An Address

ON

ACUTE MANIFESTATIONS OF CHRONIC DISEASE.

*Delivered at the Opening of the Winter Session of the
Midland Medical Society.*

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MR. PRESIDENT, LADIES, AND GENTLEMEN,—I have been oppressed by the feeling in the preparation of this address that it is unworthy of the occasion, and of the honour which your Society has done me by asking me to follow the distinguished men who have appeared before you in previous years. I have been conscious that one who enjoys the high privilege of opening your winter session might well have had something less commonplace to offer you in return for the respect you show him than such a paper as I might write on the Acute Manifestations of Chronic Disease. And yet I should like you to accept this introduction as an apology for my treatment of the subject, not for the subject itself, nor for the selection of it, on an occasion like the present.

I believe we cannot too fully bring it home to ourselves that what we commonly call "acute disease" is in many instances nothing else than an acute illness in the course of a chronic disease. It is certain that this relation of acute to chronic disease, whilst acknowledged in a general way, is from one cause or other readily overlooked or disregarded in our routine work, the acute element alone being recognized, the chronic element—the disease proper, possibly of great gravity—ignored. What is even more important, if the significance of an acute illness be correctly observed, it is not always appreciated in its practical bearings. These are the different aspects in which I propose to introduce this subject to your notice. Let us examine it in these different aspects. If it be presented to you as clearly and fully as it deserves, it may serve to interest you for an hour now, and prove of practical service to you in the future.

I will try to make my contention clear to you at once by means of a concrete illustration. A middle-aged lady, of good social position, and enjoying, as far as her many friends could see, excellent health, woke up one morning with pain in the abdomen and was sick. She took an aperient, but still felt unwell. On the third day she went to a picnic, and the same night became definitely worse. The next morning she was seen by the doctor, who diagnosed appendicitis from the history and symptoms, and this opinion was confirmed the following day by the appearance of fullness in the right iliac fossa, with tenderness somewhat above and behind McBurney's point. The temperature was moderate—about 100°; aperients brought away hard white stools. The ordinary treatment of appendicitis of somewhat mild type was employed, including enemata, which removed more hard faeces, with a good deal of local pain, and the patient was distinctly better. But the improvement did not continue. Pain returned; nausea, ending in a little vomiting, became a prominent symptom; the abdomen was more distended, and the motions were found to contain mucus and blood. After a few more days, during which these symptoms continued, definite coiling was developed in the abdomen; and now the diagnosis began to clear up. The case was not one of acute appendicitis of mild type, but of chronic intestinal obstruction. Operation was had recourse to, but without success. A ring-shaped growth was found in the descending colon, which appeared, judged by its characters, to have been forming extremely slowly, without producing discomfort or disorder of any kind.

When we review this case we see how it illustrates the various points which I have mentioned. What was regarded as a primary disease of acute course, whether gastro-enteritis or appendicular affection, was an acute manifestation of an insidious pathological process in the bowel, which had been progressing for months previously. The relation of the illness to the chronic disease was overlooked; and

the failure to appreciate it led to an entirely incorrect prognosis, both immediate and remote, and to inappropriate treatment. The case, as a whole, left an unsatisfactory—not to say unhappy—impression on one's mind, even whilst one felt that it was bound to end fatally sooner or later; and yet, unless I am mistaken, the errors that were committed in connexion with it are not uncommonly repeated by us in different ways and from different causes. What these causes are—at any rate, the chief of them—I propose now to inquire.

In the first place, then, to revert for a moment to the case which I have just narrated, you will agree with me that it was one of real difficulty diagnostically; one in which the history in particular was of a deceptive and misleading character. Probably one might have reached the truth if one had remembered the accepted aphorism that "the first evidence of chronic intestinal obstruction may be acute intestinal obstruction." Be that as it may, the case serves to illustrate what I would venture to call the first and least blameworthy way in which we may fail to appreciate that an acute illness with which we are suddenly called upon to deal, is but an acute manifestation of a chronic disease, namely, *essential difficulty of diagnosis*. There may be little or nothing in a case to suggest the relation, whilst there may be very much in it to support another and even more probable explanation of the facts; and the more obvious diagnosis is chosen.

