(the speaker) might have been lucky, but out of 23 open operations by middle line incision he had had no operation mortality.

Mr. GREY TURNER (Newcastle) pointed out the necessity of differentiating the symptoms of stone in the lower part of the ureter from those associated with the appendix. It was important to make certain, before making a diagnosis of stone in the ureter, that small quantities of blood could be seen in the urine. He was very chary about operating on small stones in the lower end of the ureter. He emphasized, further, the necessity for rectal or vaginal examinations, and also maintained that it was advantageous to open the peritoneal cavity simply for the purpose of locating the stone by exploring the ureter with the finger.

Mr. R. P. ROWLANDS (London) said: I congratulate Mr. Kidd very sincerely on his excellent and instructive paper. My experience of the *x*-ray method of diagnosis is not so fortunate as his. I have removed stones from the ureter in at least fifteen cases during the last ten years when radiographic experts had failed to reveal any stone. Stones rarely form in the ureter, but descend into it while still small from the kidney. Patients who suffer from them are often middle-aged and stout, and many of the stones are either too small or too translucent to cast a shadow with the *x* rays. Therefore the diagnosis has often to be made in spite of a negative *x*-ray report. In these circumstances I have found cystoscopy, after injecting two grains of indigo-carmine intramuscularly, a very valuable and simple method of determining if the ureter is or is not obstructed. Within fifteen to twenty minutes the pigment can be seen issuing freely from the normal ureter, whereas none or very little may escape from the obstructed ureter. This serves to determine the side and degree of obstruction. The method is quite safe, and it is much simpler and easier to adopt than ureteral catheterization. It does not necessarily follow that the obstruction is due to a stone;* it may, for instance, be caused by an abnormal artery pressing upon the ureter, or the formation of a valve at the junction of the ureter and pelvis of the kidney, but it is just as essential to relieve the obstruction, whatever may be the cause of it.

Treatment.—Although ureteral calculi should be given a good opportunity to pass spontaneously, as Mr. Kidd advises, I do not agree with him that it is safe to leave them for two years, for they may irretrievably damage or even destroy the kidney. A stone completely blocking the ureter may permanently destroy the kidney in a few weeks even without any evidence of inflammation or hydronephrosis. It is true, however, that ureteral calculi do not often continue to obstruct the ureter completely for a long time. If the stone cannot be shown to be moving downwards on repeated *x*-ray examination during some six months, I think it wise to remove it in order to restore the kidney to its natural function, and to save it from the mechanical and infective changes which are bound to follow. It is specially important when the stone appears to be of a large size, for an operation becomes urgent when the signs of infective changes or hydronephrosis or anuria develop. I think the statistics quoted by Mr. Kidd are far too gloomy, and probably date back some years. I have not lost a single patient after the removal of a stone in the ureter, and in only one instance have I had to perform secondary nephrectomy, owing to intractable changes in the ureter and secondary destructive changes in the kidney. I have used the incision advocated by Mr. Kidd, but I do not altogether like it, because it does not give a very good access to the very lower end of the ureter. For this reason I generally adopt a long paramedian valvular extraperitoneal incision, displacing the rectus and peritoneum inwards. This gives splendid access without any risk of hernia following. I do not like any form of intraperitoneal operation for the removal of a stone from the ureter, for the urine in these cases is generally septic, and drainage is usually necessary. As instances of some of the troubles which may arise from stones in the ureter I briefly mention two cases:

Case 1.—A nurse, aged 50, had calculous anuria of six days' duration, and was very ill, unconscious, and vomiting. Cystoscopy revealed muco-pus at the orifice of the left ureter. The right ureteral orifice was very small. A stone was rapidly removed from the left ureter a little below the kidney. The patient, after axillary saline infusion of four pints, passed seven pints of urine during the day. She regained consciousness three days later. Ten days later anuria returned, and a stone was then removed by the anterior paramedian incision mentioned above from the left ureter low down, and the patient recovered. Six years earlier she had had a severe attack of right renal colic, and the right kidney had become completely destroyed. I believe that this not uncommonly occurs, and that it is not often recognized when the obstruction is unilateral. Ligation of the ureter will similarly destroy the kidney almost painlessly in the absence of sepsis.

Case 2.—A stout lady had left renal colic followed by high fever for two months. Bacilluria was diagnosed, and a vaccine was tried without relief. Cystoscopy revealed complete obstruction of the left ureter, but operation was declined for a month; the left kidney was then found to be in a condition of acute ascending nephritis with multiple abscesses. A small stone was removed from the left ureter a little below the kidney. Nephrectomy was considered inadvisable. It was hoped that the kidney would recover; it did recover, completely but slowly. Eight years later a calculus became impacted in the upper part of the right ureter, which it completely obstructed. Meanwhile over a pint of normal urine a day was passed by the left kidney. The stone was removed three days after impaction and the patient went home well three weeks later. The contrast between the results of the first and second operation in this case is very marked, showing the enormous value of prompt removal of a stone from the ureter. It may be added that the right pelvis was already full of pus at the time of the operation.

