

## Local News

### ENGLAND AND WALES

#### Mental Health of Children

The Child Guidance Council reports that of forty-three recognized child guidance clinics in England and Wales, twenty-five are still open. This number represents all clinics except those in London and Southampton, and they as usual undertake the treatment of nervous, difficult, delinquent, and retarded children. Some of these clinics are situated in receiving areas, and so are available for the treatment of the more seriously disturbed evacuees. Addresses of these clinics and particulars of sessions, etc., may be obtained from the Council's new offices at 23, Queen Square, Bath (telephone: Bath 2390). It is hoped that some of the London clinics may reopen shortly. The Tavistock Clinic Children's Department has been removed to Westfield College, Kidderpore Avenue, N.W.3, and is open, but unable at present to receive non-paying patients. The West End Hospital for Nervous Diseases children's department is closed, but juvenile cases can be seen in the general psychotherapy department. It is hoped that the clinics attached to St. Thomas's Hospital and the Queen's Hospital may reopen shortly. Urgent cases can be seen at the child guidance unit at Great Ormond Street Hospital for Sick Children. The Maudsley Hospital is closed and removed to Mill Hill Emergency Hospital, but work for children is being carried out at the following London County Council "North" London Clinics: St. Mary's Hospital, Highgate; St. Charles's Hospital, Ladbroke Grove; Mile End Hospital, Bancroft Road, E.1. Cases can be seen at these hospitals by appointment only.

#### Arrangements under Cancer Act

The Minister of Health, in a circular (No. 1884) to county and county borough councils, states that he has decided to extend until March 31, 1941, the period in which they have to submit their arrangements under the Cancer Act, 1939, for his approval. The Act provides that the arrangements must be submitted within one year from its commencement—that is, by March 29, 1940—or such longer period as the Minister may in any case allow. The Minister states that he realizes that by reason of the heavy pressure of extra work in recent months it has not been possible for local authorities generally to give such attention to the matter as would enable them to submit their arrangements within the statutory period, and he has therefore granted a general extension of just over twelve months.

#### The National Central Library in Time of War

In times of peace the British Isles has, in addition to a splendid public library service, a system of library co-operation (in which the British Medical Association takes part) whereby all persons requiring books for any serious purpose are able to obtain them through their local public, university, or other library. The country is divided into a series of regional library systems, each system covering a group of neighbouring counties, and each having a regional bureau at which a union catalogue of the non-fiction books in nearly all the libraries in the area has been, or is being, compiled. The keystone of the national system is the National Central Library, which, in addition to being itself a great lending library, is the national centre for the inter-lending of books between one library and another. The system has become so efficient that practically any kind of serious literature can now be obtained on loan. The service is available to every branch of the community, from persons requiring information on the humblest everyday matters to research workers needing highly specialized and technical literature. In time of war the national library service will not only continue to be of the utmost importance to those who need books for general purposes, but it will also be of greatly increased value to

Government Departments, organizations, and persons needing special literature in connexion with work of national importance. The National Central Library will naturally give priority to the latter service, as it is recognized that in tracing material for persons doing research on all forms of armaments, chemicals, foodstuffs, medicine, and so on, the Library will be filling a gap the existence of which was so serious a drawback during the last war. The organization of the National Central Library, with its great union catalogues and other unique bibliographical material, and the access it has to over twenty-one million books in other libraries in the British Isles, places it in an exceptional position to give service in time of war. Owing to the risk of the destruction of property at the headquarters of the National Central Library in London, all the union catalogues, as well as all other irreplaceable or scarce bibliographical material, have been removed to Bourne Lodge, Bourne End, Hemel Hempstead, Herts. The non-bibliographical books are remaining at the London headquarters in Malet Place, W.C.1.

## Correspondence

#### Doctor and Patient in War Time

SIR,—As a surgeon my only reason for taking part in this correspondence is that the neuroses in war time are less likely to be solely the concern of the physician than they often are in times of peace. The war casualty is in fact more likely to have wounds of the spirit in addition to those of the flesh than is his peace-time counterpart. Should war actually involve the civilian population of this country then this combination of injuries will certainly increase rapidly. Already war neuroses can be detected in patients attending surgical (and other) out-patient departments. Some of the arguments put forward by Dr. Geoffrey Evans in his letter in the *Journal* of October 7 (p. 742) strike me as being so fallacious as to call for comment, and also by implication to imperil the fundamental relationship between patient and doctor. Under war conditions a free choice of doctor is no longer possible, either in the Emergency Medical Service or in the Services, and this fact is an additional argument for maintaining an important relationship unimpaired.

