

is not rising. This measure may send the temperature up quickly, and the patient should be watched for this eventuality.

The treatment should be continued each day until the choreic movements have disappeared. It is usually found that the dose of typhoid vaccine must be doubled each day in order that it may be effective, but no general rule can be made as patients react differently. It is a good plan in starting to increase the dose by half that of the day before. A rough guide is that it should be increased freely when the previous day's dose gave a poor result and only slightly when the former one was attended with a very high fever. But even after a high fever a larger dose is usually necessary if an adequate fever is to be maintained. If it is found that a dose of vaccine has not been sufficient, it may be supplemented two to four hours later by another and smaller one.

Most patients show a marked improvement after two or three treatments, and are usually free from choreic movements in a week. As would be expected the milder cases improve more quickly than the severe ones. Patients with a long history of chorea before admission to hospital may be slow in their response to treatment, and it should be remembered that in these patients habit movements may be superimposed upon those that are essentially of choreic origin. At the end of the fever treatment the patients are kept in bed for a few days and are then allowed up for a week before discharge from hospital. The usual length of stay in hospital is three weeks. This compares very favourably with the seven weeks which most other modes of treatment require. Mention may be made of those cases of chorea which on admission to hospital show a cardiac murmur of rheumatic origin. This need not be regarded as a contraindication to treatment, unless it is thought that the circulatory system cannot support the effects of a high fever. The treatment so far has proved satisfactory. It has considerably shortened the duration of the stay in hospital and is not accompanied, so far as is at present known, by complications. The patient's discomfort attendant upon the treatment is much less than might be expected, and is probably preferable to the weeks in bed and long continuance of the choreiform movements associated with other methods.

I have to thank Dr. Charles Hendee Smith and Dr. Lucy Porter Sutton of the Children's Medical Division, Bellevue Hospital, New York City, and the Department of Paediatrics, New York University, for allowing me to treat cases under their direction, for teaching me their methods, and for permitting me to write this note.

Memoranda

MEDICAL, SURGICAL, OBSTETRICAL

POST-OPERATIVE INTESTINAL OBSTRUCTION

A case reported by Mr. A. Davies under this heading in the *Journal* of January 7th was interesting and helpful. The following case, which came under my care, involved a similar sequence of problems, but with variations.

The patient, aged 10, was admitted to the St. Albans and Mid-Herts Hospital on November 6th, 1930, with the history that for three days she had had abdominal pain with vomiting.

On November 7th an appendicectomy was performed. The appendix was found to be ulcerated but not perforated, and the abdomen was closed without drainage. Subsequent progress was uneventful and the patient was discharged as fit fourteen days later.

On February 28th, 1932, the patient was re-admitted with a history of sudden onset of abdominal pain on the previous day, frequent vomiting, and pain on micturition; temperature was 101° and pulse 146. On examination there was no abdominal distension, but rigidity and tenderness, especially in the right lumbar and right iliac regions. A laparotomy was performed that evening, and a nine-inch loop of small intestine was found constricted by an adhesion. The constricting band was incised, and the gut, which was dark purple in colour, on being treated with warm saline so improved in appearance as to be considered viable. The abdo-

men was closed without drainage. During the following three days the patient's condition was satisfactory: the temperature fell gradually to normal on the third day, and the pulse rate decreased. Much abdominal pain, with occasional vomiting, was not considered abnormal. Anti-gas-gangrene serum was given with morphine and heroin, and on the third day an enema was administered with good result and passage of flatus. On the fourth day blood and mucus was passed per rectum, vomiting increased in frequency and became faeculent, and the abdomen became more distended. An exploration was undertaken, and the affected loop of bowel was found to be gangrenous and perforated. The pelvis was full of foul intestinal contents, which welled out of the abdominal wound. A Paul's tube was inserted into the healthy gut proximal to the gangrenous portion, the latter being brought into the lower margin of the wound and left *in situ*; the pelvis was drained. Resection was considered inexpedient in view of the condition of the patient, but especially in view of her age. Subsequently the ileum drained freely through the enterostomy; the wound gaped widely and ten days later the segment of bowel, together with its mesentery, separated through the lower extremity of the wound.

