

# St. Bartholomew's Hospital



Journal.  
1918—19







Official copy.

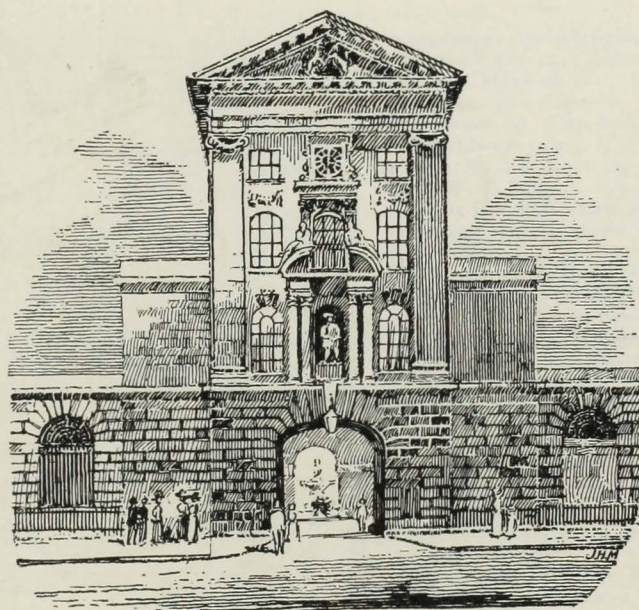
Journal Office.







# ST BARTHOLOMEW'S HOSPITAL JOURNAL



VOL. XXVI.

---

1918-1919.

LONDON:

ADLARD & SON & WEST NEWMAN, LTD.

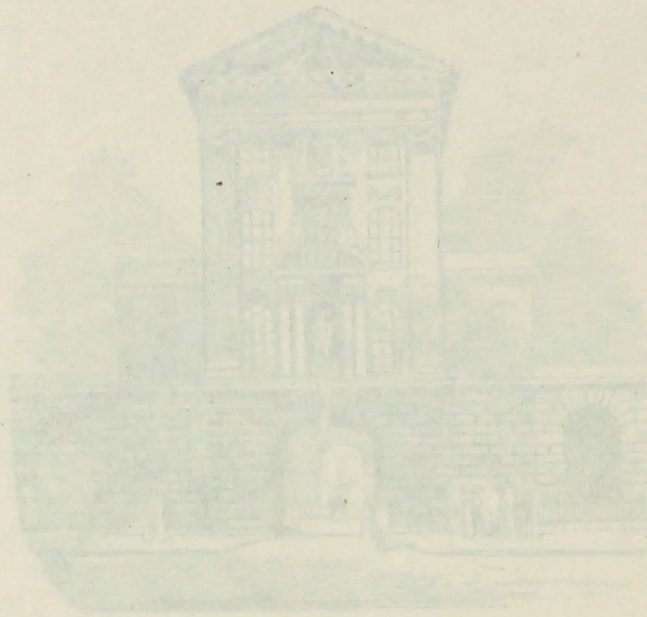
BARTHOLOMEW CLOSE, E.C.

---

1919.



# ST. BARTHOLOMEW'S HOSPITAL JOURNAL



VOL. XXVI.

1918-1919

LONDON

ADLARD & SON & WEST NEWMAN LTD.

BARTHOLOMEW CLERK & CO.

1919



# INDEX TO VOL. XXVI.

	PAGE		PAGE
Abernethian Society: Meeting and election of officers, etc., 58.		Correspondence: Amœbic dysentery, the treatment of, by H. W.	
Baron Meyendorff's discourse on Bolshevism in Russia, 86-87.		Hanschell, 123-124; ditto, by S. R. Prall, 147; ditto, by	
<i>Lancet</i> re Society's debate on Medicine versus Surgery, 1. Lecture by Alex. Macphail, 122. Abstract of		James L. Maxwell, 111. Heart-strain, by Adolphe Abrahams,	
paper read by A. E. Gow ... ..	75-80	31, 70; ditto, by Thomas Horder, 44; ditto, by	
Abrahams, A.; on the late A. E. Stansfeld: an appreciation ... ..	40-42	D. S. Pracy, 70; ditto, by Leslie Thorne-Thorne, 43-44, 55.	
Ackland, R. C.; the facial hospital ... ..	145-146	Medical Notes; by J. H. P. Graham, 7. Medical service,	
Acute intestinal obstruction; two cases of, by Samuel Green		a State; by L. B. Cane, etc., 100. Medicine versus Surgery,	
	134-135	by C. W. T. Baldwin, 19; ditto, by L. Bathe Rawling, 7-8;	
Address, changes of; lists of 8, 20, 32, 44, 56, 72, 88, 100, 112, 124,		ditto, by Gerald Stanley, 19. Mitral stenosis, by Adolphe	
136, 148		Abrahams, 69-70; ditto, by P. Hamill, 87-88; ditto, by	
Amœbic dysentery; notes on the treatment of chronic, by		B. B. Sharp, 56. Protein shock and intravenous vaccine	
S. R. Prall ... ..	82-83	therapy, by A. E. Gow, 110; ditto, by J. R. R. Trist, 110.	
Ancient surgery; by Philip Gosse ... ..	6	Reconstruction; by A. D. Wall, 111. Sarcoma of the	
Annual dance ... ..	89, 101-102, 113, 114	tongue, a case of; by Ernest H. Shaw ... ..	88
Annual past and present cricket and tennis matches, notice, etc.,		Cox, H. C.; a case of chondro-sarcoma of the humerus treated	
	102, 113, 120-121	by fore-quarter amputation ... ..	5-6
Annual view day; notes on, by G. W. T. ... ..	101, 107-108	Cricket match, the Past and Present, by one of the "Old Uns" ... ..	120-121
Antarctic expedition, etc.; notes on ... ..	90	Cystoscope; some practical points in the use of the, with	
Appeals: <i>Re</i> Bart's men who have fallen in war, 45. Notice		illustrations, by W. Girling Ball ... ..	49-53
<i>re</i> JOURNAL, 91, 137. <i>Re</i> the late A. E. Stansfeld's family,			
47, 58, 74, 89, 102. <i>Re</i> the late Harry Blakeway's family, 74,		Daab, S. A. El; bilharziosis ... ..	83-84
75, 89, 102, 114		Daly, I. de Burgh; a case of auricular flutter: the effect of	
Appointments, lists of 8, 20, 56, 58, 88, 100, 112, 114, 124, 126, 136,		treatment by digitalis ... ..	141-145
138, 148		Diabetes; certain aspects of, by W. Langdon Brown ... ..	104-106
Armistice days and capture of German gun by Bart's men;		Dinner, Old Students' ... ..	138
by W. S. S. ... ..	22, 27-28, 74	Dresser's Vade Mecum; the, by W. S. S. ... ..	146
Armstrong-Jones, Sir Robert; the mind, its defects and dis-		Doctors' meeting at Steinway Hall ... ..	9
orders ... ..	28-29		
Auricular flutter: the effect of treatment by digitalis; a case of,		East Wing, the, during the War and after ... ..	45
by I. de Burgh Daly ... ..	141-145	Eccles, W. McAdam, appointed Surgical Adviser at War Office ... ..	114
		Elections, 126, 137; ditto to Royal College of Physicians of	
Back from the war; by J. R. R. T. ... ..	109	London, 11, 102, 138; ditto and nominations for the	
Ball, W. Girling; some practical points in the use of the cysto-		Council of the Royal College of Surgeons, note <i>re</i> the ... ..	73
scoope, with illustrations ... ..	49-53	Entrance scholarships awarded, list of ... ..	11
Barrow, R. Murray; a case of "Spanish influenza" treated by		Examination lists, etc. ... 32, 44, 72, 100, 112, 113, 124, 136, 148	
intravenous injection of sodium salicylate ... ..	29-30	Experiences in Mesopotamia and India, by P. Hamill ... ..	36-38
Bart's men capture a German gun; by W. S. S. ... ..	22, 27-28, 74		
Bart's men; notes <i>re</i> old, and the JOURNAL, etc. ... ..	73	Facial Hospital, the, by R. C. Ackland ... ..	145-146
Bart's men's return to Hospital duties ... ..	22, 34, 73, 89	Final Fellowship Classes, notes <i>re</i> the ... ..	46
Bartholomew's Hospital; the history of St., by Norman Moore ... ..	58	Fractured femora; modern methods of treating, by W. Etherington	
Beyers, C. F.; three cases from Lucas and Henry wards ... ..	132-134	Wilson ... ..	106-107, 116-120
Bilharziosis; by S. A. El Daab ... ..	83-84	Freshmen welcomed to Hospital ... ..	1
Birthday and other honours, lists of 2, 10, 11, 22, 34, 45, 46, 58, 89,		Froin's syndrome; two cases of, by R. G. Canti ... ..	15-17
90, 102, 113, 114, 125, 126, 137, 138		From the Front, by Haldin Davis ... ..	2-3
Blakeway, the late Harry; an appeal for family ... ..	74-75, 89, 102, 114		
Boucaud, J. E. A.; thoracotomy and complete suture ... ..	18	Gaudeamus Igitur or View Day, by G. W. T. ... ..	107-108
Bourne, Geoffrey; influenzal empyema ... ..	62-65	Genasprin, note on new product ... ..	68
Bowlby portrait fund; the ... ..	114, 135, 136	German gun captured by students ... ..	22, 27-28, 74
Bowlby, Sir Anthony; notes on his retirement from the Hos-		Gosse, Philip; ancient surgery ... ..	6
pital, 113; his address before the Abernethian Society ... ..	127-133	Gow, A. E.; editorial notes on paper by, 74; ditto, concerning	
Bradshaw lecture: carcinoma of the tongue, by D'Arcy Power,		"protein shock" and intravenous vaccine therapy ... ..	75-80
22; ditto, published in book form ... ..	74	Green, Samuel; two cases of acute intestinal obstruction ... ..	134-135
Brown, W. Langdon; certain aspects of diabetes ... ..	104-106	Growth of surgery of the front in France: an address by Sir	
By the way ... ..	72	Anthony Bowlby ... ..	127-133
Canti, R. G.; Froin's syndrome, two cases of ... ..	15-17	Hamill, P.; experiences in Mesopotamia and India ... ..	36-38
Capture of German gun ... ..	22, 27-28, 74	Heath, W. E.; a case of sarcoma of the tongue ... ..	54-55
Chondro-sarcoma of the humerus treated by fore-quarter		Heerden, J. A. van; a case of malformation of the tracheo-	
amputation; a case of, by H. C. Cox ... ..	5-6	oesophageal septum ... ..	65-66
Christmas at the Hospital ... ..	33	Herringham, Sir W. P.; State Medical Service—Medical	
Chronic amœbic dysentery; note on the treatment of, by S. R.		Representation in Parliament, 11, 12, 13, 22; ditto, Medi-	
Prall ... ..	82-83	cal Education in London, 47, 49, 58-61; ditto, notes on	
Clinical evenings at Bart's resumed ... ..	58	resignation of, etc. ... ..	137
Cope, John L., and the Antarctic Expedition, etc.; notes on ... ..	90	Horder, Sir Thomas J.; Medical Notes ... ..	3-5, 14-15, 26, 53-54,
			61-62, 73, 103-104, 115-116, 140-141



	PAGE
Hospital and pre-war conditions, notes on, 101; ditto, reconstruction in all branches, 92-99; ditto and School, Foundation of, 91-92; ditto staff in war time, by D. W. W. ...	19
House appointments ...	126
Influenzal empyema, by Geoffrey Bourne ...	62-65
Intestinal obstruction; two cases of acute, by Samuel Green ...	134-135
Intra-ocular foreign bodies in France; some points in the treatment of, by R. Foster Moore ...	80-82
Jacksonian Prize for 1918, received by J. A. C. Forsyth ...	102
<i>Lancet</i> re debate on medicine versus surgery ...	1
Lucas and Henry wards; three cases from, by C. F. Beyers ...	133-134
Macphail, Alex.; lecture on need of reform in provision of anatomical material ...	122
Marlborough; Bishop of, notes re the ...	46
Medical education and practice; reconstruction in, by H. J. Waring ...	38-40
Medical education in London, by Sir W. P. Herringham ...	47-49, 58, 59-61
Medical notes, by Sir Thomas Horder ...	3-5, 14-15, 26, 53, 54, 61-62, 78, 103-104, 115-116, 140-141
Medical representation in Parliament and a State Medical Service, by Sir W. P. Herringham ...	11-13
Memorial appeal (suggestion of) re Bart's men who have fallen in War, 45; ditto re late Blakeway and Stansfield families ...	47, 58, 74, 75, 89, 102, 114
Mesopotamia and India; experiences in, by P. Hamill ...	36-38
Mind, the: Its defects and disorders, by Sir Robert Armstrong-Jones ...	28-29
Moore, R. Foster; some points in the treatment of intra-ocular foreign bodies in France ...	80-82
New Year greetings ...	33
New Year entry of students at the Hospital; notes on ...	45
New product, "Genasprin," note on a ...	68
Nurses' Home; an appeal to Bart's men ...	89, 113-114
Obituary and Roll of Honour: Bailey, J. C. M.; 103. Bate-man, A. G.; 103. Batten, T. E.; 6, 7. Blakeway, H., and an appreciation by A. M.; 57, 66-68. Brigstocke, R. W.; 74. Carlyle, T.; 23. Cherritt, B. W.; 35, 47. Connolly, J. H.; 23. Cowper, G. M.; 11, 30. Dandridge, W. L.; 11, 30. Drage, Lovell; 138. Dunstan, J. L.; 23. Garrod, B. R.; 59. Glenney, H.; 11, 30. Guthrie, L. G.; 47; an appreciation by A. C.; 68. Hadwen, J.; 23. Hampton, Thomas, 74; an appreciation by C. F. C.; 86. Hawes, C. S.; 47; an appreciation by J. A. N.; 86. Heald, W. M.; 2. Jukes, A. M.; 35. Kemp, W. G.; 59. Leftwich, R. W.; 90-91. Lemarchand, F. W.; 57. Lush, P. J. F.; 35. Macmillan, E. D.; 114. Malden, W.; 23. Manton, J. A.; 91. Nias, J. B.; 74; an appreciation notice by D'A. P.; 85-86. Patten, C. A.; 23. Perrin, M. N.; 103. Randall, W.; 138. Reid, J. M.; 34. Simaika, L. E. A.; 57. Stansfield, A. E.; 22; notes on, by R. G. C.; 40-41; an appreciation by A. Abrahams; 41-42, 58. Sturdy, A. C.; 103; notes on his career, etc., by M. H. H. V.; 121-122. Syrett, E. F.; 91. Taylor, R. B.; 23. Watkins, Arthur, 101; 24 years steward to the Hospital, notes on his career, etc., by J. S. S., with pictures; 107-109. Wilks, George; 126. Winter, L. A. ...	35
Parliamentary representation of the medical profession, notes on the ...	9, 22
Power, D'Arcy; surgical aphorisms ...	25-26, 35
Prall, S. R., note on the treatment of chronic amoebic dysentery ...	82-83
Protein shock and intravenous vaccine therapy, by A. E. Gow ...	75-80
Rahere Lodge; installation meeting; list of officers appointed ...	122-123
Reconstruction: Notes on, 1; and the end of the Great War, 21; in all branches of the Hospital work, 92, 99, 102; number of JOURNAL, notes on, and Major W. McAdam Eccles' assistance therein, 89; in medical education and practice, by H. J. Waring ...	38-40
Resident staff, lists of ...	23, 59, 102, 103

	PAGE
Resignations: Bailey, R. Cozens, 103; Bowlby, Sir A., 113; Herringham, Sir W. ...	137
Retrospect ...	137, 139-140
Return, by H. T. ...	99
Reviews: Allen, R. W.; Practical Vaccine Treatment, 147. Bainbridge, F. A., and Menzies, J. Ackworth; Essentials of Physiology, 148. Bruce, J. Mitchell, and Dilling, Walter J.; Materia Medica and Therapeutics, 71. Candy, Hugh C. H.; A Manual of Physics for Students of Medicine, 20. Candy, Hugh C. H., and Luff, Arthur P.; Manual of Chemistry, 71. Clarke, Ernest; The Errors of Accommodation and Refraction of the Eye, 20. Cumberbatch, Elkin P.; Essentials of Medical Electricity, 99. Cuning, Joseph, and Joll, Cecil A.; Aids to Surgery, 111. Dilling, Walter J., and Bruce, J. Mitchell; Materia Medica and Therapeutics, 71. Duval, Pierre; War Wounds of the Lung, 43. Elmslie, R. C.; The After-Treatment of Wounds and Injuries, 111. Fleming, Robert A.; A Short Practice of Medicine, 147. Goodall, A.; Aids to Histology, 112. Gould, Sir Alfred Pearce, and Gould, Eric Pearce; Elements of Surgical Diagnosis, 99-100. Gray, Hy.; Anatomy, Descriptive and Applied, 19, 20. Gray, H. M. W.; The Early Treatment of War Wounds, 71. Green, W. H. Clayton; Pye's Surgical Handicraft, 111. Hayes, Reginald; The Intensive Treatment of Syphilis and Locomotor Ataxia by Aachen Methods, 99. Heath, Charles J.; Otitis Media, 43. Howard, Russell; The Practice of Surgery, 32. Joll, Cecil A., and Cuning, Joseph; Aids to Surgery, 111. Johnstone, R. W.; A Text-Book of Midwifery, 31. Jones, H. Lewis; Medical Electricity, 8. Keith, Robert D.; Clinical Case Taking, 43. Lewis's Medical and Scientific Library, 111. Luff, Arthur P., and Candy, Hugh C. H.; Manual of Chemistry, 71. Maloney, Michael P.; Irish Ethno-Botany and the Evolution of Medicine in Ireland, 147. Menzies, J. Ackworth, and Bainbridge, F. A.; Essentials of Physiology, 148. Moore, Norman; The History of St. Bartholomew's Hospital, 70-71. Muir, Robert, and Ritchie, James; Manual of Bacteriology, 71. Palmer, Margaret D.; Lessons on Massage, 43. Ritchie, James, and Muir, Robert; Manual of Bacteriology, 71. Rogers, Kenneth; Musings of a Medico, 56. Stewart, G. N.; A Manual of Physiology, 32. Stevens, Thomas G.; Diseases of Women, 147. Whiting, Arthur; Aids to Diagnosis, 20. Wood, P.; The Whole Duty of the Regimental Medical Officer ...	71-72
Sarcoma of the tongue; a case of, by W. E. Heath ...	54-55
Spanish influenza treated by intravenous injection of sodium salicylate; a case of, by Murray Barrow ...	29-30
Staff; list of members returning to hospital ...	46
Stansfield Memorial Fund ...	47, 58, 74
State medical service, by R.A.M.C.T., 24; ditto, by Capt. in R.A.M.C. ...	120
Steinway Hall meeting; doctors at ...	9
Students, new; number of ...	9
Students' Union ...	30-31, 42-43, 55, 69, 74, 87, 123, 136, 147
Students' return and social life at the Hospital; notes on ...	45
Surgery; ancient, by Philip Gosse ...	6
Surgery of the front in France; a sketch of the growth of the, by Sir Anthony Bowlby ...	127-133
Surgical aphorisms, by D'Arcy Power ...	25-26, 35
Thoracotomy and complete suture, by J. E. A. Boucaud ...	18
Tongue; carcinoma of, Bradshaw lecture by D'Arcy Power ...	22
Tracheo-oesophageal septum; a case of malformation of the, by J. A. Van Heerden ...	65-66
Treasurer's report and notes re Royalty and Hospital ...	102
Typhoid fever; a case of intussusception occurring in, by H. W. Toms and C. Langton Hewer ...	17-18
War; back from the, by J. R. R. T. ...	109
Ward-life, episodes of; "The Jolly Ronukers," by D. W. W. ...	84-85
Wards, rearrangement of ...	22
Waring, H. J.; reconstruction in medical education and practice ...	38-39
Wilson, W. Etherington; modern methods of treating fractured femora ...	106-107, 116-120
Women students; decision against admission of ...	1, 2
Women's Guild; notes re annual meeting, etc. ...	74



# St. Bartholomew's Hospital



"Æquam memento rebus in arduis  
Servare mentem."

—Horace, Book ii, Ode iii.

## JOURNAL.

VOL. XXVI.—No. 1.]

OCTOBER 1ST, 1918.

[PRICE SIXPENCE.

### CALENDAR.

Tues., Oct.	1.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Fri., "	4.—Dr. Calvert and Mr. D'Arcy Power on duty.
Tues., "	8.—Dr. Morley Fletcher and Mr. Waring on duty.
Wed., "	9.—Clinical Lecture (Surgery), Mr. D'Arcy Power.
Fri., "	11.—Dr. Drysdale and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Drysdale.
Tues., "	15.—Dr. Calvert and Mr. D'Arcy Power on duty.
Wed., "	16.—Clinical Lecture (Surgery), Mr. D'Arcy Power.
Fri., "	18.—Dr. Morley Fletcher and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Drysdale.
Tues., "	22.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Wed., "	23.—Clinical Lecture (Surgery), Mr. D'Arcy Power.
Fri., "	25.—Dr. Calvert and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Dr. Fletcher.
Tues., "	29.—Dr. Morley Fletcher and Mr. Waring on duty.
Wed., "	30.—Clinical Lecture (Surgery), Mr. Waring.
Fri., Nov.	1.—Dr. Drysdale and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Fletcher.

### EDITORIAL NOTES.

**ONCE** more it is our duty at the commencement of the academic year to welcome Freshmen to the Hospital, and to congratulate them on the choice of their *Alma Mater*. Bart.'s has established a wide reputation as a teaching centre, and is, of course, the oldest Hospital in the Metropolis, if not in the country.

Our new colleagues—especially those coming to us from the Universities—will realise that the social side of the Hospital, of necessity, must be curtailed. But brighter days are ahead, the spirit of victory is in the air, and St. Bartholomew's will not be far behind when we can enjoy again the piping days of peace.

Meanwhile it is the student's duty to carry on. He should regard his work—as indeed it is—of national importance, endeavour to qualify at the earliest possible moment, and thus maintain not only the reputation of the Hospital, but also do his bit towards ensuring that the most glorious

of all professions shall not fail the nation in its greatest hour of need.

\* \* \*

We note with much interest and not a little satisfaction that the debate on Medicine *versus* Surgery, held under the auspices of the Abernethian Society and reported in the July issue of this journal, formed the basis of the editorial article in the educational number of the *Lancet*.

In spite of what the surgeons may say as to the seriousness or otherwise of the debate, and whilst agreeing to a certain extent with the *Lancet* that "the champions of medicine and surgery were not so judgmentic in the expression of their views as they would have been on a more responsible occasion," we still contend that the majority of those present regarded the discussion in quite a serious light. Naturally the evening was not without its humorous side; but taken as a whole, and certainly when it came to voting, the serious and intelligent interest of the men appeared to us to be a feature of the evening.

We are glad to learn that the *Lancet* endorses the victory of Medicine, and that this conclusion has been repeatedly forced upon medical teachers on both sides of the Atlantic.

Major Rawling's vigorous reply to Major Stanley will be read with much interest. We may add that our columns are always open to our readers, and we shall welcome any further contributions to this most interesting discussion.

\* \* \*

Much is being said and written concerning "reconstruction" at the present time. Many will have seen Sir George Newman's "Some Notes on Medical Education in England," and will appreciate much of what he has written on the subject.

Postgraduate study is another branch of the same matter, and it is to be hoped that London will be able to obtain, and retain, much of the prestige which before the war was accorded to enemy countries. St. Bartholomew's must not be behind in all this.

Perhaps it may disappoint some, but after very careful consideration our School has decided against throwing open its doors to women, in spite of the fact that it is recog-



nised that they will have a very important share in the care of the health of the nation in the future. Several other well-known medical schools are, however, receiving them.

\* \* \*

We desire to warmly congratulate Major-Gen. W. G. A. Bedford, C.B., C.M.G., A.M.S., on being made a K.C.M.G.

\* \* \*

The following St. Bartholomew's men have been honoured in connection with the military operations in Mesopotamia. To these gentlemen we offer our heartiest congratulations:

*C.B.*: Col. W. H. Starr, C.M.G., A.M.S.

*M.C.*: Temp. Capt. J. A. Noble, R.A.M.C.

To be Brevet-Major: Capt. A. M. Dick, I.M.S., Capt. T. J. C. Evans, M.C., I.M.S.

\* \* \*

Several Bart's men have been mentioned in despatches by Lieut.-Gen. W. R. Marshall, Commander-in-Chief of the Mesopotamia Expeditionary Force. The list is as follows:

*R.A.M.C.*: Lieut.-Col. (Brevet Col.) M. H. G. Fell, C.M.G., Lieut.-Col. (Temp. Col.) S. F. St.D. Green, Temp. Capt. H. H. Raw, Col. W. H. Starr, C.M.G., A.M.S., Temp. Capt. C. A. Weller.

*R.A.M.C. (Special Reserve)*: Capt. W. B. Wood.

*R.A.M.C. (T.F.)*: Major (Temp. Lieut.-Col.) F. E. Fremantle.

*I.M.S.*: Capt. A. C. L. O'S. Bilderbeck, Major (Acting Lieut.-Col.) H. M. Cruddas, C.M.G., Capt. A. M. Dick, Capt. T. J. C. Evans, Major W. H. Leonard, Major F. P. Mackie, Capt. C. J. Stocker, M.C., Capt. A. J. Symes.

\* \* \*

We have pleasure in congratulating Fleet Surgeon F. J. A. Dalton, C.M.G., R.N., on being made a Chevalier of the Legion of Honour, the decoration being conferred by the President of the French Republic for distinguished services rendered during the war.

\* \* \*

We have to congratulate Lieut.-Col. R. F. Standage, I.M.S., on being appointed Consulting Surgeon to the Forces in East Africa.

We notice also that Lieut.-Col. Standage has been elected an Associate of the Order of St. John of Jerusalem.

\* \* \*

The following are the official statements of services for which the Military Cross has been conferred:

"Temp. Capt. E. W. D. Hardy, R.A.M.C.—His dressing-station was situated at cross-roads, the only place available, and during a whole day was obviously a target for exceptionally intense bombardment. He displayed the greatest courage and supreme contempt of danger, remaining at his post and dressing wounded the entire day while everybody else was dug in."

"Capt. C. Newton-Davies, M.B., I.M.S.—During the attack, when the battalion was brought to a standstill by

frontal and enfilade fire of all kinds, he exposed himself continually in moving from place to place to render aid to wounded cases. It was owing to his courage, devotion to duty, and skilful organisation that the wounded were successfully collected and evacuated."

"Temp. Capt. R. Stansfeld, R.A.M.C.—During an engagement he carried his medical pannier forward through a heavy barrage, and moved about under heavy shell-fire over the captured ground, collecting and bringing in the wounded. He set a splendid example of courage and devotion to duty."

"Temp. Capt. R. B. Taylor, R.A.M.C.—He searched for a missing stretcher-bearer for two hours under heavy shell-fire, at last finding him in a shell-hole and assisting to carry him back. Throughout nine days' fighting he was constantly going forward under fire, searching for and bringing in wounded."

\* \* \*

We note with much pleasure that Sir Dyce Duckworth has been elected *Membre Correspondant*, "*honoris causa*," de la Société Médicale des Hôpitaux de Paris.

\* \* \*

We are glad to hear that Capt. F. G. Chandler, M.D., R.A.M.C., has been awarded the Raymond Horton Smith Prize of Cambridge for 1917.

\* \* \*

The Index for Vol. XXV (1917-1918) of the JOURNAL will be published and distributed with the next issue.

\* \* \*

#### ROLL OF HONOUR

It is with very deep regret that we learn of the death of Lieut. W. M. Heald, R.A.M.C. He was attached to the Lancashire Fusiliers, and died of wounds on September 8th. Lieut. Heald was the only son of the Rev. C. W. and Mrs. Heald, of Chale Rectory, Isle of Wight, and was educated at Marlborough and St. John's College, Cambridge. During the first two months of this year he acted as house-physician at this Hospital.

We desire to express our deepest sympathy with the Rev. and Mrs. Heald in their sad bereavement.

#### FROM THE FRONT.



HE following interesting letter has reached us from Capt. Haldin Davis, R.A.M.C.(T.), who is now serving with the troops in Palestine:

"We are now actually holding a portion of the line, and my position is on the reverse slope of a high hill, which slopes precipitously down to a waddy or watercourse at the bottom, and if I fall out of bed I am likely not to stop rolling till I get there. Things, however, are very quiet, and (*Deo gratias*) very few casualties about at present. This battalion has been here just a week without any, and



the battalion that we relieved was here six weeks without any. We shall have some malaria, however, as we have to hold a place in the bottom of a waddy which swarms with *Anopheles*. Two cases have occurred already. All the field ambulances now are officered by the British officers who came out with them.

"It never rains here from April to late October, and the heat is not very excessive. It must be one of the best climates in the world, especially in the hills. I have not had a single case of chest or nasal trouble since we left Egypt, and the health of the men is extremely good. Malaria is the only dangerous disease here. One of my duties is to go into No Man's Land and to oil certain wells to circumvent the *Anopheles*.

"The hills are rocky but fertile, and there are heaps of vines, figs and mulberries and grapes, which are just beginning to get ripe.

"Notwithstanding these delights, however, I would not mind being back in civilised parts. I feel bound to confess that the simple life has no particular charm for me. I should be glad to come out here for a holiday to admire the scenery, but to stay here indefinitely is a prospect which leaves me cold."

## MEDICAL NOTES.

By Sir THOMAS HORDER, M.D.

(Continued from Vol. XXV, p. 105.)

### ON CARDIAC BRUITS—continued.

(31) The most important of the cardiac bruits to elude discovery is probably the diastolic bruit indicative of aortic regurgitation in the early stages of the disease. The reasons for this are two: (i) The bruit is prone to be "soft" and "distant," requiring a trained ear and a quiet room for its detection; (ii) it may only be heard to the left of the sternum, and sometimes only to the left of the sternum at its lower end. If either or both of these conditions be present the diagnosis may be entirely missed. It is therefore a good rule never to quit the auscultation of a heart, and certainly never to quit the auscultation of a hypertrophied heart (*vide* §18), until the observer is sure that the bruit is not present in this situation.