Dr. Geoffrey Evans says in connexion with the doctor's attitude to his patients that "we must sedulously refuse every thought of fear, regret, resentment, and the like, because these thoughts arouse emotions that have a weakening effect." Is this thorough-going self-purgation possible, biological, or wise? Reason may overcome fear, etc., but I doubt if this complete suppression of emotions can be carried out without our becoming medical automata towards our patients. Slogans have a habit of coming home to roost. On all sides we are told, "Your courage, Your cheerfulness, Your resolution, will bring us victory." This may be true, but it leaves unanswered the question whether the victory is to be of force, of reason, or of the spirit. At the present time I am (with hundreds of my colleagues) haunted by the fear of my inability to pay my rent, rates, taxes, etc.; I am filled with regret at many of the actions of the Ministry of Health; and I burn with resentment at the treatment meted out to some of my friends in the present emergency, treatment which would hardly be justified even under a dictatorship. But I do not as yet feel weakened by the emotions which have been aroused, and as far as I am aware neither my relationship to my patients, nor my patients themselves, nor my surgical ability, has been adversely affected. Whether I can control these emotions for the three years envisaged by the Government remains to be seen.

I cannot believe either that it is necessary or advisable to purge ourselves so thoroughly in order to help war-worn patients. The best that we give our patients is usually given unconsciously, and I doubt if we shall improve matters by a course of auto-suggestion. I know I shall not be a good doctor unless I can keep a credit balance from which to

within the class of individuals covered by the Act. That judge, said his lordship, would never have referred to that admission unless he had thought it was right. In those cases, therefore, the law had been regarded as settled, and he could not now rule differently unless he thought they were wrong. In fact, he thought they were right, and that as the doctors were acting in pursuance of a duty laid on the Council they were entitled to the benefit of the Act.

### INSANITY AND CIVIL RESPONSIBILITY

Insanity as a defence to a criminal charge—usually murder—is familiar. By the "MacNaghten rule" a man is responsible for his actions unless by reason of disease of the mind he did not know what he was doing or that what he was doing was wrong. It has recently been held in the Divorce Court<sup>1</sup> that intention is a necessary ingredient of the matrimonial offences of cruelty or desertion, and that if the respondent, by reason of insanity, is incapable of forming the intention to be cruel or of retaining the intention to desert, the petition on those grounds must fail.

The degree of insanity which will afford a sufficient answer to a civil action of negligence has been discussed interestingly in a county court case by his honour Judge Konstam, K.C.<sup>2</sup> A cab driver suddenly swerved from his proper side and ran into a lorry. He immediately got out and stabbed himself several times with a carving knife. He said he had swerved to avoid a cyclist, and the medical evidence showed that no cyclist had been there and that the man suffered from hallucinations and delusions. The judge was satisfied that the swerve was due to the sudden impulse of an unbalanced mind, but found that the driver understood the nature and consequences of his act. He remarked that the question was not covered by any direct or binding authority. Lord Esher, in *Hanbury v. Hanbury* (1892), treated the test of responsibility as the same in criminal and in civil actions, but no question of negligence arose in that case. His honour quoted textbook writers who said that the question for the jury was whether the defendant was sufficiently self-possessed to be capable of taking care, and that the lunacy must be so extreme as to deprive its victim of all power of deliberate choice. Sudden illness, other than mental, which deprives its victim of the power of using skill and care is a good defence. The learned judge therefore concluded that there exists in law a sound distinction between negligence and other grounds of action. As this driver was not sufficiently self-possessed to be capable of taking care, and the swerve was not the conscious act of his volition, neither he nor his employers could be held responsible.

This judgment is not a binding authority, but seems to rest on solid foundations and to point to the tests which the High Court would probably apply in a similar case.

<sup>1</sup> *British Medical Journal*, September 9, p. 590.

<sup>2</sup> *United Koshier Poulterers Ltd. v. Prouse*. 1939: 6 *Law J.*, C.C.R. 241.

**Experimental Pulmonary Embolism.**—Intravenous injection of air, fat, or a starch suspension in rabbits caused changes in the electrocardiogram similar to those found in infarct of the heart muscle, and also changes typical of a right bundle-branch block (old nomenclature). In the majority of experiments the electrocardiogram returned to normal after recovery from the embolism, although widespread necroses were present in the wall of the right ventricle. These changes seem to be due to the sudden overloading of the right ventricle.—*Electrocardiographic and Histological Examination of Heart in Experimental Pulmonary Embolism produced by Air, Fat, or by Starch Suspension*. R. Walder.—*Beitr. path. Anat.* May 26, 1939, 102, 485.

