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LESSONS OF THE HARNETT CASE.

WE publish verbatim, at page 990 of this issue, the judgements delivered in the House of Lords on May 15th in the appeal of Mr. William Smart Harnett. The fact that the unanimous decision of the Lord Justices in the Court of Appeal in favour of Dr. Adam and Dr. Bond has been unanimously upheld by the Law Lords, and that the grave reflections cast upon both Dr. Adam and Dr. Bond by the answers of the jury to questions put to them by Mr. Justice Lush have been shown by the members of both appeal courts to be entirely lacking of foundation in fact, are matters that afford complete satisfaction to the medical profession, since the characters of two of its members, one of whom holds a highly responsible position in the administration of our lunacy laws, are now vindicated beyond cavil.

The facts of the case are set forth in detail in the judgement of the Lord Chancellor. Here we merely wish to refer to certain main issues arising out of the tortuous maze of evidence given in the course of the fifteen days over which the hearing in the King's Bench Division dragged, bearing in mind that all this evidence was given eleven years after the facts occurred, and, human memory being what it is, was somewhat hazy in character.

It was not disputed that on November 10th, 1912, when the original reception order was made, Mr. Harnett was of unsound mind; but Mr. Harnett's condition improved to the extent that, on December 12th, 1912, he was allowed to go home for twenty-eight days on a leave of absence on trial order, made under Section 55 (3) of the Lunacy Act, 1890—in a form settled by the law officers of the Crown—which stipulated that the medical officer should at any time before the expiration of twenty-eight days have power to take back the said patient into the licensed house "if his mental condition requires it." Mr. Harnett left the mental home at Malling Place with his brother, but on the morning of December 14th he called at the offices of the Commissioners in Lunacy in Victoria Street, London, apparently for the purpose of asking that he be put in the care of the police and not of his brother. What happened at the offices is not quite clear from the evidence, but the Law Lords accepted the facts that both the secretary, Mr. Dickinson, and Dr. Bond thought Mr. Harnett was in an excited state and unfit to be at large, and that, after identifying Mr. Harnett's case in the files, they telephoned to Dr. Adam their opinion. Upon this, Dr. Adam sent a car and fetched Mr. Harnett back to Malling Place, where he examined him, and, finding him worse mentally than when he was released on trial, detained him under the original reception order. Mr. Harnett stayed at Malling Place until February 22nd, 1913, and thereafter he was confined at different asylums until October 15th, 1921, when he escaped. Owing to the anomalous Section 85 of the Lunacy Act, 1890, which says that an escaped lunatic can only be retaken within fourteen days of escape without a fresh order or certificate, Mr. Harnett, by eluding recapture for that period, regained his liberty and was declared sane by eminent alienists whom he consulted.

The action against the two doctors was not founded in negligence, as was the case in Everett *v.* Griffiths and Anklesaria (1920, 3 K.B. 163; 1921, 1 A.C. 631), but in conspiracy and false imprisonment. The allegation of conspiracy was dropped early in the course of the proceedings, and was clearly negatived by the jury by their answers to questions 13 and 14. There remained the allegation of false imprisonment, and the jury, by their answer to question 17, found that Dr. Adam was not responsible for the false imprisonment. It was admitted all along by counsel for Dr. Bond that Dr. Bond was responsible for the detention in the Commissioners' offices on December 14th, 1912, and his liability in damages for this act followed from the jury's finding that Mr. Harnett was sane on that date. It was not open to Dr. Bond *qua* Commissioner to plead the protection afforded by Section 330. This is now the only point left open: a new trial has been ordered for a jury to determine these damages for a period of detention which, the Lord Chancellor said, in a just view could not extend beyond 7 o'clock of December 14th.