(32) The cases in which the bruit of aortic regurgitation is of maximum intensity at the lower end of the sternum, and to the left of the mesial line, are not uncommon. More uncommon are the cases in which the maximum intensity of the bruit is at the pulmonary base. In a few rare instances the bruit may be confined to this last-named situation, in which event mere anatomical considerations suggest a diagnosis of pulmonary regurgitation; but the presence of the arterial signs of aortic incompetence—jerking pulse at

the wrist, visible arterial pulsation at various points and capillary pulse, together with signs of hypertrophy of the left ventricle, demonstrate that the defect is in the systemic and not in the pulmonary system. It may be added that if the diastolic bruit is heard only in the pulmonary area, and none of these concomitant features is present, a diagnosis of aortic regurgitation cannot be made. But this reservation also holds good when the bruit is heard in the more common situations.

(33) Bruits which "come and go" from day to day, and in some instances even from hour to hour: (i) The systolic bruit of mitral regurgitation, when that condition is secondary to failure of the left ventricle, as in dilated heart complicating renal disease (*vide* §30); less often when primary mitral regurgitation is complicated by severe heart failure with great dilatation; and in acute endocarditis. (ii) The presystolic bruit of mitral stenosis both at the beginning and at the end of the course of this disease—when the disease is in a stage of evolution, as may be observed in prolonged cases of subacute rheumatism in children; and when "auricular fibrillation" supervenes, with general dilatation. (iii) The bruits associated with acute ulcerating endocarditis (but see §29.)

### ON MORBUS CORDIS.

(34) Between patients suffering from aortic disease and patients suffering from mitral disease certain broad clinical differences are observable.

(i) *Facies*.—In aortic disease patients tend to pallor, because the arterioles are badly filled; in mitral disease patients tend to cyanosis, because the venules are badly emptied.

(ii) *Pain*.—This is common in aortic disease, and may be of all degrees of severity up to true angina. (But when true angina is present, consider the question of associated lesions, such as coronary atheroma, etc.). In mitral disease pain is quite uncommon.

(iii) *Night starts and bad dreams* are more common in aortic than in mitral disease.

(iv) *Sudden death* is not uncommon in aortic disease; it rarely occurs in mitral disease.

(v) *Heart failure*, when it supervenes, shows three important differences: (a) Dropsy is both less common and less marked in aortic than in mitral disease. (b) Heart failure proceeds more rapidly in aortic than in mitral disease, and, once it has arrived, compensation is much less likely to be re-established in the former than in the latter condition. This is because the burden of the extra work has been borne by the ventricle throughout in aortic disease, so that by the time dilatation sets in the myocardium is no longer intrinsically sound. On the other hand, in mitral disease, at the time of initial dilatation, the myocardium has potential energy which can be called forth by treatment. Hence it follows that "mitral" patients not uncommonly give a history of



one or more bouts of heart failure with dropsy, etc., from which good recovery has been made, but "aortic" patients rarely do. (c) In the response to treatment the difference may be inferred from (b).

(35) The ætiology of pure mitral regurgitation is quite different from pure mitral stenosis. Mitral regurgitation is a residual condition resulting from an old acute rheumatic endocarditis; mitral stenosis is a progressive condition due to sclerosing (? rheumatic) endocarditis. Hence the rule is to get a history of rheumatic fever in cases of mitral regurgitation, and a history of chronic rheumatism, or chorea, or growing-pains, or of no rheumatic affection at all, in mitral stenosis.

(36) Ascites may be the first sign of cardiac dropsy in mitral stenosis, preceding for a considerable time œdema of the legs. (Ignorance of this fact sometimes leads to an erroneous diagnosis of cirrhosis of the liver.) The explanation of this fact is as follows: In mitral stenosis, owing to the inability of the left auricle to discharge its contents into the left ventricle, and the consequent inability of this latter chamber to assist in overcoming the valvular defect, there is a gradually increasing venous reservoir formed by the left auricle, the pulmonary circulation, the right heart and the venæ cavæ. The hepatic veins, the largest tributaries of the inferior vena cava, become dilated and share in this venous reservoir, leading to great congestion of the liver and to increased pressure in the portal system. (It is to state this same fact in terms of morbid anatomy to say that the most marked instances of "nutmeg liver" occur in mitral stenosis.) This state of things may become definitely established before as yet there is any appreciable failure on the part of the heart muscle. Hence local dropsy of the peritoneum may precede general œdema. Conversely, in mitral regurgitation, although a similar venous reservoir forms, it does not proceed to anything like the same extent, because the left ventricle comes into play from the first in the compensating mechanism. Hence it is that in this disease, dropsy, when it appears, appears as the result of heart failure; and inasmuch as the whole venous system is equally affected, it appears first in the legs, since gravity determines the disposition of the œdema.

(37) The same considerations explain the relatively greater frequency of hæmoptysis in mitral stenosis than in mitral regurgitation, whether the hæmorrhage results from a general pulmonary engorgement or from hæmorrhagic infarction. The pulmonary veins participate in the reservoir formation quite early; it is not, therefore, surprising that hæmoptysis should occur at a period in the course of mitral stenosis when other complications are absent. In short, hæmoptysis in mitral stenosis by no means indicates the arrival of dilatation of the heart; in mitral regurgitation, however, it generally does.

(38) Another important clinical difference between mitral stenosis and mitral regurgitation is the greater tendency to embolism in the former disease. The emboli consist of fragments of clot which forms in the dilated left auricular appendix, not of "vegetations from the mitral valve." The valve cusps in mitral stenosis are thick, smooth, and fibrotic, and are quite free from vegetations; moreover, the thrombosed auricular appendix can be demonstrated post-mortem, and not infrequently the embolus can be seen to correspond to the free surface of the clot in texture, colour, and microscopic appearances.

(39) Certain general features characterise patients who are the subjects of congenital morbus cordis (as against acquired morbus cordis)—marked cyanosis, clubbing of fingers and toes, polycythæmia, immaturity, and attacks of pulmonary and cerebral congestion. But it should be observed that if morbus cordis is acquired *very early in life*, the patient approximates to the congenital type in some or all of these features.

(40) Every branch of natural science pauses in its progress after a time, awaiting the introduction of a new method or a new instrument which shall open a fresh field for investigation. By means of the polygraph and the electro-cardiograph a brilliant chapter has been added of late years to our knowledge of the cardiac arrhythmias, and in the attempt to segregate these there have been advanced several valuable hypotheses which serve as bases for further work.\* But let us not decry the instrument that ushered in the last advance, nor forget that the workman will probably prove to be just as fallibly over-confident of the tool he now handles. Yesterday's observer with a familiar instrument to help him; to-day's observer with a new instrument to learn; his mistakes may be different, but they will not be less.

"With that injudicious enthusiasm which has at all times heralded a new method of observation, fabulous qualities were at first attributed to the stethoscope." True; but for "stethoscope" read "electro-cardiograph," and in a hundred years the same sentence will be written again.

(41) "Failure of compensation"—a term that has fallen into disrepute, not to say disrespect. But why? "Heart failure," proposed as a substitute, means nothing else, for the definition offered—"That condition in which the heart is unable to maintain an efficient circulation during the efforts necessary for the daily life of the individual"—is the definition that clear-minded teachers give of "failure of compensation." And in minds that are not clear "heart failure" is quite as liable to become "attendant verbiage" as is "failure of compensation" or any other nomenclature. But in this matter the critic is not quite fair to traditional teaching. He speaks as though "compensation" and

\* A chapter in which British medicine, as represented by Mackenzie, Lewis and others, takes a foremost place.



"decompensation" were terms applied to *all* forms of heart disease, whereas they were only applied to cases of primary valvular disease. In primary myocardial disease, in angina, in toxic heart states, and in dilatation consequent upon extrinsic factors these terms were not used.\* In these last-named conditions "heart failure" is certainly as apt a generic term as can be desired with which to express the signs and symptoms of cardiac inefficiency.

(42) "No one ever dies of mitral regurgitation." Nor of tabes dorsalis, cirrhosis of the liver, nor pulmonary phthisis—chronic diseases all, but subject to developments that are prone eventually to be lethal.

(43) "When I have looked at the enormous mass of muscle which forms the ventricular wall in these cases" (of heart failure in aortic regurgitation), "I have often wondered whether those muscle-fibres represent a genuine hypertrophy, or whether some disease condition has taken part in the increase." It has; the microscope reveals, in greater or less degree, degeneration of the muscle-fibre, interstitial myocarditis, and sclerosis of the arteries.

## A CASE OF CHONDRO-SARCOMA OF THE HUMERUS TREATED BY FORE-QUARTER AMPUTATION.

By H. C. Cox, M.R.C.S., L.R.C.P.

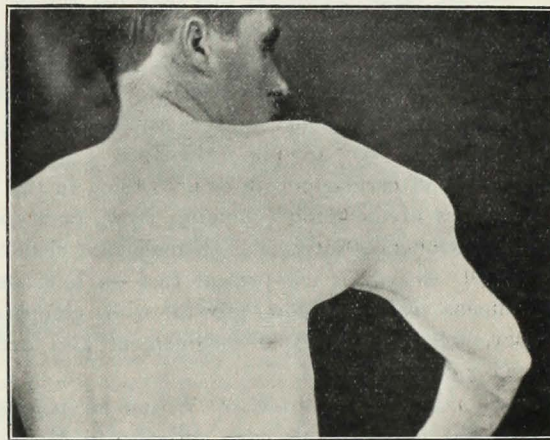
**T**HE patient, a man, æt. 28, was admitted to Colston Ward, on June 17th, 1918, under the care of Capt. Harold Wilson, complaining of a lump at the upper end of the right arm. He gave the following history: At the age of eight, his father noticed a lump, about the size of a walnut, which appeared at the outer side of the upper end of the right humerus. It was hard, painless, caused no inconvenience, but steadily grew larger. He was first seen by Capt. Wilson at the beginning of 1915, and in February of that year was admitted to Annie Zunz Ward. The mass, which was now 6 in. long and about 3 in. broad, was found to be arising from the upper end of the shaft of the right humerus, and was composed of cartilage. It was locally excised. Sections of the growth showed a typical ossifying chondroma of a non-malignant character.

In March, 1917, patient was re-admitted to Annie Zunz Ward, the growth having recurred to about its former size. There was, in addition, an enlarged gland felt in the right axilla. The mass was again excised, and the histological

\* The writer holds no brief for the "physicians" who "give a good prognosis in cases of extreme exhaustion (*sic*) because compensation was good, and there was no objective sign of heart failure." Nor for that "professor of medicine who rejoiced the heart of a man with aortic disease, who could not walk a hundred yards without being pulled up by pain, by telling him that his outlook was good as there was no dropsy, and, therefore, compensation was good."

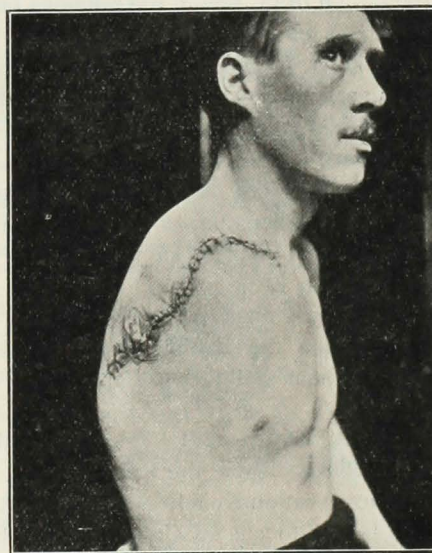
report showed again an innocent chondroma. On discharge there was still free movement of the right shoulder-joint, and the arm was still quite useful.

On re-admission in June of this year, the patient showed an irregular swelling occupying the upper one-third of the



BEFORE OPERATION.

right humerus. It was very hard and nodular, painless, and the covering skin was not attached. There was now considerable impairment of movement at the right shoulder joint. The enlarged gland in the right axilla was also felt. The general condition of the patient was excellent.



FOUR DAYS AFTER OPERATION.

A diagnosis of chondro-sarcoma of the right humerus was made, and at Surgical Consultations the unanimous opinion was that the best treatment was removal of the arm by a fore-quarter amputation. This procedure was accordingly carried out by Capt. Wilson, and the whole of the right arm, together with the scapula, outer half of the clavicle and axillary contents, were removed.



Except for the sudden development of post-operative shock two hours after the operation, successfully treated by intravenous saline infusions, the patient made an uninterrupted recovery, and was discharged on July 4th, thirteen days after the operation.

Pathological investigation on this occasion showed the growth to be a typical chondro-sarcoma.

The interest of this swelling lies, perhaps, in its pathology. The common situations for chondromas to occur are in the long bones of the hand and foot, and such tumours are essentially non-malignant.

In the event of cartilaginous tumours arising in the long and flat bones of the body (humerus, ilium, or scapula), they always, sooner or later, take on malignant characters. This is well shown in the present case—a long period of seventeen years of slow growth with comparative innocency, followed by rapid enlargement and definite final sarcomatous structure.

The writer is indebted to Capt. Wilson for permission to publish the notes of this case, and also to Mr. Zerolo for the excellent photographs with which it is illustrated.

## ANCIENT "SURGERY."



E are indebted to Capt. Philip Gosse, R.A.M.C., The Sassoon Hospital, Poona, for the following translation from *Avesta*, the religious book of the Parsees.

In a covering letter, Capt. Gosse says that the translation is from a very ancient Sanskrit book, and, amounting to practically an ancient form of "College Final in Surgery," may prove of interest to readers of the JOURNAL. Capt. Gosse adds that it must have had its distinct disadvantages in those days to be a dissenter, as the unbeliever seems to have been used as a living "subject" in the practical Operative Final.

Book: *Fargard*, vii; verses 94 and onwards:

"Creator! When the Faithful wish to make themselves Physicians whom shall they first cure, the Unbelievers or the Faithful?"

"Then answered the Creator: 'They shall make trial of healing the Unbelievers before the Faithful.'

"If he begins to cut an Unbeliever for the first time and he dies: if he begins to cut an Unbeliever for the second time and he dies: if he begins to cut an Unbeliever for the third time and he dies, then he is incapable for ever.

"The Faithful shall not consult him afterwards: he shall not cut the Faithful; nor shall he wound by cutting.

"If the Faithful afterwards try him, if he cuts the Faithful, if he wounds them by cutting, then shall he atone for the wound of the wounded with the punishment of the Baodho-varsta.\*

\* "Sins committed wilfully."

"If he cuts one of the Faithful for the first time and he recovers: if he cuts one of the Faithful for the second time and he recovers: if he cuts one of the Faithful for the third time and he recovers, then is he capable for ever.

"According to their wish the Faithful afterwards make trial of him: he shall cut the Faithful as he pleases; he shall heal them by cutting at his will."

## Scale of Fees allowed to be charged by a Surgeon.

The cure of:	Fee:
A priest . . . . .	A pious blessing.
Master of the house . . . . .	Value of a small beast of burden.
Ruler of a clan . . . . .	Value of a middle-sized beast of burden.
Chief of a tribe . . . . .	Value of a large beast of burden.
Ruler of a territory . . . . .	Value of a chariot with four oxen.
Mistress of a house . . . . .	A female ass.
Wife of chief of clan . . . . .	A cow.
Wife of chief of tribe . . . . .	A mare.
Wife of ruler of district . . . . .	Female camel.
A boy from the village . . . . .	Value of a large beast of burden.
Large beast of burden . . . . .	Value of a middle-sized beast of burden.

## OBITUARY.

FREDERICK EUSTACE BATTEN, M.D.Cantab.,  
F.R.C.P.



THE announcement in the *Times* of the death of Dr. Frederick Batten on July 27th, after a severe operation, was sad news to all who knew him, and especially to those friends, of his who were his contemporaries at Cambridge and St. Bartholomew's.

The profession has lost in him one of its most loyal and devoted workers, and his friends, one whom they can never replace.

My first introduction to Fred Batten was at Cambridge some thirty odd years ago, where he had matriculated after leaving Westminster School. We were at practical work in one of the laboratories, and I remember it was his entire absorption in his work in hand, to the oblivion of everything else, which first attracted my attention. It is a trivial recollection, but the love of work for its own sake and his power of concentration upon it were so characteristic of him afterwards, that there is some little interest in recalling it as a first impression.

Coming up from the rowing school at Westminster, it was natural he should take to the river, and he soon found a place in one of the Third Trinity boats in training for the Lent races. I do not know that he arrived at high distinction as a "wet-bob," but he was more than useful in a boat, and always pulled his weight and a little bit over.

The only other diversion I remember him at all prominent in was as a member of the "Owls" Debating Club, of which he was a great supporter, and occasionally he would speak at the "Union."



At St. Bartholomew's, which he entered in 1887, he passed four years in his quiet and rather retiring way, taking his Cambridge M.B. in 1891, and becoming House-Physician to Sir William Church soon afterwards.

At the end of a year in that capacity he was for some time Casualty Physician, after which he spent some six months in Berlin, doing post-graduate work and learning the language.

On his return he soon settled down to the work, to which his inclinations and qualities were inevitably leading him, and appointments which he obtained at the Hospital for Sick Children, Great Ormond Street, as well as at the Hospital for the Paralysed, Queen Square, became the starting-point of the work with which his name has ever since been associated.

For over twenty years his life was devoted to work associated with these hospitals, to scientific research, to the work of various societies, to teaching, and to fulfilling the innumerable and exacting obligations inseparable from the life of a consulting physician.

In 1901 he was elected to the Fellowship of the Royal College of Physicians, of which he had been a member for seven years.

As a consultant his methods were simple and direct. Preliminaries as brief as courtesy would allow, a very thorough examination, and a diagnosis prompt and decisive. He abhorred "sloppiness" and indecision, and was assuredly not guilty of such things himself. It has been said that he faced psychological problems and their modern aspects with some diffidence and reluctance. I believe this was true, and I can quite understand it. His own mind was itself so direct and free from anything morbid, that it must have been uncommonly difficult for him to follow the mental vagaries of patients suffering from a psychosis only, but his sympathy and patience were never wanting, and always equal to the occasion.

Batten had the kindest and most genial temperament, which showed itself to everyone with whom he came into contact.

In manner and conversation he was sincere and unaffected, keenly interested in almost any subject under discussion, and frequently enlivening it with a half-humorous and cheery laugh very characteristic of him.

His attitude to mankind was so simple and unobtrusive that it was difficult to realise, unless you knew him well, what strength of character lay behind it.

Natural instinct and good taste, the best traditions, and education in its widest sense, combined early to put him on a course of life from which he never seems to have swerved for a moment—a course directed by a code of morals beyond criticism. To attempt to lift the veil and look for the source of such unusual strength of character would be vain, and perhaps impertinent, especially as he was the last man to discuss his deepest convictions himself,

Enough for us that what he gave the world was of the best, and for which those who knew him well will always be thankful.

He died at the early age of 52, in the full vigour of his life, and when the fruits of his work were just coming to full maturity.

Dr. Batten was the son of the late John Winterbotham Batten, K.C., and brother of Dr. Rayner Batten, who also was educated at St. Bartholomew's.

In 1907 he married Jean, the daughter of the late John Stevenson, F.R.I.B.A., who survives him and to whom a host of friends extend their deepest sympathy. F. J. D.

## CORRESPONDENCE.

### MEDICAL NOTES.

*To the Editor of the 'St. Bartholomew's Hospital Journal.'*

SIR,—Reading the Medical Notes written for the JOURNAL by Sir Thomas Horder emphasises the little aid the average text-book gives in teaching the principles and practice of medicine. The Notes strongly recall the critical style of *Fagge's Medicine*, and deepen regret at it being so long since a new edition of that work appeared. A work is much needed to deal more critically with the principles and practice of medicine than does the ordinary text-book; it is much to be hoped that one may be written, or a revision of Fagge's work on its original lines undertaken.

Possibly the JOURNAL could do much to further these suggestions.

I am, Sir, etc.,

J. H. P. GRAHAM,

*Lieut.-Col., R.A.M.C. (S.R.).*

### MEDICINE VERSUS SURGERY.

*To the Editor of the 'St. Bartholomew's Hospital Journal.'*

SIR,—It is very interesting to hear that our humble debate on the relative merits of surgery and medicine "at the present time" have sufficed to give Major Stanley "much amusement" in his leisure hours. Major Stanley, however, would have been wiser not to rush into print in order to criticise so freely the merest abstract of a debate, with no knowledge whatsoever of the conditions thereof. It may interest him to know that it was common knowledge throughout the Hospital that neither I nor Capt. Ball, the proposer and seconder of the motion, were in agreement with the terms of motion. The Secretary of the Abernethian Society, however, persuaded us to act, and, being sportsmen, we complied with his request. The attendance at the meeting—a record one—and the enthusiasm displayed, showed clearly that we were fully justified in so doing, the debate being replete with interest and humour. Major Stanley may have periods of luxury and ease, but we, at home, have no such leisure hours, and the debate was a very welcome relaxation.

Major Stanley would probably retaliate by saying that even a Parliamentary debate does not justify one in making "fallacious, dangerous and untrue statements"—*vide* his criticism of my remark that "in France at the present time it is the surgery that counts, not the medicine." I would remind Major Stanley that R.A.P.'s, A.D.S.'s, and C.C.S.'s do not occupy the whole field—he forgets that there are hundreds of hospitals in England, manned by thousands of medical men, the greater proportion of whom are engaged in the treatment of the wounded and sick, and that we have every opportunity of estimating the relative importance, both for the present and the future, of the surgical and medical cases arriving from France and elsewhere. From the time at which the debate was held, and ever since, we have been overrun with surgical cases. For example, at No. 1 London General, Camberwell, to which hospital I have the honour to be attached, surgical cases bear to medical a present relation of about  $3\frac{1}{2}$  to 1. And this has been going on for the greater part of this year, at the time of the debate, and both before and after. And what about France? Is Major Stanley still of the opinion that surgery is of so much lesser importance? Has he still leisure hours in which to offer criticisms on debates and papers on subjects of which he can have so little real knowledge?



Of course there are innumerable medical cases treated in France, admitted perhaps to C.C.S.'s, but only a small proportion of these require the services of a consulting physician. Any medical officer is perfectly capable of dealing with such cases, whether he knows more surgery than medicine or more medicine than surgery.

Does Major Stanley appreciate in the slightest degree the fact that the great excess of surgical cases transferred to this country throws such a burden on those who practise surgery that it is almost beyond our powers to deal with them? We have no leisure in which to criticise other men's statements and works.

And what a prospect for future surgery amongst these countless thousands that we see daily in hospital and in the streets! Truly, after all, Sir, there is more in our motion than appears at first sight.

I would add also that if the surgery in France were all of the nature as described and as carried out by Major Stanley—mere "butchery" and "excisions"—our attempts at home to cope with the surgical work would be doomed to absolute failure. Perhaps his version accounts for the many nerves we have to mend, the limbs we have to straighten, the deformities we have to rectify. Thank goodness there are others who hold different views and who act in other ways—*vide*, for example, the excellent results of cranio-cerebral surgery that are admitted in my wards.

In Major Stanley's second criticism, in relation to my statement "that the physician is not wanted, except here and there," he carefully omits the last four words. Such an omission is quite inexcusable. In addition, if he had not been quite so hasty in his criticisms, he would have been able to find out that, as per context in my speech, "physician" referred to "consulting physicians" only.

As regards the "conscripting of the medical profession and converting them into surgeons," there may be some justifiable exaggeration; but, after all, there is a good deal of truth in the statement. Hundreds of medical men, many of whom have done no surgery for many years, are perforce converted into surgeons. Major Stanley says he can carry out this quick change. Lucky surgeons; but, alas, poor patients!

Major Stanley is obviously labouring under some confusion of mind, for, after strafing the surgeons, more especially myself, he turns the vials of his wrath on to the devoted heads of the physicians, and such is his mental balance that he at once contradicts all his previous statements. For example, he admits that, after a raid or push, "as many as nine teams have been added to a C.C.S., and yet that it is good work if 30 per cent. of all wounded are operated on." Is not this, Sir, an argument showing that the Government motion was, after all, not so far from the truth?

In conclusion, Sir, I would add that it is a pity that Major Stanley, in his C.C.S., cannot view the whole question from a broader point of view, with some glimpse into futurity, with some thought of the thousands of surgically maimed and crippled in England at the present time.

I am, Sir,  
Yours sincerely,  
L. BATHE RAWLING,  
*Major, R.A.M.C.T.*

## REVIEW.

**MEDICAL ELECTRICITY.** By H. LEWIS JONES. Seventh edition. Revised and edited by LULLUM WOOD BATHURST. (H. K. Lewis & Co. Ltd.) Pp. 588. Price 15s. net.

No man has done more to bring electro-therapy to its present high standard than the late Dr. Lewis Jones, whose lamented death was regretted by so many Bart.'s men.

Dr. Bathurst is to be congratulated on the production of the new edition, which has been brought quite up to date—no easy matter when we consider that electro-therapy is a subject which must, of necessity, be constantly undergoing improvement. This was well shown by Dr. Lewis Jones in the last edition, in which he ventured to predict the possibilities on the one hand of the ionic, and on the other the thermal effects of electricity, both of which are being fulfilled.

A lot of new data has been included in the section relating to the electrical testing of muscles, a subject which is daily becoming of more importance as a routine test.

The book contains nearly 200 illustrations—a most necessary feature in a volume which deals with a subject so highly technical.

## APPOINTMENTS.

CARLYON, Capt. T. B., R.A.M.C., appointed R.M.O. 1st London General Hospital, Camberwell.  
EL-DAAB, S. A., M.R.C.S., L.R.C.P., appointed Casualty Officer, St. Thomas's Hospital, S.E.  
VALERIE, Lieut. J., R.A.F., in charge of No. 1, M.T. Depot, Hurst Park.

## CHANGES OF ADDRESS.

CANE, Major A. S., R.A.M.C., D.A.D.M.S. Base and L. of C., G.H.Q., British Salonika Force.  
CARLYON, Capt. T. B., R.A.M.C., R.M.O., 1st London General Hospital, Cormont Road, Camberwell, S.E.  
RAW, Capt. H. H., R.A.M.C., 23, St. Hilda's Terrace, Whitby, Yorks.

## BIRTHS.

GATES.—On September 8th, at Laurel Mount, St. Helens, the wife of Joseph Gates, M.D., D.P.H., of a daughter.  
DAVIES.—On August 29th, at Loretto, Ystrad-Rhondda, to Marjorie, the wife of Dr. J. P. H. Davies—a daughter.  
EVANS.—On August 25th, at Plas Darland, Wrexham, North Wales, Ermine, wife of Temporary Surgeon Geoffrey Evans, Royal Navy, of a son.  
GOVER.—On August 18th, at Penarth, Glamorgan, the wife of Lieut.-Col. John Maxwell Gover, D.S.O., R.A.M.C., of a son.  
STACK.—On Sunday, August 25th, at Arvalee, Clifton, the wife of Capt. E. H. E. Stack, R.A.M.C.(T.), of a daughter.

## MARRIAGES.

DICKINSON—MALCOLM.—On August 6th, 1918, at St. Pancras Church, by special licence, by the Rev. E. L. Metcalfe, Capt. W. R. Dickinson, R.A.M.C., only son of Mrs. and the late J. Dickinson, of Maryport, Cumberland, to Euphemia Livingstone, eldest daughter of Mr. and Mrs. Alexander Malcolm, Balam, Kimmage, co. Dublin.  
MILLER.—KELSON.—On September 3rd, at St. Wilfred's, Hayward's Heath, Capt. Robert Molineux Miller, D.S.O., R.A.M.C., son of the late Robert Miller, of Wimbledon, to Annie Mortimer, daughter of the late Thomas Mortimer Kelson, Captain 6th Royal Regiment, and Mrs. Kelson, Birling, Hayward's Heath.

## DEATHS.

HARRIS.—On August 9th, 1918, at Southampton, Florentia Caroline Harris, widow of William John Harris, M.R.C.S., of Worthing.  
HEALD.—On September 8th, 1918, in hospital abroad, from wounds, Lieut. William Margetson Heald, M.R.C.S., L.R.C.P., R.A.M.C. (S.R.), only son of the Rev. C. W. Heald, of Chale Rectory, Isle of Wight.  
HODGSON.—On April 3rd, 1918, William Joseph Hodgson, M.D. St. And., M.R.C.S., of Thornbury, Rochdale, aged 84.  
MAGUIRE.—On September 21st, 1918, at a nursing home, John Edward Carbery Maguire, M.R.C.S., L.R.C.P., of "Burgoyne," Elm Park Road, Winchmore Hill, N 21, from pneumonia and typhoid.

## NOTICE.

*All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, St. Bartholomew's Hospital Journal, St. Bartholomew's Hospital, Smithfield, E.C.*

*The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., at the Hospital.*

*All communications, financial, or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.*



# St. Bartholomew's Hospital



"Æquam memento rebus in arduis  
Servare mentem."  
—Horace, Book ii, Ode iii.

## JOURNAL.

VOL. XXVI.—No. 2.]

NOVEMBER 1ST, 1918.

[PRICE SIXPENCE.]

### CALENDAR.

Fri., Nov.	1.—Dr. Drysdale and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Fletcher.
Tues., "	5.—Dr. Calvert and Mr. D'Arcy Power on duty.
Wed., "	6.—Clinical Lecture (Surgery), Mr. Waring.
Fri., "	8.—Dr. Fletcher and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Fletcher.
Tues., "	12.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Wed., "	13.—Clinical Lecture (Surgery), Mr. Waring.
Fri., "	15.—Dr. Calvert and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Dr. Drysdale.
Tues., "	19.—Dr. Fletcher and Mr. Waring on duty.
Wed., "	20.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri., "	22.—Dr. Drysdale and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues., "	26.—Dr. Calvert and Mr. D'Arcy Power on duty.
Wed., "	27.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri., "	29.—Dr. Fletcher and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues., Dec.	3.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Wed., "	4.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri., "	6.—Dr. Calvert and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Dr. Calvert.

### EDITORIAL NOTES.

**T**HE Dean informs us that the entry of new students shows a substantial increase on that of last year. Whilst there is a slight decrease in the numbers of Oxford and Cambridge men this year, the new London University students have increased, and this is the case also with Conjoint Board men. The total number of full-time students who have joined this year is 107, against 78 in 1917.

\* \* \*

The large attendance of doctors at the Steinway Hall meeting on October 1st proved the great interest taken by the profession in the agitation having as its object the support of medical men as candidates for Parliament. It certainly is a gross anomaly that the profession finds so little representation in Parliament. With the Ministry of

Health in a state of incubation, and with so many of the problems of reconstruction intimately bound up with the national health, the resolution unanimously passed at the meeting should receive a cordial welcome from all medical men, and, if it knows the things that make for its salvation, from the public also. As the result of the meeting an Executive Committee has been formed, consisting of representatives of a number of corporate bodies within the profession and also of several unofficial members; amongst the latter we note the name of one of our medical staff, Sir Thomas Horder, and of two old Bart.'s men, Mr. Howard Marshall and Col. Woodwark.

