*Papers and Originals***THE DISCARDS OF SURGERY***

BY

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I should like to discuss what we have discarded from our surgical repertory, in all its facets, over the past 30 years. The thrill and charm of surgery is that it is not static; no one should ever be satisfied with his own results. If we have reached the point of personal satisfaction we have failed. It is always dangerous for methods to become standardized, and we must be suspicious of the great technicians, for with them the particular case or the disease is sometimes made to suit their method. We do not want to reach the stage of the robot surgeon, when thought is no longer necessary.

Fortunately this danger is remote; although the surgeon may become somewhat stereotyped and his methods standardized, the patient is always fortunately going to be an unknown problem full of unexpected possibilities. The diagnosis of the acute appendix, for example, has shattered many a reputation. The intelligent man is thrilled to find that he has made a mistake and that it was a case of Crohn's disease, a carcinoid, a Meckel's diverticulum—the small man is annoyed with everyone except himself. Even the so-called simple hernia can have a salutary humbling influence when we find no tissue with which to close the gap, or a large sliding mass with no sac.

Experience, often bitter, helps in such cases, and it is only by discarding many so-called reputable methods that a system is evolved to suit not only the patient but also the individual surgeon.

Fashions in Instruments

Most surgeons are travellers, and most of us have in a cupboard or on a shelf instruments that we have brought back from our various trips to foreign surgical centres. We saw Finsterer work in Vienna, Sauerbruch in Berlin, and Schoemaker at The Hague. From Paris we brought back the universal Reverdin needle—not realizing that this was produced because the French surgical glove with its thick rubber and stiff gauntlet did not allow any finger movement or even any sensation of touch. I have seen a French surgeon do a gastroenterostomy from skin incision to skin closure with Reverdin needles alone—different ones for skin, muscle, peritoneum, and the anastomosis. Recently I saw a cleft palate done with Reverdin needles from beginning to end.

Visitors to this country have been similarly impressed by techniques. It was a wonderful sight at one time to see our American visitors cross St. Thomas's Street from Guy's Hospital to Down Bros., having seen Arbuthnot Lane demonstrating his "no-touch" plating operation, and buy a complete set of his bone instruments.

Why in so many cases have these tools failed in our hands? In many instances it is due to some idiosyncrasy of their inventor. Arbuthnot Lane's instruments are

always recognizable by their weight and Berkeley Moynihan's by their lightness. A well-known London thyroid surgeon used to use gloves size 5½ and another surgeon with whom I worked used No. 9. How can we hope to adapt ourselves to their techniques and instruments? Ernest Miles was left-handed and his technique was influenced by that; his insistence that a rectal examination should be done with the left hand was also for that reason, and not because it facilitated the examination of the pelvic colon, as is claimed by some.

In some cases developments in other fields have made instruments obsolete. I remember using regularly Pannett's triple-bladed peritoneal forceps to hold the retreating edges of the peritoneum together in the rigid abdomen with the patient struggling under chloroform or ether. These went out overnight—like the button-boots—with the introduction of curare. Like Murphy's button, they will soon be an interesting examination exhibit for the student rash enough to aspire to an honours degree. Lane's plates themselves became almost a discard. The failures were often thought to be due to sepsis, but in many cases they were due to the chemical and electrical reaction between living bone, its fluids, and the unsuitable metal. New non-ionizable metals have helped to overcome this problem. Possibly those dangerous drugs, the antibiotics, have also partially helped to make modern plating again a first-class form of bone fixation.

It is delightful to see certain instruments of torture disappearing. For years an unpleasant compression instrument called a tongue forceps was always on the anaesthetist's table. To hold a slimy tongue successfully it had to grip so hard that it reduced the latter to a swollen mass of raw flesh. It differed little in shape or indeed in appearance from a similar instrument used at one time at the other end of the body. Piles may be expendable but the tongue is not. The simple rubber airway does this all so much better and with no trauma.

Retractors are another problem. No one is satisfied with any one else's, and each surgeon wishes to alter them to his own requirements. It may be only to add half an inch here or change the angle 10 degrees there, but to him it is essential. Certain instruments seem to work better in some countries than others. The de Petz clamp, an ingenious machine when it works, has not caught on in this country as it has in other places. Is there a basic underground resistance movement from the nursing world, or have we not the same amount of technician help in this country as they have in Continental theatres?

