He discussed the indications for this procedure and the precautions which must be observed. From an analysis of the large series of patients on whom he had performed lengthening operations he concluded that two-inch lengthening could be safely and easily obtained, that tibial lengthening was more certain and easier to control than femoral lengthening, and that many of the complications experienced by other surgeons were due to extensive and unnecessary stripping of the periosteum and damage to the soft tissue.

Operation for Calcaneo-cavus.—Mr. BRYAN MCFARLAND (Liverpool) said the essential steps of the operation were the removal of a substantial wedge of bone from the posterior third of the os calcis, and its insertion into a niche on the dorsal surface of the neck of the astragalus, close to the articular surface for the tibia. If the wedge was inserted accurately it formed a block to excessive dorsiflexion. The procedure and patients before and after the operation were clearly illustrated by a cinematograph film.

Osseous Dystrophy following Icterus Gravis Neonatorum.—Dr. FRANCIS BRAID (Birmingham) gave a full account of two patients who had a disease characterized by (1) jaundice of the familial icterus gravis type at birth with acholia; (2) pathological pigmentation of the skin; and (3) a generalized cystic condition of the bones, which developed some time after birth. The bony changes might possibly have represented an accompanying developmental defect, or they might be secondary to cirrhosis of the liver (present in both patients) which could very well have disorganized the storage and utilization of vitamins.

Tuberculous Infection of Bursa over Great Trochanter.—Mr. T. S. DONOVAN (Birmingham) described five patients who had suffered from tuberculous infection of the subgluteal bursa. He made a plea for early excision; treatment by immobilization of the hip in recumbency had proved ineffective.

Snapping Jaw.—Mr. A. CAMERON ARMSTRONG (Liverpool) discussed the pathology of this condition, and an operation for the removal of the torn meniscus was described and illustrated by a cinematograph film. Through a short oblique incision in front of the ear the zygomatic arch was exposed and a half-inch of it removed (to be replaced at the end of the operation) immediately in front of the eminentia articularis. This procedure gave a clear view of the anterior and anterolateral aspects of the joint, and excision of the meniscus was easy. In the two patients on whom the operation was performed a temporary paresis of the frontalis muscle developed, but recovery was complete in a few weeks.

Radiographic Changes of Childhood as Seen in Adult Life.—Dr. J. F. BRAILSFORD (Birmingham) showed an interesting series of radiographs of various bone dystrophies in patients with whom he had been able to keep in touch from childhood to adult life. He discussed the relationship between epiphyseolysis of the upper end of the femur and renal rickets, and described in detail the radiological appearances in the "pre-slipping" stage. He regarded infantile coxa vara as a localized bone dystrophy. Bone changes of a similar nature were sometimes seen in cleido-cranial dysostosis and in Albers-Schönberg disease.

Non-traumatic Dislocation of Toes.—Mr. SAYLE CREER (Manchester) gave an account of thirty-six patients in whom non-traumatic dislocation of one or more toes at the metatarso-phalangeal joint had occurred, the majority in connexion with hallux valgus and metatarsal arch defects; pes cavus was present in only one patient. In three cases there were plantar sinuses leading down to the dislocated joints. Mr. Creer disagreed with Branch's theory that the dislocation was produced by interosseous muscle action, and he demonstrated very clearly in a cinematograph film that these muscles on faradic stimulation had an action quite different from that ascribed to them by Branch. It was therefore concluded that the extensor tendons were the dislocating factors, in association, of course, with deformities already present. Treatment consisted of tenotomies of the extensors in the early stages; when the dislocation was long established excision of the base of the phalanx was necessary.