\* \* \*

In a sympathetic leader in *The Times* the difficulties facing the profession in regard to the whole question were fully stated. It was more than hinted that the situation would not be helped if young men with axes to grind were sent into the House. We might add that it would be helped just as little by sending old men with a hobby. And unfortunately the men between these two extremes, really representative men who are alive and who are successful in their profession, are so busy that they cannot possibly find time for campaigning. University seats are few, and the political caucus is jealous of the "safe" seats which might be available. It will be the work of the Committee, no doubt, to convince the party whips that a few up-to-date doctors would be a definite asset in the House, and a relief to the public, from an equivalent number of the traditional carpet-baggers who sit there year by year.

\* \* \*

Since writing the above we hear that Sir Wilmot Herringham has decided to stand as a candidate for the University of London. It occurred to us that Sir Wilmot's views would be of considerable interest. We accordingly wrote asking him for his opinion on two subjects: (1) the desirability or otherwise of a State medical service; and (2) the question of a larger representation of medical men in Parliament. We had two objects in view, first, the "pumping" of a candidate—and candidates are designed for that purpose—and secondly, that the subjects might be



presented to our readers in a controversial form, which is usually the more interesting aspect.

\* \* \*

We are pleased to congratulate Temp. Lieut.-Col. A. G. P. Gipps, R.A.M.C., on receiving the D.S.O., the official notice stating that the award was given for distinguished and gallant services rendered on the occasion of the destruction or damage by enemy action to hospital ships, store ships, and transports.

\* \* \*

Our congratulations to Capt. J. J. H. Beckton, R.A.M.C., who has received the Italian Bronze Medal "*Della Salute Publica*," and also to Temp. Lieut. A. R. Jennings, R.A.M.C., on receiving the Order of St. Sava. Both these decorations have been conferred by the Allied Powers for distinguished services rendered during the course of the campaign.

\* \* \*

In a recent issue of the JOURNAL we reported that Major F. G. Lescher, M.C., R.A.M.C., was a prisoner in German hands. We now have to congratulate him on being awarded a second bar to the Military Cross. The official announcement is as follows: "When his camp was heavily shelled he had the wounded removed, and attended them in the open for six hours. Again during the night, when the transport was bombed, he proceeded to the scene and extricated the wounded men and attended to them, although the enemy continued to shell the position."

\* \* \*

Our congratulations to Capt. J. A. Bell, M.C., R.A.M.C., on being awarded a Bar to the Military Cross. The official record states that he "was ordered to replace a medical officer, who was wounded, and at once went up through a very heavy barrage, established a dressing-station in the open, and showed the greatest coolness and devotion to duty in attending the wounded under very heavy shell-fire. He continued his fine work for several days, and was the means of saving many lives. His courage and fine example greatly inspired all ranks with him."

\* \* \*

We had recently to congratulate Surgeon Eric Fiddian, R.N., on being awarded the Board of Trade Bronze Medal for saving life at sea. It now affords us much pleasure to be able to give the following official details:

"A British steamship stranded on a rocky coast. The vessel broke in two amidships, and was then abandoned by her crew, who lowered themselves by ropes on to the rocks.

"On the following day the wreck was observed by an officer who had been sent out to look for her, but on account of the heavy seas he was unable to land or render any assistance to the crew. On January 3rd he arrived again on the spot in one of His Majesty's trawlers, and after great difficulty found anchorage. He then, with Surgeon Fiddian and two leading deck hands, succeeded

in reaching the crew and in gradually transferring them to his trawler, for which purpose it was necessary to make three trips. On each occasion the rescuers were obliged to wade up to their waists in water in order to get the boat away from the beach. The temperature of the atmosphere at this time was 20 degrees below zero. The rescue, however, was successfully completed."

\* \* \*

A month or two ago it was with deep regret that we had to report the death in action of Temp. Capt. E. P. W. Wedd, R.A.M.C. It will be recalled that a few weeks before being killed he was awarded the Military Cross. The official details have just appeared and these we gladly publish:

"For conspicuous gallantry and devotion to duty in traversing shell-swept roads and searching trenches under heavy fire till he found and tended the many wounded."

\* \* \*

The following official details of services for which the Military Cross was awarded are now to hand:

"Temp. Capt. D. Crellin, R.A.M.C.—For conspicuous gallantry and devotion to duty in remaining at an advanced dressing-station till all the wounded were clear, in spite of the enemy's approach, and the rain of gas and high-explosive shells."

"Temp. Capt. A. P. Fry, M.B., R.A.M.C.—For conspicuous gallantry and devotion to duty in going from place to place across the open under heavy machine-gun, rifle, and shell fire, to attend to the wounded. His absolute fearlessness undoubtedly saved many men from bleeding to death. Throughout he displayed devotion to duty of a high order."

"Temp. Capt. S. J. L. Lindeman, R.A.M.C.—For ten days he worked unceasingly, tending wounded under heavy fire, saving many lives. On one occasion, under intense machine-gun fire, he still continued dressing and collecting wounded, and his complete disregard of danger set a fine example to those under him."

"Capt. C. G. Meade, R.A.M.C.—While brigade headquarters were being shelled this officer worked unceasingly, attending wounded gunners and infantry. Later, on receiving an urgent message from a battery, he set off by himself through a heavy barrage, and though suffering from the effects of gas, performed his duties in the open, regardless of all danger. He behaved splendidly."

"Capt. (Act.-Maj.) J. M. Smith, M.B., R.A.M.C.—For conspicuous devotion to duty when an enemy shell exploded an ammunition dump near his dressing-station. He rushed to the spot, organised a rescue party regardless of exploding shells, and continued to attend to the wounded until all were removed to safety. He saved many lives by his gallant conduct."

"Capt. (Act.-Maj.) A. L. Yates, M.D., R.A.M.C.—He maintained his medical posts under heavy shelling as long



as it was possible, and was responsible for the collection and evacuation of several hundred wounded of other divisions, as well as a great many of his own."

\* \* \*

In the list of Bart.'s men who have been elected officers of the Royal College of Physicians of London, and which was reported in the September issue of this JOURNAL, we omitted to mention the names of Dr. Arnold Chaplin, who was elected to the office of Harveian Librarian, and Dr. Arthur T. Davies, who was elected a member of the Finance Committee of the College.

To these gentlemen we offer our apologies for the omission.

\* \* \*

The Entrance Scholarships this year have been awarded as follows:

*In Science (Senior).*—C. L. Pasricha, Caius College, Cambridge.

*In Science (Junior).*—B. M. Tracey, Monkton Coombe School, Bath.

*In Arts.*—J. Maxwell, Highgate School.

*Jeaffreson Exhibition.*—N. E. Laurence, Queen's Royal College, Trinidad.

#### ROLL OF HONOUR.

It is with very deep regret that we have to report the death whilst on active service of three more St. Bartholomew's men. Practically no details are yet to hand, but these we hope to publish in a later issue:

Capt. G. M. Cowper, R.A.M.C., was educated at Cambridge University and at this Hospital, and qualified in 1914. He joined up on the outbreak of war, and was latterly attached to 35th Field Ambulance.

Lieut. W. L. Dandridge, R.A.M.C., attached 103rd Field Ambulance, qualified in November, 1917, and joined up early in the present year.

Both Capt. Cowper and Lieut. Dandridge are reported to have died from wounds.

Lieut. Howard Glenny, R.A.M.C., died of pneumonia on October 9th at Basra, Mesopotamia. He had only been ill a few days, and just prior to his death was doing the work of the Medical Quartermaster.

To the relatives and friends of these Bart.'s men we extend our deepest sympathy.

### STATE MEDICAL SERVICE: MEDICAL REPRESENTATION IN PARLIAMENT.

To the Editor of the 'St. Bartholomew's Hospital Journal.'



IR,—You ask me what I think on two questions: (1) A State Medical Service, and (2) Medical representation in Parliament. I will try to answer you.

The material I have for answering the first question is only the articles in the *Lancet* of July 20th, 1918—one by Prof. Moore and Mr. Parker on behalf the State Medical Service Association, one by Sir Bertrand Dawson, and one by Dr. Lauriston Shaw. The first quotes the views of the British Medical Association, of the Panel Medico-Political Union, and of the London Panel Committee. These I have not seen first-hand, but the article seems to analyse them clearly.

Of these various statements there is only one, that of the S.M.S.A., which proposes any radical change in the present system. This body suggests a system of a military character. In each area it would establish—

(1) A group of chief practitioners with senior and junior assistants—call them majors, captains, and lieutenants for clearness.

(2) A lower grade, say second lieutenants, including house-surgeons and registrars.

(3) Higher grades of local and central administrative officers, like lieutenant-colonels and colonels, who would be employed by the Ministry of Health to control the service and keep it up to a high standard of efficiency.

All would be whole-time officers, and promotion would take place from the lower grade to the higher.

The authors employ no military terms, but the scheme is military in design, and is, in fact, very much like the organisation of the R.A.M.C.

I have been working in this system for the last four years, and have, therefore, some means of judging its effects. I have no hesitation in saying that though it is the only possible system for an army, and has done its work in an admirable way, it is the worst for civil life that can well be conceived.

Let me grant at once that in the Army it secures certain objects mentioned in the article.

(i) An easy provision of substitutes to take the duty of an absentee.

(ii) Distribution of officers in proportion to needs.

(iii and iv) Regular pay and holidays, and, if wished, study-leave.

But it does not (v), as the authors of the article suppose insure against waste of time. These unfortunates of the R.A.M.C. serve tables if ever men did. If you want to know how much time and how much paper a system can waste, from the highest to the lowest rank, go to the office of an army, or, indeed, of any Government department.

Nor does it (vi and vii) render a man more independent.

He is not in the Army dependent upon his patients, but he is far from independent of the public or of his superior officers. I remember even, when I first came out, a certain reluctance to allow post-mortem examinations for fear of what would be



said, though these were necessary if we were to learn anything about wounds and disease. I once was told by an officer, "Of course a word from you might ruin me." As far as I was concerned that was quite untrue, but it might have been true if I had been a Regular, and it seems to me horrible that a man should think such a thing. An official system does, in fact, prevent independence and discourage originality, not by the wish of anyone, but because where a man's prospects depend upon the opinion of his superiors—well, it cramps his style.

And yet (viii) it does not relieve him from the competitive struggle. This is keen and anxious in the

R.A.M.C. as it is elsewhere. *(a State Medical Council)*

Take now the drawbacks to the proposed system. The first is the question of promotion. In every Government service the leading fact is seniority. The men are so uniform and have so little opportunity of being otherwise that selection is extremely difficult. It is equally difficult to get rid of an incompetent. When selection is exercised it invariably gives rise to dissatisfaction. I heard the last lists of the R.A.M.C. freely discussed, and I was surprised at the amount of distrust that was exhibited. If that happens in a small body, what would happen in a body twenty times the size? What knowledge could the inspector possibly have of the real character of a man's work in practice, or whether he was doing it well or ill? Supervision in such matters would be a farce.

The second drawback is the bad effect upon a man's efforts which is exercised by the possession of very moderate prospects, which he can hardly be deprived of, but can hardly hope to improve. Professors naturally make light of this. A professor has the most interesting work a man can have, and has a natural love of work or he would not be a professor. A general practitioner has—and do what you will must have—an immense amount of the duller work in the world, and there is no one who can tell whether he does it well or ill. What do you suppose will be the effect upon a man not naturally industrious (and how many of us are?), who, working out his attendances at an average of a few pence for each, thinks that he is paid too little, yet sees no prospect of getting more by working harder?

And akin to this is the effect upon the general level of the profession. At present we recruit from a very good intellectual class. Men feel when they come to us that the system is elastic and that there is room for a good man to make his way. If you turn it into a rigid organisation where the power of individual effort is reduced to a minimum you will get recruits no doubt, but they will be as a rule of a much lower class of mind. There are, no doubt, exceptions. I have known one or two. But the other is the broad rule, and includes the vast majority of men.

So far I have argued the scheme upon its merits. But

in addition it is worth while to think of the practical difficulties of putting the scheme into practice. It would be a proposal nothing less than revolutionary, and, as far as I can gather, would be opposed by the great majority of the profession. The Insurance Act was difficult enough to pass, but this would be twice as difficult. The Insurance Act resulted in a much-needed and considerable increase in professional incomes, and it relieved doctors from slavery to the clubs. This change would offer no increase of income, and very small advantages of other kinds. The only grounds on which a Government would take it up would be a general desire for it on the part of the profession, and an obvious advantage to the public by improvement in practice. I think it would be resisted by us, and would not only not improve, but would greatly lower the standard of practice. It does not seem to me to be within the range of practical politics.

On the other hand, I anticipate a considerable increase in part-time appointments such as those now in existence, which will be not only a public advantage, but also will, I hope, provide some compensation to those who have lost their practice through military service.

None of the other statements contain anything more than a few additions and improvements of the present system. They suggest further provision of hospitals, and especially of scientific equipment and *personnel*, so as to bring their advantages within the reach of many more patients. They propose further that not only shall these be provided, but also the hospital staff, so far as they treat insured persons, shall be paid out of public funds. Sir B. Dawson wishes the hospital to be the centre of medical advance in the neighbourhood. Dr. Lauriston Shaw's article, though rather long, adds nothing fresh except a proposal for a National Medical Council.

In such proposals we should all concur. They are only aids to a process which has been going on all my life. Hospitals are increasing everywhere, and they are everywhere improving practice. Their staff is chosen, except in the great centres, where specialism has become necessary, from the local practitioners, and though those who are not on the staff do not attend the hospital for instruction, the staff brings its experience to the local meetings. There is no doubt whatever that in the last forty years medicine and surgery have improved not only in country hospitals, but also in private practice, quite as much as in the big centres. The public are infinitely better treated than they were. This has been the course of things—the natural course of things—under the present system. What sufficient ground is shown for turning it upside down? I am firmly opposed to any radical change because I believe it would be a disadvantage to the profession, and I am equally forcibly opposed to it because I am convinced it would be a disadvantage to the public.



In answer to your second question I think it is highly desirable that there should be a certain number of medical Members of Parliament.

It is important in the first place for the discussion of matters relating to public health. The Prime Minister said truly that you cannot make an A1 nation out of a C3 population. The aim of the Public Health service has always been to improve the very bad conditions under which many of our people live. We have had no one inside the House to support them except a few men who were members of the old parties, imbued with that party wisdom which is national foolishness. Our profession has had to speak as outsiders, and medical officers of health as servants. Improvements have been made, but much more remains to be done, and there are none who realise so well as doctors the extreme importance of the subject.

It is important also for individual practice. I have already discussed various schemes for this part of our work. If any legislation affecting practice is proposed, it is most important that it should be discussed in the House by medical men. No one can realise its probable effect upon the public but those who can understand its effect upon our own profession.

I foresee changes in the position of the hospitals and in many parts of medical education. It is most important that they should be discussed by medical members.

The improvement that has taken place in public health and individual practice has been the result of scientific discovery. This depends upon the provision of equipment and *personnel*. No one but ourselves can realise the immense importance of research in the advancement of both these sides of our work, and whether there be a Minister of Research or no, the knowledge that a medical M.P. can bring forward on this subject will be of great service.

Nor would this support be confined to medicine. All branches of science are akin, and though we are not chemists or physicists, we speak the same language and think in the same way. We know what research means to our own art, and therefore realise its necessity for all.

I will go further. We are a learned profession and a teaching profession. In a world of business and material interest the claims of learning and of teachers are of little account. I do not suppose that any class is so likely as ourselves to insist upon better education of all kinds and a better treatment of the teacher.

And that brings me to the last point, namely that medical members will be able to represent the just claims of our profession and state its grievances. One, the subordinate position of the Medical Adviser to public bodies, I have already mentioned. Another is the administration of the Insurance Act. These come to my mind at the moment, and, writing here in France, I have not by me the means of reference to others. A medical M.P. would not represent

medical men if he put professional before national interests. Our profession would be indignant if he did. But he certainly ought to make it his business to defend the former when the two do not clash. A profession gains no honour or influence by not pressing its claims. On the contrary, it is despised for its want of self-respect. I see that the Government asked the staffs of voluntary hospitals to undertake consultative service for military patients gratuitously. I wonder whether they would make such a proposal to lawyers!

And so with the whole of science. I hear that before the war Government offered 42s. a week for a qualified chemist,\* and the present rate does not seem to be much above three guineas. That appears scandalous to us who know what a scientific training means, and it is suicidal if the nation needs chemistry. But I do not suppose anybody but people like ourselves would look upon it as other than natural, or think it of much importance.

You may ask perhaps, How should we work in the House? The Minister of Health will no doubt be the proper person to initiate legislation. I am not very hopeful about a National Medical Council, to include laymen, such as Dr. Lauriston Shaw suggests. It seems to me that a Medical Council or Advisory Board to assist the Minister would be better formed by medical men alone. That, if set up, will be his main reliance in preliminary stages. But the support of medical members will be of great assistance in the House and in committees, and they will also be of use in bringing necessary matters to notice by means of questions. I should hope that they would form themselves into a private committee, which would be in constant consultation with the various representative professional bodies, and would act as their spokesmen in the House. I do not believe that any layman can speak with half as much weight as one of ourselves on matters of public health, of practice, or of medical education, or can represent nearly so well the problems of a life which we alone have seen at first hand.

I am, Sir,

Your obedient Servant,

W. P. HERRINGHAM,

*Major-General (tempy.),*

*Consulting Physician to the Forces  
in France.*

G.H.Q., France;

October 15th, 1918.

[\* We take it that Sir Wilmot Herringham refers to an analytical chemist. Some few years ago we remember seeing an advertisement for qualified analytical chemists at Woolwich Arsenal. The candidates were required to possess the qualification of the Institute of Chemistry, and preferably should have had a university training. The salary offered was £100 per annum. Such a condition of affairs of course, is nothing short of monstrous.—Ed.]



## MEDICAL NOTES.

By Sir THOMAS HORDER, M.D.

(Continued from p. 5.)

## MORBUS CORDIS (continued).

(44) Aortic disease evolving in youth or adolescence is the result of acute endocarditis complicating rheumatic fever or scarlet fever; arising between twenty-five and forty it is generally due to syphilitic aortitis; coming on after the age of forty it generally signifies atheroma of the base of the aorta and of the aortic cusps.

(45) If the symptoms in a case of aortic regurgitation advance somewhat rapidly, without recurring rheumatism, and especially if they include anginoid attacks, the cause is probably syphilis, producing gummatous infiltration of the wall of the aorta. The recognition of the cause in these cases is of the greatest importance, because thorough treatment usually leads to good results.

(46) Embolism in morbus cordis occurs as a complication of two conditions—mitral stenosis and ulcerating endocarditis. It is uncommon in any other form of heart disease. The source of the embolus is different in the two diseases; in mitral stenosis it is the clot which forms in the left auricular appendix (*vide* § 38); in ulcerating endocarditis it is the vegetations which form upon the infected valves, or, less often, upon the mural endocardium. But the organs chiefly affected by the embolic process are the same in both cases—the spleen, kidneys, brain and extremities. And even the results of the process are not so dissimilar as is often thought, because the infarcts produced in the case of ulcerating endocarditis, though infective, rarely suppurate, the reason for this being that the pathogenicity of the streptococci, which are by far the most common micro-organisms in the disease, is very slight.

(47) Embolism may occur at a stage in the course of mitral stenosis when as yet there is very little deviation from the normal cardiac response to physical effort, and it may occur long before the onset of "auricular fibrillation." This fact should be remembered in considering the question of prognosis in this disease.

(48) When embolism in morbus cordis is cerebral in distribution, the most common result is right hemiplegia with aphasia: right hemiplegia because the embolus enters the left common carotid artery more often than the innominate, the former vessel arising from the top of the aortic arch; hemiplegia because the embolus comes to rest in the middle cerebral artery, the direct continuation of the internal carotid; with aphasia because the lesion is virtually a cortical one, the obstruction of the middle cerebral producing ischaemia of Broca's convolution followed by softening.

(49) Shortness of breath on moderate exertion is due either to anæmia, emphysema, myocardial inadequacy or mediastinal disease. The first and second of these causes are not difficult to determine. When they are absent it is probable that the breathlessness is due to changes in the heart-muscle. But if careful examination and inquiry reveal no other evidence of myocardial disease, care must be taken to exclude a mediastinal lesion by radiographic investigation before it is decided that the heart is responsible for the symptom.

(50) "The patient had a 'heart attack.'" When presented with this fact in a medical history it is of great importance to get the patient's analysis of his symptoms at the immediate onset, during, and immediately after, the attack. He should be encouraged to make the account as full as he pleases. If the patient expands her sensations over-much, and enlarges the zone of reference beyond the known limits of a cardiac response, this fact itself is of value in assessing the nature and the significance of the event. The interrogator should ask as few leading questions as possible, but after the patient's own account has been given some questions of a leading character will probably be necessary; the interrogator must be prepared to attach less weight to the answers given to these latter questions than he has done to the information spontaneously afforded. An effort should be made to collate the patient's experience in terms of *breathlessness, pain, loss of consciousness, exhaustion, palpitation, sweating, flushing*. But due regard must also be paid to other sensations, of nervous, vaso-motor and visceral origin, included by the patient in his general account. In assessing values to these sensations the intelligence of the patient should go for much, his imagination for very little.

The analysis of the "attack," conducted in this manner, will in most cases take the observer pretty far towards a decision as to its nature, whether *paroxysmal dyspnoea* ("cardiac asthma"), *syncope* ("a faint"), *angina*, *heart-block*, or simple *palpitation*. Two other types of heart attacks—*paroxysmal tachycardia* and "*auricular flutter*"—require actual observations at the time of their occurrence to determine their nature correctly. Needless to say, any one of the five types first mentioned may be impossible of differentiation without objective data gleaned by the observer at the time of the attack. These objective data include the *facies* (distress, pallor, cyanosis, sweating, flushing), the *posture* (orthopnoea, restlessness, immobility) the state of the *arterial and venous pulse*, and, in the case of auricular flutter, a *polygraphic tracing*.

(51) ". . . there is no sufficient evidence that a healthy heart is ever damaged by muscular exertion, however severe or prolonged that exertion may be. . . . Is it to be supposed that the organ (*i.e.* the normal heart) is so ill-protected that it is to be damaged by actions natural to man?" (Lewis). But surely it is in the qualification



expressed by the word "natural" that the explanation of cases of—to many quite critical observers—undoubted heart-strain lies. Can the excessive effort of the rowing-man and the track-racer, for example, be termed "natural"? And if it is not natural, then is it not unnecessary to explain the damaged heart in these cases, which all physicians of experience occasionally meet with, as "examples of heart-poisoning from foci of infection or of undetected structural heart disease."

(52) In treating a case of heart-failure the heart should not be conceived of as a whole, but rather as a series of chambers, in one of which the main trouble lies. Is it the left ventricle that is in difficulty? Or the left auricle? Or is it the right side of the heart? If the burden falls primarily or chiefly upon one of these rather than upon the others—and this fact is clearly recognised—the indications for treatment are more definitely established, and, therefore, response to treatment is more likely to be effectual.

(53) Angina pectoris is by no means always associated with high arterial tension and diffuse arteriosclerosis. What may not inappropriately be called the "asthenic" type of the disease is not at all uncommon. In this type the blood-pressure is often subnormal, the circulation is poor, peripheral venous stasis is common and a condition of asystole is present. The patients are usually over sixty years of age. Post-mortem, the heart is not enlarged, it may even be small and under weight, with the appearance termed "brown atrophy." Atheroma is usually present in one or more of the coronary arteries.

(54) Anginal pain is often induced by cold, and especially by walking against a cold wind. A patient suffering from aortitis will be able sometimes to walk briskly upstairs without discomfort, and yet will be unable to walk even slowly on the level, if faced by bleak air, without considerable pain.

## FROIN'S SYNDROME.

By R. G. CANTI, M.B.(Cantab.).

**T**WO cases exhibiting Froin's syndrome have occurred recently and at the same time in the wards of this Hospital. This condition has not often been recorded, and as it seems probable that examples are not infrequently overlooked, I am taking the opportunity of giving a brief *résumé* of the subject together with short notes of the cases.

Froin's syndrome is not a disease *per se*, but a morbid state of the lumbar puncture fluid which may be found in several diseases when certain well-defined conditions are

fulfilled. The two chief characters which constitute it are the formation of a heavy coagulum and a yellow colour of varying intensity. The coagulum is such that frequently the test-tube may be turned upside down without spilling the contents. Thus, apart from the other characters presently to be described, observations may be carried out and interpreted by the bedside without the aid of laboratory apparatus.

The condition was first noticed by Lépine in 1903, and in the same year Froin collected several cases and drew attention to the syndrome, which has since been observed by a number of workers, including Mestrezat,\* who gives an excellent account of it. The latter, up to the year 1912, had collected twenty-one cases, including those of Froin.

The conditions essential for the production of the syndrome are as follows:

There must be some lesion in or about the cord which blocks the subarachnoid space, so that the flow of cerebro-spinal fluid is obstructed and stasis exists in the closed cavity below the lesion.

Further, there must be some changes in the walls of the blood-vessels of the meninges permitting passage of plasma and red blood-cells to take place into the closed cavity.

Appreciating, then, the kind of lesion that is necessary for the production of the syndrome, it is not difficult to draw up a list of diseases which might bring about these essential conditions, and such a list is actually found to correspond with one prepared from the clinical observations and autopsies of the cases recorded. The majority of them are found to have been caused by meningo-myelitis or chronic meningitis, and for these syphilis has been occasionally responsible, but more often, as usually happens with cases of this nature, the aetiology has remained obscure. Of the remainder, a new growth, either primary or secondary, situated in the cord or its surrounding structures, has proved to be the most important cause, and cases of Pott's disease and tuberculous meningitis have been described.

On examination of the cord the obstructive lesion is most often seen in the dorsal or lumbar region, but is not necessarily confined to this situation. The following alternatives, of which one or more may be present at the same time, have been recorded: The meninges may be bound down to the cord by fibrinous adhesions; the cord may be swollen and oedematous so as to fit tightly in the dural sheath as a finger in a glove; a mass of pus, shut off by adhesions from the remainder of the subarachnoid space, may surround the cord; an inflammatory exudate may lie in the extradural space and press upon the dura mater and its contents; a new growth may obstruct the subarachnoid space.

With regard to the blood-vessels, macroscopical examination usually reveals hyperæmia of the meninges with

\* *Le liquide céphalo-rachidien*, Paris, 1912.



engorgement of the larger vessels. Even if this is not present to the naked eye, histological examination always discloses inflammatory processes with accompanying engorgement of capillaries and extravascular collection of their contents. In cases of neoplasm small hæmorrhages may take place directly into the cerebrospinal fluid from the vessels or blood-spaces of the growth.

More extensive examination of the cerebrospinal fluid reveals certain other characters, among which the quantity and quality of the protein are of importance.

The *tension* is variable. The *quantity* of fluid obtainable is generally small—often only a few drops—owing to the rapid fall of tension in the circumscribed subarachnoid space.

In *appearance* the fluid is usually clear or slightly turbid, this being dependent in some degree on the nature of the disease. The consistency is usually watery whilst the fluid is being collected, but clotting may take place so rapidly that the needle becomes plugged. Usually clotting begins in about ten minutes, but it is sometimes delayed for many hours. The typical clot is heavy and gelatinous, and, as previously stated, is sufficiently firm to withstand inversion of the containing tube.

The *colour* is golden-yellow, or sometimes brownish or greenish-yellow, and is due to pigments derived from the breaking-down of the hæmoglobin of the red blood-cells. It is usually sufficiently obvious to claim immediate attention, though occasionally it may only be detectable as a pale straw tinge when the fluid is viewed axially in the test-tube.

The total *protein* content is extremely high, being generally in the neighbourhood of 1 per cent., though more than 2 per cent. has been recorded several times. Globulin is always present, and may form as much as one-third or more of the total protein. Albumoses and peptone are present, and are due to the slow breaking down of the more highly organised proteins which have remained in the closed meningeal sac for a prolonged period.

The *reduction of Fehling's solution* varies in accordance with the disease. The test is frequently obscured by the biuret reaction.

There is usually a slight increase in the total *cell content*, and a differential count shows a preponderance of lymphocytes. Red blood-cells may also be present. Both kinds of cells may be found either normal in appearance, or in various stages of disintegration.

To sum up, the following characteristics of the cerebrospinal fluid constitute Froin's syndrome:

- (1) The formation of a heavy coagulum.
- (2) A yellow colour.
- (3) The presence of a large quantity of protein.
- (4) The presence of albumoses and peptone.

The conditions under which it may take place are:

(1) Obstruction to the flow of cerebrospinal fluid in the subarachnoid space by a lesion usually situated in the dorsal or lumbar region.

(2) Changes in the blood-vessels of the meninges.

The diseases in order of frequency in which these conditions may be met, and consequently in which Froin's syndrome may occur, are:

(1) Meningo-myelitis or chronic meningitis of various origins.

(2) New growths, primary or secondary, in or about the cord.

(3) Tuberculous meningitis.

(4) Pott's disease.

I have to thank Major Morley Fletcher and Capt. Girling Ball for their kindness in allowing me to quote the two following cases:

CASE I.—*Syphilitic meningo-myelitis*.—C. H—, male, æt. 50, was admitted on July 25th, 1918, complaining of pains and weakness in the right leg, which had begun three months previously.

The patient was able to walk and looked fairly healthy. On examination of the nervous system the eyes were found to react to light and accommodation, and there was no ocular or facial paralysis. The triceps and supinator reflexes were brisk and the knee-jerks present, though difficult to elicit on the right side. Ankle clonus was absent, and neither extensor nor flexor response could be obtained on plantar stimulation. The abdominal reflexes were normal. Weakness was present in the hamstring muscles of the right side, and there was a wastage of 2 in. of the right thigh, the muscles of which gave weak normal electrical reactions. The sphincters were normal. The patient complained of pain at the back of the neck and of tingling in the left arm. There was diminished sensation to light touch on the inner sides of both thighs, and a lack of discrimination between heat and cold over the same areas. There was a loss of sense to the tuning-fork in the bones of the legs and pelvis.

The Wassermann reaction of the blood was positive. The patient remained in hospital for seven weeks, during which time he improved slightly under treatment.

