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VOL. 39, No. 4

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MEDICAL
JOURNAL

THE UNIVERSITY OF WESTERN ONTARIO
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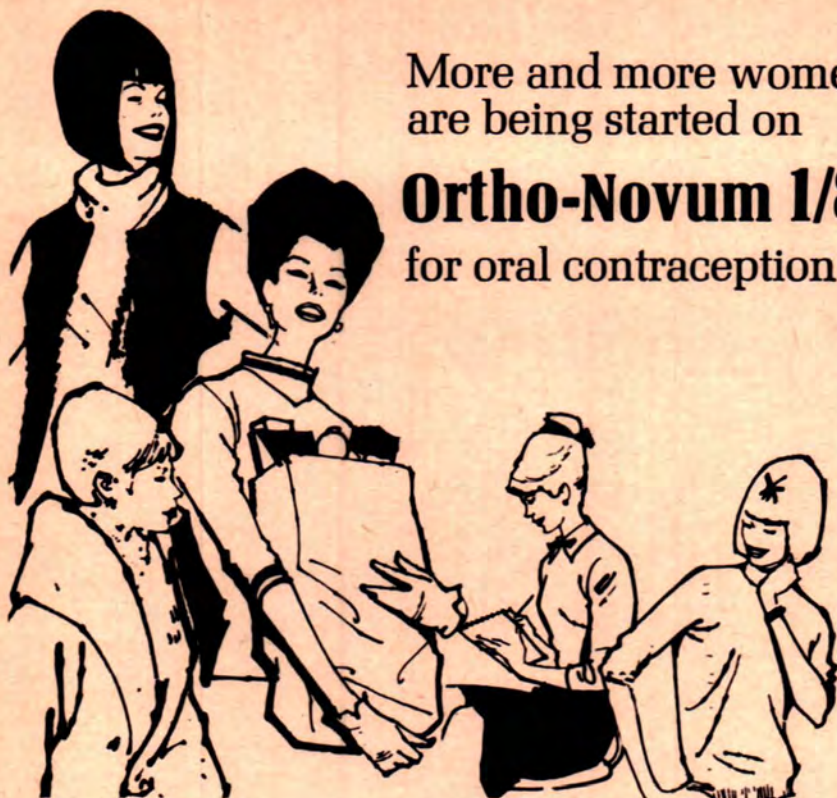
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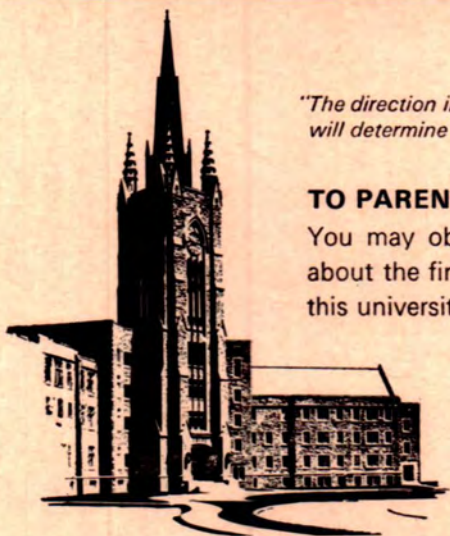
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MEDICAL JOURNAL

VOL. 39, NO. 4, JUNE, 1969

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CONTRIBUTIONS will be accepted with the understanding that they are made solely to this publication. Articles should be of practical value to students and medical practitioners. Original research work is most welcome. Articles should not be longer than 3,000 words, and we will more readily accept those of shorter length. Introduction and summary of conclusions, should be included. Drawings and photographs will be accepted, the former to be in black ink and drawn clearly on white cardboard.

All articles submitted must be typewritten, on one side of paper only, with double spacing and two inch margins on each side. Canadian Press (American) spelling must be adhered to. The format for references is as follows: For books: Author(s): title of book, publisher, place, year. For Journals: Author(s): title of article, name of Journal (abbreviated as in the World List of Scientific Periodicals), volume: page, year.

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MEDS '69



The Journal Staff

Editorial

A collective sigh of relief will no doubt be heard when this last issue of the year is distributed as this will be the last time I will have the privilege of inflicting an editorial on the readership. I have mixed emotions regarding my demise; certainly I am pleased that the hectic rush to meet the printer's deadline is a thing of the past because such effort is not consistent with my normal lazy attitude. However I will more than miss the good fellowship of the many people who have made the Journal possible.

It is always difficult to single out individuals in a situation such as this where teamwork is of the essence. Nevertheless my sincere gratitude must go to all the Journal staff for allowing themselves to be bullied, coerced, badgered and generally maltreated; the faculty advisors for their advice and encouragement; the alumni and faculty for their support, both as contributors and subscribers; the student body and Hippocratic Society for giving me the opportunity of endeavouring to ruin the good name of the Journal; Hunter Printing for their perseverance and finally all the unsung of heroes who in many ways have held my hand, and unselfishly given assistance when it was so often required. Possibly the only reason I can offer for being editor during the past two years has been aptly summed up by Piet Hein, the inventor of Grooks who has observed:

Let the world pass in its time-ridden race,
never get caught in its snare.
Remember, the only acceptable case
for being in any particular place
is having no business there.

The word teamwork has already been used and I am tempted to at least offer a small number of my normal trite remarks with regard to the Health Sciences Centre and its relationship to the medical team. It would not be unkind to state that although Western has a Health Sciences Centre the majority of us in the Medical School have done very little to encourage and nurture this young infant. Whether or not one subscribes to the principle of such an organization the unescapable truth is that the physician, now and in the future, will have to rely more and more on the paramedical professions in order to adequately treat the patient. There would appear to be immediate and long range advantages in bringing all the health professions together under one roof but most of us have not taken advantage of this opportunity to realize the enormous potential which such a union offers.

It would not be unreasonable to suggest that at the present time the Medical School is experiencing difficulty in encouraging the undergraduate body to keep together and enjoy the professional and social opportunities it offers. Therefore the critic would suggest that if we melded with the other faculties our tenuous state of cohesion would be seriously compromised and indeed lost altogether in a vast conglomerate.

My own analysis would lead me to believe that such an arrangement could only be of benefit to us. Not only would it enable the embryo physician to appreciate the complex problems in total patient care but also realize from an early time in their training that the other professions have much to offer us in their specialized skills. If the multifarious relationships were improved on all fronts this could but increase rather than decrease the pride and affection we have in our own faculty, and that the traditions we have, scanty though they are, would be appreciated and fostered more than at present. The only tradition that would be broken would be the insularity of dealing with the other health disciplines and this would be more than welcome.

It is to be hoped that next year will see the Hippocratic Council and the various classes make a serious effort to organize events to which all the other members of the Health Sciences Building would be invited. What could be more delightful than having a physiotherapist available in the event that someone tears a conjoint ligament during an enthusiastic frug; or a statuesque nurse ready to lay a cool soothing hand on a fevered brow following a hectic game of table tennis; or indeed having a graduate student in Pathological Chemistry performing blood alcohol levels on everyone performing in Tachycardia—the advantages defeat the imagination.

The foresight and energy of our senior faculty after a long hard fight has provided us with an unexcelled opportunity to increase the potential of the Medical School and as students we should use it wisely and with enthusiasm knowing that the person who will benefit the most will be the Patient. If you cannot agree with even this statement I would respectfully suggest you are in the wrong profession.

Martin G. J. Wood

... And the Beat Goes On!

As you read this, I will have assumed the position of Editor-in-chief of our beloved and revered 'Journal' with all the dubious honors and privileges enjoined therein. Whatever sentiments this information arouses in you, it causes a great variation in my glucose tolerance curve. Having watched with horror over the past two years as Martin's hair has grown whiter and his days of useful practice drastically reduced, I ponder the mental stability of any mere human (sic) organism voluntarily accepting the task of publishing four information-packed, thought-provoking issues in the coming year. If it were not for the former editor's genius for organization and his willing patience to impart to me a few of the fundamentals of journalism, neither I nor this widely acclaimed periodical would be where we are today.

The Journal requires that all the staff and contributors work to a deadline. This often requires certain sacrifices by those concerned, a fact not always appreciated by the average reader; over 200 man-hours for each issue. I am heartened by the declarations of faith and support that have been offered by the majority of the present staff and gratefully but humbly (sic) accept their offers to increase already herculean effort.

Blood, sweat and tears notwithstanding, all will be for naught unless we receive an abundance of that unmentionable bourgeoisie attribute known affectionately as money. Future plans include a new cover, increased artwork, a myriad of pictures, special symposia of unparalleled erudition and the enlarging of our scope to glean material from areas not intimately related either geographically or politically with the medical school. When I attempt to impart some of my enthusiasm to the treasurer of Hippocratic Council, he develops a glazed look and while staring at a point just above my left ear does a credible imitation of a petit mal seizure.

To those of you who like to write, read, compose letters, sell advertising or even just open mail, the Journal has a special niche put aside for you. I think that you will find the work satisfying and stimulating. The next time you are getting a drink of water and the door to our office is open, please feel welcome to drop in and introduce yourself. It's a humble abode, but we will always make you feel at home.

H. Ronald Wexler

* * *

Gems from the Faculty

- Dr. D. W---x. 1. Re. Querying order sheet on Medical Rounds: "Why would you want to order a VDRL on a 40-year-old Christian lady with children!"
2. Re. Electives: "Electives are nonsensical except for the gifted".
- Dr. G. H-----n. Re. Secondary Megacolon with overflow incontinence: "When this child had a bowel motion it wasn't a movement, it was a whole symphony".
- Dr. H. V-----e. Re. Secondary Renal Osteodystrophy: "Whilst this child was in Montreal her skeleton leaked through her kidneys".
- Dr. N. C----n. Re. a Psychiatric patient: "This patient obviously has constipation of the mind and diarrhoea of the mouth".
- Dr. F. B--n. Re. Renal Function Tests: "The best and simplest test of renal function for a woman is to get her pregnant".
- Dr. D. W-----e. "Schizophrenic labour may not be efficient but its cheap".
- Dr. J. W---s. Re. Sign in office: "Blessed are they who run around in circles for they shall be known as wheels".
- Dr. J. R----n. Re. Substitutes for human breast milk: "Moose milk should not be given to the premature human infant as it has a high ash content".

Your Part in the Team

Pat Wall, School of Nursing

Dr. J. W. Mullner, of the Brockville Psychiatric Hospital, was quoted recently in the London Free Press as referring to an "atmosphere of mistrust, fear and frustration" created in that institution by the lack of "communication and consultation between the medical, nursing and administrative staff". Perhaps, if the situation in Brockville were an isolated one, it would not be worthy of notation. However, similar cases of communication breakdown, or some degree thereof, are commonly found in present-day hospitals.

As a result of our concern for this problem, my classmates and I arranged the student inter-disciplinary panel discussion on the topic of Roles and Relationships within the Health Team, held on Thursday, February 13th, at 7:00 p.m. It is our belief that good inter-disciplinary communication should begin at the student level, thus eliminating, perhaps, some of the misconceptions and communication breakdowns that can occur in the work situation. The panel presentation and ensuing open discussion were intended as an experiment in student understanding between the health disciplines at Western.

Student panel members were: Mr. David Kenny, Dentistry III; Mr. Martin Inwood, Medicine IV; Miss Kristin Jessop, Physiotherapy III; and Miss Pamela Nicholson, B.Sc. N.—Plan A—Public Health Nursing (final year). The panel moderator was Miss Rosemary Gadsby, B.Sc. N.—Plan A—Nursing Service Administration (final year). There was at least one faculty member from each discipline in the audience, to act as a resource person, along with Dr. J. I. Williams of the Department of Sociology. The panel members each spoke for a few minutes on their field of endeavor; what they saw as their particular responsibilities and how they saw themselves fitting into the larger scheme of a multi-disciplinary health team.