Local News

ENGLAND AND WALES

London School of Medicine for Women

The annual dinner of the London (Royal Free Hospital) School of Medicine for Women was held at the Savoy Hotel on December 1, Mr. E. Ulysses Williams presiding. In proposing the toast of "The School and the Hospital," the chairman mentioned various matters of domestic interest, including the honours and appointments gained during the year by old students, for all of whom the school maintained an affectionate regard. He also congratulated Mr. L. E. C. Norbury, surgeon of the hospital, on his election as a member of the Council of the Royal College of Surgeons. One event of the year was the installation in the physiological department of a cinematograph with sound, which would be of great advantage to those working there. The toast of "The Guests" was proposed by Mr. J. D. McLaggan, and was coupled with the names of Miss Helen Simpson (Mrs. Denis Browne) and Sir Girling Ball. He appraised Miss Helen Simpson's novels, saying that she was primarily a teller of stories and not one of those modern writers who probed too deeply into the abysmal depths of the human mind. Of Sir Girling Ball he said that his most distinguishing characteristic was his enormous fund of common sense. Among other guests he mentioned Mr. Denis Browne, who had acquired a great reputation as a soldier and a surgeon, but whom he remembered also as a tennis player "up to Wimbledon standard" on the old court at the back of Great Ormond Street; their old friend Sir James Berry; Dr. Hamilton Fairley, who had come in the place of Sir Leonard Rogers; the Editors of the *British Medical Journal* and the *Lancet*; and Sir Walter Schröder, who, as the doyen among coroners, carried with him a tradition of dignity and courtesy which it would be difficult to match. Miss Helen Simpson began her reply with the remark that she was that "scourge of the profession"—a doctor's wife. Soon after entering that state she had a succession of illnesses which enabled her to look on the profession from the outside as well as from within and led her to offer a few observations as a patient on the manner in which doctors might better conduct their art or craft, or, as it used to be called in the Middle Ages, their "mystery." She thought it a mistake for doctors to take patients too much into their confidence. With scarcely an exception, what patients wanted from doctors was not reason but magic, and, indeed, the profession showed some appreciation of this when they used an astrological sign at the beginning of their prescriptions. Another consideration was that each patient believed himself to be unique, and resented being told that the doctor knew all about his particular complaint. It was a difficult task a doctor had to do—to keep patients in their place and at the same time to bolster up their conceit of themselves, to range them in classes and also to see them as individuals, and to combine the spirit of a vocation with the pursuit of a profession. It seemed odd to her that a profession embodying all these qualifications should for so long have been closed to women. She quoted from Lord Horder's inaugural address delivered at the school a few weeks previously that medicine seemed a natural profession for women to follow, and that the perfect doctor combined the woman's sensitiveness with the man's strength. It was a curious attitude, surely, to suppose that it was womanly to dress a wound but unwomanly to stitch it up, womanly to nurse but not to doctor. Women had something to give to the profession, perhaps not least because they had not quite the same herd instinct as men, nor quite the same reverence for tradition. Such challenge to tradition was not unhealthy in a scientific calling. Sir Girling Ball, who

also responded, spoke of a recent visit he had paid to the London School of Medicine for Women, and said that although the building dated back for nearly seventy years he had been struck by its modernity, especially the first-rate dissecting room. It lacked only space to expand, and he had wondered whether it would be possible to acquire a piece of land for this purpose from the Foundling Hospital. He felt that the schools in London should get much closer together, and in his capacity as Dean of the Medical Faculty of the University he intended to do his utmost to bring this about. There should not be all these separate bodies doing the same kind of work. A committee of the deans of the various medical schools was now in existence, and more and more important educational subjects came before it. After the chairman's health had been proposed by Mrs. Scott-Brown and duly honoured, the company broke up for dancing.

Scientific Treatment of Delinquency

Many influential people attended a dinner at the Savoy Hotel, London, on November 29 in aid of the Institute for the Scientific Treatment of Delinquency, under the chairmanship of Viscount Hailsham. The occasion was well timed in view of the recent publication of the Prison Commissioners' report and the introduction into Parliament of the Government's Criminal Justice Bill. The main purpose of the dinner was to raise funds to carry on and extend the work of the Institute at its clinic at 8, Portman Street, W. Some £2,000 a year is needed for maintenance and extension of the out-patient clinic to provide further staff and for research into the causes of crime. The clinic is operated by a staff of medical consultants and psychotherapists, who give their services voluntarily. The cases with which it deals are sent by magistrates, probation officers, social workers, and others; the opinions of the Institute's experts on these cases are co-ordinated by a director and a report is sent to the appropriate person, usually a magistrate. The speakers at the dinner were the Lord Chancellor (Lord Maugham), Viscount Samuel, Lord Roche, Mr. St. John Hutchinson, K.C., and Dr. Denis Carroll, a director of the clinic. The Lord Chancellor, commending the appeal, referred to the great progress made in penal reform during the present century. He said that the Prevention of Crime Act, 1908, and the Children's and Young Persons Act had effected a revolution in the law, and the new Criminal Justice Bill would bring about further important reforms. Lord Samuel said that in this Bill the Institute would have its charter. The dinner was organized by Countess De La Warr and Mrs. Harry Sacher. The appeal fund now exceeds £3,720, and more than £1,000 was collected in the room.

