of this attitude of the British Medical Association and of the local practitioners as a body and of the warning notice of the medical journals the medical staff of the hospital held a meeting at which it was unanimously decided that the whole staff resign.

In conclusion, I would again emphasise the facts (1) that the staff of the Hampstead General Hospital resigned on a matter of principle; (2) that we took this step in deference to the wishes of the British Medical Association and of the local practitioners of the neighbourhood; (3) that after being associated so long with this institution, having been present at its birth, having watched its evolution and growth with increasing pleasure and pride, and having guided it into its present state of maturity, we have not resigned our posts on the staff lightly.

Lastly, is it too much to express the hope that the leaders of the profession will stand shoulder-to-shoulder with the general practitioners in this struggle, and will demonstrate once more, as was done at Bristol, that we are all brethren?

I am, Sir, yours faithfully,

AUGUSTUS H. COOK,

Senior Surgeon, Hampstead General Hospital.

Hampstead, Feb. 24th, 1908.

RECEPTION HOUSES FOR RECENT CASES OF INSANITY.

To the Editor of THE LANCET.

SIR,—I am sorry your correspondent, "A Medical Superintendent, County Asylum (England)," writes anonymously, as in general I do not care to reply to such communications. There are some points, however, raised by your correspondent which show that he has not grasped the substance of my communication. This may be due to a want of lucidity on my part, but the contention of my paper was that it is quite possible to treat all classes of recent admissions to asylums under exactly similar conditions to those that prevail in general hospitals, without seclusion and restraint. I was not aware that about 90 per cent. of the English asylums have carried out the methods suggested in my paper, but my error is excusable in view of the fact that several medical superintendents of English county asylums, members of the London County Council, and other English county councils, who have visited the reception house at Woodilee, were not conversant with any similar mode of dealing with recent admissions. Perhaps your correspondent will emerge from his anonymity and give the name of some of the places where he knows the system spoken of is in vogue.

In regard to your correspondent's remarks about the doors being locked at night, I may say in this connexion that there would be no objection to the doors being unlocked at night so far as the nursing and the care of the patients are concerned, but doors are locked on the same principle on which the medical superintendent of a county asylum locks the doors of his own house at night.

I sympathise with the attitude of your correspondent with regard to female nurses being in charge of the male hospital. I had the same views as he now holds, previous to the introduction of such nursing into this institution, and after a short trial of female nurses I thought my primary views were to be confirmed. A subsequent and more efficient trial has convinced me of the value of female nurses in the hospital for male patients. Is there something so radically different in mental disease as to demand a different system of nursing to that of general bodily disease? There are no male nurses, as far as I know, in general hospitals.

Your correspondent's reference to the recovery-rate at Woodilee Asylum is not a happy one. During the seven years I have been superintendent of this institution there has been an average recovery-rate of 37 per cent. on the admissions. This average, as far as I am aware, does not fall far below the usual. I assume that your correspondent's reason for bringing forward the recovery-rate is that in view of the conditions under which newly admitted patients are treated there ought to be a larger recovery-rate. Perhaps your correspondent is not aware of local conditions which influence the recovery-rate of this institution. In Glasgow we have mental wards in which temporary cases of insanity (which swell recovery-rates), such as cases of delirium tremens and doubtful cases of illness, are treated to a conclusion. Secondly, we have in this asylum a home for imbecile children, and there has been during recent years a comparatively large number of children

admitted annually who, as they are all included in the admission numbers, adversely affect the recovery-rate. If there is any other point that your correspondent would like information on I will be very glad to afford it him.

I am, Sir, yours faithfully,

HAMILTON C. MARR.

Glasgow District Asylum, Woodilee, Feb. 25th, 1908.

ANÆSTHESIA AND ITS MORTALITY.

To the Editor of THE LANCET.

SIR,—I am asked by "G. H. R. D." to explain a statement which I made at the last meeting of the Medico-Legal Society. It is quite true that I there pleaded for a more thorough instruction in the administration of anæsthetics as a prelude to a reduction in the present regrettably high death-rate from these agents. So far as I am able to follow his arguments, "G. H. R. D." contends that if my thesis is correct we should expect to find a lower death-rate at those hospitals at which instruction is most thorough. Up to this point I fully agree with him—in fact, it would not, I think, be difficult to prove this contention. But when he states that the mortality from anæsthetics is lower in provincial, Scotch, and Irish hospitals than in our London hospitals I confess I cannot follow him. I am sure there are other readers of THE LANCET besides myself who would be glad to know how he has arrived at the data upon which he has based this statement. I take it he is aware that there are no coroners' inquests in Scotland—a fact which has for many years stood in the way of any comparison between the respective anæsthetic death-rates of England and Scotland. But even if "G. H. R. D." were able to bring forward statistics in support of his statement I very much question whether such statistics would satisfy the profession, for there is, perhaps, no question before us at the present time concerning which statistics are more likely to be fallacious than that under consideration. It seems to me that if deaths during anæsthesia are to be reduced in number—and I maintain that such an achievement is perfectly practicable—this can only be done by increasing and disseminating the knowledge we already possess of the clinical and physiological action of these substances; by placing their administration at our hospitals in the hands of experienced and specially appointed officers; and by exerting all the means in our power to prevent inexperienced and unqualified persons, outside our hospitals, from employing drugs with whose properties they are not sufficiently familiar.—I am, Sir, yours faithfully,

