LEGACIES TO MEDICAL CHARITIES

BY

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The subscription incomes of the medical charities, by which are meant especially the Royal Medical Benevolent Fund and the Royal Medical Foundation of Epsom College, are still far below what they ought to be, although the persistent efforts of the British Medical Association on their behalf have brought about improvements in this respect. In what follows, I want first to emphasize that a plea for legacies is not meant to supplant, but to supplement, the prime duty of the profession to subscribe annually.

At the Annual Meeting in Belfast last July I was able to give some statistics which I had collected by study of the wills and bequests column of the daily press, and these have now been further analysed. My investigation covered a consecutive period of exactly twelve months. I took a basic figure of £20,000, and excluded every (medical) estate below that figure. It is, of course, clear that a medical testator with no dependants or near relatives who has £10,000 to dispose of owes a much greater obligation to be charitable than one with double that amount who leaves a widow and a large family; but it is impossible to allow for factors such as this, so the base line was selected on the assumption that all members of the profession possessing property of that value can afford at least a small legacy to one of the charities of their own profession.

Before going any further I ought to make two things quite clear: first, that though the total number of the estates dealt with is surprisingly large, it contains only a small fraction of the medical practitioners who die in any one year; and, secondly, that most of the largest estates, which swell the total to imposing dimensions, have obviously and notoriously not been accumulated by successful practice, but are the results of non-professional activities or inheritance from ancestors engaged in more lucrative pursuits. All the same, in my view a qualified medical man (or woman) who is fortunate enough to inherit wealth owes as great a duty to the medical charities, both during life and as a testator, as one whose prosperity has been the result of professional success. I have included in my collection a few estates left by the widows of doctors whenever they have exceeded my datum line.

The total number of these estates noted during the twelve months was 115, with roughly a total value, before deduction of death duties, of £4,978,000. These very considerable figures certainly surprised me, and may possibly surprise others; but I do not think they can be a freak result (except perhaps by the inclusion of three six-figure estates not acquired in the practice of medicine), because the numbers per month fluctuated remarkably little right through the whole year.

It might reasonably have been anticipated that the two medical charities would have benefited very considerably from the wills of these wealthy individuals. The Royal Medical Foundation of Epsom College, however, has in prospect (for it is not yet to hand) but one legacy of £300 from among the whole lot; the Royal Medical Benevolent Fund has done rather better, with (I think) one good legacy and two or three smaller ones. But the grand total can only be described as miserable and unworthy. One per cent. would have brought in £50,000, which would have put both charities in a position to afford help worthy of a great profession.

Another distressing feature of the list is the discovery that few among the larger estate owners have ever subscribed during their lives to either of these medical charities—the cynical will say that is why they left

such large fortunes, but probably the real reason is more often thoughtlessness. In one case where a medical widower left £52,000 it was discovered on inquiry that the local charities secretary had many times approached him for a subscription, and had every time been refused on the ground of insufficient means! A further anomaly is disclosed in a few of the cases where large legacies (sometimes running into several thousands) are left to all sorts of philanthropic organizations, often very deserving ones, without a thought of the claims of our own professional charities. For instance, not long ago a doctor left about £10,000 among four separate missions to the heathen; he had never subscribed to any of the medical charities. Another one, also recently, left some thousands among selected charities, and he too had never contributed to the Royal Medical Benevolent Fund or to the Royal Medical Foundation of Epsom College. A woman doctor with no dependants left an estate of £37,000, without a legacy to medical charity, although during her life she had bought and presented to the National Trust a well-known beauty spot for preservation in perpetuity. She, too, appears never to have subscribed to any medical charity during her life.

One could multiply instances of similar complete disregard of those claims which might be thought to lie very near the heart of medical testators, but perhaps I have said enough. I will add just this, that the Council of Epsom College have during the years 1936 and 1937 together sanctioned capital expenditure—in their view, and in my own view, necessary expenditure—amounting to about £17,000; and in consequence have to face an exceedingly heavy overdraft from their bankers or else to sell out investments. Either expedient will, of course, reduce the income of the Foundation; and this disadvantage could have been avoided if the testators above recorded had taken what appears to me a just view of their responsibilities. I present these statistics to the profession in the earnest hope that those who can afford to help the medical charities in this way will not forget or neglect to do so. May they live long to enjoy the sensation of knowing that their duty has been done!

R. Lévy-Dreyfus (*J. Urol. méd.-chir.*, July, 1937, p. 5) considers that intestinal fistulae rarely follow operations on the kidney. He has been able to trace only fifty-five cases in the literature. The fistula is caused either by manipulation of the kidney during operation or by the persistence of tuberculous infection or perirenal suppuration. In the cases reported tuberculosis was responsible for the largest number of cases; other causes may be lithiasis, perinephric suppuration, and neoplasms. Fistulae of the colon were most common, though there was an almost equal number of duodenal and right colic fistulae. The intestinal opening is seldom longer than 1 cm. and is often a good deal smaller. The first sign of a fistula is the escape of intestinal contents from the wound or scar, accompanied by local inflammation and fever. This usually occurs in the first few days after operation, although cases have been seen when a much longer period has elapsed, and one instance is noted where a fistula of the colon was not observed until ten years after the removal of a tuberculous kidney, though a sinus had persisted since the operation. Fistulae of the colon tend to heal spontaneously and rapidly in about 65 per cent. of cases, with a gradual decrease of intestinal discharge. Surgical treatment may be necessary for those cases in which the fistula does not heal. When the perforation is in the colon an entero-anastomosis followed by a colectomy is the procedure of choice. The prognosis in cases of duodenal fistulae is more serious, and operative treatment carries such a high mortality that medical measures should first be tried. The most simple form consists in keeping the patient in the ventral or lateral decubitus for a long period, with the reduction of fluids by the mouth.