Sir HAMILTON BALLANCE (Norwich) thought it was unnecessary to risk opening the peritoneum in these cases, and he had a personal dislike to small incisions such as Mr. Kidd had described; his preference was for the lateral incision parallel to the iliac crest, this incision enabling him to deal satisfactorily with every part of the lower ureter in the pelvis. Hernia did not result from that long incision even when extended forward to the rectus. There was risk of infection of the cellular tissue, and he always employed a drain. So long as that incision gave him proper access to the stone he was disinclined to go through the peritoneum.

Dr. CHARLES MAYO (Rochester, U.S.A.) desired to commend the stand taken by Mr. Kidd in advocating the removal of stones from the lower part of the ureter by the method described, with which he was familiar and knew to be employed by Dr. Brash in the Mayo clinic. In his experience, however, the open operation was just as safe as the method by operative cystoscopy. If the patients had a history of passing many stones, then he thought that the waiting plan might be adopted, but, if otherwise, then operation ought to be performed. It appeared to him that some regard should be had to the method of formation of the stone. The stone was not formed in the ureter; it was due to bacterial action in the kidney. Two types of bacteria were required—one in the original situation of formation of the stone in the kidney, and the other acting secondarily with the addition of calcium salts in its passage down the ureter.

* See *Guy's Hospital Gazette*, xxviii., 1914, pp. 191-6.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

ACUTE OEDEMA OF THE LUNGS.

THE recent correspondence in the columns of the BRITISH MEDICAL JOURNAL on the subject of acute oedema of the lungs or acute suffocative catarrh has directed attention to an interesting type of case in which the etiology is obscure. The transudation of fluid from the blood in the pulmonary circulation to the alveolar spaces must be primarily due to either (1) greatly increased pressure in the pulmonary system, or (2) gross changes in the structure of the lung capillaries.

As Dr. McNaughton pointed out, the explanation usually given is that the condition is due to persistent action of the right heart, with failure of the left heart—that is, to (1) above. Acute oedema of the lung does not appear to have been attributed to sudden vaso-dilatation of the lung capillaries or physical changes in their walls, presumably because at present it is generally considered that the blood vessels of the lungs are almost entirely devoid of any vaso-dilator or vaso-constrictor nerves.

The notes on the 18 cases recently reported in the BRITISH MEDICAL JOURNAL unfortunately do not give information on the state of the patient's heart during an acute attack, and in some cases only has the state of the pulse been noted. On comparing the 18 cases, however, I am struck by two points which seem to favour an "angioneurotic" instead of a "cardiac" theory of the origin of this condition. (1) In two of the most typical cases (Dr. Gale's and Dr. Yellowlees's) the pulse was said to be "full, rapid, and bounding," and "strong and quick" respectively. (2) With one exception the only cases which did not end fatally were those treated with atropine and morphine, drugs which act directly or indirectly on the vegetative nervous system.

This therapeutic evidence appears to support the view that acute oedema of the lungs is not due to a gross defect in the action of the heart but to the reflex effect of a pathological stimulus acting through the vegetative nervous system in a vagotonic individual.

From the notes on several of the cases reported it seems probable that the attacks were originated by some toxic agent absorbed from the gastro-intestinal tract, in this respect closely resembling certain forms of asthma arising from errors in diet, which are recognized as typical examples of over-action of the vagus. This theory would also be supported by the result of the use of atropine in these cases. The effect of morphine, too, is quite compatible with such a view, as presumably this would act chiefly by depressing all the sensory cells throughout the body, thereby reducing or removing the effect of the irritant stimulus causing the reflex action.

Although the number of cases reported is too small to warrant any inference, the sex incidence is of interest, as only 6 out of the 18 cases were in females. The characteristics of the vagotonic person tend to be masculine in type and those of the sympathicotonic person feminine.

It is interesting to note that Laignel-Lavastine includes acute oedema of the lungs as one of the vegetative syndromes indicative of an endocrine disorder, and suggests that the gland at fault is the suprarenal (? deficiency). In the recent edition of *Diseases of the Nervous System* by Jelliffe and White the condition is referred to in the article on Angioneurotic Oedema, and it is said: "The view here tentatively adopted is that it is a neural reaction brought about through the vegetative nervous system, which controls reciprocal tension relations, or cellular chemical composition relations."

No definite evidence has been afforded by any of the cases recently reported in the BRITISH MEDICAL JOURNAL in favour of the view that the condition is due to disorganization of the cardiac action, and the alternative theory, that the condition is a reflex nervous phenomenon arising in certain vagotonic individuals from certain unknown causes, seems to be much more satisfactory. The question might be settled by making a careful note of the condition of the heart and circulatory system generally while the attack is actually in progress.

London, S.W. W. CAMERON DAVIDSON, M.B., Ch.B.

THE TREATMENT OF RINGWORM.