Lay Analysts at London Mental Hospitals

At the meeting of the London County Council on November 29 the Mental Hospitals Committee reported that it had considered a request by the director of research of the Institute of Psycho-Analysis for a small number of lay analysts in training at the institute to be allowed to be present to observe the reactions of patients when they were being examined at St. Bernard's Hospital, Southall. It was stated that the medical staff of the hospital were willing to co-operate in the arrangement, which meant the attendance at the hospital from time to time of two or three persons, not medically qualified, who were in training with a view to the practice of psycho-analysis. It was unusual for these students, in the course of their training at the institute or in their ordinary practice after training, to get experience of the major psychoses, and it had been represented that acquaintance with these would provide a useful background for other experience. The Mental Hospitals Committee had decided to grant the permission asked for, in the first instance for one year, when the arrangement would be reviewed. It was not proposed that lay analysts should be employed by or on behalf of the Council either in the mental hospital service or under any arrangements made for after-care.

The proposal met with some opposition in the Council. Mr. F. S. Henwood moved and Dame Florence Barrie Lambert seconded an amendment instructing the committee to defer the permission until the Mental Health Committee of the British Medical Association, which was understood to be investigating the question of non-medical psycho-analysts, had reported. [The Mental Health Committee was appointed by the Council of the Association to inquire into the present medical equipment and provision for dealing with mental health in this country, with particular reference to the problems of the treatment and prophylaxis of the psychoneurotic and allied disorders.] Mr. Henwood considered that the proposal to allow persons who had no medical training to be present during the examination of patients was open to question. The patients were those who had been sent to a mental hospital under magistrate's order, they were at the mercy of the Council, and the Council had special responsibilities towards them. He also suggested that the question might be referred to the Council's medical officers as a body. The proposed action was defended by Mr. J. R. Oldfield, who said that the Institute of Psycho-Analysis was a perfectly proper body in every respect. The trainees were merely to be present as observers. The people observed were so acutely deranged that they would be unconscious of the presence of the trainees. He added that the Council had the only concentration of acute cases available in London, and if its assent were not forthcoming it was as good as saying that the trainees should have no experience at all. The medical superintendent of the hospital and his staff were in favour of the new departure, and the patients would in no way be jeopardized.

The amendment was defeated, and the report sanctioning the permission for the lay analysts to be present was approved.

SCOTLAND

Hospital Co-operation

The Secretary of State for Scotland, Mr. John Colville, discussing the need for co-operation in hospital services at the recent meeting of the Victoria Infirmary, Glasgow, said the work of voluntary hospitals was a natural expression of the spirit of liberty which was dearly prized in this country. The nation showed a sure instinct in cherishing the voluntary hospitals, but it would be a bad mistake for them to hold aloof from the municipal hospitals. The voluntary hospitals had recently sent him a memorial urging the need for co-operation in Scotland, and this initiative was a tribute to the voluntary hospitals. Changing conditions in medical science and the increased scale on which hospital services had now to be conducted had created the need for co-operation in this field of public work. Diseases that had formerly crippled or led to untimely death were being attacked with patient and confident skill, and the people of Scotland were healthier than formerly, although disease still took too heavy a toll. Mr. William Gray, chairman of the hospital, announced that Viscount Weir had given £7,000 for the building of a fracture clinic as recommended by the Departmental Committee on the Rehabilitation of Persons Injured by Accidents. The Victoria Hospital in the fifty years of its life had grown from an institution of eighty-four beds to one of 555 beds, treating 11,000 in-patients and 114,000 out-patients annually. Lord Provost Dollan of Glasgow referred to the antagonism which had formerly existed between the voluntary and municipal hospitals; this, he said, no longer existed in Glasgow because of an increasing understanding that the municipal and voluntary hospitals were not competitors but were working in the same cause.