But our failure is more often due to difficulties of other kinds. We suspect that an acute illness which we are called upon to treat is something more than appears on the surface. We feel morally convinced, as the saying goes, that there is another, possibly a graver, disease beneath it, but we fail to confirm our suspicions from want of evidence, whether in the patient's history or in his present condition, of the existence of a chronic disease with which the acute illness could be connected. The attack appears to be an isolated event in the patient's medical experience. Either the inquiry into the course of the case is not close enough, or it is baulked by the truth being forgotten, or, for some reason or other, withheld from us. I remember an instance of this difficulty which was related to me many years ago in another connexion by my old friend, that acute observer Sir Richard Quain. He was asked to see in consultation a lady of middle age who had developed a rapid tuberculosis of the lungs during attendance on her son dying of the same disease. Quain was no believer in the infectious origin of phthisis, and you can understand the satisfaction with which he informed the family practitioner that he recognized in the patient a lady whom he had himself treated for tuberculosis twenty years before. She had of course been tuberculous ever since, and the present was but a fresh manifestation of her chronic disease; but the medical attendant she was now under had failed to get at the truth, and exactly reversed the order of what was very likely after all an instance of infection.

But not only the history, the very phenomena—the symptoms and signs—of chronic disease, which we naturally look for and trust to as guides in such a case, may be wanting. The sole evidence before us that an acute attack for which we are treating our patient is but a manifestation of a grave pathological change of chronic course may be the sudden and brief event itself. Perhaps the best example of this cause of failure to determine the real significance of an acute illness of importance is afforded by some instances of haemoptysis. How often has it occurred to all of us to meet with haemoptysis, of every degree of severity, which was accompanied by no physical signs in the chest that could be described as morbid, nor by any disturbance of function that deserved the name of a symptom, and which left positively no trace behind of its essential nature. Let me mention a case in point.

A lad of 17 was brought to me fifteen months ago complaining of weakness only. His father had been alarmed by the occurrence of haemoptysis four weeks previously, and wished to have an "independent opinion." Thorough examination of the chest failed to yield any morbid signs beyond trifling impairment of resonance at the right apex. But I declined to discount the importance of haemoptysis at 17, and I was strengthened in the serious view I took of the case prognostically by ascertaining that the mother had died of pulmonary

tuberculosis. The confirmation of the diagnosis was reached later, when I learned from his regular medical attendant that the patient had had an attack of quiet dry pleurisy eighteen months before the hæmoptysis.

Our single guide in cases of this character, our safeguard in prognosis and treatment, is experience. We have had much occasion to follow the after-history of the subjects of hæmoptysis; and we recognize that for all practical purposes hæmoptysis of this type means tuberculosis, which will sooner or later manifest itself again in the same or in some other and worse fashion. But how can we expect the young practitioner, fresh from hospital, to appreciate the bearing of a case of this kind? Although he be trained on more scientific and practical lines than his predecessors of our time, the newly qualified man still leaves his hospital and school of medicine with an acquaintance with disease in great measure theoretical. He enters practice with an attitude of mind that may be called artificial, and his early observations of acute disease, which strike him most forcibly and impress him most deeply, serve only to confirm it in him. And so the hæmoptysis passes; no evidence of phthisis remains or is developed; and the existence of tuberculosis is presently forgotten. It takes him years of close observation and careful thought to have this truth brought home to his mind. I can fancy some of you saying to yourselves that of course it would occur to all of us, even the most inexperienced, that hæmoptysis is not an acute disease *per se*, but a complication or incident of chronic tuberculosis. I acknowledge that this is so when hæmoptysis occurs in the course of a case of phthisis under treatment. But when hæmoptysis is the first and only evidence of the disease to attract attention, its significance is certainly not always appreciated.