## The Services

### HEALTH OF THE ARMY IN PEACE

The report on the health of the Army for 1937<sup>1</sup> is the seventy-third such volume, which means that the first appeared in the 'sixties, when the sanitary reforms brought about by the Sidney Herbert Commission were beginning to have their effect. The present report gives us a picture of an Army healthier than it has ever been during that three-quarters of a century history. The same causes affect the health of the military and of the civil population, but conditions of selection and discipline in the Army favour a still higher standard, while, on the other hand, the soldier, particularly at foreign stations, faces certain liabilities which make him a more likely prey to disease. Of both soldier and civilian the paradox holds good that at a moment when their protection from disease was most assured, their liability to wounds, injuries, and violent death was never greater. The onslaught of disease has been stayed, but this other Moloch, whose blind strokes no medical wisdom can avert, gets a new momentum.

#### Hospital Admissions

The rate of admissions to hospital in 1937 decreased by 14.1 per 1,000 of strength as compared with the previous year, and was only 21.5 per 1,000 higher than the rate for 1935, which was the lowest recorded since the great war; while the death ratio of 1.97 per 1,000 and the ratio of 6.8 for invalids discharged from the Service were absolutely the lowest. The principal causes of admission to hospitals were influenza, inflammation of areolar tissue (chiefly boils and carbuncles), inflammation of tonsils, and venereal diseases. Influenza shows a considerable increase over the previous year. It heads the list of causes of admission in all the home commands except the Western, where inflammation of tonsils has that pre-eminence. The principal cause of invalidity leading to discharge from the Army was tuberculosis. It is worth noting in passing that the Royal Army Medical Corps had almost the highest incidence of pulmonary tuberculosis to be found in any unit.

The effect of common ailments on military efficiency varies according to the station. In the home commands local injuries account for the greatest number of lost days. By far the most common of these were fractures of the tibia and/or fibula and the radius and/or ulna, followed by the carpus or metacarpus. In India the commonest cause was malaria, although the rate for malaria was down on the year, and indeed was the lowest yet recorded. The reasons assigned for this satisfactory result are less rainfall, earlier onset of cold weather, more intensive applications of anti-malarial measures, and greater co-operation between civil and military health administrations. The treatment of malaria in India is carried out sometimes with quinine and plasmoquine, but usually with atebirin followed by plasmoquine. It is pointed out that the investigations under the auspices of the Malaria Commission of the League of Nations Health Organization have confirmed in every respect the careful initial work undertaken in the military hospitals in India on the use of synthetic drugs.

#### Value of New Drugs

An extensive trial has been made at nearly all the Army stations of drugs of the sulphonamide group, and it is stated that these drugs have effected the saving of life by overcoming infections by the streptococcus—not necessarily haemolytic—notably severe attacks of erysipelas and septicaemia, and that less severe disorders, such as pyelitis, cystitis, and other genito-urinary infections are rapidly cleared up by this form of treatment. Some forms of streptococcal tonsillitis have been found to get well quickly, while others appeared to resist the action of the drugs. Staphylococcal infections are

<sup>1</sup> H.M. Stationery Office. (2s. 6d. net., postage extra.)

not usually influenced, but one instance is recorded where staphylococcal septicaemia was rapidly brought under control. The reports from Army stations have encouraged the belief that this group of drugs will also reduce the mortality of cerebrospinal fever.

As to venereal diseases, it is mentioned that the polyvalent vaccine of mixed gonococcal and secondary organisms was tried in several areas with some measure of success, but this again has been abandoned in favour of sulphanilamide, which has been used in the treatment of gonorrhoea at home and abroad with apparently satisfactory results. The evidence available, says the report, indicates that it is a great advance on any treatment hitherto adopted. The dermatological specialist at Aldershot states that the whole atmosphere of the gonorrhoea wards has altered with the introduction of this new remedy. The patients, instead of being dull and troublesome, are now cheerful and anxious to get on with their treatment.