*Pathological examination of the cerebrospinal fluid, August 13th.*—*Quantity obtained*: About 4 c.c. *Colour*: Faintly yellow. *Appearance*: Slightly turbid large spontaneous clot throughout. When examined twelve hours after withdrawal, the clot was just free from the walls of the test-tube, whose shape it retained. *Cells*: Total number not counted owing to the clot. A stained film showed almost all the cells to be lymphocytes, a few endothelial cells were present, and no polymorphonuclear cells seen. *Albumen* (Aufrecht): 0.8 per cent. *Globulin* (ammonium sulphate): Very marked ring. *Reduction of Fehling's solution*: Obscured by biuret reaction. *Wassermann reaction*: Strongly positive.



CASE 2.—*Tuberculous meningitis*.—W. T—, male, æt. 17½, was admitted on June 27th, 1918, with the diagnosis of tuberculous glands in the neck. An abscess in the neck was incised on two occasions, the last of which was on July 26th. Subsequently to this, though he was able to get up and go about the ward, he did not do well, and suffered at times with intense frontal and vertical headache, and pain in the back of the neck. On August 8th he became worse and was kept in bed. The fundus oculi was found to be normal. There was an internal squint of the left eye. The neck was stiff, but there was no retraction. There was paresis of both legs, which was more marked on the right side, where there was some loss of sensation to light touch, though pain could be felt. On August 13th he first became drowsy and tremulous, and later unconscious, rolling his head from side to side. On August 15th he was still unconscious and sinking, and exhibited aimless and tremulous movements. On August 16th he died.

*Pathological examination of the cerebrospinal fluid, August 9th.*—*Quantity obtained*: About 15 c.c. *Colour*: Faintly yellow. *Appearance*: Rather large clot present, which fell to the bottom of the test-tube. Supernatant fluid moderately turbid. *Cells*: Total number not counted owing to clot. A stained film showed the great majority to be lymphocytes. *Albumen* (Aufrecht): 1·3 per cent. *Globulin* (ammonium sulphate): Present. *Reduction of Fehling's solution*: Absent.

*August 15th.*—*Quantity obtained*: About 5 c.c. *Colour*: Golden-yellow. *Appearance*: Moderately turbid firm spontaneous clot throughout. The test-tube could be inverted. *Cells*: Total number not counted owing to clot. A stained film showed them to be practically all lymphocytes. *Albumen* (Aufrecht): 1·1 per cent. *Globulin* (ammonium sulphate): Very marked ring of granular appearance. *Reduction of Fehling's solution*: Obscured by biuret reaction.

*Autopsy.*—The lesions found were: Tuberculous meningitis, extensive pulmonary tuberculosis, tuberculous tonsils, early tuberculous ulceration of ileum, tuberculous cervical, mediastinal and mesenteric glands. The brain weighed 52 oz. Much slightly turbid watery fluid was seen beneath the membranes at the base. Numerous grey tubercles were present there and extended along the courses of the anterior and middle cerebral vessels and around the medulla to the roof of the fourth ventricle. The cerebral ventricles were slightly distended, and the choroid plexuses were injected but showed no obvious tubercles. The lesions in the cord were more marked than those in the brain. Over the cervical swelling the vessels were much engorged and stood out prominently. Here the membranes were hyperæmic, cedematous, and adherent posteriorly to the cord, so that stripping was carried out with difficulty. Obstruction appeared to be complete at this place. The greater part of the canal and surface of the cord were studded with

tubercles, which, though sparse in front of the cord, were confluent behind it. The corda equina was densely matted together and studded with tubercles.

## A CASE OF INTUSSUSCEPTION OCCURRING AS A COMPLICATION OF TYPHOID FEVER.

By H. W. TOMS, M.R.C.S., L.R.C.P., and C. LANGTON HEWER, M.R.C.S., L.R.C.P.



E are indebted to Dr. Drysdale and Mr. Moreton for permission to publish details of this case.

The patient, Edith R—, æt. 24, was admitted to Hope Ward under the care of Dr. Drysdale on April 13th, 1918, complaining of headache and feverishness.

She stated that she had been quite well until April 3rd, ten days previous, when she began to have headache. The next day she was worse, had no appetite and felt feverish, and on the 5th she took to her bed. During this time she had no cough, epistaxis, or nausea, and she stated that the action of her bowels was quite normal. On the 7th she was seen by her doctor, who diagnosed enteric fever, and on the 13th she was admitted to this hospital.

On admission, patient looked pale, with cyanosed lips; her tongue on each side of the middle line was coated with a thick fur, and on examination of the trunk several small rose-spots were found on the thorax and abdomen. Nothing abnormal was discovered in the chest, and the abdomen was not noticeably distended or tender, but the spleen was palpated, extending 1½ in. below the costal margin in the left nipple line. No nervous manifestations were found, and cerebation was normal. Temperature 102·2° F., pulse 116, respirations 20. A white blood-count showed 11,000 white cells, and Dreyer's test a titre to *B. typhosus* of 1 in 500.

More rose-spots appeared from time to time, and on the 18th patient became gradually more drowsy and toxæmic, had several attacks of epistaxis, and developed a cough. The temperature was not very typical, the fever being rather of the remittent type. Since admission constipation had been marked.

On the 23rd patient was very drowsy, and the abdomen was a little full. The liver dulness, however, was normal. On the 25th, 26th, and 27th she vomited, and the pulse-rate increased in frequency; but on the 29th she was much better, constipation was less marked, and the temperature began to come down slowly. During the next fortnight patient continued to improve, and, with the exception of a little peripheral neuritis, developed no new symptoms. On the 16th, however, her temperature began to rise, one fresh rose-spot was discovered, and constipation returned. On the evening



of the 19th the temperature dropped from  $101^{\circ}$  to  $97.8^{\circ}$  F., there was some vomiting, and the patient complained of vague pain in the abdomen. The pulse-rate, however, was lightly decreased, distension was not more marked, and the liver dulness was normal. The abdomen moved well on respiration.

On the afternoon of the next day, the 20th, the pulse-rate rose from 120 to 140, the temperature remaining about the same, and the pain became more localised to the right iliac fossa, and more of the nature of colic. Three small stools were passed, but contained no blood. Vomiting continued, and it was decided that a leucocyte count should be taken. This showed 13,400 white cells—a moderate leucocytosis, which could not be taken as any definite evidence of perforation, as a typical leucopenia had never been present. Surgical opinion was in complete agreement that laparotomy was not indicated. At mid-day of the 21st pain was obviously increasing in intensity, and as it was thought likely that the patient had a leaking ulcer with some localised peritonitis, Mr. Moreton was asked to explore the abdomen.

This he did at 3.45 p.m. An incision, 4 in. in length, was made through the right rectus muscle. On opening the peritoneal cavity a fair quantity of straw-coloured and faintly blood-stained fluid escaped. No gas was present, however. On exploration an intussusception, enteric, becoming entero-colic, was discovered. The neck appeared to be about 5 in. from the ileo-cæcal valve, and extending 4 in. up the ascending colon. The cæcum was not involved, but was distended with gas.

Reduction was effected without great difficulty and the gut inspected. It was stiff with oedema, and the apex was congested, but it appeared viable. On palpation no apparent cause for the intussusception could be found. The gut was therefore returned to the abdominal cavity, and the wound closed in layers without drainage.

The patient was taken to Lawrence Ward, and, with the exception of some anæsthetic vomiting, passed a good night. The following morning an enema was given, with fair result. This was repeated in the evening. The patient passed flatus, and stated that she was quite relieved from the pain prior to operation. The temperature in the evening rose to  $101.4^{\circ}$  F. Albumen water, whey and brandy were given by mouth. The temperature remained irregular, and on the 25th rose to  $103^{\circ}$  F. She improved considerably, however, in the next few days, and her bowels acted well. On the 30th she had slight epistaxis and bleeding from the gums. Hæmorrhagic spots also appeared on the chest and back. The stitches were removed, and the wound looked perfectly healthy.


She was re-transferred to Hope Ward on the same day with a temperature about  $100^{\circ}$  F., and still very toxæmic. She improved slowly, her temperature came down, and on June 8th she felt "hungry." Her condition became steadily

better, but unfortunately she developed the carrying habit, which considerably prolonged her stay in hospital.

The above case, we think, is interesting both on account of the rarity of the complication—we have only been able to find one other such case on record—and the difficulties attendant upon its diagnosis.

## THORACOTOMY AND COMPLETE SUTURE.

By J. E. A. BOUCAUD, M.R.C.S., L.R.C.P.

N recent years, many papers illustrating the good results of modern surgery of the chest have been published in medical journals. These dealt with war wounds of the chest and their complication and treatment, as carried out in France, and the possibilities of the application of the same methods in civilian practice. As most cases of gunshot wounds of the chest require immediate treatment, surgeons in England have to their credit only a small proportion of the total number of such cases. Many cases have been admitted to the Military Wing of St. Bartholomew's Hospital, but one which with the kind permission of Capt. Girling Ball I am able to record below is of special interest, it being the first case in which thoracotomy with complete suture was performed at this Hospital.

The patient æt. 30, a corporal of the Canadian Infantry, was wounded on August 8th, 1918, had slight hæmoptysis for four days and some dyspnoea and pain in his left side. He was admitted to the Military Wing of St. Bartholomew's Hospital on August 18th with a small superficial wound just below the inferior angle of the left scapula; he complained of pain in his side on breathing, and shortness of breath; there were signs of fluid at the left base. X-ray examination showed the presence of a hæmothorax, fracture of the seventh rib, and a shrapnel ball, the position of which altered when the patient moved.


The treatment consisted in (1) excision of the entry wound, which was sutured, and healed by first intention; (2) resection of 3 in. of the seventh rib in mid-axillary line, evacuation of the blood, removal of the shrapnel ball, and irrigation of the pleural cavity with water, and finally complete and careful suture of the wound in layers.

The fluid removed was examined bacteriologically and found sterile. But for a great deal of surgical emphysema the patient made a straightforward recovery, the wound healing by primary union.

Early in October there was still flattening of the chest on the left side but fair expansion, and the breath-sounds were feebler than on the right side. He was put on graduated exercise but his reaction was poor; his general condition is such as to warrant the most sanguine expectations after further exercise treatment.



## HOSPITAL STAFF IN WAR TIME.

1.  HIS tragic never-ending fight  
Has made us callous creatures quite,  
Nor weep we longer at the sight  
of anguish;  
The vasty numbers of the slain  
Have dulled the feelings of the brain  
For those who lie in deadly pain,  
or languish.
2. We've grown so very cold of late,  
We'll leave a baby to its fate  
Whose heart has slowed its anti-nat-  
al rhythm;  
Our condescension will not stoop  
To treat an infant with the croup  
Unless he's brought his little coup-  
on with 'im!
3. We rise to join the Junior Staff;  
And then we surely have the laugh,  
For see those patients in yon draugh-  
ty passage!  
We keep them waiting in a bunch  
While we have breakfast, tea or lunch,  
Maybe we'll tend them in the Röntg-  
en gas age.
4. And when we toddle to the War  
We shed no liquid teardrops for  
A shrapnel-wound, a gassing, or  
"a piff-rent,"\*  
Each man is but a case, you see,  
With whom a purge must needs agree—  
Unless that wounded man is me—  
That's diff'rent.

D. W. W.

## CORRESPONDENCE.

## MEDICINE VERSUS SURGERY.

*To the Editor of the 'St. Bartholomew's Hospital Journal.'*

SIR,—Through your columns I really must thank Major Rawling for again contributing "much amusement" to my "leisure hours"; his reply to my letter is too delightful. Major Rawling, I know, is a fisherman. In his letter he tells us that he is a sportsman; he knows therefore how pleasant and satisfying it is to see his fish rise and take the bait so carefully selected and temptingly displayed. Ten days past the Somme has been far behind my back and only small frogs are to be found in the water of the shell-holes. Nevertheless, sir, that pleasant satisfaction has been mine.

\* "Piff-rent": a rent caused by rifle bullet.

I can well believe that the debate was replete with humour; did I not say that it gave me much amusement to read even the "merest abstract" thereof? How could it be otherwise when the proposer of the motion was not in agreement with its terms, and when, therefore, he spoke contrary to his convictions for fear that the Secretary of the Society might call his sporting instincts into question? Why deny me the humour of the scene? Scenes from *Alice in Wonderland* spring to mind.

I might take up all the points raised by Major Rawling in his letter, and further support my view in the cause of medicine (and I see that the *Lancet* also takes my view), but as he assures me he has no "leisure in which to criticise other men's statements and works," I will not tempt him to contradict himself again on this statement and criticise once more my statements in a very lengthy letter to your valuable JOURNAL!

Were it not for the humour of the situation and the great amusement Major Rawling has given me, I should be inclined to reply to the gibes and sneers levelled by him at my professional ability and judgment; this sort of thing from one whom one respects as a man and as a surgeon are calculated to hurt and do harm.

As to Major Rawling's remarks about "luxury and ease" and "leisure hours" out here, this merely makes one smile and clinches one's contention that he is quite ignorant, not only of surgical and medical affairs in the front area, but also of all other affairs there.

In conclusion, sir, I would invite Major Rawling's mind to dwell on this before repeating such statements.

With apologies, Sir, for thus trespassing on your space.

I am, Sir, etc.,

GERALD STANLEY,  
Major, R.A.M.C.

B.E.F.;

October 14th, 1918.

*To the Editor of the 'St. Bartholomew's Hospital Journal.'*

SIR,—The reply of Major Rawling to Major Stanley's letter concerning the debate upon "Medicine versus Surgery" at the meeting of the Abernethian Society indicates throughout that Major Rawling was "stung," for anger is the prominent feature of his contribution. The angry man is generally unconvincing, and the perusal of Major Rawling's letter led many who read it to the opinion that he had "given himself away." He decries the opinion of his opponent, and in a loud voice declares the priority of claim of the surgeon specialist. The very same attitude is being adopted by some with regard to the proposed State Medical Service, and at a time when unselfishness is proved to be the very essence of patriotism. Was not Major Stanley's letter to be interpreted as the chivalrous attempt of a gentleman to defend the person unfairly attacked? "Methinks" Major Rawling "doth protest too much." His impassioned rhetoric does not lead us into a fallacious train of thought.

One has often noticed in this country that the Tommy, finding that the native fails to appreciate his French, raises the pitch and volume of his voice. Abuse is no argument, and if Major Rawling wishes to enter into a controversy many further points might be adduced to show him that he is quite wrong in adopting this attitude. Further, I would like to tell Major Rawling that it is evident that he has the most meagre knowledge of the work of C.C.S.'s in France, and that in the opinion of his colleagues Major Stanley is a surgeon of unexceptionable skill and indubitable ethics.

Yours faithfully,

C. W. T. BALDWIN,  
Major, R.A.M.C.T.

CASUALTY CLEARING STATION, B.E.F. ;  
October 9th, 1918.

## REVIEWS.

ANATOMY, DESCRIPTIVE AND APPLIED. By HENRY GRAY. Twentieth Edition. Edited by RICHARD HOWDEN. (Longmans, Green & Co) Pp. 1324. Price 37s. 6d. net.

It says much for any work that, although the first edition appeared as far back as 1858, it should still rank as a standard book on that particular subject. Gray's *Anatomy* has, of course, undergone many changes since it was first published. The first edition covered 750 pages, while the present volume has increased to nearly double that



size. Prof. Howden has been associated with the editorship since 1901, and the present volume is probably as good as any work on Anatomy in the English language.

We feel it our duty to have again to deplore the fact that preference is given to the Basle terminology, although in all fairness it should be stated that where a new name differs materially from an old one the latter is placed within brackets after the former. But this does not alter the fact that throughout the volume the recognised terminology is the "new"—a condition of affairs which is all the more remarkable in view of the recent decision of the Anatomical Society to abandon the Basle nomenclature, which they regard as a totally unnecessary change.

Not the least interesting part of the present edition is a biographical sketch, with photograph, of Henry Gray, F.R.S., F.R.C.S. At the early age of 25 he was elected a Fellow of the Royal Society, and was only 34 years of age when he died.

We should perhaps state that the notes on applied anatomy in the present edition have been revised by A. J. Jex-Blake and W. Fedden Fedden, and there are, at least, 60 new illustrations.

**A MANUAL OF PHYSICS FOR STUDENTS OF MEDICINE.** By HUGH C. H. CANDY. (Cassell & Co., Ltd.) Pp. 451. Price 7s. 6d. net.

This is a text-book which we have every confidence in recommending to the student. It is concisely and clearly written, the author taking great pains to make his meaning clear in as few words as possible, and yet at the same time neglecting nothing which would be of help from an examination point of view. Its handy size enables it to be slipped into the pocket—an innovation which other publishers might well copy. We congratulate the author upon being modern enough to introduce an aeroplane by the way of illustration, but we express lack of confidence in its flying ability. Also we hesitate to accept the statement that the movements of camphor floating upon warm water are due to its partial solution.

**THE ERRORS OF ACCOMMODATION AND REFRACTION OF THE EYE.** By ERNEST CLARKE. (Baillière, Tindall & Cox.) Pp. 243. Price 6s. net.

The fourth edition of this well-known work does not materially differ from the last edition. The book is mainly intended for students and is essentially practical, all unnecessary details being rigorously excluded.

Some ninety-two illustrations are included in the text, and the book has been thoroughly revised and brought up to date.

We regard the volume as quite one of the most readable and practical of the many books available on this important subject, which, for some reason or other, appears to be out of favour with the average student.

**AIDS TO DIAGNOSIS.** By ARTHUR WHITING. (Baillière, Tindall & Cox.) Pp. 167. Price 3s. 6d. net.

The basis of this useful little book is essentially clinical and not pathological. As pointed out in the preface, the plan has been to start with the leading symptom or symptoms, and, after arranging the diseases presenting these symptoms in groups, to differentiate the members of each group, so far as possible, as clinical entities.

The result is a collection of extremely useful data, although, as the author points out, the power of diagnosis is largely a matter of practice.

The section on "The Differential Diagnosis of Infectious Fevers," by Dr. Henry Cuff, still remains one of the best chapters in the book. In the light of recent work, the chapter dealing with "Diseases of the Heart" has been considerably revised.

We can recommend the book with every confidence to the student, who often finds it so difficult to piece together all the evidence which goes to make an accurate diagnosis.

### APPOINTMENT.

ROBERTS, Surgeon W. E., R.A.N., made Acting Staff-Surgeon, Aug. 27th, and appointed to H.M.A.S. "Brisbane" from H.M.A.S. "Tingira."

### CHANGES OF ADDRESS.

BOUSFIELD, P., 7, Harley Street, W. 1.

MAPLES, E. E., "The Warrens," Calabar, Southern Provinces, Nigeria.

SAMY, A. H., 16, Naser Street, Abbassieh, Cairo, Egypt.

SHIRLEY-JONES, E., Royal Societies Club, St. James's Street, S.W. 1.

STOCKER, Major E. G., R.A.M.C.T., O. i/c Medical Division, Military Hospital, Sutton Veny, Wilts.

TAUNTON, T. J., 102, Lansdowne Road, Clapham, S.W.

WILLIAMS, C. O. O., St. Albans, Shakespeare Road, Worthing. (Temporary address.)

### BIRTHS.

ILOTT.—On October 16th, at Seaton, Devon, the wife of Capt. Cyril H. T. Ilott, R.A.M.C., of Bromley, Kent, of a daughter.

LAWRENCE.—On October 1st, at Kenley, Gravesend, to Margaret (née Cleghorn), the wife of Stephen M. Lawrence, M.D., B.S.—a daughter (Sarah Hilary).

PETERS.—On September 7th, at 24, High Street, Petersfield, to Frances Williamina (née Vérel), wife of Capt. Rudolph A. Peters, M.C., R.A.M.C.—the gift of a son.

PRITCHARD.—On September 19th, at 33, Harley Street, W., the wife of Major H. Pritchard—a daughter.

RAMSAY.—On September 14th, at Eldon Place, Blackburn, the wife of Capt. J. Ramsay, R.A.M.C.(T.), of a daughter.

STRAHAN.—On August 30th, at Hong Kong, the wife of Stuart Séguin Strahan, M.B., of a son.

### MARRIAGE.

HAMILL—ZEHEMAYR.—On Thursday, October 24th, at St. Bridget's Church, Isleworth, by Rev. Fr. Green, Philip Hamill, M.D., D.Sc., M.R.C.P., Major, R.A.M.C., younger son of the late Philip Hamill and of Mrs. Hamill, of 5, Avonmore Mansions, Kensington, to Louisa Maude, second daughter of the late F. F. Zehetmayr and of Mrs. Zehetmayr, of Belle Vue, Ailsa Road, St. Margaret's.

### DEATHS.

CARLYLE.—On October 21st, 1918, at St. Bartholomew's Hospital, from pneumonia, Thomas Carlyle, Surgeon Probationer, R.N.V.R., only son of Lieut.-Col. and Mrs. Carlyle, aged 24.

COWPER.—On October 3rd, 1918, of wounds, Capt. Geoffrey Moore Cowper, R.A.M.C., late 35th Field Ambulance, son of Mrs. Cowper, 67, Duke Street, Darlington.

CUNNINGTON.—Killed by the explosion of a bomb in an advanced dressing station on March 23rd, 1918, Edward Charles Cunnington, only son of Capt. B. Howard Cunnington, of Devizes.

DANDRIDGE.—On October 5th, 1918, of wounds received in action, Lieut. W. Leslie Dandridge, R.A.M.C., attached to the 103rd Field Ambulance, the dearly loved and youngest son of Mr. Alfred Dandridge, Brookslough, Albemarle Road, Beckenham, Kent, aged 24.

GLENNY.—On October 9th, 1918, of pneumonia, on active service, Lieut. E. H. Glenny, R.A.M.C.

HAMILTON.—On September 16th, 1918, suddenly at Heathfield, Heswall, Robert J. Hamilton, F.R.C.S.E., of 82, Rodney Street, Liverpool.

HOBDAV.—On September 29th, 1918, at Llandudno, James Hobday, B.A.(Cantab.), M.R.C.S., L.R.C.P., beloved husband of Nancye Hobday, aged 47.

### NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, Smithfield, E.C.

The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., at the Hospital.

All communications, financial, or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.



becomes Matthew, and the Ophthalmic Ward is known as Albert Edward. The whole of this block, with the exception of Casualty, is now given over to the military.

\* \* \*

The following gentlemen were nominated to the Resident Staff, commencing November 1st, 1918:

*House-Physicians—*

Dr. Tooth.	G. J. Sophianopoulos.
Dr. Calvert.	R. J. Perkins.
Dr. Fletcher.	G. Lyon-Smith.
Dr. Drysdale.	G. A. Fisher.

*House-Surgeons—*

Mr. D'Arcy Power.	M. V. Boucaud.
Mr. Waring.	G. Millar.
Mr. Eccles.	R. D. Jones.

*Medical Receiving Officers*

W. L. Berry.
H. J. Pollard.
H. Franklin.

*Surgical Receiving Officers*

H. Corsi.
D. P. Guilfoyle.

*Intern Midwifery Assistant*

J. A. van Heerden.
--------------------

*Extern Midwifery Assistant*

C. F. Krige.
--------------

*House-Surgeon to Throat, Nose, and Ear Department*

F. T. Birkitt.
----------------

*House-Surgeon to Ophthalmic Dept.*

N. J. Macdonald.
------------------

*House-Surgeon to Venereal Dept.*

C. W. Bennett.
----------------

*House-Surgeon to Military Wing*

J. E. A. Boucaud.
-------------------

*Resident Anæsthetist*

D. A. Blount.
---------------

\* \* \*

The influenza epidemic has meant an exceedingly busy time for the Hospital staff, and the number of out-patients treated has been unprecedented. Many members of the Hospital have themselves been victims of the disease, no less than twelve of the Junior Staff being down at one time. These, we are glad to state, are convalescent again, but it is with very great regret that we have to report the death of two well-known and popular students, who had both only recently resumed their medical studies after some years of absence with His Majesty's Forces. Surgeon Sub-Lieut. T. Carlyle and J. L. Dunstan both succumbed in Hospital to pneumonia following influenza.

A Memorial Service was held in the Hospital Church on each occasion. It is hardly necessary to state that their death cast quite a gloom over the Hospital.

\* \* \*

We regret to have to record the death of Dr. C. A. Patten, who for more than fifty years was Medical Officer of Health for Ealing. After study at this Hospital, Dr. Patten qualified M.R.C.S.Eng. in 1861. Deceased had held many appointments, and was Honorary Consulting Medical Officer at the King Edward VII Memorial Hospital, Ealing. He had also been Divisional Police Surgeon. Dr. Patten was seventy-nine years of age.

\* \* \*

## ROLL OF HONOUR.

It is with feelings of very great regret that we have to report the death of several more Bart.'s men under this

heading. Again we beg to offer our deepest sympathy to their relations and many friends.

Capt. R. Brewitt-Taylor, M.C., R.A.M.C., was killed in France by a shell on August 22nd when he was on his way to the front line with his stretcher-bearers. Capt. Brewitt-Taylor left England for France in August, 1914. He served as Regimental M.O. through 1915, was in Mesopotamia in 1916, and in France again during 1917-18. At the time of his death he was attached to the 7th Field Ambulance.

Surgeon Sub-Lieut. T. Carlyle, R.N.V.R., died of pneumonia in St. Bartholomew's Hospital on October 21st, aged 24. The only son of Lieut.-Col. Carlyle, he entered the Hospital in October, 1913. He volunteered as a Probationary Surgeon two years ago, and only returned to Hospital at the beginning of this session.

Capt. James Harris Connolly, R.A.M.C., died at the Acheson Military Hospital, Regent's Park, London, on October 23rd, aged 42. He was educated at Edinburgh University, where he graduated M.B. and B.C. in 1902, and M.D. with commendation in 1906; and also studied at King's College Hospital, London, at St. Bartholomew's, and at the London and Middlesex Hospitals. After filling the posts of House-Surgeon to the Royal Albert Hospital, Devonport, of Senior House-Surgeon to the Chesterfield and North Derbyshire Hospital, and of Resident Medical Officer to the Throat Hospital, Golden Square, London, he went into special practice in London, and held the appointments of Chief Assistant in the Aural Department at St. Bartholomew's and of Surgeon-in-Charge of the Throat, Nose and Ear Department at the Queen's Hospital for Children. He took a temporary commission as Lieutenant in the R.A.M.C. on October 10th, 1914, and was promoted to Captain after a year's service.

Surgeon Lieut.-Commander John Hadwen, R.N., was reported as having died on service in the casualty list published on November 2nd. He was educated at St. Bartholomew's Hospital, and took the diplomas of M.R.C.S. and L.R.C.P.Lond. in 1907. He graduated B.Sc.Lond. in 1905, and M.B., B.S. in 1907. He entered the Navy as Surgeon on May 14th, 1909, and in the early part of the war was serving in H.M.S. "King Edward VII."

Capt. Walter Malden, R.A.M.C.(T.F.) died at Cambridge on October 28th, aged 60. He was educated at Cambridge, where he graduated M.A. in 1885, M.B. in 1886, and M.D. in 1905, and at St. Bartholomew's Hospital, taking the diplomas of M.R.C.S. in 1886 and the M.R.C.P.Lond. in 1909. He held the posts of Clinical Pathologist and Director of the Clinical Laboratory at Addenbrooke's Hospital, Cambridge, and was Honorary Medical Officer of the Charity Organisation Society and of the Cambridge Rescue and Prevention Society. He took a commission as Captain in the R.A.M.C.(T.F.) on the staff of the 1st Eastern (Cambridge) General Hospital on May 6th, 1908, and was Pathologist to that hospital.



## STATE MEDICAL SERVICE.

The views of Sir Wilmot Herringham on this all-important question have been the subject of much interest. The following letter from a well-known Bart.'s man, who, however, wishes to remain anonymous, will be read with equal interest, especially as the writer takes the opposite view to Sir Wilmot, and is all in favour of some form of State Medical Service:

*To the Editor of 'St. Bartholomew's Hospital Journal.'*

DEAR SIR,—I venture to forward to you some reflections which have been gradually shaping themselves in my mind, and, I doubt not, in the minds of many other medical men now serving with the R.A.M.C. in France. The singular smoothness and, on the whole, great efficiency with which the machine works, both on its administrative and its more purely professional side, naturally lead to the question whether such a service as now exists for the benefit of the Army should not be extended after the war for the benefit of the nation. I do not think I am exaggerating if I say that not a few medical men who would have unhesitatingly rejected the idea four years ago as either impracticable or as undesirable have become less contemptuous, and even strong advocates, of such a change owing to their experience of the advantages of a great organisation such as the R.A.M.C. Of course the problems faced and solved by the R.A.M.C. in France are infinitely smaller and less complicated than those which would confront the organisers of a national service scheme; yet if the whole question be faced boldly and without too great a deference for tradition and usage the problems are not, I think, unsolvable. Certainly practical experience in the R.A.M.C. is sufficient to convince most men that it is possible to handle efficiently and quickly the diseases and injuries of two, three, or four million individuals; and if for such a number, why not for a whole population of forty millions?

But taking a further point, such a service may be possible, but is it desirable—(a) for the patient, (β) for the profession, (γ) for the general advance of medical knowledge? Speaking for myself and for, I believe, the majority of men who have served with the R.A.M.C. in France, I have not the least doubt as to the answer to the first of these questions. The ready access to specialist opinion, even for the more trifling ailments, and the concentration of skilled surgery at important centres, and the rapidity and ease of transport are advantages which are not, under our present system, available for the bulk of the civil population. But perhaps the most willing admiration is given by medical men to the system of convalescent camps, which serve to bring back to full efficiency the soldier incapacitated by injury or disease. With all our resources at home we have never approached the Army results, though the methods are well within our reach. I would not deny, however, that there are obvious disadvantages to the individual patient in the development of routine methods of dealing with all

cases of injury or disease, nor maintain that a national service would necessarily be entirely without reproach. "Official methods" is a sneer which, though often undeserved, yet has sufficient truth in it to cause some degree of trepidation to the advocate of an extension of a "service" to the needs of a nation. Yet the balance, in my own judgment, inclines to such a service.

The advantage to the medical profession as a whole is more dubious. I have heard much *pro* and *con* argument, and at present, with Omar, have "come out by the same door wherein I went"—that is, I am at a loss; with a tendency, however, to believe that the inevitable levelling-up which takes place in a covenanted service would be a disadvantage without some safeguards, which could, I think, be devised. There is the encouraging fact that the level in such a service as for example the Indian Civil Service is, and is maintained high; and the maintenance of this high level depends, among other reasons, upon a scale of rewards and honours sufficient to attract the right type of men. If our National Medical Service is to reach and maintain a similar high level of efficiency the rewards and honours must be sufficient to attract able and industrious men, and there must be such opportunities of securing promotion, and such provision for removing the incompetent or the idle, as will serve to keep the whole *personnel* contented, and in good reputation with themselves and the rest of the nation.

