less than £200 a year, and I believe this statement to be true. I read in the *Times* of October 12th the address of the President of the Royal College of Surgeons on a post-graduate course. How is this possible with such an income? In the same paper Professor G. H. Nuttall makes the complaint that the best men have to leave research work to struggle for a living. I say again that no man should be allowed to enter the profession unwarned unless he has a private income to fall back on, and can therefore afford to wait.—I am, etc.,

Caxton, Oct. 23rd. JOHN GILES.

SIR,—I am glad that some correspondence has been evoked by my letter published some weeks ago. The letters which have since appeared show, I think, that the need of further effort is realized, and that there is a willingness to co-operate. I have corresponded with many of my friends on the subject, and have had a ready response, but they have been surprised to find how many plead ignorance of the existence of the fund. This is hardly to be wondered at when one considers that there are but eighty local secretaries throughout the kingdom. Appeals are sent out from time to time, but such have little effect when impersonal. We owe gratitude to the Branch secretaries of the Association, who have done much in the past, and many of whom must have been disheartened with the result of their efforts; but it is impossible for them to come into personal touch with all the members in their area.

I learn that an appeal is now being issued to the Divisional secretaries asking for a representative of the fund in each Division. If this suggestion is carried out there should result a large increase in the subscription list. I trust that the result may be to place the fund on a much more substantial basis.—I am, etc.,

November 1st. J.P.

THE METROPOLITAN ASYLUMS BOARD AND ITS ASSISTANT MEDICAL OFFICERS.

SIR,—The controversy which has been taking place in the BRITISH MEDICAL JOURNAL between the Metropolitan Asylums Board and their former medical officers has been of the greatest interest to me, as it is but a short time since I myself held the post of Assistant Medical Officer at Darenth Asylum, and I would like to be allowed to make a few comments, founded on my own experience, regarding this matter.

Respecting the chief cause of dispute—that is, the fact that the assistant medical officers are subordinate officers, I can most heartily endorse the view that it is difficult to uphold one's authority in the institution, and the whole of my time there I felt keenly that there was always an adverse influence thwarting any efforts towards general improvement and smooth running. On more than one occasion, to my knowledge, the lay officer sending for the assistant medical officer for an emergency case or the examination of a new attendant entering the service has ventured to exercise the right of selection of the medical officer summoned, and totally to disregard the well-known regulations (or customs) respecting the proper person to be called.

Messrs. Barwell, Herklots, and Kennard were wise indeed to give no names in stating their case, as, first, this would simply lead to one or more lay officers being made scapegoats, and thereby enabling the Board to justify itself.

And secondly, this would have left the real source of the trouble untouched, that source being in my opinion the policy of the Board to centralize everything, even to minute details, in its own hands at its offices on the Embankment.

The Board confesses that the assistant medical officers, being subordinate officers, are treated as principal officers in such matters as "dietary, the privilege of receiving and entertaining friends, and in several other ways." This is the whole weakness of their case; if in some ways, why not in all? Even the Metropolitan Asylums Board have to acknowledge that the rules, regulations, and rations apportioned to, say, resident head attendants for instance, and the hours they must keep, not even the most docile of medical men would submit to. Furthermore, were the assistant medical officers made principal officers, there would cease to exist that "Gilbertian" condition which obtains in the absence of the Medical Superintendent (namely, the first assistant medical officer being Acting Superintendent) and puts a subordinate officer in control of the higher rank principal officers.

The committee room is the common room on sufferance only, and in my time we were often threatened with eviction for the most insufficient causes, and many childish restrictions were placed on our use thereof. The room where we messed on committee days was a small back one, which was inexpressibly dirty during the whole seven months of my stay in the institution. To the pavilion quarters, which were my rooms, the same remark applies as regards paper, whitewash, and paint, and within a short time of my arrival at Darenth I headed a written list of repairs, etc., necessary there, with a request that they should be whitewashed and either painted or papered (I cannot remember which of the two last now).

With regard to Section XXII, in which the Asylums Board express such tender solicitude that young medical men should be discouraged from staying in imbecile asylums for long periods, they are to be congratulated on the success with which they have accomplished their kindly purpose, for the number of medical officers and *locum tenentes* who have passed through Darenth in ten years is enormous. I have good reason to believe it is more than fifty—an eloquent testimony to the discomfort of their position.

The report published in the BRITISH MEDICAL JOURNAL of October 28th, I can say from personal experience of the service in question, simply represents an old acquaintance—the wolf in sheep's clothing—once more.—I am, etc.,

Cricklewood, Nov. 1st. SIDNEY J. ORMOND.

