never vanished. Looked at in this way, how essential it becomes to make every effort to bring the nutritional factor to the maximum point of efficiency, not only in order to promote local repair, but to increase the general resistance against the essential cause of the disease! This will not necessarily be effected by excision or by short-circuiting, but by the more rational methods to which I will now briefly refer.

3. As regards medical treatment, many cases of duodenal ulcer, both acute and chronic, recover, and recover completely, under the medical régimes of starvation, semi-starvation, the milk, egg, and slop treatment, the Lenhart diet, and so forth. It is also true that many of these cases relapse. In hospital patients almost any method may be followed by rapid and striking improvement, mainly on account of the change from a wholly indiscreet dietary indulged in before admission. The value of all statistics based on treatment of this class of case is, therefore, seriously discounted. So little is this sometimes realized that I have been assured by physicians of wide hospital experience that new medical methods of treating gastric and duodenal ulcer are hardly wanted. This view, based on the experience that the hospital class do well under the time-honoured régimes of starvation followed by slops, is a very one-sided view, quite apart from the fact that a vast number of these cases relapse. For since 1907, when two small papers appeared under my name advocating a broader conception of the pathology of the disease than is generally taught, and urging the trial of treatment on somewhat novel lines, I have been concerned in applying, directly and indirectly, the principles there enunciated to more than 200 cases of ulcer of the stomach or duodenum. The demand, therefore, for a somewhat more effective medical régime than the ones I have mentioned has not been small. Further, as the great majority of these have been private cases, the question of grossly inappropriate diet before treatment does not apply as in the case of patients of the hospital class.

The treatment I advocated was this:

For acute cases, with hæmorrhage, subcutaneous injections of sterile normal horse serum and feeding by the mouth at the very earliest opportunity with small dry meals, mainly of meat.

For chronic cases, full meat diet in an appropriate form from the start, with repeated oral doses—never on an empty stomach—of an antilytic serum specially prepared.

None of the duodenal cases treated by me, alone or in consultation, were recent ones except one. All were private cases. Every one was a derelict of some other method of treatment, and some were of ten, fifteen, and even twenty years' standing. Of these 24—this number not including the surgical cases referred to—there have been 2 that showed a very temporary tendency to relapse, and 1 failure that was unable for domestic reasons to persevere with the treatment. The test, therefore, has been a very severe one, though I shall call none of them cures till at least three years have elapsed.

The relief of pain, hæmorrhage, hyperchlorhydria, and dyspepsia has in all cases been most striking.

The history of the gastric cases is equally good, though with the greater number of cases the failures have naturally been more numerous. I am unable to attribute these results to the meat diet alone, as in three controls in which I withheld the serum for a fortnight progress was absent until the serum was added.

The *rationale* of my treatment is briefly as follows:

1. If it be true that duodenal ulcer is a symptom and not a disease, the absorption of adequate protein in suitable form cannot but increase the resistant powers of the body as a whole to the unknown determining cause of the disease. Moreover, local repair must certainly be assisted thereby.

2. If protein food is presented to a case of ulcer in which we know that the digestive fluids exhibit a high degree of peptic and tryptic avidity, a certain proportion of these peptic and tryptic molecules will be saturated by the protein. If now, at the height of digestion, be added a serum with a high antipepsin and antitrypsin content, some of the unsatisfied residue of peptic and tryptic bodies will combine therewith, and the ulcer itself thus be indirectly shielded by diversion of these bodies.

3. Once more, if an ulcer is constantly being bathed in sections laden with trypsin and other proteolytic ferments set free from disintegrated leucocytes, other tissue cells, and from bacteria, the administration of a serum charged with antipeptic, antitryptic, and other inhibitory bodies, cannot but have great

value. That is to say, the eroding activity of ferments from these sources must to a great extent be kept in check by such serum. That this is not a matter of theory only can be proved by any one who cares to treat a superficial ulcer which is constantly being bathed in highly tryptic pus, by the simple expedient of dressing it with sterile gauze soaked in sterile normal serum.

Whatever the *rationale* of this treatment the clinical results are undeniable, and though at first it met with quite legitimate scepticism, doubt is rapidly giving place to inquiry, inquiry to trial, and trial to conviction. Making every allowance, therefore, for personal bias and inevitable failures, I feel justified in adding my testimony to that of those who declare that the medical treatment of duodenal ulcer is approaching a sounder basis than it has perhaps reached in the past.