The Lord Chancellor characterized it as a remarkable fact that no direct question was put to the jury either as to the alleged conspiracy or as to the alleged false imprisonment. Dr. Adam not being found liable for false imprisonment, there was no further ground of action against him on the statement of claim, and the question of negligence arose out of his defensive plea of Section 330—open to those who act *bona fide* and with reasonable care in pursuance of the Lunacy Acts. The *bona fides* of Dr. Adam was clearly established by the jury's answer to question 13, but in their answer to question 15 they said that he did not take reasonable care in exercising his power to retake Mr. Harnett (under the leave of absence order). Mr. Harnett's counsel throughout advanced the amazing contention that the medical officer had no power of recapture outside the mental home, and that a recertification was needed before Mr. Harnett could be brought back unless "his mental condition requires it." As the jury had found that Mr. Harnett was sane on December 12th, it followed from this argument that Dr. Adam had not, in fact, exercised that reasonable care which afforded him the protection of Section 330. The Lord Chancellor scotched this argument. Such a provision as "if his mental condition requires it" could not, in his view, mean that the medical officer was to take back the patient at the risk of having it found by inquiry many years after that the patient's mental condition was consistent with his remaining at large. The medical officer was the judge of the patient's mental condition, and in him the power to retake the patient rested, and that power was capable of being exercised wherever the patient might be found. The argument that the onus was upon Dr. Adam to prove that he had exercised reasonable care was also described by the Lord Chancellor as fallacious. If such a power was exercised negligently the remedy (if any) would, of course, be by an action for negligence and not for false imprisonment, but the Law Lords agreed with the Court of Appeal that there was no evidence to substantiate the jury's answer to question 15 that Dr. Adam had not taken reasonable care. The case against Dr. Adam was thus shown to be built on the flimsiest of foundations—inferences of fact and law which three Lord Justices and five Law Lords have unanimously agreed ought never to have been drawn. Further, the Law Lords disapproved of the form of some of the questions put to the jury, particularly questions 7, 8, and 9, to which the jury answered that Dr. Bond did not honestly believe that the plaintiff was of unsound

mind, or that he was fit to be at large, or was dangerous to himself or others. The Lord Chancellor pointed out that it was common ground that the effect of the jury's answer to question 10 was that Dr. Bond's belief that the plaintiff had escaped from his brother's charge was the reason for his having Mr. Harnett sent back. But we agree with Lord Buckmaster that this explanation of the earlier answers of the jury is inadequate. Even assuming that Dr. Bond may have made a mistake—and from certain observations which Lord Buckmaster made in the course of the hearing in the House of Lords we infer that he, at any rate, did not think Dr. Bond had made any mistake at all—he could find nothing in the evidence that on any interpretation of the word could cast the least reflection on his honesty: "I think it is to be regretted that a question should have been left to the jury in such a form that the verdict taken upon it must, in the plain meaning of the words, cast a reflection upon Dr. Bond's character which no sophistry can explain away."

The most disturbing aspect of the Harnett case to the medical profession was that of the doctrine enunciated by Mr. Justice Lush—the doctrine of continuing responsibility. Heavy damages were the fruits of the direction of Mr. Justice Lush to the jury: "taking into consideration the whole purpose for which he was so detained." The Lord Chancellor said the findings on damages were "obviously coloured" by such and similar directions. We have, in discussing the case a year ago, described as amazing the dictum of Mr. Justice Lush that once a man is certified insane each subsequent certification by a doctor and each adverse report by a visitor is a mere formality, a mere act of omission to find the patient sane, and not a new act intervening to break the chain of causation. The Lord Justices, fortunately for the medical profession, took a different view of the law, and held that this chain had been broken at "innumerable points." It appeared to the Lord Chancellor to be impossible to hold that the detention of the appellant at the offices for a few hours was the direct cause, not only of Mr. Harnett's being retaken and conveyed to Malling Place, but also of his being confined in that and other mental homes until October, 1921. Dr. Bond could not, he said, on any intelligible principle, be held to be responsible for the consequences of those events; Lord Dunedin looked upon such a suggestion as preposterous.

Medical men are now free from the fear they quite legitimately entertained after the judgement of Mr. Justice Lush: that when they certify a patient it is possible that a jury, sitting some years hence, may find that selfsame patient to have been sane on the date of the original certification, and that the doctor responsible for such certification may be made liable in damages for the whole period of detention, in spite of the many subsequent independent certifications by other medical men during that period.

But we do realize, with the Lord Chancellor, that the verdict of the jury and the heavy damages they gave against Dr. Adam and Dr. Bond were the outcome of a belief that Mr. Harnett was quite sane during the whole period from 1912 to 1921, though there was no actual finding that Mr. Harnett was sane after December 12th, 1912. This fact, as the Lord Chancellor said, gives rise to anxiety, though we agree with him that even if Mr. Harnett was sane during his confinement it was no reason for visiting vindictive penalties upon persons who acted in good faith and who were not responsible for any defect in the law.

