scene. A pioneer paper on this subject appeared in the *British Journal of Dermatology* by Louis Wickham of Paris in 1906. A little later the chemists began to contribute a series of powerful therapeutic compounds, the first of which was salvarsan—the famous 606—the dramatic effects of which will never be forgotten by those who were witnesses of its introduction into medicine. Later they demonstrated the therapeutic qualities of gold, and still more recently they have given us sulphonamide and its modifications. Perhaps the most important contribution to dermatological therapeutics emanating entirely within the medical profession has been the treatment of varicose and traumatic ulcers of the legs by means of adherent elastic bandages, which we owe to Dickson Wright. This method has relieved, and indeed cured, many thousands of sufferers from one of the most distressing and disabling of all non-fatal complaints. All these advances may be traced within the columns of the journal whose jubilee we are now celebrating.

One of the landmarks of the progress of dermatology in this country was the formation of the London School of Dermatology at St. John's Hospital in 1923. It is a remarkable fact that Stowers, who in 1882 had been successful in forming the Dermatological Society of London, and in 1894 the Dermatological Society of Great Britain and Ireland, which did not confine its membership to specialists but admitted all interested in skin diseases, was again the prime mover in the formation of the London School of Dermatology. In accomplishing this task he had great difficulties to overcome, and only great tact and perseverance brought success to his efforts. The formation of the school was celebrated by a dinner given to Stowers on October 10, 1923. The Jubilee Number before us will be found extremely interesting by all those who are connected with the study of the progress of dermatology, and we venture to think it also appeals to the wider medical public. It is embellished by portraits of the dermatological heroes of the epoch.

Reports of Societies

PSYCHOLOGICAL FACTORS IN PHYSIOTHERAPY

In the Section of Physical Medicine of the Royal Society of Medicine on November 18, Dr. COLLIS HALLOWES presiding, a discussion was held on psychological factors in physiotherapy.

Dr. H. CRICHTON-MILLER said that a compromise attitude towards disability—the conscious wish to be well associated with the unconscious wish to be ill—was commoner among patients than was usually supposed. There were two fallacies to be avoided: one that the will to be ill was equated with malingering; the other that the will to be ill was based on rational considerations. Physiotherapists were specially interested in this subject because physical treatments tended to be long and expensive, and therefore the more to be desired by patients of a certain psychological make-up. There were patients who pursued an interminable course of physical treatments from motives other than a desire for cure. It might not have occurred to the physiotherapist that the patient whose fibrositis was so resistant to treatment was for some obscure reason anxious to continue his or her visits. The unconscious gratification derived from the treatment might be stronger than the desire to be well. The cost of treatment was not necessarily a deterrent. The discontented menopausal wife of the affluent man found a satisfaction in exacting from her spouse the doctor's fees. Even when the treatment, such as electrical treatment, induced pain, it was possible that to the patient a form of torture had a hidden and morbid fascination. There were patients, especially females, who "enjoyed" painful symptoms, and to whom cure was an unwelcome discontinuance of pain. Chief among these were the hypochondriacs. The essence of hypochondria was a compulsive expiation. The original factor was repressed guilt which called for absolution or expiation, and made any form of suffering, such as insomnia or pruritus, to be desired.

A familiar patient was the one who had had to endure scepticism on the part of his family or his doctor. Such a patient sought vindication, and exulted when a specialist gave the opinion that an operation was necessary. The inevitable spectacular character of some forms of physiotherapy gave patients a comfortable feeling that their complaints were shown to be valid and their family's scepticism was rebuked. Thus the popularity of physiotherapy might sometimes be based on considerations of this kind, and depend more on personal prestige than on therapeutic value. The seekers after Christian Science and spiritual healing were often really in search of cure by magic. Not that these cults, whether orthodox or heterodox, all partook of magic; many of them were analogous to good psychotherapy, but the patient attracted to such forms of cure craved for that superiority which was associated with initiation into any obscurantist cult. Dr. Crichton-Miller also reminded the physiotherapists of a psychological difficulty among themselves. Every specialist in a sense had an unconscious bias towards his own department, and in the case of physiotherapy there might be an equally unconscious bias owing to vested interest in equipment, though it was far from his mind to suggest that the physiotherapist tended to become a panaceamonger, only that the specialism was rather more liable than others to that unconscious bias which tended to warp diagnostic discrimination.