Mr. Kenny, defining the dentist's sphere of responsibility as including all oral and some cosmetic problems, referred to him as a "screening agent" for medicine. "The dentist" he said, "is constantly seeing 'well' people, and is often the first to discover a latent medical problem, for example,

hemophilia." The nurse was seen as responsible for teaching dental hygiene, and as a referring agent for the dentist. Mr. Kenny said that he felt that communications could be better between the medical, dental and nursing professions.

Miss Jessop, referring to the physiotherapist's role as a rehabilitative and teaching one, said that their main avenue of contact with the doctor is through the patient's chart. The physiotherapist attends and participates in interdisciplinary conferences, where these are used. However, the physiotherapist does not enter into active consultation otherwise, between professions.

Miss Nicholson, referred to the nurse as a "jack-of-all-trades", assuming many different, but inter-related roles. At different times the nurse is teacher, consultant, interpreter, referral agent, moral-supporter and co-ordinator. As a student, especially in the University setting, the nurse spends a sizable portion of her time cultivating her ability to interact with patients. She often assumes the co-ordinator role, acting as communication medium between the doctor and patient and between various members of the health team.

Martin Inwood, concentrating on the team concept, said that "in the final analysis, the physician is the 'boss'." He continued to point out that very little about a "team" concept is taught in Medical School, with the result that the newly graduated physician is not really qualified to lead the team. He learns about the other health disciplines and defines his leadership role through trial and error. Martin Inwood suggested that medical students should meet with students of the other disciplines at the student level, to learn their various roles and how they can best be used to improve patient care.

The discussion was turned over to the audience and an animated interchange of ideas ensued, centred on the lack of inter-disciplinary communication and suggested solutions for the problem. The question of whether or not there is a team structure in existence in hospitals; and further, whether the adoption of such a structure should begin at the hospital or student level was raised.

Mr. Inwood suggested that the change should be instituted simultaneously at both levels. In response to a query about "how we use the skills of others to achieve our common ends", which is central to the team concept, Mr. Inwood said that since most medical men do not know the range of skills of others, this is an impossibility. Reference was made, from the audience to "a tremendous lack of communication, which is appalling".

Several suggestions for an increase in communication at the student level were offered, such as multi-disciplinary C.A.M.S.I. trips, multi-disciplinary clinical sessions, and some type of a course in the team concept and communication. Dr. Warwick pointed out the difficulties involved in instituting new courses and Mr. Inwood said that such changes would have to come from faculty, rather than students.

The meeting was adjourned with the general agreement that inter-disciplinary student sessions were definitely desirable and that every effort should be made to continue from this initial starting point.

In retrospect, I feel that the session was a success, if only for the fact that it was a first and a desire was displayed on the part of all attending to make sure that it wasn't the last of its kind. Perhaps due to our rather haphazard publicity techniques, the attendance was less than desired. There

were two medical students, apart from Mr. Inwood. The rest of the audience contained a smattering of representatives from the other faculties. The majority of the audience, however, was made up of members of Dr. Williams' Medical Sociology class, who were asked to attend the session in lieu of tutorial classes that week. It is hoped, however, that the interest generated in those who did attend will rub off on some of their classmates. The Deans of the Faculties of Medicine, Dentistry and Nursing, as well as Miss Morgan, Director of Physiotherapy, have all expressed their interest in continuing with similar sessions.

As a member of the Nursing profession, I am constantly aware of the lack of understanding across professional lines, and cannot help but wonder what effect this has on the patients for whom we care. I would think that, the patient being our prime concern, he should be the focus of hospital organization. However, we in the health professions have a peculiar "pecking order", within which the patient occupies the lowest rank. The "pecking order" seems, to me to be set up long before we reach the hospital as full-fledged practitioners. The complex of buildings at Western which comprise the Health Sciences Centre, afford us a perfect opportunity to break down the barriers before they are firmly established, but some effort on everyone's part is necessary to make the health "team" a reality.

* * *

Fact Sheet Relating to the Medical Profession in Canada — 1967-'68

1. There are approximately 25,000 practising physicians in Canada.
2. There are about 21,360 general practitioners.
3. There are about 3,500 residents and interns.
4. Canada rates eighth in the world in the number of physicians in relations to the total population.
5. There is one physician for each 840 people in Canada.
6. In 1965, there was one doctor per 1,000 of population.
7. There are about 1,019 medical students who will complete their fourth year this year.
8. About half of this number intend to specialize, following their internship.
9. The number of first year medical students in Canadian medical schools has not risen appreciably since 1962. In that year the total was 1,061. In the current year the total is 1,233.
10. About 38 per cent of the non-Canadians attending Canadian medical schools are U.S. citizens, while 60 per cent are citizens of other Commonwealth countries. The number of U.S. students has diminished in recent years, while the number of Commonwealth students has risen.

NOTE: The above information was obtained from the April 13, 1968 edition of The Canadian Medical Association Journal.

"The Doctor, his Patient and the Illness"

Revisited

Dr. G. J. Maier '68

Originally I intended to write a review of Dr. Michael Balints now well read book with the above quoted title. If not an exposition chapter by chapter I at least intended to deal with the three major parts of the book; diagnosis, psychotherapy, and general conclusions, in that order. However, I have abandoned this structured and unimaginative approach and will instead expose the tasty meat via a somewhat natural progression starting with the patient who develops an illness, the offering of symptoms to the practitioner who must accept some, and finally, perhaps the consultation where diagnosis is devined. This form allows revelation of the various levels of interaction between the patient and his illness, the doctor and the patient, the doctor and the illness and the doctor and his consultant.

By way of a short introduction into the book let me say that it was the result of a study done at the Tavistock Clinic in London, England roughly over the 1951-55 period where one or two psychiatrists and eight to ten general practitioners met weekly to investigate the pharmacology of the drug-doctor. The aim was research and training and the book I believe has laid the ground work and basic philosophy for organized study of General Practice. This book when published in 1957 became a basic text for the philosophical pioneers of Family Practice. It was also immensely readable to doctors of all fields, but especially doctors who are aware of their psychotherapeutic powers because it illustrates its results by means of well chosen case histories, ones so typical that every doctor can immediately recognize these people from his own experience. (I assume all doctors, even surgeons, utilize psychotherapeutic principles no matter how poorly they understand or are aware of them). Needless to say I will be unable to describe the cases, but then you must have some reason to read the book itself. The final point I wish to make is that the book investigates the 25% of General Practice, which deals with the functional, and it shows us quite well why we are so organically minded and points out that if the Family

Practitioner is to become effective in helping 25% of his practice he must be given the training to allow him to feel secure in the vital area of psychotherapy.

Consider then the person who is in the process of developing or recognizing an illness in himself. He first becomes aware that something is going wrong as he develops symptoms and even signs. He adopts the traditional almost innate view that something "bad" is going on inside himself which he would dearly like to have out. During this unorganized state of his illness when he is largely alone with it and it is most unknown to him, he is most threatened by it and as a consequence he may begin to act entirely different. As the illness organizes the patient finally comes to the point when he begins to complain. Thus it is that in this relatively unorganized state he seeks his doctor and "offers" him his symptoms.

Usually the practitioner has the advantage of knowing the patient during his well periods which facilitates inquiry and neutralizes the change of personality. He should also be aware that psychoanalysis is about to develop a new conception which may be called "basic illness" or perhaps "basic fault" in the biological structure of the individual, involving in varying degrees both his mind and his body. The origin of this basic fault may be traced back to a considerable discrepancy between the needs of the individual in his early formative years (or possibly months) and the care and nursing available at the relevant times. This creates a state of deficiency the consequences of which are only partly reversible. Although the individual may achieve a good, or even very good adjustment, the vestiges of his early experiences remain, and contribute to what is called his constitution, his individuality, or his character make-up, both in the psychological and in the biological sense.^{1,2} Thus the "clinical illness" would be considered as a symptom, or exacerbation of the the "basic fault".

In order to deal with the patient the practitioner must really face three problems: what to treat, when to start, and eventually

how to stop. Consider for a moment how simple the task and how well prepared to commence therapy if the symptoms offered were those of a broken arm. However, if the symptoms only suggest idiopathic pain, the doctor in order to make the diagnosis and commence therapy must increase his depth of diagnosis. To this end Dr. Balint suggests we increase our power of observation and actually note facts concerning the patient's conversation, dress, behavior, thought processes etc. He also feels that the art of listening must be developed.

"Our experience has invariably been that, if the doctor asks questions in the manner of medical history-taking, he will always get answers—but hardly anything more. Before he can arrive at what we called "deeper" diagnosis, he has to learn to listen. This listening is a much more difficult and subtle technique than that which must necessarily precede it—the technique of putting the patient at ease, enabling him to speak freely. The ability to listen is a new skill, necessitating a considerable though limited change in the doctor's personality. While discovering in himself an ability to listen to things in his patient that are barely spoken because the patient himself is only dimly aware of them, the doctor will start listening to the same kind of language in himself. During this process he will soon find out that there are not straightforward direct questions which could bring to light the kind of information for which he is looking. Structuring the doctor-patient relationship on the pattern of a physical examination inactivates the processes he wants to observe as they can happen only in a two-person collaboration.³ With some of these new tools the practitioner will decide to give the patient a "long interview". Being relatively convinced he is dealing with a functional disorder he will want to start by giving the patient enough time so focus can rest on the real problem.

This would appear to be the optimum plan of attack. However, in reality few practitioners feel comfortable with psychotherapy and consequently are very ineffectual in aiding their functional patients—a source of dissatisfaction for both themselves and their patients. Instead of adequately dealing with these people they rely on two or three other means of therapy which are exposed by Dr. Balint.

The first concerns reassurance and advice, the two most used forms of medical treatment. The experienced doctor generally feels he has acquired a well proved "common-sense" psychology which enables him to deal with his patient's psychological or personality problems. "But minor surgery, for instance, does not mean a doctor can pick up a well-proved carving-knife or a common-sense carpentry tool and perform

minor operations. On the contrary, he has to observe carefully the rules of antisepsis and asepsis, he must know in considerable detail the techniques of local and general anesthesia and must have acquired skill in using scalpel, forceps, and needle, the tools of the professional surgeon. Exactly the same is true of psychotherapy in general practice. The uses of empirical methods acquired from everyday life are as limited in professional psychotherapy as a carving-knife and screwdriver in surgery".⁴

Second the practitioner, as alluded to above, can fail to deal with the complaints on a functional basis at all. He will usually do this by eliminating pathology with appropriate physical examinations and tests. Further, and partly because the burden of responsibility weighs on him, he may begin liberally referring the patient to appropriate specialists. By so referring he "dilutes the responsibility" for the patient between himself and the specialist, a process referred to as the "collusion of anonymity". The chief loser in this situation is the patient who may regress to playing off one doctor against the other or flatly feel rejected because his offer of illness is always negated.

The fact of referral of course is a double-edged sword, and I feel that Dr. Balint's remarks here stem from his English setting where a greater gap exists between hospital and family doctors. Primarily the relationship between consultant and practitioner was found unhealthy as it perpetuated the teacher-pupil relationship. The practitioner often looks with ambivalent respect to the consultants who by their standing ought and often even do know more. However, if events do not confirm this the practitioner feels critical and dissatisfied but usually he hesitates to express his feelings. Actually the consultant should know more in his field and the practitioner should know more about the patient. Then the two can combine their knowledge, neither feeling dominant. The consultant should be viewed only as an expert assistant who is loaned patient responsibility. If communication breaks down the practitioner must be prepared to take over.