The Lord Chancellor enumerated the existing safeguards, and said it might be—"I do not say that it is"—the fact that all these precautions are insufficient, and that the lunacy laws require to be further strengthened in the interests of the persons whom they may affect. The proceedings in the Harnett case in the King's Bench Division were the direct cause of the holding by a Royal Commission of the inquiry into the administration of our lunacy laws, and we look forward with interest to the publication of its findings. While we have always insisted that the public at large must be protected against the dangers to which it would be exposed if lunatics were allowed to move about unrestrained, we have always placed as much, if not more, emphasis upon the protection of the individual against improper confinement. We have on several occasions urged that the hard-and-fast legal procedure in England should, in the interest of the patient, be approximated more nearly to the Scottish methods, as in their early stages many forms of mental disorder are curable by suitable treatment, for which statutory provision should be made.

Whatever new legislation may be the outcome of the Royal Commission, the members of the medical profession will continue loyally to administer the lunacy laws, and to discharge those large responsibilities which have been placed upon them on the theory that they can be trusted; and, now that the final decision in the Harnett case has shown that Section 330 is a sure shield to all medical men who act *bona fide* and with reasonable care in pursuance of the lunacy laws, they will feel, while performing their tasks, a sense of security which would have been grievously lacking if the judgement of Mr. Justice Lush had been allowed to stand.

THE SPREAD OF SMALL-POX.

AN incidental effect of the renewed prevalence of small-pox since its minimum in 1917 is the resumption of the outpouring of letters to the press by opponents of vaccination whose knowledge of the subject is in inverse ratio to the assurance they display in dealing with it. So long as variola retains the mild form which is now presented in most countries—a form which Jenner described as occurring epidemically in 1789—it may be thought hardly worth while to pay any attention to the influence of such commentators. Fortunately the children who are being attacked by small-pox, owing to their parents' neglect to have them vaccinated, are being vicariously punished much more lightly than they would have been in the nineteenth century, and while that remains the case there is temptation to treat the silly dialectics of the letter-writers with silent contempt. But there is probably some risk of sober-minded people misunderstanding the silence, and from that point of view we shall call attention to some statistics which Dr. C. C. Pearce, senior surgeon to the United States Public Health Service, Chicago, has published in a recent issue of the *Boston Medical and Surgical Journal* (April 9th, 1925).

Dr. Pearce's data are based on the records of the United States Public Health Service relating to all quarters of the globe. Small-pox, he observes, remains the most widely distributed plague in the world, there being practically no country permanently free from it. During the year ending June 30th, 1924, 149,550 cases of small-pox with 22,346 deaths were reported by health officers throughout the world to the United States Public Health Service. One-fifth of all these cases occurred in the United States, forty-

five States reporting a total of 30,771 cases. Apart from China and India, during 1923 only three countries in the world where vital statistics are kept and are available exceeded the United States in their small-pox rate. These countries were Switzerland, Russia, and Greece, which had rates respectively of 55, 43, and 33, as compared with 27.1 per 100,000 in the United States. On the other hand, in South Africa, Egypt, Algeria, Finland, Hungary, and the Baltic republics the small-pox rate ranged from 3.9 to 0.35 per 100,000, while the Scandinavian countries, Australia, and New Zealand reported no cases at all. During 1924 3,073 cases occurred in Minnesota with 306 deaths—a mortality of 9.9 per cent. Of the 306 fatal cases none had been successfully vaccinated within seven years, and 243 had never been vaccinated. Forty-seven had been vaccinated, but the successful vaccinations ranged from eight to seventy-five years before the fatal attack, and in 16 there was no definite history of vaccination. In an outbreak at Windsor, Ontario,[1] there were 67 cases and 32 deaths between December 12th, 1923, and March 17th, 1924. Within two weeks over 50,000 persons were vaccinated, and the epidemic promptly subsided. The outstanding features of the epidemic were that all the deaths occurred in unvaccinated persons; that seven out of every ten unvaccinated persons who contracted the disease died, the fatality among the unvaccinated being 71 per cent.; one man, aged 80, who had been vaccinated sixty years before, and who lived in the same house as a man with malignant small-pox, developed a mild attack from which he quickly recovered. The rapid increase that may occur in the virulence of a small-pox epidemic is shown by the experience of Detroit. Between September 1st, 1923, and March 15th, 1924, 710 cases occurred with only 4 deaths. On the other hand, during the period March 16th to June 1st, Detroit had 795 cases with 105 deaths. Exclusive of the cost of the patient's treatment in hospital, which amounted to $2.39 a day for each patient, the epidemic cost the Health Department of Detroit $127,854, and it was calculated that the time lost on account of 784 persons who had small-pox between April 13th and August 31st, 1924, was 163 years, 8 months, and 17 days.

