Nova et Vetera

A SWEDISH HOSPITAL A HUNDRED YEARS AGO

In *Svenska Läkartidningen* for January 5, 1940, Dr. J. Adams-Ray has published an account of his studies of the records of the Växjö Hospital, which 100 years ago contained fifty beds and was under the administration of a committee responsible for the administration of public funds. The records reveal a level of sanitation at which promiscuous spitting on the floor was already frowned at: witness the purchase in 1839 of two dozen wooden spittoons. In 1835 the medical superintendent asked the committee to grant funds for the provision of hospital clothing for the patients in the place of their own clothing, which "besides being injurious to health, offensive to the sight, dirty, tattered, and infested with vermin, facilitates the unlawful departure from the hospital and the smuggling into it of spirits and unsuitable articles of food. For not infrequently the patients have run away, and have later been found in some tavern, overcome by strong drinks." For some months the committee boggled at this expenditure, but at last consent was given to the desired reform, and the patients blossomed out in a hospital uniform distinguished by blue facings. The caretaker, Holmquist, was everything and did everything. As hospital contractor he was responsible for the commissariat, providing the patients with a dietary on whose quality the committee had occasion to comment in 1838. Holmquist's administrative duties included the emptying of dustbins, accompanying the doctor on his rounds, helping him at operations, changing dressings, and preparing and dispensing medicines.

Range of Services

The recovery rate in this hospital was remarkably high; of the 377 patients treated in 1838 only eleven died in it. As many as 101 of these patients were treated for syphilis, whereas there appear to have been only a couple of acute abdominal cases in this year—hence, perhaps, the low mortality. According to a decision taken by the committee in 1835, only ten of the beds were to be reserved for non-venereal cases, and there were to be only two beds for accidents. Many of the syphilitics had acquired their disease innocently enough; the records show that the doctors were careful to distinguish between syphilis contracted as a venereal disease and syphilis contracted by other means than sexual intercourse. The treatment for syphilis consisted of either a course of mercury or a dietetic regime whose severity is more than hinted at in the record of the girl Nilsdotter, who "began with the dietetic cure but could not stand it for more than fourteen days."

In 1838 the operations numbered nineteen. The three patients operated on for hare-lip were all discharged cured. Yet one of them was a boy of 14 with a double hare-lip, "the middle portion being retained." An 11-year-old girl was operated on for "hydrorachitis"—a collection of fluid over the os sacrum, found at operation to be cloven. She died three days later, screaming with pain. The only abdominal operation was a "laparocentes" for ascites. Another abdominal case, ending fatally, was that of a 50-year-old crofter for whose intestinal obstruction an enema, a bath, castor oil, and calomel were prescribed. Operative treatment was so little in favour that collections of pus seem never to have been incised; poultices or medicines were also dispensed with, bandages alone being considered sufficient. The patients had to bring their own bandages and dressings—"one skälpund old, fine linen"—as well as two clean shirts. With two exceptions bandaging was the only treatment for fractures. Leeches were prescribed for sprains, as well as "fomentum frigidum."

No Feasting on Holy Days

The medical superintendent in 1840 suggested to his committee that on holy days the patients should be given special cheer in conformity with the customs of certain other hospitals in the land. The committee regretted that funds did not permit of the proposed change in the hospital dietary. Commenting on the thrifty attitude of the committee in this matter, Dr. Adams-Ray remarks that the finances of the hospital were at times embarrassed by the loans made out of its funds to the members of the hospital committee. If they could not refund what they had borrowed, they could at any rate nip in the bud extravagant schemes for feasting the patients on holy days.

MEDICAL WAR RELIEF FUND

A committee representative of the British Medical Association, the Royal Colleges, and the Royal Medical Benevolent Fund has decided to establish a special fund for the assistance of members of the profession who find themselves in financial straits as a direct result of war conditions. Already many generous subscriptions have been promised by individual practitioners and Panel Committees. The legal formalities connected with the registration of the fund are nearing completion, and it is hoped to publish next week a fuller announcement and an appeal to the profession as a whole.