On the financial side I may say in parenthesis that the terms suggested in a pamphlet suggested by the Medico-Political Union are ludicrously inadequate. Such inducements to enter a National Medical Service would serve to attract only the "duds" of the profession.

The ideal which I have at least partially shaped is of a service which should include the whole medical profession, men and women, the R.A.M.C., the Naval Medical Service, the Colonial, the Prison, and all other medical services; that qualification in the profession would mean the entering into the service of the nation, and the devotion of one's life-time to that service. The private practitioner would disappear; the medical man would be as much the servant of his country as the soldier, the sailor, or the civil servant.

Lastly—and to my mind this is a potent argument in favour of such a service—the gain to medical knowledge enabled by the power to direct and endow research would be enormous. No one who has followed the achievements of such bodies of medical men as those controlled by the Home Office, in recent years, or by the Medical Research Committee in the present war, can have any doubt upon this point.

These reflections are crude, and immature, but they may serve, Sir, to stimulate some of your readers to consider the problems involved, and to deal in print with the difficulties they meet. My own mind has not yet reached a clear conception either of what is necessary, or of methods,



but I hope that I may later return to the subject, and sketch in greater detail the essential features of a National Medical Service.

Yours sincerely,

B.E.F.


Major, R.A.M.C.T.

## SURGICAL APHORISMS.

By D'ARCY POWER, F.R.C.S.(Eng.).

*"Till old experience doth attain  
To something like prophetic strain."*

Milton—"Il Penseroso."

(1)  IR GEORGE HUMPHRY crystallised the rules for the examination of surgical patients in the words, "*Eyes first and much; hands next and least; tongue not at all.*" It is useless to begin by asking about the family history in a case of acute intestinal perforation, yet many do so.

(2) In appendicitis trust to the physical signs rather than to the symptoms. Local tenderness remains when the appendix has perforated or is gangrenous, even though there be no abdominal tension. Many have died because the surgeon has trusted the pulse and the temperature when he ought to have examined the abdomen.

(3) In appendicitis the most sure way to convert a mild into a severe attack is to give aperients and mask the pain with morphia. In these cases, if the bowels must be opened, administer an enema; if pain is to be deadened give aspirin.

(4) Remember the pithy French saying, "*There should be no third day in appendicitis.*" On that day the patient is either on the high road to recovery or his appendix has been removed.

(5) In appendicitis beginning suddenly there is a rise of temperature; in acute perforation of the stomach or duodenum the temperature falls.

(6) In London a patient with acute perforation of the stomach or duodenum rarely walks to a hospital. He is so ill that he seeks advice instantly, and will either call for an ambulance or will take a cab without counting the cost.

(7) In acute perforation the patient lies still fearing to breathe; in gall-stone colic he rolls about with pain.

(8) Acute duodenal perforation may occur without any previous history of indigestion.

(9) In acute perforation there may be an entire absence of abdominal rigidity when the patient is first seen, but there is always local tenderness at some point above the umbilicus.

(10) In acute gastric and duodenal perforation there is a point of maximum tenderness over the seat of perforation, and there may be a tender spot in the right iliac region. The patient refers his pain to this spot, and is often operated upon therefore for appendicitis.

(11) In acute perforation the pulse, temperature and general condition improve as the shock passes off, and more quickly in duodenal than in gastric perforation. Be not deceived. Operate at once. Intestinal paresis will surely occur, the abdomen will swell, and the time for successful operation is then well nigh past.

(12) Remember that the contents of the stomach and duodenum are sterile, and that after rupture of these organs the contents soon trickle into the iliac fossæ. Drain the fossæ and remove the drainage-tubes within forty-eight hours, for they will then have done their work.

(13) Influenzal peritonitis *does* sometimes occur, but so rarely that the more usual causes of obstruction should be rigorously excluded before a diagnosis is made and an expectant treatment adopted.

(14) Many conditions of the gall-bladder produce the symptoms of biliary colic besides gall-stones. It is unwise, therefore, to tell a patient before an operation that he has gall-stones. It is safer to say that his gall-bladder is inflamed or that he has cholecystitis.

(15) Patients with intra-peritoneal secondary hæmorrhage occurring after abdominal operations when the external wound has healed are usually found to give a positive Wassermann reaction.

(16) Persistent pain and sleeplessness are of extremely bad import after an operation for acute suppurative peritonitis.

(17) Want of confidence and the use of too small a catheter are the common causes of failure to relieve the retention of urine due to senile hypertrophy of the prostate. In these patients the catheter must be pushed well home or the bladder will not be reached; as there is no stricture, a full-sized catheter is passed more easily than a smaller one.

(18) The incidence of syphilis often falls upon a single group of tissues, the rest of the body remaining comparatively healthy. Such incidence often depends upon unusual strain or use of the affected tissue, as is seen in the aneurysm of athletes.

(19) The French say that "*Tubercle is often born on the bed made by syphilis.*"

(20) Gummatous synovitis closely resembles tuberculous inflammation. In gummatous synovitis the articular carti-



lage is usually unaffected, and there is consequently less pain and a more useful joint.

(21) Every chronic inflammation of bone and of the vertebræ is not tuberculous.

(22) Acute osteomyelitis is still diagnosed too often as acute rheumatism. Examination of the affected part in acute osteomyelitis shows that the seat of pain is at the epiphysial line, the joint in the earliest stage being as yet unaffected.

(23) Operate in osteomyelitis before pus is formed, and tell the friends of the patient why you do so, or they may say that you operated unnecessarily.

## MEDICAL NOTES.

By Sir THOMAS HORDER, M.D.

(Continued from p. 15.)

### ON PULMONARY TUBERCULOSIS.

(55) Certain physiological differences between the two sides of the healthy chest, when it is subjected to physical examination, are frequent sources of error in the diagnosis of phthisis. These differences, which are found especially in young patients, in females, and in those in whom the chest-wall is thinly covered, are these: Expansion and percussion resonance are relatively deficient over the upper lobe of the right lung, and in the same situation the breath-sounds may be bronchial in quality. It is this last sign, in particular, which so often leads to error, and it is not at all uncommon to find a diagnosis of phthisis based almost entirely upon it. It follows, from the facts above stated, that less significance should be attached to any of these three signs when present on the right than when present on the left side. The explanation of these physiological differences is doubtful, but it is probable that the chief factor in their causation is the relatively higher level at which the right bronchus lies as compared with the left.

(56) In a well-established case of phthisis the lesion is much more often bilateral than the physical signs lead one to suppose. This is due to the fact that in physical examination of the chest the less affected side is taken as the standard wherewith to compare the side on which the disease-process is more advanced.

(57) Just as the lesions in phthisis may be regarded as being, in most cases, more extensive than the physical signs suggest, so the time that the lesions have been present may be regarded as being, in most cases, longer than the history indicates.

(58) Skiagrams in cases of suspected phthisis must always be interpreted in conjunction with the clinical features. Events prove pretty conclusively that many of the cases of

so-called hilus-phthisis are really due to old (arrested) glandular disease. And what is true of shadows at or near the root of the lung is equally true of shadows about the bronchial tubes and near the diaphragm; their significance cannot be properly judged apart from general considerations. Beneficial though it may be in all these cases to treat the patient as though he were the subject of active tuberculosis—and there are few of us whose health does not benefit from abundance of fresh air, rest and good food—the good results of treatment by no means prove the diagnosis of active disease to have been correct.

(59) When examination of the chest reveals the signs of bronchial catarrh, any or all of the following features should raise a suspicion of phthisis. (i) The signs are largely or entirely unilateral; (ii) the signs are more marked at the apex than at the base; (iii) the *râle* has the consonating quality, indicating that it is produced near to solid lung or in a cavity; and (iv) the constitutional symptoms (fever, sweating, anæmia, loss of weight and strength) are disproportionate to the amount of the catarrh, and are more marked than is usual in simple bronchitis. The final court of appeal must always be the search for tubercle bacilli in the sputa: three successive negative examinations of material *which is properly chosen* may be considered to exclude phthisis.

(60) It is not common to find the "physical signs of phthisical cavity" of which some authors speak—hyper-resonant percussion note and cavernous breathing. Nor is this surprising, because it is reasonable to suppose that the fibrosed lung and thickened pleura which generally cover a phthisical cavity lead to deficient, rather than to increased, percussion tone; and seeing that the cavity is by no means empty, there is no special reason why the breath-sounds should be cavernous. But in point of fact cavity is diagnosed more by the knowledge that the disease is advanced and that the sputa are purulent and abundant than from special signs. Yet if amphoric breathing and bell sound are present, and if pneumothorax can be excluded, cavity may be diagnosed with confidence.

(61) Tuberculosis of the lung, considered from the point of view of morbid anatomy, exists in three main types:

(i) *Chronic caseating broncho-pneumonia*.—This is the lesion in "ordinary phthisis." The physical signs may be those of broncho-pneumonia, but are quite as often those of the associated lesions—bronchitis, emphysema and thickened pleura.

(ii) *Acute caseous pneumonia* ("pneumonic phthisis").—A somewhat uncommon disease. The signs are those of an extensive lobar pneumonia.

(iii) *Acute miliary tuberculosis*.—The signs, when present, are those of wide-spread capillary bronchitis.

(To be continued.)



## BART'S "CAPTURE" A GERMAN GUN.

**A**T ten o'clock on the third night of the armistice a three-ton A.S.C. motor waggon, procured by stealthy and nefarious bribery and corruption and crammed with conspirators, left the Smithfield Gate of the Hospital.

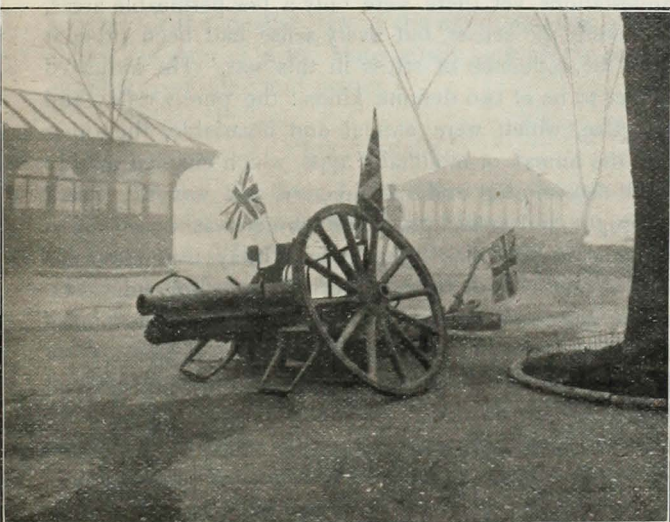
A banner (debtor to Catering Company—one tablecloth) floated over the canopy bearing the words "BART'S FOR EVER" in large, if somewhat straggly, black letters, and from within came the sound of ironmongery violently beaten with pokers, and so the avalanche of noise swept down Giltspur Street into the night. On it went down Holborn, heralding its approach by *fortissimo* cries of "BA-A-A-RT'S," the

The reply was obvious:

"Can't we?" And what were two among so many?

By superhuman exertions some self-sacrificing individuals got the trail of the gun lashed up to the frame of the waggon, despite the pressure of the too curious crowd and the suffocating blast of the exhaust pipe in their faces.

It was done. Everybody climbed on board; members of the crowd who had taken their places *in absentia* were slung out, and the lorry started with a jerk. The tailboard not being fastened up, at least five people fell out into the road. By good luck the rope broke at the same time or the gun would have gone over them. The casualties were collected, the rope re-tied, and a fresh start made. This time the gun started satisfactorily, but after going about ten yards one of the wheels came off. In spite of the shouts from those



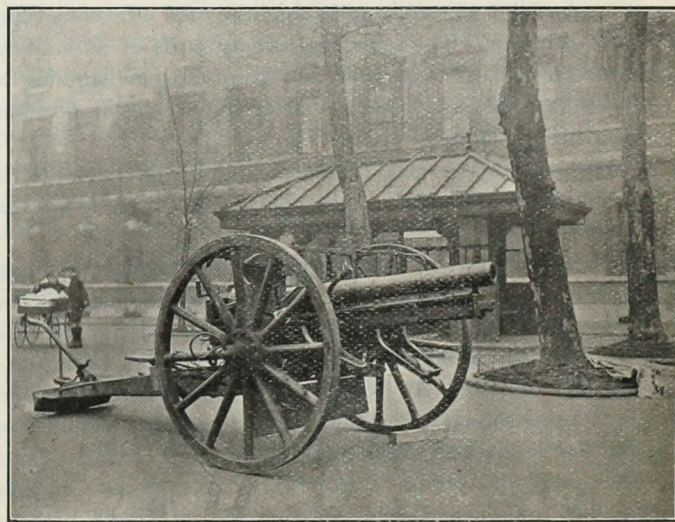
THE GUN AS "CAPTURED."

only incident in the comparatively deserted streets being an invasion by boy scouts. This being an exclusively Hospital show, all hands were piped to repel boarders, and the invaders were gently but firmly deposited in the road.

Speed slackened somewhat in Trafalgar Square, which was crowded with people. We cheered: the crowd cheered: everybody cheered: stately policemen looked on with a kindly and sympathetic eye, regarding us merely as joy riders.

Then came the *coup d'état*. The lorry swung round at the Admiralty Arch and stopped, the tailboard dropped, and a crowd of pirates, led by a strange and fearsome figure with a coil of rope round his waist and brandishing a femur in his hand, streamed off the lorry and through the Arch. Somewhat amazed, the crowd gathered round. Back came the landing party at full speed, towing behind them a 77 mm. German field gun. The inevitable and ubiquitous policemen appeared:

"You can't have that gun!"



THE GUN AS "RESTORED."

behind, those in front heard not and heeded not, and on went the car of Juggernaut, the gun reeling drunkenly behind on one wheel and the axle, striking sparks out of the road and making a truly satisfying noise. By the sides ran men armed with stretcher poles to clear a passage through the crowd. On the steaming bonnet (there was no water in the radiator when the sorely tried engine got back to the Hospital) there sat, with Spartan fortitude, one with burnt-corked face and an unspeakably disreputable bowler hat, minus the brim, who blew unceasingly upon a whistle. High overhead on the canopy rails, one of Gamage's cheapest and noisiest drums added to the din.

Having got safely through Trafalgar Square without killing anybody, so far as is known at present, there was a check in the Strand. Two resolute policemen stood in the way and the waggon had to stop. A moment later it started again, the policemen disappeared (exactly how I know not), and their places were taken by Colonial soldiers who ran on ahead to



clear the way. The pace quickened and the rest of the Strand and Fleet Street were taken non-stop. Several "specials" waved a greeting when they saw the lorry with its banner, but as it passed them and the trophy came into view, their faces changed and once again took on their most official look, but too late to do anything.

Up Ludgate Hill and across to Holborn, up Giltspur Street and round to the Smithfield Gate came the trophy—a flying vision of sparks and noise. The gate was shut but in a few minutes it opened—again I know not how it was wangled—and a thunderous din arose as the gun went through the archway. On meeting the second archway the driver, who had driven so well the whole way, made his first mistake. The gun being dragged along as it was did not ride behind the waggon centrally but swung out to one side. Hence the waggon got through safely, but the one remaining gun wheel hit the arch and straightway fell off. The rope snapped again. The remaining twenty yards of its journey into the Square were slow and painful—man-handling a wheel-less gun is not easy—but at last it was in position near the Fountain.

Of the other events of that night, of interviews with detectives and of visits to the police station, this is not the place to speak!

Next day the gun was propped up on its one remaining wheel and a wooden stool, and was surrounded by an admiring crowd most of the morning. However, the crowning touch—unhoped for and unexpected by most—was yet to come. At half-past one in the afternoon, when the crowd was at its greatest, including many members of the staff, a taxi dashed into the Square, and out of it came four men who produced from it, as a conjurer produces rabbits from his hat—the missing wheel! Well, perhaps not *the* missing wheel, but at any rate, and good enough, a wheel. It was looted in broad daylight. *Succès épatant!*

The gun now stands in the Square as it stood in the Mall—complete except for the damage done to it by shell-fire.

The following morning it was securely chained to the Fountain, for an ultimatum arrived from some envious rivals to the effect that if not delivered up to them they would take it. So far they have not done so.

This, then, is a chapter of that gun's adventurous journey from Essen to Bart.'s. The earlier chapters remain an unknown epic of valour, which will probably be revealed some day; as for its future history, it is unfortunately a "claimed" gun, so it will probably have to be restored to its rightful captors. But it is a trophy that eclipses the milk-churn of our envious rivals!

W. S. S.

## THE MIND : ITS DEFECTS AND DISORDERS.

*An Epitome of Four Lectures on Physic delivered at the Gresham College,*

By Sir ROBERT ARMSTRONG-JONES, M.D., F.R.C.S.,  
F.R.C.P.

### LECTURE I.

**S**IR ROBERT ARMSTRONG-JONES described the structure of the brain, and indicated the indescribable stress endured by those engaged in active warfare under modern conditions, which had undermined the resistance of the bravest troops. He described the human body as immersed in a world full of energy manifestations, yet there were only a few permeable areas, which were the senses, but every sense had been brought under the influence of stress in this war. He indicated conduct to be of two definite kinds: the purely reflex and instinctive, which were animal and invariable, the other being the human or modifiable type, which enabled man to be self-determining and self-directive, and was the result of thought and reflection. The former was based upon definitely inherited lines of nervous pathways; the latter was based upon a fine network of nerve-fibres which education and training brought into use, and it should be the aim of all teachers to make full use of all the native impulses, of all spontaneous interests, of all the native automatisms, and even the useless movements of the child so as to fit him for fresh "associations," and to adapt the child for his future life of activity. He described the history and evolution of the nervous system from its most rudimentary forms in animal life, and indicated that the human brain had in its microscopic structure an infinite capacity for further development and progress; that as speech and the upright position of man had taken *eras* to develop, so there was a vast future for the progress of the human mind towards spiritual perfection.

### LECTURE II.

Sir Robert Armstrong-Jones described the avenues of the mind, which were "windows" admitting different forms of energy into the brain, and urged that the medium should be kept clear by the exercise of attention and the will. Distraction by temptation should be avoided by inspiring ideals of self-sacrifice and usefulness. The greatest pleasure to thinking man is in the exercise of his intellectual faculties, and the human organism was an example of the most beautiful adjustments adapted to make use of information coming in to the mind in a world full of activities. The value of the individual to the community depended upon a ready adaptation to ever-changing conditions, and progress must depend upon being able to use material



reaching the mind through the senses, and education should emphasise attentive observation, recording accurately and arriving at correct conclusions.

## LECTURE III.


Sir Robert Armstrong-Jones described the elements of the mind, which consisted in an evolution from simple to more complex elements, just as the brain developed from the simple reflex cell into an aggregation of independent neurones. He laid great stress on the power of the will, and stated that many persons suffering from shell-shock were fortified by suggestion, and that habit was an important factor in the development of the will. He referred to the emotions and recent discoveries which tended to demonstrate that they were biological reflexes, having a teleological end—the welfare of the body. He believed there was support for the idealist view of the mind, and the war had shown the error of a too materialistic view of the relationship between mind and matter.

## LECTURE IV.

Sir Robert Armstrong-Jones delivered the last of the series of Gresham Lectures on Physic upon mental abnormalities. He laid stress upon the attention and the will being the great conditioning factors in the intellectual life. He referred to the great number of functional nervous cases resulting from the stress of war, and that provision for re-education and re-evolution should be provided for these, and soon; as otherwise the force of habit would set in to mar recovery. He also urged the necessity for an immediate change in the law relating to the insane, as the best treatment during the early stages was now impossible of attainment under present legal conditions. He considered mental diseases to rest upon a tripod of causes, viz. heredity, alcohol, and venereal diseases, which are all remediable and should be controlled; two of these were receiving immediate attention, and social work was necessary to inform the people of their deadly effects; one of these, alcohol, was the source of all the others.

## A CASE OF "SPANISH INFLUENZA" TREATED BY INTRAVENOUS INJECTION OF SODIUM SALICYLATE.

By Surg.-Lieut. R. MURRAY BARROW, R.N.

N October 26th, in the forenoon, Lieut. F—, R.N.R., reported himself to the surgeon on duty, complaining of shivering, headache and backache. No cough; bowels constipated. On examination patient looked ill; complexion pale; expression anxious.

Temperature 100° F., pulse 88, respirations 24. Headache, frontal; throat slightly injected; tonsils not enlarged. Chest: Nothing abnormal discovered. Pulse full and bounding. Abdomen: Nothing abnormal discovered. Bowels always irregular. Urine normal. Muscles generally tender, particularly erector spinæ. Nervous system normal.

Patient was put to bed on milk diet. Dover's powder gr. x was given *statim*, and a mixture containing sod. sal. gr. xx, sod. bicarb. gr. xxx was given four-hourly.

Condition not improved by the evening. Temperature 103° F., pulse 92, respirations 28. Calomel gr. iij was prescribed.

October 27th: Patient developed cough and rusty sputum. The cough was painful towards the front of the chest. Examination failed to find anything but harsh breathing over both upper lobes. Patient's expression was then such as to give cause for alarm, resembling that of cases of fatal peritonitis. The complexion was grey, eyes sunken, with dull expression. Mental condition was that of great depression and a desire not to be disturbed.

It was then decided to give an injection intravenously of sodium salicylate gr. v. This was dissolved in 8 c.c. sterile water warmed to blood heat and injected. In half an hour the patient felt relief from his pains and more restful. Strychnine gr.  $\frac{1}{16}$  was given hypodermically directly after to counteract any depressing effect on the heart, and was repeated four-hourly till 6 a.m., October 28th. The patient had a good night up to midnight, but slept badly thereafter. Temperature at midnight was 102.4° F., pulse 96, respirations 24. There was relief in the cough, and the sputum became less blood-stained.

October 28th, 6 a.m.: Temperature 102° F., pulse 88, respirations 24. Intravenous injection repeated, followed by strychnine as before. Again the patient expressed relief of his subjective symptoms, and only complained of headache. The sputum was now yellow and thick; cough very slight. I then decided to repeat the injections six-hourly, followed by strychnine gr.  $\frac{1}{16}$ . As the ship was under way the patient found it hard to rest, and could not sleep for the vibration of the propellers. A draught of chloral  $\bar{c}$  pot. brom.  $\bar{a}\bar{a}$  gr. xx was given at 10 a.m., but he only slept for twenty minutes. At noon temperature 102° F., pulse 84, respirations 28. Patient complaining of no pain at all, but inability to rest. The sleeping draught was repeated at 2 p.m., and gave him forty minutes' sleep, the pulse being regular and full. Inj. morphinæ hyp. gr.  $\frac{1}{4}$  was given at 4 p.m. Temperature 102.2° F., pulse 88, respirations 26. After the morphia patient slept well for four hours, and was much rested.

No intravenous injection was given till 10 p.m., when it was repeated in the same dose and solution. Temperature 102.6° F., pulse 82, respirations 28. Patient feeling much better altogether; took some hot cocoa and milk. Calomel



gr. ij was given. He perspired then slightly for the first time since the beginning of his illness, and slept till 12 midnight. He had very occasional cough; no complaint of pains anywhere.

October 29th: Patient did not sleep till 4 a.m., when his temperature was 102.4° F., pulse 86, respirations 28. He slept on and off till 8 a.m. and felt better. Temperature 101.6° F., pulse 86, respirations 24. He was given salts, and his bowels were moved; he took some toast and tea. It was then decided to move him to a hospital ship.

It is difficult to claim anything specific for this form of treatment, but in view of the rapidity of the course of the complaint and of the necessity to find a mode of controlling it early, I suggest that the intravenous injection of salicylate of soda might be tried in these cases.

I did not keep the patient sufficiently long to increase the dose of salicylate, nor apparently was there any need. It would be interesting to see how much one could give without harmful effect.

## OBITUARY.



THE following have already appeared under our Roll of Honour. Some additional facts have since come to hand, and these details we gladly publish.

Capt. G. M. Cowper, who died of wounds on October 3rd, was educated at Darlington Grammar School and Trinity College, Cambridge, going on to St. Bartholomew's Hospital, London, where in 1914 he took the Conjoint Diploma. He joined the R.A.M.C. on the outbreak of war, and after six months of duty as anæsthetist at a base hospital in England he went to Le Treport with a hospital unit, where, in addition to his regular duties, he had charge of surgical huts and acted also as honorary secretary and treasurer of the officers' mess. Last year he became attached, first to a West Riding Regiment (Duke of Wellington's), and later to a field ambulance. Finally, just before his death, he was transferred to a Dorset Regiment, and it was while working at his regimental aid post that a direct hit by enemy artillery inflicted wounds which shortly proved fatal. Capt. Cowper's superior officers write of his whole-hearted devotion to the work in hand, whether professional or recreative, which made him a true comrade, while his considerateness endeared him to the patients and nursing staff. His loss is keenly felt by all his associates.

Lieut. W. L. Dandridge, who died of wounds on October 5th, was the youngest son of Alfred Dandridge,

of Beckenham, Kent. He was educated at Sherborne School, going on in 1912 to Emmanuel College, Cambridge, where he graduated in Arts. In 1916 he went to the Isonzo front with a Red Cross ambulance, returning to England after a few months to complete his medical curriculum. After obtaining the diplomas of the Conjoint Board, he joined the 103rd Field Ambulance in France, and it was while accompanying a party of stretcher-bearers to the front line on October 3rd that he was wounded, surviving his injuries only for a few days. Enthusiastic in his work and of a bright and cheery disposition, Lieut. Dandridge will be missed by a large circle of friends.

Lieut. Ernest Howard Glenny, youngest son of Mr. and Mrs. Edward H. Glenny, of Manor Park, London, died of pneumonia at Basra, Mesopotamia, on October 9th, 1918, aged nearly twenty-seven years. He was educated at Redland Hill House, Clifton, Bristol, and at the Leys School, Cambridge. Having in 1913 decided to take up Medicine, he entered St. Bartholomew's Hospital, gained the Willett Medal, and qualified M.R.C.S. and L.R.C.P. in 1917. After three months as House-Physician at this Hospital, he was called to join the R.A.M.C., and from Blackpool was sent to Mesopotamia, where he was appointed Medical Officer at No. 3, British General Hospital, in March, 1918. He remained there until he was removed to the Officers' Hospital, Beit Naama, Basra, seriously ill with pleuro-pneumonia on October 4th, and died on October 9th.

## STUDENTS' UNION.

### RUGBY FOOTBALL CLUB.

#### ST. BARTHOLOMEW'S HOSPITAL v. ST. PAUL'S SCHOOL.

The Hospital Football Club opened their season on October 5th with a match against St. Paul's School, which was won by 2 goals (10 points) to 1 try (3 points). The game throughout was keenly fought, and the schoolboys, though the lighter side, played a determined game, the result being uncertain until late in the second half. The Hospital owed their success mainly to the superiority of the outsides, M. Thomas scoring two clever tries, both of which C. F. Krige converted.

#### ST. BARTHOLOMEW'S HOSPITAL v. NATIONAL PHYSICAL LABORATORY.

On October 12th the Hospital opposed the National Physical Laboratory at Teddington and won by 66 points to *nil*. The Laboratory were quite outclassed and the play was entirely in their half. The game was merely a succession of tries; all the outsides, including the full back, crossed the line, and also several of the forwards. C. F. Krige and M. Thomas ran through the defence whenever they had the ball.

#### ST. BARTHOLOMEW'S HOSPITAL v. THE PUBLIC SCHOOLS SERVICES.

The Public Schools Services XV were the opponents on October 26th at Richmond, the Hospital winning by 4 goals and 6 tries (38 points) to *nil*. The Hospital showed their superiority from the outset and held the upper hand throughout. The game was keen



# St. Bartholomew's Hospital



"Æquam memento rebus in arduis  
Servare mentem."

—Horace, Book ii, Ode iii.

## JOURNAL.

VOL. XXVI.—No. 3.]

DECEMBER 1ST, 1918.

[PRICE SIXPENCE.

### THE END OF THE GREAT WAR.

#### THE BEGINNING OF TRUE RECONSTRUCTION.

**T**HE War is over. The Allies have conquered. Right has triumphed over Might. A great sacrifice has been made, but a great recompense will result. Our brothers have died—have died gloriously—in order that we may reap the fruits of a lasting peace. Our Hospital has given nobly to the service of King and Country. Every student, unless physically prevented, has served on sea, on land, or in the air. Nearly two thousand Bart.'s men have answered the call to every front and every clime. Hundreds of our nurses have pressed into the ranks and shown that the British Nursing Profession is second to none. Of one and all we are justly proud. We reverence our dead, we uphold our maimed, and we welcome back our safe and sound.

Now we must turn to what the termination of the World War is to mean to us as a Hospital and as a Profession. It should mean the beginning of greater things in our history, already truly great. It is not enough for us to rest on our past; we must consider the future. A true reconstruction does not mean the destruction of our heritage, but the building up on its sure foundation of an edifice which will be of still greater service to humanity. The ideals of our profession—both the medical and the nursing—are essentially scientific and humanitarian, and unless we keep these ideals always in the foreground, our reconstruction will be but an empty sham.

We shall have to "reconstruct" in our Medical School, in our Nursing School, in Research, in Medical Practice, and in the new relations which are arising between our professions and the public. Let us therefore put our whole energy into the matter, and let us make ourselves worthy of the men and women who have set us so great an example in their unparalleled devotion and sacrifice. x



## CALENDAR.

Fri.,	Nov.	29.—	Dr. Tooth and Mr. Waring on duty.
Tues.,	Dec.	3.—	Dr. Calvert and Mr. McAdam Eccles on duty.
Wed.,	"	4.—	Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri.,	"	6.—	Dr. Fletcher and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues.,	"	10.—	Dr. Drysdale and Mr. Waring on duty.
Fri.,	"	13.—	Dr. Tooth and Mr. McAdam Eccles on duty.
Tues.,	"	17.—	Dr. Calvert and Mr. D'Arcy Power on duty.
Fri.,	"	20.—	Dr. Fletcher and Mr. Waring on duty.
Tues.,	"	24.—	Dr. Drysdale and Mr. McAdam Eccles on duty.
Fri.,	"	27.—	Dr. Tooth and Mr. D'Arcy Power on duty.
Tues.,	"	31.—	Dr. Calvert and Mr. Waring on duty.
1919.			
Fri.,	Jan.	3.—	Dr. Fletcher and Mr. McAdam Eccles on duty.