A telegram from the *Times* correspondent in New York, dated May 17th, states that that city has voted $80,000 (£16,000) for a special campaign by the Health Department to prevent the spread of small-pox. There were, he said, "only six cases in the city at that time, but the prevalence of the disease in Philadelphia, Camden, and some neighbouring suburbs has led the health commissioner of New York to emphasize the need for precaution, especially as most of the cases reported throughout the country in recent weeks have been of a virulent type, with a large percentage of deaths."

While this is the position in America the infection continues to spread in England. In the first four months of this year the total number of cases reported has been 2,393. According to the record in the Registrar-General's reports, the weekly numbers, from January 3rd to May 2nd, which began with 91, have mounted gradually to 176 in the seventeenth week, the highest figure so far reached. In the eighteenth week 162 cases were notified. The North of England and the Midlands have been mainly affected, Northumberland, Yorkshire, Derbyshire, Notts, and Northampton all being involved.

The health officers of the great cities of the industrial region cannot but be in continual anxiety, especially if the disease prevails in rural or urban districts near them. The fact that they have hitherto been largely successful in keeping the disease at bay is most creditable, and their continued success will be watched with keen interest. The cost to the public funds is mentioned by Dr. Pearce in respect of America, and is receiving attention in places affected in this country. There have even been mutterings of abandonment of hospital isolation, and resort to such segregation as might be possible at home. That is a counsel of despair to which the public health service of this country is unlikely to listen. It is quite true, however, that the task of the medical officer of health is now made extraordinarily difficult. He has to contend with concealments of recognized cases, with failures to recognize the disease, and with much neglect of vaccination even in some localities where small-pox has been prevalent. He struggles to discover contacts, but in the circumstances there is great risk of lists being incomplete, and he may well feel the task almost hopeless. Where the infection has already taken firm hold of a community the only course is to continue trying to wear down the enemy by steady perseverance in vaccination, isolation, and search for contacts. In some places control has been accomplished by such means and the disease gradually extirpated. Where the invasion is only beginning, vigilance from the very onset is the only policy. The officer should waste no time in academic discussion of what he ought to call the malady, whether alastrim or small-pox or para-small-pox, or what else. His duty is to try to stamp it out and leave such topics for elaboration after he has done so. A complete list of contacts, with surveillance of them from the very beginning, is of infinitely more value than the devising of appropriate names for purposes of registration. Also, it seems to us that in the present circumstances of this country, and with the present type of small-pox, local health authorities may as well cry for the moon as for absolute compulsion of vaccination. If Parliament is wise it will exercise all reasonable pressure, and will at least reverse Mr. Wheatley's withdrawal of the order issued by Mr. Neville Chamberlain when previously at the head of the Ministry of Health, regarding the form of vaccination notice to parents; the altered form is as much an invitation to omit vaccination as a request for its performance. In the meanwhile the basic fact remains that every parent who chooses to do so can by vaccination and revaccination of himself and his family obtain complete protection against small-pox, whether mild or severe, diagnosed or undiagnosed, isolated in hospital or left uncontrolled. And for the instruction of such part of the public as is willing to accept instruction the data collated by Dr. Pearce from the United States Government's reports are to be added to the great store already available.

[1] See the BRITISH MEDICAL JOURNAL, March 29th (p. 584) and July 19th, 1924 (p. 123).

SLEEPING SICKNESS CONFERENCE.

AN international conference on sleeping sickness is being held in London this week under the chairmanship of Mr. Ormsby-Gore, Under Secretary of State for the Colonies; the other British representatives are Dr. Andrew Balfour, C.M.G., director of the London School of Hygiene and Tropical Medicine, and Dr. A. G. Bagshawe, C.M.G., director of the London Bureau of Tropical Diseases. The conference is being attended by representatives of France, Italy, Belgium, Portugal, and Spain. A committee of experts nominated by the League of Nations in 1922 to obtain information as to the prevalence of sleeping sickness and tuberculosis in equatorial Africa made a series