An interesting report is forthcoming from the vaccine department of the Royal Army Medical College, which supplies vaccines for the use of both the Army and the Royal Air Force. Increased demands were made in 1937 for all types of vaccines except the mixed influenza and catarrh vaccine, which is no longer recommended as a routine prophylactic. Over 99 per cent. of the troops and their families who embarked for service over-seas availed themselves of typhoid-paratyphoid inoculation. Diphtheria in 1937 showed a remarkable decrease among the Army population; this is credited to the immunization of the Army children, 95 per cent. of whom are now immunized with toxoid-antitoxin floccules. In another part of the report a great deal of useful information is included on the pathological work in the military laboratories in India.

#### Medical Examination of Recruits

It will be remembered that in 1936 the War Office decided that an attempt should be made to recondition applicants for enlistment who were below the standards for weight and chest measurement. Hitherto these men had been rejected outright. A course of special training for under-developed lads and border-line recruits suffering from various defects was instituted, and of those who completed this course in 1937, 90.5 per cent. were subsequently passed as fit. The after-history of these squads has been studied, and has shown that about one-third of them continued to make steady progress, and in most of the others there was intermittent progress. The average height and weight of all recruits enlisted in the home commands, other than the Southern Command, was 66.5 in. and 130.63 lb. respectively, but in the Southern Command a system has been instituted whereby heights and weights are recorded in age groups, and the other commands are now to adopt the same system. The average increase of weight among recruits under training during the year was 9.17 lb. This figure shows a fairly steady increase year by year. The chief cause of rejection is disease of the middle ear, including deafness. This cause accounts for more than twice as many rejections as either of the next two principal causes—namely, loss or decay of many teeth and defective vision.

In the light of the events of 1939 the year 1937 must be described as a year of peace, yet various operations were taking place in different parts of the world and were causing concern to those who had in charge the health of the British Army. The war in Spain, for example, caused Gibraltar to be overcrowded with refugees. In Palestine a number of troops were kept in conditions of field service, but the general health was good, and, although parts of Palestine are malarious, the malaria was well controlled. In India active operations were in progress in Waziristan, in which British and Indian troops were engaged, but here again health was very good, and sick rates were only slightly in excess of those obtaining in times of peace. For the first time evacuation of casualties was carried out by air from Waziristan, which is on the North-West Frontier. The number evacuated by air was just over 100, and the time as compared with road and rail was shortened by about five-sixths. Finally, in the Far East there was not only a major war but a cholera epidemic.

Conditions were at their worst in Shanghai, with an appalling lack of sanitation, but the British troops were apparently almost immune. Only at Shanghai did any cases of cholera occur among military personnel; these numbered only five, and were considered to be due to neglect of orders and consumption of ice-cream from an unauthorized source. The outbreak of cholera among the civil population led to a much larger quantity of cholera vaccine than usual being supplied from the Royal Army Medical College. A strain of *Vibrio cholerae* obtained from Shanghai was incorporated in the vaccine.

Attention is being paid in every command to the hygiene of Army barracks. It is mentioned that at Gibraltar the polishing of the barrack floors is thought to have contributed to a decrease in the respiratory group of diseases—coughs, colds, and sore throats—which fell from 171 to 111 per 1,000 of strength. Married quarters are being improved, maternity and child welfare centres for soldiers' families are multiplying, and the report touches on many matters which favourably affect the comfort and well-being of the soldier and those dependent on him. More than half this volume is taken up with separate reports from the eight commands at home and the thirteen countries abroad in which the British Army is stationed.

#### MENTIONS IN DISPATCHES

##### OPERATIONS IN WAZIRISTAN

The King has approved the promotion of Major M. P. Power, O.B.E., M.C., R.A.M.C., to be Brevet Lieutenant-Colonel for distinguished services rendered in the field in connexion with the operations in Waziristan.

The names of Lieutenant-Colonel J. R. N. Warburton, M.C., R.A.M.C., Major M. P. Power, O.B.E., M.C., R.A.M.C., Captain W. M. Stewart, R.A.M.C., Lieutenant-Colonel R. A. Logan, I.M.S., and Assistant Surgeon (Second Class) R. J. A. Ronto, I.M.S., have been brought to notice by the Commander-in-Chief in India for distinguished services rendered in connexion with the operations in Waziristan.

##### OPERATIONS IN PALESTINE

The names of Colonel A. Hood, C.B.E., R.A.M.C., Major J. W. Malcolm, O.B.E., M.C., R.A.M.C., Captain K. G. F. Mackenzie, R.A.M.C., and Flight Lieutenant L. M. Crooks, R.A.F.M.S., have been brought to notice in recognition of distinguished services rendered in connexion with recent operations in Palestine.