Psychology of the Cripple

Dr. R. G. GORDON described possible reactions of the cripple to his condition. A very common reaction, though perhaps not so common as it used to be, was resentment against society and a development, as a compensation to the disability, of a spirit of aggressiveness. It was to be found in Shakespeare's conception of the hunchback Richard III:

> "Deform'd, unfinished, sent before my time
> Into this breathing world, scarce half made up,
> And that so lamely and unfashionable
> That dogs bark at me as I halt by them.
> . . . since I cannot prove a lover, . . .
> I am determined to prove a villain."

It was probable that something of the psychology of Kaiser Wilhelm II depended on his crippledom from birth paralysis. The physiotherapist if confronted with this aggressive attitude must try to make his patient see that he had to adjust himself to his crippledom, and that it was to his advantage to modify his resentment. Then there was the cripple who was in a chronic state of irritability because of pain; the more irritability he exhibited the more sensitive his nervous system became, and thus a vicious circle was established. Other patients accepted their disability in a state of apathy, and again a psychological approach was necessary, with re-education for social life; some sank into extreme despair, and suicide became a possibility. Dr. Gordon believed that the normally constituted person did not commit suicide; suicide was proof of a psychopathic mentality. Finally, there was the desirable attitude towards the crippled state, such as was exemplified by President Franklin Roosevelt, who not only exhibited determination to overcome the disability, but had shown, especially in recent events, his sympathy for and desire to help the unfortunate. Each patient must be taken as a separate problem. Some sort of occupation in which a use could be found for the disabled limbs was desired. The physiotherapist also should

learn with which patients, and at what stage of their treatment, he himself could in a measure fade out of the picture. Sometimes the change over to a less impressive person than oneself, provided one kept the psychological elements of the case in mind, was desirable.

General Discussion

Dr. J. B. MENNELL took up a reference by Dr. Crichton-Miller to "railway spine." He had been taught to believe that this was a psychological entity, but since he came to know something about differential diagnosis he had changed his opinion and was now convinced that there was often a definite physical lesion, and that so long as this was untreated the psychological lesion would persist. Dr. C. B. HEALD remarked that he had been puzzled occasionally by finding that a treatment which he had adopted more or less in despair did good when it had no business to do good. What was the explanation? Dr. WILFRID EDGECOMBE referred to a certain class of patients at spas, not hypochondriacs but commonly called neurasthenics, whose sole occupation was their health. Was it well to rob these people of their one interest in life? Dr. DRURY PENNINGTON asked how the "obsession" of the specialist for his specialism was to be overcome. Dr. P. P. DALTON mentioned the profound effect of the mind on rheumatic disease. He had recently seen a patient in whom some readjustment of her family life had led to immediate clearing up of deformed finger-joints. Dr. G. D. KERSLEY spoke of the association of gout with worry. Dr. DAWSON, taking up the question of self-murder, said that he had seen at a seamen's hospital Chinese patients in whom clinically no disease at all could be discovered, yet within three days they were dead. Was it an example of the will to die? Dr. KERR RUSSELL spoke of the reactions of the physiotherapist to the fact that in his specialty, unlike most others, there were large numbers of unqualified people doing practically the same work. Dr. C. W. BUCKLEY said that no single cause accounted for rheumatoid arthritis. Here was an agent of low virulence which in the ordinary individual produced no ill effects, but constitutional factors, type of musculature, the stance, and various matters of that kind came in. Dr. W. YEOMAN mentioned patients in whom acute gout was apparently induced by worry, also a patient who had had two attacks of generalized psoriasis, the first during the war, when he was extremely worried, and the other during the recent crisis. The PRESIDENT said that many people who undertook physical treatment only did so in the last resort when they were already in a state of chronic invalidism. Had they come earlier physical treatment might have done them good much more rapidly.

Dr. CRICHTON-MILLER, in replying, said that he was not prepared to admit with Dr. Gordon that all suicides were of unsound mind. There were people who took their own lives who could not be considered unsound. A great deal could be said about spontaneous death amongst Orientals, but there was no doubt that the will to be ill, the will to recover, and the will to die were factors to be taken into consideration. As for "railway spine," he agreed that there were some cases which no amount of compensation would clear up until the physiotherapist had treated them, but there were others which no amount of treatment would improve until the compensation question had been adjusted.