of recommendations, which were approved by the Council of the League of Nations at its session in Rome last December. One of the recommendations was that such a conference as is now meeting should be held. In opening the proceedings on Tuesday last, Mr. Ormsby-Gore said that one of the outstanding problems encountered during his recent tour in Central Africa was that of the human and animal diseases the infection of which was carried by tsetse flies. The tsetse fly, he said, occurred in belts of varying sizes practically throughout the whole of tropical Africa from Senegal on the north-west to Zululand on the south-east. The great outbreak of sleeping sickness in Uganda about twenty years ago, when roughly one-tenth of the total population of the protectorate died, had attracted much public attention in this country. The disease, though less severe, was still prevalent in Uganda, and a report from Northern Rhodesia had been received stating that an epidemic outbreak of a severe form occurred in 1923 in an area where its presence had not previously been recorded. The position was serious also in the Belgian and French colonies, including those in West Africa; one of the most important pieces of work in connexion with the problem had been carried out in the Portuguese island of Principe, and at the present time the disease caused grave anxiety in the Spanish island of Fernando Po. In 1900, shortly after the great outbreak in Uganda, an international conference was held in London; it met again in the following year; a general agreement was not reached, but Great Britain founded the Sleeping Sickness Bureau. During the outbreak in Uganda and Nyasaland in 1908 it was discovered that the infection was carried there, not by the tsetse, *Glossina palpalis*, which was the vector in Uganda, but by *Glossina morsitans*, which conveyed trypanosome diseases to domestic stock. The investigations of Dr. Kinghorn and Dr. Yorke in Northern Rhodesia, and of the Royal Society Commission under Sir David Bruce in Nyasaland, led to the appointment by the then Secretary of State for the Colonies of a committee; its report was presented to Parliament in May, 1914, but the outbreak of war a few months later prevented any immediate action. Other nations had taken the matter up, and Dr. Kleine had ascertained that a developmental cycle of the trypanosome occurred in the tsetse fly. Investigations into the treatment and prevention of the disease by the use of drugs were instituted by French, German, Belgian, and American scientists, but though questions of this nature have not yet been answered the most important problems at the moment were administrative. In Central Africa, where native social life and custom was so intimately bound up with the keeping of cattle and other domestic stock, the problems of sleeping sickness could not be dissociated from those of animal trypanosomiasis (nagana), and Mr. Hornby of the Tanganyika Veterinary Institute had made some valuable observations on the treatment of nagana, but the inquirers were everywhere brought back to the physical and administrative problem of the control and eventual extermination of the tsetse fly itself. The task was tremendous, but there was hope, and if the problem could be solved something very notable would be done for the African native and for the advance of civilization and development in Africa. Mr. Ormsby-Gore then referred to what he described as the very remarkable achievements of Mr. Swynnerton in the Shinyanga district of the Tanganyika Territory (of which that investigator gave some account in our columns not very long ago), and to what had been done by Father Cirvenga in another part of the same territory. During a visit to Shinyanga Mr. Ormsby-Gore had been able to satisfy himself that the experiments, which were on a considerable scale, were being attended by a large measure of success. The conference had been summoned to discuss the possibility of carrying out the recommendation of the League of Nations Council that a special international epidemiological commission should be sent to equatorial Africa. The terms of reference to the conference suggested that attention should be concentrated on the purely medical aspects of the problem as it affects sleeping sickness in man, but it was hoped that all sides of the question would be considered. The object of the commission, therefore, would be to survey the fly areas of tropical Africa, noting any extension or decrease, to make further researches into the bionomics of the tsetse fly, to make experiments on a field scale for the extermination of the fly, and to investigate the prevention and treatment of both human and animal trypanosomiasis. For such a task there would be required the services of entomologists, protozoologists, veterinary and medical scientists, and men of administrative and zoological experience such as Mr. Swynnerton.

THE PROJECTION OF THE RETINA IN THE BRAIN.

THERE appear to be two main schools of thought with regard to the projection of the retina in the brain. The one, led by Henschen, holds that every spot on the retina has a definite localization in the external geniculate bodies, in the optic radiations, and in the cerebral cortex of the occipital lobes. According to this view the macula is represented by a circumscribed area in the brain, and the dorsal or uppermost part of the retina is represented in the upper part of the geniculate body, radiation, and cortex. The other school, led by von Monakow, denies that each part of the retina has a definite localization, and holds that the macula is represented over a wide area. Dr. B. Brouwer, professor of neurology in the University of Amsterdam, in a lecture delivered at Charing Cross Hospital Medical School on May 15th, described the views of these two schools, and showed how recent work carried out by him had led him to take an intermediate position. He referred to the work reported by Holmes and Lister during the war, which went to support Henschen's theory. These workers found that bullet wounds of the occipital lobe caused localized patches of blindness in the fields of vision. His own method of investigation has been to enlist the aid of an ophthalmological colleague to make localized lesions in the retinae of experimental animals; these were killed some time later, and the areas of degeneration in the brain were then examined histologically after being treated by the Marchi method. In this way Professor Brouwer has been able to study the brains of some sixty animals. In rabbits, where a very high proportion of the optic tract crosses, the principle of an exact localization of each part of the retina in the external geniculate bodies was completely upheld. In cats, where more fibres appear to be uncrossed, this localization was still found to be fairly exact. Further experiments were then carried out on monkeys in which the arrangement of the optic tracts and the existence of maculae rendered the conditions very similar to those existing in man. The results in these cases were somewhat more difficult to interpret on account of the fact that there is only a small portion of the field of vision which can be seen by one eye alone, but the inner part of the retina, which is the part concerned with monocular vision, had been destroyed in certain monkeys, and areas of degeneration were found to exist in a localized portion of the lower part of the external geniculate body of the opposite side. The areas of degeneration corresponding to lesions of the macula were not small, but were spread out over a great deal of the external geniculate bodies of both sides. The parts of the retina nearest to the macula were represented in areas of the geniculate bodies nearest to the areas of macula projection, and the periphery of the retina was represented around the periphery of the geniculate bodies. Professor Brouwer thus agrees with Henschen as far as localization of retinal projection is concerned, and with

