of the school was made prior to that report; but I want to speak about it on the broader lines in connection with this conference. This report printed in one of the Ottawa papers, I take it is liable to be copied and circulated by the Associated Press. It is more than likely it will be. It is a contentious article, far more contentious, I think, than what actually occurred. I do not think the original resolution ever meant that such an idea should be conveyed. I think it is a great misfortune this meeting has had this unhappy incident; it is the one blemish on the meeting. I think it has put us in an unfortunate position, where our dignity has suffered considerably, our dignity as serious minded medical men, the leaders, may I say, of the medical profession throughout Canada.

I think the resolution as it now stands, and as it may be carried on to our friends on the other side of the line, coupled with this strong protest as advertized in the Associated Press, would be construed in a way as an unfriendly act. I think it is an unfriendly attitude for us to take an eye for an eye, if such were the intention, with our friends to the south. I have learned from our good friend Dr. Bazin a new interpretation of the word harmony. Perhaps it is justifiable under certain conditions. He says if we are going to promote harmony, the first thing is we must not allow ourselves to be trampled upon. I do not like to be trampled on any more than anybody else, but I think there is a point of expediency here, and that a satisfactory solution of this problem can be arrived at in another way. I had intended to say nothing about this, for I am

entirely in sympathy with any of the schools that have been unhappily treated in this matter, and will do all I can personally to avert the criticism.

But let me say just this, in explanation, as I see it. The American committee have decided on this for their own purposes. We have nothing to say about what the American committee on education want to do for themselves. They are entitled, if they like, to make a survey for their own purposes. We can refuse to give them any help when they come to us, but they are entitled I think to say this: They do it because our students apply to them for positions, students of every university, and that is where I think Dr. Connell naturally feels resentment, and so might other schools if they have been unjustifiably treated. But the question is, is this the best way to handle it? What will happen? We send on this resolution and ask that they do not publish their reports on our schools. It seems an ordinary, simple thing, but what would happen if it becomes a fait accompli, and no further report is issued by the American committee—and the resolution simply requests that nothing be published in future? It simply means they will accept that *statu quo* of 1924 for all time. What evidence have they got? Unless we invite more friendly relations it means that we are going to suffer; at least, McGill and Toronto won't suffer, but Queen's will suffer, and the others that are put in that unfortunate position; they will suffer because the *statu quo* of 1924 will remain.

I think it will reflect discredit on us all if it is done in that way. There is an Association of American Medical Colleges in relation to the American Committee on Medical Education, and I would suggest that instead of this action being taken, that at all events an effort be made by personal interview, if you like, by each university undertaking to communicate privately with the colleges or with the committee. Some of us will be mightily glad to take it up with them for the protection of the schools concerned. We will do anything you like in that way that we can. We are, of course, sympathetic with the idea of the resolution, but I do not believe this is quite the way to do it. I do not want to take up more time; I could say something further about it, but I would ask, in conclusion, this conference not to place itself on record in a way that is undignified or unfriendly, but to try and correct this misunderstanding by individual means rather than by a formal request to the American Medical Association from this conference. I think we can arrive at our object by other means, and I certainly hope we will agree to do so.

Dr. Jas. M. MacCallum: I have always gone on the principle that the least said the soonest mended, and I hesitate to say anything about this at all. I am in sympathy with what Dr. Martin has said, and I sincerely sympathize with the feelings of Queen's and the other institutions. There is a gentleman named Abram. Flexner who is now compiling another report on medical education, and I am in a position to know that there are criticisms of my university which I do not think are justified. I think I also am in a position to say that the University of Toronto will not ask anybody to take their part. This is a private fight. I am Irish by descent and also Scotch and like a fight, and what impresses me about this is that nothing has been heard as yet from the other bodies which are affected. I advocated the *entente cordiale*, and you see what the result of it was. That speech that was delivered last night is another effect of my speech. Dr. Normand will deny that, but then that is a part of the entente cordiale. I am quite sure that if Dr. Connell and his witty friend, Dr. Austin, will employ the means and methods of the *entente cordiale* as practised by myself they will have no trouble at all.

I do regard this with a great deal of apprehension, and I am sure that if Dr. Connell will adopt what I believe to be the proper method, and will act upon the principle of the entente cordiale, he will get results which he will have no reason to regret.