WITH reference to the note by Dr. W. P. Elford it is interesting to record that the treatment he advocates approximates closely to that carried out at the school clinic at Stoke-on-Trent since 1914. I have been unable to lay my hands on the exact number or to remember the name of the contributor, but this form of treatment was described in the BRITISH MEDICAL JOURNAL of that or the previous year.* The details are:—

1. The hair over and for a short distance round each patch is well shaved and afterwards thoroughly washed with soap and water and finally with ether to remove as much grease as possible.
2. The area is then painted with tincture of iodine.
3. *When thoroughly dry* the painted area is sprayed with ethyl chloride.

The active agent is of course the small amount of ethyl iodide formed.

The treatment is repeated twice a week. The average duration of treatment does not exceed a month for scalp cases, while in body cases it is even shorter.

ROBERT HUGHES, M.B. Lond.,
School Medical Officer, County Borough of Stoke-on-Trent.

* The reference appears to be to Dr. C. H. Foley's note in the JOURNAL of March 21st, 1914, p. 651.—ED.

POISONING WITH HYDROCHLORIC ACID: RECOVERY.

THE following case may be of interest, because, in spite of the large amount of acid swallowed, recovery occurred with comparatively little after-effects:

I was called one evening to a young man who had swallowed from a cup, as far as could be ascertained by careful investigation, about 3 oz. of fuming hydrochloric acid (spirits of salts). He had just previously had a heavy meal. He was found a few minutes after the occurrence and promptly given a tumblerful of hot water and mustard.

When I saw him he was lying on the floor in a state of extreme collapse, with very rapid pulse, dyspnoea, cold extremities, and intense abdominal pain. He had vomited and continued to do so, bringing up with much retching quantities of dark brown material with mucus and blood-stained froth. He was given at once morphine hypodermically (which was repeated), milk by the mouth, and within a few minutes sodium bicarbonate in water in fairly large quantities, which was mostly returned. He was also given strychnine and caffeine in large doses hypodermically, and put to bed with hot-water bottles. The following morning the temperature was 100°, pulse 128, and respirations 26. He complained of great pain in the epigastrium and of intense thirst. He was given ice to suck, Vichy water by the mouth, and nutrient enema with brandy.

Dr. Clive Riviere, who saw him in consultation later in the day, advised bismuth carbonate made into a paste with paraffin by the mouth, sodium bicarbonate in albumin and water by the mouth, and in the enemas in view of the possibility of acidaemia. The bismuth and paraffin, of which a drachm was given four-hourly, seemed to be very beneficial in easing pain and nausea. He slowly recovered without any serious complication beyond some left-sided dry pleurisy which subsided and some nocturnal delirium. The highest temperature was 101.8°. The back of the throat was white and corroded, but gradually cleared. When I last saw him, a month after the occurrence, he was up and had been out and was taking semi-solid food.

The fact that he had just taken a large meal and was immediately given an emetic, combined with his youth, accounts, I think, for his recovery. I have not seen him since, as he left the neighbourhood, but I have heard recently that he is much debilitated, can only take semi-solid food, and has to have a bougie passed daily.

London, W. HOWARD STRATFORD, F.R.C.S.Edin.

Reports of Societies.

THE OXFORD OPHTHALMOLOGICAL CONGRESS.

THE eleventh annual meeting of the Oxford Ophthalmological Congress was held at Oxford on July 14th, 15th, and 16th. The proceedings took place in the Department of Human Anatomy of the Museum, kindly lent for the purpose by Professor Arthur Thomson, whilst members once more enjoyed the hospitality of Keble College. The attendance was large and included a number from overseas, prominent amongst whom were Professor Harvey Cushing, Dr. Luther C. Peter (Philadelphia), Professor Van der Hoeve (Leyden), Professor Holth (Christiania), Dr. S. Lewis Ziegler (Philadelphia), and others. The chief features of the meeting were, on the first day a discussion on perimetric methods, and on the second day the Doyne Memorial Lecture.

Perimetric Methods.

The discussion was opened by Dr. LUTHER C. PETER, who limited his remarks to the newer methods of perimetry and the types of cases for which they were especially adapted. After pointing out the inefficiency of the ordinary perimeter in recording changes in the central zone, the opener proceeded to discuss the various modern instruments specially adapted for this purpose. Dr. Peter then urged a change in the nomenclature from linear measure in millimetres to angle subtended in degrees or minutes, and discussed the size of the test object, especially for colour studies. The size for the central zone should subtend an angle of half a degree and that for the peripheral zone one degree. The special methods required for the study of bilateral central scotomata were (*a*) by making use of muscle sense, and (*b*) by the speaker's method of combining perimeter and campimeter.

A good discussion followed, in which the following took part: Professor VAN DER HOEVE, Mr. A. H. SINCLAIR (Edinburgh), Dr. MARX (Leyden), Professor HARVEY CUSHING,

the panel patient as occasion requires, and perhaps I had better add that it is quite a common occurrence even to feel the pulse. The panel system receives a large amount of quite unmerited abuse. A panel is largely what the individual practitioner makes it.

