below is a type. Whose confession of faith—*quâ* anæsthesia—might be briefly expressed somewhat as follows: (1) there is one anæsthetic, and that is chloroform; (2) chloroform may be given anyhow, anywhere, by anyone; (3) if a patient during the course of any anæsthesia shows signs of impending dissolution he is said to take the chloroform badly! (4) if he does nothing of the kind he is said to take it well; (5) if the patient unhappily succumbs, then it is "an act of God" (as defined by the late Lord Young); (6) an anæsthetist may be defined as "a latter-day nuisance of no use to the surgeon and a curse to the general practitioner"; (7) "there is no need more for the anæsthetist than for a hypodermic injectionist or other poisonist."

Lest I seem to exaggerate let me cite the following. I happened a few days ago to get on to the subject of the teaching of anæsthetics and the present movement in that relation with a surgeon of acknowledged ability and operative dexterity. He immediately gave it as his deliberate opinion that there was no more need for such special instruction than for special instruction in the use of the syringe commonly associated with the name of Higginson! I may say it was put a little more baldly. In reply to my query if "as surgeon in charge of a case he prepared to superintend the anæsthetic and remove some feet of gangrenous bowel, for instance," he replied "Certainly." Time and place scarcely permitted of further discussion, but I challenge that gentleman here and now to amplify his views and state them at length, *coram populo* as it were, and you, Sir, whose motto has always been "Audi alteram partem," will surely afford him the hospitality of your columns. Pray let us hear him. I submit that such an attitude argues a magnificent self-reliance, I had almost said *self-assurance*, and possibly a scarcely justifiable belief in the hyper-development of his five senses. It is plain that either the anæsthesia or the operative technique must suffer under such conditions and I think some ground is given for the remarks occasionally made in certain quarters that patients are too much used as "*clinical material*." There can be no question as to the greater risk run by the patient.

Now such a position is taken up for several reasons. One is the possession of a hidebound prejudice and unwillingness to accept any sort of reform or progress; another is a determination not to allow anyone or any circumstance to detract from the supremacy and magnitude of the surgeon. To the financial aspect of the question I hardly care to allude; at any rate, that question has been recently threshed out in your columns on general principles by Dr. F. W. Forbes-Ross. It would be unfair and ungracious of me in the extreme if I did not freely and gratefully acknowledge that there are many surgeons who welcome one's presence at an operation and readily admit their disinclination—nay, their incapacity—to take charge of the anæsthetic as well as carry out some grave surgical operation, or indeed a comparatively trifling one. But a class of surgeon and teacher such as I mention exists and has to be reckoned with. And further, they will readily grant a student a certificate as to "instruction in anæsthetics" when possibly the man has merely given chloroform five or six times—in the same theatre in which they are operating.

In the Edinburgh school the late Professor Annandale was the first to recognise the clamant necessity of proper instruction of students, and in view of his seniority all honour to him. On the lines laid down by him some six years ago teaching has since been conducted in the Royal Infirmary, so far as his wards are concerned.

I am, Sir, yours faithfully,

THOMAS D. LUKE,
Lecturer on Practical Anæsthetics at the University of Edinburgh.

Edinburgh, April 4th, 1908.

THE PRESENT PROSPECTS OF THE MEDICAL PROFESSION.

To the Editor of THE LANCET.

SIR,—Dr. Forbes-Ross admits that "the patient or the patient's friends must needs agree" to the proposed division of fee between the consultant and the general practitioner, and Dr. Saundby concedes that if the facts are fully disclosed the proposed division would be a "perfectly honest and fair transaction." Obviously, if the full facts were *not* disclosed the transaction would amount, as Dr. Saundby points out, to a secret commission received from the consultant by the general practitioner. If the practice advocated by Dr. Forbes-Ross were to become common, how would it work? How would a patient, perhaps a commercial man himself, regard a proposal from his medical attendant in some such form as this? "You need an operation. I recommend Mr. ———. The total fee will be so much, of which one-third will be returned to me on the nail for my services in assisting at the operation and afterwards." The patient from his own knowledge of commercial transactions might not improbably ask whether a rebate of one-third was not rather a large one, and whether all surgeons offered the same attractive terms. It is obvious that if one consultant offered a large rebate to the general practitioner and another consultant a small one or none, the practitioner who recommended the former would risk the accusation of desiring the highest rebate rather than the highest skill. No amount of specious argument ought to blind us to the essential dangers of Dr. Forbes-Ross's proposal. In practice it would soon come to mean the bribery of general practitioners by consultants for the sake of gaining their patients, because the system of rebates is not one which in practice could be openly avowed to any patient with common sense.

When Dr. Forbes-Ross says that the general practitioner is as much entitled to be paid for his services in connexion with the operation and afterwards as the consultant all will agree with him. Further, if it were the custom to recognise and pay for those services at the same time as the consultant is paid I think it would be a good practice, but that payment should be made directly by the patient to the general practitioner and never by the consultant out of his fee.