## EDITORIAL NOTES.

**A**T the moment of going to press we hear with deepest regret of the death, from pneumonia following influenza, of Dr. A. E. Stansfeld. Our sense of loss lies beyond any expression in words. In his day one of our most brilliant and popular students, his later work had more than fulfilled the promise of his earlier years. The tremendous amount of work always so willingly undertaken by him in this and other Hospitals had brought him a reputation unique for a man of his years. There can be little doubt indeed that the result of overwork lessened his chances of recovery. The Hospital, and indeed the medical profession as a whole, has lost one of its most promising members.

To his wife and family we offer our very deepest sympathy.

\* \* \*

Sir Wilmot Herringham's letter on State Medical Service and Medical Representation in Parliament has roused widespread interest. The *Lancet* refers to it in their issue of November 23rd, while in the *British Medical Journal* of the same date the letter forms the basis of the weekly editorial article. In an extremely interesting note the *B.M.J.* contrasts Sir Wilmot's views with those put forward by Col. Maurice in an article in *The Hospital*. The view taken by this writer is very much on the lines of the letter which appears in this issue, namely, that some form of State Medical Service is most necessary. For our part we would regret to see any scheme in force which would tend to the elimination of that all-important factor in general practice, namely, the personal element.

\* \* \*

In a recent editorial we ventured to suggest that Bart.'s would not be far behind when we could enjoy again the piping days of peace. We were not far wrong in our prophecy. The news of the signing of the Armistice was received with tremendous enthusiasm. Lectures—in fact

anything approaching work—were at a standstill. Guy's paid a visit to the Hospital in the afternoon, and St. Mary's came in force the following day. But the climax was reached on Wednesday evening, when Bart.'s certainly came into their own. The programme was nothing more or less than the capture of one of the German guns from the Mall, and right well was it carried out. A description of the "capture" appears elsewhere in this issue, and is certainly more accurate in detail than the highly picturesque report which appeared in the *Star*.

Bart.'s men are tremendously proud of their achievement, and it is to be hoped that the War Office authorities will allow the Hospital to keep their trophy, especially as quite a number of the students are artillery officers.

\* \* \*

We note with pleasure that Temp. Major W. J. Gow, R.A.M.C., has been brought to the notice of Lieut.-Gen. Sir J. L. van Deventer for distinguished services rendered.

\* \* \*

Three Bart.'s men have been decorated recently by the President of the French Republic, and to these we offer our congratulations:

Lieut.-Col. J. H. Hugo, D.S.O., I.M.S., receives the Croix de Chevalier of the Legion of Honour, and Temp. Capt. J. B. McFarland, M.C., R.A.M.C., and Temp. Capt. (Acting Major) H. B. G. Russell, R.A.M.C., the Croix de Guerre.

\* \* \*

We are pleased to be able to congratulate Capt. (Acting Major) J. M. Smith, R.A.M.C., on being awarded the Military Cross.

\* \* \*

Our congratulations to Lieut. K. C. J. Jones, M.C., the Bedfordshire Regiment, on being awarded the M.B.E. for an act of gallantry not in the presence of the enemy.

The award should have been included in our note of the Birthday Honours of June last.

\* \* \*

The subject of the Bradshaw Lecture delivered by Lieut.-Col. D'Arcy Power before the Royal College of Surgeons on November 14th was "Carcinoma of the Tongue." A distinguished audience was present, and the lecturer is to be congratulated on the masterly way in which he handled the subject.

\* \* \*

Col. H. H. Tooth, C.M.G., has resumed his duties at the Hospital after two years' service with the Forces abroad.

\* \* \*

There have been several alterations lately in the arrangement of the wards. They are as follows:

*South Wing*: Matthew is now Lucas, and Elizabeth and Martha are re-opened.

*West Wing*: Radcliffe is now Abernethy, while Coburn is entirely devoted to war pensioners.

*North-east Wing*: Abernethy becomes Radcliffe, Lucas



and fast, but the Hospital three-quarters were altogether too clever for their opponents. C. F. Krige (2), C. Griffith-Jones and M. Thomas scored in the first half, Krige converting twice. In the second half Krige (2), Thomas, Griffith-Jones, Johnstone and Llewellyn crossed the line, and Shaw was successful with two kicks at goal.

#### ST. BARTHOLOMEW'S HOSPITAL v. WELSH GUARDS.

Played at Ranelagh on November 2nd, and probably better left without comment. The Guards team found, early in the game, that they would not have the football all their own way, consequently they gave up football and tried to win by "any means," with the result that the game was of the most unpleasant type. It ended in a draw of a goal and a try each; Thomas scored twice for Bart.'s and Krige converted once. The Hospital has scratched further fixtures with the Welsh Guards as a protest.

#### ST. BARTHOLOMEW'S HOSPITAL v. MILL HILL SCHOOL.

Played at Mill Hill on November 9th, and won by the Hospital by 3 goals and 3 tries to *nil*. The outstanding feature of the game was the splendid way in which the School forwards, light as they were, hustled the Hospital forwards from the very beginning. The Hospital outsidemen were much better than their opponents, and so crossed the line six times, but the forwards had a splendid lesson in "how to get on with it." Johnson, Krige and Thomas each scored twice, and Krige converted three of the tries.

#### ST. BARTHOLOMEW'S HOSPITAL v. GUY'S HOSPITAL.

Played at Honor Oak Park on Saturday, November 16th, in the presence of many students and nurses from both Hospitals. The game was very keen and very closely even, but Guy's were just superior in all departments of the game. Their forwards got the ball very much oftener than ours, and their three-quarters always knew exactly where to find each other (while our "three's" did not), and always managed to break up any attack on our part. The game, as a whole, was devoid of incident except very occasionally. The first half was give and take with the game up and down the field—rather more in the Bart.'s half. We had hard luck when Orchard dribbled away from the pack, picked up and "dropped" at goal; it was a splendid kick and only just missed. In the second half Guy's scored twice. A wild pass amongst our three-quarters was intercepted by Krige, of Guy's, who raced through and punted for Keet to follow up and score. The second try was again an "opportunity" score. From a long kick the ball bounced off Salmon's shoulder; Krige, of Guy's, following up, seized the chance and scored. Crook converted the first try, but failed with the second. Salmon was injured and had to leave the field, but no further score was made while Bart.'s were one short. On the game Guy's were the better side—eight points better—but they were fortunate in getting them, for none of their concerted movements were successful. A. J. Trollope's refereeing was ideal.

## CORRESPONDENCE.

### "HEART-STRAIN."

To the Editor of the 'St. Bartholomew's Hospital Journal.'

SIR,—Long before I was qualified to practise medicine—before I was permitted, therefore, to open my mouth at all, let alone with the hope that anything I could say would be treated as of any authority—I held the view that the healthy heart could not be damaged by muscular exertion, however severe. This view was not, as I say, the outcome of clinical knowledge or experience, but resulted from the observation of first-class athletes engaged in the most strenuous physical exertion, and their after-histories.

It has been no small source of gratification to me to observe during the past few years a growing tendency for cardiologists of whose ability and reputation there can be no question to support this opinion; and in his last edition of *Clinical Disorders of the Heart-Beat* (from which Sir Thomas Horder quotes in paragraph 51 of his

"Medical Notes" in the current number of the JOURNAL) Dr. Lewis dogmatically expresses this view.

To this Sir Thomas Horder demurs. He points out first of all quite logically that in writing of "actions natural to man" Dr. Lewis is begging the question, and that the feats of exertion which lead to damaged hearts could not be termed "natural."

It is not for me to defend Dr. Lewis, still less to interpret what may have been in his mind; but if I had been writing this paragraph on my own behalf, I would boldly have gone further and substituted for "natural" the unambiguous adjective "possible."

And so at once I become most embarrassingly in conflict with my old teacher, who states that these are "cases [of damaged hearts] which all physicians of experience occasionally meet with."

I wonder if I dare regard myself as a physician of experience! Perhaps, after all, in this connection I may, for I have had exceptional opportunities to observe prominent athletes from many parts of the world, and so equally exceptional opportunities for studying "heart-strain." I have been hunting the genuine "athletic heart" for many years now, and I have never caught it.

I know that whenever a prominent athlete dies, particularly of some affection of the chest, his demise is always written down and credited to the evils of athletics; but the type of fellow I have come across who "strained his heart in a race" is invariably a man with vasomotor instability, who never had much pluck, and who takes for granted that his symptoms of distress indicate that his heart was permanently injured. And yet what athlete of experience has failed to suffer from such symptoms during his career without the slightest permanent ill-result?

Even the statistical method has shown that the life-expectation of athletes actually exceeds that of the average healthy man. Taking the first Harvard crew of 1852, the increase was 1.6 years per man as compared with the selected lives of insurance tables in which a man of twenty had a life-expectation of 42.2 years: and the same result was found by the late Dr. Morgan in his investigation into the life-histories of men who had rowed in the inter-Varsity race.

I am writing in no spirit of criticism, but with the earnest desire to thresh out the subject. Sir Thomas's clinical experience is, of course, immeasurably greater than mine; my experience of athletes and athletics is probably greater than his. I have seen a large number of what I have taken to be healthy hearts showing no trace of having been affected by admittedly severe exertion. It is perhaps a question of criteria and of weighing evidence, but I really should like to be convinced that "heart-strain" is so common that most physicians of experience have an opportunity of satisfying themselves in the case of men with athletic ability, first, that undoubted damage to the heart was present, and secondly, that such damage could be directly traceable to some physical effort.

I am, Sir,

Yours faithfully,

ADOLPHE ABRAHAMS,  
Major, R.A.M.C.

THE CONNAUGHT HOSPITAL,  
ALDERSHOT;

November 9th, 1918.

## REVIEWS.

A TEXT-BOOK OF MIDWIFERY. By R. W. JOHNSTONE. Second Edition. (A. & C. Black, Ltd.) Pp. 495. Price 12s. 6d. net.

Johnstone's *Midwifery* is deservedly popular, in spite of the fact that students in the Metropolis are often prejudiced against text-books emanating from "across the border." It is not to be expected that a book of this size should go into such elaborate details as are to be found in larger works on the subject, but the essential facts are clearly stated, and this is what is required for examination purposes.

The present edition does not materially differ from the first, but the notes on the use of pituitary extract in labour and the details regarding the use of scopolamine and morphine are noteworthy additions.



THE PRACTICE OF SURGERY. By RUSSELL HOWARD. Second Edition. (Edward Arnold.) Pp. 1244. Price 25s. net.

This most excellent work on surgery has been thoroughly revised, the paragraphs on "Military Surgery" receiving special attention. Some thirty-seven chapters go to make up the text. The illustrations are extraordinarily good, especially the eight coloured plates, which do great credit to both artist and printer.

Students are often in doubt with regard to a suitable book on what is perhaps the most difficult of the "Final" subjects. To such students we have every confidence in recommending Russell Howard's work, and we do so because special emphasis has been laid on that very important side of surgery, namely, diagnosis and treatment.

The volume can be recommended with equal confidence to practitioners who are desirous of obtaining a thoroughly reliable and up-to-date treatise on the subject.

A MANUAL OF PHYSIOLOGY. By G. N. STEWART. Eighth Edition. University Series. (Baillière, Tindall & Cox.) Pp. xxiv + 1245. Price 21s. net.

In spite of war conditions this well known work on physiology has undergone many changes, and several additions have been added since the appearance of the last edition. The chapters dealing with the chemical phenomena of respiration and the functions of the endocrine organs and metabolism receive special attention; Cushny's recently formulated fixation-reabsorption theory of urine formation is also dealt with at some length. The bibliography, which has been added as an appendix, is an extremely valuable addition, and should prove most useful to teachers and also to advanced students.

Stewart's volume has always been very practical in character, and we are glad to note that the Practical Exercises are still retained in the one complete volume.

We still have hopes that one day a book on physiology will be written which embraces more clinical work. This is, perhaps, the only fault we have to find with this really valuable work. Possibly the author may see his way to correct this omission in a future edition.

## EXAMINATIONS, ETC.

### UNIVERSITY OF OXFORD.

In a Congregation held November, 1918, at Oxford, the following degree was conferred:

M.D.—E. H. White (in absence).

### THE ROYAL COLLEGE OF PHYSICIANS.

The following has been admitted a Member of the College: G. Bourne.

### CONJOINT EXAMINING BOARD.

#### First Examination. October, 1918.

Part I. Chemistry.—E. A. Austen, R. G. Cochrane, W. Moody Jones, I. Kinsler, E. Obermer.

Part II. Physics.—G. L. Brocklehurst, R. G. Cochrane, I. Kinsler, C. A. Moody, E. Obermer.

Part III. Elementary Biology.—R. A. E. Klaber, A. J. D. Smith.

Part IV. Practical Pharmacy.—C. H. Bulcock, R. H. Clarke, B. H. Cole, A. W. Taylor, C. J. L. Wells, D. O'Donovan.

#### Second Examination. October, 1918.

Anatomy and Physiology.—G. K. Arthur, T. A. Eccles, C. S. C. Prance, S. R. Simaika.

#### Final Examination. October, 1918.

The following have completed the examination for the diplomas of M.R.C.S. and L.R.C.P.: L. H. Bartram, W. L. Berry, F. T. Burkitt, W. M. Casper, E. A. Crook, G. A. Fisher, D. P. Guilfoyle, R. D. Jones, G. Lyon-Smith, G. Millar, H. L. Pridham.

## CHANGES OF ADDRESS.

HADFIELD, C. F., 42, Devonshire Street, Portland Place, W. (From December 7th, 1918.)

LITTLEJOHN, C. W. B., Scotch College, Melbourne.

MYERS, C. S., Lieut.-Col. R.A.M.C., 16, Bryanston Square, W.

## BIRTHS.

BURNE.—On October 19th, at Singapore, C. V. (née Turner), the wife of Dr. T. W. H. Burne, of a daughter (Diana).

GILLIES.—On November 6th, at Twydens, Foots Cray, Kent, Kathleen, the wife of Major H. D. Gillies, R.A.M.C., Queen's Hospital, Sidcup, of a daughter.

JONES.—On October 30th, at Coleford House, near Bath, the wife of Capt. P. T. Jones, R.A.M.C., T.F.R., of a son.

TATCHELL.—On November 3rd, the wife of Percy Tatchell, 29, Barkston Gardens, S.W. 5, of a daughter.

## SILVER WEDDING.

JONES—ROBERTS.—On November 4th, 1893, at Christ Church, Lancaster Gate, by the Rev. Canon Hughes, uncle of the bride, assisted by the Rev. W. Page Roberts, of St. Peter's, Vere Street, and the Rev. C. J. Ridgeway, Vicar of the Parish, Robert Jones (now Robert Armstrong-Jones), M.D., B.S., of Claybury, Woodford Bridge, Essex, to Margaret Elizabeth, eldest daughter of Sir Owen Roberts, J.P., D.L., of 48, Westbourne Terrace, and of Plás Dinas, Carnarvon, N. Wales. Present address, 9, Bramham Gardens, S.W., and Plás Dinas, Carnarvon.

## DEATHS.

FAVELL.—On November 2nd, 1918, at Brunswick House, Glossop Road, Sheffield, Richard Favell, Ch.M., M.R.C.S., aged 70.

MALDEN.—On October 28th, 1918, at Bateman House, Cambridge, Walter Malden, M.D.(Cantab.), Capt. R.A.M.C. (T.), aged 60.

PATTEN.—On October 22nd, 1918, at 17, Mount Park Road, Ealing, Charles Arthur Patten, L.R.C.P., M.R.C.S., aged 79.

STANSFELD.—On November 25th, 1918, at 19, Bentinck Street, Cavendish Square, W. 1, of pneumonia following influenza, Alfred Ellington Stansfeld, M.D., F.R.C.P., aged 35.

## ACKNOWLEDGMENTS.

*New York State Journal of Medicine, Guy's Hospital Gazette, The Nursing Times, The British Journal of Nursing, The Hospital, The League News, Journal of the Department of Public Health, Hospitals, and Charitable Aid, Long Island Medical Journal, Otago University Review, St. Mary's Hospital Gazette, The Hospital, The Medical Review, Giornale della Reale Società Italiana d'Igiene.*

## NOTICE.

*All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, Smithfield, E.C.*

*The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., at the Hospital.*

*All communications, financial, or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.*



# St. Bartholomew's Hospital



"Æquam memento rebus in arduis  
Servare mentem."

—Horace, Book ii, Ode iii.

## JOURNAL.

VOL. XXVI.—No. 4.]

JANUARY 1ST, 1919.

[PRICE SIXPENCE.]

### CALENDAR.

1918.

Tues., Dec. 31.—Dr. Calvert and Mr. Waring on duty.

1919.

Fri., Jan. 3.—Dr. Fletcher and Mr. McAdam Eccles on duty.

Tues., " 7.—Dr. Drysdale and Mr. D'Arcy Power on duty.

Fri., " 10.—Dr. Tooth and Mr. Waring on duty.

Tues., " 14.—Dr. Calvert and Mr. McAdam Eccles on duty.

Fri., " 17.—Dr. Fletcher and Mr. D'Arcy Power on duty.

Tues., " 21.—Dr. Drysdale and Mr. Waring on duty.

Fri., " 24.—Dr. Tooth and Mr. McAdam Eccles on duty.

Tues., " 28.—Dr. Calvert and Mr. D'Arcy Power on duty.

Fri., " 31.—Dr. Fletcher and Mr. Waring on duty.

Tues., Feb. 4.—Dr. Drysdale and Mr. McAdam Eccles on duty.

### EDITORIAL NOTES.

**D**URING four long and what at times seemed interminable years, New Year Greetings have necessarily been touched with sadness. It seemed a paradox to speak of happy and prosperous times in the face of a world calamity.

With the advent of peace all this has been changed, and we desire to take full advantage of this unique opportunity in wishing our readers the happiest of new years.

The year just ended, crowded as it has been with suffering and anxiety beyond the memory of man, is past; we are entering a new world. The future offers unparalleled prospects, in which the medical profession must play a big part. At this glad season of the year let us resolve to do our bit. Bart.'s has done nobly in the past: it will not fail in the great problems of the future.

\* \* \*

What might be described as the Armistice Christmas was celebrated at Bart.'s with great enthusiasm. In the morning Santa Claus went round the wards of the Hospital, attended by one of his assistants, a "nurse," and Fred, his donkey. He received an uproarious welcome from children of all

ages, from ten to three score years and ten! After he had distributed presents, he paid two visits to the nurses' dining-room and had an enthusiastic reception.

In the afternoon there were several concert parties going round the wards. The "Beery Bolsheviks," five most dreadful-looking ruffians in gory operation gowns and red, dishevelled wigs, in private life members of the Resident Staff and students, worked extremely hard the whole afternoon, giving no less than eleven performances. Their ingenious limericks and burlesque opera caused great amusement.

The Roland Ramblers were even better than last year. The two other parties, Miss Kelly's and Miss Fathers', both gave excellent shows, though unfortunately the latter were handicapped by the absence of their pianist. There were also impromptu sing-songs in various wards. The thanks of the Hospital are due to all those ladies and gentlemen who gave up their Christmas Day to the patients.

It would be an impossible and invidious task to attempt to describe the wards. Much time and trouble had evidently been spent on them, and the results, though widely different, were all good.

That important function, tea, was more in evidence than during the last four years, and late that night, after hearing the Resident Staff serenading Mr. Hayes, the Warden, and the Steward, those with sensitive consciences went to bed and dreamt uneasy dreams of that moribund maiden, Dora, and her decree that "between the hours of 3 p.m. and 6 p.m. no meal shall consist of more than one and a half ounces of cake, scone or biscuit"!

\* \* \*

May we suggest that an early opportunity should be taken to put the Museum into something like working order? Bart.'s is justly proud of its collection of pathological specimens, and quite rightly steps were taken to guard these valuable treasures from hostile aircraft. We realise that it is impossible to get back to pre-war conditions at a moment's notice, but we certainly think the Museum should receive early attention.



Now that the war is over, the question of a fitting memorial to commemorate Bart.'s men who have fallen should receive early consideration. We shall be glad to have any suggestions from our readers regarding the form which they consider the memorial should take. One suggestion which appears to us to be excellent is that a tablet inscribed with the names should be put up in the Abernethian Room, where it would remain as a permanent Roll of Honour. Some of our readers may have other ideas, and we shall be pleased to hear from them.

\* \* \*

We have always known that Col. Waring had some very definite ideas on medical education and its reconstruction, and we feel sure his views reported in this issue will be read with considerable interest.

With the great majority of his proposals we are in entire agreement, although doubting very much the desirability of extending the curriculum to six years. This might be possible, of course, providing that it was made compulsory to complete the Chemistry and Physics (we would not include Biology as Col. Waring suggests) prior to entering the Hospital.

There is one suggestion we would like to add, and that is that the student should receive more definite instruction in the wards in the writing of prescriptions. A student just qualified generally has a fair working knowledge of his Hospital Pharmacopœia, but without that he is more often than not completely at a loss. This is certainly a point in reconstruction which might be considered.

Anent Col. Waring's statement that at least half the British Pharmacopœia could be conveniently deleted, we would like to point out that while this might apply in this country, the B.P. is of an international character, including as it does Colonial Addenda.

Discussing the subject with the Pharmacist to the Hospital, we gather that a considerable amount of progressive medical treatment is dependent upon unofficial preparations—a fact well illustrated in the popularity of pituitary, camphor, and other injections. Another cogent example is the various biological products which constitute such an important factor in modern treatment.

It follows therefore that whereas possibly half of the preparations in the British Pharmacopœia could be conveniently dispensed with, additions might be made which would more than compensate for any deletions.

\* \* \*

It affords us unusual pleasure to learn that Capt. T. E. Osmond, R.A.M.C., and Capt. E. G. S. Cane, R.A.M.C., who were taken prisoners after the capitulation of Kut-el-Amara, have arrived at Alexandria.

\* \* \*

Amongst the recently repatriated officers from Germany we are glad to see the name of Major M. Donaldson, R.A.M.C.,

who was taken prisoner last March. We shall look forward to his early return to the Hospital.

\* \* \*

Our congratulations to T/Capt. P. Selwyn Clarke, R.A.M.C., on receiving the Military Cross. The official details are as follows:

"For conspicuous gallantry and devotion to duty. After an unsuccessful attack he went out into 'No Man's Land' and attended to many wounded, being exposed to heavy shell and machine-gun fire the whole time. His courage and coolness were a fine example to the stretcher-bearers working under him, and encouraged them in their difficult and dangerous task."

\* \* \*

Major Sydney R. Scott, M.S., F.R.C.S., having completed the investigations on the ear and aviation which he undertook at the request of the Army authorities in France, has relinquished his temporary commission in the R.A.M.C., and has returned to his duties at this Hospital.

Capt. Foster Moore has also relinquished his commission, and is back at work in Hospital.

\* \* \*

Our congratulations to Major F. P. Mackie, I.M.S., on being awarded the O.B.E. for distinguished services in connection with military operations.

\* \* \*

Capt. A. R. Cook, Uganda Medical Service, has been made a Chevalier, Ordre de Leopold. We congratulate Capt. Cook on receiving this honour, which was conferred by the King of the Belgians.

\* \* \*

In a recent despatch from General Sir Charles Munro, Commander-in-Chief in India, we note with pleasure the name of Col. H. J. Barratt, I.M.S., whose services, we understand, have been of particular value.

\* \* \*

We are asked to state that a Final Fellowship Class will be held for the next Examination, which takes place in May.

\* \* \*

Sir Thomas Horder's "Medical Notes," which have been the subject of so much interest, are unavoidably held over. The next of the series will appear in the February issue.

\* \* \*

We regret to have to record the death of Lieut.-Col. James More Reid, late of the Royal Army Medical Corps, at the age of sixty-two years. Educated at Edinburgh and the Medical School of this Hospital, he joined the Medical Service of the Army in 1884, and took part in operations on the North-West Frontier of India in 1897-98 with the Tirah Expeditionary Force, receiving the medal with two clasps. He was also engaged in China in 1900, was mentioned in despatches and received the medal.



We also learn with deep regret of the death from pneumonia of Dr. Percy J. F. Lush, youngest son of the late Lord Justice Lush. He took the M.A., M.B., and B.Ch. degrees at Oxford, and was a student at this Hospital. Dr. Lush, who was in his sixty-first year, had been House-Surgeon and House-Physician at the West London Hospital, and Clinical Assistant in the Throat and Ear Department of the Hospital for Children, Great Ormond Street. At the time of his death he was Medical Superintendent of St. Columba's Hospital, Avenue Road, St. John's Wood.

\* \* \*

#### ROLL OF HONOUR.

In spite of the fact that hostilities have ceased we regret to have to include several additional names under this heading.

To the relatives and friends of these Bart.'s men we offer our deepest sympathy.

Capt. Bertram Walter Cherrett, M.B., R.A.M.C., died at Nairobi on November 4th from pneumonia following influenza.

He was attached to the East African Medical Force, and was Medical Officer of Health for Nairobi.

Capt. Andrew Monro Jukes, M.D., I.M.S., died in Egypt on October 18th from heart failure after rheumatic fever. He was the only son of Dr. and Mrs. A. Jukes (C.M.S., retd.).

Capt. Lawrence Amos Winter, M.D., R.A.M.C., died on November 15th at the 20th General Hospital, France, from pneumonia following influenza.

He was 50 years of age, and prior to joining the Service was in practice at Sheerness.

### SURGICAL APHORISMS.

By D'ARCY POWER, F.R.C.S.(Eng.).

(Continued from page 26.)

(24) The cricoid cartilage is the guide both for laryngotomy and for high tracheotomy. Its position, therefore, must be verified before an incision is made for either operation.

(25) In the operations of laryngotomy and tracheotomy the windpipe has not been opened in the living body unless air rushes out. Inexperienced operators assign many reasons to account for the absence of this outrush.

(26) The first outrush of air is usually followed by a short period of apnoea. Put in the laryngotomy or tracheotomy tube, and then wait until the respirations become regular before proceeding farther.

(27) Do not suture the incision after laryngotomy lest surgical emphysema follow. A dressing of dry gauze kept in place by strapping is sufficient.

(28) Remember that the advance of science now permits of visual exploration of the trachea, bronchi, œsophagus, stomach, rectum, and bladder. It is no longer necessary to guess about the condition of these parts nor to be content with skiagrams. Look and see what ails them.

(29) A bacillary infection of the urinary tract is easily mistaken for appendicitis or ureteric calculus by those who rely more on the statements of the sufferer than upon the results of a thorough examination.

(30) An examination of the breast should be made with the patient recumbent. The tension of mammary tumours, their consistence and extent can thus be more readily determined than when the patient is sitting in a chair.

(31) Injury may produce a galactocele even in a virgin breast.

(32) It is better to have attention drawn to a tumour of the breast by pain than accidentally. Mastitis is often painful, whilst mammary cancer is usually painless in the early stages.

(33) The presence of a mammary cyst does not exclude malignant disease. It is unsafe, therefore, merely to aspirate such swellings. They should be excised.

(34) It is rare to get cancer of both breasts simultaneously; it is usual to get symmetrical mastitis.

(35) Tubercle and the gonococcus cause epididymitis; cancer and syphilis affect the body of the testicle. These four infections must be excluded before the rarer causes of enlarged testicle are considered.

(36) I do not remember to have seen a child with acute intussusception in whom the temperature rose above normal. The temperature, therefore, is important in making a diagnosis between this condition and acute inflammation of the intestinal canal in children.

(37) "Exploratory laparotomy" should be expunged from the list of surgical operations. It shows that the case has not been considered in every aspect.

(38) There are three stages in the career of a surgeon: in the first he loses the fear of hæmorrhage; in the second he ceases to multiply operations; in the third he acquires the moral courage to stop in the middle of an operation when he finds the conditions inoperable. There is a final stage which he never attains with the present span of life—the ability to gauge correctly the vital resistance of the patient, yet upon this depends the success of every operation.



## EXPERIENCES IN MESOPOTAMIA AND INDIA.

By P. HAMILL, M.D., D.Sc., M.R.C.P., Major R.A.M.C.

**T**WO years' experience in Mesopotamia and Bombay is not a sufficient foundation for anything more than a few general observations on matters of medical interest. Perhaps I have been unusually fortunate, for in addition to the experience of a war hospital and a military infectious hospital for British troops, I have also, through the courtesy of many European and Indian practitioners, had an opportunity of seeing a number of interesting cases in Indians.

As regards the diseases, the difference between Eastern and London experience lies chiefly in the relative proportions and severity of the cases. Some common disorders were quite new to me; of these sand-fly fever and dengue were the chief. We had smallpox in all degrees of severity, but not very often, and occasionally cholera and plague. We had two cases of kala-azar and one of rat-bite fever, which recovered completely. Malaria, the enteric group, dysentery and liver disease, which are the cause of so many admissions in India, were already familiar; while relapsing fever and typhus, which were prevalent in one batch of Turkish prisoners, had once or twice been seen at home.

Febrile and intestinal affections form a large proportion of the total admissions. The reason of this is not far to seek. The combination of warmth and moisture favours the growth of micro-organisms productive of jaundice and diarrhoea. In those who have been long in the East, and in many natives, the whole bacterial content of the gut is often greatly changed. Yeasts abound in many patients, and in others lactose-fermenting organisms may be hard to find. Intestinal parasites are common. Worms of various kinds—particularly threadworms and *ankylostoma*—are very frequent, and the latter must be constantly borne in mind as a cause of the anæmia, which is so common in the tropics. Protozoa were found in a considerable percentage of the cases which passed through my hands; amœbæ of various kinds, and flagellates, such as *Lamblia* and *Trichomonas*, were the chief. All the bilharzia cases were imported.

This is not the occasion for a discussion of the pathogenicity of the intestinal Protozoa. They have a way of being more easily found at some times than others, particularly during an attack of diarrhoea. That may mean a variety of things—that they are not then broken up, that the factor producing diarrhoea produces a condition favourable for their development, or even that at these times one searches more diligently. My own impression is that one becomes tolerant of these creatures—as of many larger—and that whilst they may not be very detrimental, they are a nuisance and should be discouraged. The *Amœba histo-*

*lytica* is definitely pathological. A careful series of investigations showed that a considerable percentage of people harbours it, albeit unknowingly. Not only may this parasite produce serious, and even fatal, dysentery, but it is responsible for a good deal of ill-health, and even death, from the hepatitis which it may set up.