Pre- and Post-operative Care

The pre-operative care of the patient has undergone considerable modification. No longer is the patient brought to the operating-table after one or two days' purgation, with finally, to add to the shock, a high

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enema on the morning of the operation. It did not seem to strike people that the patient who was operated on as an emergency often did so much better—with no time for preparation—than the patient who had been several days in the ward. Skin preparation has also changed. Shaving of the scalp is no longer so drastic; with many, even the pubic hair is no longer looked on as expendable. I remember when a gastric operation could not be carried out until all infection from teeth and gums had been dealt with; this meant a delay of several days in many cases.

Some surgeons used to remove their own dental plates, wear white gloves at night, and in certain Continental clinics have an entire bath before an operation. Our modern surgeons would find these white gloves somewhat awkward for gardening, sailing, golfing, and fishing. Moynihan wore white gloves, it is said, in bed at night for aseptic reasons. Schumacher wore his white gloves because he had an x-ray dermatitis with malignant changes.

Over the last few years the rectum has come back into its own. It is again looked on as an organ for defaecation. For a time it was a repository for any form of unwanted fluid. The rot set in with Murphy's rectal drip or proctoclysis. From saline to tap-water it progressed to brandy for shock and then hot coffee, with finally the so-called nutrient enema—where a minor form of mixed grill was inserted into a tube which nature intended only to absorb water—if even that—or otherwise it would have supplied it with the necessary digestive mechanism.

Early ambulation needs no mention, but the value of early drinking is not appreciated by many young surgeons who have not seen the awful problems of acute parotitis with its high temperature, extreme pain, trismus, and even death. John Ryle's duodenal tube, now called a gastric tube, has allowed drinking without danger.

Discarded Operations

Of the operations that have been discarded we should ask ourselves—Why were they originally planned and what is responsible for their being discarded?

First, we have that vast group of tuberculosis infections which until 1937 could only be dealt with by drastic surgery, palliative surgery, or compression. The skill required in the dissection of caseous glands in the neck—almost a daily operation thirty years ago—is now no longer necessary. The scarred neck in Great Britain is almost a thing of the past. Ingenious operations on the chest, such as phrenic crush or section, cutting of adhesions, extrapleural compression, pneumothorax, pneumoperitoneum, and thoracoplasty are rarely seen. Thanks to streptomycin and its allies surgery has changed from being a flanking into a frontal attack. The fear of the lung pedicle no longer exists and the lung tourniquet, like the tongue tourniquet, has vanished. The limb tourniquet we know has more disadvantages than advantages, and we now see it occasionally attached to the end of the bed after an amputation more as a fetish or talisman than for any valuable purpose.

Another group of operations that has disappeared is that of the plications and the "pexys." When I was a young man my chief was a urologist, and so every few weeks we had to perform a kidney suspension. Should the kidney be embedded in a pocket in the perinephric

fascia? Should a transfixion stitch be put through it to fix it to the surrounding tissues? Or should it be suspended from the twelfth rib by a broad strip of its own capsule—like a shirt hanging from a clothes-line? This was a constant problem. Here was an operation based on anatomy and not on physiology. We could not foresee then that the kidney transplant from a uniovular twin or a friendly doctor would function equally well when transplanted into the groin with anastomosis to the femoral vessels. Waugh, who was the father of the present technique of tonsil dissection—a delightful piece of surgical skill—was also responsible for the foolish operation for fixation of the caecum into the right iliac fossa. He could not have realized that to stitch an organ with constant peristalsis to a fixed structure was bound to fail. It is interesting to note how many men can have brilliant original ideas and fail on other scores.

Barium meals—or bismuth meals at that time—were showing that the intestine in many cases was low-lying and distended and so plications and fixations became popular to try to standardize the shape and level of the gut—one might as well try to standardize the colour of one's hair. These operations were described later as "operations done by and on neurotics." We are now constantly surprised when doing a laparotomy to find the entire bowel fused together in solid adhesions and yet the patient symptom-free.

Effect of Antibiotics

With the arrival of the sulpha drugs and penicillin mastoid suppuration suddenly decreased and empyema of the thorax with the various problems of drainage almost disappeared. The long guttered tibia with a tender adherent scar, with sinuses breaking out for many years later, has become a thing of the past, as has the deep grotto in a bone with hard eburnated bone around it. The large sequestrum involving the length of a long bone with neighbouring joint involvement and resultant crippling is indeed now a museum specimen.

