do what is necessary, without clean linen, warm clothes, woollen jackets, stockings, drawers, etc., which are not to be had. The Basle charitable agency has received similar distressing reports from Marienberg, Coblenz, and other places, on the truly terrible destitution which prevails among the prisoners.

REPORTS OF SOCIETIES.

POOR-LAW MEDICAL OFFICERS' ASSOCIATION.

TUESDAY, NOVEMBER 29TH, 1870.

JOSEPH ROGERS, M.D., President, in the Chair.

THE PRESIDENT delivered an address, of which the following is an abstract. After some introductory remarks, he said: Shortly after our last meeting, in July, Dr. Rumsey, the President-elect of the Public Medicine Section of the British Medical Association, wished me to read a paper on Poor-law Medical Relief, at the then forthcoming annual meeting at Newcastle-on-Tyne. Though fatigued with the labours devolving on me in my official capacity during our association year, I felt it would be politic to comply with his request, and for this reason. Hitherto, as you know, Poor-law medical reform has been mainly advocated by gentlemen who are, or have been, connected with the Society, and who are therefore open to the suspicion that, in seeking reform, they are influenced by selfish feelings. But I thought that, could I succeed in enlisting the sympathies and securing the active co-operation of the British Medical Association, with its 4000 members, the large majority of whom are in no way connected with the administration of the Poor-laws, but possess large powers for aiding us by their constant, I may say daily, intercourse with our law-makers, a great point would be secured. Actuated by this feeling, I went to Newcastle, and before the Section in the Town Hall gave a *resumé* of those statistics and the deductions which have been drawn from them, which at our successive quarterly meetings durings the last two years I have brought before you. At the conclusion of my address, Dr. Burke, who occupies a position in the Irish registrar's office similar to that which Dr. W. Farr holds at Somerset House, rose and in an able speech fully endorsed all that I had stated as to the benefit his country had derived from the operation of the dispensary system. The Section was much struck with the comparisons I instituted between the medical relief arrangements that prevailed in the two towns of Newcastle and Belfast; they are as follows:—

	Medical Officers.	Cost of Medical Relief.	Population.	Total Poor-law Expenditure.
Newcastle:	8 ...	£853 ...	110,968 ...	£43,093 0 0
Belfast:	18 ...	£3,700 ...	146,529 ...	£22,114 12 5

Ultimately it was resolved that the Committee which had been appointed at Oxford, in 1868, to confer with the Council of our Association, should be reappointed. This, on being submitted to the general meeting, was carried by acclamation.

The resolution, which was adopted, gave power to the Committee to add to their number. Now, as the Association Committee of two years ago had never been called together, it was not improbable, unless some gentleman undertook the initiative, that a similar occurrence might happen again. But I had not travelled specially to Newcastle to point out the evils of the present system and seek the aid of the Association, with any intention of allowing such an abeyance. On my return to town, I set to work to beat up recruits for the Committee, and in this I have been much assisted by our excellent friend Dr. Rumsey; indeed, without his aid, and the use I was permitted to make of his name, I probably should not have succeeded in enlisting the support of so large a number of representative, medical, and other gentlemen. Among those who readily agreed to join the Committee, were several gentlemen (members of the British Medical Association) who had directed their attention specially to the important question of registration of disease; and as they had applied for an interview with Mr. Göschen, it was suggested that we should combine our efforts, and go to the President as a united deputation; and, as the request for the registration of disease was based upon the proposal that the Poor-law medical officers should make a weekly return of all new cases of disease which came officially under their observation, it was considered desirable to formulate certain propositions, which would cover the whole ground of Poor-law medical reform. Our main reason for arriving at this conclusion was, that to go to the President of the Poor-law Board simply for registration of disease, would be to admit that the service was in so perfect a state of organisation as to permit registration to be immediately and efficiently carried out; but those members of the deputation who had studied the question of English medical relief, and were acquainted with its imperfections, knew that such registration, under existing circumstances, would be almost worthless.

