

Correspondence.

"Audi alteram partem."

THE PRIMARY EXAMINATION FOR THE F.R.C.S. ENG. :

AN APPEAL TO THE PRESIDENT OF THE ROYAL COLLEGE OF SURGEONS.

To the Editor of THE LANCET.

SIR,—May I ask the courtesy of your columns for the following appeal?—I am, Sir, yours faithfully,

WILLIAM OSLER.

DEAR MR. PRESIDENT,—All who have at heart the interests of medical students must have been gratified to see in this morning's *Times* the continued (increasing?) high percentage of rejections—82! But must we wait for a total rejection before the College realises the rottenness of the present system? System it must be, dear Makins: for are not the teachers who fail so ingloriously among the best of your Fellows (in anatomy at any rate); are not the examiners, who are so successful, picked men of the same class; and the unhappy victims—well, it seems ridiculous to say so—but are they not our very best students? For results, see the *Times*, 27 rejections out of 34!

In your skill and judgment the profession has unusual confidence. Induce the College to relieve an intolerable situation. Abolish a system which is a reproach alike to teachers and examiners, and worst of all a cruel perversion of mental values to the student at the very time of life when such values count. The alternative? Back to John Hunter:—

1. Do away with the necessity for Fellowship classes.
2. Make the candidates spend the time (now wasted in cramming) in the laboratories and hospitals.
3. Let them come to the examiners' board with proofs of personal study and research in anatomy or physiology for the Primary—and, may I add, in pathology or surgery for the Final.

Sincerely yours,

WILLIAM OSLER.

Oxford, May 9th.

* * By all who have the interests of medical education at heart Sir William Osler's appeal will be endorsed. The fact cannot be got over that the unsuccessful candidates, who are as a lot the pick of the students, have been prepared for the Primary Fellowship by the class which finds them later to have been badly prepared.—ED. L.

ACUTE EPIDEMIC ENCEPHALITIS.

To the Editor of THE LANCET.

SIR,—As most of your readers will have learned from papers and correspondence in your journal, and from a memorandum recently issued by the Medical Officer of the Local Government Board, there is a prevalent epidemic of acute encephalitis, but neither of the above sources of information quite covers the symptomatic field.

I have recently seen and verified post mortem two cases of acute hæmorrhagic encephalitis in adults over 40 years of age in which the clinical picture has included a rapidly progressive hemiplegia and aphasia, associated in both instances with epileptic convulsions, and in one with hemianæsthesia, hemianopia, and optic neuritis. It appears, therefore, that the inflammation may affect any part of the brain and produce a great variety of physical signs and symptoms, according to its incidence. There seems to be little or no evidence in favour of its connexion with any food poison, but further information with regard to the nature of the infective agent is urgently required.—I am, Sir, yours faithfully,

Wimpole-street, W., May 14th, 1918. E. FARQUHAR BUZZARD.

BOTULISM.

To the Editor of THE LANCET.

SIR,—The following appears to be another case of "botulism" arising at about the same time as most of those recently recorded, and occurring in a man of 41, who is in an advanced stage of phthisis and whom I attended two years ago for angio-neurotic œdema:—

From March 31st to April 6th he daily ate sausages, which were purchased on March 30th, and were observed to be of a nasty colour before they were finished. Since that date he has had no food of any description prepared from pig. About April 8th he became much feebler than usual and would not dress or exert himself; his temper also became uncertain. On the 16th he caught cold, followed by much

increase in cough and sputum, physical signs of bronchitis, and a temperature varying from 100° to 101.2°. There were some nocturnal delirium, a very foul mouth, profuse sweating, and constipation. These symptoms continued unaltered until early on May 2nd, when right-sided facial paralysis suddenly occurred, the temperature dropping to 97° and remaining after this under 99°. At that time there were no signs of any paralysis of limbs, or oculo-motor muscles, and no ptosis or pupillary alterations, nor was there retention of urine or difficulty in swallowing.

The lethargy has gradually increased to what appears complete unconsciousness, from which he suddenly rouses, though only partially. Slight ptosis of the right eyelid, occasional external squint of one or the other eye, and nystagmus are now present, though the eyes move freely in every direction. There is hypertonia of the muscles of all the limbs, but less of the right arm and leg than of the left, and the right limbs are now paretic. Knee-jerks are increased and there is a tendency to ankle clonus on both sides. Kernig + on both sides. Right plantar reflex is flexor and left extensor. Diaphragm moves well, but there has been persistent hiccough since last night. There are constant clonic movements of the left arm and hand. The fundi, which were examined to-day by my partner, Dr. H. Nuttall, are normal.

I am, Sir, yours faithfully,

Colwyn Bay, May 6th, 1918.

ROBERT E. LORD.

PS.—The patient died 36 hours after the preceding notes were written, the only additional symptoms being difficulty in swallowing which appeared late on May 6th, and retention of urine which necessitated catheterisation on the 7th.

EPIDEMIC STUPOR IN CHILDREN.

To the Editor of THE LANCET.