Perhaps we must not be too optimistic about these drugs, as the writer of 25 years hence may be including some of them in his discards. The consultant at one time was the one to order the antibiotics; now his main function seems to be to see that his patients do *not* get them. Penicillin has become too safe and too cheap. I am sorry that the slick expression of a "protective umbrella of penicillin" was ever invented. However, when we think of the days when cellulitis was treated with multiple incisions and drainage-tubes, and of carbuncles assaulted with the drastic surgery of excision, cruciate incisions, or cautery, then we must realize that the antibiotics have certainly helped soft-tissue infection. No longer do we see a limb being amputated as a last but useless resort in the patient dying from septicaemia. Some brilliant surgeons and pathologists might to-day be living had these drugs been invented a year or two earlier.

To deal with the saga of the treatment of burns would be a lecture in itself, but we do see now that Wilson's suggestion of tannic acid, based on the cold tea of the ancients, was an attempt to form a protective coagulum or crust, and was a step in the right direction. Modifications of his method, employing other agents such as picric acid, gentian violet, and triple dyes, have been used. They have indirectly led the way to the present

exposure treatment whereby a crust of normal exudate or serum, if kept sterile and allowed or even helped to coagulate, gives the perfect dressing until skin replaces it either by normal growth or by skin graft.

Some operations were suggested by the post-mortem findings: for example, decapsulation of the kidneys. At necropsy in cases of anuria a tense swollen organ was found and it was suggested that benefit might have resulted from early relief of tension and decompression. During the war I did a few of these operations in the then Gold Coast for blackwater fever, and since the war at the request of the obstetricians I have done two for the anuria of the cortical necrosis of pregnancy. The artificial kidney has replaced this useless operation, and has given the patient time to survive if the renal changes prove to be of a reversible nature. This pump, if used selectively, has great value, and it is a pleasant contrast to the hit or miss method of peritoneal dialysis which seemed to have very little to offer in return for the danger which it entailed.

Surgical Serendipity

Some operations were accidental discoveries—cases of surgical serendipity—and, although some may persist, many do not. *Post hoc, ergo propter hoc*, is not sound reasoning in surgery. An interesting example was the operation suggested by Wilson Hey for peptic ulcer. In preparation for a gastrectomy he had deprived the stomach of its four main blood-supplies along the lesser and greater curvatures, when suddenly, at the request of the anaesthetist, he had to stop. The abdomen was hurriedly closed, and the patient made a good recovery and the ulcer was apparently cured. To rationalize this success he made the suggestion that it was the cutting of the sympathetic fibres which accompanied the blood-vessels that had produced this effect, and so an operation easy to perform and with no mutilation of the stomach itself appeared on the market. Popularized and publicized, it offered great possibilities, especially in those countries where the staple diet is a carbohydrate one and where a large reservoir is necessary. Howard Somervell carried it to South India, and it survived for many years before it was displaced. It was based on a completely wrong conception, since it is the parasympathetic nerve supply that needs to be dealt with.

The cutting of the parasympathetic in the form of vagotomy below the cardiac branches now in existence for 19 years was based on careful animal experimentation and research in dogs by Lester Dragstedt. So often, unfortunately, the analogy does not always hold good between animal experiment and human pathology. Someone has said there is little relationship between "the healthy frog and the diseased man." Vagotomy in theory was the answer to the hyperacidity problem, and yet it was a failure by virtue of its side-effects and had to be discarded. I remember doing this operation on a woman aged 20 shortly after it was described, and for several weeks her life was in danger with almost cholera-like diarrhoea, and so the operation, so far as I am concerned, was abandoned. Dragstedt in 1943, speaking of his own operation, said: "It is permissible to entertain a hypothesis but not to be entertained by it. When it has been proved untenable by facts it must be discarded." Little did we realize that, although a failure by itself, vagotomy would in symbiosis with another operation, which itself had become almost a

discard through being a partial failure, form the basis of a combined operation which in many parts of Britain is the operation of choice for duodenal ulcer to-day.