On April 19th a further operation was undertaken, the skin of the abdominal wall having become severely excoriated by the digestive action of the ilial contents. There was an extensive "matting" between coils of gut. The ileum above and proximal to the enterostomy was clamped and divided, the distal end invaginated, while a lateral anastomosis was performed between the proximal portion of ileum and the transverse colon. On April 22nd the bowels opened naturally. The patient was again discharged on June 4th, both the local and the general condition being very favourable.

After re-admission three months later the functionless enterostomy was closed by dissection and invaginated extraperitoneally, and the patient finally discharged on October 29th.

This case demonstrates, as did the one previously recorded, the difficulties of diagnosis in surgical conditions of the abdomen. In the interim between the initial operation for intestinal obstruction and the following exploration, the patient's general condition was no criterion of the pathological state. The case also illustrates the inherent faculty of the peritoneum to procure the restoration of vital functions. This has been the only case in my experience of the separation of a segment of gut together with its mesentery by natural means and its extrusion through the abdominal wound.

D. S. MORGAN JONES, F.R.C.S.Ed.

Honorary Surgeon, St. Albans and
Mid-Herts Hospital.

P.S.—Since the above was written the recurrent formation of a mucocele necessitated a complete resection of the blind gut, which was undertaken on March 7th with an entirely successful issue.

A CASE OF GENERALIZED VACCINIA

Although, after vaccination, secondary pustules are sometimes seen round the primary mark, a case of generalized vaccinia is comparatively rare.

On December 1st, 1932, I vaccinated D. H., a well-nourished, healthy baby weighing 15 lb. and aged 3 months, using Government establishment lymph, and making one scar on the left arm. At the same time I vaccinated an elder child, H. H., aged 10 years, in the same house, using the same lymph. On December 7th I inspected both arms, and found them clean and healthy, presenting the features of a normal six-day vaccination. On December 20th the medical officer of health asked if I would call and see the younger child, as some spots had broken out over the body.

When I saw it I learned that the spots had begun to appear about three days previously. The outer surface of the left arm was bright red, the colour extending from 1 inch below the shoulder to about 1½ inches above the elbow. This arm was covered by necrosed skin, and presented the appearance

of a large blister out of which the fluid had been withdrawn. There was a very slight temperature (99° F.). The child was restless, fretful, and irritable, and refused its food. On the wrists, thighs, legs, and head there were raised pearly spots in varying stages of development, and of various sizes. Some were umbilicated, and some appeared more like the spots of alastrim than those of small-pox. On December 21st the child was admitted to Fazackerly Hospital under the care of Dr. C. Rundle, the medical superintendent. On admission there were numerous small vesicles around the original larger one on the left arm, and the spots on the body had developed into typical vaccination pustules. The distribution was then: face, back of scalp, both wrists, left thumb, right buttock, and several on the right leg and thigh, and soles of both feet. The temperature was still 99° , pulse 132, respiration 34. On December 23rd the temperature went up to 100.4° . The pulse was 144, and the lesions were spreading with copious eruption on both legs and buttocks, and on the face some of these were the size of a shilling. The temperature then fell to normal and remained so until December 26th. On December 25th fresh pustules developed on the back and front of both thighs, but with no accompanying rise of temperature. On December 26th the temperature again rose to 99.6° , and the arm became very baggy and was inclined to slough. There were numerous water vesicles at the outer edge. The child was taking food well. On December 27th the temperature rose still further to 100.4° , pulse 178, and the child developed convulsions and died.

The post-mortem findings were as follows: The body was that of a well-nourished child. Over the outer surface of the left upper arm was a bare, bright-red, inflamed area 4 inches long by $3\frac{1}{2}$ inches in diameter, and extending approximately from the shoulder to the elbow. There was some deeper coloration of the central portion, suggesting that this was the oldest part of the lesion, and that it had commenced there. The body was covered with raised pearly spots, varying from about $\frac{1}{8}$ inch up to $\frac{1}{2}$ inch in diameter. The larger of these were depressed in the centre and had thickened edges resembling blebs, and giving the appearance of developing vaccination pocks. The largest and oldest lesions showed necrosis in the centres and the formation of crusts. There was little or no pustulation. The distribution of the lesions was general, but they were more numerous on the lower limbs than on the trunk and upper part of the body. The thoracic organs were healthy, except for some terminal congestion and oedema of the lung bases. The liver and spleen both showed areas of necrosis, having the characters of vaccinia lesions. The other abdominal organs showed no abnormality. Microscopical examination of the skin lesions showed these to have the character of vaccinia papules. The same characters were found in the focal lesions of the spleen and liver. No changes of importance were found by microscopical examination in the brain and spinal cord, or in the other organs (suprarenals, heart, kidneys, pancreas) which were examined in this way.