Local News

INDIA

Public Health in Bombay

The estimated population of the Province of Bombay is 19,500,000, with 18,000 Europeans and 14,000 Anglo-Indians. The birth rate in 1938, according to the annual report of the Director of Public Health which has just been received, was 38.59 per 1,000, and the death rate 27.85. The birth rate among the Europeans was 13.98 and the death rate 8.38, and among the Anglo-Indians the figures were 15.73 and 9.38 respectively. The birth rate of the province tends to rise and now exceeds all previous records since 1901. An excessive birth rate, says the Director, is not to be welcomed, for it is the most important cause of the high infant mortality (now 174.16 per 1,000 births) and of maternal mortality (5.51 per 1,000), besides being a drain on the health of the mothers and the resources of the fathers. The death rate in Bombay, which is the highest in India except in the Central Provinces, is now only slightly influenced by the epidemic diseases. Influenza and measles caused many deaths in 1938, and measles was a large contributory cause of the high infant mortality. Respiratory diseases showed an increased incidence, as did dysentery and diarrhoea. The cholera incidence in the year under review, for the first time since 1933, was light. The number of small-pox deaths increased, but the case mortality rate indicates that the disease now prevailing is less virulent, mainly owing to the communal immunity that is developing in the populace by vaccination and revaccination. Deaths from plague were reduced to just over 400, compared with five-figure totals in many years previous to 1935. The Bombay Government has ordered that physical education should be compulsory for all children, and that satisfactory medical arrangements should be made for the examination of each pupil in Government educational institutions at the beginning of every year.

Hospitals in Bengal

The annual report on the hospitals and dispensaries in Bengal shows that in Calcutta there are forty-eight such institutions following the Western system of medicine. There are also three hospitals following the Ayurvedic system and four homoeopathic dispensaries. The number of indoor patients during the year was 74,000. Cases of cholera

numbered close upon 5,000 and those of amoebic and bacillary dysentery 22,500. The largest hospitals in Calcutta are the Eden Hospital for Midwifery, which in the year had 8,626 in-patients, and the Campbell Medical School Hospital, which had 12,586. In the mufassil (provinces) there are altogether 1,533 hospitals and dispensaries following the Western system of medicine, fifty-six of them being State institutions, and there are seventy-six following the homoeopathic system, twelve the Ayurvedic, and five the Unani. Complaint is made of the inadequacy of the nursing arrangements both in Calcutta and in the mufassil. In all the hospitals and dispensaries of the province there are 2,769 medical officers but only just over 1,000 nurses, midwives, and dais (wet-nurses or handy-women). Two expert committees have been appointed by the Government to investigate the possibility of establishing a medical college at Dacca and also a training institution in pharmacy at Calcutta.

Antirabic Work in India

The second Pasteur Institute in India, which was opened at Coonoor, Madras Presidency, in 1906, has gone on increasing in usefulness until in 1938, 11,703 Asiatics and 287 Europeans were treated. The number of deaths from rabies among all the treated cases was twenty—a mortality rate of 0.17 per cent. The victims in twelve of these fatal cases had not received a full course of treatment, but the others had done so. All the twenty deaths were among Asiatics, and they followed dog-bite in fifteen cases, jackal-bite in three, and fox-bite in two. The appointment of a special research officer has enabled the Institute to undertake research work on rabies on a larger scale than was formerly possible. Experiments are being made with the object of improving the antirabic vaccine now in use. The present vaccine, while satisfactory from the point of view of a low associated mortality among treated cases, is not as good as it might be from the point of view of dosage and duration of treatment.

Correspondence

Surgical Treatment of Air-raid Casualties

SIR,—Messrs. A. R. Hodgson and G. K. McKee (August 3, p. 147) raise two very important points that cannot be over-emphasized—namely, (1) the tourniquet is a very dangerous instrument that should never be applied by an unqualified person (or, for that matter, by most qualified persons); and (2) that one must lie flat as soon as the scream of a falling bomb is heard.