SIR,—Time alone will determine whether the four instances of the symptom-complex characterised by stupor observed by Dr. F. E. Batten and Dr. G. F. Still, and recorded in THE LANCET of May 4th, "justify the conclusion of a new disease of epidemic origin." That the onset, duration, and symptom incidence of disease processes in general are changing so as to render clinical diagnosis obscure and frequently impossible is unquestionable, and many common instances might be cited—i.e., the alteration in the type of rash of measles. It is reasonable to assume that this change of bodily reaction to disease is due to three main factors: (1) The introduction of new bacterial strains from all parts of the globe; (2) the absence of natural immunity; and (3) lowered resistance from restricted diet.

In five cases, four of which were female children, of similar nature occurring under my care and conforming to no standard of group symptoms, the bacteriological investigations during life being nil, two proved at the post-mortem examination to be tuberculous meningitis, one pneumococcal leptomeningitis, and the remaining case acute miliary tuberculosis, the last-named presenting the clinical picture described by Professor A. J. Hall in THE LANCET of April 20th as the asthenic type of toxic ophthalmoplegia.

I am, Sir, yours faithfully,

May 6th, 1918.

L.R.C.P.

SERUM TESTS FOR SYPHILIS.

To the Editor of THE LANCET.

SIR,—In THE LANCET of May 4th, in a timely leading article under this heading, you summarised some of the factors involved in the standardisation of the Wassermann reaction. As a firm believer in the desirability of such standardisation I should like to draw attention to one additional consideration.

The technique employed in this laboratory fulfils the conditions laid down in the excellent report issued by the Medical Research Committee. Quantitative results are obtained by varying the amount of patient's serum employed. Until the middle of last year each test included five different dilutions of serum, and the results were recorded by noting the amount of fixation produced in each tube. With the increased material and the improved clinical records available under the scheme now in force it was felt that more strictly quantitative results were desirable, especially in the direction of records of the upper limits of strongly positive reactions, since, by any method involving the use of only a few tubes, this limit is not reached in a considerable number of cases. We have therefore modified our technique by adding to the tubes employed in each test, so that the dilution of patient's serum varies from 1/7.5 to 1/960. This involves putting up nine tubes, including the serum control, but to economise the reagents a preliminary test is carried out using the serum control and the tubes containing the 1/7.5 and 1/120 dilutions. This divides the serum into negatives, positives, and strongly positives, and the intervening or additional dilutions are then tested to obtain the exact dilution which produces the result regarded as

standard. In our case this is the complete fixation of $2\frac{1}{2}$ M.H.D. of complement previously determined by titration in the presence of antigen. Three M.H.D. are actually employed, and the tube showing half hæmolysis is chosen as standard; or, as more usually happens, the dilution required is calculated from the readings obtained from two tubes, by a method similar to that advocated by Dreyer and Inman¹ for reading agglutination results. Upwards of 1000 sera have now been tested in this way and the results recorded, and to some extent tabulated. Only once has a serum produced the standard result in a dilution greater than 1/1000, but sera showing a titre by this method greater than 1/500 are fairly common. The effect of treatment, or of its too early cessation, is clearly observable in repeated tests, and figures have been obtained with regard to early cases, untreated cases coming under observation at a late stage, and other matters which promise to be of considerable value.

It is my personal belief that there are sound theoretical and practical reasons in favour of obtaining quantitative results by progressive dilution of the patient's serum, but many workers of great experience prefer to vary the amount of complement, while a few vary the amount of antigen. The relative merits of these methods is clearly a matter for impartial consideration and decision. If it be objected that any such method involves the employment of too large a series of tubes and too great an expenditure of time, it can, I think, be answered that in a laboratory where a large number of tests are carried out as a routine on certain appointed days, these objections lose much of their significance, since by suitably arranging the day's programme little extra time is needed, nor should an objection on this ground be allowed to stand, unless the additional work involved is so great as to be impracticable.

I would like strongly to urge that, in addition to a standardised method for diagnostic purposes, a standard for quantitative records should be set up. Such a standard should be so arranged that the *maximum* strength of reaction is recorded in each case, and a reasonably accurate measurement of such strength should be provided for. If any such method could be agreed upon, it should be possible within a comparatively short time to have at our disposal a very large mass of data which, when correlated with the clinical findings, should enable us greatly to increase the accuracy and certainty of interpretation of the test and to understand better the significance of many of those borderline reactions which are met with from time to time, and which may lead to so much difficulty.

It would probably be sufficient, at first, if a standard technique were adopted which could be modified along stated lines to allow accurate quantitative results to be obtained and recorded in a uniform manner, the simpler readings being accepted for diagnostic purposes. If only a reasonable number of workers recorded their results on a standard scale, so that they could be readily coördinated, the desired end would be attained.—I am, Sir, yours faithfully,

W. W. C. TOPLEY.

The Department of Pathology and Bacteriology,
Charing Cross Hospital, May 10th, 1918.

THE ARMY MEDICAL SERVICE AND MEDICAL PROGRESS.