It is obvious from the pathological report that this was a blood-borne infection. Professor Dible, pathologist of Liverpool University, has never seen a case of this kind in his experience. It could hardly have arisen from any septic infection, as both parents and home were extremely clean, and there was no evidence of such infection being present. While I was in Persia several thousand vaccinations were done either by me or under my supervision. The scar was made and the lymph was allowed to dry on. It was impossible to keep either pads or bandages on the natives' arms, so after drying they were left uncovered. No untoward result had ever been seen. I have had several letters on the subject, and in one the writer has reported to me a case of general vaccinia which occurred in a baby that had been washed with water in which an elder child, who had been vaccinated, was bathed.

I am deeply indebted to Professor Dible for a report on his post-mortem and bacteriological findings, and to Dr. C. Rundle, medical superintendent, Fazackerly Fever Hospital, for his notes on the case whilst it was under his care.

C. J. DE VERE SHORTT, M.B., D.P.H.
Late M.O.H. and Port Health Officer,
Abadan, S. Persia.

Reports of Societies

OVARIOTOMY

At the annual general meeting of the Section of Obstetrics and Gynaecology of the Royal Society of Medicine, with the president, Mr. J. P. HEDLEY, in the chair, Dr. HERBERT SPENCER, in a review of six hundred and fifty-eight ovariectomies, remarked on the paucity of *personal* records of complete series since Spencer Wells published in 1882 his *One Thousand Ovariectomies*, with a mortality rate of 23.2 per cent. Dr. Spencer had published his first fifty cases (in 1893) with one death; but in his complete series there were thirty-five deaths (5.3 per cent.), of which twelve occurred after the removal of malignant or suppurating tumours.

Dr. Spencer emphasized the importance of the entering of particulars in an analysis book by the operator immediately after the operation and recovery or death of the patient. No patient was discharged from hospital or home before the twenty-fourth day after operation. As an illustration of the influence on statistics of early discharge from hospital or home, he stated that, of the thirty-five deaths, one occurred (from syncope) on the twenty-second day, two (from embolism) on the twenty-fourth day, one (malignant) on the thirty-fourth day, and one (from cachexia) five months after operation. The youngest patient was aged 14, the oldest 82, eleven patients being over 70 years of age. Sixty-three cases associated with pregnancy had been already published in detail. Adhesions were present in 448 cases; torsions of the pedicle in eighty-five; twelve tumours had been tapped before operation. There were thirty-three benign ovarian tumours (in addition to seventeen malignant cysts), which were papillomatous; sixty-six were dermoids; twenty ovarian fibroids (eighteen fibromata, two adenofibromata); forty-five were parovarian tumours (eight complicating pregnancy); sixty-three tumours were suppurating; sixty-seven malignant (of which six were sarcomata and two endotheliomata). The proportion of malignant tumours was just over 10 per cent. Dr. Spencer thought that the proportion (20 to 25 per cent.) often stated in textbooks was exaggerated, and that the error was due to mistaking benign for malignant papilloma and fibroma for sarcoma. He had personally removed eleven papillomatous benign ovarian tumours, which, after coeliotomy, had been declared by experienced gynaecologists to be inoperable and mostly malignant; and as a result of a personal experience of this kind, if a patient with a tumour, supposed to be malignant, was found to be in fair condition two years later, he advised the operator to believe, with him, that a mistake had been made, and remove the tumour. In Dr. Spencer's opinion all benign tumours could, and should, be removed. With regard to malignant tumours he was of the opinion that many of these could be removed with advantage, even in presence of secondary growths. Cases in support of this opinion were mentioned, such as cancerous tumours remaining well six and seven years after unilateral removal; a patient well four years after removal of cancer of the ovary and breast; and a patient with pseudomyxoma ovarii et peritonei who survived four operations, and died of heart disease seventeen years after the first operation. A notebook with details of the cases was exhibited.