THE ANNUAL MEETING OF FELLOWS AND MEMBERS OF THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

SIR,—The annual farce of a so-called meeting of Fellows and Members of the Royal College of Surgeons will again shortly take place. The members are, however, as far as ever from obtaining any voice in the management of their own College.

Last year, out of a body of some 16,000 members, the Council was able to secure the attendance of 34, and from recent unsatisfactory answers of several of the Members, it appears in the highest degree probable that this number will be still further reduced this year. Such figures indicate dissatisfaction and mismanagement combined in the highest degree. For where is the use or object in calling together or attending a meeting where any and every expression of opinion on the part of the Members is not only studiously ignored, but is usually acted upon in a manner diametrically opposed to the unanimous vote of those who are Members of the College, and who have taken the trouble to attend the meeting?

So far as the receipts of the College are concerned, we note that out of a grand total of £18,623 paid by the candidates, £12,611—equal to two-thirds—are absorbed by expenses, of which £6,648—equal to one-half—go into the pockets of examiners.

It is reported that the Council of the College is carefully considering the question of granting a qualification in Tropical Medicine, as a means no doubt of enabling still more cash being taken out of the pockets of the unfortunate candidates, and again splitting up the consolidated triple qualification in Medicine, Surgery, and Midwifery; and in the very near future the doubly qualified man of the past will be told that he is not fit to attend an ordinary case of diarrhoea during an epidemic of cholera, because he does not possess a certificate in Tropical Medicine, or in other words the older man will be qualified to attend one of his own countrymen, but he will not be fit to attend a nigger.

So far as the title of "Doctor" is concerned, it is within the certain knowledge of the writer that the Royal College of Physicians of Edinburgh, in the past, has through its Secretary, addressed its Licentiates as "Dr.," and this notwithstanding the extract from their laws quoted on folio 5 of the report of the Royal College of Surgeons of England.—I am, etc.,

Putney, S.W., Oct. 25th. ALBERT S. MORTON,
A Member of the Royal College of Surgeons of thirty years' standing.

SYNCOPAL BRADYCARDIA.

SIR,—A word more is called for in support of the view that the extra sounds heard in Dr. Maynard's case of syncopal bradycardia[1] were caused by auricular contractions, and not, as Dr. Gossage suggests, by abortive ventricular systoles.

I realize that under the circumstances it is impossible to finally demonstrate my view, but I am confident that there is sufficient evidence to justify its acceptance. Dr. Gossage will agree with me that Dr. Maynard's patient must be classed

[1] BRITISH MEDICAL JOURNAL, October 7th.

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as either a true or a false bradycardia; in other words, that the infrequent pulse noted was due either to infrequent ventricular systoles, or to the presence of abortive ventricular systoles which do not reach the wrist, the radial pulsations being less frequent than the heart beats.

The tracings published by Dr. Maynard give strong evidence that the case must be classed with the true bradycardias. In fact, if I understand Dr. Gossage aright, he is in accord with this view; stating, as he does, that all the cases of syncopal bradycardia so far recorded "tend to show that the infrequency of the heart rhythm is entirely due to the ventricles, while the rhythm of the auricles remains normal."

The presence of the sounds heard between the obvious ventricular contractions is, however, a stumbling block to Dr. Gossage; and it seems to him "that the extra sound requires something special for its production, and that special something can only be an abortive ventricular systole." There is the appearance of a contradiction here, if not more.

Dr. Maynard's case is somewhat similar to the second of my two cases published in the BRITISH MEDICAL JOURNAL of October 21st.

In this patient a subsidiary sound can sometimes be heard. The tracing on page 1035 shows at which period of the ventricular diastole it was heard. This sound can only be due to a systole of the auricle or to an abortive ventricular systole; if to an abortive ventricular systole then it must have invariably occurred at or about the period of auricular systole and have been of such a character as never to have given any other sign of its existence.

Some days ago I had the pleasure of examining with the *x* rays a similar case of true bradycardia. There were forty ventricular systoles per minute and eighty auricular systoles, only every second systole of the auricles exciting a ventricular response.

The ventricle was seen to remain motionless with the exception of the forty contractions per minute. I freely admit that I was unable to see the auricle contracting during the long pause, but there was other evidence of its systole.

The movement of the ventricle during systole is so easily seen on the screen that I cannot believe that the ventricle could beat even abortively and the contraction escape recognition.

In this patient the ventricle occasionally responds to every auricular systole and then beats for three or more consecutive contractions at the rate of eighty per minute, showing that when the ventricle does receive a stimulus it responds with a full, vigorous, and strong contraction. With such a condition of muscle one can hardly assume that there can be abortive ventricular systoles, and yet I have occasionally heard a short faint murmur in the long pause of the heart.