#### CASUALTIES IN THE MEDICAL SERVICES

##### ROYAL NAVY

Probationary Surgeon Lieutenant HERBERT JULIAN CORNELIUS, R.N.V.R., who lost his life when H.M.S. *Royal Oak* was sunk by a submarine in Scapa Flow on October 14, took the M.R.C.S., L.R.C.P. as recently as January, and the M.B., B.S. of the University of London in June. He was elected a member of the British Medical Association on June 6.

#### DEATHS IN THE SERVICES

Surgeon Rear-Admiral Sir PATRICK BRODIE HANDYSIDE, K.B.E., C.B., R.N. (ret.), died at Gullane on October 15, aged 79. He was born in March, 1860, and was educated at Edinburgh Academy and the University of Edinburgh, where he graduated M.B., C.M. in 1883. Entering the Royal Navy as assistant surgeon in 1884, he became fleet surgeon in 1903 and surgeon rear-admiral on April 17, 1917. He was made C.B. in 1918 and K.B.E. in 1919. In 1918 he also received the Japanese Order of the Sacred Treasure (Second Class). As surgeon of H.M.S. *Fox* he served in the campaign of 1898 in Sierra Leone, landed with a force which took Manah Salya and Kwalin and rescued a party of eighty refugees, receiving the West African medal, with clasp for Sierra Leone. He married Lilly Chester, daughter of Lieutenant-Colonel H. M. Blenkinsop, late I.M.S. He had been a member of the British Medical Association for forty-three years, and at the Annual Meeting of the Association held at Brighton in 1913 he was vice-president of the Navy, Army, and Ambulance Section.

Major-General WILLIAM CHARLES HUGHAN FORSTER, C.I.E., I.M.S. (ret.), died suddenly at Northlew, Devon, on October 11, aged 65. He was born on June 15, 1874, and was educated at

Edinburgh University, where he graduated M.B., C.M., with honours, in 1896, subsequently taking the D.P.H. at Cambridge in 1899. After filling the posts of house-surgeon for out-patients at Edinburgh Royal Infirmary and assistant resident medical officer at the National Hospital for Consumption, Ventnor, he entered the Indian Medical Service as lieutenant on July 27, 1899, attaining the rank of colonel on November 27, 1927, and of major-general on November 5, 1929. He retired on July 19, 1933. After four years of military duty he entered civil employ in April, 1904, as deputy sanitary commissioner in the Punjab. In April, 1909, he was appointed professor of hygiene and pathology in the Lahore Medical College and in August, 1918, became sanitary commissioner of the Punjab, the title of his office being changed to director of public health in November, 1921. On promotion to the administrative grade in 1927 he was posted to the inspector-generalship of civil hospitals in Burma, and in November, 1929, he was promoted to surgeon-general of Bombay, with the rank of major-general. In 1932-3 he was a member of the Bombay Legislative Council. He served on the North-West Frontier of India in the Waziristan campaign of 1901-2, receiving the frontier medal with a clasp. He was the author of several articles in *Scientific Memoirs*.

Lieutenant-Colonel THOMAS BIGGAM, R.A.M.C. (ret.), was born on January 15, 1874, and was educated at the University of Edinburgh, where he graduated M.B., Ch.B. in 1897. He entered the R.A.M.C. as lieutenant on April 25, 1900, became lieutenant-colonel on December 26, 1917, and retired on April 30, 1920. He served in the South African War, when he took part in operations in Cape Colony in 1900, and in the China War of 1900, receiving the medal.

Lieutenant-Colonel GILBERT HENRY DIVE, D.S.O., R.A.M.C. (ret.), was born in New Zealand on May 29, 1882, and was educated at Wanganui College, the University of Otago, and St. Bartholomew's Hospital. He took the M.R.C.S., L.R.C.P. in 1906, the M.R.C.P. in 1910, the D.P.H. Oxford in 1911, and the D.T.M. and H. of the English Colleges in 1925. He was house-physician at the West London Hospital in 1907 and house-surgeon at St. Bartholomew's Hospital in 1908-9. He entered the R.A.M.C. as lieutenant on July 31, 1909, and was clinical assistant to the professor of tropical medicine at the Military Hospital, Millbank, from 1910-12. He was a member of the British Expeditionary Force at Tsingtau in 1914, when he was mentioned in dispatches. He received a brevet majority on January 1, 1918, became major on July 31, 1921, and retired on May 29, 1937, shortly after his promotion to lieutenant-colonel. He served in Belgium and France in the war of 1914-18, when he was mentioned four times in dispatches. He received the D.S.O., the Médaille d'Honneur des Epidémies, and the Croix de Guerre. He had been a member of the British Medical Association since 1926.

