showed that in the last resort, if all the preceding methods of treatment have failed, leucotomy holds out a fair chance of success. He had been especially concerned to avoid unpleasant personality changes by placing small cuts at open operations, and he now favours a restricted orbital undercutting procedure, ultimately to be carried out stereotactically.

The topical subject of community care was illustrated in a series of exhibits by Dr. E. A. RITCHIE. Of special interest were a number of patients doing several unskilled and semi-skilled assembly and dismantling jobs. They were representative of some 150 patients attending workshops in the hospital and doing paid work provided by five industrial firms and two Government departments. It was suggested that, beyond the benefit of regular occupation, this demonstration to the patient of his earning power was of therapeutic import not only in long-stay but also in recent cases.

Another new development at St. Augustine's Hospital is an adolescent unit for 16 boys between 12 and 16 years of age. The problems they presented, and the ways in which they were treated, were put over very clearly by Dr. G. C. TURLE and Mr. C. WOOLLEN, the child psychotherapist. While encouraging self-expression, strikingly demonstrated in the use made of a "smear room," they believe that discipline is necessary too. All the members of the staff are used to get these young patients to respond positively to adults, and in this way are helped with their own disturbed attempts to become adults.

CATHEDRAL ARCHIVES

Three medical items were among the ancient documents shown in the Cathedral Library by the archivist, Dr. WILLIAM URRY, on Friday and Saturday morning. One was a recently found contemporary copy of the Folkestone Parish Register for 1578 containing the entry of William Harvey's baptism on April 6. The other two documents related to early G.P.s of Canterbury: one, the oldest-surviving local borough survey (c. 1166), noted that "Petrus Medicus" had paid his mid-Lent rent of 12d. and a 3½d. labour-service charge to the Cathedral monks. He and his son John, also a doctor, must have been done out of a considerable amount of business by Becket's shrine, said Dr. Urry. Godefrid the baker, whose name appeared frequently in records of this time, had three sons, all of whom were cured by the touch of a rag dipped in Becket's blood. The shrine accounted for large numbers of cures, and the annual list of takings (from pilgrims) kept by the monks showed £94 for the shrine alone in 1261-2. Another medical man was Magister Feraminus, M.O.H. to the monks, whose name appeared in a monastic register for 1189. He was prone to visions and through his political activities fell foul of Henry II.

Other documents included a parchment bearing the marks of William the Conqueror and Queen Matilda and dated Easter, 1072, in which Lanfranc, Archbishop of Canterbury, persuaded several bishops to agree to his superiority over York; Thomas of York himself added a reluctant "concedo" to his signature. A small piece of parchment with a large seal was the penance of Sir William De Tracy, one of the four murderers of Thomas Becket, granting the manor of Dacombe in Devon to Canterbury, and sustaining a monk perpetually praying in the Cathedral for the De Tracy family. A romantic connexion with Tudor times was a rosebud found in the City Plea Roll at the page containing the last of many entries relating to the family of Christopher Marlowe, shortly before his murder in 1593.

SOCIAL OCCASIONS

The Civic Reception given by the MAYOR OF CANTERBURY on the first evening of the Meeting was noted in the first part of our report. On Friday evening the East Kent Division gave a most successful Wine and Cheese Party at the impressive new Frank Hooker School. The guests were received by Dr. I. H. K. STEVENS, chairman of the Division,

and Mrs. STEVENS. On Saturday evening Messrs. Pfizer Ltd. sponsored a concert by the Boyd Neel Orchestra, conducted by Mr. RAYMOND LEPPARD, in the Great Hall of King's School. Works by Handel, Mozart, Warlock, Wirén, and Britten were played to a large and enthusiastic audience. Earlier in the evening the Christian Medical Fellowship held a Buffet Supper at "The Pilgrims," under the chairmanship of Mr. D. F. ELLISON NASH, at which Mr. S. FARRANT RUSSELL spoke.

On Sunday there were Matins in the Cathedral, where Canon A. O. STANDEN was the preacher, and Principal Mass at St. Thomas's Roman Catholic Church. Golfers were catered for at Prince's Golf Club, Sandwich, Canterbury Golf Club, and the Royal Cinque Ports Golf Club, Deal. The Whitstable Yacht Club offered hospitality, and at least one medical visitor had a most enjoyable sail in a Flying Dutchman. In the afternoon there was a small ceremony in Folkestone, where wreaths were laid at the foot of William Harvey's statue by Dr. A. TALBOT ROGERS, Chairman of the Representative Body, Dr. E. R. CULLINAN, representing the Harveian Society of London, and the MAYOR OF FOLKESTONE.