A fact which is often overlooked is that there are, there always have been, and there always will be, two distinct types of men in the profession: There is the man who is a gentleman by nature, not necessarily by birth, who has high ideals of the healing art and of his duty to his patients, and there is the man who is in the profession to get all he can out of it. By their works ye shall know them. One type is hall-marked, the other bears a trade mark, both indelible. Nothing can alter this, whatever system is in vogue, whether panel, whole-time service, or what not; the two types will always be in evidence. Can there be any doubt which of the two is a "proper doctor"?

I have my own ideal of a "proper doctor," and have met him on many occasions in Harley Street, in the slums, and often in insurance practice, but your correspondent does not fill my picture, for he lacks one essential quality—the saving grace of charity.—I am, etc.,

Lenham, Kent, July 5th. J. TEMPERLEY GREY.

CALCIUM IN THE TREATMENT OF TUBERCULOSIS.

SIR,—Nature's remedy for tuberculosis is first fibrosis and then calcification. The amount of fibrosis may be regarded as evidence of the amount of resistance of the patient. Fibrosis comprises two factors: the imprisonment of the tubercle bacillus and its toxins on the one hand and the systemic attack of the white (giant) and other cells and their constituents on the other. Whilst, therefore, building up fibrosis and all it implies, on the one hand, by means of sanatorium environment and treatment, I wonder if, on the other, by giving lime salts in a colloid or finely divided form, we could not do something to cut short the life of the tubercle bacillus in glandular, pulmonary and other tissues.

What is the exact composition of the calcareous nodules found in healed tuberculous glands and scars? I believe that along the lines of combination of the chemical constituents with the vital we may in time work out a cure for tuberculosis.—I am, etc.,

Newcastle-on-Tyne, July 3rd. T. M. ALLISON.

MORTALITY OF VENEREAL DISEASES.

SIR,—In the BRITISH MEDICAL JOURNAL for July 17th, 1920, p. 80, there is a serious misstatement of fact (presuming correct reporting). Sir J. Crichton-Browne refers to the "three chief killing diseases" as cancer, tuberculosis, and venereal disease. This latter can only mean syphilis, as no deaths are ascribed to gonorrhoea in the Registrar-General's report.

The figures for 1917 show total deaths in England and Wales as follows:

Tuberculosis	55,934
Cancer	41,158
Pneumonia	39,832

Instead of being the third killing disease, syphilis comes a very long way down the list and was responsible for 2,127 deaths in the statistics above mentioned for 1917.—I am, etc.,

CHARLES RUSS, M.B.Lond., M.R.C.S., L.R.C.P.,
Honorary Physician, Electrical Department, Male Lock Hospital.

London, W., July 27th.

Universities and Colleges.

UNIVERSITY OF OXFORD.

AT a congregation held on July 20th, the following medical degrees were conferred:

D.M.—F. L. Apperly (*in absentia*).
M.CH.—N. A. Sprott.

UNIVERSITY OF CAMBRIDGE.

PROFESSOR G. H. F. NUTTALL reports that Mr. and Mrs. P. A. Molteno have undertaken to make an additional contribution of £6,000 in order that the Molteno Institute of Parasitology may not suffer from the increased cost of labour and material, and the original plan be maintained.

UNIVERSITY OF LONDON.

THE Senate has appointed Dr. W. S. Lazarus-Barlow to the new University Chair of Experimental Pathology, tenable at the Middlesex Hospital Medical School.

The following candidates have been approved at the examination indicated:

M.D.—(*Medicine*): T. I. Bennett, F. V. Bevan-Brown, G. Bourne, J. A. Drake, A. R. Elliott, *G. Marshall, J. G. Moseley, H. B. Russell, J. H. Sheldon, T. P. Williams, Irene Yates. (*Pathology*): S. F. Dudley. (*Mental Diseases*): T. Beaton, M.D., H. W. Hills. (*Midwifery and Diseases of Women*): Marian N. Bostock, *A. Goodwin, W. Salisbury, R. S. Townsend. (*State Medicine*): E. N. Ramsbottom, *H. Stott. (*Tropical Medicine*): C. C. Chesterman, M. D. Mackenzie.

* University medal.

LONDON HOSPITAL MEDICAL COLLEGE.