von Monakow in the matter of a large area of projection for the macula. He is at present engaged on further work in which he hopes to trace the projection of the retina in the cerebral cortex. He has also given a lecture on this subject at the University of Sheffield during the present week.

AMERICAN POST-GRADUATES IN LONDON.

THE programme of the visit to London of the Inter-State Post-Graduate Assembly of America from June 2nd to 4th is now complete. Arrangements have been made for lectures (at Wigmore Hall) in the mornings, beginning at 9.30, and hospital visits in the afternoons, continuing until 5 o'clock or later. In order that no time may be lost after lunch a fleet of motor buses has been chartered to convey the visitors to the hospitals. Following the inaugural ceremony by H.R.H. the Duke of York on the first morning there will be four consecutive lectures, each lasting half an hour, and on each of the next two mornings six such lectures. The chairmen at the three morning sessions will be Sir Humphry Rolleston, Sir John Bland-Sutton, and Sir StClair Thomson respectively. Sir Humphry Rolleston is to open the lecture list with a discourse on gall-bladder disease, and he will be followed by Sir W. Arbuthnot Lane on "The first and last kink," Sir Thomas Horder on "Changes in the incidence and course of common diseases," and Dr. A. F. Hurst on "The pathogenesis and treatment of Addison's anaemia and subacute combined degeneration of the spinal cord." On the second morning Professor H. Maclean lectures on renal disease, Mr. A. J. Walton on gastro-jejunal ulcer, Colonel L. W. Harrison on the combating of venereal disease by free treatment centres, Mr. W. E. Miles on cancer of the rectum, Mr. T. P. Dunhill on auricular fibrillation in exophthalmic goitre from the point of view of surgical treatment, and Dr. Strickland Goodall on the heart in influenza. On the final morning Dr. Gordon Holmes takes for his subject suprarenal disease, Sir Walter Fletcher medical research in Great Britain, Mr. James Sherren the choice of operations in gastric and duodenal ulcer, Sir StClair Thomson cancer of the larynx, Dr. H. C. Cameron functional nervous disturbances in children, and the last lecture is by Lord Dawson of Penn, whose subject is "The speed of life and disease." Post-graduate programmes for the afternoons have been offered by thirty-four general and special hospitals, the number of visitors to each institution being limited usually to twenty or thirty. The programmes generally include a round of the medical wards, surgical operations, clinical and pathological demonstrations, visits to special departments, the exhibition of historical and other specimens, and in some cases brief lectures. Practically the whole of each hospital staff will be at the service of the visitors. The institutions offering this hospitality include the Radium Institute and the London School of Hygiene and Tropical Medicine. On June 3rd the Royal Society of Medicine will give an evening party, when Mr. W. G. Spencer, honorary librarian of the Royal Society of Medicine, will exhibit over fifty examples of American medical literature before 1861. The executive committee, which is responsible for the arrangements as a whole, including a number of social functions in the late afternoons and evenings, consists of Sir Humphry Rolleston, Sir W. Arbuthnot Lane, Sir StClair Thomson, Sir William Hale-White, Sir Holburt Waring, Mr. W. Girling Ball, and Mr. Philip Franklin (honorary organizer). The medical programme committee consists of more than forty members, under the chairmanship of Sir Holburt Waring, and there are four honorary secretaries—namely, Professor Arthur Ellis (medical), Mr. W. Girling Ball and Mr. H. W. Carson (surgical), and Dr. Eric Pritchard (special departments). The bureau and headquarters will be at the house of the Medical Society of London, in Chandos Street, Cavendish Square, where also an exhibition of surgical instruments and medical products has been arranged. The Inter-State Post-Graduate Assembly of America, which is directed by the Tri-State District Medical Association, comprises, it is stated, 55,000 members. The number accompanying the President, Dr. Charles Mayo, to Europe on this occasion is expected to be about 300. The London visit will be followed by visits to Ireland, Scotland, and the English provinces, and later in the month the party will proceed to Paris, where Professor Tuffier has charge of the arrangements.