Ladies' Programme

An excellent social programme for the ladies was arranged by Mrs. I. H. K. STEVENS. On Friday a large party was entertained to lunch by Messrs. Pfizer Ltd., and then taken over Dover Castle and the Pfizer works at Richborough. Dr. BERTHA BRIANT led a tour on Thomas à Becket, and there was a visit to a notable private art collection. These tours were followed by a tea party attended by 71 ladies. On Saturday there were interesting tours of the Cathedral and the city, and Dr. WILLIAM URRY, the archivist, lectured in the Cathedral library. Local hostesses entertained 30 ladies to lunch, and in the afternoon there was a demonstration on the art of make-up by Messrs. Lancôme from London. This was followed by tea which, as on Friday, was kindly provided by the local Division of the British Medical Association.

THE AFTERCARE OF THE HOSPITAL PATIENT*

BY

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The subsequent experience of patients treated in some Scottish hospitals is the subject of this report. In the west, our original work was based primarily on 705 men treated in the general medical wards of four hospitals for acute cases; they were seen in hospital and visited in their own homes over a period of two years after discharge. The mean age of the patients was 49 years; 18% were over 64.

The wards involved treat many very seriously ill people, as may be judged from the fact that the immediate ward mortality is about 15%. Within the five years preceding the admissions with which we were concerned, 22% of the patients studied had already had in-patient treatment for the same or a related condition, while, in addition, 12% had had out-patient hospital care. The readmission rate was especially high among those suffering from diseases of the blood, digestive system, and circulation.

The clinician in charge classified just over 9% of those patients on discharge from hospital as "cured" and

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73% as "improved"; he estimated that 40% were likely to be fit to return to their own job within three weeks of leaving hospital and a further 3 to 4% fit for alternative employment.

Employment After Discharge

Within three months of leaving hospital, 9% of the patients had died and 5% were readmitted; 64% continued to improve, 24% remained very much as on discharge, still far from well, and 11% had clearly deteriorated; so that roughly one in four had gone downhill. At the end of three months 61% of the survivors between the ages of 15 and 64 were back at work, but fully one-fifth of them were in jobs that could only be regarded as unsuitable. The proportion in unsuitable work was high among lads between the ages of 15 and 19 (often suffering from heart disease) and at ages over 50, many of the latter also being cardiac cases. Of men registered as handicapped under the Disabled Persons (Employment) Act, only 32% were in employment three months after leaving hospital. The proportion of men back at work after three months did not correspond closely with the clinician's estimate of fitness for early return; it was much more closely related to home conditions and nature of employment.

Nor was the picture any brighter two years after the patients left hospital. By that time 26% had died; 47% had maintained the improvement initiated in hospital; 16% were classified as "condition unchanged," still far from established good health; and 10% had deteriorated. Rather less than two-thirds of those still alive had derived substantial and lasting benefit from hospital care. In the course of these two years 27% of the survivors had been readmitted to hospital on at least one occasion. Over a period of seven years—the five preceding the admission on which the study was based and the two following it—48% of the survivors had at least one other spell of hospital treatment and fully half of these had two or more additional spells.

Two years after leaving hospital 27% of the survivors were not in employment; the proportion not at work was nearly twice as high among the men who had been unskilled labourers as among those who had been in non-manual jobs. Just under 20% of those who were working were in jobs regarded as unsuitable; the proportion in unsuitable work was highest between the ages of 45 and 64, and rather higher among men who had taken up new work after their illness than among those who had returned to their old job. Of those who were alive two years after leaving hospital, 22% had done no work during that period and a further 10% had worked for less than one of the two years.

Causes of Breakdown

So much for the bare facts, which can only be regarded as disappointing. For most patients hospital care is but an episode in a very much longer tale of medical supervision. Transition from the sheltered atmosphere of the modern hospital ward to the icy chill of the workaday world is a testing time, and it is not surprising that many soon break down; in our series relapse often came from bad social and environmental conditions rather than from any inevitability on medical grounds.