The prizes and certificates awarded to the successful candidates for the session 1919-20 were distributed by Dr. Robert Hutchison on July 5th. The following is a list of the awards:

"Price" Entrance Scholarship in Science (£100), L. Mushin. Second Entrance Scholarship in Science (£50), H. Taylor. Price University scholarship in Anatomy and Physiology (£52 10s.), Miss C. M. Ottley. Medical Prize (£20), D. Hunter. Prize in Clinical Obstetrics and Gynaecology (£20), M. C. Hartley; Honorary Certificates, J. R. Zeitlin and Miss M. E. Kennedy. "Andrew Clark" Prize in Clinical Medicine and Pathology (£26), D. Hunter; Honorary Certificates, P. Steinberg and F. H. W. Tozer. Surgical Prize (£20), D. Hunter; Honorary Certificate, Miss M. E. Kennedy. "Anderson" Prizes in Elementary Clinical Medicine (£3 each), Miss D. J. Fox, Miss D. Gibson, F. H. Mather; Honorary Certificates, H. D. Lawson, Miss H. R. Ashton, Miss D. S. Russell, and Miss M. E. Dixon. In-patient Dressers' Prizes (£5 each), C. S. Cloake, Miss D. Gibson and W. Thomas (equal, prize divided), Miss H. R. Ashton, Miss G. H. Jones; Honorary Certificates, Miss G. Denham and Miss D. S. Russell. Practical Anatomy (£6 Prize), Miss S. H. G. Robinson, (£2 Prize) P. H. O'Donovan, (£2 Prize) A. J. Reed; Honorary Certificates, D. R. Blunn, G. N. Golden, S. A. Grant, K. W. Todd, Letheby Prizes: Organic Chemistry (£15), R. T. Brain; Honorary Certificates, L. Mushin; Chemical Pathology (£10), C. S. Cloake; Honorary Certificate, F. C. Hunt. Sutton Prize, Pathology (£20), M. Tree. Buxton Prizes in Anatomy and Physiology (£31 10s.), G. N. Golden; Honorary Certificate, Miss D. Peake. Arnold Thompson Prize in Diseases of Children (£15), Miss O. G. Potter; Honorary Certificates, Miss D. J. Fox, Miss M. E. Kennedy.

LONDON SCHOOL OF TROPICAL MEDICINE.

The following were successful at the examination at the termination of the sixty-third session:

*T. J. D. Lane (gained Duncan Medal), *R. Jamison, *Miss E. J. O'Driscoll, *F. E. Reynolds, M. D. Mackenzie, J. M. MacKay, R. B. Hawes, J. Glavina, J. Forrest, V. E. Critien, S. A. Eldaah, J. V. Holmes, G. C. R. Wilson, J. H. Parry.

* Passed with distinction.

KING'S COLLEGE.

The following appointments have been made by the Delegacy: Dr. O. Inchley, lecturer in pharmacology; Dr. J. E. Hadfield, lecturer in psychology.

UNIVERSITY OF MANCHESTER.

THE following have been approved at the examinations indicated:

B.Sc. (PUBLIC HEALTH).—E. N. Ramsbottom.
D.P.H.—W. Ash, Sybil Bailey, J. C. Beckitt, Hilda Brade-Birks, J. P. Charnock, W. J. McIvor, C. G. Magee, Kathleen O'Donnell, W. J. A. Quine, A. Renshaw, L. S. Robertson.

UNIVERSITY OF SHEFFIELD.

THE following candidates have been approved at the examination indicated:

THIRD M.B., CH.B.—E. S. Clayton, Mary P. Gell, R. D. S. Inman, R. T. Lee, Elsa F. Page, R. Platt (distinction in Pathology), P. H. Sharp.

UNIVERSITY OF BRISTOL.

O. C. M. DAVIS, D.Sc., has passed the examination for the degree of M.D.

UNIVERSITY OF EDINBURGH.

AT the university court held on July 19th it was resolved, in view of the greatly increased cost of laboratory material, to make an additional charge in respect of laboratory training in the Faculties of Arts and Science, commencing on October 1st.

The court expressed its gratification at the further grant of £500 made by the Combe trustees towards the equipment of the laboratory in connexion with the Combe Lectureship in Physiology.

Dr. James Miller has resigned the post of Lecturer in Morbid Anatomy on his appointment to the Chair of Pathology in Queen's University, Kingston, Ontario.

Dr. W. T. Ritchie has been granted recognition for three years as an extra-mural lecturer in medicine.

The regulations drafted by the Faculty of Medicine for the diploma in tropical medicine and for the diploma in psychiatry were approved.

Dr. James E. M'Cartney was appointed Lecturer in Bacteriology.

ROYAL COLLEGE OF SURGEONS OF EDINBURGH.

THE following gentlemen, having passed the requisite examinations, have been admitted Fellows:

H. B. Atlee, J. C. Bell, F. Cameron, A. R. Campbell, F. E. Feildon, J. A. Ferriere, T. G. Fetherstonhaugh, T. W. Hancock, S. L. Harke, W. K. Irwin, G. B. Isdale, H. H. Jamieson, C. King, J. T. M'Auslin, A. J. M'Creadie, W. A. Mein, A. C. N. Misbah, D. M. Morison, G. T. Mowat, W. G. Oakeley, G. H. Peall, H. N. M. Puckle, M. E. Robinson, R. J. Silverton, A. F. Sinclair, F. W. Stone, F. K. Te Water, C. Uren.

Medico-Legal.

LIBEL ACTION AGAINST A MEDICAL OFFICER OF HEALTH.