WELSH CRIPPLES.

As readers are aware, a movement for the better treatment of cripples and for their education during treatment has been making steady progress in England. An account of the position then reached was given in our columns on August 2nd, 1924 (p. 204), and since then meetings have been held in many counties, with the result that much public interest has in every instance been aroused. It is primarily a matter for the education authorities, but they require support and stimulation, and those concerned in the movement are in need of funds to carry on the crusade. The movement, although it originated in the marches of Wales—in Shropshire, at Baschurch, in the institution established by Miss Hunt—has not yet made much progress in the Principality. We are glad to learn, however, that attention is now to be given to the matter. The Welsh National Memorial Association, established for the treatment of tuberculosis, has already done a good deal by setting up hospitals at which non-pulmonary tuberculosis is treated. There is the North Wales Sanatorium at Llangwyfan, near Denbigh, the St. Bride's Hospital, recently opened in Pembrokeshire, and the Glan Ely Hospital, Cardiff, to mention only some of the largest. In this connexion the Prince of Wales's Hospital established in Cardiff during the war for the treatment of soldiers and sailors who had lost a limb should be mentioned. In its foundation Sir John Lynn-Thomas took the initiative, Lord Tredegar gave the site, and Mr. Percy Miles and some other wealthy men in Cardiff made large contributions for its equipment and endowment. The number of war cases has now largely diminished, and the hospital has been able to undertake the treatment of civilian cases from all parts of Wales and Monmouthshire. In addition to residential ward accommodation, which is already being largely utilized for children, it possesses workshops and exercising grounds, where the cripple can receive his earliest instruction. Sir John Lynn-Thomas, who is at present himself, we regret to learn, physically crippled by a fracture into the knee, sustained early in March while on a visit to Florida, is not allowing this handicap to interfere with the planning of a national scheme for Wales. A gift of £50,000 from an anonymous donor, to meet preliminary expenses, has just been announced. This gift and other contributions which may be received will be vested in trustees, whose first duty it will be to take a census of cripples; it is estimated that there must be at least 20,000 cases in Wales and Monmouthshire who need orthopaedic treatment. The English scheme, which owes its present advanced position largely to the leadership of Sir Robert Jones, is to be extended, with suitable modifications, to Wales, and the Prince of Wales's Hospital at Cardiff will, it is thought, offer suitable headquarters. It is intended to hold a conference in the autumn to which every health and education authority in Wales and Monmouthshire will be asked to send representatives. The scheme will then be fully explained by Sir Robert Jones and others, and, it is hoped, very shortly thereafter brought into action. It has the support, we understand, of the Welsh Board of Health and the Welsh Board of Education.

INTERNATIONAL CONGRESS OF RADIOLOGY.

THE International Congress of Radiology, which is to be held in London from July 1st to 4th, will consist of three sections—radiology, physics, and electrotherapy and physiotherapy. As the number of papers in the section of radiology is very large it will probably meet in two divisions sitting simultaneously, the one hearing and discussing papers relating to diagnosis, and the other those bearing on therapy. The section of electrotherapy and physiotherapy will hold three sessions; the first dealing with actinotherapy, and the second with diathermy. In the physics section Professor Hopwood will open a discussion on the organization of a hospital radium service. On the opening day that section will meet with the section of radiology for a discussion on the standardization of dosage, which will be opened by Sir William Bragg from the physical standpoint, and by Dr. Béclère of Paris from the medical. On the evening of that day the Duc de Broglie will give the Sylvanus Thompson memorial lecture, and has chosen for his subject the absorption of x and gamma radiations and the secondary radiations which accompany them. On July 3rd Sir Berkeley Moynihan will deliver the Mackenzie Davidson memorial lecture on the relation of radiology and surgery. The congress dinner will be held on the evening of the second day.

SPOKEN AND WRITTEN ENGLISH.