To begin with, we are blinded to the truth by the *circumstances attending an acute illness*. These may impress and influence the most experienced of us so much as to prejudice our judgement and our management of the case. The circumstances connected with a sudden, grave, and possibly critical illness absorb so much attention, and raise questions of such magnitude and urgency in respect of the prospects of recovery and the means of treatment, that not only the mind of the patient's friends, but the mind of the doctor himself, are diverted from remote and more important considerations. The present only is regarded: the suffering, the danger, the immediate result. Consider, for instance, the following case:

A woman of 32 was admitted into Charing Cross Hospital in July last for violent pain in the abdomen. She had been to the Charing Cross Station to see a friend off, and went thence to the Embankment for a walk, when she was suddenly seized with severe pain in the hypogastrium and down both thighs. She was brought at once to the hospital. The note taken on admission is to the effect that she complained of pain in the lower region of the abdomen, particularly the right side, which was comparatively full, with impaired respiratory movement; that the whole of the front of the abdomen was extremely rigid and tender; but that there was no definite tumour. The temperature was already 102° F. You will agree with me that the circumstances attending the invasion in this case and the patient's admission into hospital were sufficiently striking, not to say dramatic, to rivet one's attention on the present; to suggest perforation of the stomach, or at any rate nothing less grave than acute appendicitis; and to divert one's thoughts from the past. And yet the key to the diagnosis, which had to be made without delay, was the patient's previous history, not the incidents of the acute attack. We discovered on inquiry that for the previous two years she had suffered occasionally from abdominal pains as the result of fatigue or exposure to cold and wet, and that indeed three months before she had actually had to lie up on account of them for a few days, although she did not send for the doctor. Intrapelvic examination revealed that the uterus was partially fixed, and that the right Fallopian tube and ovary were enlarged. The case was one of chronic disease of these structures and pelvic peritonitis. If this case had occurred to one of us in private practice, where excitement runs high and deliberate inquiry and examination are more difficult to carry out than in a hospital, we probably should have failed to reach the correct diagnosis. And if the danger pass and the result be recovery, the sense

of relief and satisfaction is supreme. An attack like this comes to be looked upon as an isolated occurrence, and recalled as an acute disease. The patient and his friends remember with thankfulness that he was "cured." The doctor passes on to the next patient, whose case, of equal interest and urgency, in its turn absorbs his attention, and forgets in the press of work that whilst recovery has occurred a grave, and possibly mortal, disease is left behind.

Still more readily may we forget the chronic element if the *acute element take the form of a substantive disease* so-called. So far I have mainly spoken of acute *phenomena* in the course of chronic disease—of hæmorrhage, of abdominal pain, of vomiting, and collapse. None of these constitutes by itself an acute disease; and you will say, and I agree with you, that they ought not to be permitted to deceive us if we exercise proper care and judgement in our clinical work. But when acute manifestations of chronic processes possess all the characters and the importance of independent diseases, they readily monopolize our attention, and lead us astray in diagnosis and treatment.

A young man of delicate build, but obviously sound, was taken with acute pleurisy. He was very ill; the fever ran high; the fluid rose in his chest; his people became very anxious about him; he was tapped, and in a few weeks a dangerous illness was safely passed, and the patient able to return to work. Our diagnosis was acute pleurisy with effusion, with characteristic clinical symptoms and signs accompanying it, with a definite invasion, dry stage, stage of effusion, increase of fluid in the pleural cavity, urgency of constitutional and local distress, performance of an operation, relief, and recovery.