For years past I have told first-aid classes that I have still to see a tourniquet applied by a first-aider efficiently or in a case where it was necessary. There are very few wounds where direct pressure and the subsequent application of a pad and firm bandage will not control haemorrhage. If this is insufficient digital pressure may be applied to the main artery at the root of the limb where it can be compressed against bone. There are only three pressure points of any value—namely, (1) where the femoral artery crosses the brim of the pelvis; (2) where the brachial artery runs behind the biceps on the inner side of the humerus; (3) where the carotid artery can be compressed against the transverse process of the sixth cervical vertebra. Efficient pressure on the subclavian artery is difficult and excruciatingly painful, and if that alone will not stop bleeding the wound must be such that the man will die of haemorrhage before anything can be done. Don't forget that the gun's crew are far too busy serving their gun to attend to him, and if the casualty is a civilian his clothes will have to be cut off and this takes a little time. By the time attention is possible the man with a severed axillary artery is dead. I was always taught that it is very rare for anyone to die of haemorrhage from a wound below the knee or elbow.

Another very important point is that a tourniquet must never be applied directly on the skin, as otherwise this is lacerated and subsequently infected. This highly important point is mentioned casually in first-aid manuals, but *all the diagrams show the tourniquet being applied directly on the skin.* I would like to suggest that the use of tourniquets be severely condemned in all first-aid books. Teach the three pressure points and tell the first-aiders to apply digital pressure there for five minutes if nothing else will stop the bleeding. Meanwhile, apply a firm pad and bandage over the wound. If on releasing the pressure bleeding returns, then a tourniquet must be applied by a medical officer *and by no one else.* Until his arrival, pressure must be kept up by relays of helpers, and more cotton-wool and firm bandages must be applied to increase the direct pressure and extend its area.—I am, etc.,

ST. GEORGE B. DELISLE GRAY,
At Sea, Aug. 16. Surgeon Commander R.N.V.R.

Treatment of Infected War Wounds

SIR,—Mr. Ronald Hare (August 17, p. 235) makes some observations on infected wounds which may assist those who are trying to select from the multiplicity of doctrines and methods of treatment which are preached and practised to-day. Some of these doctrines and methods are revivals from ancient times. We now accept the fact that pus may be laudable, there is a whisper about the revival of carron oil for burns, and we adopt the teaching of Erichsen of half a century ago when he suggested that unpadded plaster could be employed with advantage. Incidentally this great surgeon remarked that in gunshot wounds the plaster occasionally need not be changed, the wound healing without continued pain or fever "under a dry scab." Surgeon Captain Lambert Rogers has drawn attention to an illustration of "the modern" plaster technique dated 1899! The fact is that a description of many of "the new" methods is best sought for in the old textbooks.

Mr. Ronald Hare attributes the successes following encasement in plaster-of-Paris to the post-operative protection given to the wound from the hands and nasopharynx of attendants and to the fact that the wound is sealed by the plaster from air-borne infection carried from septic cases treated near by. He states that the real source of infection—namely, the *Streptococcus haemolyticus* of Group A—rarely is present when the wound is inflicted, and is denied access by asepsis during débridement and by the treatment just mentioned. A long clinical experience supports this view. In hospitals where septic cases were isolated as if suffering from the plague and where asepsis in the wards was made the same religion as it was in the theatre, severe cases of infection were seldom seen. There were opportunities before the war of comparing the results with cases treated in hospital by lax methods during the post-operative period, and the contrast was lamentable.

Fixation is desirable for all infected wounds in the early stages. Any form of effective immobilization combined with infrequent dressings will give equal results; plaster-of-Paris is by no means a *sine qua non.* Prevention of movement lessens the risk of dissemination and gives the local and general rest and comfort which Nature demands. For many years we treated severe infections of the hand and arm by rigid immobilization in gutter splints and avoided arm baths, moist dressings, and movement (*Lancet,* 1936, **2**, 1010). Sometimes a change from the latter to the former treatment gave dramatic results.

As a rule I prefer splints (of the pattern described by Sir Robert Jones) to plaster in the early treatment of the war wounds as I see them. This lesson was learnt in the last war. The Böhler, Winnett Orr, and Trueta methods, however ideal, are not so safe, and are best reserved for a time when skilled assistance is at hand and, above all, when the surgeon is within easy reach and can keep the cases under close personal observation. I have seen lately many minor disasters from the use of primary plaster when applied under adverse conditions. Even when applied by an expert things may go wrong, necessitating removal of an extensive plaster and its re-application. In the case of badly wounded men this is by no means a minor procedure.