I am, Sir, yours faithfully,

EDWARD DEANESLY, F.R.C.S. Eng.

April 8th, 1908.

THE TREATMENT OF "MANIA"?

To the Editor of THE LANCET.

SIR,—I am under an obligation to THE LANCET in its issue of March 28th for a fair and generous criticism of my little text-book upon "Mental and Sick Nursing," but your reviewer credits me by implication with a want of sympathy in this volume for the so-called "bed treatment" for cases of mania. I need hardly state that this is not the case, for on p. 76 I refer to the great advantage secured by rest in the recumbent position in bed for days together, and during which period I advocate, if the circumstances demand it, a generous treatment of dietary, and in order to save life supplemented if necessary by forced feeding. Again, on pp. 146 and 147 various details are given as to the preparation and administration of nourishment in regard to forced alimentation. Your reviewer somewhat categorically states that the day for the treatment of acute cases of mania by vigorous outdoor exercise is past, but I ventured to point out in my book that such patients when taken out into the freedom of gardens and open places put forth fewer efforts at violence and restlessness than when kept in bed, even when the bed itself is located in the open air. In support of this, witness the struggling of patients tied down to ambulance carriages by various instruments of mechanical restraint and its complete cessation when they are released upon their admission into the asylum, where, I need hardly say, the application of restraint even for acutely maniacal patients is practically unknown.

There seems to be an unsettled tendency in these materialistic days with regard to medical treatment generally, and the flood of pamphlets, vaunting unfailing remedies for the cure of all human ills, which is blown into one's waste-paper basket from Germany and America, and indeed from all the four winds of heaven, is evidence of this, as well as of the inadequacy of the so-called "drug" treatment. We know too well that there are advocates for the exclusive treatment of insanity by medicines, and the old notion is still urged that unless "medicine out of a bottle" is prescribed there is no "hospital treatment." Indeed, I am frequently asked by advocates of this school of treatment, "What drugs do you use directly to affect the brain?" Some, however, wear their rue with a difference and at all cost advocate no drugs, only the exclusive application of "bed treatment"—not infrequently the cause of sleepless and restless nights, tossing off of bedclothes, and consequent chills. Others there are who advocate a rigid dietary with the sole object of controlling the "intestinal flora," veritably

believed and looked upon as being the *causa causans* of mental disorder. Moreover, there are not wanting those who consider the fine flower of attainment in the cure of insanity to be the application of serum therapy by intravenous injection, which alone they suggest can control toxic agencies and re-establish the normal bio-chemistry of the vital organs.

After nearly 30 years of experience of mental diseases, ranging considerably over 12,000 cases of all forms and varieties of insanity—using these terms in the sense interpreted by Mercier—I am convinced that the proper treatment of insanity must be the study of each case upon its merits and that to advocate any special treatment as the exclusively correct method is to establish the "idol of a cult" which subsequent experience will inevitably demolish as has already occurred in the past. Whilst so much and strenuous importance appears to be laid upon either the "drug" treatment, or the so-called hospital treatment, or bed treatment in open places, I feel compelled to enter a protest against any one method and also to regret that, in my opinion and that of many others, too little importance is being attached to the purely mental influences—viz., the influence of one mind upon another, whereby qualities such as insight, tact, common-sense, inspired by a feeling of brotherhood and sympathy, fail to receive due appreciation. These mental influences are qualities which should have a higher recognition in the treatment of the insane, for they alone can suggest lines of thought which will facilitate to him the normal appreciation of the outside world, these alone are capable unobtrusively of controlling disordered volition—both inwardly by encouraging self-control and outwardly by directing conduct along reasonable and right channels. Surely it will be acknowledged that at all times and in all ages of medical knowledge the cure of disease has not been wholly or entirely by physical means, but by a judiciously utilised appeal to reason associated always with the coöperation of the patient. These qualities, in my opinion, have ceased to secure their due and formerly recognised place in dealing with variations of that subtle *something* which characterises and distinguishes man—viz., the possession not only of consciousness but of self-consciousness, the capacity not only of exercising a "will" but of having an outlook into the unknown future of time and life. The impression is left upon my mind that your reviewer is dominated by an "idol."

I am, Sir, yours faithfully,

Claybury, March 31st, 1908. ROBERT JONES.

THE INTERNATIONAL SOCIETY OF TROPICAL MEDICINE.

To the Editor of THE LANCET.

SIR,—I am in receipt of a letter from Professor Nocht, deputy-chairman of the German Society of Tropical Medicine, in which he states that the first meeting of that society will be held on April 15th–16th, 1908, in Hamburg; and that the members of the German society will be very happy to meet members of allied societies from abroad. Professor Nocht has requested me to make this fact known. The opening meeting will take place at 9 A.M. on April 15th in the Institut für Schiffs- und Tropenkrankheiten, Hamburg.