Was not this an acute disease? In the fullest and most correct sense of the term it was not. The diagnosis—the name, "acute pleurisy with effusion," proved to be incomplete and therefore incorrect. The disease was tuberculosis. The pleurisy was followed two years later by pulmonary phthisis, and when fresh inquiry was made into the patient's history it was found that he had had strumous glands removed from his neck as a boy, and a passing hæmoptysis at 18. We had been so much occupied with the observation of the physical signs of the pleuritic attack, with the anxiety of the patient's relatives, and with the performance and success of paracentesis, so satisfied and relieved by the issue of the case in restoration of health; in a word, the case had been so complete as an instance of acute disease that we failed to inquire into its origin and neglected to anticipate the future.

Acute pleurisy would appear to be the disease that of all others is the one most likely to lead us astray in this respect. I shall never forget being asked by an old friend of my own, a distinguished member of our profession, to examine his chest for a stitch in the side, and finding a small patch of dullness there and weak friction sound. I confess I thought lightly of the observation and its possible significance for the first day; but when on the second day I discovered that there was polyuria and albuminuria, I became alarmed at once, and reasonably so, for this was the beginning of an illness which proceeded to pericarditis, and ended fatally within a fortnight. So with pleurisies of other and possibly more obscure origin. Last year about this time I drew attention in the Hunterian Lecture to the frequent association of acute affections of the pleura and lungs with chronic disease within the abdomen, such as carcinoma and hydatid of the liver, gastric ulcer, and appendicitis. This is a relation which is peculiarly easily overlooked unless one be fully convinced of the soundness and practical importance of my contention: that the apparent completeness of the acute illness in its objective characters as a substantive disease must not be allowed to divert us from searching for the main or primary process.

In addressing a Society like yours, I need not do more in passing than refer to those instances of failure to observe the due relation of an acute illness to a chronic disease which are the result of haste, thoughtlessness, or clinical inattention. These are unfortunately not altogether uncommon failings on the part of some of us when our interest and power of observation are exhausted, temporarily, by prolonged, unrelenting anxious work. It is under such unfortunate circumstances as

these that we call an attack of urgent paroxysmal dyspnoea by the name of "asthma," and omit to diagnose in one case aortic aneurysm, in another case diabetes or uraemia, of which the patient dies in a few hours. Similarly, the exercise of proper care and the expenditure of a little more time would prevent us from falling into the error of speaking cheerfully of a case of sudden faintness which is nothing less grave than a syncopal seizure in general paralysis of the insane.

This introduces me to the next aspect of my subject. Even if we have determined the existence of a chronic pathological process beneath an acute illness, and noted the relation of the one to the other, *the observation and the considerations which it suggests are not always appreciated in their full practical bearings*; they are not applied in prognosis and treatment. An important patient of ours, a wealthy lady of 60, is in bed with severe bronchial catarrh. We recognize that she is thoroughly gouty, for we have had her under our care at different times before—for acid dyspepsia, sciatica, vesical irritability, and eczema, one or more. But now that she is acutely ill, have we the courage of our convictions? Do we deny her the champagne for which she craves, to relieve the sinking, lowness, prostration or faintness, as she variously calls it, which is a characteristic feature of the bronchial attack? I fear not. We do not act up to our diagnosis; we treat the acute phase of the disease only, and that phase unwisely. Or in a case of gastric ulcer, although we may have been struck by the observation again and again that haematemesis occurs very commonly *per menses*, do we always take the trouble to direct our women patients, the subjects of this disease, to spend the period in bed on several subsequent occasions in order to prevent a recurrence? These are very ordinary instances of the want of thoroughness which is displayed in the application of what we are pleased to call our "convictions," but they serve to impress on us one of the most important practical bearings of our present subject—I mean its relation to treatment, to which I will presently return.

I believe you will now agree with me that the observation, recognition, and sufficient appreciation of the intimate relation that often exists between acute illness and chronic disease involve issues and actions which we cannot afford to neglect—which, indeed, we ought to keep constantly before our minds in our daily rounds. But it is well to be definite. Let me put the question frankly and plainly. When we meet with what at first sight appears to be an acute disease, what advantages are to be gained by taking the time to consider whether it may not be an acute manifestation of a chronic process? With your permission I will attempt to answer the question categorically.