Lieut.-Colonel GREEN-ARMYtage reminded the Section that he had published in 1930 the findings and results of 547 consecutive operations for ovarian neoplasms. He was of opinion that the incidence of malignancy was greater than Dr. Spencer had indicated (10 per cent.), for in his series microscopically malignant tumours amounted to 21.4 per cent., a figure which approximated more nearly to the statistics of Döderlein and Lippert. He considered also that the chances of recurrence in the opposite ovary in cases of papilliferous tumours was greater than Dr. Spencer had suggested. In recent years, when there was ascites and an extrinsic type of papillary tumour in one ovary, he had preferred to remove the uterus and both ovaries. With regard to pulmonary embolism, he had found this accident a very rare com-

have made special arrangements for their admission. This is well illustrated by noticing that there are forty-two cases of cancer of the tongue that have been treated at the radio-therapeutic clinic during 1930 and 1931, thirty of which were growths that had started in the posterior half of the tongue, and only twelve in the anterior half. It is well known that cancer of the tongue is more hopeful if it starts in the anterior half, and such cases have obtained admission elsewhere in larger numbers than those in which growth had started in the posterior half."

These matters are of vast importance as enabling some conclusions to be reached upon large numbers of patients who are prevented from being received into the large voluntary hospitals, where until recently most of the available statistical material has been prepared. Moreover, in many cases the disease was found to be so advanced that little or nothing could be expected from the curative point of view; nevertheless, radiotherapy has been employed in all cases when there was possibility of rendering the patient's remaining span of life as comfortable as possible under the circumstances. Since the last report the equipment of the department has been augmented by the installation of one of the most recent and efficient types of high-tension generator, together with an equally modern deep-therapy tube enclosed in the latest Holfelder "cannon." The new apparatus can be used for from eight to twelve hours each day. It is interesting and good news to hear that expert physical advice has been requisitioned in connexion with the department. This is specially mentioned in connexion with the radium work, and Mr. W. V. Mayneord of the Cancer Hospital has been engaged in research work bearing upon the question of the amount and distribution of the radium dosage. It is essential for the development of radiation therapy in this country that there should be the fullest and most complete co-operation between physician, surgeon, pathologist, physicist, and instrument maker. The last of these is a highly trained electrical engineer whose specialty it is to advise upon the lay-out of installations, and who by his experience is specially qualified to give technical advice upon many practical points, which might escape attention in the first instance, but which later on give unmistakable evidence of the fact that they have been overlooked. We think the London County Council is to be warmly congratulated on this aspect of its hospital work.

THE BIRTHDAY HONOURS

The Honours List issued on June 3rd, on the occasion of His Majesty's birthday, includes the names of the following members of the medical profession:

K.C.B. (Military Division)

REGINALD ST. GEORGE SMALLRIDGE BOND, C.B., M.B., F.R.C.P., F.R.C.S., K.H.P., Surgeon Vice-Admiral R.N.

K.C.V.O.

THOMAS PEEL DUNHILL, C.M.G., M.D.

MORTON SMART, C.V.O., D.S.O., M.D., Commander, late R.N.V.R.

Knights Bachelor

ARTHUR WILLIAM GARRARD BAGSHAW, C.M.G., M.B., Director, Bureau of Hygiene and Tropical Diseases.

RAYMOND HENRY PAYNE CRAWFURD, M.D., F.R.C.P., consulting physician, King's College Hospital; Registrar of the Royal College of Physicians of London.

WILLIAM STEWART DUKE-ELDER, M.D., D.Sc., F.R.C.S., Ophthalmic Surgeon, St. George's Hospital.

ROBERT MCCARRISON, C.I.E., Colonel I.M.S., K.H.P., M.D., F.R.C.P., Director, Nutritional Research, Indian Research Fund Association.