Dr. P. S. McKibben (London): In London we have suffered from the classification in which we have been placed by the Council on Medical Education for a number of years, and I grant that the problem is a considerable one. But as I see the situation at present, so far at least as it affects ourselves, I am inclined to think that this resolution will do our status more harm than good. I know some of the men on this council, and I do not understand why Canadian schools should have been classified in this way. I cannot understand why, after a lapse of several years, the council has seen fit to reclassify the Canadian schools. It seems to me that the suggestion is a good one, that the matter might be taken up privately; it might be the best thing in the circumstances to approach privately some or all of these men. By this means we should no doubt obtain far better results than would accrue from the adoption of this resolution. I doubt whether the resolution, if adopted, would reflect the real spirit and dignity of this body.

Dr. G. R. Cruickshank (Windsor): About forty years ago the Russian Government sent out a commission to examine the medical schools of the world for its own information. This sort of thing is not new, and I do not think that we Canadians object to anyone inspecting our schools. Rather, we are glad to have anyone come, and I want to assure Dr. Connell that nothing on earth can injure the reputation which his own school enjoys.

The CHAIRMAN: There has necessarily been some warmth in the discussion of this subject, which is one that we have not had really very much time to consider. I do not know what this Conference may decide to do in regard to the resolution that has been submitted, but there are two courses open to us. In the first place, now that the matter has been aired, the resolution might be withdrawn. On the other hand, however, if we vote on the resolution we put ourselves on record as either approving of or opposing its principle. If I may be allowed to offer a personal opinion, I should think the better course would be to withdraw the resolution, seeing that the matter has been at least commented upon.

Dr. HILL: Subject to your ruling, Mr. Chairman, I would suggest that a substitute resolution be entertained to the effect that it is the sense of the conference that this matter be referred to the individual faculties of medicine throughout Canada, to be dealt with as they see fit.

The CHAIRMAN: That would be an amendment to the resolution before the chair.

Dr. AMYOT: I would second that motion.

Dr. J. C. CONNELL: As a matter of procedure, no resolution of this kind should call for a divided vote. I recognize the advisability of withdrawing the resolution, and I am prepared to accept that suggestion.

Dr. LOW: I would move that the resolution be laid over for further discussion at the next conference. It might be desirable to take the matter up on some future occasion.

The CHAIRMAN: That is really the effect of Dr. Connell's suggestion. With the consent of the seconder, the motion is to the effect that the resolution be withdrawn, and that further consideration of the whole matter be deferred to the next annual conference.

Dr. THORNTON: Seeing that the mover and seconder of the resolution are willing to withdraw it, I suggest that the whole discussion of this question be deleted from the official record, so that the printed proceedings will take no cognizance of what has been said on the subject.

Dr. CRUIKSHANK: I am not sure that such a course could be followed after the publicity which the matter has received.

Dr. REHFUSS: If it did not appear in the official record that action had been taken in regard to the matter, the silence of the report on this particular point would be an argument against the press statement which has rather exaggerated the sentiment of the conference on the whole question. I am inclined to agree with Dr. Thornton. If the discussion on the subject were omitted from the official report, the resolution would disappear and the press would be placed in the position of having exaggerated the matter.

The CHAIRMAN: I do not think we should be in order in adopting such a course. This matter was on the programme, it was announced from the chair, a paper was read on the subject, and it was referred to the Resolutions Committee. It seems hardly proper to delete the discussion which has taken place on the question. That is merely my opinion. It does seem to me, however, that the proper thing to do would be to stand by what we have done. I think Dr. Connell's suggestion is the right one; it would be well to withdraw the resolution.

Resolution withdrawn.

Resolution No. 2.

> Whereas in each province the act requiring registration of all medical practitioners was passed to ensure safety to the public by protecting them against unqualified individuals, many of whom advertised themselves as doctors or practitioners, or otherwise unwarrantedly presume to indicate an ability to treat disease;
>
> Therefore be it resolved that the attorney-general in each province be urged to enforce the laws of the province with respect to irregular practitioners.

Resolution agreed to.

Resolution No. 3.

> Resolved that the Conference on the Medical Services of Canada in session assembled at Ottawa on December 20, 1924, records its warmest approval of the proposal that the federal Department of Health issue regulations in regard to the potency of such drug stuffs as require physiological standardization, namely, arsphenamine and its derivatives, digitalis, pituitary extract and adrenalin, and urge that all such drugs exposed for sale as standardized products should be approved by the Department of Health at Ottawa before being sold, and further, that the

conference expresses its gratification that the Department of Health proposes to provide the requisites for the adoption of this policy.

Resolution agreed to.

Resolution No. 4.