THE PSYCHIATRIST AND THE CRIMINAL LAW

A joint meeting of the Medico-Legal Society and the Section of Psychiatry of the Royal Society of Medicine was held on November 24, His Honour Judge Earengey presiding. The subject of discussion was "The Place of the Psychiatrist in Relation to the Administration of the Criminal Law."

Dr. R. D. GILLESPIE, in opening, discussed the place of the psychiatrist in magistrates' courts. The magistrate apparently, in dealing with a number of charged persons—most of them probably first offenders—had no means of knowing about their state of mind unless the offender appeared obviously ill or had been reported by a police official as suspected of mental disease. There were precedents for a better system in some courts of the United States, to which a psychiatrist was permanently attached with the duty of examining the offenders psychiatrically, especially after conviction and before sentence. The mere appearance of a prisoner for a few minutes in the dock was an impossible situation from which to single out the individual who was a psychiatric problem, and a night or two in the cells afforded only a slightly better basis for observation. A psychiatric report could be both brief and simple and a useful guide to a magistrate wishing to impose as appropriate a form of sentence as it might be in his power to give. It had been suggested that there should be legislation to obtain a routine psychiatric examination of certain classes of offenders—for example, sex offenders. Except in so far as it might be useful to have legislation of this kind introduced in the hope of obtaining wider facilities later, Dr. Gillespie said that he would prefer to see wider powers given so that convicted persons might receive sentences founded on a survey which at least included the psychiatric aspect.

The M'Naghten Rules

Later in his remarks Dr. Gillespie addressed himself to the M'Naghten rules. That judges themselves found the rules unwieldy and unreal was, he said, shown by the way in which they appeared to refrain from applying them. But so long as the rules remained in force it seemed to be the duty of psychiatrists to interpret them literally, and not to strain their conscience and distort their use of language in order to try to achieve an impossible task—that of moulding this abstract and unreal formula to actual knowledge. Otherwise they would bring psychiatry into disrepute and would not, in the long run, help the mentally ill. It must remain for the legal machinery to see that no ultimate injustice was done. As a matter of fact, it must only rarely happen that there was any fundamental difference of opinion between the psychiatrists who appeared for the prisoner and the prison medical officer who appeared for the Crown. A joint report would often be possible, or, if that was not legally desirable, separate reports could be submitted beforehand, and the psychiatric witnesses examined and cross-examined on them. If this were coupled with judicial recognition of the fact that the dividing line between sanity and insanity was not sharp, and that there were in consequence degrees and indeed kinds of responsibility, the position would rest more certainly upon the facts, including the psychiatric facts, rather than upon a formula.

Mr. ROLAND BURROWS, K.C., Recorder of Cambridge, said that in his view the answer to the problem set for discussion was implicit in the very form of words setting out the subject-matter. The place of the psychiatrist must be assistant and not dominant. By a psychiatrist he meant a person trained in medical knowledge who was specially interested in the abnormal working of the mind—mainly, if not entirely, in such abnormalities as were the result of mental disease. By the criminal law he understood the body of rules of conduct compliance with which was insisted upon by the State on pain of punishment. The content of that body of rules was a matter for the State to determine. The object of criminal proceedings was primarily to ascertain whether the accused was proved to be guilty or not. Underlying this was the principle that organized society must insist upon a standard of conduct to which members had to be made to conform. The object of medical treatment, on the other hand, was the prevention, cure, or alleviation of some bodily ailment.

In Mr. Burrows's view the M'Naghten rules had stood criticism and would continue to stand it for many years to come. They could be readily understood and applied by persons who gave their minds to the subject. Some members of the medical profession, faced with people suffering from mental trouble, committed themselves to a definition of insanity which would prevent anyone from

being classed as sane. They suggested that they were prepared to let anybody off the consequences of crime. By the very nature of their profession medical men when on the bench made very bad justices. His experience of medical men, with one conspicuous exception, was that they were quite incapable of weighing evidence. Their practice disabled them from taking a dispassionate view. The rules of evidence which lawyers followed were totally disregarded by doctors. Medical men suffered from a not wholly unfounded fear that they might find themselves defendants in proceedings. In his own jurisdiction he had found gross cases where persons had been before him for criminal offences, and on listening to their history he had gathered that they had been released from an institution in circumstances "in which I, an untrained layman in medical matters, would have bet any sum of money that they would commit a criminal offence after their release."