[The propositions handed in to Mr. Göschen, and subsequently forwarded to the Royal Sanitary Commission, with the request that they should be printed as an appendix to their report, have already been printed in the BRITISH MEDICAL JOURNAL for October 22nd.]

After commenting favourably on some of the propositions, Dr. ROGERS continued. As regards the fifth proposition (relating to the Registration of Disease), I urge the Association to support it, not only because it would render a signal service to the community, by giving early warning of the outbreaks of epidemics, and to science, by affording a clue to the causation and topography of certain obscure forms, and notably of hereditary disease; but also because, if adopted, it would be the first step to official recognition of the position which Poor-law medical officers ought to hold, viz., that of health-officers, in connection with, and under the direct control of, the State.

The seventh proposition distinctly formulates that which I have just referred to, by suggesting that certain additional duties should be performed by the Poor-law Service. This, if adopted, would practically place them in the distinct position of health-officers.

You may have read, in the published reports of the deputation, that I urged, as a preliminary to the adoption of sickness registration, a complete recast of the whole service. Having been instrumental, with others, in bringing forward the propositions, it would have been unreasonable and inconsistent for me to take any other course; but, though still holding that opinion, I strongly advise that the Association should throw no obstacle in the way of this reform, even though it be effected under the imperfect Poor-law arrangements at present in force. I am satisfied that no attempt will be made to oppose on you increased obligations, without additional remuneration. The public and the House of Commons know fully how inadequately your services are requited. As regards the amount which should be paid for such additional labour, the scheme which I would suggest, if adopted in its entirety, would involve the necessity of returning each week to the health-officers of the town, county, or part of county, not only the gross number and character of all new cases of disease, preventable or otherwise, but the existence of nuisances, or other things prejudicial to public health, which might be observed in the medical officer's district. If the area and population in urban and rural districts were adjusted, such reports or returns might be paid for by a definite and equal amount; but until such be the case, I see no other solution of the difficulty, save a graduated fee, the lowest sum being 2s. 6d., rising from that to 10s. 6d.; the variation in amount to be determined upon a recognised principle by the central authority. The fee for the registration of disease, and for sanitary reports, should, like the rewards for vaccination, be a government charge.

You are aware that, in my last address, in briefly referring to the report of the Poor-law Board then just issued, I stated that I would at this meeting direct attention to the medical section of it, with the view of exposing the numerous fallacies which it contains; and as a large portion of it was occupied by an attempt to discredit the Irish system of medical relief, by making out that it was something totally different from what its advocates had asserted, I forwarded a copy to Dr. Maunsell, an Irish dispensary physician, who has devoted considerable attention to Poor-law questions, and requested him to give me his opinion on certain marked passages. I will now read you his reply.

"I find that the mean number of paupers in receipt of out-door relief in England was 784,906; and of in-door, 157,740; that is, over five times as many received out-door as did in-door relief; while in Ireland, 288,953 received in-door, while but 50,257, or less than one-fifth, received out-door relief. I attribute this discrepancy to the fact that, as the vast majority of the out-door cases are those of sickness, they come under the Medical Charities Act in Ireland, while in England they become cases of out-door relief. To assimilate the numbers, the 775,327 dispensary cases ought to be added to the 50,257 for Ireland. Now let us see the economy of it.

"Rate per head out-door relief, in England, £4 5s. *per annum.*

"Rate per head out-door relief, in Ireland, less than £1 *per annum.*

"The expenditure for out-door relief was £48,184 for 50,257 paupers; for those relieved under the Medical Charities Act (number 775,327) the expenditure for medical officers, apothecaries, midwives, medicines, medical appliances, rent of dispensaries, fees for vaccination, registration, etc., was £123,713, or something over 2s. 6d. per head. In fact, it appears to me to come to this: in England, under your system, you divide the ready-made article under two heads, the in-door paupers,

which costs you £8 10s. *per annum* to support; the out-door paupers, £4 5s.; that these latter are augmented to an inordinate degree by the want of a Medical Charities Act, which would enable some effort to be made to stay them on the threshold of pauperism; that is, when it arises from sickness. This we have, and this we apply, and do so efficiently at the cost of 2s. 6d. per head; and the consequence is, that, while our health and strength is improved, and thousands of us are not demoralised by considering ourselves paupers even in name, our rates are but 2s. 11¾d., whilst yours are 7s. ¾d. per head of the population.