Concerning referral to psychiatrists, Dr. Balint, himself a psychiatrist, feels that the practitioner must be prepared to do more psychotherapy himself. The practitioner's office offers a special atmosphere for psychotherapy which differs entirely from the psychiatric interview. The practitioner first of all deals with the patient in that critical unorganized phase of his illness. As a result no rigid patterns are established thus allowing the practitioner a greater scale of "response" to offer his patient's, a fact which enables him to weather many situations

which are beyond the technical possibilities of a psychiatrist. It is part and parcel of the practitioner's routine work to start and stop treating patients. Even if the psychotherapeutic relationship is broken off the patient will likely return with some organic problem, or therapy may continue through another member of the family. However, it is the essence of therapy to completely terminate the relationship with the psychiatrist, so stopping for him has a "finality" about it.

The relationship between the practitioner and patient is different too because therapy usually starts with a well patient. The two mature together and form what Dr. Balint calls "the mutual investment company". This is an interesting and rather insightful analogy for it accurately expresses one real joy of family practice. The more each partner gives, and tries, the greater the company prospers and the more dividends are paid. This area is the high prize of family practice to enjoy, but also to investigate, for specialists are no party to this company. Much work remains to be done in this area and several of the problems awaiting solution are listed.

Finally I wish to speak of one of these areas. This is the attempt to define the most therapeutic effect, but also one of the greatest potential side effects of the drug doctor. This concept is called "the Apostolic Function".

Every doctor has an unshakeable idea of how a patient ought to behave when ill. "It was almost as if every doctor had revealed knowledge of what was right and what was wrong for patients to expect and to endure, and further as if he had a sacred duty to convert to his faith all the ignorant and

unbelieving among his patients".⁵ It is the exercise of this function which will determine the therapeutic outcome. He will be a good psychotherapist in relation to his understanding of his own needs and expectations of therapy, and of his own feelings. An important part of this function is his urge to prove to the patient, to the world and above all to himself that he is good, kind, knowledgeable and helpful. He must learn he is human too. To the many listed problem areas the answer given is a realistic adequate training, one which gives the practitioner insight into himself.

EPILOGUE

This book I am told is immensely more enjoyable after four or five years of practice. Even now almost at the end of my intern year I can appreciate this because even though my experience is limited I can recognize some of the cases presented as real people. Nevertheless the analogies and philosophy presented can be very useful to the third and fourth year student especially now that they experience the family practice clinic at St. Joseph's. I would encourage all to read the book.

The Doctor, His Patient And The Illness

Michael Balint, M.D.

Published by: International Universities Press, Inc., New York

References

1. Neither italics, nor quotation marks are mine.
2. *The Doctor His Patient And The Illness*, page 255-6.
3. *Ibid*, page 121.
4. *Ibid*, page 109.
5. *Ibid*, page 16.

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Physicians Duty

A Physician's duty to his patient has been brilliantly epitomized as:

Guérit quelquefois—To cure occasionally

Soulage souvent—To relieve often

Consoler toujours—To comfort always

Pappworth M.H. *A Primer of Medicine*, Butterworths 1963.

Remember that there is no such thing as a "never" or an "always" in clinical medicine. "Never" means "hardly ever" and "always" means "nearly always". Do not be over-concerned with the exceptional case.

Pappworth M.H. *A Primer of Medicine*, Butterworths 1963.

A Medical Undergraduate Society

David Peachey '71

This Medical School has a problem which is by no means unique. I am sure that it is found throughout this country in the majority of Medical Schools and would not be surprised to find it an international problem. Moreover, there seems little doubt that most of us have at some time considered this point. The simple fact is that nobody seems to know anybody else, not just in other years but often even within one's class.

The etiology behind such a condition has four parts to it:

1. Obviously, the "split" between the first two academic years and the last two clinical years plays a major role.
2. There is not a true opportunity for acquaintances to be made. Of course, AKK is there, the Osler Society is there, Alpha Omega Alpha is partially there; but, none of these function very well as a meeting ground—nor were they designed for that purpose.
3. Idiopathic
4. "The Studying Vegetable",
 - (a) congenital
 - (b) acquired

There might be many possible solutions to a situation like this, but only one is apparent to me. And I must confess that it was presented to me by a faculty member who wishes to remain anonymous, and so shall he remain. That solution is the formation of a Medical Undergraduate Society. There could be many ways of operating such a society and what follows is only one of them.

EDITORS NOTE:

The following extract is reprinted from the February 19th 1931 issue of the U.W.O. Gazette. David Peachey's suggestion merits your enthusiastic support particularly when one considers that such an organization existed in years gone by and was more than appreciated by our illustrious predecessors.

M. J. I.

The Medical Undergraduate Society would be an organization of which every medical student would be a member. The leadership would be provided by the Hippocratic Council. This society would meet once a month, perhaps the last Thursday of the month. Attendance by all would be expected, those refusing to partake being labelled as a CV (congenital vegetable). The evening would open with standard Hippocratic Council business which would be followed by an opportunity for anybody in the audience to ask questions, raise objections, or present new complaints. When this is finished, approximately half an hour would be given to a guest speaker, preferably but not necessarily non-medical in credentials. At the conclusion of the speech, another half hour would be devoted to circulating, drinking beer or coffee, and eating sandwiches. Then as the final part of the evening, the floor would be given to the person called the "presenter", a fourth year student holding that position from election by his class. The "presenter" would present a case history of the previous month which would be challenging, humorous, instructive, or any combination of the three. At the end of this presentation, members of the audience would be asked or may volunteer to solve the mystery presentation. Again, these solutions would hopefully combine challenge, humour, and instruction.

That's all there is to it, one night a month. Obviously, such a plan is not ideal and could probably be improved upon. Just as obviously, that is where you as a medical student would play one of your two roles. The other role would be to mark your calendar and be sure to show up. So if you like the idea, tell your class president, or John Evans, or somebody. If everybody just sits back, it will NEVER happen.

MEDICAL SYMPOSIUM A DISTINCT SUCCESS

NEPHRITIS IS REVIEWED IN ALL ITS ASPECTS

The Medical Undergraduate Society held its second Symposium on the night of Tuesday, Feb. 17, with the president, Martin Le Boldus, as chairman. Although the attendance was somewhat cut down by the morbidity of the current epidemic and the military ambitions of a number of students, those present showed a lively interest in the subject of Nephritis in particular and the Symposium scheme in general.

Bill Fraser, '34, and Jim McDermott, '33, in masterly style reviewed the normal kidney from the morphological and physiological stand-points. Carl Morlock, '32, gave a comprehensive description of the pathological picture in Nephritis. The subject thus introduced, Cyril Sullivan and George Robinson, '31, described Nephritis from the clinical aspect. The former stressed the fact that alcohol was seldom an etiological factor in acute Nephritis, although, unfortunately, it may operate in producing the chronic case. He also pointed out that in an infant of two years or less with a temperature in the neighbourhood of 103°F. one should think of acute Nephritis. A number of gross specimens and microscopic sections illustrating the various pathological manifestations of the disease were on display in the pathology laboratory.

These Symposia fill an urgent need in medical undergraduate activities. The student learns to express his scientific thoughts in public. The Symposium, being essentially an undergraduate affair, furnishes an atmosphere devoid of the restraint which the presence of our intellectual superiors might introduce. The various years are brought into closer contact and the junior class-men are able to learn much from those who have almost completed their course. For these reasons the continuance of the Symposium is entirely justified.

The next Symposium will probably be in two weeks' time, the subject to be "Pernicious Anemia". Case histories will be presented by members of Meds '31.

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Poor Teaching

Too many people are over-concerned with the techniques of teaching and pay too little attention to what is taught and by whom. Undoubtedly the greatest of all educational handicaps is poor teaching and no system and no revision of the curriculum can overcome such a misfortune.

An important cause of poor clinical teaching is over-specialization. The narrow specialist usually lacks a broad view of medicine, is incapable of seeing the patient as a whole, is often abysmally ignorant outside his own narrow field and so, when he teaches, is very likely to give the student a completely wrong start because of peculiar slant. So often the narrow specialist ceases to think in real clinical terms and attempts to draw everything into his net. For example, a patient complains of anorexia, lassitude and loss of weight. Doctor A immediately emphasizes the likelihood of respiratory failure; but Doctor B, on seeing the same patient discusses only liver failure; Doctor C automatically expounds on pituitary dysfunction; and Doctor D babbles on hypokalaemia. But the good clinician would realize immediately that this triad may be the presenting manifestation of many diseases ranging prognostically from an anxiety state to extensive carcinomatosis.

A Clinical Trial Student Exercise — Acute Tobacco Withdrawal

Dr. J. M. Parker and H. D. Madill, Department of Pharmacology

Drug trials when drugs are given, not for therapy, but purely to observe effects in individuals not requiring the drug, pose certain ethical problems. For student exercises, in organizing and carrying out a trial, one solution is to utilize a drug substance already in use. Caffeine-containing beverages have been used and onset, degree and duration of diuresis observed. Such beverages have been used and the subjects psychomotor performance tested.¹

Present day concern over the harmful effects of smoking suggested a study of the effects immediately following abstinence from smoking. Several psychomotor and mentation tests were available if sufficient subjects could be found.

The following trial was proposed to and accepted by the class of '71 as a laboratory exercise: the organization into groups, subjects, observers, etc. was done by the class. A survey of the class revealed only 14 smokers out of 75, of which only 7 qualified as cigarette smokers willing to abstain for 2 days; the other 7 were mixed pipe, cigar and mild cigarette smokers. 7 of these agreed to serve as continuing smoker controls. A further 7 non-smokers agreed to smoke at one stage in the trial—these were all non-smokers as opposed to abstaining former smokers. The latter were not encouraged to resume smoking. A further 5 groups of 7 each served as non-smoking controls while 14 students served as recorders.

Methods

Tests employed:

V test—a stylus is moved down a metallic V and the point at which contact occurs noted. Scores for 10 trials were recorded.

Tremor box—a stylus is inserted into a hole, contact made with the base, and withdrawn. A fault is scored if the side of the aperture is touched.

Nuts & Bolts—this test introduced the test day as a substitute for the typewriter

consisted of threading nuts and bolts in a dexion strip with vision barred by a wall around which the subject reached with both hands.

Tracking—consisted of following an undulating tape on a kymograph drum with a stylus. Faults were recorded every time the stylus left the tape track and touched the metallic drum.

Symbols—to relate unfamiliar symbols to their numerical designate in a 30-second time period.

Addition—to add 3 digit-numbered columns in a 90-second period.

Mood²—to allocate mood descriptive cards to categories as to how they describe subject's mood at the instance of testing.

Cigarettes were supplied for the abstainers and non-smokers smoking. Because of traffic problems in getting at tests, the only subjects tested immediately after smoking were the abstainers at the mood test immediately after 3 cigarettes. The non-smokers only smoked 1 cigarette. Rates of smoking and inhaling were not standardized as in a recent cannabis study².

A practice day a week before the test was used to familiarize subjects with the tests and develop traffic patterns for groups for tests.

The groups as tested consisting of 7 groups, each containing a smoker continuing, an abstaining smoker, a non-smoker smoking, a control and observer. A further 8 groups were made up of 4 controls and observer.

The practice period showed up deficiencies in the tests, such as unclear instruction sheets, poor selection of test times, etc., as well as traffic problems. Changes were made to attempt to remedy these difficulties.