Fixation in plaster is excellent when indicated, but familiarity with alternative methods of immobilization will be found very helpful to those dealing with the surgery of to-day.—I am, etc.,

Aberdeen, Aug. 28. W. I. DE C. WHEELER.

Universities and Colleges

UNIVERSITY OF LONDON

Recognition of Teachers

The following have been recognized as teachers of the University in the subjects indicated in parentheses:

University College: Dr. R. J. O'Connor (Anatomy). *London Hospital Medical College:* Dr. R. R. Bomford (Medicine); Mr. Arthur Lister (Ophthalmology); Mr. Hermon Taylor (Surgery). *St. George's Hospital Medical School:* Dr. W. M. Levitt (Radiology). *Middlesex Hospital Medical School:* Dr. C. A. Keele (Pharmacology); Dr. J. E. Roberts (Physics as applied to Medical Radiology); Dr. B. W. Windeyer (Radiotherapy). *St. Mary's Hospital Medical School:* Dr. F. Himmelweit (Bacteriology). *London (Royal Free Hospital) School of Medicine for Women:* Dr. P. E. T. Hancock (Medicine); Dr. Lilian M. Dickson (Anatomy); Dr. Winifred A. Leyshon (Physics). *London School of Hygiene and Tropical Medicine:* Dr. F. Murgatroyd (Tropical Medicine). *Royal Dental Hospital of London School of Dental Surgery:* Mr. I. H. Hovell (Dental Anatomy and Dental Surgery).

Sanderson-Wells Lecture

It was reported at a meeting of the University Court on July 3 that Dr. Sanderson-Wells, who last autumn founded prizes in the pathology and physiology of food (see *London University Gazette*, February 21, p. 3), had offered to endow a lecture, to be known as the Sanderson-Wells Lecture, and to be given at such intervals as the University might decide, on some subject of moment bearing upon "The Nature, Causes, and Cure of Human Ailments, with Special Reference to Soil Fertility, Tissue Resistance, Food, Health, and Disease." The offer was accepted and the cordial thanks of the University have been conveyed to Dr. Sanderson-Wells.

Awards

London Inter-Collegiate Scholarships Board awards of medical entrance scholarships and exhibitions have been made on the results of the Board's examinations as follows:

UNIVERSITY COLLEGE.—*Medical Scholarship:* D. R. Wilkie. *Bucknill Scholarship:* P. A. Reed. *Medical Exhibitions:* G. F. Bacon, J. V. Ellis.

KING'S COLLEGE.—*Warneford Scholarships:* Joy M. Douglas, D. K. M. Toye. *Sambrooke Scholarships:* C. R. B. Vincent, P. T. Clover.

KING'S COLLEGE HOSPITAL MEDICAL SCHOOL.—*Science Scholarship:* T. A. Richards.

An additional second medical examination for internal and external students will be held in December, 1940, beginning on Monday, December 2. Entries must be received not later than October 28.

The University of Lucknow has been added to the list of institutions from which the University receives certificates for the complete course preparatory to the M.B., B.S. degrees for external students.

The Royal Hospital, Wolverhampton, has been recognized for a further period for the purposes of the Diploma in Clinical Pathology for external students.

The Ph.D. degree in the Faculty of Medicine (non-clinical) has been conferred on W. P. Rogers (London School of Hygiene and Tropical Medicine) for a thesis entitled "Studies on the Biology of Certain Parasitic Nematodes, with Reference to its Bearing on the Problem of Disease Prevention and Control."

UNIVERSITY OF LEEDS

Moynihan Lecture

The first lecture of the series endowed by the late Lord Moynihan of Leeds in memory of his mother will be delivered at 3 p.m. on Wednesday, October 2, in the Riley-Smith Hall of the Leeds University Union by Surgeon Rear-Admiral Gordon Gordon-Taylor, F.R.C.S., under the title of "The Moynihan Tradition." Members of the medical profession are cordially invited to attend.

