

been posted to Aldershot, and Surgeon-Major Drury has obtained sick leave from that station. Surgeon-Captain Barton has rejoined at Holme. The death of Surgeon-Captain Waller has been reported from Bengal.

#### ARMY MEDICAL STAFF.

Brigade-Surgeon-Lieutenant-Colonel John Ross Murray, M.D., F.R.C.S. Edin., has been placed on retired pay.

#### ARMY VETERINARY SCHOOL.

Veterinary-Captain Seaward Longhurst, Army Veterinary Department, has been appointed Professor, vice Veterinary-Captain Fred Smith, whose period of service in that appointment is about to expire.

#### INDIAN MEDICAL SERVICE.

The following appointments have been made:—Surgeon-Captain A. H. Nott, Officiating Second Resident Surgeon of the Presidency General Hospital, to act as Civil Surgeon of Birbhum. Surgeon-Captain B. D. Basu, I.M.S., has been transferred from general duty, Scinde District, to general duty, Bombay, Deesa, and Aden Districts. Brigade-Surgeon-Lieutenant-Colonel R. P. Ferguson, A.M.S., having been appointed an Army Medical Officer in the Bengal Command, has been directed to proceed to Allahabad in order to take over the administrative medical charge of that district. Surgeon-Major B. Doyle has been posted to Ferozepore. Mr. H. A. Hall and Surgeon-Lieutenant-Colonel S. M. Salaman, M.D., have respectively delivered over and received charge of the Yerrowda Central Gaol. Surgeon-Captain A. V. Anderson, M.B., has been appointed to act as Deputy Sanitary Commissioner for the Western Registration District. The following promotions are made subject to Her Majesty's approval:—To be Surgeon-Lieutenant-Colonel from Oct. 1st, 1892: Surgeon-Major A. N. Rogers-Harrison, M. P. L. Beech, and H. P. Esmonde-White. To be Surgeon-Majors from Oct. 2nd, 1892: Surgeon-Captain J. L. Van Geyzel, H. N. V. Harington, G. M. F. McKee, J. A. F. Burton, and F. J. Doyl.

#### NAVAL MEDICAL SERVICE.

The following appointments have been made:—Fleet Surgeon J. Lyon, M.D., to the *Impregnable*. Staff Surgeons: T. E. H. Williams to the *Pelican* and G. F. Watts to the *Beagle*. Surgeons: William R. M. Young to the *Wildfire*, for Sheerness Dockyard; R. Hickson to the Bermuda Hospital; O. S. Fisher to the *Alacrity*; J. Lowney to the *Redpole*; E. E. P. Tindall to the *Plover*; E. C. Lomas, M.B., to the *Pigmy*; J. Dawson to the *Pembroke*; B. S. Mends, to the Portsmouth Division, R.M.A.; A. Kidd to the *Caroline*; E. E. Bray to the *Mercury*; E. J. Swan to the *Archer*; F. W. Parker to the *Cambridge*; and E. A. Shaw, B.A., M.B., to the *Hearty*.

#### VOLUNTEER CORPS.

*Artillery*: 2nd Hampshire (Southern Division Royal Artillery): Surgeon-Captain B. J. Guillemard, M.D., has resigned his commission. The Volunteer Officers' decoration has been conferred upon the following:—Surgeon-Lieutenant-Colonel Thomas Henry Moxon, 1st Norfolk Artillery; Brigade-Surgeon-Lieutenant-Colonel Stephen Moulton Hopson, 3rd Volunteer Battalion, the Norfolk Regiment; Brigade-Surgeon-Lieutenant-Colonel Geo. Sampson Elliston, 1st Volunteer Battalion, the Suffolk Regiment; Surgeon and Honorary Surgeon-Major John William Harper, retired, 2nd Volunteer Battalion, the Suffolk Regiment; Surgeon-Major Daniel Bailey Balding, 1st (Hertfordshire) Volunteer Battalion, the Bedfordshire Regiment; Surgeon-Major (ranking as Lieutenant-Colonel) Alfred T. Brett, M.D., retired, 2nd (Hertfordshire) Volunteer Battalion, the Bedfordshire Regiment; Honorary Assistant Surgeon William Gimson, M.D., retired, 3rd Volunteer Battalion, the Bedfordshire Regiment; Surgeon and Honorary Surgeon-Major Theophilis Wm. Trend, M.D., retired, 2nd Volunteer Battalion, the Hampshire Regiment; Brigade-Surgeon-Lieutenant-Colonel Henry Robert Smith and Surgeon and Honorary Surgeon-Major John Robert Kealy, M.D., retired, 3rd Volunteer Battalion, the Hampshire Regiment; Brigade-Surgeon-Lieutenant-Colonel Fredk. Fawson, Lee, M.B., 1st Wiltshire Rifle Volunteer Corps.—*Rifle*: 2nd (Westmoreland) Volunteer Battalion, the Border Regiment: Surgeon-Lieutenant R. W. Leeming has resigned his commission.—4th Volunteer Battalion, the King's (Liverpool Regiment): Surgeon-Captain W. J. Fleetwood, M.D., has been appointed Surgeon-Major.