Results

Both staff and observers were impressed with the competitiveness and high motivation of the class. This was shown by the marked improvement even after the practice the week before.

Several test results were skewed in the direction of perfect scores, making any analysis difficult.

The *V* test showed no changes. All results were skewed in the direction of perfect scores. All groups performed equally well.

The *Tremor box* results were recorded differently by some groups and, therefore, could not be analyzed.

Nuts & Bolts—this test was not checked out in advance. It was time consuming causing traffic problems. A very strong learning trend was shown. The smokers—all three groups—abstainer smoking, 2nd trial; smokers and non-smokers smoking, 1 cigarette 2nd trial, performed less well compared to the non-smoking controls.

Tracking test—Table I. This showed gross learning effects amongst control subjects.

TABLE 1: TRACKING TEST
Mean scores for errors in the tracking test

Group	Number of Subjects	Pretreatment Trial	1st Post Treat. Trial	2nd Post Treat. Trial
Control	30	24.9	22.0	18.7
Abstainers after 3 cigarettes	7	24.9	24.3	23.7
Non-Smokers after 1 cigarette	7	31.1	24.1	23.9
Continuous Smokers	7	28.0	28.8	26.3

MOOD TEST

TABLE 2: Score changes in Mood Test following the smoking of one cigarette by seven non-smoking subjects

Mood Factor	Subjects							Diff. Pre vs. Post Treat.	
	1	2	3	4	5	6	7	\bar{x}	s
Concentration	2	-9	-9	0	-2	2	-13*	-4.0	5.6
Aggression	-1	-1	-1	-2	-1	-10	6	-1.4	
Pleasantness	3	3	1	4	-3	0	7	+2.1	
Activation—Deactivation	+ 2	2	0	2	2	-1	3	+1.4	
	- 4	-5	0	-13*	-2	0	-5	-4.1	4.45
Egotism	+ -2	-1	2	-1	1	-3	-2	-0.9	
	- 0	0	0	1	0	-1	0	0	
Social Affection	5	3	-3	3	0	2	-2	+1.1	
Depression	+ 0	0	-2	0	1	3	-2	0	
	- 0	1	-2	0	-1	0	-2	-0.6	
Anxiety	+ 1	0	1	-1	2	-2	1	+0.6	
	- 0	-2	1	2	1	2	-2	-0.3	

* These subjects showed significantly lower scores in these two mood components. i.e.—Less "concentration" and less "negatively active" that is more "active".

Continuous smokers showed themselves less able to do the task than the control non-smokers and showed less learning effects. Abstainers were less able to do the tasks while abstaining and showed a marked recovery or learning effect after smoking 3 cigarettes. Non-smokers treated (1 cigarette) had a high initial score but showed learning.

Symbols—the time intervals were too long, for the test-producing data badly skewed toward perfection. This also happened with the Addition Test.

Absenteeism—as in any trial with humans, on the day of the test subjects were missing—dental appointments, visits to the Dean and to Toronto—also caused losses. Similarity of surnames resulted in one subject being categorized in the wrong class.

Mood—Table 2. In 5 of the subjects small changes were shown in this test. 2 of the subjects, both of whom showed reliability, had significant changes when their abstaining test was compared with the test immediately after smoking 3 cigarettes.

Discussion—the competitiveness and motivation showed in the continued learning resulted in a greater change over the 1st, 2nd and 3rd trials on the test day than was anticipated. This produced a background of change which obscured other changes among the smoking groups. When it was apparent how few smokers were in the class, the trial for all practical purposes, in terms of pharmacological results, should have been cancelled, but it was continued as a laboratory exercise and because of the enthusiasm shown by the class.

Conclusions

The entire class of '71 took part enthusiastically in a clinical trial type laboratory exercise, in marked contrast to a previous animal experimental laboratory.

In terms of pharmacological effects, the small number of smokers (gratifying from a public health and example point of view) precluded any meaningful results.

There was a suggestion among the small group (7) of smokers abstaining that their performance on the tracking test was worse from abstaining and recovered with three cigarettes.

Mood changes among 2 of this group reached levels of significant change from abstaining to smoking 3 cigarettes.

Acknowledgements

This trial would not have been conducted without the support and self-organization provided by the class of '71 and their president, L. Tusz. Dr. C. W. Gowdey and the rest of the staff of the Pharmacology Department gave invaluable advice and help. Finally, Mr. J. Paterson is thanked for his help with the tabulation and analysis of the results.

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Eye-Openers

Viva la Difference

Four different races make up the British people. The Scots who keep the Sabbath and everything else they can lay their hands on. The Welsh who pray on their knees and their neighbours. The Irish who don't know what the devil they want but are willing to die for it. And the English who consider themselves a race of self-made men, thereby relieving the Almighty of a dreadful responsibility.

What's A Name?

A woman had just given birth and was busily looking through the telephone book. The nurse asked her why and she said she was looking for a name for the baby.

Said the nurse: "Why we have a lovely little book that suggests first names for both boys and girls".

"That's not what I'm looking for said the damsel, "I need a last name".

Summer Research

P. Nichol '70

Summer Externship At Scarborough General Hospital

Bill Clark '70

Last summer I had the opportunity of externing at Scarborough General, a 450-bed community hospital in northeastern Toronto on Lawrence Avenue. I had decided before starting to work at the hospital that I would try to see as many departments as possible in order to get some sort of an idea about the actual practice of many of the specialties. I was assigned to the psychiatric service for the first 2 weeks but after that I would make out my own time-table and Dr. LaForeste, Chairman of the Continuing Education Committee, would arrange it.

The psychiatric service at that time was in the process of developing a thorough and comprehensive community mental health programme for the Scarborough area and was treating on an in-patient basis, chiefly acute cases.

My daily routine on this service consisted of an adult group therapy session from 9 until 10 a.m.; from 10 a.m. until 11 a.m. I would do an admission history and physical or attend to any of the minor medical problems of the patients on the ward and from 11 a.m. until 12 a.m. we would have a staff conference, which was attended by the nursing staff, public health nurse, social workers, psychologists, occupational therapists, child care workers and the psychiatrist whose patients were under discussion. These conferences were very fruitful in developing a better understanding and insight into the patient's behavior, past history and ongoing problems and future possibilities.

In the afternoon I would catch up on any routine admissions but usually around 2:00 o'clock everything was in order and then I would work with Dr. J. Ward. This was usually the most stimulating part of the day since Dr. Ward had a mixture of individual therapy sessions, family therapy sessions and interviews of people who were in the Emergency or the I.C.U. after attempted suicides. After each session Dr. Ward would briefly explain his appraisal of the situation or would ask me to express my opinions. I look back on these sessions as my most interesting learning experience to date.

Then I rotated into surgery for three weeks since I had spent much more time than I had originally anticipated in psychiatry and I had to completely re-arrange my schedule. Most of the time on surgery, I acted as a surgical assistant for Dr. O'Dwyer and Dr. Stitt and went on patient rounds with them. When they were not in the hospital I would assist anyone operating at the time and the Sister in charge of scheduling surgical assistants gave me a wide range of operations from ophthalmology to orthopaedics. The operations in ophthalmology and E.N.T. were fascinating to observe and orthopaedics and general surgery gave me the opportunity to review some anatomy and occasionally do some active procedures and I must admit everything seems 100 times easier when you're just holding retractors or cutting ties.

Following surgery I served on Obstetrics and Gynaecology for two weeks. Routine seems like an impossible thing on this service since patients do not know exactly when they are going to deliver. I had the opportunity to assist in hysterectomies in the afternoon and the mornings varied between deliveries, D&C's, circumcisions and the Unwed Mothers Clinic on Mondays. This service was starting to become really interesting when my two weeks were over.

Medicine was my next rotation and although I worked to stay on obstetrics a little longer, I thought I should try to keep up with my already changed schedule. The daily routine on Medicine consisted of Dr. Cameron's ward rounds in the morning followed in the afternoon by reading up in the library some of the cases observed and then a few hours in the Emergency with the intern on medical admissions.

This service was very interesting as well but with only two years of medical school under my belt and very little clinical experience, at times I felt like locking myself in the library to try to find out what was going on but the interns were helpful and told me there was still much time to learn and just pick up what I can at this stage.

Although I hadn't observed as many of the fields of medicine as I had originally intended to, my summer had convinced me that the practice of medicine is stimulating and enjoyable in its many and diversified aspects and that I had a life time of learning ahead.

If anyone is interested in spending a summer externing, I would recommend Scarborough General Hospital. If you are single, residence is available. For further information contact Dr. R. La Foreste, Chairman of the Committee for Continuing Education, Scarborough General Hospital.

Summer Externship In A General Practice Hospital

Wayne Helmer '70

Thirty miles east of London, in a picturesque city of 25,000, stands the Woodstock General Hospital, a modern, well-equipped hospital of two hundred and twenty-five beds. It was in this setting that I spent my second summer as a medical student, under the watchful eye of the pathologist, Dr. Michael Dietrich, a well-known figure to second year pathology students.

Dr. Dietrich endeavoured to keep me busy through the summer months and to this end he arranged for me to start at the break of dawn (7:00 a.m.). One of my early-morning assignments involved venepunctures to collect, hopefully, blood samples which were hastily returned to the laboratory where I was instructed in hematological techniques. The laboratories at the Woodstock General Hospital are housed in the new wing, finished last year, and the facilities enable the technologists to carry out the majority of the laboratory tests of benefit to the modern practitioner. A rotating schedule enabled me to spend a few weeks in each area of the lab—hematology, bio-chemistry, cytology and 'bugs'.

The remainder of the morning was spent examining microscopic sections of the "surgicals" or of previous autopsies. I'm sure these sessions tended to brighten the day for Dr. Dietrich as he was always amused at my diagnosis. After lunch, I examined the gross surgical specimens and learned to

dictate in the special jargon of the pathologists, e.g., consistent with, similar to, etc. My greatest "find" during these sessions occurred on cutting open a uterus removed at operation—inside was a coiled plastic structure, surely the cause of the poor lady's trouble.

The summer routine was occasionally interrupted by: autopsies (10 in the first week); sternal punctures for bone marrow examination, trips to the O.R. to see interesting pathology, surgical removal of the pathologist's gall bladder and other things. The doctors at the Woodstock General Hospital were extremely friendly and helpful. I was welcome at any operations, with an opportunity to assist at most, and I was encouraged to examine patients and appear for deliveries.

Like many smaller hospitals, the Woodstock General is not a teaching hospital, but the medical staff and nursing staff are extremely interested in medical education and the learning experience is unlimited. This is particularly true of the hospital administrator, Mr. Peter Smith, who would welcome inquiries from interested students.

I would like to extend my personal thanks to Dr. Michael Dietrich, whose wit, knowledge, experience and swimming pool made for a most enjoyable summer, and to Dr. Dwight Smith, a surgeon, whose surgical skill is only surpassed by his amazing gift with people.

* * *

"Medicine is to be learned only by experience; and is not an inheritance; it cannot be revealed. Learn to see, learn to hear, learn to feel, learn to smell, and to know that by practice alone can you become expert. Medicine is learned by the bedside and not in the classroom. Let not your conceptions of the manifestations of disease come from words heard in the lecture room or read in the book. See, and then reason and compare and control. But see first".