Mr. Burrows added that in the case of some unfortunate individuals he had been forced to impose sentences of imprisonment when in his opinion they ought to have been remanded to some place where they could receive mental treatment. But he had reflected that in prison they would at least have a roof over their heads, food and occupation, and medical men to supervise them. That was better than sending them out into the street.

Dr. DENIS CARROLL said that it would be of great value to administrators of the law if psychiatrists would undertake a research into groups of delinquents and the appropriate methods for dealing with them. Until comparatively recently the role of the psychiatrist was almost entirely restricted to the question of insanity and criminal responsibility, but in view of recent advances in psychiatry a court would be grossly neglecting valuable assistance if it refused to regard the psychiatrist in any role save that of an alienist. The psychiatrist might afford information which would materially affect the magistrate's view as to the usefulness or otherwise of punishment for a particular offender. That the final decision lay with the court and not with the expert on behaviour was an advantage, because it meant that the protection of the public would not be lost sight of in considering the interests of the misdoer.

Mentally Abnormal Cases in the Courts

Dr. LETITIA FAIRFIELD said that the function of the psychiatrist was to assist the court in its duty of fixing responsibility and also to advise on the disposal of the person charged. It was not the duty of the court *prima facie* to inquire into the mental state of anyone who came before it, but only to find out if a crime had been committed and the responsibility of the person charged. To attack the M'Naghten rules was like hitting a child! The only reason why they were continued in existence was that no one in the courts paid any attention to them. It was an amusing study in the art of compromise to go through the judgments of the courts during the last fifty years with regard to mental disease and capital punishment. As regards mental disease the courts were deplorable in theory, but in practice there was little ground for criticism except in dealing with some of the minor offences. In the case of certain offences such a large proportion of the offenders turned out to be mentally abnormal that on the ground of common sense and economy the courts would be justified in employing a psychiatrist before verdict and sentence. The chief of these offences were the sex category, but they included also arson, and what were known as "poison pen" cases.

She had great sympathy with the desire of the lawyer to be master in his own house, but she reminded him that his original function was to protect the prisoner from injured parties or relatives, whose vengeance was likely to be more severe than that of the law, also from the priest, and nowadays from the schoolmaster, and in certain cases and countries from the politician. The psychiatrist had been badly handicapped because by force of circumstances he was so often employed by the prisoner and was not an official appointed to advise the court. She would welcome the official psychiatrist, not because she favoured the bureaucratic practice of medicine, but because the psychiatrist who was acting as the servant of the court had a very considerable advantage.

Dr. H. CRICHTON-MILLER, in summing up the discussion, said that apparently the two professions were going to quarrel over the M'Naghten rules for ever. The rules were only a narrow gate through which the legal profession might pass, in the eyes of their medical colleagues, into light and salvation. None of the medical speakers had claimed that the psychiatrist should have a dominant position in the courts; he would be there in the position of assistant to the magistrate or of assessor, and he hoped that the new legislation would make it possible for him oftener to fill that role. Mr. Burrows had been very emphatic that the services of medical men should be restricted to suffering humanity. "Some of us think that humanity is apt to suffer by the slight myopia of some magistrates on certain occasions, and therefore with clear conscience we do what we can to correct these errors of refraction."

IMMUNITY IN INFLUENZA

At a meeting of the Section of Epidemiology and State Medicine of the Royal Society of Medicine on November 25, Dr. J. A. H. BRINCKER presiding, a paper on "Immunity in Influenza: the Bearing of Recent Research Work" was read by Dr. C. H. ANDREWES.