Sometimes the work itself was grossly unsuitable, either from its nature or from the circumstances in which it was done, having regard to the man's condition;

sometimes the trouble arose from unhappy relations with foreman or workmates. On leaving hospital, far too many men returned to jobs which could scarcely fail to precipitate another breakdown in the not-far-distant future. The non-manual worker is fortunate in that he can usually go back to his own job. The skilled worker unable to continue at his trade has a good chance of finding non-manual work; but for the unskilled labourer the choice is often between a pick and a shovel, and, not surprisingly, the proportion unemployed two years after leaving hospital was about twice as high among the unskilled as among the others.

The hospital physician estimated that the breakdown in health that had led to admission was preventable in 10% of cases—mostly cases in which the patient suffered from some acute intoxication or in which he had been grossly remiss in his observance of the way of life demanded by the medical condition from which he was known to suffer. Instances of this are the case of the patient with peptic ulcer who committed some major indiscretion of diet; that of the diabetic who did not continue with the balanced insulin treatment which had been mapped out for him; and, less often, that of the patient suffering from pernicious anaemia who failed to continue his prescribed therapy. These patients were not drawn from any particular age-group, but included a relatively high proportion of unskilled manual workers.

When the men were seen in their own homes, it soon emerged that the breakdown that had taken them to hospital was in some cases the direct outcome of bad social, economic, or environmental circumstances—such as grossly defective housing, lack of adequate home care, or patently unsuitable work; 15% of the cases studied could be classified as falling into this group, so that in about 25% of cases a major preventable factor of one kind or another could be regarded as being present. Nor does this figure of 25% exhaust the tale of cases in which social or environmental factors contributed to breakdown or interfered with recovery; these contributory social factors were mainly associated with employment, and assumed greatest importance between the ages of 45 and 64.

It was estimated that only about one-third of the patients given advice calculated to prevent relapse could be counted upon with reasonable certainty to accept the advice given to them. Some of this unwillingness to accept advice could be traced to reluctance to give up a job or a way of life to which the patient had become accustomed or which he liked, but many who knew that their job was beyond their strength were unable to find one more suitable.

Bridging the Gap

In the nature of things, much devoted and highly skilled hospital treatment can have little prospect of restoring effective working capacity, for many patients on admission are already gravely, even hopelessly, ill; but our experience leads us to ask what can be done to obtain a greater measure of permanent benefit from hospital care. Much depends on the part which we wish hospitals to play in the Health Service. Some could, with profit, undertake a greater measure of constructive work than at present; there is much scope for the hospital as a diagnostic centre in the early, more promising stages of disease, and the best hospitals might well take a larger place in helping to shape the careers

of young disabled persons. Under present conditions, with so many with established illness clamouring for admission, this may sound Utopian. It is certain that, assuming continuance of the present pattern of hospital admission, we are lamentably short of convalescent accommodation—especially the kind of graded convalescence which has the express object of restoring capacity for work and bridging the wide gap between hospital ward and everyday life.

Until we provide conditions which give a man a reasonable chance of maintaining the improvement which hospital care has initiated, a large fraction of costly in-patient treatment can only be the merest palliative patchwork. Much of our housing is still grossly unsatisfactory, though it is being improved; many invalids lack the kind of benevolent home background that so often makes all the difference between progress and relapse. The State has set up machinery to help the handicapped to find suitable jobs, but many disabled men, especially unskilled labourers, cannot get suitable work even in time of relatively full employment.

The simple fact is that, in Scotland at all events, effective aftercare is yet only in its infancy, so far as the common major illnesses of the people are concerned; and it very badly needs development if the work of the hospitals is not to continue to be speedily undone. Integration is an overworked word, but it is not too much to say that lack of effective integration of health and social services can be disastrous for the welfare of the patient. We must do more to help the family doctor in his struggle to keep the patient on his feet, and more to encourage the patient to try to follow a way of life that will be satisfying to him and within his compass. It is important to preserve all that is best in our hospital tradition, but equally it is important to try to view hospital care in true perspective.