A CASE of some little interest came before Mr. Justice Roche and a common jury in the King's Bench Division on July 15th. The plaintiff was a Mrs. Mabel Copeland, and she brought an action for damages for libel against Dr. Thomas Orr, the medical officer of health of the borough of Ealing.

It appeared that the plaintiff entered the service of the town council as a lady sanitary inspector in June, 1911, and from that time until Dr. Orr's appointment as M.O.H. in September, 1915, her duties consisted mainly in visiting newly born babies. On her return from her holidays in September, 1915, Dr. Orr, having entered upon his duties whilst she was away, the plaintiff was instructed by Dr. Orr to take up the returned scarlet fever cases. As a result the plaintiff saw the Chairman of the Public Health Committee, whom she asked for a testimonial with a view to obtaining another appointment. However, she changed her mind, and things went fairly smoothly for a time. In April, 1917, as the result of a new scheme of health work which Dr. Orr then introduced, the plaintiff again decided to resign, and wrote to the town council for a testimonial. The council asked Dr. Orr to report to them on the plaintiff and her work, and the doctor prepared a written statement, in which he said that the plaintiff was late in arriving at the office, absented herself without permission, and was unsatisfactory in the performance of her duties. This statement was handed to the Public Health Committee at their next meeting.

At about this time a letter had been written by the plaintiff's sister to Dr. Orr which stated that the plaintiff had been ill as a consequence of Dr. Orr's harsh and aggressive attitude towards her. This letter was laid before the Committee, who called upon the plaintiff to attend before them and support the statements contained in her sister's letter. She did not do so, and the council eventually decided to dismiss her from their employment. The plaintiff then brought her action against Dr. Orr for libel contained in the report which he had submitted to the Committee in April, 1917, and the doctor pleaded that the report was made bona fide at the request of the Committee in circumstances which rendered it privileged.

The plaintiff in the witness box spoke of the defendant's manner towards her having been harsh and brusque, and referred to an interview on one occasion on which the defendant had said that either he or she had "got to go." The plaintiff's sister was also called, and the evidence of the former chairman of the Public Health Committee, which had been taken on commission, was read.

This closed the plaintiff's case, and Mr. Hemmerde, K.C., who appeared as counsel for the defendant, submitted that the plaintiff had not proved that the defendant had acted from any malicious motive in making his report, and that the case ought therefore to be withdrawn from the jury. The judge, however, said he thought it best to hear the case out, although he was inclined to think there was no evidence of malice. The defendant then went into the box and detailed his association with the plaintiff, and in particular dealt with the circumstances under which he made the report to the Committee. The plaintiff was lacking in method, and her records were in arrears. He honestly believed the statements contained in his report, which were founded chiefly upon his own observations. He had no personal feeling against her, nor desire to get her out of her employment. Two other witnesses spoke to the unsatisfactory way in which the plaintiff had carried out her duties.

In his summing up to the jury the judge asked them to say whether in making the report to the council the defendant acted bona fide, and pointed out that being actuated by malice did not necessarily mean ill will, although ill will was a form of malice. It meant an indirect and improper motive, and might be expressed in this way. The defendant had of course to report to his council because he was asked to do it. The report was therefore privileged. But a person in such circumstances must not abuse the occasion, and the question was whether he had done so. The judge also intimated that there might be a question which he would have to decide thereafter as to whether there was any evidence upon which they could find in favour of the plaintiff.

The jury found £25 damages in favour of the plaintiff, and the judge postponed entering judgement pending legal argument. On July 19th the case was mentioned to the court by Mr. Hemmerde, who moved that judgement be entered for the defendant, on the ground that there was no evidence of malice, and Mr. Justice Roche, in the course of a somewhat lengthy argument by counsel on both sides, said: "Speaking as a great believer in juries, this is one of the cases which occurs now and then in which one's faith is a little shaken. I say no more than that. It is not for me to set the jury's verdict aside as being an unreasonable verdict, but I am entitled to say that I am very dissatisfied with it. It is difficult, however, to say that there was no evidence which could be submitted to the jury."

Judgement was therefore entered for the plaintiff for the sum of £25. We understand that an appeal has been entered by the defendant.

The Services.

HONOURS.

O.B.E. (MILITARY).

CAPTAIN WILLIAM NIVEN GREER, R.A.M.C.(S.R.), and temporary Captain David Vincent O'Malley, R.A.M.C., have been appointed O.B.E. (Military Division) in recognition of valuable services rendered in connexion with military operations in Burma.

MENTIONED IN DISPATCHES.

The names of the following officers have been brought to the notice of the Secretary of State for War for valuable and distinguished services rendered in connexion with the military operations in the theatres of war indicated:—*South Persia Force:* Major R. G. G. Croly, I.M.S., and Captain (acting Lieut.-Colonel) J. B. Hance, I.M.S., attached South Persian Rifles. *Kuki Punitive Operations:* Captain T. Fleming, R.A.M.C., Captain W. N. Greer, R.A.M.C. (S.R.), and temporary Captain D. V. O'Malley, R.A.M.C.