"In page 48, 'another important distinction is to be borne in mind; it is, that whilst in England a medical order is treated like any other order for poor relief, and the recipient is at once counted as a pauper, in Ireland the receipt of a medical order does not entail any such result. There does not appear to be much cause for congratulation on that score; you call it out-door relief, and make them paupers at a cost of £4 5s. a-head; we call it medical relief, and do not demoralise them by making them paupers, at a cost of 2s. 6d. per head. I call this per head, as I have divided the expenditure on dispensaries by the total number of tickets; this large class alluded to differs therefore merely in name, and tells very much in our favour, both socially and economically.'

"In page 50, it says 'that it is evident that a much greater proportion of sick paupers are required to come into the workhouse hospitals in Ireland with its dispensary system, than in England without it.' It argues thus, because it chooses to say, on whose authority I don't know, that the sick poor admitted into the Irish workhouses in 1868 numbered 112,071; out-door poor, 50,257. Now, if you turn to page 17 of the Irish Poor-law Commissioners' Report, your will find, after the year 1868:—

'Total number admitted in sickness 55,607
'Number admitted who were not sick 185,237

'Total number admitted during the year...240,843.

"It attributes this circumstance 'to a more strict state of the law, which, in the case of the able-bodied, prohibits out-door relief,' etc. *There is no such law.* 'And to the necessity of removing the sick poor from their wretched homes, where there would be no chance of recovery.' This is very pretty writing, but it is not the fact. If the patient choose to remain in his home, we cannot remove him against his will, *and still our death-rate is less than yours.*

"With regard to 'the ready access of gratuitous medical attendance, and the serious additional charges it would entail on the public burdens.' Has it done so in Ireland with the present faulty arrangements? With regard to 'its pauperising tendency, by diminishing self-reliance,' etc. Is not that exactly what it prevents? in contradistinction to your system, which makes every poor person who cannot at the moment pay a doctor, a pauper.

"In page 51 they assume, 'that, because 50,257 persons only appear on the lists as out-door paupers, all the persons relieved under the Medical Charities, 775,327 could pay, and are not paupers as they would call them.' I grant you that a great number of them could pay something, but not to such an extent as would operate in any such degree as they would have you to suppose, as a transfer of patients from the private to the public practitioners; besides, this is merely a bugaboo to enlist practitioners against the system. Of course, the faults of our system are not going to be adopted by you.

"This specious argument comes next: 'There are few medical men in the rural districts in Ireland, while in England, on the other hand,' etc., and it takes the whole of Ireland, and compares it with London. On this subject you might as well correct them. It is true that in Ireland there are 2410, and that 949, or three-eighths, are Poor-law Medical Officers. The number of medical men in England and Wales is 10,616. You appear to have 623 Unions; and I imagine, if you count the medical officers, they bear a very close proportion to ours. Next they say, in London alone there are 3,228 medical practitioners, or one to every 1,000 of the population. Now it so happens that in Dublin and its environs there are 500 practitioners, and the population is 412,053, or more than one to every 1,000 inhabitants; but if you deduct 3,228 from the total of English medical men, you have but 7,000 for the rest of England and Wales. Take Churchill's *Directory*, and look at the local list, with the towns and villages where medical practitioners reside. Birmingham shows 250; Brighton and Bristol, 100; Liverpool, 300; Manchester, 300; and many have 100, 80, and 50; now, if you deduct these from the remaining 7,000, I think you will find that there are just as few medical men in the rural districts of England as there are in Ireland.