Each operation alone was a discard, but together a most valuable combination resulted. Gastro-enterostomy itself was hard to displace. With the dynamic backing of Berkeley Moynihan, with the operation's great success in women, and with its relatively low death rate, it was kept in the forefront for a long time. Moynihan fought for it until he died, and in the U.S.A. it had the backing of Balfour, a man of very considerable prestige. I remember a senior surgical colleague coming back from Leeds. He had asked Moynihan his indications for a gastro-enterostomy. Moynihan said nothing, but he drew the stomach and first part of the duodenum on a piece of paper. He divided the stomach by vertical lines into three portions: antral, mid-gastric, and cardiac. Then, starting with the duodenum, he wrote in the four areas "always," "often," "sometimes," "never," and handed the paper back without a word. That was looked on in my younger days as the blueprint for gastro-enterostomy. We would agree only with the last one of these now.

Sympathectomy

We all at one stage of our surgical careers were carried away by the attractions of sympathectomy.

My first consultant appointment was to a children's hospital, and I blush to think what I did to cases of Hirschsprung's disease in those days—a lumbar puncture with spinal anaesthesia. What hope was there of that ever doing any permanent good?

Lumbar sympathectomy on the left side and later on the right side was advocated, and finally we resected the distended portion of gut, leaving the contracted aganglionic segment behind. This was surgery at its worst. Presacral sympathectomies for dysmenorrhoea had some satisfied clients—satisfied that something was being done—but the condition was in no way improved.

Just before this Royle had produced his theory of plastic tone for spastics, and so they, like many others, had a lumbar ganglionectomy carried out. A dry warm foot but no change in spasticity resulted.

In a genito-urinary department the question of hydro-nephrosis being due to sympathetic imbalance often arose, and so the operation of Papin and Ambard was popularized for some time—denervation of the renal blood-vessels. It was a difficult and tedious affair, and had been rushed off the drawing-board without any well-authenticated physiological proof. It did not make the nephrectomy some months later any easier to perform.

Leriche was renowned for his periarterial sympathectomy. Even severing the artery and removing a segment was being carried out. This always seemed absurd, as the unfortunate limb was already struggling with its inadequate blood-supply. This work of Leriche's has not stood the test of time, but he must and will be remembered and respected as a pioneer, as a trainer of young men, and for his own personal integrity.

A few years ago in Britain three main sympathectomies had survived out of those originally suggested: the lumbar sympathectomy for the lower limb, the thoraco-lumbar for hypertension, and excision of the stellate ganglion area for the upper limb. Even these have now a very much reduced popularity. For high blood-

pressure the figures of the Lahey Clinic are worth mentioning. In 1947 there were 265 splachnicectomies performed, in 1957 there were 15, and in 1958 there were only three. This was not because the operation necessarily had proved a failure, but because a ganglion-blocking drug capable of carrying out a medical sympathectomy had been invented. The surgical take-over bid for hypertension had not survived very long.

Some years ago mental illness was a drug problem, but in 1937 prefrontal leucotomy and lobotomy came into the field to replace electric convulsion therapy—the knife had superseded the drugs. Now the pendulum has swung the other way again and we see that in the Lahey Clinic in 1947 there were 209 lobotomies, in 1957 there were 18, and in 1958 there were five. New more-selective procedures to control anxiety and agitation without sacrifice of the intellect had been invented. This coincided also with the advent of the tranquillizers.

Surgery of the Abdomen

The surgery of the abdomen has been prolific in discards. One of the most famous of these is colectomy. When it was introduced by Arbuthnot Lane as the cure for chronic constipation he did not seem to realize that this necessary body function was allowed wide variations, and that each person had his own standards—not like a golf course with an accepted bogey for all. Arbuthnot Lane, however, went further in his assertion that all ills from brain tumour to cancer of the breast could be prevented by it. His work on fractures was pioneer work. His cleft-palate operation may not have been accepted, but it was an interesting conception. Colectomy, however, was quite wide of the mark, and during his later years he became quite unbalanced about it, as seen by the famous case of the French boy who was sent to him with an ununited fracture for plating; Arbuthnot Lane suggested removing his colon instead (Sir Henry Newland).

Although colectomy for constipation has become like the biblical stone that the builders rejected, in its modern form it has become the very corner-stone in the treatment of the intractable diarrhoea of ulcerative colitis. Here was a discard which, when used for a different purpose, has become one of the most valuable operations in use at the present time.