(Sir. Wm. Osler). Pappworth M.H. A Primer of Medicine. Butterworths 1963

Meds-at-Home 1969

The annual Meds-at-home dinner and dance was held on Saturday, February 1, 1969, at the Hotel London. The members of London's foremost profession gathered in their resplendent finery to eat, drink and frolic in the best Fielding tradition. The more than 500 gathered first in the various courtesies rooms for libations, descending afterwards for a dinner in the Crystal Ballroom. The guest speaker this year was Charles Lynch, director of the Southam Press News Service. Mr. Lynch began by roundly chastising the medical profession for their lack of interest in travelling to the far-flung rural and northern areas to practice their art. In rebuttal, I would only like to say that there are more Canadian-trained physicians north of Sudbury than there are members of the Southam News Service; one might ask Mr. Lynch why he prefers to reside in Ottawa rather than Capreol. The assembled dignitaries led by the 69-ers in the back tables showed their displeasure with Mr. Lynch's opinions in their usual direct fashion—buns! Once Mr. Lynch got the idea, he settled down to talk about what he knows best—politics, and here we were all immersed in fascinating stories and opinions concerning our Prime Minister by a man who has made a lifetime of study of the Ottawa scene.

After the toasts to the Medical school and reply, Dr. H. S. Cameron showed his true colours when he informed us that the class of '69 was not the best class to graduate from Western, but that they weren't the worst. The Hippocratic Honour Awards were presented to the people who in the opinion of both faculty and students had contributed the most extracurricularly to the school. The recipients themselves stated that each award was really won by the efforts of many. Those chosen for this year were Martin Inwood, Bob Birnbaum, Dick Johnson, Reid Finlayson, Rich Hawkins and Doug Holder. Muscle-bound Jim Laing received the sweatsock award as the man who had contributed the most to athletics within the Medical School. The archive staff sends their heartiest congratulations.

After dinner, celebrants retired again to the bar and thence to the dance floor where they attempted to undulate to the strains of Ron Brown and his orchestra. All too soon the witching hour approached and the revelers went their ways to various congregations and/or to sleep (sic).

As Charles Lynch the famous or infamous journalist was the speaker, the Journal is privileged to reprint Mr. Lynch's column which appeared in the Globe and Mail, subsequent to his visit with us.

H. R. W.

MDs INCONSISTENT

LONDON, Ont. — When medical students are displeased with after-dinner speakers, they throw buns at them.

I got my share from the ladies and gentlemen of the medical school of the University of Western Ontario, but their aim was poor and I was able to get through my address unscathed, partly because the lectern provided a good shield.

Having spent the greater part of the weekend discussing the problems of the medical profession, I got the feeling its members, learners and practitioners, would like to throw buns at a lot of people, including politicians.

Here at UWO one of the big gripes is the delay in getting started on a long-awaited university hospital, due to uncertainty over federal funds for the project.

The hospital was supposed to be well along by now, adding to the number of hospital beds in the city of London, and providing a much-needed adjunct to facilities of the school of medicine.

As it is, not a sod has been turned, and the desolate site is shown to visitors as an example of the perfidy of governments who introduce medicare with one hand, and hamper medical education with the other.

The doctors themselves are not much more consistent, of course.

They argue against the evils of medicare and state intervention in the practice of medicine, and they holler for more government money to educate doctors. You have to chase them pretty hard to get them to admit the business of educating doctors is pretty highly socialized now, and that without public funds there would be few if any medical schools.

Inside the medical profession itself, there is uncertainty about the federal government's drive to bring down the price of drugs. But the MDs themselves are uneasy that

they may have been brainwashed by the name-brand drug companies.

This week, for example, the second-year class of the local medical school is off to Detroit for a look at the big drug laboratories there as guests of the manufacturers.

It's a lavish junket, and one with which students of all Canadian medical schools are familiar. The idea is to show the budding medics the meaning, and cost of producing namebrand drugs under quality-control conditions.

Once students get the idea, the companies never let them forget it—and the net effect is to produce a situation in which MDs will prescribe name-brand drugs for their patients and defend manufacturers in any showdown over prices.

The idea that generic drugs—the ones with no brand names—are cheaper is something that most doctors regard with mixed feelings. Their insistence on quality control is understandable since nobody would want to prescribe drugs of uncertain quality for their patients however cheap they might be. Will the federal government guarantee the reliability of generic drugs from places like Italy and Poland?

The doctors' problem is how to convey these misgivings to the parliamentary

committee now considering the drug bill, without sounding like a hired claque for the U.S. drug industry.

The financial attractions of medical practice are not disputed, though they have not caused any stampede to get into the profession. Half the new doctors hanging out their shingles in any given year have to be imported from overseas.

And doctors point out, somewhat defensively, that the MD is usually self-employed, a condition that carries with it financial problems as well as benefits.

There's a suspicion in the medical profession that if every lawyer reported his income under the legal heading, lawyers would be at the top of the income list. As is it, the doctors say, lawyers get caught up in corporate structures and lose their professional identity, becoming highly paid executives whose incomes don't get into the professional statistics. Very few doctors, it is pointed out, ever become corporation presidents or chairmen of the board.

The main problem the doctors seem to have is one of articulation. They are conservative by nature, and you won't find many student radicals in medical schools. They have a fear of sounding silly—as frequently, on public questions, they do. (Exit speaker, in a hail of buns.)

* * *

Letters to the Editor

The Journal welcomes letters from its readers on any subject under the sun provided the Postmaster General will allow it to be sent through the mail. Provocative, scurrilous and image shattering letters are particularly welcome.

What About the Defence?

While passing the bulletin board in the Medical Sciences Building, I was taken somewhat aback by a poster advertising a panel discussion entitled "Your Part In the Team". Under this heading was a diagrammatic representation of the "team" which consisted of doctor, dentist, nurse, physiotherapist.

To me this is analagous to a football team with a coach and the forwards only.

May I be permitted to enquire after the defence e.g., social worker, radiographer, biochemist, bacteriologist, laboratory technologist, dietician and the plethora of ancillary members?

Yours faithfully,

Michael J. Diver

Graduate Student in Pathological Chemistry

Prize Winning Papers For 1967-'68

The Rowntree Prizes in Medical History for 1967-68 were awarded to:

First Prize — Nicolass H. Buma '71

Second Prize — Daniel Slipacoff '71

Third Prize — David K. Peachey '71

The McGuffin Scholarship in Radiology was awarded to:

Martin J. Inwood '69

The prize winners have prepared synopses of their papers for publication in the Journal. The original papers may be found in the Health Sciences Library.

A History of Psychiatry

Dan Slipacoff '71

As Francis Bacon once said, "What is present depends much upon what remains behind". Definitely before we can have a working knowledge of the concepts of modern psychiatry, we must have a firm background of the beliefs that have been held by our predecessors.

When we study disease of any kind in primitive society, the most striking feature is that all illness, physical or mental, was regarded as having the same basis—"bewitched by the devil". Therefore, in those cultures, magic, religion and medicine were intricately intertwined. Sick or old, people were killed off as probably were the mentally ill.

In examining the earliest monotheistic nations, we find little change. The early Jewish, Chaldean and Assyrian societies grew from demonology, with a basic hostility towards those afflicted with neuroses and psychoses. Mental illness was observed and found its way into the Bible. Saul apparently suffered from recurrent depression, both homicidal and suicidal. Also, the ecstatic states of some of the prophets were very suggestive of pathological mental states. In Leviticus, it is plainly stated that "a man also or woman that hath a familiar spirit, or that is a wizard, shall surely be put to death; they shall stone them with stones: their blood shall be upon them". This reference is particularly important for in centuries to come, it was used as justification for the execution of the mentally ill.

The Hindu culture appears to be a link between demonology as shown in primitive societies and the more scientific outlook on mental disorders as expounded by the Greeks. Similarities between the two include the soul inhabiting the heart, finding expression through parts of the body, and possessing characteristics close to our ideas of perception (called *manco* by the Hindus), intelligence (*boudhi*), and consciousness (*ahinbara*). The Hindus believed in transmigration of soul and that the act of uniting the body and soul was accomplished when a human being was born. The working state was a manifestation of this unit, as was dream, deep sleep and ecstasy. Death was regarded as a parting of body and soul. In India today, one finds the effects of these beliefs, for if one was to accept transmigration then by having many children this would give more bodies for the free souls; thus even though pestilence pervades today, fecundity is still a dominating feature.

The roots of Greek medicine were found in man's uncertainty and his obscure speculation on his place in the world. The healer was regarded as the spiritual and medical authority of society. Aesculapius is considered the god of medicine and Hippocrates the Father of Greek Medicine. In spite of such obstacles as mysticism and abstract philosophy, Hippocrates introduced psychiatric problems into medicine. He fostered the separation of medicine from philosophy and theology with the

often mentioned view of illness as a natural process moving toward recovery, chronicity, or death.

He classified mental disorders into phrenitis, mania and melancholia; described what was later known as neurosyphilis and recognized the relationship between elation and depression which Kraepelin later showed is different phases of the same diseases.

In 130-200 A.D. we come to the great Galen, who classified mental disorders into physical and emotional. He spoke of patients whose reasoning power was affected and called this condition anoxia. Galen's major role was to insist that the physician be a dissector—definitely a revolutionary thought and did much to further the subjects of anatomy as a science. Galen described hysteria as having its origin in the uterus where sperm was retained and underwent putrefaction. Hippocrates believed that wandering of the uterus caused hysterics and recommended marriage and pregnancy as a treatment.

Between the fall of the Roman Empire (476 A.D.) and the early part of the eleventh century—the Middle Ages—or “the Epoch of Retrogression”, the early development of Christianity led to the revival of supernaturalism, the spread of theology, and the extension of faith healing, under the dominance of theology. Nevertheless, a hospital specifically for the mentally ill appeared in Jerusalem in 490. Rhazes (841-926), a great Persian physician, headed a hospital in Baghdad which had a section for the mentally ill.

Batholomaeus had a humane attitude toward the mentally ill and an interest in occupational activity for such patients. Witches were sought when it came to impairment of sexual and intellectual functions. Spain, known as the “cradle of psychiatry”, seemed to be ahead of the rest in establishing psychiatric hospitals and in 1425 an asylum was established in Zaragoza.

During the Renaissance (1300-1500), psychiatry (with other branches of medicine) was still generally backward although hospitals were being built. Vives (1492-1540) showed the thought of the times for, although some were treated kindly, others were treated with cruelty. “Remedies suited to the individual patients should be used. Some need medical care and attention to their mode of life; others need gentle and friendly treatment, so like wild animals they may gradually grow gentle; still others need instructions. There will be some who will require force and chains, but these must be used so that the patients are not made more violent. Above all, as far as possible tranquillity must be introduced in their minds,

for it is through this that sanity and reason return”.

During the 17th century belief in the devil and involvement in issues dealing with witchcraft were linked with men with high reputation in medicine. This might not be too surprising if one realizes that in the 20th century, the Minister of Social Affairs for Lower Saxony in West Germany, having investigated witchcraft for one year, is conducting a campaign to exorcise this superstition.

Rene Descartes, a French physician-philosopher, proposed that the pineal gland was the seat of the rational soul. Descartes ‘Six Metaphysical Meditations’ contain the following statements:

“I am as long as I think; For it may be that when I cease from thinking, I may cease from being . . .
It necessarily follows that I am because I think”.

One of the outstanding men of the 18th century was Franz Anton Mesmer (1734-1815) who aided in the development of Mesmerism, hypnotism, and psychoanalysis. He originated the modern versions of the doctrine of Animal Magnetism. Although considered a quack by most physicians, a small group of psychoanalysts regard him as one of the founders of their craft. He tried to prove that the sun, moon, and planets acted on living beings by means of a subtle fluid called “Animal Magnetism.”