KEDAR NATH DAS, C.I.E., M.D., Principal, Carmichael Medical College, Calcutta.

HUGH THOMAS DYKE ACLAND, C.M.G., C.B.E., F.R.C.S., Christchurch, New Zealand, Vice-President of the Royal Australasian College of Surgeons.

C.B. (Military Division)

JAMES ANDREW HARTIGAN, C.M.G., D.S.O., K.H.P., Major-General, late Royal Army Medical Corps, Deputy Director of Medical Services, Aldershot Command.

WILLIAM HUGH LEONARD, F.R.C.S., Colonel, late I.M.S.

C.M.G.

JOHN LANGTON GILKS, F.R.C.S., East African Medical Service, Director of Medical and Sanitary Services.

FREDERICK ARTHUR MAGUIRE, D.S.O., M.D., F.R.C.S., F.C.O.G., Gynaecologist, St. Vincent's Hospital, Sydney; Colonel A.A.M.S.

C.I.E.

JAMES MCPHERSON, K.H.S., Brevet Colonel I.M.S., Residency Surgeon in Mysore, Bangalore.

WALTER LIDWELL HARNETT, Lieut.-Colonel I.M.S., Professor of Surgery, Medical College, Calcutta, and Surgeon to the College Hospital, Bengal.

JAMSHEDJI NASARVANJI DUGGAN, O.B.E., L.M. and S., F.C.P.S., D.O.Oxon., Professor of Ophthalmic Medicine and Surgery, Grant Medical College, and Superintendent, Sir C. J. Ophthalmic Hospital, Bombay.

O.B.E. (Military)

BIJITENDRA BASU, L.M.S.Calcutta, F.R.C.S.Ed., Major I.M.S., Specialist in Ophthalmology, Rawalpindi District, India.

ALEXANDER DAWSON, M.B., Lieut.-Colonel R.A.M.C., Assistant Director of Pathology, Eastern Command.

ST. GEORGE EYRE HARRIS, M.D., temporary Major R.A.M.C., Cambridge Hospital, Aldershot.

O.B.E. (Civil)

EVAN EDWARD OWENS, M.C., L.R.C.P. and S.Ed., L.R.F.P.S. For political and public services in Glamorgan.

CLERMONT GRANTHAM HILL, Senior Surgeon, Khartum Hospital.

FREDERIC GARDINER ROSE, M.D., Medical Superintendent, Leger Asylum, British Guiana.

ERACHSHAW DINSHAW SHROFF, L.R.C.P. and S.Ed., L.R.F.P.S., Health Officer of the Karachi Municipality, Bombay.

MAURICE REVELL SINCLAIR, Captain I.M.S., Officer on special duty with the Political Officer in Sikkim.

MISS PATRICIA RUTH ELLIOTT, M.B. For services as a missionary doctor in the Straits Settlements.

I.S.O.

Companion

CHARLES FRANCIS LASSALLE, M.D., Deputy Surgeon-General and Medical Inspector of Health, Colony of Trinidad and Tobago.

Kaisar-i-Hind Medal (First Class)

Mrs. LAURA MARGARET HOPE, M.B., B.S., medical practitioner, Bengal.

SAMUEL GEORGE STEELE HAUGHTON, O.B.E., Lieut.-Colonel I.M.S., Officer Commanding, Indian Military Hospital, Quetta.

The 182nd annual report of the City of London Maternity Hospital covers the year 1932, and shows that there has been a reduction in the number of admissions and deliveries, associated with a longer average stay in hospital and an increase in the average total cost for mothers and children. There was a considerable fall in income during the year, mainly owing to a decrease in legacies and donations. A successful week-end course was organized for medical practitioners, and a residential post-graduate course for practising midwives proved popular and helpful. In the medical portion of the report it is stated that the mortality rate was 5.91 per 1,000 for delivered cases.

nor his servant, but an "independent contractor" upon whose skilled collaboration and assistance he depends. If, however, the selection of the anaesthetist has been left to the surgeon, he would probably be held to owe the patient a duty to exercise reasonable care in selecting a competent anaesthetist. A surgeon who consents to operate with an anaesthetist whose competence he has reason to doubt probably does so at his own risk.