THE POOR LAW AND THE MEDICAL PROFESSION.*

BY THE LATE JNO. MILSON RHODES, J.P., M.D.,
ALDERMAN OF THE COUNTY PALATINE OF LANCASTER.

WHEN I was informed that you had done me the honour of inviting me to address you, much as I appreciated your kindness, I felt that I was, I will not say between the devil and the deep sea, for I would not for one moment venture to think either of you as the guardian of the former, but that as a member of the profession and Chairman of the Central Poor Law Committee for England and Wales, I was between the Scylla of the profession and the Charybdis of Poor Law administration. Probably under those circumstances the best course in my position to-day will be to imagine myself on the bench, and to do my best to well and truly try and true deliverance make between those who wish to reform the Poor Law and those who propose under the sole and not very courteous heading "to smash the guardians." That the report, or perhaps it would be more correct to say the seven reports, will receive the unanimous approval of the country I do not for one moment believe. That the Royal Commission has collected an enormous amount of information I cheerfully acknowledge, but they appear to have been too much divided among themselves to issue one *common sense* report, and, as regards some of the reports of the special investigators, from what I have seen of them their true value is—well, not very greatly due to work of bed rock knowledge. All the same the report is of considerable value, but so far as medical assistance is concerned the whole credit is most probably due to Dr. Downes, the only member of the profession on the Commission, and I am afraid the only member who had a thorough practical acquaintance with the urban and rural unions. Considering the splendid work he has accomplished, not only in regard to the Commission, but also in regard to the reform of the workhouse dietaries and workhouse nursing, it is a wonder that his services have not long since received that acknowledgement which they richly deserve. His memorandum and his evidence before the Commission are oases in the arid desert littered with the notions of the charity cranks and the Fabian faddist.

Before dealing with the strictly medical aspect of the question allow me for a minute to direct your attention to the "Statistical Memoranda Relating to Public Health and Social Conditions." No more valuable Blue Book has been issued in the thirty years that I have been connected with the Poor Law.

That report shows that the general death-rate in the last half century has fallen from 20.8 to 15 per 1,000, a loss of at least 100 cases of sickness per 1,000 to the medical profession; but the coster, hawker, the general labourer, and the innkeeper and the publican still have a death-rate of more than double that of the engineer, clerks, etc. As you are all doubtless aware the rate of pauperism for England and Wales has fallen, but the institutional treatment of disease has enormously increased; the Commission recommend that we should copy our friends the French and substitute for our present term Poor Law, "Assistance Publique" or "Public Assistance." I do not think it will make much difference as regards the sick. There has

* The paper was read before the Manchester (South) Division of the British Medical Association after the author's death.

been, and there is, a steadily-increasing demand upon our union hospitals, to use the common term—not workhouses—used to describe them; the demand is no doubt due to increased confidence in their system of administration. That statement is no mere fancy of mine. The Registrar-General's returns show that the percentage of deaths in union hospitals in England and Wales has risen from 5.6 in the year 1871 to 9.7 in 1906, a rise from 28,753 to 51,356. The ratio of deaths in asylums during the same period has risen from 0.8 to 1.9, or more than double, the deaths in hospitals, 2.6 to 6.6.

Those figures prove the correctness of the statement "that with the growth of the population, especially in the large towns, hospital and the medical provision for general diseases has become one of the most important parts of the Poor Law service."

A census taken in 1907 made public a fact which many of us had long been aware of, namely, that one-third of the total number of persons receiving public assistance were cases of medical relief—that is, about 250,000 per annum. With figures like those before you, you will probably be of my opinion, that there ought to have been one member of the Commission who had had official experience of Poor Law hospitals—gentlemen like Dr. Alexander or Dr. Reynolds. You have to wear the shoe to feel where it pinches. If the Commission was not to exceed a certain fixed number, surely certain of the clergy could have been spared. One doctor to four clergy is very much like a hap'orth of bread to a gallon of sack.

One of the London papers asked me if I would state briefly my opinion on the reports, and I think my answer was almost a record, summed up in the old saying, "A plague o' both your houses."