The points I would advance in favour of the assumption that in Dr. Maynard's case the auricles were responsible for the subsidiary sounds are:

1. There is undoubted evidence in the sphygmograph that there were several auricular systoles to every recognizable ventricular systole.

2. That the clinical history of the patient and the character of the sphygmograph point to the case being one of heart block, or at any rate of depression of conductivity.

3. That in other such cases sounds have been heard synchronous with waves in the jugular vein, which waves have been demonstrated to be due to isolated auricular systoles.

4. There is no evidence in the tracings of any extra systoles, and our knowledge of their characteristics and also of heart block is opposed to the assumption, that any such extra systoles occurred.

Dr. Gossage is not satisfied with the assumption that the sounds were produced by the auricles, although auricles have been proved capable of producing sounds, and have, in the case under discussion, been demonstrated to be contracting more frequently than the ventricles just at or about the time the sounds were heard.

He assumes something still more difficult of acceptance—namely, that a ventricle which responds in a strong and vigorous manner to a stimulus should frequently give small abortive contractions, of which there is not at any time the faintest trace.

He believes that this "extra sound requires something special for its production," and states that "that special something can only be an abortive ventricular systole." The reason he advances for this assertion is that "there are such things as extra-ventricular systoles," that these extra-ventricular systoles "are often very feeble, and that they produce sounds"—all of which is very true, but which appears to me to be no reason for believing that in this particular case extra-ventricular systoles were in any way responsible for the subsidiary sounds.—I am, etc.,

Liverpool, Oct. 30th. JOHN HAY.

SIR,—I am gratified that the case of syncopal bradycardia which I reported in your issue of October 7th, has provoked such an interesting correspondence as has appeared in the BRITISH MEDICAL JOURNAL. A perusal of the correspondence emphasizes the fact that the determination of the actual cause of the subsidiary sounds and impulses is by no means easy, and I have some diffidence in entering further into a discussion of this obscure point; but my personal contact with this particular case may, however, give my impressions a certain value.

I agree with Dr. Herringham that we should not be too positive in our interpretation of sphygmographic and cardiographic tracings, and I feel that great care must be necessary to correlate inequalities in the descending limb of the sphygmograph with recorded venous movements.

The force of the secondary impulses and the distinctness of the sounds produced, had they originated in the left ventricle, would to my mind have made a more definite impression on the descending limb of the sphygmograph than the slight sinuosities observed in those I published in the JOURNAL of October 7th; looking through other of the sphygmographs I took I find no trace of even these slight sinuosities.

The difficulty, to my mind, lies between the ascription of these sounds and movements in the heart to the right ventricle and to one or both of the auricles.

As regards their possible auricular origin the situation in which these secondary impulses were felt might certainly suggest their being due to contraction of the right auricle and I do not feel that I can disprove such a possible causation of the phenomena in question, but I confess that if such were the case I must revise altogether my preconceived notions of the power of auricular systole.

I do not think that the argument from the physical signs of mitral constriction as an index of the power of auricular systole can be accepted without reservation because the mechanism of the production of the signs of that lesion are still in dispute.

The force of the secondary impulses was out of proportion to the distinctness of the sounds (with the straight stethoscope one could feel them in such a distinct manner) and was to my mind much more suggestive of the more powerful action of a ventricle. I have already argued that such power could not have been exerted without leaving a definite mark on the descending limb of the sphygmograph had it been due to the action of the left ventricle. I am, therefore, of the opinion that the subsidiary cardiac movements were originated in the right ventricle, and that the case was one of hemisystole.—I am, etc.,

London, Oct. 31st. J. SEYMOUR MAYNARD.

THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS BY THE ROENTGEN RAYS.

SIR,—I was very pleased to read Dr. Theodore Williams's remarks in his communication to the Tuberculosis Congress about the value of the Roentgen rays in the early diagnosis of pulmonary tuberculosis, but I do not think that he laid sufficient stress upon the great importance of calling in their aid to every case of suspected phthisis, still I am very glad to see that he is convinced of their value, inasmuch as he seemed very sceptical when I read my paper before the Clinical Society in May, 1904. He divides the cases into three classes

1. Where early tuberculosis is indicated by the rays before its detection by auscultation and percussion.

2. Where the presence of tubercle is localized simultaneously by Roentgen rays and physical signs, and this is by far the most numerous class.

3. Where the physical signs detect lesions which are undetected by the Roentgen rays. "This class is quite as numerous as No. 1."

With this last statement I cannot agree, for I have been making a study of these early cases for the past five years and I can honestly state that I have never missed detecting the presence of lesions that were localized by auscultation and percussion, but on the contrary I have in many cases proved the presence of disease in one or both lungs when it was not detected by the ordinary methods of examination; it is quite clear that the number of cases in Class 1 will depend entirely

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