#### EXAMINATION.

A medical examination has been ordered by the War Office of candidates for the Royal Military College, Sandhurst, to

be held at the Offices, King-street, Westminster, on the 28th and 29th inst.

#### SICKNESS IN THE ROYAL WELSH FUSILIERS.

According to the Indian papers the Peshawur Valley has been very unhealthy this year. The Royal Welsh Fusiliers have lost many men during the hot weather and rains, and have a large number of sick in hospital with fever. The regiment is stated to be under orders for Nowshera. The whole valley is well known as a malarious locality, and the form of fever which occurs there has certain features which have given rise to the name of "Peshawur fever"; and it is alleged that the unusually heavy rains which occurred a few months ago gave rise to a considerable increase of that disease. Removal from the locality and complete change of climate is recognised as the only remedy where it is at all intractable and does not yield to treatment.

The usual "Report on the Sanitary Measures in India in 1890—91," for presentation to both Houses of Parliament has just been issued. It contains chapters on the health of the European and native, with which we have already dealt, on the health of prisoners in gaols and on that of the general population, together with chapters on medical institutions, including medical schools and lunatic asylums, and on sanitary works. Appended to the report are abstracts of reports by the Sanitary Commissioners in India, and memoranda by the Army Sanitary Commission in England. We hope soon to deal more fully with this blue-book.

## Correspondence.

"Audi alteram partem."

#### THE BRADSHAW LECTURE.

To the Editors of THE LANCET.

SIRS,—Dr. Gee in his recent Bradshaw Lecture, which is published in the current number of THE LANCET, told us among other things that he had sometimes found the scalp in tuberculous meningitis too tender to bear shaving and commended this observation, among others, to the consideration of "those who find a difficulty in believing that leeches or blisters applied to the skin can possibly affect a deeply seated part with which the skin has no obvious connexion." I do not know whether Dr. Gee meant his admonition for me, or only whether the consciousness of coming within its scope made me suppose so; but when something is commended to my consideration by a person in a place of authority, and one whom I respect so much as Dr. Gee, it behoves me to give my respectful consideration to it. As it is not easy to say what is possible I will be content with what is probable, and I will deal in especial with the subject of meningitis, to which he has given prominence. The case stands thus, if I may try to expand Dr. Gee's statement of it without misrepresentation. The scalp may become tender in meningitis, though there is no obvious connexion between the seat of the tenderness and the seat of the disease; therefore I am to consider whether irritation of a neighbouring but unconnected surface may not act beneficially upon a subjacent region of inflammation. Now I deny the major and dissent from the conclusion which is implied. If the scalp become tender under meningitis I presume it is because the roots of the fifth nerve, which lie at the base of the brain, are irritated by the inflammatory products or the inflammatory condition there present, whereby the branches of the same nerve which go to the scalp are made hyperæsthetic. This appears to be simple enough, but I do not see how it bears upon counter-irritation or local bloodletting. Does it afford any ground to suppose that irritation of the scalp will influence the course of meningitis? At most it displays a sensory consent between the roots and the branches of the same nerve, a condition of which we have many other examples. If, by appealing to the branches of the fifth nerve, we could influence its roots, does it follow that we should thereby lessen the inflammation around them which is the cause of the irritation, not its consequence? As well might we hope to benefit a case of renal stone by applying remedies to the tender or painful testicle.

Thus stands the case when we have an obvious and intimate nervous connexion between the surface and the position of the inflammation below; but when I try to follow further the line of thought which Dr. Gee indicates, and to follow it in the direction of the tradition of counter-irritation, there I find myself lost in mystery. Because a deep inflammation affects painfully a nearly connected surface, does it follow that irritation of a surface will affect beneficially a remotely connected deep inflammation? Here, I confess, I fail to see my way. Is there some remedial sympathy between surfaces and organs dependent on propinquity rather than anatomy, which travels across country rather than by recognised routes? Some such fancy has guided the practice of generations, and even still has its influence. Shall we continue to blister the wall of the chest as exactly over a vomica or a mass of hepatisation as our diagnosis permits or the nape of the neck for any cerebral affection, even though it permits of no diagnosis? Such things have been done. I do not know whether Dr. Gee would carry his argument to these practical issues. He does not say so; for the sake of his patients I hope not. But he has commended to my consideration facts which appear to lead him in this direction, and I cannot do less than consider them.

I am, Sirs, yours truly,

W. HOWSHIP DICKINSON.

Chesterfield-street, W., Nov. 14th, 1892.

## SMALL-POX IN LEICESTER.

To the Editors of THE LANCET.

SIRS,—Your impressive note of warning in THE LANCET of last week may possibly have some effect on the minds of those who are responsible for the present state of things at Leicester. Will you allow me to accentuate your remarks by stating facts within my own experience which may be worth recording?