That the Poor Law needs reform in several ways is an opinion I hold as strongly as any; but are the so-called improvements suggested real or only apparent, and are all their statements facts? Take, for example, the statement made at page 847 of the Report. The writers state: "We have, however, to record that in the great majority of unions, especially those of rural or semi-rural character, the boards of guardians have shown themselves equally impervious to both sides of the advice and injunctions of the Local Government Board, and have continued with a minimum of improvement. Much the same primitive provision for the sick poor alike for those residing in their own homes, and those within the general mixed workhouses, in which the authors of the report of 1834 seem tacitly to have acquiesced." The most charitable thing to think about that is that the writers (I do not say the signers of the Report) have had very little practical experience of Poor Law administration, or they would not have written such nonsense.

In the last quarter of a century a reformed dietary, compiled on really scientific lines, has been adopted in all the workhouses of England and Wales. It is true, as the Majority Report states, that prior to 1865 the poor were chiefly nursed by paupers, who were often illiterate, drunken, and altogether unsuited for such work. I think I did more than anyone else to get the Local Government Board to issue the celebrated nursing order of 1897, which directed that "no pauper inmate of a workhouse may now be employed" to perform the duties of a nurse in the sick or lying-in wards of the workhouses, and no pauper inmate may be employed as an attendant in the sick or lying-in wards of the workhouses, or upon any pauper in the workhouse who requires nursing, unless such inmate shall be approved by the medical officer for the workhouse for the purpose, or shall act under the immediate supervision of a paid officer of the guardians.* That was an enormous improvement from the professional point of view, because it gave a power of veto to the medical officer. That was, in my opinion, the greatest reform in Poor Law accomplished in this or any other country in the world. There are other improvements, but I simply quote these to show that ignorance or prejudice must have played a considerable part in the preparation of certain parts of the Report.

I am quite aware that there is a complimentary phrase or two in regard to the medical profession in the Minority Report, but it is not the first case of "damning with faint praise."

If proof was required of the incompetency of the Commissioners—with, of course, the exception of Dr. Downes—as regards the number and aspects of the reports, it is found, in my opinion, in the lame and impotent conclusion they have come to in Recommendation No. 13: "That, with a view to enlisting the services of all competent medical practitioners in the locality of a provident dispensary, the British Medical Association be requested to suggest a general scheme, or scale of fees and wage limit, to be applied by their local Branches as local circumstances may suggest." Gentlemen, has the provident dispensary system in Manchester been one that has given satisfaction to the profession at large, and has it the support of the British Medical Association? And there is another question in this recommendation, and that is, Do you think the authorities (never mind whether guardians or health committees) would be willing to hand over the treatment and the payment for thousands of cases to a provident dispensary committee?

I see in the Report references to the French and German evidence given before the Commission by my colleagues, Dr. Munsterberg and M. Monod, but so far I have seen little if any evidence that use has been made of their expert knowledge, not only of *assistance publique* in France and Germany, but of all the countries of the world. Both, or perhaps it would be more correct to say all, the reports appear—at any rate in respect of the term used in regard to relief—to have taken their ideas from the French by adopting the term "Public Assistance" instead of "Poor Law." (I think the Commissioners might have done more than adopt the names, and given us a little more about the *Loi de l'Assistance Publique* and its result.) The population of France is practically the same as that of England, but the number of patients receiving medical attendance and relief at home is 498,033, or very nearly double the number we have in England. That total is greater than it was five years before by 151,000 cases, and the cost has also increased in like manner. Physicians' and surgeons' honoraria rose in the same time from 1,730,000 fr. to 2,819,000 fr. Drugs and dressings, which are a separate item, and are usually provided by the chemist, rose from 1,528,000 fr. to 2,961,523 fr.; the latter appears to have come off better than the former. The cost per case has risen from 9.86 fr. to 12.07 fr. That would amount to 5s. per case without medicine or dressing.