STUDENTS IN A TEACHING HOSPITAL

In a teaching hospital it is part of the training of students to perform subordinate duties such as dressings, passing catheters, taking specimens of blood, and treating minor ailments and injuries in the casualty department. The question may at any time arise: Who is responsible for injury resulting from lack of reasonable skill or care in a student? The question is not an easy one. The governors of the hospital contract with the medical school to give facilities to students to learn their craft within the hospital under the direction of the visiting and resident physicians and surgeons. The hospital governors do not exercise any control over the students who learn within the walls of the hospital. Nevertheless, one of the duties of the hospital to its patients is to protect them or warn them against any dangers they may encounter in the hospital. In certain circumstances the ministrations of the student may conceivably be quite dangerous, and the question arises whether a patient who enters a teaching hospital of his own will knowingly and willingly takes the risk of being attended in some circumstances by a student. There is no explicit guidance in either the law reports or the textbooks, and the legal liability would probably vary according to the particular case. It seems reasonable that the hospital or the teachers should be liable for any injury caused by the delegation to a student of a duty which he could not reasonably be considered competent to perform. On the other hand, the governors are never in a position either to control the student or to decide what duties may be properly delegated to a student in any particular case. This seems to be peculiarly a matter of professional skill, within the compass of the medical staff alone and outside the interference of the governors altogether. The inference is, therefore, that if harm happens through a student being given a task that is, in the view of a reasonable man, beyond his capacity, the liability should rest on the person who appointed him to that task. If, however, a student who was considered on reasonable grounds fit to perform a certain task caused injury by performing it negligently, it does not seem good law that the teacher who ordered him to perform it should be held responsible unless he was present and in a position to control the student. If the qualified medical staff were liable for isolated acts of negligence by students in their absence, clinical teaching would be very seriously hampered, if not brought to a standstill altogether. When a member of the staff is present and in a position to exercise control the position is different; he would then, it is submitted, have to answer for any injury due to the student's lack of due skill and care.

THE QUALIFIED ASSISTANT, THE LOCUMTENENT, AND THE TECHNICAL EXPERT

Applying the principles laid down in the textbooks and in the cases that have been cited, it appears that a medical man in private practice contracts to treat his patient with reasonable skill and care, and can only delegate these duties with the consent of the patient. If, however, the patient consents to be treated by a qualified assistant or locumtenent, the doctor's duty ceases when he has exercised reasonable skill and care in selecting a competent qualified assistant or locumtenent, and he will not be responsible for any isolated act of negligence by such a person. Whether the patient has consented must be a matter of fact; a patient's consent need not be given in so many words, but may sometimes be implied from the fact that he has allowed the substitute to treat him. When, however, a busy medical man finds he cannot pay a certain visit and sends his assistant or locumtenent instead, he may put the patient into a position in which he has to choose between putting up with the substitute and

going without treatment altogether. In such a case the jury is not likely to regard the patient's acquiescence as consent, and the substitute will be in the position of the doctor's agent, for whose negligence he (the doctor) is responsible. If a medical man benefits financially by the work of another, there is at any rate a presumption that the other is his agent. It is worth noting that a panel doctor, by the form of his contract with the Insurance Committee, undertakes liability for his assistant's failure to give a patient proper care and attention.

On the other hand, when a doctor prescribes expert treatment to be carried out, with the consent of the patient, by a medically unqualified person skilled in that treatment, such as a registered biophysical assistant—a qualification which implies competence in many kinds of treatment, such as massage, electrotherapy, and hydrotherapy—he is not responsible for specific acts of negligence by such persons if he has good reason to believe that they are competent to carry out the treatment which he has prescribed, and if it is the custom of the profession to delegate such treatment to such persons. He has discharged his duty when he has exercised due care in the selection of an assistant or independent expert competent to perform the task in question. If, however, a subordinate is performing a duty in his presence and he is able to exercise control, he may be liable for that subordinate's negligence. Whether a given person was in fact a subordinate, and whether the doctor could properly have exercised control, is a question for the jury in the particular case.