## Universities and Colleges

### UNIVERSITY OF OXFORD

Sir Charles Sherrington, O.M., G.B.E., M.D., F.R.S., formerly Waynflete Professor of Physiology in the University, has been elected to an honorary Fellowship at Magdalen College.

### UNIVERSITY OF CAMBRIDGE

The outgoing Vice-Chancellor, Professor H. R. Dean, M.D., F.R.C.P., Master of Trinity Hall, has been elected to the Council of the Senate.

At a congregation on October 21 the following medical degrees were conferred:

M.B., B.CHIR.—\*N. Langdon-Down, \*G. Oppenheimer, \*D. L. Ridout, \*A. M. Ogilvie, \*G. S. Robinson, \*A. Hargreaves, J. D. Younghusband, N. J. P. Hewlings, J. C. R. Nuttall-Smith, J. B. Murray, B. W. Powell, J. W. Shackle.

M.B.—\*J. G. Warren, \*L. J. Haydon.

\* By proxy.

### UNIVERSITY OF LONDON

#### LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE

The following candidates have been approved at the examination indicated:

ACADEMIC POSTGRADUATE DIPLOMA IN PUBLIC HEALTH.—Eva M. Cran, M. Daniels, Christina A. Gunn, S. M. H. Naqvi, G. H. Shaw, C. S. Thomson, N. V. Williams.

### UNIVERSITY OF DURHAM

The following candidates have satisfied the examiners at the examination indicated:

FINAL M.B., B.S.—J. K. Adamson, M. Anderson, D. O. Bowes, Sheila D. M. Brown, W. E. Chapman, Margaret I. Dufty, F. N. C. Evans, R. J. Gray, J. D. S. Hethcote, S. Hickling, K. J. Higham, A. F. Hutchison, J. W. G. McDougall, E. A. Milner, R. H. Richardson, T. J. W. Robson, J. P. Simpson, T. D. Todd.

### UNIVERSITY OF WALES

The following candidates have satisfied the examiners at the examination indicated:

DIPLOMA IN PUBLIC HEALTH.—Part II: H. L. Ackerman, D. J. Davies, S. H. Graham, C. T. Jones, J. J. O'Reilly, J. Paterson, H. R. Stubbins, \*A. J. Thomas.

#### WELSH NATIONAL SCHOOL OF MEDICINE

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

HYGIENE.—Mary E. Budding, Doreen M. E. Cranch, Enid Curran, \*Joan B. Davies, T. C. H. Davies, I. L. R. Evans, D. I. Harries, Marguerite J. Hennelly, Helen C. Hodges, \*D. D. Howell, O. Howell, D. H. Jenkins, R. T. Jenkins, G. A. Jones, J. V. Jones, Anne N. M. Llewellyn, J. E. Lloyd, Mary E. Lloyd, S. Love, Brenda M. Mead, D. G. Morris, R. E. Packer, Mary G. Powell, H. V. Roberts, D. C. Taylor, C. E. Thomas, T. Walker.

\* With distinction.

### ROYAL COLLEGE OF SURGEONS OF ENGLAND

A quarterly meeting of the Council of the Royal College of Surgeons of England was held on October 12, with the President, Mr. Hugh Lett, in the chair.

Mr. R. St. Leger Brockman was re-elected a member of the Court of Examiners for a further period of five years.

Mr. H. F. Humphreys was re-elected a member of the Board of Examiners in Dental Surgery for a further period of five years.

It was decided to cancel the arrangements for holding the forthcoming primary examinations for the Fellowship in India, Egypt, and Australasia.

It was not found necessary to make any change in the regulations for the Primary or Final Fellowship examinations during the war.

It will be possible to conduct the Fellowship and dental examinations in London in the normal way on the next occasion.

The following arrangements have been made regarding Lectures: Arnott and Erasmus Wilson demonstrations, the autumn series has been cancelled; Hunterian Lectures, the lecturers will be asked to deliver their lectures if able to do so, if unable, they may publish the lecture and use the title "Hunterian Professor"; Moynihan Lecture, to be given by Professor Ernest W. Hey Groves in March, 1940; Thomas Vicary Lecture, to be given by Sir Walter Langdon-Brown as arranged on November 30, but at 3 p.m.; Bradshaw Lecture, to be given by Sir James Walton as arranged on December 14, but at 3.30 p.m.