There is no doubt in my mind that sufferance has been too much the badge of all our tribe in regard to the fees paid to the medical officers, but there is something worse than sufferance, and that is a want of *esprit de corps* in the profession. I know of a case where a member of the profession took an appointment at a low figure simply to keep another man out. I know for a fact of another case where a candidate for a medical officer's position offered to do the work of the medical officer for nothing if he got the vaccination fees. I carefully explained to him that I could not possibly support him, first, on the ground that he was not loyal to his colleagues, and secondly, that the offer was an insult to the guardians, as it implied that they had not considered the question, and were extravagantly spending the money of the ratepayers on medical out-relief. Whatever sins the guardians are guilty of—and the number with which we are charged is so many that the writers of the Minority Report judged us to be guilty of death—they are, at any rate, not guilty of over-paying their medical officers. Mr. N. A. Stonham, in his evidence before the Commission, states that the Report of the Local Government Board shows that the remuneration averages about 3s. 3d. per case—not per visit—and that is, in my opinion, about what it is here. He also stated that whereas he received in 1892 at the rate of 3s. 4d. per medical order in Stepney, it was in 1907 only 1s. 6d. per order, or less than 50 per cent. There are plenty of places where the payment is much worse than that. Mr. Rushbridge in his evidence stated that he knew of a case where the district medical officers paid about 8,000 visits and dispensed 20,000 mixtures for the remuneration of £120, or 1d. a visit and the same sum for a mixture. Speaking as a guardian, I say that such a case as that is a disgrace to the board that practises such an abominable sweating system, for if the sick poor are properly treated it is done, not at the cost of the ratepayers, but at the cost of the very life-blood of the medical officer.

* In the Minority Report the Northern Workhouse Nursing Association is quoted. The Association was wound up ten years ago.

Dr. Downes in his evidence—and very valuable that evidence is; as a matter of fact the official evidence furnishes nine-tenths of what is valuable, that is, so far as the evidence is yet published, and that is not half—pointed out that in London you have two classes of out-relief medical orders, the temporary and the permanent. Now, I think under that system you might do better than we are doing at present. There is one matter that it is only right to point out, and that is that the Poor Law Commissioners who preceded the Local Government Board recommended in their report of 1839 that the payment should be per case treated. I am quite aware that there were reports from both sides against the system, but it is to Parliament that you owe the thoroughly unsatisfactory condition at present existing. No doubt the motor car has made it easier for the medicus who can afford one to rush through the country like a rocket, but that does not apply to the sick poor, and I do not think that our present system does fit the case. I am quite aware that a resolution was passed by one board that every member of the profession should be a district medical officer and vaccination officer. Now, with regard to the latter I am in thorough agreement; as you all know, the object of the vaccination officer was that he might be able to select a thoroughly satisfactory case from which to vaccinate the children. With vaccination from the calf there is no longer the necessity to pick and choose the case, and the sooner we adopt the Scottish system and pay the practitioner who does it, as you pay the practitioner who notifies a case of infectious disease, the better; but when you come to the question of medical assistance the case is different, for there are a very considerable number of members of the profession who would strongly object to be at the call of every Dick, Tom, and Harry at any hour of the day or night.

During the last ten years *assistance médicale gratuite* for the poor has been the law in France. Previous to that date it was under the Bureau de Bienfaisance.

At the present time uniformity has not been reached across the Channel; 59 departments allowed the patient to select the practitioner they desired, and in 24 the medical officer was appointed for a special area. In one department both systems were at work. The medical officer is paid by the visit in 57 departments, and by contract in 27.

That *assistance médicale gratuite* is very largely made use of is proved by the report recently issued, which showed that with a population of 35 millions, no less than 1,389,627 were on the permanent medical relief list, and 30,107 were admitted as urgent, in addition to those admitted by the *préfet*. The number was 1,421,392; the cost of visits and medicine and dressing was over 4 francs per case; rather more than half of that was for medicine.

Between 1895 and 1902 the number of cases of outdoor medical assistance has risen enormously, and the cost also, as the following figures prove:

Totaux Année.	Honoraires de Médecine.	Honoraires de Sages-femmes	Médicaments et Appareils.	Totaux
346,879	1,730,680fr. 54c	163,620fr. 21c.	1,528,520fr. 85c	3,422,821fr. 60c.
554,252	3,458,737fr. 27c.	258,221fr. 20c.	3,613,090fr. 74c.	7,030,049fr. 21c.

Coût moyen: 1895, fr 9.86; 1902, fr.12.68.