In the 19th and 20th centuries, we find psychiatric activities focussed on attempts to solve basically four questions:

1. Why does one person become mentally ill and another not?
2. Why does this person break down in a particular time period?
3. What determines the pattern of abnormal behaviour?
4. What is the origin and meaning of each individual symptom or expression within the pattern of behaviour?

During the period 1800-1900, psychiatry built up classifications of the psychoses. In 1805, Johann Christian Reil founded the first journal for mental disorders and is regarded by some as the father of modern psychiatry.

Jean Martin Charcot (1825-1892) was among many investigators examining hypnosis at this time and has been credited with hypnosis respectable. For him hypnosis was really an experimental neuroses. He also did much work on hysteria. “It is to the ovary alone that one has to look for the source of the fixed clear pain of hysterics . . .” He was however, unaware of the psychological aspects of hysteria.

Sigmund Freud (1856-1934) devoted most of his early work to neurology and he used electrotherapy to treat neuroses. The collaboration of Freud with Joseph Breuer (1840-1925), who had been working with hypnosis in connection with neurosis, played an important role in the development of psychoanalysis.

Alcoholism was a concern to many psychiatrists at this time. Wernicke described alcoholic hallucinations; Thomas Sutton studied delirium tremens, and Korsakoff became identified with multiple neuritis, memory deficiency, disorientation, and confabulation. Paranoid conditions were first described in 1868 by William Sandler. Another important step was the study of Kohlbaum on catatonia and he introduced the term, "cyclothemia". Kraepelin (1856-1926) took a big step in moving psychiatric thought from a philosophical nature towards a more scientific basis. He studied many reaction patterns and classified them as simple, phrenic, catatonic, and paranoid. He was concerned with causes of mental illness and the relationship between psychotic states and infectious diseases.

Jung (1875-1961) was not satisfied with the dominance of the basic sexual theories as proposed by Freud and thought the ego and spiritual parts of the person demanded more attention. Whereas, Freud's contributions were mainly directed to the neuroses, Jung was particularly concerned with schizophrenia.

Another deviant from Freud was Alfred Adler (1870-1937). He became interested in the general feelings of inferiority in the individual, which he thought were engendered by inadequate growth, structure and performance.

Adolf Meyer is mentioned frequently as the leading psychiatrist in the United States during the first half of the 20th century and has been referred to as the strongest link between the medical psychology of Europe and America. "We know now that we must attack the psychiatric problem from the biological site, from the point of view of mental, physical, and physiological pathology". A large step was taken by Manfred Sakel (1900-1957) who developed insulin shock treatment for schizophrenia.

During the early 20th century, pharmacotherapy came into prominence for the reduction of anxiety and diminution in the intensity of neurotic and psychotic symptoms. Surgical procedures were initiated in 1936 by Egos Maniz.

Much has been written as to what the future holds for psychiatry. In the past, the development of psychiatry reflects advances and retreats, and periods of light, and darkness. I think the author S. M. Schneck has the right attitude when he stated: "One is justified in having faith in the years to come; psychiatry will continue to play a fundamental role in the healing art of medicine and in the scientific study of nature and the search for the truth. Precisely what the future holds in store, remains to be seen . . ."

The Black Death

David Peachey '71

In the Middle Ages, the term "plague" was used very generally to describe all fatal epidemic diseases. Today however, "plague" is a much more qualified word, used to describe an acute, infectious, contagious disease of rodents and man that is caused by a short, thick, gram-negative bacillus, "Pasteurella pestis," or simply, the plague bacillus. The disease in rodents is called sylvatic plague, while in man there are three types, bubonic, pneumonic and septicemic. The most widely known form of the disease is bubonic plague and is so called because it is characterized by the appearance of "buboes" or large, inflamed lymph nodes in the groin or armpit, or on the neck. Bubonic plague is usually transmitted by the bite of one of many insects that are normally para-

sitic on rodents. When the rodent dies, the insect can continue to live from it for about two months, at which time a new host is sought. If no other rodents happen to be available, then the new host is most likely to be man. The most important of these insects is the rat flea, "Xenopsylla cheopis." Bubonic plague may metastasize to the lungs, thereby causing pneumonic plague, or it may lead to a general blood-stream infection, causing septicemic plague. Septicemic plague can also arise from direct contact between any object contaminated by the plague bacillus, and the mucous membrane of the nose and throat.

The first symptoms of bubonic plague are headache, aching joints, general malaise,

nausea and vomiting. Then, suddenly, the lymph nodes of the groin, and less commonly of the armpit and neck, are painful and swollen. The sufferer's high temperature, which is accompanied by shivering, varies from 101°F. to 105°F. The pulse rate is high and respiration is rapid and deep. Toxins from the plague bacillus attack both the right side of the heart and the kidney tubules. Then, congestion of the brain causes depression, dizziness, restlessness, stupor and finally a degree of maniacal delirium. If the attack is not fatal, the temperature gradually decreases until it is normal, about two weeks after the onset of the disease. Otherwise, death occurs within five days. The first signs of pneumonic plague are exhaustion and fever, accompanied by bad coughing spells and painful breathing. The victim's sputum is slimy and tinted with blood. At a later stage of the attack, the sputum is free-flowing and bright red in colour. Death from pneumonic plague occurs within two or three days from the first signs. Septicemic plague is characterized by the sudden onset of an extremely high fever. Within several hours, the sufferer's skin is marked with purple blotches which eventually fill in the whole surface of his body. Death from septicemic plague takes place within twenty-four hours of the onset of the attack. The purple colour is typical of the last hours of victims of all forms of the plague and is due to respiratory failure. The colouring accounts for the ominous name for the disease, the Black Death.

The earliest recorded epidemic of the Black Death is 224 B.C. in China. The next recorded epidemic is indisputedly the most horrible of history. Conservative historians estimate that between 1347 and 1350, the Black Death exterminated one-third of the population of Europe. It paid no heed through which doors it trespassed. It was blind to age, wealth and colour. At Narbonne, one-quarter of the population was killed and at Béziers, eighty-five percent. One hundred thousand died at Rouen and another one hundred thousand at London. The death toll at Norwich mounted to fifty-seven thousand. This grim list is endless. No war has ever caused such losses but the two World Wars shook the foundation of mankind. One can barely imagine, therefore, the physical and moral impact of the Black Death on the Middle Ages. During the next three hundred years, the plague returned periodically in less hostile manners. In 1665, a climax was again reached in England. In London alone, seventy thousand deaths were recorded (twenty percent of its population). Then, from England the Black Death spread South and East. The following year was

marked by the Great Fire of London, after which the plague disappeared from England, and shortly thereafter, from Europe. In the East, the disease remained endemic until 1894 when another epidemic struck China. From there, it struck Africa, Australia and finally America in 1900 at San Francisco. In 1924, an epidemic at Los Angeles claimed thirty lives from the thirty-two sufferers. Plague-infected ground squirrels were found in Nebraska in 1935. In 1956, extensive treatment failed to save the life of an isolated victim in California. Therefore, it is easily seen that the Black Death has gradually diminished throughout the world. In fact, in 1959, less than 300 died from it in all the world. Much effort and money is annually put forth to maintain this level. The greatest problem in the world today is in Asia, followed, in order, by Africa, South America, and surprisingly, Australia.

As has been proven throughout history, mankind's terror never fails to lead him to extremes. The Scots in derision dubbed the Black Death as the "foul death" of the English until it crossed their border and eliminated one-third of the population. Some accused the convenient Jews of poisoning the air and the wells. Many considered that the uncertainty of life justified their enjoyment of all license. Others thought that their only hope was in placating an angry God, while still others thought that any attempt to stop the progress of the disease was sacrilege.

The scientific warfare against the Black Death was held back tremendously by the lack of knowledge of microscopic life. In 1880 some of this knowledge began to be acquired, giving a spark of hope to the researchers that struggled with the plague. However, it was not until 1894 in Hongkong that Alexandre Yersin, a pupil of Pasteur, and Shibasabura Kitasato, a pupil of Koch, made the first great advance in the history of the conquest of the disease. Working independently, these two men were able to isolate the bacillus pestis. At last the laboratory struggle against the Black Death had a starting place from which to work. The association of the Black Death with rats was so obvious that it was noted by numerous scientists much before it could be proved. The close relation between the two was shown to be invariable, but the exact nature of the relation was still an unanswered question. One hypothesis, put forward by P. L. Simond of Spain was that the disease was transmitted by infected fleas. This claim was put to test by the First Indian Plague Commission and was, somehow, found faulty and discarded much to the surprise and disappointment of workers around the world. Then, in 1902, Bombay witnessed one of the most interesting developments in the war

against the Black Death when Professor W. M. Haffkine developed a plague vaccine. Part of his production, which showed great promise from the start had been to treat his culture with carbolic acid, the purpose of which was to kill the bacilli but leave unharmed the anti-toxin. In an effort to meet a quantity demand from the Punjab, the acid was omitted. As fate would have it tetanus germs were in a particular bottle and all inoculated from it died. After a prolonged investigation, the Haffkine laboratory was exonerated, and he was re-employed by the government of India. In 1907 the Second Indian Plague Commission announced that their predecessors were wrong and that the fleas were definitely plague carriers. The commission proved its case with an extremely simple experiment. Cages containing rats were hung at different heights with plague-infected fleas hopping about below. The rats that were suspended above the four inch high jump record of the fleas remained healthy, while those within range sickened and died.

What lies in the future with respect to the Black Death? Undoubtedly, sufficient funds and dedicated workers will prevent a recurrence of the tragedy of the past. Perhaps this sentiment was best expressed by

one of the great researchers of the plague, Dr. Victor Heiser. "New York is a safe port. The New Yorker may seek his Sabine Farm as a pleasant refuge; he need never be driven there by the blind panic which possessed the citizens of Florence when the Black Death had stormed their walls and taken their city in a sad and wonderful manner.' But the citizens of San Francisco, Mobile and New Orleans must still exercise vigilance if they wish to sleep in peace." Within this passage, Dr. Heiser gave the most apt non-medical description of the Black Death that can be found. The Black Death was indeed a sad and wonderful thing.

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Length of Essay was 2,500 words.

A Review of Radiation Induced Human Chromosome Aberrations

Martin J. Inwood '69

The purpose of this paper was to present a review of human chromosome aberrations as induced by ionising radiation. Up until the last ten years, almost all the knowledge in radiation induced chromosome changes had been obtained from studies on plant cells and chromosome preparations from various animal species other than human. Recently however, there has been a steady accumulation of information on the response of human chromosomes in this regard.

After introducing the subject in terms of definitions and experimental problems, the author discussed human chromosome damage under five main headings:

1. Chromosome aberrations associated with ionising radiation.
2. The effects of accidental radiation.
3. The effects of diagnostic X-rays.
4. The effects of Therapeutic radiation.
5. The effects of parenterally introduced ionising preparations.
6. The effects of chronic exposure.

In all the above instances chromosome aberrations have been noted either as a long or short term effect. However, it has been very difficult to relate the length and dose of radiation to the expected degree of

chromosome damage. Certainly damage does occur, but how this may be interpreted is subject to an extremely large number of variables.

The discussion contained within this paper endeavoured to examine the fact that if any practical significance can be attached to the use of induced chromosome aberrations as an index of somatic damage to a patient, a greater degree of control must be exerted on the many variables involved. This is particularly relevant when considering standardization of culture and karyotyping procedures, the formulation of specific dose-aberration indices, and the need for

more exhaustive and fully controlled prospective studies of irradiated individuals.