Under the Partnership Act, 1890 (Sections 10 and 12), each partner in a firm is liable for the misdoings of the others in the firm's ordinary business. If, therefore, one of the partners in a medical firm is so unfortunate as to have damages given against him for negligence, any of the others may be made to pay the whole of the amount. If the injury was caused by fraud or culpable negligence, the offending partner may in some cases be ordered by the Court to indemnify the others, but he may not have the means to do so. Every member of a partnership would therefore be well advised to insure himself against the risk of being held liable in damages for the act of another practitioner, over which he cannot exercise the slightest degree of control. Even if his partners are absolutely competent and trustworthy, juries are not.

** Since the three parts of this article on "Negligence of a Subordinate" were written, Mr. H. C. Dickens, barrister-at-law, has delivered a valuable lecture to the Medico-Legal Society entitled "Negligence in Hospital and its Legal Consequences," in which he dealt with some of the same points and with certain others. This paper will in due course appear in the *Medico-Legal and Criminological Review*.

Universities and Colleges

UNIVERSITY OF OXFORD

At a congregation held on June 3rd the degree of Doctor of Medicine (D.M.) was conferred on F. Hawking.

UNIVERSITY OF BRISTOL

Dr. Geoffrey Hadfield, F.R.C.P., Professor of Pathology in the University of London (Royal Free Hospital, London School of Medicine for Women) has accepted an invitation to fill the Chair of Pathology shortly to be vacated by Professor Walker Hall.

Dr. J. W. de W. G. Thornton has been appointed Lecturer in Pharmacology and Mr. J. D. A. Gray senior Pathological Officer in the Department of Preventive Medicine.

UNIVERSITY OF SHEFFIELD

At a congregation on July 1st the honorary degree of Doctor of Science will be conferred upon Professor J. B. Leathes, F.R.S., Dean of the Faculty of Medicine, and upon Mrs. May Mellanby.

UNIVERSITY OF ST. ANDREWS

Mr. Francis Robert Brown, M.B., Ch.B., F.R.C.S.Ed., has been appointed a lecturer in clinical surgery in the University.

Medical News

The summer dinner of the Australian and New Zealand Medical Association in England will be held at the Trocadero Restaurant, Piccadilly, on Friday, June 16th, at 7.45 for 8 p.m., with Mr. L. Graham Brown, F.R.C.S., in the chair. Sir Thomas Wilford, High Commissioner for New Zealand, will be the official guest. All medical visitors from Australia and New Zealand, whether members of the association or not, are cordially invited to be present. The honorary secretaries are Mr. E. T. C. Milligan and Mr. Philip Jory (26, Queen Anne Street, W.1).

The annual general meeting of the Paddington Medical Society will be held on Tuesday, June 13th, in the Great Western Royal Hotel, Paddington, at 9 p.m., when the presidential valedictory will be delivered by Dr. G. de Swietochowski, and officers for the coming year appointed.

The British Institute of Philosophy announces that an address will be given by Sir Herbert Samuel entitled, "The Tree of Good and Evil," at University College, Gower Street, on Wednesday, June 14th, at 8.15 p.m. A limited number of seats are available for the public, and applications for tickets should be made to the director of studies, University Hall, 14, Gordon Square, W.C.1.

The St. Cyres Lecture for 1933, on "Some Observations on Coronary Thrombosis," will be delivered by Professor John Hay at the National Hospital for Diseases of the Heart, Westmoreland Street, W.1, on Tuesday June 13th, at 5 p.m. All members of the medical profession are invited to attend.

At the Princess Elizabeth of York Hospital for Children, Shadwell, E., to-day (Friday, June 9th), at 8.45 p.m., Dr. A. P. Cawadias will give an address on "Hippocrates and Hippocratic Principles of Practice in Contemporary Medicine." Dr. A. M. Gossage will preside. Visitors are welcomed.