And, first, I pass over with a bare mention the value of correct knowledge for its own sake, and would remind you that an acute illness, if properly investigated, often *directs our attention to the existence of a disease which has lasted for an indefinite length of time but been entirely unsuspected, and which it is of vital importance that we should recognize*. A few weeks ago I saw in consultation a little lad of 13 with pericarditis. He had been enjoying his holidays much too well—playing cricket, and had broken down with the usual "chill." But it was easy to determine that this was no primary disease. In addition to those of acute pericarditis, there were all the ordinary signs of chronic valvular disease, of the existence of which his parents had no knowledge, but the discovery of which in this alarming way would be of infinite importance to them in the future. Unfortunately the discovery sometimes comes too late. I recently met with a case of mitral stenosis in a lady of 50, which had remained unrecognized until it came under notice by an acute illness. The lesion had been invaded by septic micro-organisms, and ulcerative endocarditis was the result.

In the second place, to have determined and to know that an acute illness is but a manifestation of a chronic disease puts us in an advantageous position for *instituting immediate treatment*. You will not require me to prove the correctness of this statement. It agrees with our daily experience; and it is well illustrated by the case of acute intestinal obstruction in slow carcinoma of the colon which I recited to you a few minutes ago. I might illustrate the point by an endless variety of cases. Let me give you one instance, far simpler in

character, but equally instructive from this point of view. A gentleman of 55, on a holiday tour in Ireland, is seized at night in his hotel with intense pain in the throat, distressing dysphagia, and considerable fever. The pharynx is found to be of a deep crimson hue, with scarcely a trace of swelling; the pulse and the whole bearing of the patient are expressive of extreme nervousness; and the aspect and history are significant. The man is gouty: the pharyngitis is an acute manifestation of goutiness, determined by holiday fare and a thorough soaking. A smart purgative, a large dose of bromide, simple local applications and low diet are followed by complete recovery in twenty-four hours.

This case, ordinary though it be, serves to impress another important consideration upon us. You observe that the disease beneath acute pharyngitis was *one of a specific kind*—gout. Once we had looked beyond the throat and the local inflammation we realized not only that there was a chronic disease to be reckoned with, but also that this was a great morbid process of the first order with a pathology of its own. This is a common experience in the cases now under review: that tuberculosis, gout, rheumatism, alcoholism, or other morbid process of equal rank, is the primary disease. A man of 50 who has suffered much in his eyes and joints for several years, is taken with acute epididymitis. There is no great difficulty connected with the treatment of his case; and yet it cannot be other than important for all concerned that his medical attendant should ask himself whether the attack may not be rheumatic like the patient's other troubles. In all these instances a little careful reflection suffices to increase to a remarkable extent our knowledge of what we have to deal with, and puts us in a position of obvious advantage in the matter of therapeutics, for, happily, the great specific processes of disease are precisely those for which we possess specific remedies of approved value.

Yet another therapeutic advantage which is gained by the correct appreciation of the significance of an acute illness is derived from the fact that it is often the means of revealing the existence of an insidious chronic disease *at an early stage*, and thus of enabling us to undertake, before they are too late, the measures proper for its arrest. Haematemesis in alcoholic hepatitis can be turned to good account in this way. It is often an early and always an alarming event, which the patient is not likely to forget, and it affords the practitioner an opportunity of speaking out which he ought never to miss. I will refer presently to the value in the same respect of early haemoptysis and pleurisy in tuberculosis.