Dr. Andrewes began with the assumption, which he believed to be true, that epidemic influenza was caused by a filterable virus. The term "influenza" was used to cover a variety of conditions, and it was difficult to find any precise clinical criterion as to what epidemic influenza was and was not. Experimental animals which were susceptible to infection had been found and the formidable task attempted of trying to find out whether there was any correlation between the presence or absence of a virus pathogenic for ferrets and mice and any particular clinical diagnostic feature of the infection in human beings. On the whole a virus which would infect ferrets had not been obtained from minor outbreaks occurring in years when there was no general prevalence of influenza. On the other hand, in the widespread epidemics of 1933 and 1937 it had been possible to obtain such a virus from a large proportion of the outbreaks. The cases had been divided into those of epidemic influenza and those of other febrile catarrhs; in other words, the "scrap-heap" of influenza had been taken and an attempt made to differentiate one single item as "epidemic influenza." It had not been possible as yet to say by examination of patients that one had epidemic influenza and another had not, but it had been discovered that there were certain features which distinguished one group from another. For example, the cases from which virus had been recovered had mostly an abrupt onset; it was exceptional in such cases to find a history of several days' catarrh. In true epidemic influenza constitutional symptoms had prevailed over catarrhal symptoms, there was much more malaise and aching in the limbs, and comparatively little coryza. But in the last outbreak, 1936–7, two of the features generally regarded as characteristic of influenza were not present: there was no particular tendency to protracted convalescence and the so-called post-influenzal depression, and no particular tendency to leucopenia, most of the white cell counts being within normal limits.

This point needed emphasis. It was very important in trying to appreciate how long was the immunity of man to influenza to realize that one could not rely on statements from a clinical point of view that this or that patient suffered from two attacks of influenza within, say, three months unless there was evidence that both attacks were certainly due to the virus. This could not even be said about successive outbreaks in an institution. A very

widespread outbreak which seemed to be influenza might not be influenza. It seemed reasonable to suppose that certain epidemics were caused by something, perhaps a virus, other than the virus of epidemic influenza which affected ferrets and mice. There seemed to be different serological races of the virus. Had the ferret been the only animal susceptible to infection the suspicion that there was more than one race of virus might never have arisen. It was only after it became possible to produce the disease in mice that a neutralization test in mice on a quantitative basis could be used and different serological races determined.

Relation of 1918 Pandemic to Later Outbreaks

After a brief discussion of the characteristics of the different influenza strains and the complication produced by cross-tests amongst different strains, Dr. Andrewes went on to consider the relationship of the pandemic of 1918–19 to the less serious outbreaks which had occurred in recent years. It was not certain that the 1918 pandemic was due to the influenza virus which had been recovered more recently. A suggestion made in several quarters was that the 1918 brand of influenza might have been preserved for posterity in pigs. In August, 1918, swine influenza broke out in the Middle West of the United States, where apparently it had never been recognized before, and it had occurred annually ever since. It had been suggested that here might be the virus concerned in the 1918–19 pandemic. It was related to the human influenza strain, but much more remotely than the human strains were related to one another. The theory had been advanced that pigs fed on garbage from certain institutions developed in their serum antibodies active against human influenza, but not against swine influenza. One of the strong arguments in favour of the suggestion that swine influenza might in the past have infected man was the finding that in adults and in children over 10 antibodies to swine influenza were commonly present in the serum, opening up the possibility that the virus had been prevalent in the past, causing the presence of antibodies, but had disappeared in comparatively recent years, so that it did not affect the younger children. But it was known that repeated inoculation of an animal with any strain of influenza would broaden the zone of reactivity of its serum so that it would react with strains other than the one with which it was infected, and evidence that this might happen with human serum had been provided by certain studies.

It had been found that, so far as could be made out, the island of St. Helena was the only place in the world which certainly escaped the 1918 pandemic. Serum from a number of the inhabitants who had been in the island since before 1918 was obtained, and it was found that although there were some antibodies against swine influenza, these were very few as compared with the findings with adult serum in England, America, and elsewhere. Fortunately—from the research point of view—influenza was brought to St. Helena from the Cape of Good Hope in 1936, and afterwards an examination of the serum of certain of the inhabitants showed that they had developed very good antibodies against the human virus as well as against the swine virus. Thus it appeared that antibodies to swine influenza could appear in human serum as a result of infection with human strains. Altogether it seemed probable, from what was known about the biological instability of viruses in general and the influenza virus in particular, that the pandemic of 1918–19 might have been due to some mutation occurring in the influenza virus. Such a mutation might have taken place in one of two ways or in both. It might have concerned an antigenic change in the virus, which would explain why the immunity of the population was so low, and it might also have concerned the increased tendency of the 1918 virus to attack the lungs. In the ferret two strains of influenza virus had been evolved from one original virus, one of them hardly attacking the lung at all, and the other attacking the lung and causing a fatal pneumonia with very considerable regularity. Thus it was reasonable to suppose that a change might have taken place in the influenza virus to explain such events as happened in 1918, and such a virus might have associated itself much more readily with ordinary pathogenic bacteria than did the usual strains.