Temporary Captain John Marsters Mitchell, R.A.M.C., has been appointed O.B.E. (Military Division) in recognition of valuable services in connexion with military operations in South Russia.

Captain Oswald Russell, the son of Major-General Sir Michael Russell, K.C.M.G., C.B., late Deputy Director-General of the Army Medical Services, War Office, has been awarded the Military Cross for conspicuous gallantry and devotion to duty near Sasiliyah (Mesopotamia) on March 7th, 1920.

Obituary.

SIR ALEXANDER DEMPSEY, M.D., J.P.,

Gynaecologist to the Mater Infirmorum Hospital, Belfast.

THE announcement last week of the death of Sir Alexander Dempsey, M.D., at his residence, Coldagh, Somerton Road, Belfast, occasioned widespread regret amongst all classes and sects in Belfast and the North of Ireland. About the end of June he became confined to the house, and gradually became weaker, and he died on July 18th.

Alexander Dempsey was born at Coldagh, Ballymoney, County Antrim, in 1852; he was educated at St. Malachy's College, Belfast, and began his professional career in Queen's College, Galway, and subsequently studied in the Roman Catholic University Medical School, Dublin, and obtained the M.D. in the old Queen's University, and the L.R.C.S.I. in 1874. He began practice in Belfast in Donegal Street, and removed to Clifton Street, which remained his professional residence to the end. Along with the late Dr. John Moore and the late Dr. William McKeown, he established the North of Ireland Branch of the British Medical Association, in which he always took a keen interest; for many years he acted as its honorary secretary and treasurer, and subsequently he was elected its president. When the Association met in Belfast in 1884 he was one of the honorary secretaries. Sir Alexander Dempsey was much associated with the public life of the city: he was appointed a justice of the peace in 1880; for many years he was a member of the joint board of the Belfast and County Antrim Asylum, and of the visiting committee of the Belfast prison. He was elected a member of the governing body of the University College, Dublin, and nominated at its inception a member of the National University Senate. Two years ago he was also nominated to the Senate of the Queen's University, Belfast.

His chief professional work was done as gynaecologist to the Mater Infirmorum Hospital, Belfast, to the rebuilding and reorganization of which he devoted much time and energy. He enjoyed a very large and lucrative practice both as a family physician and, amongst those of his own denomination, as a consultant. On several occasions he acted as local examiner in obstetrics and gynaecology in the Queen's University and as extern examiner in the National University of Ireland. In 1911 he received the honour of knighthood.

Sir Alexander Dempsey was esteemed for his genial disposition, his openness and fairness, and his high professional abilities. He was a favourite with all classes and creeds, both amongst his professional brethren and the

public generally. He is survived by a brother, two sons (one Dr. Alex. J. Dempsey, late of the R.A.M.C.), and a daughter, with whom much sympathy is felt.

WE regret to learn of the unexpected death of Lieut.-Colonel W. D. SUTHERLAND, M.D., C.I.E., I.M.S., Imperial Serologist, Calcutta. He was taken ill on June 22nd with acute appendicitis and, in spite of very early operation, he died in the Calcutta Medical College Hospital on June 27th, when he had almost completed his full service for pension, leaving a widow in England and a son in the army. He took the M.B., C.M. degrees at Edinburgh University in 1888 and subsequently the M.D., entered the Indian Medical Service in March, 1890, and saw military service in Burma. In July, 1894, he entered the civil medical department of the Central Provinces, where he served for many years. He made a special study of medico-legal tests for blood stains, including the serological test, and wrote a small book on the subject while on leave, which led to his being placed on special duty in Calcutta for investigation of the serological test, and in 1914 he was appointed to charge of the newly-created post of Imperial Serologist, which included medico-legal blood tests for the whole of India. His technique was extremely good, while he was an accomplished linguist and well up in foreign medical literature, and his valuable work in this line was recently rewarded by the grant of the C.I.E. His sudden and untimely death is a great loss to science and to his service, as well as to the Calcutta School of Tropical Medicine, in which he was to have lectured, while he was also a member of the governing body of the Endowment Fund, under which the school is about to open as a research institute until such time as the Government of India can provide a teaching staff. Colonel Sutherland was a most accomplished man, a valued colleague and a true friend to many, and a most entertaining and popular companion; his scientific work was most careful and reliable. He will be greatly missed by his many friends, while his unexpected death when so near his retirement is one of the many calamities inseparable from work in the tropics. His last remains were given a military funeral, which was largely attended.

Medical News.

THE house and library of the Royal Society of Medicine will be closed during the whole of August for repairs and cleaning.

A POST-GRADUATE course conducted by members of the staff will be held in the Radcliffe Infirmary and County Hospital, Oxford, commencing on Friday, October 1st, and terminating on Saturday, October 9th. Further particulars can be obtained on application to the Secretary, Post-graduate Course, Radcliffe Infirmary, Oxford.