Though liver abscess is not at all uncommon, its incidence bears but a small proportion to the total number of cases of amœbic dysentery. Hepatitis—both acute and chronic—is, on the other hand, very common indeed. How much we owe to Sir Leonard Rogers for the introduction of emetin in the treatment of this disease it is hard to estimate. Its action in the majority of cases is almost miraculous, and has to be seen to be believed. Again and again one sees patients very ill, with the liver rapidly enlarging, high fever, leucocytosis, etc., in whom the development of an abscess seems imminent; but a few injections produce great relief, and a thorough course leads in time to resolution.

The possibility of amœbic hepatitis must always be kept in mind as a cause to be considered in any case of slight right-sided dulness of the lung, with or without pleurisy or pain. The characteristic pain referred to the point of the shoulder is by no means always present. Many early cases are most baffling, but careful clinical observation leads one in time to recognise them with comparative ease. When an abscess is suspected, exploration of the liver with a needle is indicated. It is fraught with little risk, and, even if pus be not found, often appears to afford relief. Puncture should be performed only on the operating-table, and everything should be in readiness for the immediate evacuation of the abscess should pus be found. Nowadays with emetin there is a tendency to avoid open operation, and to be content with evacuation of the abscess with an aspirator. A patient may sometimes be walking about within two or three weeks of the removal of over a pint of pus from his liver.

Malaria is wide-spread, and the parasite is always ready to take one at a disadvantage. At home one is taught in diagnosis to find, if possible, a single cause which will explain all the phenomena. In the East patients are ambitious, and often aspire to two or even three affections at the same time. Malaria and chronic or acute colitis—frequently of amœbic origin—or an attack of hepatitis are among the commoner complications chosen. In England it is not considered “good form” to be so grasping, but it must be remembered that “there ain't no Ten Commandments” east of Suez.

P.U.O.—How often one sees a patient so labelled! At least it is honest, if not used as a cloak for slackness—and I am glad to say it seldom is. We are almost entirely ignorant of the causative agent of the commoner acute febrile diseases—sand-fly fever, dengue and seven-day fever. The latter is common enough in April and May, and sometimes simulates mild enteric so closely even to the presence



of rose-spots, slight enlargement of the spleen, low pulse-rate, etc., as to deceive even the elect. But there are differences in the tongue and other points, which enable one to differentiate the cases after short experience. Typhoid and paratyphoid organisms cannot be isolated from the blood and stools, and there is no increase in agglutination titre. From two or three cases we have isolated coliform bacilli in the blood-culture, but their precise nature was not definitely established. Recent observations on cases classed as "Enteric Group" have shown that *B. fecalis alkaligines* and *B. coli* may be found in the blood-stream from time to time. There is obviously a large field open for investigation.

So many acute febrile diseases begin with shivering, headache, and pains in the back and limbs that in the early stages it is often well-nigh impossible to make a diagnosis. If there be an epidemic one naturally thinks first of the disease commoner at the moment, whether it be influenza, sand-fly fever, dengue, malaria or smallpox. Thus, a man who returned to England many months ago was seized this year in London with characteristic headache and pains. When admitted to hospital he was convinced that it was another attack of dengue, from which he had suffered in India. He turned out to be a typical case of influenza. I have had two or three cases admitted to my wards as P.U.O. which I thought at first to be dengue or influenza. Next morning they developed beautiful smallpox rashes—in one case whilst I was examining him. They were transferred to the Infectious Hospital, but beyond disinfection of bedding and re-vaccination of all in the wards no further steps were necessary, and the wards were not closed. I wonder if it would have been as safe to retain these patients as it is to keep enterics. We have had no smallpox among the attendants in the infectious hospitals, and the risk of transfer of the disease by contacts is probably not appreciable in an efficiently vaccinated population.

The most difficult cases are those in which for weeks or even months there is an evening rise of temperature of one or two degrees without much indisposition. Sometimes, especially in new-comers, it is malarial in origin, and there may be an increase of mononuclears, though the parasite is hard to find. In such cases a course of quinine affords relief, or a frank malarial attack supervenes and the parasite is detected. It is important to examine carefully for signs of tubercle and the other causes of continued fever common at home.

Nevertheless one cannot help thinking that the heat-regulating centre is unstable in a warm climate, and that mild infections produce greater disturbances of temperature than they would in England. Heat regulation is undoubtedly more difficult, especially when the humidity is high and the conditions unfavourable to evaporation, so that heat is not readily lost. However, I am not satisfied that this is the sole cause, for I have seen patients who were

apparently in normal health, except that their temperatures rose nearly every evening to 99° or 100° F., with but slight malaise. There appears in some cases to be a seasonal variation, for I have seen a Parsi whose temperature for several years rose to 102° or 103° F. daily from about the middle of April until the onset of the rains (usually the middle of June), but did not rise during the equally warm, damp weather of September and October. In this case and in that of one or two others under my care the most searching investigations were repeatedly carried out by different observers with negative results. The condition is well recognised, and has been discussed fully by Rogers. A voyage to Europe usually breaks the "habit," but it is apt to relapse after the patient has been back in India for a few years.

At first it is surprising to find how profusely one perspires on slight exertion, especially in the warmer and damper months. Stone in the bladder and kidney is very much more common in India than in England, and is probably due to excessive concentration of the urine.

Baghdad boil, known also as Delhi button and Punjaub sore, is not common in Bombay. Most of my cases have been in patients returning from Mesopotamia. My colleagues, Capt. Shorten and Capt. Barnard, in the radiographic department, were very successful in treating these most indolent and unsightly lesions by doses of X rays. We have also used the vaccines prepared by Dr. Roy in a few cases with good results. It is interesting to note that microscopically a section of a Baghdad boil may very closely simulate an epithelioma, though anaplasia is not present. This fact should be borne in mind when confronted with an indolent ulcer with raised edges on a limb.

Amongst the Arabs of lower Mesopotamia one sees occasionally on the ankle the pigmented scar of a healed Baghdad boil, and I am informed that they differentiate two types and practise inoculation—possibly with a view to prevention of further attacks. Whether infection with the Leishman-Donovan bodies which produce Baghdad boil yields any immunity against kala-azar it is hard to say. I do not know whether the latter disease occurs amongst the Arabs; it is, however, worthy of record that I have seen two patients invalided from Mesopotamia in whom I diagnosed kala-azar clinically, though the parasite was not found in blood-culture or on spleen puncture. One of these was under my care, and recovered after a course of injections of antimony tartrate; the other was in another hospital, and under similar treatment had already greatly improved when I left India.

Amongst minor disorders may be mentioned prickly heat and crops of boils. Not everyone is affected by prickly heat. The onset is surprising; most of those in my unit first experienced it in the Red Sea on our voyage out in August, 1916. On leaning back in a deck chair it felt as though dozens of pins had been driven in between the shoulders. Later there



was violent itching, and a good rub against a friendly stanchion or davit was most grateful. One can sympathise with the Scot who blessed the Duke of Argyll! The following verse from the *repertoire* of a Mesopotamia concert party was received with acclamation :

"The greatest trial in life for us has been the prickly heat,  
It makes us want to scratch ourselves all day from head to feet ;  
It really is the worst complaint a man could ever catch,  
And the only thing to do for it is scratch and *scratch* and  
SCRATCH !

"I don't suppose we'll cease to scratch for months and months and months,  
I don't suppose we'll cease to scratch for months and months and months ;  
The natives tell us here that when you've had it once  
There's nothing to do but scratch and scratch for months and months and months."

Bombay, though seldom very hot (on but few days in the year does the temperature much exceed 90° F.), is never very cold—even the "cold weather" corresponds fairly well with an English June. The difference between day and night temperature is small and the humidity is high. This lack of temperature variation is one of the chief disadvantages, for the hot weather with the heavy rains is relaxing, and there is no stimulus of cold to restore vigour. It is surprising how great an improvement results both in patients and ordinary residents from a few days' change to a cooler and drier climate at a short distance from the coast.

As an all-year-round station Bombay is probably as good as any. It possesses the advantages of a large town, good shops, electric light and fans (a great comfort), and a water-carriage system of drainage, which is a joy to the eye and ear of those who have long been up-country. There are delightful drives in the surrounding country, good bathing, golf, etc.

The central meeting-place for Europeans is the Yacht Club. Considering that the harbour is particularly beautiful, it is a matter for some surprise that there are not more sailing members. No regatta was held during the two seasons I was in Bombay, but club races took place every Saturday from October to April. There are three classes, of which the Tom-Tits (Clyde Sea Mew Class) provide the largest entry. They are splendid little vessels, and are to be found at all the chief yachting centres in India and Ceylon.

Nearly everyone in India and Mesopotamia passes through Bombay sooner or later, and it is surprising how many old friends one meets. Bart.'s men are to be found everywhere. A good story is told of a Bart.'s dinner at Calcutta : A — Hospital man was dining alone at another table, and the chairman sent him a note inviting him to join the gathering. He refused with regret, and expressed his surprise that they had failed to observe that the — were dining !

## RECONSTRUCTION IN MEDICAL EDUCATION AND PRACTICE.

By H. J. WARING, M.S., M.B., B.Sc.(Lond.), F.R.C.S.,  
Col., R.A.M.C.

[We are indebted to the courtesy of the Editor of the *Lancet* for permission to print the following report of Col. Waring's remarks on this interesting topic at a recent meeting of the Medical Society of London.]

**I**N his opening statement Col. Waring said it was impossible to divorce medical education from medical practice. The objects to be aimed at in medical reconstruction could be put in the following brief form : (1) To improve the education of students so as to make them more efficient for medical practice ; (2) to improve the conditions under which medical practice is carried on ; (3) to obtain the largest output of good work from medical men with the least expenditure of energy ; (4) so to arrange the conditions of medical practice that the practitioner could have more time for recreation and more opportunities for bringing his medical knowledge up to date. He was assuming that it was not the intention of the State to create a whole-time medical service ; the draft Bill did not foreshadow that.

### THE MEDICAL CURRICULUM.

Five years was too short a period of study if clinical subjects were to be adequately taught. When, in 1892, the medical curriculum was lengthened to five years, it was the intention that the added year should be devoted to clinical work, but owing to some deficiencies in organisation and to some matters concerning the organisation of the schools the preliminary subjects still occupied the whole period. Two suggestions had been made to remedy that. The first was that the chemistry, physics, and biology course should be completed before the commencement of medical study ; this could be done by rearranging the work at the public and secondary schools in the case of students who did not go to the older universities. In many public schools the courses of instruction were so arranged that the chemistry, physics, and biology taught sufficed for the first examination ; the same was also true, to a lesser extent, of many secondary schools. If the need were made very clear, the public schools would also fall into line. In Scandinavia the period of study had been extended to six years, and he was told by medical men there that it was satisfactory ; but he thought the better solution of the difficulty was the completion of the chemistry, physics, and biology before entering the five-year course of medicine and surgery.

### MEDICAL EDUCATION.

He felt that anatomy should be taught by professed anatomists, but taught less from the morphological than from the surgical side. These professors should be shown



the need for emphasising the latter aspect—*i. e.* in the use of the living model and the normal X-ray appearances, especially in regard to the bones. It was also absolutely necessary to teach the lymphatic system of the body more thoroughly. There should be a schedule of anatomy, for some parts need not be taught in detail, such as learning every individual muscle of the back. Owing to the paucity of material, he thought it necessary that there should be a new Anatomy Act; and if that were the general view there should be a collective representation made, for the present was an opportune time. Applied anatomy would have a fitting place during the clinical period, and should be taught by a surgeon. Physiology had become such an enormous subject that its professors showed a tendency to teach it as a science apart, rather than human physiology as a factor in general medicine. The chemist should be attached to this department, and the time had now arrived for the general inclusion of a bio-chemist. Pharmacology should be taken in the intermediate period, in close association with physiology. He thought that the essentials of bacteriology should be taught before the student commenced his actual medical work; it could be done in a compulsory three months' elementary pathology and bacteriology course.

With regard to *materia medica* the student had an enormous amount to learn, as the Pharmacopœia was now very extensive. A number of physicians and surgeons could probably cut it down to one-half with advantage to the medical student and without material disadvantage to medical practice. General medicine and surgery were well taught in all the medical schools. He had a suggestion to make, however, with regard to midwifery and gynaecology—namely, that separate teachers should be appointed for these two subjects. There had been a great tendency for the teaching of midwifery to be left to the younger man; when the teacher was older he inclined to the gynaecological or surgical side. There were now many special departments, and as medical education was at present constituted it was almost impossible for the ordinary student to go through all of them satisfactorily. The medical student should go through a special course in each one of these. Owing to the difficulties in providing material, the majority of students never went through any satisfactory course in operative surgery; it was usually only those who went in for the higher degrees who did so. Concerning the equipment of the medical student for practice, he thought the teaching of mechano-therapeutics and massage was not satisfactory in any of the schools, yet many conditions could only be treated satisfactorily in that way. Consequently, that branch of practice went, by default, to quacks. In the States the gentleman who called himself an osteopath got a big practice. Mechano-massage should not be taught alone to the medical student; nurses should be included. He would have much more done in the teaching of preventive medicine; he did not mean public health work and sanitary

science, but the prevention of the occurrence of disease. That was very much wanted in English medical schools. There should also be included in the curriculum a definite course on medical ethics. At present, to a great extent, the student had to learn it after he had entered on practice. It need not be an extensive course. Nurses should be regarded as part of the medical profession, but in the past they had not been catered for as they should have been. He did not think nurses were given sufficient opportunities for doing surgical dressing. It was also a question whether surgical sisters and those in charge of operation theatres should not have practical instruction in administering anaesthetics. In military practice during recent years they had done very useful work of this kind.

#### POST-GRADUATE STUDY; MEDICAL SCHOOLS; CONDITIONS OF MEDICAL PRACTICE.

With regard to post-graduate schools, he thought that in London the profession had made a mistake. In most of the schools an attempt was made to teach graduates and undergraduates together. It would attract many to the wealth of clinical material in London if graduates could have courses distinct from those for undergraduates. At the present time most of the medical schools in London were associations of private individuals for the instruction of students, and their emoluments were derived from the fees paid by the students. He did not think university education could be satisfactorily carried out on the fees paid by the student. Recently the Board of Education had given grants to some schools, and those had during recent years enabled some of them to survive. He did not think the method of giving grants was a good solution. Every medical school should be a corporate body; should be controlled by a governing body, both professional and lay. The large hospitals should, he thought, have an arrangement by which the members of the Navy, Army, and Air Services could have definite study courses in the schools. It seemed a pity that as men became seniors in these services they were made administrators, to the loss of the scientific side.

He also made a plea for team work in ordinary practice. Practices should not be a one-man concern, but should consist of men with varied qualifications, so as to ensure thorough investigation for every patient. London was worse provided than any other place with private institutions for medical and surgical treatment. Many of the "surgical homes" had been chosen because the property was cheap, and in some the sanitary and other arrangements were very unsatisfactory. Some were a definite disgrace to the profession. Under the new Ministry of Health he would have it as a condition that every one of these houses should be passed as in a fit sanitary condition before it was allowed to be so used. An interesting question was as to how far it was desirable for a nursing home to belong to a medical man. He thought such homes ought to be legitimately



possible provided they were certified by some public body as suitable.

Much had recently been heard about making an A 1 community out of C 3 material. As things were at present constituted he did not think that was possible. The criminal, the congenital idiot, the feeble-minded, and such people were allowed to go free so long as they were not dangerous to the community. Two feeble-minded folk married, or did not marry, and additions to the C 3 ranks ensued. That could probably only be effectively stopped by means of sterilisation. Lastly, how far was the profession justified in prolonging the dreary lives of people suffering from incurable and crippling conditions, such as ectopia vesicæ and imperforate anus?

## OBITUARY.

ALFRED ELLINGTON STANSFELD, M.D.(CANTAB.),  
F.R.C.P.



GLOOM has been cast over our Hospital by the untimely death of Dr. A. E. Stansfeld, which took place on November 25th from pneumonia following influenza.

Alfred Ellington Stansfeld was born at Stoke Newington in 1882. He received his earlier education at the Central Foundation School and entered St. John's College Cambridge, in 1902 with a Major Scholarship in Mathematics. This he held for five years, although, shortly after going into residence, he received permission to relinquish his studies in Mathematics in favour of Natural Sciences. He gained First Class Honours in the Natural Sciences Tripos, receiving the degree of B.A. in 1905. In the second part of the Tripos he took Physiology as his subject, and once more gained First Class Honours. In 1907 he entered St. Bartholomew's Hospital with an Entrance Scholarship, and during his brilliant career as a student won the Kirkes' Scholarship and Gold Medal, and the Burrows' Prize in 1908, the Brackenbury Medical Scholarship in 1909, and the Lawrence Scholarship and Gold Medal in 1910.

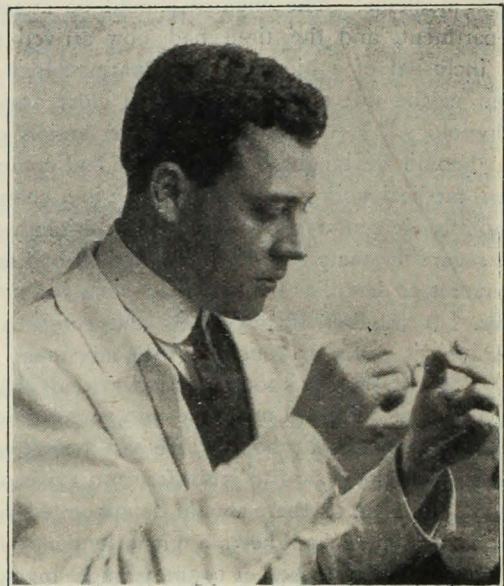
After qualifying at Cambridge in 1909 he went on a voyage round the world, returning to St. Bartholomew's Hospital in 1910 as House-Physician, and afterwards held the appointments of Casualty Physician, and Clinical Assistant to the Skin Department. He entered the Pathological Department in 1912, being first Junior and later Senior Demonstrator of Pathology, which post he held at the time of his death.

He was also Pathologist to the Special Treatment Centre for pregnant women at Thavies Inn.

At the Metropolitan Hospital he was elected Assistant Physician in 1912 and full Physician in 1916.

He became Member of the Royal College of Physicians in 1911, took the degree of M.D. at Cambridge in 1915, and was this year elected Fellow of the Royal College of Physicians.

Stansfeld's death has robbed the Hospital and the medical profession of one of its most brilliant members. He was a man of great intellectual achievements, and possessed powers of perception which were rapid and accurate. His clearness of thought and his simple and lucid methods of reasoning, tempered with kindness and understanding, made him not only a successful and popular teacher, but a friend to whom all could go in their difficulties. He was ever willing and eager to give a helping hand, to advise and encourage those who came to him, and it



DR. A. E. STANSFELD.

was not only students who came, but there was scarcely a member of the Hospital with whom he had not some close association. His room in the Pathological Laboratory was often to be seen filled with men who collected there to ask his opinion and advice.

At the Metropolitan Hospital he took an active part in administration and gave great assistance to the Committee. He was a good disciplinarian, and arranged many difficult matters with tact and forethought. Though full Physician he still continued to attend out-patients, and acted as Pathologist to the Special Treatment Department. In the formation of the latter he took a great part, and it owes its success largely to his untiring energy. He was Secretary to the Medical Committee, and a medical representative on the House Committee and Committee of Management.

The greater part of his time, however, was taken up by work in the Pathological Department of St. Bartholomew's Hospital, in performing the routine work, teaching the



students, and organising their classes and lectures. Research had necessarily to take second place, but he was able to perform much valuable work, and interested himself in problems connected with blood and its diseases and in immunity. His apparatus for the transfusion of blood is now in frequent use in the wards. In pathological technique he excelled, and was never satisfied with an experiment unless it was done to the best of his ability. His studies in asthma and anaphylaxis were much interrupted during the war, and have remained unpublished, being in an incomplete form at the time of his death. Among his published works are: "The Treatment of Diseases of the Blood" and "The Treatment of Diseases of the Spleen," *Practitioners' Encyclopædia of Medical Treatment*, 1915; "The Present Position of Vaccine Therapy," *St. Bartholomew's Hospital Reports*, 1916; "The Principles of Treatment by Transfusion of Blood," *Lancet*, 1917; "Apparatus for Transfusion of Blood by the Citrate Method," *Lancet*, 1917.

It was perhaps in Clinical Medicine that Stansfeld shone brightest, and he owed his success to every attribute which makes the brilliant physician. In his examination of his patients he was extremely thorough and systematic. He applied his extensive physiological and pathological learning in a masterful manner, and left no stone unturned in his endeavour to arrive at the diagnosis, or to treat his patients to the best possible advantage. He approached his cases, too, from the human side, and made them feel that he took their ills personally upon himself, and gained their lasting love and confidence.

Stansfeld leaves behind him a widow and three children, and to them we offer our most sincere sympathy. His death at so early an age comes upon us as a great shock, and we mourn his sad loss. His career, so brilliantly begun, gave full promise of a great future and of upholding our most noble traditions.

R. G. C.

#### AN APPRECIATION.

One of the penalties of friendship has again fallen to my lot: this is the third occasion I have contributed to the JOURNAL a few words in memory of a departed friend. The privilege, though a sad one, is one which I would not lightly forego; it affords an opportunity to relieve over-charged feelings by giving expression to the crowding memories of old associations; and on this, as on the other occasions, I am grateful thus to be identified with one who I am proud to remember was my friend.

When I was appointed House-Surgeon to the late Mr. C. B. Lockwood we corresponded with Dr. Ormerod's "firm" and Stansfeld was my contemporary house-physician. Hitherto our acquaintance had been pleasant, but limited. I had known him first at Cambridge as having a reputation for brilliancy which can hardly have been equalled. I had met him and had been delighted to claim him as an

acquaintance, but our paths did not lie together: he was soaring on the highest peaks of Physiology; I was toiling laboriously up the smaller heights leading to the first part of the Natural Sciences Tripos.

So that it was as fellow House-men that our friendship really began. I doubt if colleagues of the Junior Staff ever consulted with the same enthusiasm that Dr. Ormerod's House-Physician and Mr. Lockwood's House-Surgeon spent those twelve months together. I am not ashamed to admit that the advantage was all on my side; and whilst Stansfeld would generously fetch me in order that I might be shown some rare or peculiar feature in medicine, I for my part perpetually called upon him for his opinion upon an admittedly surgical condition. Yet in the most charming way Stansfeld never failed to create the impression that so far from his conferring a favour, he himself had reason to be grateful and was under an obligation.

Often and often on full duty when retiring to bed in the small hours of the morning I would say to him half jokingly and half in earnest, "I shall fetch you out later on if I am in trouble," and he would invariably reply with unmistakable sincerity, "Oh, I shall be so glad if you do."

How many H.-Ps. even of the keenest enthusiasm would be prepared to accept such a gratuitous burden and submit to a deprivation of their scant leisure? Yet I am perfectly certain that in his greatness of heart Stansfeld regarded this appeal to his assistance as actually the accordance of a favour to him.

And when time brought him higher up the ladder of professional distinction he was just the same. To help a friend or even a casual acquaintance who had no sort of claim upon him no amount of trouble was too great. Like most young physicians and surgeons of ability Stansfeld ran the gauntlet of exploitation, but from his glorious wealth of intellect he gave ungrudgingly and uncomplainingly. In the face of the most heartbreaking meanness of a professional colleague he would express no resentment, although his own strict sense of duty towards his brethren permitted no slightest departure from financial obligations whenever he was in a position to dictate.

Of Stansfeld's early scholastic career I know nothing. He came to Cambridge as a Major Scholar of St. John's College, and with an ability which so impressed the College authorities that, although he had gained his Scholarship for Mathematics, they permitted him to study Natural Science, as indeed they would have permitted him to read History or Music or Oriental Languages, or anything else he liked.

Of course he took a Double First in the Natural Sciences Tripos. Still more, of course, he never failed in an examination. I doubt if he ever competed for a prize or scholarship which he did not win, and the Honours List at Bart's bears tribute to the extent of these. *Inter alia*, he achieved that very rare distinction, the Lawrence Scholarship (under old regulations), and had he sat for the Final



Fellowship—of course he had passed the Primary quite casually!—or the M.Ch., I am perfectly certain they could never have ploughed him.

Perhaps I may be permitted just one story of an examination. When he was up for the Final M.B. at Cambridge, his papers naturally demonstrated to the examiners that they were dealing with a candidate of exceptional merit. A fellow-examinee overheard Sir Clifford Allbutt during the clinical examination taking Stansfeld to a case and asking him to examine it and give an opinion—"not as an examinee, but as a colleague." And the Regius Professor of Physic was subsequently heard discussing the result with another examiner in this wise: "By Jove, Stansfeld is a clever fellow. I showed him that case over there [it was an obscure condition of mediastinal disease], and 'pon my word he really persuaded me that the opinion I had formed of it was wrong!"

Stansfeld was academically so brilliant that I doubt if the full extent of his capacity was ever generally realised. Without appearing to read very much—indeed, his practical work gave scant leisure for reading—his knowledge of medical literature was almost encyclopædic. But in addition he had rare clinical acumen, a clear-headed capacity for the utilisation of the knowledge he possessed, and a practical acquaintance with physical signs which gave him at the bedside a faculty for diagnosis far beyond the experience of his years. Add to all this the possession of remarkable vitality, energy, and patience. I never saw him ill or even seedy, and after three or four successive nights of work as Senior H.P. one invariably found him in the morning fresh, smiling and good-humoured as ever, keenly anxious to begin another full day's work.

I suppose no genius is ever unaware of his superiority, and with all his sublime simplicity and modesty Stansfeld possessed a pleasing dogmatism which arose out of the sense of power in his knowledge. And yet nobody was ever more tolerant of other people's inferiority, and nobody more enthusiastic—almost absurdly enthusiastic—about other people's capacity in those directions in which he himself did not excel or upon which he did not regard himself as an authority. And whilst his eyes shone and his face lit up with a merry smile as he positively gloried to hear of the achievements of any of his friends, of his own successes it was almost impossible to get him to speak, and only casually did one gather how his brilliancy over difficult cases had brought him in front of others far more eminent in the profession whose judgment one would have expected to be much greater. And Stansfeld was no mere academic diagnostician. With a real bull-dog tenacity he would fight every inch of the road to save a patient whom others had abandoned as hopeless. I could, indeed, quote striking examples out of my own knowledge, but these would appeal only to readers who knew Stansfeld, and they could all supply for themselves examples equal to mine.

Stansfeld had no enemies. This is a rash generalisation to say of any man, but I utter it without hesitation. Some men disliked him I have no doubt; his code of honour was so high that men of poorer clay resented even this evidence of superiority, whilst envy of his ability impelled inferior minds to doubt his clinical capacity on the principle that a clever man is always impractical. But the true nobility of his character shamed into silence his most adverse critics, and so Stansfeld could never have had an enemy.

Fearless in every undertaking, he allowed no personal considerations to stand in the way of his duty. I remember once on the question of an appointment he gave his vote in favour of a man for whom he had no liking rather than to an admitted friend, because he was convinced that the former was the better man for the appointment, and felt that he was in honour bound to support him. How many of us would be disposed thus fearlessly to submerge our personal prejudices in the cause of justice! Can it be wondered at that if Stansfeld may have lost a "friend" he never made an enemy?

\* \* \*

Once the first sting of personal grief is past, it is almost a duty to remember that not only must this hospital mourn one of her greatest sons, but that British Medicine itself has sustained a loss. Stansfeld would have gone far, and the highest honours must inevitably have been his. Nothing could have resisted that combination of mighty intellect, untiring application, and unswerving rectitude.

But my thoughts swing back inevitably to the days when we were on the House together, two boys just beginning the practice of their profession, and I shall always remember him for his kindness of heart even more than for his brain.

A common friend (G. G—) who may read these lines may remember in a conversation several years ago expressing to me the opinion—"Stansfeld is one of the very few men one can really call 'a friend.'"

I think that Alfred Stansfeld himself would be prouder of this epitaph than of any other to which his great intellect and Christian character would entitle him.

A. ABRAHAMS.

## STUDENTS' UNION.

### RUGBY FOOTBALL CLUB.

#### ST. BARTHOLOMEW'S HOSPITAL v. ST. THOMAS'S HOSPITAL.

Thomas's, unfortunately, could only field a very weak side at Chiswick on November 23rd, the result being a win for the Hospital by 54 points to *nil*. As the score suggests, the game was a very one-sided one. Beaten for possession in the scrum and outclassed behind, Thomas's were on the defensive during the whole game. Receiving from almost every scrum, Cockell made full use of his opportunities and opened up the game in excellent style, with the result that the Thomas's line was crossed on twelve occasions. Tries were scored by Johnstone and Hendley (3 each), Krige and Thomas (2 each), Cockell and Orchard (who also dropped a clever goal). Krige was successful with 7 placed kicks.



ST. BARTHOLOMEW'S HOSPITAL *v.* R.A.F. WIRELESS STATION.

On November 30th the Hospital visited Biggin Hill, the opponents being a R.A.F. team. Although the game itself was not of the highest order, the visit was most interesting and greatly enjoyed. The ground was altogether against good football, and the team never settled down, most of the tries being the result of clever individualism. As in most of the previous matches our outsides quite outclassed their opponents, and the score would undoubtedly have been a heavier one had the forwards given them more opportunities. The final score was 34 points to 3, and the tries were shared between Thomas, Hendley, Cockell, Orchard, Llewellyn and Johnstone, the latter being also responsible for a clever dropped goal. Shaw, Johnstone and Macdonald converted.

ST. BARTHOLOMEW'S HOSPITAL *v.* R.M.A. (WOOLWICH).

The Hospital had little difficulty in defeating the "Shop" at Woolwich on December 7th, the final score being 42 points to *nil*. Their team, however, was a weak one, Camp claiming several members of the regular XV. Playing up the slope, the Hospital maintained a steady pressure for the whole of the first half, but were only successful in crossing the line on four occasions, the half-time score being 16 points to *nil*. On changing ends, however, the Woolwich defence completely broke down. In spite of the heavy ground and greasy ball, Bart.'s played their most convincing game of the season, and the handling of the outsides—especially Johnstone and Hendley, was extremely clever. Hendley (5), Thomas (3), Orchard and Llewellyn (2 each) were the scorers, and Johnstone (2) and Macdonald (1) placed the goals.

ST. BARTHOLOMEW'S HOSPITAL *v.* NEW ZEALAND CONVALESCENT HOSPITAL.