Vaccination of Human Beings

Dr. Andrewes went on to discuss certain difficulties or points of doubt in planning the vaccination of human beings. First of all, the workers were still open to conviction as to whether they were trying to do the right thing in vaccinating and producing an active immunity. Might there not be mutations of virus which were more important in bringing about an epidemic than had been realized as yet? No enormous amounts of vaccine could be made; the vaccine was made from filtrates of mouse lung, and was difficult to produce on a large scale. It was necessary to select a likely section of population, carry out vaccination, and await an epidemic to prove the value or otherwise of the procedure. It was not known whether the production of a rise in antibodies in man was a good guide to the immunity induced by a vaccine. It had been found in ferrets that there was a very good correlation between active immunity and the amount of antibodies in the serum so long as the work continued with a single strain of the virus, but if cross-tests were carried out between strains or between human influenza and swine influenza the results were discordant.

Another problem was whether living virus or killed virus ought to be used. Stokes and his colleagues in America had used living virus with impunity, and had obtained apparently a threefold reduction in the incidence of febrile infections in the vaccinated people as opposed to the controls. But he felt on this subject that as the killed virus would experimentally immunize animals it ought to be given every chance before the more hazardous procedure of using live virus was attempted. At the same time, the possibilities of using an attenuated virus must be explored, because in a severe epidemic such a virus might be more economical and also more rapid in its results. As to the source of virus in making a vaccination, tissue culture virus was more satisfactory in theory than virus made from mouse lung, but, unfortunately, none of the tissue culture virus seemed to reach such a high titre. In theory, again, one would use a mixed strain containing the different antigenic components in fairly equal proportions, but in practice the mixed strains employed had been of very low titre. The only strain which was really potent and virulent was a highly specific one. What was being done in experiments taking place at the moment was to combine a highly specific and virulent W.S. strain with another which was not so virulent but a good deal more polyvalent.

As to when to vaccinate, since 1929 epidemics had come along very regularly every four years, but the same periodicity had not been shown on the Continent as in England. On the question of frequency, it was not hoped to get a very durable immunity from vaccination, and therefore, to be certain of producing an effect, it would be wise to vaccinate every year.

SIGNIFICANCE OF DREAMS

At a meeting of the Medical Society of Individual Psychology on November 10, with Dr. H. C. SQUIRES in the chair, Dr. EDWARD A. BENNET read a paper on the significance of dreams.

Dr. Bennet said that the dream as a mode of mental activity within the experience of all had an immediate significance for psychologists. But this significance was enhanced when it was found that the dream contained information which could be incorporated into conscious

life and could assist the psychoneurotic patient to understand his illness. The limitations upon observation and recording excluded the use of the scientific method in the study of dreams. Their significance could only be seen when the concept of the unconscious was introduced. Emphasis was laid upon the view advocated by Jung—that the unconscious was the natural background of the mind. The dream was not the road to the unconscious, it was the unconscious. The aim of dream analysis and of psychotherapy was to remove the restrictions imposed by unnaturalness and artificiality. The dream, as the natural mind, could provide exactly the material required for adjustment and hence for optimum efficiency.

Many made the mistake of studying the dream as though it were an extension of conscious thinking. But the dream was rather a picturesque paraphrase of something new. Each incident in it could be thought of as causally connected with what went before. A series of dreams might be coherent and could provide not a commentary upon, but an important addition to, conscious life. When this information was assimilated the patient could take over responsibility for his life with understanding. Patients could be trained to work at their dreams in their own time and not only during the analytical session. Thus the duration of treatment could be shortened. The conflict in psychoneurotic illness was between two "goods" (using the word "good" in its philosophical sense). Hence the difficulty many had in reconciling their nature and its possibilities with that which training had commended. Dreams would show clearly how such a situation could be met.