During the past few years we have been working with another similar group of patients discharged from acute medical wards in Glasgow to find out whether, by the energetic use of all the statutory and voluntary agencies available in the city, we can help to obtain better results than those described earlier in this paper. We have certainly been able to help some patients, but what proportion is not yet clear. Before long we should be able to assess the results objectively—to judge not merely the measure of our success but the reasons for our failures; and the results may help to lend promising direction to aftercare.

OPHTHALMOLOGICAL SOCIETY OF U.K.

DR. IDA MANN'S BOWMAN LECTURE

[FROM A SPECIAL CORRESPONDENT]

The Ophthalmological Society of the United Kingdom held its 81st Annual Congress at the Royal Society of Medicine from April 13 to 15. The meeting included a symposium on "The Late Complications of Aphakia," a discussion on "Neovascularization in Ocular Disease," the Bowman Lecture, and various papers.

Anthropology and Pathology

This year's Bowman Lecture was delivered by Dr. IDA MANN, who left her chair in ophthalmology at Oxford 12 years ago to practise in Western Australia; and the subject of her talk, "Climates, Cultures, and Eye Disease," derived from her interest during these last 12 years in the country and people of her adoption. Her thesis, which, as she said, could as well have been titled "Anthropology and

Pathology," underlined the relationship of disease to the varying habits and climates of peoples who were separated by the accidents of geography—a study that had been too long neglected, and which yearly became more difficult as geographical barriers receded and man's energies were directed more to cope with his cultural than his physical environment.

The naked influence of climate in determining the nature of the food supply (proportion of animal to vegetable matter) and parasites (incidence of insect vectors) was in fact generally overridden by that of culture (the habits of the previous tribes that immigrated into any particular region)—whether the race was settled or nomadic, rice- or cereal-eating, wearing wool or leather, etc. Thus, the incidence of infectious diseases like trachoma was greater in Muslim communities, where it was furthered by the use of cosmetics and by the seasonal pilgrimages to Mecca through the most highly infected countries in the world. Religion likewise might promote genetic diseases by placing limitations on the persons with whom marriage was permitted; it might encourage eccentric habits resulting in anaemia like the ritual blood-letting in the Wongada tribe no less than the refusal to accept transfusion by Jehovah's Witnesses; or there might be taboos on rational treatment such as were found alike in primitive tribes and among sophisticated Christian scientists.

Application to Eye Disease

In applying her thesis to eye diseases, Dr. Mann first considered the incidence of convergent squint. Among full-blooded Australians, who were practically all hypermetropic, and most of whom were intermingled with the European stock, sharing their education and diet, convergent squint was apparently unknown, while about 2% of the white population was so affected, half of these having a hereditary basis. This would suggest an underlying anatomical causation—in contrast to divergent squint, which was much more regularly distributed among different racial groups. Similarly, myopia was virtually confined to the white population (4.8% of causes of blindness), while its frequency was double this figure in England, and greatest of all in Malta. Glaucoma, too, was almost absent from the aboriginals of Australia and New Guinea (1% of blindness in contrast to 13.6% in England). Iceland had the highest incidence of hereditary glaucoma, 47% of their cases of glaucoma having a genetic basis.

The incidence of cataract was often thought to be greater in the tropics, although there was little statistical support for this, and endocrine or nutritional factors might well determine its frequency in different countries. The varying incidence of uveitis, too, reflected many factors that were difficult to assess, the incidence of onchocerciasis being affected by clothing habits, and of toxoplasmosis by the domestic animals employed; however, the Australian aboriginals had a surprising freedom from sympathetic ophthalmitis, in spite of an ample supply of untreated perforating wounds. The distribution of trachoma had excited much interest in the past, and its spread by man's migrations reflected again and again the wars and religious fervour of past centuries, just as its incidence in the wake of these human tides reflected the habits of the tribes it infected.

Many other eye diseases also lent themselves to a rewarding geographical analysis, such as the various nutritional diseases that so directly depended on the natural foods in a district, the high incidence of pterygium and pingueculum on the bright sandy coastline of Western Australia (but equally in the dark jungles of Brazil), and the spread of varying patterns of virus conjunctivitis. For the study of geographic pathology was as wide as the whole world, and as limitless as time.

London County Council now authorizes 687 chiropody sessions a week as against 587 sessions a week in January, 1960, and 487 sessions a week in January, 1959. (L.C.C. Council Meeting, February 14.)