In 1882 the same thing happened at Nottingham as that which has just taken place at Leicester. At that time a group of wooden sheds or huts was all that Nottingham possessed for the hospital isolation of scarlet fever and small-pox, both of which diseases prevailed concurrently, and both of which were required to be notified in accordance with the provisions of a local Act of Parliament. A patient in one of the scarlet-fever huts caught small-pox. Some were of opinion that infection took place across the open space which separated the huts; by others it was considered more likely to have been the consequence of a forbidden communication between the inmates of the scarlet-fever and small-pox huts. The mode of infection, however, was not the essential point, the fact of real importance being that a person who had been removed from home to the huts in order to prevent the spread of scarlet fever had been attacked with small-pox, owing to the proximity of the disease, whilst under the care of the municipal authority. After such an experience, I could not, as medical officer of health, allow any case of scarlet fever to be treated at the huts without personally satisfying myself that, by vaccination or revaccination (according to age and other circumstances), I had effectually guarded against the recurrence of so serious an accident. The town council of Nottingham set to work soon after to improve their defences against epidemics, and they now have one of the best isolation hospitals in England. It is surprising that Leicester should be so far behindhand in 1892.

I would take this opportunity of calling attention to other sources of danger for which the authorities of Leicester ought to be fully prepared. In a community where the proportion of the unvaccinated is increasing year by year, and where notification and isolation are mainly relied on for protection against small-pox, there must always be the danger of "unrecognised cases." A person passing through the disease in a slight, modified form, and able to go about as usual, may start an epidemic. An illustration of this has occurred within my own observation. Then there are the "doubtful cases" and those of "mistaken diagnosis," which should be provided for in anticipation. In the establishment of isolation hospitals, I have of late years urged very strongly the need for a sufficient number of detached "observation wards." I am afraid that Leicester is very badly equipped in this as in other essential respects.

I am, Sirs, yours obediently,

EDWARD SEATON, M.D. Lond.

Clapham Common, S.W., Nov. 16th, 1892.

## "MEDICAL AID ASSOCIATIONS."

To the Editors of THE LANCET.

SIRS,—It has been said, Why may not the public coöperate and secure medical advice at coöperative prices? I cannot for a moment admit that the practice of medicine lends itself to this so-called coöperative method, for I believe the more deliberate the attempt to identify the science and art of medicine with a trade or business the more disastrous will be the result to the public. The profession and an ordinary trade, to which modern attempts are being made to reduce it, are as different in essentials and in the handling they require as are such diverse subjects as scientific discovery and galvanised iron bucket making. The identification will destroy the essential principles of our profession—it will destroy the incentive to excel. What, it may be asked, is the use of all our sanitary legislation and efforts to prolong life and reduce sickness if side by side we allow to grow up a system opposed to the essentials of good medical practice—a system which abolishes all incentive to good practice in our practitioners, who are daily fighting with disease and death—a system which all admit cannot but tend to produce perfunctory work, which, in medicine of all things, is synonymous with bad work? Does anyone doubt that these are the real results of a system of fixed wage-paid medical service? Is it necessary to particularise when speaking to an audience of medical men?

But let us examine a little more closely what our questioner means by "coöperative," and let us not confuse coöperation with combination. "Coöperation" is derived from *co* and *operari*, and thus signifies conjoint labour, not a mere combination or conspiracy to secure a certain end. In its general spirit it may be described as a theory of labour, and in its general aim as an industrial force. The only indispensable labourer in a Medical Aid Association is the doctor; it is his capital, in the form of skill, and his labour which alone create the wealth. Those who do not labour or contribute to the earning have no right to share the result of another's industry, and to call such a sharing coöperation is a contradiction in terms. Coöperation seeks to make and to retain wealth by taking into partnership those who, by their labour, create it. In Medical Aid Associations there are no such labourers other than the doctor. If it be said that the committee work, it may be properly replied, It is true they hold totally unnecessary meetings, but that is not productive labour. If those retain who do not earn, the scheme ceases to have any claim to be called coöperative, but it may fairly be classed as a combination to defraud. If it be said that the goodwill is supplied by the members and that this represents the capital of the business, it may properly be replied that this exploiting of medical skill and labour for profit by lay capital is one of the fundamental abuses of the system, a reform of which is demanded. A coöperative store is a coöperation of small capitalists to employ their own capital and to run their own business, which differs from the practice of medicine inasmuch as to do so does not require a licence. By so using their own capital they save the middleman's profit, and do not make their profit by underpaying their servants for the amount of work done. The saving is effected by interest on capital employed and not by taking part of the earnings of their workers. If Medical Aid Associations do anything they create the middleman; they certainly do not abolish him.

What is the economic position of a medical man? The labour of the doctor is indirectly productive by preserving or restoring the health and consequent power of work of the productive workers. Now, there can only be coöperation in this sphere of usefulness by a combination of medical labourers working together so that all may share in the result of their industry in proportion to the amount contributed. There can be no coöperation proper between one medical man and a large number of laymen; although it is manifest there can be a combination on the part of a number of laymen to transfer to their own pockets what is fairly and justly earned by and belongs to the medical worker. To regard such a combination as coöperation is, however, altogether fallacious. A well-known author on coöperation says: "Coöperation touches no man's fortune; it seeks no plunder; it causes no disturbance in society; it subverts no order; it has its hand in no man's pocket. It seeks its ends by means which leave every other person an equal chance of the same good." Let us see how this fits Medical Aid Associations. Now, in these businesses a profit may be