Edinburgh Hospital Problems

At the annual meeting of the League of Subscribers to the Royal Infirmary, Edinburgh, it was stated that whereas twenty years ago the ordinary expenditure for maintenance was £87,000, last year it was £186,000, and the number of patients twenty years ago was 11,181, while last year it was 21,936. The chairman of the Board announced that the new maternity hospital and nurses' home were nearly completed, and would, it was expected, be in occupation by March 1, 1939. Maintenance of the maternity block was going to add about £30,000 a year to expenses, and it would be necessary for the citizens of Edinburgh to take a greater interest in the maternity work. The managers of the Infirmary were ready to meet representatives of the local authorities to discuss matters involving the municipal hospitals and the Infirmary, and among other things a contributory scheme would require careful consideration. Mr. Andrew Eunson, honorary secretary of the League, reported that there had been a considerable increase in contributions. In 1918 they received £1,600 from employees in public works and businesses; in 1938 this had risen to £32,000. The Edinburgh municipal hospitals were not full, while the Infirmary had a waiting list of over 3,000. The solution seemed obvious—namely, to utilize the empty municipal beds for the waiting patients. It had been suggested that a contributory scheme should be started under which the treatment of members of the scheme would be paid for either in the municipal hospital or in the Infirmary. Such a scheme, however, could not be adopted for Edinburgh alone, because more than half of the patients in the Infirmary came from outside of the city. A contributory scheme must therefore apply to the whole of the south-east of Scotland, but the charter of the Infirmary did not permit the institution of a general system of payment, and the attitude to a contributory scheme of the other voluntary general hospitals in the area was not yet known.

Correspondence

Primary Abdominal Tuberculosis

SIR,—The contribution of Drs. Stefan Engel, Ruby O. Stern, and G. H. Newns on the danger of primary abdominal tuberculosis in children (November 19, p. 1038) is both timely and welcome, as it calls attention to a condition which is preventable and is a far more serious menace than commonly supposed. They have well shown how frequently a fatal termination may be anticipated in numbers of very young children. Nevertheless, I believe the infection exists in many children and may often be overcome by suitable treatment and in some cases cured naturally without its presence having been diagnosed or even suspected. It would be of value if a similar investigation to theirs were conducted in children from the age of 5 to puberty. I have been interested to observe the much higher proportion of cases of primary mesenteric tubercle admitted to this hospital in recent years. This is probably in part due to improved early diagnosis, though it must be admitted that many were only discovered at laparotomy, especially for appendicectomy.

Except in fulminating cases where meningitis supervenes, comparatively early diagnosis should not be so difficult as the authors would have us believe. Even apart from family history or conditions known as likely to produce infection the general appearance of the child, his facies, malaise, irritability, apathy, capricious appetite, occasional attacks of colicky pain relieved by warmth and pressure, sometimes diarrhoea alternating with constipation, in a few cases vomiting, should lead to a tuberculin test being applied. Stigmata of tuberculosis as described by Rivers, ichthyosis, deflected nasal septum, and even squint, though by no manner of means invariable, do sometimes occur and should put us on guard. Localiy, frequent absence of abdominal reflexes and localized abdominal tenderness on deep palpation with slight muscle guarding are common, and in more advanced cases the doughy abdomen associated with matted intestines and sometimes free fluid in the flanks makes the presumption of tuberculosis very probable. In acute cases there may be tenderness in the flanks and occasionally very easily palpable enlargement of iliac and groin glands on the side affected. Pyrexia is an uncertain sign, but a moderate degree in untreated cases is common.

On the pathological side haematological examination should be undertaken, as it may afford valuable confirmation of clinical findings, and the sedimentation reaction of the blood should always be ascertained. Examination of the stools for occult blood and tubercle bacilli should invariably be made, and the by some discredited Triboulet test for intestinal ulceration or, as I would prefer to call it, intestinal permeability has, in my hands, proved valuable both as one of the many aids to diagnosis and also as a guide to the conduct of treatment. *X*-ray examination may be of little if any value at the onset, but later is often of very real help.

I cannot but believe that if investigations somewhat on these lines were undertaken in suspected or doubtful children many cases would be discovered and subsequent disability, invalidism, or even death averted. The tuberculin tests, harmless if of the Pirquet variety, may supply a useful initial hint. Failure to undertake these and perhaps other investigations may lead to dissemination and dangerous sequels. These facts are beginning to be appreciated and are already having favourable effects. They should be emphasized.—I am, etc.,

Alton, Hants, Nov. 28. HENRY GAUVAIN.