I am, Sir, yours faithfully,

G. H. F. NUTTALL,

Cambridge, April 3rd, 1908. Honorary Secretary-General.

WHY SILK?

To the Editor of THE LANCET.

SIR,—Silk may be regarded as a type of the material employed for ligatures and sutures which, after burial in the tissues of the human frame, if neither extruded nor removed, persists for many months or even years. The heading of this letter is suggested by perusal in recent surgical literature of the following cases.

In the "Annals of Surgery" for November, 1907, Mr. H. M. Rigby describes the removal by an iliac incision of a calculus impacted in the ureter. The ureter was closed by silk sutures. Symptoms recurred. Another calculus was removed from the ureter and two more calculi were passed per urethram. Each of these last three calculi had as a nucleus a silk ligature. Mr. Rigby now advocates suturing the ureter with catgut. In THE LANCET of March 21st, 1908, in his first Lettsomian lecture, Mr. Charters J. Symonds records five cases of nephrectomy, performed for tuberculosis of the kidney. In four of these cases the behaviour of the ligature was as follows.

CASE 1.—Operation in 1907. The pedicle was secured with silk. "The loin sinus did not close till the ligature came away nearly six months after operation."

CASE 2.—Operation in March, 1907. The pedicle was secured with silk. "The drainage-tube was removed in two days and apparently primary union followed." "About six weeks after operation the loin became swollen and a low form of suppuration developed." In November, 1907, there was "a return of many of the symptoms existing before nephrectomy." "In the absence of bacilli I attributed the symptoms myself to the loin sinus kept up by the pedicle ligature. This was removed under ether."

CASE 4.—Operation in November, 1907. Material of pedicle ligature not stated, but on Jan. 8th, 1908, seven weeks after operation, "the sinus in the loin, though giving little trouble, will no doubt continue to discharge till the ligature comes away."

CASE 5.—Operation in November, 1897. "The ureter, very thickened, was ligatured and the silk brought out through a rubber drain, into which the end of the ureter was drawn. The ligature came away some eight months after operation." I am, Sir, yours faithfully,

Plymouth, March 26th, 1908. C. HAMILTON WHITEFORD.

CHOLERA AND PLAGUE IN THE HEDJAZ AND ELSEWHERE.

(BY THE BRITISH DELEGATE TO THE CONSTANTINOPLE BOARD OF HEALTH.)

SINCE the time of writing my last letter, published in THE LANCET of Feb. 29th (p. 678) the cholera outbreak in the Hedjaz has almost completely come to an end. In Mecca no cases were observed after Feb. 8th. In Jeddah, where 113 cases of the disease with 95 deaths had been recorded in the week ending Feb. 2nd, only 15 cases and 25 deaths were seen between Feb. 3rd and 8th; on the three following days 5 fresh cases and 8 deaths were registered, and after the 11th not a single case or death appeared to have occurred there. In Yanbo, where 18 cases and as many deaths had occurred in the week ending Feb. 3rd, there were 8 cases and 8 deaths between Feb. 3rd and 13th, 3 cases and 3 deaths between the last-named date and Feb. 20th, and 13 cases with 10 deaths from that date to March 11th.

The total number of cases of cholera in the principal towns of the Hedjaz since the beginning of the epidemic on Dec. 13th last down to March 11th is put at 6378 and that of deaths at 5695. But these figures do not include the statistics of the outbreak to the north of Medina and in connexion with the Hedjaz railway. They are also probably considerably below the truth, even for the towns to which they refer. Written reports are now being received from the health officers of some of those towns and these furnish some details of interest which supplement the bare figures hitherto alone received by telegraph. Thus in Jeddah there were two periods of the epidemic. In the first, which lasted from Dec. 27th, 1907, to Jan. 7th, 1908, some 20 deaths occurred; these all resulted from infection imported by four pilgrims' ships arriving at Jeddah from Yanbo (as described in an earlier letter). Then from Jan. 7th to 17th there was a cholera-free period; on the 17th the caravans began to arrive back at Jeddah from Mecca and a second and much more severe epidemic period set in which lasted until Feb. 11th. In all, 416 cases of cholera with 379 deaths were registered in Jeddah. Of this total 182 cases occurred among Indian pilgrims, 64 among Turkish, 41 among Bokhariots, 24 among Soudanese, 21 among Russians, 16 among Yemenis, 15 among Afghans, 11 among Tripolitans, and the rest among Chinese, Egyptians, native Arabs (only 8 cases), Algerians, Javanese, Tunisians, Bosniacs, Persians, Europeans, Albanians, and Somalis. The maximum period of the epidemic fell on Jan. 24th. Very few cases were isolated in the barrack which does duty for a hospital in Jeddah. Most of those afflicted seem to have died in the streets and the sufferings of the pilgrims were greatly increased by torrential rains which fell incessantly for 48 hours. It is stated, however, that the infection did not seem to have been spread by water. The new distilling apparatus which the Turkish Government has put