† You will notice that most of the increase has gone into the pockets of the chemist, and not the doctor. Some of the items that have attracted the attention of the auditors:—If our *chère amie* on the other side the Channel are:—in a case of caries of femur 260 francs was charged for 13 kilos of granulated kola; another used 169 metres of iodoform gauze at a cost of 591 francs, or 350 francs per metre, and 78 kilos of cotton-wool at 6 francs the kilo; the kola was replaced by quinine wine, and in another case peptone *sèche* was substituted for a bottle and a half of champagne a day—nearly as bad a come down as the pop and cockles for champagne and oysters.

The French nation has found, as we shall find, that the reform of the Poor Law *en bloc* is nothing like so easy as it looks; recent as the *Loi d'Assistance Publique* is, uniformity in France appears to be a term interchangeable with the Greek Kalends. In some parts of France there is, or has been, a strike of the medical practitioners, and

no wonder. I should trust you would strike, too, if you received per pauper on the permanent list 150 franc in your own parish, 250 francs if four kilometres off, and 3 francs if more than four kilometres. In some parts the mean cost has been 486 francs, in another part 31.74 francs; the average cost per case has been in departments less than 10 francs, 13 in 1900, 13 in 1901, and 12 in 1902.

For cases of an urgent character the fees were:

- 6 francs in the parish where the medical officer resides.
- 7 francs where the distance is four kilometres.
- 8 francs where the distance is more than four kilometres.

The medical officers *de la somme* struck and resigned *en bloc*, having, to their honour be it said, made arrangements amongst themselves to treat the sick poor gratuitously for four months. In Paris itself the honorarium was fixed annually at sums of 1200, 1500, or 2000 francs.

The system has many faults; there is not only, as M. Trichet points out, the difference between the man who scamps his work and the man who does not, but also the man who does it conscientiously has in the *arrondissement* where there are several officials the most to do, and receives no more for his labour.

To remedy that it was proposed to pay by the visit; against that the charge was made that there would be a very large number of unnecessary visits made, and it was recommended that there should be so much per case and so much per visit, and that system has I believe been adopted.

It is not only France that is troubled on this question. Germany, where they have State law as well as Imperial law, has also been troubled. In Strassburg the medical relief was provided by nine medical officers, whose duty it was to look after the sick poor, something on the plan of certain writers who think they understand Poor Law, and have never had a day's practical experience of administration. That system was, to put it mildly, found defective, and the sick poor under the Poor Law may apply to any of the seventy doctors who have accepted the terms proposed by the municipalities, namely:

- 1 mark for a consultation in the day time.
- 2 marks for a consultation in the night time.
- 1.50 marks for a visit in the day time.
- 3 marks for a visit in the night time.

Against that proposal were raised the objections:

1. A considerable increase in the number of visits.
2. Increase in the consumption of medical extras.
3. Abuse of prescription of mixtures pleasant to take and stimulating, prescribed with the idea of increasing the *clientèle* of needy and unscrupulous medical men.

To meet that difficulty the Corporation of Strassburg resolved that when the medical officer's fees exceed the estimate of the municipal budget, which is calculated on the tariff for insurance against sickness of 5 francs per indigent and 10 francs per pauper family, the account of the medical practitioners will be reduced in proportion. At a congress of our French colleagues held last year they were of opinion:

1. That the free choice of the medical officer should be given to every pauper.
2. That every member of the profession accepting the terms of the department should be placed on the list as a medical officer of the public assistance.
3. That the law should apply to the towns having autonomy as soon as possible.
4. That all medical relief should be on the Vosgien system.
5. That for the settlement of all conflicts there should be an arbitration board—half councillors and half medical men—with a neutral chairman.
6. The congress expressed a very strong view against all the associations who desired to prevent the patient having the free choice of his medical adviser.
7. That a visit of consultation should never be less than 2 francs.

8. The present 2 franc fee should be 3 francs.

9. The present 3 franc fee should be 4 francs.

It is evident that the question of the remuneration of the medical officer is one that demands the careful attention of all members of the profession; we are, I am afraid, in the medical profession drifting into two sections, the official and the non-official, and the interests of the one

appear to be sometimes opposed to the interests of the other; for example, the sanatoriums are, no doubt, excellent things, but there is equally little doubt that the use of them has diminished the income of the general practitioner to a very considerable extent, though he has had to pay his quota towards supporting them, and though he derives no benefit from them. I have brought the example of France forward because it is evident that (though I have not the slightest doubt, after studying the practical administrative working of public assistance in most of the countries of Europe, that ours is the best in the world) there are things that might be improved, and that one of these is the control of the administration of public assistance.