Glycosuria

SIR,—The matter of which I give details confirms what I have long suspected—namely, that diabetes is an insidious disease, often of slow progress and of long duration before its discovery, giving no distress to its victim and no means of diagnosis to the physician save by urine testing, and causing essential cell destruction. Volunteers for the auxiliary fire service of the air raid precautions scheme in the borough of Crosby had a sample of their urine tested. Of 132 men examined, eight were found to have glycosuria, their ages ranging from 26 to 40 years. The precipitation on testing was rapid and copious in all but one case. Each of the eight men said that he felt quite well and strong, and all save one followed occupations involving hard work; every objective symptom was absent except that one man stated that at times he had pains running down the limbs, which he attributed to a "little rheumatism." On physical examination the vision of each man was normal; no examination of the disk was made. Diagnosis was only possible by examination of the urine.

Each man was referred to his own doctor. One practitioner, to whom I had referred one of the men, said that in the last few weeks, on testing samples of urine, he had discovered five cases of glycosuria which, owing to the absence of subjective symptoms and physical signs,

of one, in which this method has been the cause of any inflammatory or bacteriological trouble. And if any further proof of the harmlessness of this method be needed it might be found in the fact that it is recommended particularly by women doctors who have found it beneficial and harmless in their own experience.—I am, etc.,

London, W.1, Dec. 1. EDWARD ELKAN.

SIR,—Mr. E. Lawton Moss (*Journal*, November 26, p. 1113) designates the insertion of tampons by the woman during the catamenia as a "new menstrual toilet." Actually it has been in use in America for the past few years (see *J. Amer. med. Ass.*, March 12, 1938).

Apart from the bacteriological considerations mentioned by Mr. Lawton Moss, with the possible resultant ascending sepsis, sterility, etc., these tampons act as a mechanical foreign body in the vagina. To insert into the vagina during periods of recurrent increased epithelial proliferation a pack composed of cotton, wadding, or gauze, which swells up and loses its pristine smoothness, is to increase the susceptibility of the vaginal mucosa to the results of mechanical irritation.

I have found in the few cases I have advised that in the majority of the women some blood escapes past the tampon, requiring the added protection of a small vulvar pad within the labia. There are also obvious difficulties in connexion with various classes and types—for example, virgins, multiparae with some degree of prolapse and/or gaping vulva, etc. The method, in its present form, cannot be advocated as a routine.—I am, etc.,

London, S.W.1, Dec. 4. MICHAEL COHEN.

Social Pathology

SIR,—I thank Dr. Hilda Weber (November 26, p. 1115) for that word! . . . "The absence of action against environmental factors which frustrate the basic needs of a community will lead to the decline of individual and therefore of national health" admirably expresses a fundamental truth. It is far-reaching in its meaning. Her palliative for London, though helpful, might be disappointing because it does not go very deep. People who are herded into masses shrink into themselves in self-defence and need altogether more space for leading their own lives. Repression ultimately leads to explosion, while real life remains. I am only writing this, however, to ask that this correspondence should be continued. We are all afraid of these subjects because they easily encroach on politics, but a detached medical or scientific outlook is badly wanted.—I am, etc.,

Letchworth, Nov. 26. NORMAN MACFADYEN.

The Services

Surgeon Commander R. C. May, M.C., has been appointed Assistant to the Medical Director-General of the Royal Navy at the Admiralty.

DEATHS IN THE SERVICES

Lieutenant-Colonel STANLEY EVERARD LEWIS, R.A.M.C. (ret.), died at Shears Green, Gravesend, on November 23, aged 61. He was born on October 8, 1877, and was educated at Glasgow University, where he graduated B.M., Ch.B. in 1902. He entered the R.A.M.C. as lieutenant on August 31, 1903, became lieutenant-colonel on June 1, 1926, and retired on August 31, 1932. After retirement he was employed at Gravesend. He served through the war of 1914–18, and was mentioned in dispatches in the *London Gazette* of October 19, 1914, and January 1, 1916. He was awarded the Legion of Honour (fifth class).

Medico-Legal

A CONFLICT OF DUTIES

CRIMINAL ABORTION AND MEDICAL SECRECY

The question whether a doctor who learns in the course of a professional relationship that a crime has been committed should inform the authorities in breach of his obligation of secrecy is no new one. It arises most often in the case where a woman, dying of septicaemia as the result of a criminal abortion, tells the doctor the name of the abortionist. Most medical men are familiar by now with the classical dictum of Mr. Justice Avory in 1914. Charging the grand jury on a bill against an abortionist, he said:

"I cannot doubt that it is the duty of the medical man to communicate with the police, or with the authorities, in order that steps may be taken for the purpose of assisting in the administration of justice. No one would wish to see disturbed the confidential relation which exists, and which must exist, between the medical man and his patient in order that the medical man may properly discharge his duty towards his patient; but there are cases, of which it appears to me that this was one, where the desire to preserve that confidence must be subordinated to the duty which is cast upon every good citizen to assist in the investigation of a serious crime. . . . It may be the moral duty of the medical man, even in cases where the patient is not dying, or not unlikely to recover, to communicate with the authorities when he sees good reason to believe that a criminal offence has been committed."