The immediate prognosis, like the immediate treatment, of acute illness cannot be expected to be successful unless the true relations of the attack be observed and appreciated. Take acute albuminuria, for instance. The sudden appearance of albumen in the urine, with general anasarca and its other accompaniments, may quite often be traced to chronic nephritis with fresh renal congestion, instead of to acute nephritis. But the connexion is readily missed unless trouble be taken to inquire into the patient's history, and to study the state of the circulation and the characters of the urine with particular care. Obviously, the discovery that old-standing Bright's disease underlies the acute attack gives an entirely different aspect to the prognosis which we have to offer from that which we should form were the disease acute parenchymatous nephritis. Even the recognition that an outburst of tuberculous infiltration in the lungs is not something entirely new but only something fresh, that is, the recrudescence of a chronic process that was quiescent and had been forgotten, is valuable as an element of prognosis.

As with the immediate, so with *the remote prognosis and the practical applications of it*. One of the chief advantages gained by correct determination of the significance of an acute illness lies in this, that it enables us to look ahead, and suggests the need and also the means of preventing a recurrence of it and its dangers. We appreciate the fact that the chronic disease which has thus been revealed to us does not pass with the attack, but remains behind, waiting as it were for another favourable opportunity to recur in an acute form. When a chronic disease has been allowed to drift on month after month, perhaps year after year, unrecognized, unattended to, or at least insufficiently treated, an acute manifes-

tation of activity secures immediate attention to the case, and compels prophylaxis against the future. Indeed an acute attack in diseases of this character, once safely passed, often proves a blessing in disguise. Rules of living are laid down; and the patient, having been usefully alarmed by the hæmorrhage or other danger that he has survived, is careful to observe them.

I now come to by far the greatest of the many advantages which we derive from a correct and thorough appreciation of the relation of an acute illness to a chronic disease. This is the indication with which it furnishes us, and happily the useful means which it often suggests to us, not simply to prevent the recurrence of similar attacks, but to *strike at and arrest the primary disease in its course* whilst it is still of comparatively slight degree and in safe situations. You will bear with me whilst I dwell at some length on this aspect of our subject. It is best illustrated by the natural history of tuberculosis, which, because it is of all serious diseases the one most subject to spontaneous arrest, is also the most deceptive. I have already referred to two common events in the clinical course of tuberculosis which open our eyes for the first time, or ought to do so if properly regarded, to the existence of this grave disease in our patients, namely, hæmoptysis and acute pleurisy. I would now ask you: Do we employ these danger signals seriously as indications for immediate, continued, and radical treatment? If we did, should we be so ready as we commonly are to congratulate our patient and his friends and ourselves on his "recovery" from profuse pulmonary hæmorrhage or acute pleuritic effusion, and allow him to return to work in a few weeks? Surely if the disease with which he is affected be tuberculosis, which has manifested itself on this occasion in his bronchi or in his pleura, and may manifest itself presently in his lung, immediate and continuous provision must be made for treating it as it ought to be treated? Why should we wait months, or even years, for evidences of infiltration of the pulmonary tissue, when acute pleurisy, consequent on hæmoptysis, has occurred to warn us what to expect? I, for one, would not and do not wait. I treat a patient recovered from hæmoptysis only—that is, without discoverable signs of pulmonary tuberculosis—or from what is still called "simple pleurisy with effusion," exactly as I would treat him did he come to me with crepitus and impaired resonance over the apex of one lung, and at least try to teach him practically what is meant by the hygiene of fresh air. This may appear to some of you an unusual and unnecessarily strong position to take up in giving advice to young persons who have been interrupted only for a few days or weeks in a career of early usefulness and greater promise which they have just commenced. Perhaps it is unusual, but increasing experience serves only to convince me that it is justifiable and correct. Hæmoptysis, pleurisy, fistula in ano, certain varieties of peritonitis, glandular enlargements—indeed, it may be nothing more than a continued fever with no discoverable location of the pathological process in the tissues—are all different phases of the tuberculous process which serve as danger signals if correctly appreciated. But they must be appreciated, as I have said, in their practical bearings. The conviction that they are tuberculous manifestations must be real—that is, it must be followed by action. I have notes of cases of this character which I have sent abroad at once after convalescence from hæmoptysis or pleurisy, and the results have been eminently satisfactory.