The eventual hope would be that if aberrations are permanently present after a patient's exposure to ionising radiation, these will either be proved to have no effect or conversely a detrimental effect on the person's life expectancy or general health. These are some of the questions that have been concerning many workers in this field and to some degree, they are being answered slowly but surely.

Length of essay 5,700 words; sixty-eight references cited and eight illustrations.

* * *

Book Reviews

AN INTRODUCTION TO CLINICAL ANATOMY BY DISSECTION OF THE HUMAN BODY

R. D. Laurenson, M.D.

The purpose of this book is to make certain that medical students spend their time in the gross anatomy laboratory to their best advantage, not just going through the motions of dissection but learning the facts that their clinical instructors use and expect students to know.

So begins what is sure to become one of the most talked-about textbooks of the year. In this distinctly fresh presentation of a traditionally dull subject, Dr. Laurenson provides a most welcome service not only to the first year medical student grappling with the minutiae of anatomy, but also to anyone wishing to understand the truly important facts and concepts of anatomy.

The style of writing is personal and direct, and little time is devoted to merely academic excursions. In essence, general principles are emphasized and specifics are played down. For example, the traditional descriptions of muscles with their origins, insertions, nerve supplies, blood supplies and actions and the exhaustive descriptions of the courses and relations of the blood vessels, all of which are found in all of the major texts are not included in this volume. Instead, significant anatomical information and relevant clinical material are integrated into clearly expressed concepts which the student is more apt to remember and to utilize.

Dr. Laurenson is to be congratulated for producing this illuminating and irresistible book.

W. B. Saunders, Philadelphia, 1968. 522 pages. Illustrated.

M. S.

FUNCTION OF THE HUMAN BODY

A. C. Guyton

As the author states in the preface: "the purpose of this text is to provide a survey of the major facts and theories in the field of human physiology. Yet the field is so great that it has been possible to cover only a small fraction of it".

These two sentences do indeed sum up the chief faults of this book, at least for a medical student readership. Too much has to be covered and too small amount of space is available to adequately explain and clarify the material. As a student reviewer it would appear presumptuous to comment on specific items. However, when the whole subject of hemostasis and intravascular coagulation is covered in three pages using outdated nomenclature and theory, one can only excuse this in the interests of brevity rather than communication.

Nevertheless if a student requires a well bound, well illustrated text which at least presents the important aspects in a superficial but readable manner then he or she must include this book in their library. However, this writer is of the opinion that it is more suited for the paramedical professions rather than the aspiring physician.

W. B. Saunders Co. Ltd., Toronto, 1969. 475 pages. 3rd edition, \$9.20.

M. J. I.

Alumni Section

As the members of our illustrious alumni have been more than reticent in volunteering any information pertaining to their activities, professional or otherwise, it was considered that the Alumni Editor should endeavour to interview certain alumni who have distinguished themselves in a variety of ways(sic). The selection is purely on merit and word of mouth and it is hoped that the sage advice and professional accomplishments which will be read of in succeeding issues will act as a source of encouragement to the benighted plight of the degreessless undergraduate.

Lloyd Grenfell Stevenson,

B.A., M.D., Ph.D., D.Litt., Meds '44



Webster's New World Dictionary defines History as "the branch of knowledge that deals systematically with the past; a recording, analyzing, co-ordinating, and explaining of past events." To most of us history is a subject that we studied in high school and as it is particularly applied to medicine a rather small part of our first year in Medical School. Not all of the graduates of our school have gone on to promptly forget everything that they learned with regard to Medical History. Dr. Lloyd Stevenson has made it his life's work.

Dr. Stevenson was born in London, Ont. in 1918. He graduated from Western with his B.A. in 1940, and again in 1944 with his M.D. After a year (1946-47) of trying to teach U.W.O. medical students some of the history of their chosen profession, he moved

to Baltimore, Md. and Johns Hopkins University where he obtained his Ph.D. Following a year of study in Great Britain, Dr. Stevenson returned to Western and taught the History of Medicine until 1954. By this time he had written two books, "Sir Frederick Banting" and "Nobel Prize Winners in Medicine and Physiology 1901-1950", along with several papers.

1954 saw Dr. Stevenson move to McGill as Assistant Professor of Medical History. In 1956 he was appointed Dean of the Faculty of Medicine and Professor of History of Medicine. Dr. Stevenson received an Honourary M.A. from Yale University and was appointed Professor of History of Medicine and Chairman of the Department of the History of Science and Medicine at Yale in 1963. He held this position until last year when he was appointed the William H. Welch Professor of the History of Medicine and Director of the Institute of the History of Medicine at John Hopkins University.

During the last twenty-five years, Dr. Stevenson has maintained a lively interest in researching and elucidating the history of the Life Sciences. Topics such as the history of eighteenth century vitalism, centering on John Hunter, and the history of Diabetes have attracted his attention. The history of lead poisoning and other types of industrial poisoning have led him to an interest in the concept of poisoning in general culminating in a book entitled: "The meaning of Poison: Logan Clendening Lectures on the History of Philosophy of Medicine."

Teaching duties for Dr. Stevenson include a survey course in the History of Medicine together with a graduate seminar, the subject of which changes from year to year. He is also responsible for supervising the thesis of M.A. and Ph.D. students and the elective work of medical students.

When I wrote to Dr. Stevenson, I included several questions which seemed at the time to be of interest to Western students and faculty, and asked Dr. Stevenson to comment on any or all. He chose to answer my query, "What part should a student play in the planning of curriculum?" This was his reply:

"One part the student can, and must play is to provide information otherwise unobtainable. The curriculum plan as written out and discussed may have little relation to the curriculum as in fact experienced by the student, and his comments in this regard are vital. He should also, I think, report his opinions (making sure, if he can, that he is

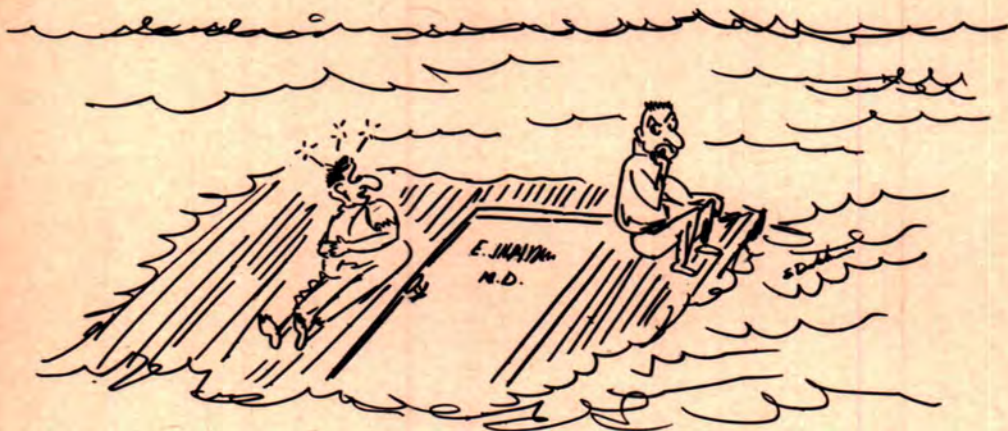
not tamely lending himself to some sort of activist propaganda) on the effectiveness of various procedures. Some teachers easily delude themselves about the value of their favourite techniques in teaching. About the actual content of the curriculum I do not think that student opinion is particularly valuable. Why should it be except in the sense already indicated? Wherever, of course, a curriculum issue affects the student primarily in his capacity as a student, he ought to be consulted from the beginning. In short, I think he has little place in the selection of WHAT is to be taught but a major part in choosing HOW it is to be taught."

In case you don't agree with him, Dr. Stevenson has suggested a course of action: "why not stick pins in the attached photograph or throw it in the fire? This might rate as a piece of research in primitive medicine."

Bob Page '71

* * *

Doodle by Dobkin



"O.K. so you only see patients by appointment, but this is different."

* * *

Blackout

A woman got into a bus with her baby. The conductor looked at the baby and said, "My goodness, what an ugly baby!" The mother was upset and so she told the conductor she would report him to the company. After some time an inspector came along. "I wish to report that conductor," said the woman. "He was extremely rude to me."

"Very well, Madam. Write down his number and the complaint you wish to make."

I haven't any paper or a pencil," she replied.

"Here you are", said the inspector, handing her a notebook and a pencil. "You write it down while I hold the monkey."

News and Views

Pat Porte '70

THE DEAN HAS A NEW ASSISTANT

Dr. J. M. Thompson has been named Assistant to the Dean-Postgraduate Education in the Faculty of Medicine. He will be assistant to Dr. D. Bocking, Dean.

Dr. Thompson assumed this new part-time post on Mar. 1 of this year. He will assist in co-ordinating the residency training programs in the affiliated teaching hospitals.

Dr. Thompson graduated from Western with an M.D. degree in 1961. He took post-graduate training in Internal Medicine and Rheumatic Diseases at Duke University, Durham, North Carolina and at the Royal Postgraduate Medical School, London, England.

He is a Fellow of the Royal College of Physicians of Canada. He returned to London in January, 1968 and is an Assistant Professor in the Department of Medicine holding a geographic full-time appointment at St. Joseph's Hospital.

SMITH-KLINE & FRENCH AWARD GIVEN TO MEDICAL STUDENT

Mr. Harry J. Bergen, a third year Medicine student, has been awarded a Smith-Kline & French Foreign Fellowship to spend nine weeks working in Thailand this summer. He will work as an assistant to the doctors in various capacities at Manorom Christian Hospital, about 300 kilometers north of Bangkok. At that hospital there is only one doctor for approximately 250,000 population.

These Fellowships have been established to provide selected medical students with special opportunities complementary to their training—to benefit from an unusual clinical experience; to view and practise preventive medicine in greatly differing societies and cultures; to observe and study diseases not common to Canada; and to realize more fully the acute need for medical knowledge and care in remote areas of the world.

Mr. Bergen, a native of Brantford, Ontario, has been at Western since 1954, entering Medicine in 1966 following second year honors Biology. During his undergraduate years, Mr. Bergen has been very active in the Student Christian Movement and also in the activities of the U.S.C. on campus, in addition to maintaining an excellent academic record.

CANCER RESEARCH GRANTS AWARDED TO THREE

Three Faculty members of the Faculty of Medicine have been awarded grants by the Ontario Cancer Treatment and Research Foundation.

Dr. Carol K. Buck, Professor and Chairman, of the Department of Community Medicine, received \$5,861 for the investigation of the "Relationship between smoking in pregnancy and cancer in children".

Dr. E. R. Plunkett, Professor and Chairman of the Department of Obstetrics and Gynaecology, received \$14,300 for research on the "Environmental factors in human mammary cancer".

Dr. Kathleen M. Stavray, Assistant Professor in the Department of Community Medicine, received \$6,011 to investigate the "Factors associated with the development of breast cancer in premenopausal versus postmenopausal women".

TENDERS TO BE CALLED FOR UNIVERSITY HOSPITAL

The London Health Association has been granted permission to call for tenders for building the University Hospital at an agreed upon reduced total cost of \$35,400,000.

The Association obtained permission by agreeing to use its own funds rather than government funds for the first year of construction.

Tenders were issued Mar. 17 with the deadline for bids to be April 30. Construction will proceed as soon as final approval is given by the Ontario Hospital Services Commission.

In order to avoid a one-year delay which was caused by the government's temporary cutback in funds for new teaching hospitals, the Association has to meet two conditions: it had to reduce the estimated cost of building and equipment from \$42,000,000 to \$35,400,000; and it had to agree to provide enough private money to carry the cost of the work until April 1, 1970, the end of the forthcoming government fiscal year. The province has agreed to allocate \$30,400,000 but not during the coming fiscal year.