FREDERIC HEWITT.

To the Editor of THE LANCET.

SIR,—As I am to some extent responsible for the teaching of anæsthetics in the Edinburgh Medical School and for the methods employed by those who give the anæsthetics, I may be permitted to, so far as may be, reply to "G. H. R. D.'s" query in your issue of Feb. 22nd. As to the use of a towel Dr. D. is under a misapprehension—or his informant is. The use of the towel for the administration of chloroform in an Edinburgh hospital is now unusual. Schimmelbusch's mask is most commonly employed for pure CHCl_3 , with one or two layers of lint. I prefer two myself. For mixtures— C_2H_5 and C_2H_6 —a metal cone (modified from Black's) is frequently employed. In many theatres Clover or Hewitt is used from time to time for ether, frequently preceded by ethyl chloride, while latterly the open method of etherisation has got a foothold, and my colleague Dr. D. C. A. McAllum, I believe, frequently employs it. The methods and anæsthetics employed are therefore varied; probably chloroform is given most frequently. In private practice the custom varies with the seniority and conservatism of the individual doctor.

From knowledge I can say that of late years the mortality in hospitals in Edinburgh has been very low and comparatively few cases have come under notice in private practice, owing, I think, largely to the disrepute into which chloroform has fallen in dental work. As to why the mortality is so low in Edinburgh just now and why it is so amazingly high in some hospitals and districts of the metropolis it is impossible to venture an opinion even. The figures given by Mr. Troutbeck at a recent meeting of the Medico-Legal Society are startling.

We cannot claim for one moment that anæsthetic teaching is more carefully or systematically carried out in Scotland than in London or that anything more than care and

common sense with a varying amount of experience is employed, but the results remain. It is certainly not due to dosimetric apparatus, which have found little favour in the north.—I am, Sir, yours faithfully,

T. D. LUKE,

Lecturer on Anæsthetics, University of Edinburgh.
Edinburgh, Feb. 24th, 1908.

To the Editor of THE LANCET.

SIR,—Under the above heading a correspondent who signs himself "G. H. R. D." makes some brief remarks in THE LANCET of Feb. 22nd, p. 597, regarding the teaching of anæsthetics and he asks the question, "Is the special instruction there [Edinburgh] more thorough than here [London]?" As an Edinburgh graduate perhaps I may be permitted to say something in the matter. At the time when I qualified—about five years ago—there was no compulsory course in anæsthetic work. There was a purely optional course. The course consisted of four systematic lectures on the theory of anæsthesia and a practical demonstration of the ways of giving anæsthetics. Those who attended the course were expected to undertake the giving of anæsthetics on ten occasions under skilled supervision. The course being optional was not attended by everyone and I know for a fact that several men who graduated with me had never given an anæsthetic. Previous to the date of the starting of this optional course probably 50 per cent. of graduates had never given an anæsthetic when they obtained their degrees.

The authorities at Edinburgh have now recognised the importance of teaching this branch of work and a compulsory course has now been instituted. This consists of systematic lectures, practical demonstrations, and personal giving of anæsthetics on a certain number of occasions (20 I believe) under skilled supervision. There can be no doubt that this was a much-needed reform, because anæsthetic administration cannot be learned by simply seeing an anæsthetic given. Practical experience is necessary and everyone before qualifying should be compelled to have practical training. When I was a student at Edinburgh the chloroform was given from a towel, but whether that method of administration is still in vogue or not I do not know.

I am, Sir, yours faithfully,

Feb. 22nd, 1908.

M.B. EDIN.

THE PRESENT PROSPECTS OF THE MEDICAL PROFESSION.

To the Editor of THE LANCET.

SIR,—I notice in THE LANCET of Feb. 22nd a letter from Dr. F. W. Forbes-Ross in which he says that in his practice when he has to operate for the patient of a general practitioner who is not a skilled anæsthetist he asks him to be present at the operation and "for his services gives him 'down on the nail' a third of the fee agreed upon for the operation, for he has earned it."