"I do not know to what extent medical clubs exist in England; but I am very much under the impression (from what I have seen and read) that both the poor and club patients are, under your starved English system, extensively attended by unqualified assistants. I see on page 58 that the number of medical officers in England and Wales amounts to 3,906; total medical men, 10,616. Ireland, 949; total of medical profession, 2,410. There is not much discrepancy to boast of then.

"I think I have now touched on most of the subjects contained in your Poor-law Report to which you directed my attention, and which has evidently been manipulated to serve a purpose."

Whilst on this subject, I may as well inform you that in 1852 (the date of the introduction of an efficient system of medical relief in Ireland), the gross expenditure on poor relief was £1,099,678, or 1s. 7d. in the pound, inclusive of medical relief, which was then only £54,289; in 1869, gross relief had fallen off to £817,772, or 1s. ¼d. in the pound, inclusive of medical relief, which had been gradually increased until it has become £123,718 on the medical charities only, and a total of £133,000, inclusive of salaries and drugs, for the Irish workhouses. There are three ways in which the Irish Commissioners state that Poor-law expenditure may be diminished: "by the improved sanitary condition of the people, and consequent decrease of sickness; by a decrease in the applicants for workhouse relief; and, lastly, by a reduction in the price of food." In the two Dublin workhouses in 1852, there were but two medical officers, and an apothecary for each, at salaries of £100 respectively; now there are three in the north and four in the south, and apothecaries, at £150 each; and yet the expenses have diminished.

Reverting to the annual report, on page 49 will be found the following:—"In England, the instances are comparatively few in which persons receive medical relief only; nearly all here who are attended by the Poor-law medical officers requiring further relief as well." Believing this statement to be generally opposed to what really does happen, I have made extensive inquiries in every county of England and Wales, and find that, as I suspected, large numbers of such poor are attended who have no other relief whatever. I will quote from the letters I have received: "For every pauper requiring relief, I attend four or five requiring medical relief only, and whose names I never even enter in my medical relief book." "The instances in my district of those who have medical relief only, would be five out of six or more." "It is very common indeed to have an order for medical attendance on the wife or children, the husband being in work at the time, and receiving no further relief." I could make extracts of a similar character from a large number of letters. On the same page I find another assertion: "The services of the Poor-law medical officers are strictly limited to the pauper class." I will again quote from letters: "I should say decidedly that, in my experience, the services of the Poor-law medical officers are *not* strictly limited to the pauper class. My services are frequently ordered and given to persons who neither require nor receive further relief; nay, more, whom the board pronounce able to provide additional relief for themselves. I have frequently to attend ordinary illness, while midwifery orders are refused on this score."

At the aggregate meeting of medical officers in June 1868, the late Dr. Colborne said, "Not only do nearly the whole of the rural labouring population, but labourers in the direct and immediate employ of the rich and distinguished, even of cabinet ministers, peers of the realm, possessors of fabulous wealth, come upon us for themselves or families as patients." Further on, he stated, "this I know to be true of at least one half of England and Wales." The letters which I have received tell me that it is equally true of the whole of the country. There is, however, just enough truth in the statements to enable the office to put them forth as the rule, when in reality they are but the exceptions.

I would not have you suppose that in exposing the fallacies in the last annual report of the Poor-law Board, I seek thereby to diminish the facilities for medical relief to the poor. I am satisfied that those facilities are not so great as they should be, inasmuch as they are now rendered by medical officers under a galling sense of injustice; and as it is not given to the best of us to pull against the stream continuously, it must happen, under the existing system, that injury is inflicted on the sick poor, who can only secure imperfect medical attendance, and increased cost on the ratepayers, who have to meet the consequences of such unavoidable neglect; this the higher death-rate and heavy local taxation in England and Wales clearly exhibit.