PROBABLY few people realize that the distinction implied in the above title exists. Dr. Henry Bradley, the senior editor of the *Oxford English Dictionary*, read a paper on the subject at the International Historical Congress as long ago as 1913. It has lately been reprinted by the Society for Pure English. It is a thoughtful pamphlet, and will well repay perusal. Dr. Bradley began by laying it down that, little as the fact may be realized, "speech and writing are two organs for the expression of meaning, originally co-ordinate and mutually independent." He thought it probable that written language was primarily ideographic, conveying ideas by means of a series of pictures, and that only secondarily did it become representative of the sounds of speech. Many educated persons do not appreciate to what an extent they read the written word, not as a combination of sound symbols, but as an ideograph or single symbol, the sight of which calls up in the mind the memory of a thing or an idea; we all know that when in doubt as to the spelling of a word we can often come to a right decision by "the look of it," on comparing the two spellings when written. Alphabetical language still preserves traces of its twofold origin, and among modern tongues English more than most shows differences between the written language of the educated and the spoken language of the multitude. This "undemocratic" character of the literary language is exaggerated by the classical tradition and by the number of words which have been borrowed and adapted from the dead languages, and of late years especially by the host of words coined mainly from the Greek to represent technical and scientific ideas and discoveries. Dr. Bradley expressed the opinion that many of these are scarcely used in the spoken language. The German method of Teutonizing every term does not recommend itself, for if the speakers of all languages followed it a scientific tower of Babel would be erected with dire results. He suggested that by international agreement all new scientific technical terms might be expressed in Esperanto or in some better universal language yet to be invented and adopted. While he looked upon radical spelling reform as impracticable, he admitted that the adoption of phonetic spelling would have some distinct advantages, among which not the least would be the greater ease of learning to spell and read and write. In a note on spelling reform he confessed that his ideas were exceedingly vague as to the extent to which reform is possible and desirable, but he thought that reformers should for the present confine the attack to those points for which there is no defence but custom. The number of homophones or words sounding alike but spelt differently and with different meanings constitutes a difficulty. If the "p" in "psychosis" and suchlike words were habitually sounded we should abolish the anomaly under which a mental derangement and a skin disease are represented by the same sounds. As regards the teaching of correct pronunciation, it must be remembered that a phonetic notation which represents correctly all the sounds in the language is something quite distinct from the more debatable phonetic spelling, which might correctly represent the speech of the educated Londoner but not that of the Aberdonian scholar, and which also might be gradually rendered inaccurate by changes of customary pronunciation, as has happened with many words in use to-day. In Chinese an ideographic character may represent all the widely differing sounds given to the same word in many dialects the speakers of which are mutually incomprehensible; consequently the written language is not subject to the same changes as are found in the alphabetical languages that attempt to convey the sounds of speech by written words.

WAR MEMORIAL TO WOMEN.

THE famous Five Sisters Window of York Minster, which has been restored by women of the Empire in memory of women who gave their lives in the war, will be unveiled by the Duchess of York on June 24th at 3 p.m. An oak screen has been placed in the Minster with the names of the women to be commemorated. There are several women doctors on this roll of honour, and it is hoped that as many of their colleagues as possible will be present on this occasion to pay tribute to their memory, whether they did war work or not. As all representatives will be wearing uniform, it is requested that all medical women present shall wear academic dress. All who have decorations are asked to wear them. During the time of the ceremony at the Minster memorial services will be held throughout the Empire—in Australia, Canada, and New Zealand. The railway companies will give special terms—return tickets will be issued at one and a third single fare, or, for parties of twelve and over, at the price of the usual single fare. Dr. Louise Fraser has organized the medical deputation, and it is asked that applications should be made to the honorary secretaries, Women's War Memorial, Assembly Rooms, York, as early as possible.

THE "BRITISH MEDICAL JOURNAL": NEW ADDRESS.

DURING the Whitsun holidays the Editorial and Printing Departments of the BRITISH MEDICAL JOURNAL will be removed from 429, Strand, to the new headquarters building of the British Medical Association in Bloomsbury. After Thursday, May 28th, the postal address for all communications intended for the Editor will be "BRITISH MEDICAL JOURNAL, British Medical Association House, Tavistock Square, W.C.1," the telephone number of the Editorial Department will be Museum 9864, and the telegraphic address "Aitiology, Westcent, London." Until further notice is given in these columns, all communications with reference to advertisements, as well as orders for copies of the JOURNAL, should continue to be addressed to the Financial Secretary and Business Manager, 429, Strand, W.C.2. It is expected that the Medical Department and the Library of the Association will be removed about June 17th, and the Finance Department about June 19th.