I should like to know how this differs from the system which in France has a very evil name and is there known as "dichotomy"? It has been universally condemned by organised medical opinion in France and its corrupt results were exposed some years ago in Gyp's tale, "Le Docteur Tant Pour Cent." We may approve of the attendance of the family practitioner and of his being paid a fee, but it ought to be paid by the patient and not by the surgeon. If it is paid by the surgeon it must indirectly come out of the pocket of the patient as it will be sure to be considered by the former in fixing his fee, and although in the case of a minor operation two or three guineas may be no excessive payment for the attendance of the family practitioner, in a major operation a third of a hundred guineas would be out of proportion to the services rendered. In France the system has been condemned because it is admitted that the payment of such large sums to the family practitioner is opposed to the interests of the patient.

In the lectures given in Paris in 1899 by M. G. Lepage and M. P. le Gendre they quote the following from an edition of Baedeker's "Guide to Paris": "It is averred that owing to the facility with which they can be performed many doctors willingly advise a number of more or less necessary operations and recommend the services of colleagues who demand enormous fees, of which they receive a considerable part," and they do this to indicate how the system exposes the medical profession to a grave imputation upon its honour. Up to the present I had believed that it did not exist in England, but as it is dangerous to the public as well as to

the profession and offers such serious temptations it should be nipped in the bud. It may be advocated as justice to the general practitioner, but it means dishonour to the medical profession.

I am, Sir, yours faithfully,

Birmingham, Feb. 22nd, 1908.

ROBERT SAUNDY.

NOTIFICATION OF BIRTHS ACT.

To the Editor of THE LANCET.

SIR,—The promoters of this Act were inspired by good intentions, but its provisions will not accomplish their objects. The storm of opposition in the medical profession that has been excited renders it very unlikely that it can be efficiently administered. There is, indeed, much in the Act that calls for amendment. The duplex nature of the duties imposed on the parent or guardian who is called on (1) to notify the medical officer of health and (2) to register the birth is likely to interfere seriously with the important work of registration. Mr. Dudman, the registrar of births for St. Marylebone, has pointed this out, and owing to the migratory character of large sections of our population his apprehensions are well founded. The best solution of the problem would be to direct (1) that registration by the parent or guardian within 36 hours of the birth of the child should be compulsory; (2) that on the day of registration the registrar should notify the medical officer of health of the district; and (3) that medical men should not be compelled to divulge professional secrets.

Were these amendments embodied in an Act the medical officer of health would receive early information, whilst the sense of injustice now felt by the medical profession would disappear, and their loyal assistance in the preservation of life would be as zealous in the future as it has been in the past.

I am, Sir, yours faithfully,

JOHN FLETCHER LITTLE,

Harley-street, W., Feb. 22nd, 1908. Medical Officer of Health.

THE SHRINE OF ASKLEPIOS AT MOUDANIA.

To the Editor of THE LANCET.

SIR,—Readers of an archæological turn of mind who noticed your annotation in THE LANCET of Dec. 21st, 1907, on this subject will be interested to learn that a further monument of medical interest has been discovered by M. Jean Gaetano on the same site. This is about 35 inches by 10 inches and bears an inscription which has been elucidated for me by the kindness of Canon E. L. Hicks. The inscription records that a certain physician, who had been sick or in some other peril, had made a vow to Asklepios, and being delivered paid thus his vow. It runs:—

"Caius Julius Chrestus
physician, to Asklepios
that dwells in the canal
on his own behalf
on account of a vow."

Canon Hicks tells me that Chrestus corresponds to the Latin Probus and that the physician was a Roman citizen having the "tria nomina." He may have received his "civitas" from Julius Cæsar, perhaps in common with others of his native town, perhaps in return for professional services. More likely by far, however, he was the descendant of an earlier man of the same name in whom the family had received its civitas, as physicians seldom rose above the rank of "libertini" in the Roman Empire. The date is probably about 50 A.D., and I felt that some notice should be taken of the discovery of the record of the piety of a distinguished practitioner who for so many centuries has been among the great number of those "of whom there is no remembrance."

I am, Sir, yours faithfully,

Highbury, Feb. 18th, 1908.

J. ALISON GLOVER.

OPEN WINDOWS AND ADENOIDS.

To the Editor of THE LANCET.

SIR,—Some time ago it occurred to me that the cold damp air of our winter nights might have some effect in causing adenoids. I consequently tried to find out how children brought up with open windows at night compared with those children who slept with closed windows. I found two cases of adenoids among 62 who had slept with closed windows and 16 cases of adenoids among 34 who had slept with the windows open. I am not altogether satisfied with these figures, however, as I found it difficult to get many children of this last generation who slept with closed windows, and