General Discussion

Dr. CRICHTON-MILLER emphasized the point made by Dr. Bennet that analysis of his own dreams was the only means by which the analyst could keep himself sensitive to the significance of his patients' dreams. Referring to persons said to be dreamless, he described the case of a young soldier who claimed never to have dreamed and also never to have wakened with a dry bed in his life. This patient was a hypopituitary type, and after the administration of thyroid his enuresis was almost completely cured and he experienced dreams for the first time. Dr. Crichton-Miller ventured to amplify Dr. Bennet's emphatic assertion of the basic truth that we are primarily creatures. He said that the real trouble began for us when we realized that we were both creatures and creators, and that it was the incompatibility of these two aspects of life that rendered the art of living so difficult.

He went on to review the position of dream interpretation in all mental analysis. He pointed out that while dream interpretation had been described as the royal road to the unconscious, it was not the first road that had been tried, nor could it be described as the only road. Before dream interpretation was attempted, Freud had laid bare the unconscious motive through hypnotism, and to-day the Freudians regarded analysis of the transference as the most important aspect of analysis. Dr. Crichton-Miller went on to say that chemically induced narcosis in some cases served a most useful purpose, and that probably evipan or similar drugs would have a considerable vogue in mental analysis in the future.

Dr. JOHN MACKWOOD said that it was difficult to separate the dream from the sleep of the dreamer. Just as the waking life had need of sleep to restore its physical energy, so had the psychical life the need of dreams to amplify its significance. The individual owed his existence to the species, but the species owed its persistence to the individual; the two were, in fact, inseparable. Various levels of sleep were necessary to restore and maintain the balance of the physical and psychical life. The deepest levels made contact with the phylogenetic origins of the species, before the dawn of consciousness; dreams from this level were mere organic gestures.

The higher levels were those of the ontogenetic unconscious of the individual. Dreams at this level were comparable to analogies which had significance for all the levels of the individual psyche, if we could interpret them. Out of the dreams came synthesis. Inasmuch as any symbolization could only be interpreted for a few of the levels, he doubted if one did much more than scratch the surface by any analysis. The experience of the dream was, in itself, a synthesis. Kent defined experience as a "synthesis of the perceptions—a synthesis which is not itself contained in perception . . . in experience our perceptions come together contingently." In the dream with affect, the affective part of perception came together contingently with that part of perception which marked an object for future action. The synthesis which took place inaugurated new forms of movement in behaviour.

Local News

ENGLAND AND WALES

Hospital Contributory Schemes

The annual conference of the British Hospitals Contributory Schemes Association was held at Liverpool on November 24, 25, and 26. The principal speaker on the first day was Lord Horder, who said that contributory schemes gave hope of new life and activity to voluntary hospitals. Payment of the full cost of maintenance of the patient should be the aim of such schemes, but whether any payment should be made to the doctor out of the funds before that aim was reached was a moot point. At present the doctor's claim was being waived, but the generosity of the profession should not be too long abused. The speakers on the second day included Professor Henry Cohen of Liverpool University, who said that the position of the young consultant was much affected by contributory schemes. If he was denied opportunities because people beyond a certain income limit were admitted to these schemes, his earlier years might be a bitter struggle. Mr. S. Clayton Fryers, house-governor of Leeds General Infirmary, speaking of contributory schemes from the hospitals' point of view, considered that payment to medical staffs should be a matter for agreement between the hospital and its staff and should not be the concern of contributory schemes. It should be a direct lump-sum payment and not a percentage of moneys received from any class of contributors. Dr. J. M. Mackintosh said that in hospital development space must be found for the promotion of convalescent treatment. There must be increased provision for research and for greater elaboration of treatment. He urged the need for co-operative arrangement with local authorities in respect of patients who made no contribution. So long as treatment was not free and universal there must, he said, be some system of charge.

Royal Dental Hospital of London

The annual dinner of the staff and past and present students of the Royal Dental Hospital of London was held on November 26 under the chairmanship of Dr. F. C. Porter. In proposing the health of the hospital and the dental school, Dr. Porter spoke of his pleasure at revisiting his old school at the annual clinical "at home" which had been held earlier in the day, and he contrasted with some envy the space and equipment available to staff and students to-day with the limitations within which an earlier generation had to be accommodated. There were two things, he said, which they all desired for the dental profession—that it should receive due appreciation from the community, and that it should be worthy of such appreciation. In his response the Dean (Mr. H. Stobie) referred to the loss which the institution had suffered