J. Zahorsky (*Arch. Pediat.*, 1940, **37**, 405) maintains that the disease which he was the first to describe in 1901 under the name of "roseola infantilis" is a distinct entity, and not, as Rietschel declares, merely an allergic reaction due to influenza. He deprecates the term "exanthema subitum" proposed by Veeder and Hempelmann, as the appearance of the rash is not unexpected by the paediatrician. Although hundreds of sporadic cases have been seen, the disease is mildly contagious, though the source of the contagion (bacteria or virus) is not yet known.

The Services

CASUALTIES IN THE MEDICAL SERVICES

ROYAL NAVY

Missing

Temporary Surgeon Lieut. James Frederick Newman, R.N.V.R.
Temporary Surgeon Lieut. Arthur Charles Shelford, R.N.V.R.

ROYAL ARMY MEDICAL CORPS

Lieut. CECIL EDWARD HURLEY, R.A.M.C., was reported as having died in a casualty list published on September 13. He graduated M.B., B.Ch., B.A.O. of the National University of Ireland in 1925 and before the war was in practice at Hull.

Wounded

Major Thomas Elliot Elliot, R.A.M.C.
Lieut. Frank Geoffrey Hibbert, R.A.M.C.

Prisoner of War

Captain (War Substantive) Percy Bailes Barker, R.A.M.C.

Prisoner of War and Wounded

Lieut. William Cecil Harris, R.A.M.C.

DEATHS IN THE SERVICES

Colonel BASIL FENTON WINGATE, D.S.O., late R.A.M.C., died suddenly in London on September 3. He was born on July 16, 1875, was educated at St. Mary's Hospital, and took the M.R.C.S., L.R.C.P. in 1899. Entering the R.A.M.C. as lieutenant in 1899, he became lieutenant-colonel in 1917, and retired with the rank of colonel in 1928. He served throughout the South African War in 1900–2, when he took part in the relief of Kimberley and in operations in the Orange Free State and Transvaal, including the actions of Paardeberg, Poplar Grove, Dreifontein, Vet River, Zand River, Diamond Hill, Pretoria, and Belfast, and received the Queen's medal with five clasps and the King's medal with two clasps. He also served throughout the war of 1914–18, in the latter part of which he acted as A.D.M.S. of the 20th Division in France, with the temporary rank of colonel, was thrice mentioned in dispatches, and received the D.S.O.

Colonel REGINALD JOSCELYN WINDLE, late R.A.M.C., died in a nursing home at Bournemouth on September 6, aged 80. He was born at Derby on August 18, 1860, and was educated at Trinity College, Dublin, where he graduated M.B., B.Ch. in 1884. Entering the army as surgeon in 1886, he became lieutenant-colonel after twenty years' service, colonel in the long war promotion list of March 1, 1915, and retired in 1917. He filled the post of physician and surgeon to the Royal Hospital for Invalid Soldiers at Kilmainham, Dublin, from 1907 to 1912. He served throughout the war of 1914–18. He leaves a widow.

Major LESLIE RAWES, R.A.M.C., T.A., died after an operation on September 12. He was the second son of the late Mr. James Rawes of Lisbon, and was educated at St. Thomas's Hospital and took the M.R.C.S., L.R.C.P. in 1905. After qualifying he filled the posts of house-surgeon to the Royal Northern Hospital and of resident medical officer to the Royal Waterloo Hospital for Women and Children. While in practice in London he was anaesthetist to the Orthopaedic Hospital at Shepherd's Bush and to the Central London Throat, Nose, and Ear Hospital. During the war of 1914–18 he served with the 84th Field Hospital in France and Flanders. He leaves a widow. He was a past president of the Chelsea Clinical Society and had been a member of the British Medical Association for thirty-one years.

Captain FRANCIS MURRAY HALLEY, R.A.M.C., died in hospital at Colombo after a short illness on June 10. He was the son of the late John Halley of the Inland Revenue, Somerset House, and was educated at the University of Edinburgh, where he graduated M.B., Ch.B. in 1915. He also took the D.T.M. & H. of the London Colleges in 1925. He served for some years in the Iraqi Health Service, and afterwards in the Malayan Medical Service under the Agricultural Board. He had been a member of the British Medical Association since 1921.