#### The Licence in Dental Surgery

Until further notice the following relaxation in the regulations for admission to the examinations for the L.D.S., R.C.S., will be effective:

1. The two-years instruction in dental mechanics is reduced to eighteen months, of which not less than twelve months must be taken at a required dental school.

2. Instruction in dental mechanics is recognized from the date of passing in two of the three subjects of the pre-medical examination (chemistry, physics, biology), but the pre-medical examination must be completed before admission to the first examination.

3. The instruction in anatomy and physiology, including special anatomy and physiology, may be signed for thirty weeks, which may be consecutive.

4. Where arrangements are impracticable for the ordinary two years' clinical work in dental surgery, during the first of which general medicine, surgery, and pathology are taken, a six-months course of instruction in general medicine, surgery, and pathology, followed by eighteen months of clinical work in dental surgery, will be accepted.

5. It will be seen that these relaxations reduce the total curriculum to three and a half years from the date of passing in two subjects of the pre-medical examinations, the six months being taken off the instruction in dental mechanics.

6. In the examinations, candidates will not be expected to work in gold, but in base metal only.

The Museum is closed but the Library will remain open until further notice. The Buckston Browne Dinner will not be held this year. The annual meeting of Fellows and Members will be held on November 16, at 3 p.m., and not 4 p.m. as previously arranged.

Diplomas of Fellowship were granted to Eric Samuel and Robert Clarence Laird.

Diplomas of Membership were granted to Phiroz Burjor Banaji, Robert Douglas Neil Bisset, John David Dudley Boswell, John Cuthbert Herapath, Henry Edwin Hobbs, Frederick Grafton Lougee, Simon Meleck, Puzhankara Ananakumara Menon, Frank Bradbury Norrish, John Ffrangcon Roberts, Allan Robert Frederick Thompson, Michael Milnes Walker, John Fisher Williams.

#### ROYAL COLLEGE OF SURGEONS OF EDINBURGH

At a meeting of the Royal College of Surgeons of Edinburgh held on October 17, with Mr. W. J. Stuart, President, in the chair, the following, having passed the requisite examinations, were admitted Fellows:

H. Ahmed, D. I. Adler, Y. N. Ajinkya, G. M. Arnott, H. A. Bali, S. P. Barnett, D. Barton, J. E. M. Cairncross, C. F. Chapple, H. M. Coleman, W. M. Couper, J. F. Curr, G. H. Darke, G. S. Dhillon, N. N. Dravid, A. S. Duncan, J. T. Farr, H. L. Fuller, F. W. Grauer, J. H. Hofmeyr, I. Karro, J. A. Kersley, A. A. Khan, G. D. Killawala, J. A. Kilpatrick, D. H. Lees, A. Lutton, J. Macaskill, J. K. McCollum, W. McKechnie, C. M. Marsden, G. D. Matthew, R. Mundy, D. F. O'Brien, A. Orlek, J. H. Pierre, D. A. Reid, J. W. Rennie, R. Roaf, H. G. Roberts, Juliet M. De Sa, J. A. L. Scott, G. C. Sen, F. D. Smith, E. Somasekhar, A. Trottier, F. R. Tucker, J. R. A. White, L. J. Wigston, J. D. Wilson.

At the annual meeting of the Royal College of Surgeons of Edinburgh, held on October 18, the following officers were elected for the ensuing year:

*President*, Dr. H. M. Traquair. *Vice-President*, Mr. W. J. Stuart. *Secretary and Treasurer and Conservator of Museum*, Mr. J. W. Struthers. *Representative on the General Medical Council*, Mr. Alex. Miles. *Convener of Museum Committee*, Mr. W. Quarry Wood. *Librarian*, Mr. J. J. M. Shaw.

## EPIDEMIOLOGICAL NOTES

### Infectious Diseases for the Week

The customary seasonal increase in the incidence of scarlet fever, diphtheria, and pneumonia (primary and influenzal) in England and Wales during the autumn has been observed during the week, but the numbers notified are well below the level of the corresponding week in 1938. The effect of the abnormal distribution of an appreciable proportion of susceptible subjects would appear on the whole to be a favourable one from the epidemiological standpoint, although it is too early to ascribe the lowered incidence solely to this factor. In Eire and Northern Ireland, where there has been no such movement of children, diphtheria has remained below and scarlet fever in excess of the figures recorded last year. To a lesser degree the same holds true for Scotland. The effect of the evacuation of large numbers of children in England is exemplified by comparison of the number of notifications of scarlet fever, diphtheria, and pneumonia in the four largest cities during the present week and the corresponding week last year, the figures for which are given in parentheses:

	Scarlet Fever	Diphtheria	Pneumonia
London ..	32 (180)	25 (125)	24 (47)
Manchester	12 (33)	12 (17)	3 (20)
Birmingham	18 (31)	22 (36)	11 (27)
Liverpool	23 (35)	29 (16)	9 (15)

It is seen that while the decreases for these diseases in England and Wales vary from some 10 to 25 per cent., notifications in these cities have fallen in some instances to a fraction of their value last year—for example, scarlet fever in London fell to one-sixth. The pneumonia figures are naturally less affected as adults are attacked more frequently than children; the observed reduction in the incidence of pneumonia may be due in part to climatic factors, to which, to some extent, may be attributed the general fall in scarlet fever and diphtheria. Dysentery is also below last year's level, although it has increased somewhat recently, the notifica-

tions for the last three weeks being 22, 23, 37. Notifications were received from twelve counties, and only one town or district in each county was affected. More than 3 notifications were recorded in Orpington (Kent) 9, Warrington (Lancaster) 6, Amersham (Bucks) 4, Colchester (Essex), Devizes (Wilts), and Bristol (Gloucester) 3 each.

### Acute Poliomyelitis

The distractions of war have perhaps in part diverted attention from the fact that poliomyelitis has reappeared in the form of outbreaks, although the weekly notifications for the whole country have at no period reached the 1938 level. In the last four weeks notifications for England and Wales were 29, 38, 43, 42 (present week), compared with 76, 60, 56, 65, in the corresponding weeks of last year. The sporadic and widely distributed character of the disease is illustrated by the fact that twenty counties are at present affected, giving a weekly average of 2 per county. Essex, which was severely hit last year, has practically escaped, while the adjacent county of Kent, across the River Thames, has produced the largest number of cases so far, urban and rural areas being equally involved. Counties reporting more than two cases were Kent 9 (Herne Bay 2, Dover urban, Dover rural, Gillingham, Maidstone urban, Maidstone rural, Whitstable, Queenborough, 1 each); Lancaster 5 (St. Helens 2, Blackburn, Bolton, Littleborough, 1 each); Middlesex 5 (Willesden 2, Harrow 1, Ruislip and Northwood 1, Yiewsley and West Drayton 1); Warwick 3 (Birmingham, Rugby urban, and Coventry, 1 each).

### Dysentery in Europe

Notification of dysentery is in force in all European countries with the exception of Portugal and Albania, but the accuracy of the data varies greatly in different countries and even in different areas of the same country, according to the facilities for diagnosis and collection of records. The distinction made in notification between the bacillary and amoebic forms of the disease is only enforced in Holland, Italy, Rumania, and Turkey. The Balkans are chiefly affected, and generally speaking the bacillary form is predominant. As in respect of enteric infections generally, dysentery has its maximum prevalence in the late summer and autumn months. In 1938 the maximum was reached in August and September in Germany and Hungary, in August in Rumania, Czechoslovakia, and Yugoslavia, and in October in Poland. In Germany the yearly numbers reported have varied from 2,525 with 122 deaths in 1933, to 7,545 with 181 deaths in 1937, while in 1938 there were 5,255 cases and 161 deaths. The character of the disease has apparently become less virulent, although in some other countries the reverse has been observed. In Hungary, for instance, the disease has become both more prevalent and more fatal; there were 1,385 cases with 260 deaths in 1933, and 6,441 cases with 717 deaths in 1938. The situation has been even worse in Poland and Rumania, in which countries there were 6,398 cases with 703 deaths and 6,459 cases with 1,182 deaths, respectively, in 1938. In Czechoslovakia and Yugoslavia there have been considerable fluctuations in the last few years; in the former notification fell from 3,059 cases (334 deaths) in 1937 to 639 cases (67 deaths) in 1938; in Yugoslavia the corresponding figures were 2,358 (148 deaths) and 1,278 (104 deaths).

*Blood Alcohol.*—In a comprehensive paper McGrath describes fully the method of estimation of blood alcohol, the various factors which may influence the concentration of alcohol in the blood, and the medico-legal aspects of the test. The test does not supply an automatic answer to the question "Was the individual drunk?" but may indicate, almost with certainty, that a person was sober at the time of taking the blood sample.—Method and Significance of Blood Alcohol Estimations. J. McGrath.—*Irish J. med. Sci.* July, 1939, 6, 304.