It is interesting how stubborn the inventor of an original idea can be; how strong in its defence and how unwilling to think that it can be superseded or improved upon. Lister fought hard to revolutionize surgery with his carbolic acid spray, but he was just as resistant and obstructive to the new phase of aseptic surgery, when it was suggested, as his opponents had been to his new antiseptic method. I hope there is a lesson for us all in this somewhere. Many of us here have had to live through aseptic, then antiseptic, and now back to aseptic surgery—for what in fact is war surgery but antiseptic surgery? Indeed, is there much difference really between the carbolic spray of Lister and the modern so-called umbrella of penicillin?

Irrigation

Mechanical treatment of infection is much less practised than it was—for example, gargles, eye-washes, vaginal douches, rectal irrigation, bladder wash-outs. The irrigation of wounds by the Carrel-Dakin method was physically satisfying, but it helped nature very little. As a student my job was to put the fine rubber tubes

into the various wounds and hope that the eusol solution would squirt out equally from all the small openings—something that was physically and technically impossible. Irrigation of the peritoneal cavity I never saw carried out. It received its death knell from the damning report published by Percy Sargent in the *St. Thomas's Hospital Reports*. I did, however, always drain the duodenal area after a perforation, and also the pouch of Douglas, as the patient was always nursed in the Fowler position after this operation. Now the abdomen is rarely drained. Very few people seem to realize that the fluid found in the peritoneum after a duodenal perforation is usually alkaline in character, and will coagulate when heated. In other words, we are draining away one of nature's valuable protein fluids.

No longer is the acutely ill patient rushed to the theatre; delay for resuscitation is time well spent. I remember a surgeon describing how he operated on a patient with a perforation of a duodenal ulcer. As he was going down the steps of the hospital to his car a man on the footpath collapsed in front of him. A diagnosis of perforated duodenal ulcer was made on the spot. The man was taken straight to the operating-theatre and the operation carried out within ten minutes of perforation with absolutely minimal peritoneal soiling. That patient died—and yet no one could have been seen or dealt with sooner. A period of resuscitation, giving him time to recover from his primary shock, might have saved his life.

A wonderful change is the modern treatment of paralytic ileus. The patient is no longer killed by surgery and surgical impatience. Gone are the foolish ideas of trying to make a paralysed muscle react to pituitary or other smooth-muscle stimulants, or trying to neutralize with anti-gas-gangrene serum the intoxication believed to arise from the increased *Clostridium welchii* colony in the gut. Gone is the idea that it is the pus around the gut in the peritoneal cavity that is at fault, which forced surgeons into performing multiple external drainage operations with finally, occasionally, drainage of the thoracic duct in the neck for fear of general blood-stream absorption. Da Costain's lymphaticostomy received a knock-out blow when the lymph from the cut thoracic duct was found to be sterile. Jejunostomy drained only a small segment of gut, but every additional surgical manœuvre merely postponed the day when normal movement with help and patience would return. To-day's gastric suction, aided by morphine and intravenous fluid replacement, has revolutionized this problem.

Anaesthetics

The anaesthetists, except for ether, chloroform, and ethyl chloride, seem to wish to retain all the modern anaesthetics, although the use of spinal anaesthesia, fluothane, cyclopropane, etc., must vary with the personal tastes of each individual. I had suspected that blind intubation of the trachea through the nose, as invented by my own countryman Ivan Magill, had been discarded to be superseded by intubation under direct vision by means of the electric laryngoscope, but I find that this is not so. Many cases of cervical deformity, trismus, tumours of mouth, jaw, and thyroid do not permit direct vision, and some of our younger men regret that they were not trained sufficiently in the old blind method. This should remain still as a valuable and necessary manœuvre.

One discard from the anaesthetist's repertory, however, would appear to be splanchnic anaesthesia. With great enthusiasm the surgeons adopted this following George Washington Crile's anoci-association, and so infiltration anaesthesia of the coeliac plexus was supposed to be a necessary part of every upper-abdominal operation. Yet the varying techniques, and the very varying approaches that were made, created considerable doubt. The French often used to put the local anaesthetic into the general peritoneal cavity. Others put it into the lesser sac, while again others, with a finger deeply placed between aorta and inferior vena cava, guided a long needle to this indefinite area, and a wide regional infiltration of retroperitoneal tissues was obtained.

Finally, there was the approach from behind, so much favoured by Gordon-Taylor and his anaesthetist, Dr. Raymond Ebenezer Apperly. I remember well assisting Gordon-Taylor to do a cholecystectomy, and 50% of the time was occupied in this difficult and dangerous lumbar approach. This has been discarded for abdominal surgery, but it has been resurrected for cases of chronic pancreatitis with a somewhat doubtful reasoning behind it.