I.—In England we have a Local Government Board composed on exactly similar lines to that described in the ballad:

O, I am the cook and the captain bold,
And the mate of the Nancy brig,
And the bosun tight and the midshipmite
And the crew of the captain's gig.

I do not believe the so-called Board has met more than twice in the last quarter of a century, and then only for a few minutes; the *President* is the Board, and in my opinion you cannot make the position too high; for the health and therefore the wealth of the country depends to a much greater extent upon that office than any other department of the State. But at the same time, while I would keep the President supreme, I would have a higher Council of Public Assistance, upon which the medical and legal professions should be represented as well as the laity. Upon the French council quite fifty per cent. are members of the profession, some of them eminent in hygiene, others in hospitals, others as alienists, and others *directly* representative of the medical profession. I believe with a Council similar we should progress steadily and safely at a more rapid pace than we have been doing, and we should probably be less troubled with red tape.

I hope I shall not be misunderstood when I say less red tape—tape, no matter whether it is red as in England, green as in France, or white as in Germany, is popularly supposed to be manufactured in the Government offices, and that some years ago was my opinion; that opinion was a mistaken one, the manufacture of red tape is almost a monopoly, and is carried on at H.M. Palace of Westminster. The vast majority of Members of Parliament have only a very elementary knowledge of Poor Law, and are not competent in many cases to criticize. I would not propose for one moment to do anything to diminish one iota the supremacy of Parliament, but could we not alter our system? Bills brought in and passed by the Colonial Parliament have, I believe, to be confirmed at Westminster—in other words, the British Parliament has a power of veto. If you enlarged the Board as I propose, there are a good many things that might be left to the Board, and so save the time of Parliament being wasted by discussing things they do not understand. That is the first reform.

II.—The *second* is that all medical men of good habit and repute should be placed on the list of medical officers, and in the event of the Board and their officers not being able to agree as to the honorarium the Local Government Board should have power to arbitrate. Of course that alteration could only come into force gradually, because the present medical officers have, and rightly have, a fixity of tenure under the existing system, and must be continued in office unless adequately compensated.

III.—The *third* is that the extra fees should be thoroughly revised. Conservative surgery has no doubt in many districts, especially the rural unions, reduced the extra fees, and the medical man ought not to be mulcted because he has restored a man's leg whole as the other instead of amputating it.

IV.—And *fourthly*, if the profession is to have the weight in the country that it ought to have we must have loyalty to each other; by that means, and by that alone, can the overworked and far too often underpaid medical officers in the Public Assistance Department of the Local Government Board hope to attain that position to which their arduous duties entitle them.

It may be thought that I have said very little about the Minority Report. I should have thought much more about it if it had been drawn up by those who had practical experience of Poor Law administration. You cannot make

a surgeon by walking through a score of hospitals, and reading what other people have done. That never did and never will make any one competent to judge the guardians.

I will give you an example or two. The Minority Report states:

So far as we can ascertain, the education given in the other Roman Catholic schools, some of which have over 100 boys or girls, and that given in the schools and homes belonging to other denominations or no denomination, apart from a series of institutions which happen to receive grants from the Board of Education as being public elementary schools, is to this day not subject to any inspection whatever.

Now what is the truth? Of the 55 Roman Catholic certified schools mentioned on page 810 of the Minority Report, it was found that 50 of the schools with 5,000 scholars were under educational inspection, and only 5, with a total of 49 scholars, were not under educational inspection. Again, at page 865, they say:

In every Poor Law infirmary—and some of them exceed in size the largest voluntary hospitals in the kingdom—all the cases have to lie in the common wards and be diagnosed, physicked, and operated on by the overworked medical superintendent and his two or three assistant medical officers. The absence, even in the metropolis and the largest towns, of visiting physicians and surgeons, is here a patent drawback of these extraordinarily mixed institutions.