To the Editor of THE LANCET.

SIR,—May I invite attention to certain reforms introduced in past years into the Army Medical Service which have, in my opinion, tended towards technical medical efficiency in the profession at large?

1. The Army Medical Service introduced the "double medical qualification" in A.D. 1860 and thus linked together the physician and surgeon classes of medical practitioners. Before that date any medical man could be "nominated" for the Army Medical Service on the strength of a single qualification in either medicine or surgery. The profession as a whole followed the Army example after many years' delay and the "double qualification" is now the rule.

2. Public competition was introduced for the Medical Service of the Army in A.D. 1860 and private patronage ceased. The R.N. Medical Service followed suit, as likewise the Indian Medical Service. At the present moment private nomination is in force for the Colonial Medical Service and the Prison Medical Service and other minor groups. In my opinion candidates for such services should compete in the Army medical examinations and be granted appointments in these smaller services only if they pass the *qualifying* standard for the Army. By this proposal I practically desire to make the existing Army Medical Entrance Examination into a qualifying *State* examination for the whole

profession of medicine. This standardisation is greatly needed in view of the many universities and colleges now appearing, each with its varying standard of efficiency.

3. *Sanitary training*.—Since A.D. 1860 every entrant into the Army Medical Service is given a sanitary course of lectures for several months on joining. Educated by these courses two great streams of trained sanitary medical officers have gone out over the Empire to preach sanitation through our foreign garrisons, and in a special manner to awaken India through the Indian Medical Service. It would well repay the State to endow, either fully or in part, the hygiene department of our Medical Schools and Colleges, and so reduce to a very low rate the financial charges for sanitary training of medical men, for which students now have to pay. Practically no scholarships or exhibitions exist for the public health students. I regard this as a lamentably retrograde condition of affairs.

4. *Secondary examinations*.—All military medical officers have to pass a secondary examination about their tenth year of service, and provision is to a certain extent made to prepare these officers for such an examination. One day this secondary course at the tenth year of medical life will be a common duty laid on all medical men, and grants in aid of the cost will come from the coffers of the enlightened State. It will well repay the expenditure by developing the efficiency of the medical men.

5. Finally, the Army Medical Service, once broken up in petty regimental groups, has become a centralised corps. It wants but little imagination to see that a similar centralisation will in a measure come upon the civil medical profession, and the cry for a Minister of Health is the visible mark of this unifying spirit. The Poor-law doctors will be linked up with the panel services and the school doctors will also join in, and one day the county medical officer of health will become the medical director of the county—controlling and coördinating all the various county medical groups under one medical administration. His position will be like the principal medical officer of an army now called the Director of Medical Services. Nothing can prevent this certain unification. Into it the Panel Medical Service will no doubt one day lapse.

It will thus be seen that the Army Medical Service has passed through a series of changes, all of which have tended towards its higher efficiency, and now we await to see very similar improvements made in the organisation of the civil branch of the profession of medicine.

I am, Sir, yours faithfully,

GEORGE J. H. EVATT, M.D.,
Surgeon-General (retired).

Junior United Service Club, May, 1918.

MEDICAL SERVICE AND THE QUESTION OF COMPENSATION.

To the Editor of THE LANCET.

SIR,—The question of a State Medical Service is one which the profession may have to deal with, at no distant date; the appointment of a Ministry of National Health is definitely promised. Unless the future of the medical profession is fully considered now, we may have to accept in the future circumstances whatever terms the Government of the day offer.

Since 1914 many men have qualified and entered the services. Some "recognition" of their work will be made, but they cannot all be absorbed at one time by general practice. Many will be prepared to accept service under the Government, at a reasonable salary, and the establishment of them in a State Medical Service would be a "recognition" which would be detrimental to the interests of the older practitioners. Surgeon-Major J. F. Gordon Dill, at the meeting of the Royal Society of Medicine last month, outlined a scheme which was published in THE LANCET of April 20th. In many respects it is similar to one which I formulated last year, but there are a few points with which he did not deal. Major Dill's scheme provides that "no personal interests must be adversely affected." That is rather vague. In my opinion, the first essential to a State Medical Service is that present practitioners *must be compensated*. Every man has a proprietary right in his own practice. It is a marketable commodity. If we become State servants we will lose our proprietary right, therefore we ought to receive compensation for the loss of that right. The compensation should be not less than one year's purchase.

Major Dill suggests a pension after 25 years' service. That may be all right for future generations of practitioners, but what about the men who have been already 25 years in practice? Surely it is not intended that they should spend the next 25 years in Government service before a pension is due to them! These men, in the past, have worked harder than the future State servants will have to work, and if they are to be compulsorily retired are as much entitled to their pension now as the young men will be 25 years hence.

The financial arrangements mentioned by Major Dill, if adequate, would perhaps be satisfactory to future men, but not to the present generation of practitioners, unless the time they have already spent in practice is regarded as "the

¹ Dreyer and Inman: THE LANCET, 1917, i., 365.