Discarded Attitudes

A pleasant change has taken place over the years in surgical relationships. Discarded are the days of the bitter acrimony and jealousies—the competition to be first in the field with a new procedure, to do an operation, as someone has said, before the “lease runs out.” Some of the animosities are almost part of history now—the actual fisticuffs that took place between Sir Peter Freyer and Hurry Fenwick over the question of total prostatectomy versus removal of the adenoma alone.

The outrageous claims that could not be substantiated are made no longer. Mortality figures were based on memory or impressions. I remember at an Association of Surgeons' Meeting in Sheffield hearing one of England's most eminent surgeons say, “In my last 800 splenectomies I regret to say I lost one case” (Sir Berkeley Moynihan).

The modern follow-up department has proved such claims to be either true or false. The almost universal appointment in all medical schools of a department of surgery with a full-time professor in charge has meant that continuity of follow-up clinics is preserved. If it falls into ever-changing hands the results are valueless.

Travel both at home and abroad has become easier. Small surgical clubs have arisen so that fewer people now work in isolation. It prevents anyone getting too important in his own eyes or too set in his own methods. Very few registrars now get their consultant appointment without having worked with many chiefs and without having seen the working of surgery, for better or worse, in the New World.

Assessment of Operations

How can operations be tried out on the human patient to have their value assessed? At the moment it is done by trial and error, and often after 5,000 operations it is decided that a certain procedure is not good. This would not arise with animals, as a true control series is carried out at the same time. Yet animal experiments may be misleading.

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An operation that had almost as short a life as its gallant inventor was O'Shaunessey's cardio-omentopexy. I remember in this very hall looking at microscopical sections showing the rich arterial cross-anastomosis between the omentum and the muscle of the cardia wall. This work was done on young greyhounds. A friend of mine from Sheffield described to me the first one that he did. The first bite of the needle into the heart wall removed a large piece of tissue, there was a large hole, and immediate death. This tissue was no longer heart-muscle—just a fibro-fatty mass which never could have been revascularized, and if it had been it had no residual muscle fibres to contract. For degenerative diseases the analogy between the young vital animal and the ageing human is really valueless. We should be using degenerating animals to have any real comparison. This sounds cynical, but animal experimentation must always be looked at realistically. For two years in my life I had to countersign requests for vivisection permits for animal experimentation in Ireland, and I got then an insight into the problems that it presents.

To suggest a control series with human patients would produce an outcry from high-minded surgeons. Yet it is possible that the placebo operation suggested by Beecher and carried out with the patients' full consent and understanding may eventually find a place in British surgery.

The beauty of a presidential address is that there is no discussion or debate. This is a protective measure laid down for the health of the president. It is fortunate in this case, as so many of you are waiting and wanting to get at me because I have perhaps discarded your best operation or your most valuable tool. I realize that many of my discards are not yours. We all have our fads. In all our golf-bags there is a disreputable rusty instrument with a hickory shaft, but it seems to stroke the ball into the hole, or at least get it nearer the hole than some modern contraptions.

Surgeons do not grow up, I am glad to say. Their surgical equipment contains some queer-looking instruments. They cling on to these, just as in their earlier years they carried in their trouser pockets something to take stones out of horses' hoofs. They may never use them, but without them life would be very dull indeed.

“During the year the Council [of the Institute of Almoners] received reports from general meetings held in every region indicating that a majority of the members now favour a change of name from almoner to medical social worker. After notifying other social work organizations, social studies departments of universities and the Ministry of Health, the Council made formal application to the Board of Trade to change the [name of the] Institute of Almoners to the Institute of Medical Social Workers. The reply received was ‘... after due consideration and consultation with other interested authorities, the Board was not prepared to give approval to the proposal that the title almoner be changed to medical social worker.’ The Council, having decided on the change of name after deliberations which have taken place at intervals over the past twenty-five years, is undeterred by this set-back and will, in due course, appeal to the Board of Trade to reconsider the matter. This report on the situation is therefore regarded as an interim one and the Council confidently hopes that before long a final decision may be reached which is more in line with current developments in social work in the medical setting.” (*Annual Report, 1961-2, Institute of Almoners.*)