The writer may attach a different meaning to the words "in the common wards," but if they mean that medical and surgical, old and young, are herded together, it is no more true of good Poor Law hospitals like Manchester, Chorlton, Birmingham, Liverpool, etc. Any one who knows the facts knows that there are visiting physicians and surgeons as well as resident medical officers at Manchester. Dr. Renolds and Mr. J. Collier were visitors, and surely they were good enough for any hospital.

At page 861 they state that "Everywhere the master and matron have still to employ pauper assistants to help in attending to the sick." That is the sort of writing that you might expect in the yellow press, but hardly what you would expect from one who wants to pose as an expert. At page 862 they talk about the nurses, and on looking at the authority I find that it is quoted from an old report of my old friend, Mr. Jenner Fust, in 1897-8—eleven years ago!

At page 863 the writers say:

We do not feel competent to determine how far the claim often made on behalf of these Poor Law infirmaries—that they are now fully equal to the endowed or voluntary hospitals—can be substantiated.

With that paragraph I cordially agree, and they might have started a good many of their paragraphs with a similar statement.

On page 863 is quoted the statement that their most significant feature, "we are informed, is that they have become largely surgical, some of them having daily operations under anaesthesia." What does "largely" mean? With the exception of about a dozen unions, I doubt if there are anywhere as many as 23 per cent. of surgical cases.

On page 863 they state that the most modern Poor Law hospitals "tend to be elaborate, ornate, and expensive; the lighting and heating, the ventilation and sanitation, the operating room and the dispensary, are all of the most costly, if not always of the most useful, character."

The most charitable thing to think about that is that the writer did not know what he was writing about. If the guardians—and there are very economical guardians on every board—have not cut down expenditure as far as possible, you may be quite certain that the Local Government Board will. In every Poor Law infirmary—and some of them exceed in size the largest voluntary hospitals in the kingdom—all the cases, we are told, have to lie in the common wards and be diagnosed, physicked, and operated on by the overworked medical superintendent and his two or three assistant medical officers. If that is true of London, it is certainly not true of Lancashire. As every gentleman here knows, the patients no more lie in common wards than is the case at the Royal Infirmary. At Crumpsall, Liverpool, Chorlton, West Derby, you will find every bit as

good classification as in any voluntary hospital, in regard to visiting medical officers. There are Poor Law hospitals where there are not only visiting physicians and surgeons, but ophthalmic surgeons and dental surgeons.*

Memoranda :

MEDICAL, SURGICAL, OBSTETRICAL.

LIME WATER IN THE TREATMENT OF VERRUCA PLANA.

A YEAR ago a young lady who had been suffering for three years with warts on the hands came to me for treatment. The condition was that known as verruca plana, and there were at least 300 to 400 warts on the back of each hand and wrist, but none on the face or any other part of the body.

I ordered her calcium chloride internally, but, as this had no effect, calcium iodide and liquor arsenicalis, and at the same time various preparations were used locally. The patient then went to France and I did not see her again for a few months, but when she returned the condition of the hands was unchanged. I then tried cauterizing the warts with acid hydrarg. nit. dil. After several applications the warts cauterized disappeared, and the patient began to cauterize the warts herself; some of the caustic got on to the healthy epidermis and oedema of the hands developed; this subsided in a day or two under local applications; but, as I was very dissatisfied with the progress—or, rather, lack of progress—of the case, I sent her to an eminent skin specialist. She was under his care for four months, and he tried various modes of treatment: magnesium sulphate internally, liq. carbonis detergens in alcohol locally, and x rays; all these having failed, he resorted to scraping each wart and applying pure carbolic acid. This had the desired effect on the wart treated; but during this time fresh crops appeared, and the patient came back to me in October quite discouraged.

As local treatment appeared useless, since crops of warts kept appearing, I fell back on an old remedy, which, as far as I can make out, has fallen into disuse, and ordered her half a pint of lime water a day for a week. In the course of four days all the warts disappeared, and since then (two months) no fresh outbreak has occurred.

I have brought this case to the notice of the profession, as none of the recent books on the subject mention lime water as a cure of this very intractable disease.

DUDLEY KENNARD, F.R.C.S.E.,

Honorary Surgeon, Westminster General Hospital.

London, W.C.