Moved by Dr. A. C. Jost, seconded by Dr. H. E. Young:

Resolved that this conference suggests to the Canadian Medical Association the advisability of calling attention, through the provincial and branch societies, to the importance of bringing about the more accurate reporting of notifiable diseases, and, toward that end, the adoption of such courses of action as to each provincial medical society seems most advisable.

Resolution agreed to.

Resolution No. 5.

Resolved that the federal Department of Health be requested to undertake a comprehensive inquiry in regard to maternal mortality in Canada.

Resolution agreed to.

The CHAIRMAN: Is there any further business for the consideration of the conference?

Dr. S. L. WALKER (Halifax): One thing has occurred to me during these three days, and that has been the excellent manner in which the duties of chairman have been carried out by Dr. Primrose. Without saying anything further, I beg to move that this conference place upon its records its cordial appreciation of, and its sincere thanks for the services which Dr. Primrose has given in his capacity as chairman of the proceedings of this conference.

Dr. THORNTON: I have pleasure in seconding the motion.

Motion agreed to.

The CHAIRMAN: I hope that both the mover and the seconder of the motion, as well as members of conference, will accept my thanks.

Dr. CRUIKSHANK: Would it not be wise to express the formal appreciation of the conference of the action of the Minister of Railways and the Minister of Health in facilitating the proceedings of the conference?

The CHAIRMAN: That is being done by the Executive of the Canadian Medical Association on behalf of the conference.

This concluded the proceedings.

FOOTNOTES:

[1]The details of the activities of the Health committee of the League of Nations were mainly obtained from charts left by Dr. Madsen, now in the possession of Dr. J. G. Fitzgerald of Toronto.

[2]Monograph by Dr. J. W. S. McCullough already quoted.

[3]Canada, House of Commons Debates. Official Report. Vol. 59, No. 93, page 4914. Thursday, July 17, 1924.

[4]These figures are supplied by the Provincial Bureau of Health, Province of Quebec.

[5]Annual Report of Sir George Newman, Chief Medical Officer to the Ministry of Health for 1923, page 95.

[6]Page 1011, *The Lancet*, November 15, 1924. See also Dr. Janet Campbell's Report No. 25, above.

Transcriber's Notes:

1. page 10—corrected 'Satistical' to "Statistical'

2. page 11—corrected 'geater' to 'greater'

3. page 11—corrected 'Instiute' to 'Institute'

4. page 15—corrected 'collosal' to 'colossal'

5. page 16—removed first line from paragraph starting under heading 'Canadian Activities' as being a repeat of a sentence from 3 paragraphs previous. Replaced with interpolated words [Several courses regarding matters of public...]

6. page 20—corrected 'wth' to 'with'

7. page 23—periods in number 45.000.000 changed to commas

8. page 24—corrected 'adminstration' to 'administration'

9. page 35—corrected 'viewpoiint' to 'viewpoint'

10. page 36—corrected 'discusson' to 'discussion'

11. page 38—corrected 'Aikins' to 'Aikens'

12. page 39—corrected 'permittted' to 'permitted'

13. page 48—corrected 'Unversity' to 'University'

14. page 58—corrected 'dstricts' to 'districts'

15. page 58—corrected 'pateient' to 'patient'

16. page 69—corrected 'quality' to 'qualify'

17. page 74—corrected 'cmmitte' to 'committee'

18. page 74—corrected 'volutary' to 'voluntary'

19. page 76—corrected 'out' to 'our'

20. page 76—corrected 'practioners' to 'practitioners'

21. page 79—corrected 'excedingly' to 'exceedingly'

22. page 81—corrected 'our's' to 'ours'

23. page 82—corrected 'thees' to 'these'

24. page 83—corrected 'In' to 'It'

25. page 83—corrected 'adquate' to 'adequate'

26. page 97—corrected 'especiallly' to 'especially'

27. page 99—corrected 'obstetries' to 'obstetrics'

28. page 101—corrected 'posteriror' to 'posterior'
29. page 104—corrected 'discontined' to 'discontinued'
30. page 107—corrected 'practioners' to 'practitioners'
31. page 112—corrected 'no' to 'do'
32. page 116—corrected 'subjets' to 'subjects'
33. page 127—corrected 'incentitives' to 'incentives'
34. page 130—corrected 'electrcity' to 'electricity'
35. page 137—corrected 'puchased' to 'purchased'

[End of *Conference on the Medical Services in Canada* by Canadian Medical Association]

[End of *Report of the Conference on the Medical Services in Canada held at Ottawa, December 18, 19, 20, 1924*]