The second of four advanced lectures for post-graduates, arranged by the Fellowship of Medicine and Post-Graduate Medical Association, will be given on June 14th, at 5 p.m., at the Medical Society of London, 11, Chandos Street, W., by Dr. C. P. Symonds, on "The Disturbance of Cerebral Function in Head Injury." A course in diseases of the chest will take place at the City of London Hospital, Victoria Park, from June 12th to 24th. On June 26th, at 8.30 p.m., at 11, Chandos Street, Dr. Roland de Hellebranth, of New Jersey, U.S.A., will deliver a lecture on "Modern Methods of Local and Spinal Anaesthesia," illustrated by lantern and cinema. There will be a practical week-end course in general medicine and surgery at the General Hospital, Southend-on-Sea, on July 8th and 9th. On June 16th, at 5 p.m., there will be an ante-natal demonstration at the Royal Free Hospital. Forthcoming courses include cardiology at the National Hospital for Diseases of the Heart, June 26th to July 8th; diseases of children at the Children's Clinic, June 26th to July 8th.

A joint conference of the British Hospital Association and the Incorporated Association of Hospital Officers is being held at Bath during the last three days of this week. An opportunity will be afforded for viewing, officially and in detail, the new Bath Royal United Hospital, which has lately been completed at a cost of £150,000.

The annual congress known as the Journées médicales de Bruxelles will be held at Brussels under the presidency of Professor Valère Cocq from June 24th to 28th, when syphilis will be the principal subject for discussion. The subscription is 100 francs, which should be sent to the general secretary, Dr. Beckers, Rue Belliard 141, Brussels. The inaugural address will be given by Professor Charles Saroléa, on "The Doctor and Medicine in European Literature." Excursions and amusements have been arranged for visitors, and on June 28th members are invited to the official inauguration of the Palais des Thermes at Ostend.

The fifth congress of the International Society of Urology will be held at the Royal Society of Medicine, 1, Wimpole Street, W., from July 10th to 15th, under the presidency of Sir John Thomson-Walker.

Lord Melchett has accepted the presidency of the British Science Guild in succession to Sir Samuel Hoare, whose three-year term of office ends in June, 1933. Lord Melchett will be formally elected at the annual general meeting to be held in the Mansion House on June 19th, at 4.30 p.m., with the Lord Mayor of London (Sir Percy W. Greenaway) in the chair.

Dr. B. Holroyd, J.P., of Pannal, near Harrogate, has been elected chairman of the Claro Guardians' Committee of the West Riding County Council for the fourth year in succession.

We have received the first issue, published in March, of a new monthly Spanish journal entitled *Revista Medica de Toledo*, edited by Dr. J. Ruiz de Guardia. It contains original articles on nervous syndromes and hepatic opotherapy, by Professor G. Marañon; treatment of infantile paralysis by irradiation of the spinal and peripheral sympathetic system, by Dr. A. Piga; and the causes of error in the determination of age by the measurement of the Haversian canals, by Dr. Daniel Ortega.

A meeting of the Physiological Society will be held in the Physiological Laboratory of the School of Medicine, Leeds, to-day (Saturday, June 10th), at 3 p.m. On July 1st the society will meet in the University Laboratory of Physiology, Oxford.

We have to announce with great regret that Sir Walter Fletcher died on June 7th after an operation.

Letters, Notes, and Answers

All communications in regard to editorial business should be addressed to **THE EDITOR, British Medical Journal, B.M.A. House, Tavistock Square, W.C.1.**

ORIGINAL ARTICLES and LETTERS forwarded for publication are understood to be offered to the *British Medical Journal* alone unless the contrary be stated. Correspondents who wish notice to be taken of their communications should authenticate them with their names, not necessarily for publication.

Authors desiring REPRINTS of their articles published in the *British Medical Journal* must communicate with the Financial Secretary and Business Manager, British Medical Association House, Tavistock Square, W.C.1, on receipt of proofs. Authors overseas should indicate on MSS. if reprints are required, as proofs are not sent abroad.

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QUERIES AND ANSWERS

Sequels of War Gassing

"YOUNG G.P." asks where he can find some authoritative information as to the sequelae of being "gassed in the war." At least 30 per cent. of my male patients (he writes) who were combatants in the war, and who are now in an industrial practice, blame the effect of poison gas on the lungs for their bronchitis, thoracic aches and pains, asthma, tuberculosis, etc. All the patients are emphatic in saying they were in perfect health before the war, and have never been thoroughly fit since their poison gas experience. What and where are the facts?