FRACTURE OF THE GREAT TUBEROSITY OF THE HUMERUS.

IN the JOURNAL of December 11th, 1909 (p. 1674), Dr. A. P. Gibbons reported a case of fracture of the great tuberosity of the humerus. I have at present a similar case under treatment.

On September 13th, 1909, a man, aged 35, slipped and fell a distance of about 20 ft. into one of the Cardiff docks; his left shoulder came in contact with the side of a ship. After being assisted out of the water he found that he could not use his left arm. The locumtenent of a doctor found that the shoulder was dislocated; the dislocation was immediately reduced, and the arm bandaged in the usual way. The joint was kept at rest for five weeks; at the end of this time he consulted a second doctor, as the locumtenent had left. He was advised to have the adhesions at the joint broken down, under an anaesthetic, because he was only able to move his arm very slightly. This was done, and there was improvement in the movements. On November 15th I was asked to examine the man on behalf of an insurance company. I found that the movements at the shoulder joint were limited—that of

abduction being nearly absent. There was well-marked antero-posterior broadening at the shoulder, thickening at the great tuberosity, and acute pain on pressure. There was also pain and crackling in the joint due to arthritic changes. A skiagram of the shoulder joint showed that the man had, in addition to the dislocation a fracture of the great tuberosity of the humerus. For the last three weeks he has been undergoing a course of massage with passive movements and exercises, and intends to resume work in a few days.

Cardiff.

W. G. WILLIAMS, M.B., Ch.B.

ON January 15th, 1907, I examined such a case as Dr. A. P. Gibbons describes, and the skiagram shows clearly a detached fragment in just the position indicated by Dr. Gibbons's diagram, but the fragment in my case was not so large as his would seem to have been. I only saw my patient some time after the accident took place, but inferred, from the history given, that the damage was done by direct violence. I agree with him that cases of detachment of the greater part of the tuberosity are probably rare, as the above is the only one I have seen in the course of thirteen years of x-ray diagnostic work. I think, however, from my experience, that it is by no means uncommon to have small fragments torn away from the region of the tuberosities in cases of complete dislocation of the humerus.

Newcastle-upon-Tyne.

WILLIAM MARTIN, M.D. Durh.

Reports

ON

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

ST. MARY'S HOSPITAL, LONDON.

A CASE OF ABDOMINO-PERINEAL EXCISION OF THE RECTUM COMBINED WITH HYSTERECTOMY.

(By MAYNARD SMITH, M.B., B.S. Lond., F.R.C.S.,
Surgeon to Out-patients.)

THE patient, a female aged 58, was admitted on October 30th, 1908, having been sent to me by Dr. W. T. Harris of Chiswick. For some eight months she had suffered from constipation, and had found it necessary to take aperients to secure an action of the bowels. She had been subject to pain in the region of the rectum at the time of defaecation, and also after standing for any length of time. Four months before admission she had passed a considerable amount of blood from the bowel, and since that time had noticed streaks of blood in the motions. She was wasting rapidly. At the time of admission she was very emaciated, and looked extremely ill. She had irregular pyrexia—the temperature rising at times to 100° F. Rectal examination disclosed the presence of a hard nodular growth completely encircling the bowel at a point corresponding to the upper part of the sacrum. The finger could not be passed through the growth, which, however, appeared to be freely movable.

Operation.

It was decided to remove the growth by the abdomino-perineal route, if abdominal exploration showed this to be feasible. The operation was performed on November 4th after the usual preparation. The abdomen was opened by a free incision in the middle line. The growth was found at the junction of the pelvic colon and rectum, and a careful examination did not give evidence of any enlargement of glands or of any peritoneal involvement. It was seen, however, that fibroids of the uterus had enlarged that organ to the size of a large orange, and that this enlargement would constitute a formidable obstacle to the performance of the operation which was contemplated. The condition of the patient, although not good, appearing to warrant the more extensive operation, I decided to remove the uterus, and afterwards to proceed to the

* Dr. M. Russen Rhodes particularly wishes it to be understood that Dr. J. Milson Rhodes's paper was incomplete at the time of his death and had not been revised by Dr. Milson Rhodes, but his recommendations are clearly defined above in the paragraphs prefixed by the Roman numerals, I to IV.