And now, in conclusion, and for one moment only, let me direct your attention to yet another consideration in connexion with this subject, which relates to medicine not as an art but as a science. A correct appreciation of the relation that I have attempted this evening, I fear somewhat laboriously, to establish between acute illness and chronic pathological changes is a *clinical key to the true pathology* of many of our most obscure and anxious cases. Acute illness, if looked at by itself, and by itself only, attracts our attention to chill, exhaustion, injury, and passing nervous influences as "causes" of disease, when they are nothing but the determining or exciting circumstances of the event or occurrence. Regarded as a manifestation of some pathological condition, acute illness compels us to look beyond mere phenomena to processes, and beyond processes to causes proper, such as the

germs or poisons of tuberculosis, gout, alcoholism, and syphilis. A man of 45 is found in urgent respiratory distress from acute laryngitis after a journey by rail. He is said to have acute laryngitis from "cold and fatigue." But it is not so—he is suffering from old-standing syphilis of the larynx with acute oedema which has been excited by these unfavourable influences. It might not have readily occurred to a practitioner called urgently to him to give him relief—if necessary by tracheotomy—that he had to deal with a case of specific disease, and that specific measures, in part at least, were the proper treatment for him.

By an intelligent consideration of disease, in this way and in other ways, as disease comes before him in his daily work, the practitioner learns to connect morbid processes and their acute manifestations with definite efficient causes, and to distinguish these from the extrinsic circumstances of life and the intrinsic conditions of the patient's body which simply promote the morbid actions of these. Contemplate for a moment how much has recently been done for medicine and for hygiene by the intelligent clinical study of neuritis and its relations to alcohol and arsenic. This is the pathology which the busiest practitioner, the humblest member of a medical society, may be in the most favourable position to advance; and the success which he attains may be as far-reaching for good as a brilliant discovery in bacteriology. Let us cultivate more carefully than we do at present the method of looking beneath the mere surface of our cases, and the superficial and present phenomena of disease, feeling assured that in doing so we are not only doing our best for our patient, but at the same time are taking an honourable part in the advancement of that great branch of natural knowledge to which we have devoted the best energies of our lives.

An Address

ON

THE CORONER AND HIS RELATIONS WITH THE MEDICAL PRACTITIONER AND DEATH CERTIFICATION.

*Delivered at a Meeting of the North London District of the
Metropolitan Counties Branch of the British
Medical Association.*

By WILLIAM WYNN WESTCOTT, M.B., D.P.H.,
His Majesty's Coroner for North-East London; Vice-President of the
District.

MR. PRESIDENT AND GENTLEMEN,—The name coroner means Crown officer, and this name has been in use for many generations. At the time of Magna Charta his title was *coronator*; in the reign of Richard I he was *custos placitorum Coronae*, and earlier still was called *coronarius*. The coroner's office is, however, much older still, being mentioned in the records of Athelstan and King Alfred. The office of sheriff is of equally ancient origin. Coroners are conservators of the King's peace, and become magistrates by virtue of their appointment, but are not necessarily justices of the peace.

The coroner is appointed for life, *quandiu se bene gesserit*, for he can only be removed by a decree of the High Court of Justice after conviction for extortion or misdemeanour, or by a writ of the Lord Chancellor after proof of misbehaviour or inability in his office. Every coroner on his appointment must appoint a deputy, who in the coroner's absence may conduct all inquests and act in every way as the principal coroner.

At the present time the coroner represents the King as a caretaker of the lives of the people, by providing that every violent death, and every sudden death of which the cause is unknown, shall be the subject of a public inquest, held before a jury of not fewer than twelve, nor more than twenty-three men of the county where the body lies. He has also the duty of holding inquiries in cases of treasure trove—the finding of buried gold and silver coins and other articles. In former times the coroner had also to inquire into wrecks, royal fishes, and prison breach. In some parts he also inquired into fires, and this duty has been lately revived in the City of London.