The first home match of the season was played at Winchmore Hill on December 14th, when the powerful New Zealand team from Hornchurch were the opponents. The heavy state of the ground rendered handling almost impossible, and on the whole the game was fought out between the two packs. The New Zealanders undoubtedly held the advantage forward, their short kicks and fast following up being quite a feature of the game. The Bart.'s pack, although without Krige and Sanford, played pluckily throughout, and their tackling was especially good. Crossing over with 8 points against them, the Hospital continued to improve, and tested the New Zealanders' defence on several occasions. After about twenty minutes' play Cockell, receiving from the scrum, made a clever opening for Johnstone to drop an excellent goal. This was all the scoring, and Bart.'s lost a most interesting game by 4 points to 8. The narrow margin of 4 points was in a large part due to the clever fielding and touch-finding of Thomas, who frequently saved the Hospital line.

## REVIEWS.

OTITIS MEDIA (MASTOID DISEASE). By CHARLES J. HEATH. (Baillière, Tindall & Cox.) Pp. 58. Price 2s. 6d. net.

We have no hesitation in describing Heath's paper (it was originally read before the Hunterian Society) as epoch-making. It is the first occasion in which the diagnosis of invisible tympanic conditions has been made possible as a guide to treatment. In the preface the author points out that he was asked to give this information during a discussion of his paper on "The Prevention of the Deafness and Mortality which results from Aural Suppuration" at the last International Otological Congress, which took place at Boston, U.S.A., in 1912, and he has certainly responded fully to that request.

We consider it the duty of every surgeon who has charge of ear cases to make himself acquainted with Heath's methods of diagnosis of the tympanic conditions which call for the "conservative" mastoid operation in order to prevent deafness through aural suppuration.

LESSONS ON MASSAGE. By MARGARET D. PALMER. Fifth Edition. (Baillière, Tindall & Cox.) Pp. x + 340. Price 10s. 6d. net.

This deservedly popular book has been thoroughly revised and brought up to date. Several new chapters have been added, the most important being those dealing with "The Treatment of Wounds," and with "Swedish Remedial Gymnastics." The chapter on "Bandaging" has been much amplified, and adds to the usefulness of the volume. Massage is a branch of medical work which has developed enormously during the last four years. For those requiring a really practical work on the subject we have every confidence in recommending the book under review.

WAR WOUNDS OF THE LUNG. By PIERRE DUVAL. (John Wright & Sons, Ltd.) Pp. 100. Price 8s. 6d. net.

This volume is an English translation of a work which originally appeared in French. It describes the very successful efforts of French surgeons in dealing with a most difficult branch of war surgery. Before the war surgery of the lung was not much in evidence. To-day it takes its place in the routine of general surgery, and affords perhaps the most striking example of the remarkable advances in surgery during the last few years. The book is extremely well illustrated, and should meet with a cordial reception.

CLINICAL CASE-TAKING. By ROBERT D. KEITH. (H. K. Lewis & Co., Ltd.) Pp. 104. Price 3s. 6d. net.

A useful little book originally written for the students of the King Edward VII Medical School, Singapore. The general arrangement does not differ materially from several other books on this subject, but the matter is very concise and to the point. We were not greatly impressed with the chapter dealing with microscopical examination; some notes on urinary deposits might very conveniently have been included in this section. Nevertheless, the student will find much useful information in this little volume, especially if he is just commencing his clinical work.

## CORRESPONDENCE.

## "HEART-STRAIN."

To the Editor of the 'St. Bartholomew's Hospital Journal.'

SIR,—I was greatly interested in Major Abrahams' letter on "Heart-strain" in the December number of the BART'S JOURNAL. My experience entirely coincides with his, and I am strongly of the opinion that the healthy heart cannot be damaged by the muscular exertion involved in the training and life of an athlete. Many hearts undoubtedly break down under athletic strain, but I am convinced that these hearts were not healthy to start with. The present haphazard method practised at public schools of not only letting, but making, all boys go in for athletics, unless they have a doctor's certificate of unfitness, is responsible for many broken lives. No doubt at some schools the boys are "passed" by the doctor before they indulge in athletics, but the usual method of examination of the heart is not detailed enough to exclude those small abnormalities which are often the only indications of a defective heart.

During the last three years I have seen a good many young officers whose hearts have broken down under the physical and mental strain of trench warfare. All these young men were passed as physically fit for active service, but in every instance a careful inquiry elicited a history of former heart trouble, such as a "strain" in school athletics, fainting attack, or rheumatic fever in boyhood. In most of these cases the only signs of defective cardiac action were a slight increase in the area of cardiac dulness to the right and sinus arrhythmia. The increase in the area of cardiac dulness had been overlooked because, as a rule, I found the area of cardiac dulness had not been percussed out, and no doubt the sinus arrhythmia had also been overlooked in the rush of an army examination. Yet all these young men were supposed to have entered the Army with sound hearts, whereas it was evident from their former histories that they all had defective hearts before they joined up. No doubt the cases in which athletes break down under training or after races can be explained in a like manner.

The accurate percussion of the area of cardiac dulness is not, in my opinion, sufficiently impressed upon the student—indeed, some teachers maintain that the area of cardiac dulness cannot be accurately percussed out. There are no doubt some medical men with a defective



sense of sound, as there are also some with "no ear" for music; but the average medical man could undoubtedly percuss out the area of cardiac dulness with accuracy if he had been taught to do so as a student and had kept up the practice. No cardiac examination is complete or trustworthy unless it includes a carefully traced area of cardiac dulness.

The above remarks may seem somewhat wide of the subject of the possibility of "heart-strain" in athletes, but they are necessary to illustrate my contention—that the athlete who breaks down is the athlete who has always had a more or less defective heart, and that, if more care was given to a detailed examination of school boys' hearts before they indulged in athletics, there would be fewer, if any, chronic cardiac troubles attributed to athletic overstrain.

I am, Sir,

Yours faithfully,

LESLIE THORNE-THORNE, M.D.

108, HARLEY STREET;  
December 9th, 1918.

*To the Editor of the 'St. Bartholomew's Hospital Journal.'*

SIR,—In his interesting letter on this subject Dr. Adolphe Abrahams quotes one of my "Medical Notes" in which I ventured, perhaps with less temerity than the occasion warranted, to dissent from Dr. Lewis in his expressed belief that a healthy heart is never damaged by muscular exertion, however severe or prolonged. Dr. Abrahams agrees with this belief of Dr. Lewis. Opinions can only be expressed; they scarcely admit of discussion. I do not therefore propose to try and convert Dr. Abrahams from his belief in the immunity of the healthy heart from strain. But two or three considerations present themselves for comment. In the first place my note did not refer to the so-called "athletic heart," to which most of Dr. Abrahams' letter refers, and for which I hold no brief any more than does he. I have not met with this type of heart, and I submit to Dr. Abrahams, with his much greater experience of athletes, when he says that it does not exist. But I do not think "exceptional opportunities of observing prominent athletes from many parts of the world" cover the ground that must be gone over in coming to a decision in this matter. And for this reason I am not conscious of any embarrassing conflict between my old pupil and myself.

The ordinary citizen is not an athlete. He is not always a young man. And he does not train. He is prone to emerge from his office or warehouse and to embark upon relatively sudden and violent exercises—of late years he has been digging trenches (or potatoes) in an admirable spirit of patriotism, to give one instance only—and to say that it is proof that he was in a fool's paradise as regards the condition of his heart, because some hours or days of these efforts produce the picture of heart-strain, seems to me to be very like special pleading.

Of course if an untrained heart is to be regarded as a diseased heart, or if the hearts of all unhealthy persons are to be regarded as diseased hearts, then we have adjusted our terms and there is no more to say, but in this case the terms are given meanings which are quite different from those given to them in connection with every other muscle or organ of the body.

Dr. Thorne-Thorne, who shares Dr. Abrahams' belief, and who also deals chiefly with athletes, introduces criteria by which he thinks hearts of dubious character may sometimes be detected early. One of these criteria is sinus arrhythmia. But the chief apostles of modern cardiology do not agree with him. Mackenzie says he regards sinus arrhythmia as "a physiological sign and not as evidence of impairment of the heart. Far less do I look upon it as evidence of disease of the heart." And Lewis writes that "the commoner forms of sinus irregularity . . . are to be regarded either as slight exaggerations of a normal phenomenon or as evidences of a mild and insignificant instability of tonic inhibitory nerve action. They should not be allowed to influence the habits of those who exhibit them." And yet Dr. Thorne-Thorne tells us they should put a veto upon a boy's athletics!

But it seems not unreasonable to ask, "Why should the healthy heart possess this fine, this enviable aloofness from the effects of strain?" We admit effects of strain in the healthy erector spinæ, in the healthy shoulder-joint, in the healthy urinary bladder, even in that master tissue—the healthy central nervous system; why not in the healthy heart? But it may be said by some that when these structures show effects of strain they, too, are not healthy. (And I remember an eminent surgeon telling a young giant, who had ruptured some fibres of his deltoid muscle whilst trying to mount an untamed horse, that the injury proved quite clearly he was the subject of an

ileal kink.) If so, then my note and this letter must be regarded as being at the most a mild protest against that school-man attitude, which bases ideas of pathology upon things as they ought to be and not upon things as they are.

I am, Sir,

Yours faithfully,

THOMAS HORDER.

[In order to save space we have taken the liberty of forwarding an advanced proof of Dr. Thorne-Thorne's letter to Sir Thomas Horder, hence the latter's reference to Dr. Thorne-Thorne's communication.—ED.]

## EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

At examinations held recently the following candidates were successful:

M.B., B.Ch.—C. F. Krige, H. W. Toms.

## CHANGES OF ADDRESS.

CAPON, H. V., 9, Cambridge Street, W.

COLLINGS, D. W., The Mount, Southwold.

SOAMES, R. M., Ridgway, Reigate Hill, Reigate.

TURNER, P. E., Catherine Booth Hospital, Nagercoil, Travancore, India.

VOSPER, S., York House, Peverell, Plymouth.

WALKER, K. M., Argentine Club, 1, Hamilton Place, W.

## BIRTH.

SCAWIN.—On November 27th, at Selway, Fairford, Glos., the wife of Major Scawin, R.A.M.C., of a son.

## DEATHS.

CHERRETT.—On November 4th, 1918, at Nairobi, B.E. Africa, of pneumonia following influenza, Bertram Walter Cherrett, M.B., Medical Officer of Health, Nairobi, and Captain East African Medical Force, aged 35.

JUKES.—On October 18th, 1918, in Egypt, of neuritis and heart failure after rheumatic fever, Capt. Andrew Monro Jukes, M.D., I.M.S., the loved husband of Gertrude (née King) and the beloved and only son of Dr. and Mrs. A. Jukes (C.M.S., retired).

LLEWELYN-JONES.—On August 14th, 1918, A. W. Llewelyn-Jones, of Westholme, Torquay, aged 52.

LUSH.—On November 28th, 1918, at 48, Avenue Road, N.W., from pneumonia, Percy J. F. Lush, M.B., B.Ch.(Oxon.), dearly-loved husband of Lydia Lush and youngest son of the late Right Hon. Lord Justice Lush, aged 60.

REID.—On November 18th, 1918, suddenly, James More Reid, Lieut.-Col., R.A.M.C., aged 62.

WINTER.—On November 15th, 1918, at 20th General Hospital, France, while on active service, from pneumonia, following influenza, Capt. Laurence Amos Winter, M.D., R.A.M.C., late of Sheerness, formerly of Farnborough, aged 50.

## NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, Smithfield, E.C.

The Annual Subscription to the Journal is 5s., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., at the Hospital.

All communications, financial, or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, the Journal Office, St. Bartholomew's Hospital, E.C. Telephone: City 510.



# St. Bartholomew's Hospital



"Æquam memento rebus in arduis  
Servare mentem."

—Horace, Book ii, Ode iii.

## JOURNAL.

VOL. XXVI.—No. 5.]

FEBRUARY 1ST, 1919.

[PRICE SIXPENCE.]

### CALENDAR.

Fri., Jan.	31.—Dr. Morley Fletcher and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Tooth.
Tues., Feb.	4.—Dr. Drysdale and Mr. McAdam Eccles on duty.
Wed., "	5.—Clinical Lecture (Surgery), Mr. Waring.
Fri., "	7.—Dr. Tooth and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues., "	11.—Dr. Calvert and Mr. Waring on duty.
Wed., "	12.—Clinical Lecture (Surgery), Mr. Waring.
Fri., "	14.—Dr. Morley Fletcher and Mr. McAdam Eccles on duty. Clinical Lecture (Medicine), Dr. Calvert.
Tues., "	18.—Dr. Drysdale and Mr. D'Arcy Power on duty.
Wed., "	19.—Clinical Lecture (Surgery), Mr. Waring.
Fri., "	21.—Dr. Tooth and Mr. Waring on duty. Clinical Lecture (Medicine), Dr. Morley Fletcher.
Tues., "	25.—Dr. Calvert and Mr. McAdam Eccles on duty.
Wed., "	26.—Clinical Lecture (Surgery), Mr. McAdam Eccles.
Fri., "	28.—Dr. Morley Fletcher and Mr. D'Arcy Power on duty. Clinical Lecture (Medicine), Dr. Drysdale.
Tues., Mar.	4.—Dr. Drysdale and Mr. Waring on duty.

### EDITORIAL NOTES.

**W**E are glad to learn that the New Year entry at the Hospital is an extremely heavy one, and considerably in excess of what is general at this time of the year. A large number of students are returning from the Army under the Order whereby Group 43—consisting of students and teachers—are to be demobilised rapidly, and there is scarcely a vacant place in any of the laboratories.

The East Wing, which for four and a half years has served for the housing of soldiers to the number of 5500, was evacuated at the end of last month and placed in the hands of the decorators preparatory to its return to civilian purposes. It is, indeed, gratifying that the old Hospital has done so well by its country, not only in giving its men and women to serve abroad in their professional capacity, but also in helping to house the wounded and sick on their return from the fray. The men in hospital have been royally treated, and it speaks well of the administration that everything has gone quietly and smoothly throughout the war. A letter of thanks has been received from the Army

Council and also from the D.D.M.S. of the London district thanking the Governors and all the Staff for their services, which we much appreciate. We hope at a later date to give some short account of the happenings in the Wing during this period.

\* \* \*

In the last issue of the JOURNAL we asked for suggestions from our readers anent a suitable memorial to commemorate Bart.'s men who have fallen in the war. We still await the suggestions. It is a very extraordinary thing, but our Hospital is often very slow in making a start, and yet they invariably get there at the finish. Several incidents occur to us as we write which demonstrate this fact. But this is an occasion when we feel that something should be done. One hospital in London has collected already nearly £3000 for a similar purpose. Bart.'s must not be behind in doing honour to its gallant sons.

\* \* \*

We are quite aware that Peace is not yet signed, but to all intents and purposes the war is over. A large number of our students who were on active service are back in Hospital, the majority of our staff have recommenced duty, and we have a large entry of new men. In spite of all this, the social life still remains to all intents and purposes dead.

With the sole exception of the Rugby Football Club, which we are glad to note is having a remarkably successful season, games are quite at a standstill. For some reason or other there have been no evening meetings this winter; the usual mid-session address has not been delivered—in fact the Abernethian Society might not be in existence.

We realise that it is impossible to get back to pre-war conditions at a moment's notice, but we think that an effort might be made to restore the Hospital to something like its normal self.

\* \* \*

The following Bart.'s men have been included in the New Year's Honours, and to one and all we offer our heartiest congratulations:

*C.B. (Military Division).*—Maj.-Gen. R. C. Munday, R.A.F. (*Civil Division*).—Surg.-Capt. A. S. Nance, R.N.



*C.M.G.*—Temp. Col. G. E. Gask, D.S.O., A.M.S.; Temp. Col. J. A. Nixon, A.M.S.; Temp. Col. E. P. Sewell, D.S.O., R.A.M.C.

*C.I.E.*—Lieut.-Col. F. E. Swinton, I.M.S.

*C.B.E.*—H. H. Dale, F.R.S.

*O.B.E.*—Lieut.-Col. F. E. A. Webb, R.A.M.C.T.; Act.-Maj. H. Burrows, R.A.M.C.T.; Temp. Maj. W. S. Dickie, R.A.M.C.; Temp. Maj. M. G. Pearson, S.A.M.C.; Maj. C. S. de Segundo, R.A.M.C.T.; Maj. G. C. Taylor, R.A.M.C.T.; Temp. Capt. J. C. M. Bailey, R.A.M.C.; Temp. Capt. F. H. Diggle, R.A.M.C.; Capt. J. C. Newman, R.A.M.C.T.; Capt. E. I. P. Pellew, R.A.M.C.; Capt. J. Ramsay, R.A.M.C.T.; Temp. Capt. K. M. Walker, R.A.M.C.; P. G. Selby.

*M.B.E.*—Temp. Capt. J. N. Martin, R.A.M.C.

*Bar to M.C.*—Capt. E. J. Bradley, M.C., R.A.M.C., S.R.

*M.C.*—Act.-Maj. G. O. Chambers, R.A.M.C.; Capt. F. H. Guppy, R.A.M.C., S.R.; Act.-Maj. B. Whitehead, R.A.M.C.; Act.-Maj. A. B. P. Smith, R.A.M.C.; Temp. Capt. W. B. Wilson, R.A.M.C.

*To be Brevet-Major.*—Capt. (Temp. Maj.) R. E. Barnsley, M.C., R.A.M.C.

\* \* \*

The following Bart.'s men have been mentioned in recent Despatches:

*A.M.S. (Staff).*—Maj. (Temp. Col.) G. E. Gask, D.S.O.; Capt. (Act.-Maj.) G. F. P. Gibbons, R.A.M.C., S.R.; Capt. (Temp. Col.) J. A. Nixon; Lieut.-Col. (Temp. Col.) R. Pickard, C.M.G., R.A.M.C.T.; Col. H. S. Thurston, C.B., C.M.G.; Temp. Col. H. H. Tooth, C.B., C.M.G.; Temp. Col. C. G. Watson, C.M.G.

*Consultant.*—Temp. Maj.-Gen. Sir W. P. Herringham, C.B.

*R.A.M.C.*—Temp. Capt. C. J. Armstrong Dash; Temp. Capt. (Act.-Maj.) W. S. Danks; Temp. Maj. W. S. Dickie; Capt. J. H. Gurley; Capt. (Act.-Lieut.-Col.) I. R. Hudleston; Temp. Capt. E. T. C. Milligan; Temp. Capt. E. I. P. Pellew; Temp. Capt. H. J. Pickering; Capt. (Act.-Lieut.-Col.) R. B. Price, D.S.O.; Capt. (Act.-Maj.) J. A. Renshaw; Temp. Capt. (Act.-Maj.) A. Richmond; Temp. Capt. (Act.-Maj.) J. E. H. Roberts; Capt. (Act.-Maj.) R. H. Rollinson Whitaker; Temp. Capt. H. S. Thomas; Temp. Capt. K. M. Walker.

*R.A.M.C.T.*—Capt. (Act.-Maj.) H. Burrows; Capt. (Act.-Maj.) H. D. Clementi-Smith; Capt. (Act.-Maj.) R. V. Favell; Capt. N. S. Finzi; Capt. J. C. Newman; Capt. J. Ramsay; Capt. S. E. Rigg.

*Canadian Army Medical Staff.*—Col. C. A. Peters, D.S.O.

\* \* \*

Surg.-Lieut. L. F. Strugnell, R.N., has been mentioned in Despatches for services rendered in the Adriatic.

\* \* \*

We are pleased to congratulate Temp. Capt. (Act.-Maj.) H. B. G. Russell, R.A.M.C., on being awarded the Croix de Guerre.

\* \* \*

It affords us much pleasure to congratulate Capt. P. H. Wells, M.C., R.A.M.C., on receiving a Bar to the Military Cross. The official details are as follows: "When moving up to an aid-post with the battalion headquarters a shell fell on the party, causing many casualties, including the only other officer. Capt. Wells, showing complete disregard for personal safety, organised the party and attended to the wounded. Throughout the day he ceaselessly carried on his duties, and under most trying conditions, being exposed to heavy shell-fire the whole time. In spite of the number of wounded he managed to attend to all and arrange for their evacuation."

\* \* \*

As announced in this issue, Capt. W. B. Wilson has been awarded the Military Cross. The following is the official record: "For conspicuous gallantry and devotion to duty. He treated the wounded of his own and other battalions; this involved passing backwards and forwards over shell-swept areas. Later, he went forward with his stretcher-bearers and searched all the ground up to the front line. He showed splendid zeal and disregard of danger, and set a fine example to those under him."

\* \* \*

Our congratulations to Dr. H. Fairley Morris, who has been jointly awarded the Raymond Horton-Smith Prize at Cambridge, which is given for the best thesis for the degree of Doctor of Medicine during the academical year.

\* \* \*

The following members of the Staff have resumed or are immediately resuming their duties at the hospital; to these gentlemen we extend a warm welcome: Mr. C. Gordon Watson (Surgeon with Charge of Out-patients), Dr. J. Barris (Assistant Physician Accoucheur), Dr. J. Trevan (Demonstrator of Physiology), Dr. A. E. Gow (Medical Registrar), Mr. R. M. Vick (Senior Demonstrator of Pathology), Capt. N. S. Finzi (Medical Officer in Charge of X-Ray Department), Mr. J. E. H. Roberts (Surgical Registrar), Dr. T. H. G. Shore (Demonstrator of Pathology).

\* \* \*

It may interest our readers to learn that the Bishop of Marlborough, recently deceased, was a lineal descendant of Percival Pott.

\* \* \*

We are now in a position to state that the Final Fellowship Classes, to which we referred in our last issue, will commence on Thursday, February 13th. The course will include Surgical Hospital Practice, Clinical Classes, Surgical Anatomy, Museum Work, Pathological Histology, and Bacteriology. There will also be classes in Ophthalmology, Laryngology, Otology, Orthopaedic Surgery, and Venereal Diseases. During the last month a course of Operative Surgery will be held.

Anyone wishing to attend these classes should apply to the Dean of the Medical School.

\* \* \*



Dr. B. W. Cherrett, whose death was included under our Roll of Honour last month, was Medical Officer of Health to Nairobi. He went out to East Africa in 1910, and was engaged in sleeping-sickness investigation until May, 1913, when he received the appointment of M.O.H. From September, 1914, until December, 1916, he held a commission as captain in the E.A.M.S., afterwards reverting to his civil duties as M.O.H. Dr. Cherrett was a keen, hard-working man, he was always cheerful, and his death is greatly felt by all who knew him.

\* \* \*

It is with very much regret that we have to record the death of Dr. Leonard George Guthrie as a result of an accident on the Central London Railway on December 23rd.

Dr. Guthrie, who was 60 years of age, was the second son of the late Mr. Thomas Anstey Guthrie, and brother of Mr. Anstey Guthrie, the dramatist and novelist. Educated at King's College School, London, and Magdalen College, Oxford, he studied medicine at this Hospital. The study of nervous disease interested him, and as Physician to the Paddington Green Hospital for Children and Physician to the Hospital for Epilepsy and Paralysis in Maida Vale he soon made for himself a name in this branch of medicine, more especially in regard to the nervous diseases in childhood. Among other professional appointments he held were those of Physician to the Hospital for Epilepsy and Paralysis, Maida Vale; Consulting Physician to the Home of Rest for the Dying, Clapham, and the Potter's Bar Cottage Hospital; and a member of the Medical Board, which examined medical men called up for military service. His leisure was devoted to the study of antiquities, and the past of his own profession formed the subject of careful and earnest research.

We hope to publish an appreciation of Dr. Guthrie in an early issue of the JOURNAL.

\* \* \*

We regret to have to announce the death of Dr. Colin Sadler Hawes, which took place at Bexhill after a long illness. Dr. Hawes had held an appointment as House-Surgeon at this Hospital, and more recently had acted as Civil Medical Officer (Anæsthetist) at the South African Hospital in Richmond Park.

### THE LATE DR. A. E. STANSFELD.



HE lamented death of Dr. A. E. Stansfeld occurred so early in his career that he had been unable to make adequate provision for his family. He has left a wife and three small children with insufficient means for a proper education. Many of his friends have thought that the best form in which they could show their regard and affection for his memory and their appreciation of his many services would be to assist in raising a sum of money which might either be devoted to the education of his children, or to such other purpose as might seem more

immediately useful. It is in the hope that many of his old friends and pupils will share this view that the present appeal is published in the columns of the JOURNAL. Some, we know, are willing to contribute substantial amounts; others may be glad to share, according to their means, on a smaller scale. Dr. R. G. Canti has consented to act as secretary of the fund and Dr. F. W. Andrewes as treasurer. Cheques may be sent to the latter at the Pathological Department, St. Bartholomew's Hospital, and will be gratefully received.

(Signed) F. W. ANDREWES,  
J. H. DRYSDALE,  
R. G. CANTI.

ST. BARTHOLOMEW'S HOSPITAL;  
*January 21st, 1919.*

### ON MEDICAL EDUCATION IN LONDON.

*To the Editor of the 'St. Bartholomew's Hospital Journal.'*

SIR,—Now that the Great War is over we are all thinking of the changes that are needed throughout the country. For myself, I have always thought that if the first great aim of the War was the establishment of liberty, and the destruction of that brutal principle of force which threatened the whole of civilisation, the second and almost equally important result would be the reforms which would in every belligerent country follow as a necessary result.

Not the least among them is the reform of education, and I have no doubt that as a part of it medical education needs—and will obtain—improvement. Now is the time to discuss the subject, and I therefore take the opportunity to bring before your readers the views which I hold upon it. We are proud, and justly proud, both of the practical education which London students receive and of the achievements of British Medicine. Yet it cannot be denied that improvements might be made in the former, or that the reputation or prestige of the latter in other countries has decidedly fallen below that which it once held.

If we look back upon medicine we can see the steps by which it has progressed. Up to the sixteenth century European medicine was as scholastic as theology. The Renaissance which enlivened the latter spread its influence into all learning. In Italy anatomy began to be studied afresh, and medicine also awoke from its slumbers, and began again to follow the example of Hippocrates and to use its eyes. Yet even in the early seventeenth century Bacon criticised the lack of observation and comparison which marked the medicine of his time. From that day to this, however, observation of the symptoms and course of disease has continued to increase, and from the latter part of the eighteenth century systematic study of morbid anatomy has been pursued. In observation both of the living and of the dead British medicine rivalled that of any other country.



But Harvey in the seventeenth century founded a new method, that of experiment, and a new science, that of the natural functions, which we call physiology. Hunter carried the same spirit into the study of pathology or abnormal function. That method took a fresh start in the nineteenth century. Since the days of Magendie and Bell an army of physiologists have ceaselessly laboured both by physical and chemical experiments to advance the knowledge of natural function. Pathology broke new ground under Pasteur, who founded bacteriology, and gave the impetus to Lister, and pathological chemistry first made itself felt in the studies of Garrod, Frerichs and Pavy on gout and diabetes.

Since this new movement began medicine has been as much engaged in the laboratory as in the wards, and whereas we have retained to the full our powers of clinical observation and have made many notable contributions to neurology, pediatrics, and especially to the study of cardiac diseases, we have not kept pace with other countries in the experimental side of pathology. This is the more remarkable, since the pre-eminence of English physiology is acknowledged. It is not due to lack of aptitude on our part, since physiology and pathology pursue the same methods and are practically the same science. It arises from the fact that with few exceptions English physicians have not risen to the occasion, have not taken a broad view of the science of medicine, have been content for the most part to confine themselves to tutorial work while young and to their wards in later life, and though often complaining of the lack of scientific facility, have not reformed their system so as to admit of it.

It is quite untrue to say, as some have said, that these defects have reacted unfavourably upon the treatment of the general public. It is indubitable, first, that the general level of practice is as high, to say the least of it, in England as in any other country; and, secondly, that the competence of general practitioners has within the last fifty years progressed to an extent that is astonishing. English physicians, too, have not only treated their own patients with judgment and skill, but have been most conscientious in their teaching, and very successful in infusing these qualities into their students. In some ways it might almost be said that their lack of the experimental method has been a source of safety.

But, on the other hand, it has had a deplorable effect on both teachers and students in fostering a spirit of content with a hand-to-mouth existence, of content to let others do the work while we take the results, of content to forego that keen desire for discovery which is the soul of science, even to belittle the laboratory as the regimental officer in his moments of discontent belittles the staff. What the teachers think the students will think too, and we in medicine are typical of the whole English race in our neglect of exact experimental methods.

Although we are ourselves partly to blame for this state

of affairs, yet the main difficulty has been the financial impossibility of increasing the expense of medical education out of the students' fees, which, up to a few years ago, were in London its only source of income. In the eighties the schools were simple affairs. Almost all subjects, except chemistry and physics, were taught by members of the staff. Physiology was confined to histology and a course of lectures. Since that time biology has been added to the preliminary subjects, and the instruction in chemistry and physics greatly extended, while anatomy and physiology have been given over to specialists, and the equipment, especially for the latter, greatly increased. Pathology has grown out of all recognition, and pharmacology has laboratories of its own. In all these branches the *personnel* also has been increased, and, though still poorly paid, costs a great deal more in salaries than in former times. There has been no money left for the scientific needs of the final subjects. We have talked about them, we have wished for them; but we have known that we might just as well ask for the moon.

The Haldane Commission was the first recognition by a Government authority of this pressing want. To it we certainly owe the idea of adding to the excellences of the present teaching a professorial system specially designed to supplement its scientific deficiencies. It remains to be seen whether Government will be prepared to give that financial help which is necessary if this idea is to be realised. It implies a Professor and a certain number of assistants working under him. The Professor must have wards for in-patients and an out-patient department. He must also have adequate laboratory accommodation and equipment in convenient connection with his wards. The whole forms what, in technical phrase, is known as a Hospital unit.

Although I suppose the details of the Professor's work will vary somewhat according to the wishes of his school, the main object of the appointment is that he should devote himself, not to the making of a livelihood by practice, but to teaching and discovery.

His influence will be felt in several directions. As a teacher I do not expect him to give his students the result of a large clinical experience: that the present medical staff of a hospital can themselves supply. Nor do I think that he will be able to train them in accurate observation and record of clinical cases any better than is now done by ourselves. In these ways the present staff of a General Hospital School have brought teaching as near to perfection as it is ever likely to reach, and their function will, I hope, continue unimpaired. But I expect the Professor, first by a wider knowledge of science in general, and of medical science in particular, to be able to throw a new light even upon common problems, and I expect him, secondly, from the fact that both he and his assistants will be actively engaged in discovery, to infuse into his students not only the spirit of criticism—I can do that myself—but the hope-