WE are asked to state that although several of the wards of the National Hospital for the Paralysed and Epileptic, Queen Square, London, are closed through lack of funds, the whole of the out-patient department is working as usual.

DURING the month of September a very complete course of post-graduate teaching will be conducted by the staff of the Glasgow Royal Infirmary. Full details as to classes and enrolment are given in our advertisement columns.

THE School Dentists' Society has resolved to increase the annual subscription for membership from 5s. to 10s. 6d., dating from January 1st, 1921.

THE Faraday Society and the Physical Society of London have arranged to hold a general discussion next October on colloidal physics and chemistry.

The treasurer of St. George's Hospital has issued a statement contradicting the rumour that the hospital is to be moved. Private negotiations which were entered upon last year for amalgamation with another hospital have fallen through. The site of St. George's Hospital was offered for sale some years ago, but no adequate offer was received; various restrictions and conditions apply to about half the site, and so reduce its saleable value. The governors have decided to extend and improve the hospital at the earliest opportunity, and eventually to rebuild it on the present site at Hyde Park Corner.

Letters, Notes, and Answers.

As, owing to printing difficulties, the JOURNAL *must be sent to press earlier than hitherto, it is essential that communications intended for the current issue should be received by the first post on Tuesday, and lengthy documents on Monday.*

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—of course not necessarily for publication.

AUTHORS desiring reprints of their articles published in the BRITISH MEDICAL JOURNAL are requested to communicate with the Office, 429, Strand, W.C.2, on receipt of proof.

IN order to avoid delay, it is particularly requested that ALL letters on the editorial business of the JOURNAL be addressed to the Editor at the Office of the JOURNAL.

THE postal address of the BRITISH MEDICAL ASSOCIATION and BRITISH MEDICAL JOURNAL is 429, Strand, London, W.C.2. The telegraphic addresses are:

1. EDITOR of the BRITISH MEDICAL JOURNAL, *Aitiology, Westrand, London;* telephone, 2631, Gerrard.
2. FINANCIAL SECRETARY AND BUSINESS MANAGER (Advertisements, etc.), *Articulate, Westrand, London;* telephone, 2630, Gerrard.
3. MEDICAL SECRETARY, *Medisecra, Westrand, London;* telephone, 2634, Gerrard. The address of the Irish Office of the British Medical Association is 16, South Frederick Street, Dublin (telegrams: *Bacillus, Dublin:* telephone, 4737, Dublin), and of the Scottish Office, 6, Rutland Square, Edinburgh (telegrams: *Associate, Edinburgh;* telephone, 4361, Central).

QUERIES AND ANSWERS.

"ELTEE," a Territorial R.A.M.C. officer entitled to the 1914–15 Star, Victory and Allied Medals, inquires where he should apply for these.

*** The Medal Branch (A.G. 10) of the War Office is at 27, Pilgrim Street, Ludgate Hill, E.C.4.

INCOME TAX.

C. H. D. inquires as to the basis on which income tax should be paid in the case of a medical partnership.

*** First of all the liability of the practice as a whole is determined—that is to say, the amount of the average profits, total receipts less united expenses, over the previous three years. Then the result is divided into the proportions provided for by the deed of partnership and the special individual expenses deducted therefrom. The united return should be the aggregate of the resulting net shares of the gross profits. Although the assessment is made on the basis that the firm is liable as a distinct entity, it is calculated, as regards allowances, rates of tax, and so on, as if it were simply the aggregate of assessments on the individual members of the firm.

P. Q. R. inquires whether he is liable for tax on fees, etc., received while acting as locumtenent and, if so, on what basis. He gave up an appointment last year and has been acting as locumtenent at various times since.

*** The income is undoubtedly assessable though it is to a large extent casual in our correspondent's case. The basis is the usual three years' average except that in the first year for that work the liability is on the first year's earnings, for the second year on the same amount, and for the third year on the average of the first two years. The value of lodgings and board received in kind is not liable to tax, and, in our opinion, P. Q. R. is entitled to deduct the reasonable expenses incurred in travelling to take up the various locumtenancies.

"RETIRED PAY" inquires how an income made up as follows will be treated for income tax purposes: Army pension £365; investment income, £25 taxed and £2 10s. untaxed. "Retired Pay" is married, lives abroad, and pays £10 for life assurance.

*** Our correspondent appears to assume that the £365 is exempt because he lives abroad; this will not be the case if the pension is paid from British and not Colonial or Indian sources. The allowances to which he is entitled are £225 plus £10, and the assessable income, £392 10s., less one-tenth of £365 = £36 10s.—that is £356 net, leaving a full liability of £356 —£225 = £131 at 3s., less the life assurance allowance of £10 at 3s., that is, £121 at 3s. If the army pension be exempt, the allowances have to be divided between the liable and non-liable income—that is, in the ratio of £365 to £27 10s., and his liability would be a matter of a few shillings only. We assume, of course, that he has no foreign or colonial income which has not been mentioned in his letter.