In reply to this opinion the Royal College of Physicians of London passed a series of resolutions laying down that a medical practitioner is not justified in disclosing confidential information without the patient's consent; that if he is convinced that a criminal abortion has been practised he should urge the patient to make a statement if to do so would not prejudice her recovery; that if she refuses he is not legally obliged to take any further action; and that if she should die he should refuse to give a certificate and should communicate with the police.

If a patient with religious belief is sincerely convinced that she is about to die, and makes in that belief a statement to any person, that statement may be received in evidence at a trial for her homicide. It need not even be reduced into writing at the time. Needless to say, a practitioner who hears a dying declaration ought to take it down in writing, and if possible have the patient sign it or make her mark. It should if possible be in her actual words, and if questions are put, the questions and answers should both be given. If there is time, the doctor should summon a magistrate, who can take her evidence on oath. If reasonable notice can be given to the accused person to enable him or his legal adviser to be present and cross-examine, her deposition will be admissible if she dies, even though the rules covering the admissibility of a dying declaration have not been satisfied.

A Recent Case

This controversy was revived recently in the Paddington coroner's court.[1] Mr. Ingleby Oddie was inquiring into the death of an unmarried woman who had died of septicaemia after an operation. Dr. Arnold Harbour, who is a divisional police surgeon but was attending the woman privately, said she told him that she had had an illegal operation, and he sent her to hospital. She was dangerously ill and was probably going to die, though an operation might have saved her life. He consulted his solicitors and his defence society on whether he should report to the police what she had said, and his solicitors and the society advised him that it was not his duty to do so. The coroner said that he did not blame Dr. Harbour for his action. He pointed out, however, that if the doctor had taken steps to warn the authorities that the

[1] *Times*, November 8, 1938.

woman had had a felony committed on her and was dangerously ill, a dying statement might have been taken from her in the presence of a magistrate. He recalled Mr. Justice Avory's charge to the grand jury and added that, although the doctor had a moral obligation to preserve the confidence of his patient, in certain circumstances that confidence should be overridden. The position, he said, was by no means satisfactory and ought to be considered by the authorities. He feared that, until something was done, the secrecy which always surrounded these cases would be maintained and many criminal abortionists would go scot-free, as he had no doubt they often did now.

The Doctor's Duty

The views of the British Medical Association have often been expressed, and are quite clearly stated in the *Medical Practitioner's Handbook* (p. 110). They are that the suggestion that a doctor should volunteer information in such circumstances should be strenuously resisted, in the belief that nothing should be done to prevent anyone who is ill from consulting a doctor in the fullest confidence that his secret, even if it be that he has been concerned in the commission of a crime, will not be reported to the authorities.

The question was discussed by the Medico-Legal Society in June, 1927.[2] There Lord Riddell stated that the views of the British Medical Association and the Royal College of Physicians did not meet with universal medical approval, and expressed the opinion that, considering the prevalence of abortion, the leaders of the profession were undertaking a serious responsibility in advising practitioners in such emphatic terms to disregard illegal acts of a most pernicious character. While everyone recognized the necessity and importance of respect for medical confidences, doctors must also recognize that the rules regarding these existed for the welfare of the community and "not for the aggrandisement or convenience of a particular class." These words probably represent a fairly large body of legal opinion. Sir William Willcox considered that if the doctor fails to persuade the patient to make a clean breast of what has happened, then perhaps it is his duty to inform the authorities after taking legal advice.

There is no prospect of any solution to the dispute, and it is hardly to be imagined that an *ad hoc* Bill will be introduced into Parliament.