OHSC approval comes in four steps: approval in principle; approval of working

drawings and specifications; permission for the tender call; and finally approval for the contract and actual construction.

Construction of the hospital will take 2½ years.

Class News

MEDS '69

"Studying more and more and enjoying it less and less" is how it goes with us. This time of year finds more of us more anxious than ever before. Those that chew fingernails have them right down already; others are on tranquilizers and sleeping pills and the rest of us can't stay out of the refrigerator. Family dogs are getting kicked and wives are getting yelled at. But, oh my, never has the rift between what we know and should know been so wide, and gone is the excuse "Oh, I'll learn it next year". Rationalization is our major defense mechanism: "Relax, no one ever fails at this point". I suppose too, that disillusionment might rank high on the list of feelings. We find at the end of medical school that we don't have all the answers—only a heck of a lot of responsibilities.

Well, as '69'ers there's something we can do well: congratulations are in order for the Veenman's who now have a baby girl and the Finlayson's, a baby boy and also the Inwood's another girl to add to their wonderful collection. The offspring of the Schiefel's hasn't arrived yet.—Ed. A boy!!

Saturday of March 1 saw the whole of Meds '69 gathered together for the first time since the first of the year. The event was a very formal meeting at the North End to fill out dozens of papers with regard to making application to write our finals. It was a rather unnerving experience to discuss the proceedings in the event of a failure. It was much more fun to discuss the plans for graduation celebrations, but it still seems to me as far away as it ever has.

The class had a party at Beta Sigma Chi on March 5 to show our collection of slides of the class collected over four glorious years. They were accompanied with much laughter and hooting. Think how we'll be laughing in 5 years!

5 Year Class Executive:

Honourary Class President—Dr. H. Barr
Class President—Martin Inwood
Vice-President—John (Tiger) Tasker
Secretary-Treasurer—Linda Richardson
Social Chairman—Bob Birnbaum

Linda Richardson '69

MEDS '70

Due to an editor-correspondent heteropatibility in last term's Journal, Dave Carswell's wife's name was omitted—her name is Carol, last name Carswell and pretty she is too.

The honourable William Wassenaar has been in office as class president for several months now and has instituted strict Parliamentary rules. The necessity for formal procedural rules at class meetings hardly seems warranted with the air of compatibility, congeniality and brotherhood pervading our class.

Unless another vote or two is taken in the meantime, neo-psychiatrist Dr. Wm. Keil is our Honourary Class President until January, '70—at which time several more motions will be introduced, discussed and discarded and Dr. Keil will be re-elected or appointed as our H.C.P. until 'death do us part'.

Payment of class dues of \$3.00 has been an unnecessarily contentious issue this year for reasons not clear to many. Explanation lies in the phenomenon of "psychofundamentalism" a manifestation of a general cerebral geographic pattern determined by electromagnetic forces at the time of conception. Examples of the aforementioned may be elicited by asking non-payers their motives. We do not condemn such action, believing it to be strictly a personal choice.

The 3rd-4th year party was not held prior to press but we extrapolate it to be a huge success.

Don Parks '70

MEDS '71

Meds '71 entertained some of the braver faculty members at a wine and spaghetti dinner on February 12. Our chefs, Jane Wachsmuth, Jean Humphrey, Bruce Bocking and Bill Payne, did an excellent job. Our guest speaker was Dr. L. D. Wilcox.

Highlight of the evening was the presentation of an engraved chisel to Dr. John Girvin, our Honourary Class President. Dr. Hugh Barr accepted the award for Dr. Girvin, who was unable to attend.

A few outstanding members of '71 also were honoured by the presentation of highly original and slightly questionable awards.

During the dinner it was proven without a doubt that buttered French bread is a far superior missile to dried buns.

The annual Parke-Davis trip was held on February 2nd and 3rd. A good time was had by all.

Meds '71 and '72 combined efforts this year for the CAMSI Drug Appeal. Volunteers from both classes collected a total of 810 pounds of drugs, donated by doctors throughout the city. The drugs were brought back to the school where they were sorted and packaged. They will be sent to mission hospitals.

Our new Class Executive for 1969-1970 is:

Hon. President: Dr. J. P. Girvin

President: Jim Gatrall

Vice-President and Social Chairman:

John Reason

Treasurer: Ben Sawyer

Merrymaker: Bob Page

Sports Rep.: Joe Powell

CAMSSI Rep.: Greg McGregor

Liaison Committee:

Jim Gatrall

Lou Tusz

Jim Hicks

Ruth Nelles

MEDS '72

Meds '72 greeted 1969 in much the same manner as it said goodbye to 1968, only instead of a sleighride party with no snow, it was a tobogganing party in the rain. This trend of events could cause some consternation to an easily daunted group of individuals, but most of those who showed up managed to suppress any anxiety over the inclement weather and thoroughly enjoyed the hospitality of Sheila Zurbrigg who had generously offered her home for a party afterwards.

With the exception of the Meds Ball, the rest of the third quarter went rather uneventfully as far as class social activities were concerned, culminating (admittedly, not the best word) in a week of term tests and what was to be an anatomy oral exam. The unexpected cancellation of the latter, though greeted with varying degrees of ecstasy at the time, merely postponed the hour of agony until the end of year when time and freedom from anxiety is available!

Late in March the class extended its warmth in more ways than one to those members of the faculty who chose to attend our lavish banquet. The year-end party promises to be an even more uplifting experience.

Among the events of the past few months that shouldn't go unmentioned are the birth of a baby boy to Grant and Sheila Peek, and by the time this appears in print Evelyn Bromberg will have become the first mother in the class. Meds '72 will be sorry to lose Sara Taman whose marriage plans necessitate

a transfer to U. of T. The number of bachelors in the class will be noticeably reduced in September. Among those planning on tying the knot this summer are John Shier, Ken Warren, Paul Zickler, John Bowman, Rex Garrett, Blair Fraser, Rick Irvine and Louis Balogh.

The class will be scattered far and wide over the summer months but a remarkably large percentage will be remaining in London, including several on summer scholarships at the Medical School.

Marilyn Hopp '72

HIPPOCRATIC COUNCIL BRIDGE TOURNAMENT

On Thursday, February 27, a successful bridge tournament sponsored by the Hippocratic Council was held in the school cafeteria. The tournament was open to medical students of all years, with a total of twenty-four taking part.

The winners, with a total of 58 points were Mike Noble and John Boekhoud of Meds '72. Next were Dave Peachey and Bruce Bocking (Meds '71) with 51, Blair Marchuk and Bob Marsden (Meds '72) with 50½, Warren Harrison and Rich Tiegs (Meds '71) with 49½, and Juho Krepp and Tom McKay (Meds '70) also with 49½. Other participants were Kelly Stapleton, Sheldon Baryshnik, John Reason, Paul Willoughby, John Shier, Bob Brock, Carol Colthart, Bob Henderson, Jean Humphrey, Marilyn Clysdale, Bev Stuart, John Feightner and Keith Rose.

The success of this tournament has encouraged the possibility of it becoming an annual event, with a trophy being presented to future winners.

* * *

The trouble with tranquilizers is that you find yourself being nice to people you don't like.

An uncrowded highway always makes us nervous—we're afraid everybody else may know something.

Intoxication—When you feel sophisticated and can't pronounce it.

Anybody who can swallow a pill at a drinking fountain deserves to get well.

Now that I'm officially 18, I don't know whether to get married or go out and see an adult movie.

Poets' Corner

The Battle of Furunculus

STAPHYLOCOCCUS Aureus,
By Gram and Koch he swore
He would invade new regions
Unconquered heretofore,
By Gram and Koch he swore it—
To take a patient's life,
And called the Cocci, young and old,
From all his colonies of gold
To aid him in the strife.

Loud rang the warning toxins,
And flashed the summons forth
On the distant slopes of Agar
And the turbid seas of Broth;
The Cocci clustered thickly
From far-off lands and labs,
Cocci of ancient culture came,
To come by tube they thought no shame,
But others of a fiercer fame
Drove up in acne scabs.

The septic hosts of Cocci
Advanced in serried ranks,
They marched upon the Blood Stream,
and camped upon its banks;
Forth flew the watchful blood-cells
Crying in wild turmoil:
'Staphylococcus Aureus
'Has come and raised a boil!

Far down the purple current
Was born the direful shout—
The polymorphonuclears
And lymphocytes rush out;
Shame on the Eosinophil,
Who comes not forth to foil
The deadly Golden Coccus
At the Battle of the Boil!

And fiercely raged the conflict,
And thick lay strewn the dead;
The Battle of Furunculus
Was coming to a head!
The pale and lifeless pus cells
In scores were borne away,
But not a single Coccus
Survived that bloody fray.

Staphylococcus Aureus
Still wields his golden chain,
Where falling in the central slough
His friends around lie slain;
Surrounded and outnumbered
Still valiantly he fights—
He sees his tawny hosts grow less,
He sees the battle's hopelessness,
Yet ever through the Yellow Press
Defies the leucocytes.

Staphylococcus Aureus
Has fallen in the fray,
Upon a martial coverslip
They bore his corpse away—
Lying in state in Canada
Embalmed he long remained,
For through he dyed Gram positive
His honour was unstained.

And still at festive seasons,
When the blood is really stirred,
Before the full post-prandial rise
Of white cells has occurred,
Then the phagocytes sit waiting
With platelets undersized
For the evening meal of microbes
Which is being opsonized;

When the trembling Eosinophile
That wrought the deed of shame,
Immune from fresh invasion
Comes forth his share to claim,
And talks of Staphylococcus,
And mocks his ancient fame
(For now the Yellow Peril
Is nothing but a name);

Some old and hoary leucocyte,
Who finds he's in the vein,
Will tell the well-known story
Of his battles once again;
While blood cells sit in roudeaux round
To hear the tale re-told
Of the battle of Furunculus
In the brave days of old.

Anon

* * *

Crooked Lake, 1966

The cold sharp wind
Whistling through the near spruce trees,
With a moaning ethereal sound.

The thin gray ice
Breaking on the shore,
Like the tinkling of a thousand distant
Chinese chimes.

The gray-blue clouds
Scurrying across the sky,
To warn that winter has not left.

The mist gray trees
Waiting patiently for sun and rain,
To nourish cover for their naked bones.

The fast black duck
Defying cold and wind,
Majestic in his long flight north.

The bright luminous fire
Dispelling all our fear,
It is April and the Spring draws near.

Dr. D. M. Mills

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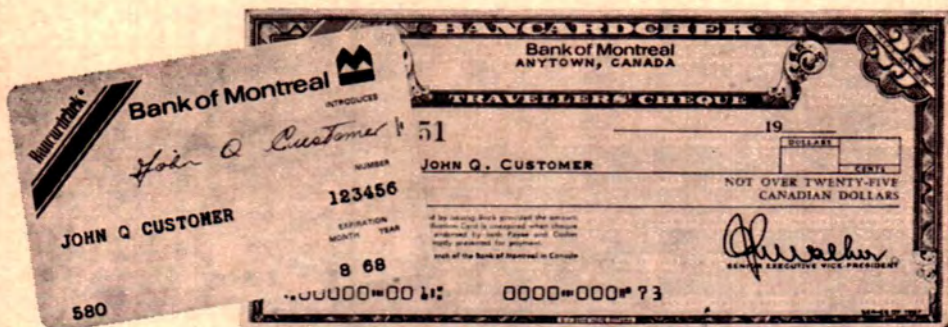
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