A STRANGE CAUSE OF DEATH

A householder and his wife were much annoyed by her brother, a youth of 21, who persisted in coming to the house and causing trouble, in spite of warnings. On one occasion the husband fetched a rook rifle and prodded the youth with it to frighten him. The youth tripped over a flower-border and fell against the man. The rifle went off and the bullet lodged in his neck. He was taken to hospital and put on the operating table. The surgeon had located the bullet and was about to remove it when his revolving stool slipped and he fell on the floor. He changed his gown and gloves and returned after about six minutes. The bullet had now altered its position, and he was trying to find it again when the patient's breathing suddenly became shallow and stopped. At the trial of the husband at Denbigh Assizes last month[3] the surgeon said he would not care to express an opinion on the cause of death. Dr. G. Roche Lynch said that if the surgeon had not fallen the bullet would have been taken out much earlier and the patient would have been on the way to recovery; in his opinion the death was due to chloroform poisoning.

Mr. Justice Hilbery, in addressing the jury, said that no degree of provocation excused the killing of a man. A person could use such force as was necessary to bring about ejection and no more, but a lethal weapon was an excessive thing to employ against an unarmed man. Death by chloroform poisoning was a risk attendant upon any operation. The jury would have to ask themselves whether death ensued through an operation advised by medical men, and if their answer was in the affirmative they could not convict of manslaughter. In order to convict of unlawful wounding they must be completely satisfied that the injury had been done unlawfully. They acquitted the accused on both charges.

[2] *British Medical Journal*, 1927, **2**, 17.
[3] *Daily Telegraph*, November 2, 1938.

A DEATH FROM PENTOTHAL

At a recent inquest held by Mr. A. D. Cowburn, the Camberwell coroner,[1] an anaesthetist gave evidence that he had administered pentothal intravenously to the deceased woman at a second operation undertaken a week after labour. It was very quick-acting and gave the minimum amount of shock. A pathologist said that he had found nothing wrong with the operation, and that a proper dosage of the drug had been given. In his opinion death had been caused by the effects of the drug, toxaemia, and the effects of the operation. The coroner, recording a verdict of death by misadventure, said that there had been no neglect, no mishap, and no accident. He did not altogether approve of the drug, but that was a matter for discussion, and for weighing all its advantages and disadvantages.

[1] *Daily Telegraph*, November 12, 1938.

Universities and Colleges

UNIVERSITY OF OXFORD

At a Congregation held on November 29 a gift of £200 a year for two years from Mrs. Hugh Watts in augmentation of the stipend of the assistant director of the Institute of Experimental Psychology was accepted.

UNIVERSITY OF CAMBRIDGE

The Vice-Chancellor has appointed Sir Edward Mellanby, K.C.B., F.R.S., M.D., of Emmanuel College, Secretary of the Medical Research Council, to be Rede Lecturer for the year 1939. The place and subject of the lecture will be announced later.

UNIVERSITY OF LONDON

Dr. H. Letheby Tidy has been elected Dean of St. Thomas's Hospital Medical School in place of the late Professor Leonard S. Dudgeon.

UNIVERSITY OF WALES

WELSH NATIONAL SCHOOL OF MEDICINE

The following candidates for the degrees of M.B., B.Ch. have satisfied the examiners in the examination indicated:

PATHOLOGY AND BACTERIOLOGY.—Mary E. Budding, T. C. H. Davies, T. Griffiths, D. I. Harries, A. B. J. Hill, O. Howell, R. T. Jenkins, G. A. Jones, J. E. Lloyd, Mary E. Lloyd, S. Love, T. Walker.

OBSTETRICS AND GYNAECOLOGY.—C. Davies, W. H. Harris, J. C. Herapath, H. R. Hudd, Margaret Morgan, C. Thomas, W. Williams.

The following candidates have satisfied the examiners:

PHARMACOLOGY.—Doreen M. E. Cranch, Enid Curran, Joan B. Davies, D. F. V. Johnston, Gwenllian M. Lewis, *W. C. D. Lovett, I. Mazin, J. B. Randell, Nest G. Richards, J. H. Stranger, E. R. Treasure, *Glenys J. Wade, G. A. Wright.

* With distinction.

ROYAL COLLEGE OF PHYSICIANS OF EDINBURGH

At the annual meeting of the College, held on December 1, Dr. Alexander Goodall was re-elected President, and the following were elected to form the Council for the ensuing year: Dr. Edwin Bramwell, Dr. John D. Comrie, Dr. Charles McNeil, Dr. A. Fergus Hewat, Dr. D. M. Lyon, and Dr. A. Graham Ritchie. Dr. Comrie was nominated Vice-President.

At an extraordinary meeting held immediately afterwards the honorary fellowship of the College was conferred on Sir Charles Bickerton Blackburn, O.B.E., M.D., Sydney, first President of the Royal Australasian College of Physicians.