On page 51, "The foregoing facts prove that the difference between the medical practice in the two countries is by no means occasioned by Poor-law regulations," etc. I contend, on the contrary, that the difference in favour of Ireland is entirely traceable to the admirable regulations which, with few exceptions, have been there carried out. There the districts are fairly equalised; salaries are much larger and placed on a uniform system; all drugs are found; and the dispensary physician can rely, in the performance of his duty, on the support of the Commissioners. Here, on the contrary, there are regulations (called general orders), it is true; but they are never enforced. Salaries are fixed by

guardians on no principles whatever; even in the same union,* districts are assigned to officers (with the sanction of the Poor-law Board) of such area as renders it physically impossible that the duties can be done. With the exception of the metropolis and a few large towns, all drugs are furnished by the medical officers. What can be said for regulations which have sanctioned 622 districts, exceeding 15,000 acres; 73 districts which extend seven miles from the medical officer's house; 204 districts, exceeding 15,000 persons; that 627 districts should be held by 291 medical officers; that 266 medical officers should attend from 1,000 to 10,000 patients annually, altogether making up 1,511 appointments contrary to the rules and regulations of the Poor-law Board, which, until quite recently, invariably crushed a medical officer if he dared to make complaint, however legitimate, of any wrong-doing, and which has led to a heavier mortality and a positively profligate (because preventable) expenditure on poor relief; and yet I find that Earl Devon, ex-inspector, secretary, and president, though he be, in his evidence before the Sanitary Commission, asserted "that, subject to a few exceptions which the necessity of the case had rendered necessary, and are sanctioned in each individual instance by the Poor-law Board, the area is 15,000 acres, and the population 15,000." I challenge the noble lord to produce his proof of the official consideration of, and interference with, the ideas of guardians respecting medical relief which he claims †

[Dr. Rogers read here extracts from letters, showing the overwork and insufficient pay of the medical officers, and the effects of false economy.]

Mr. W. H. Smith, M.P. (one of our honorary members) has placed a notice on the paper that he will, early next session, call attention to the administration of poor relief in the metropolis, and move the appointment of a Royal Commission. I regret that his notice of motion has been so framed as to exclude the rest of England and Wales. Still, though thus limited, a commission honestly determined to gain information would lay bare the vicious arrangements in our local and central administration, and so effect a large public service. I, therefore, urge you to press on all Members of Parliament whom you may know, the importance of Mr. Smith's motion, and beg them to support it. Should you be met by the remark that, if carried, it might embarrass the Government, say that poor-law questions have never been considered of such importance as to jeopardise, only to inconvenience, an administration; and that without Parliamentary pressure, the department will rest contented with the *status in quo*, and no change of a beneficial character will ever even be attempted.

I have secondly to remind you that our friend, Dr. Brady, has resolved to introduce a Bill, having for its object such reform in medical relief as will place the service on a more satisfactory footing; and, in order to secure a favourable consideration when it comes on for second reading, has pointed out, through the medical press, what kind of information will best suit his views. At present, as you too well know, guardians believe that they best serve their own and their constituents' interests by making the cheapest possible bargain with their medical officers. In this false view of economy, they have either been supported, or at least left undisturbed, by the Poor-law Board, which almost seemed to look to them for enlightenment. To obtain facts, to show how much they have been in error, is what Dr. Brady requires. I, therefore, beg of you to put into his hands or mine any such information as will exemplify the evil consequences to the community that have resulted from the faulty arrangements which have been permitted to exist in all matters relating to the care of our sick poor. I have given you cases in point above. Can you not each of you from your own experience furnish others?

In conclusion, allow me to congratulate you on the signal success which has hitherto attended our efforts; not only are our ranks continually recruited by the accession of members of the Poor-law service, but many gentlemen (the *élite* of the profession), Members of Parliament, distinguished political writers, and others, support our cause, and, in the press, on the platform, and in Parliament, are prepared to urge that the objects for which we strive shall be conceded. Can it be doubted that yet a little while and their complete realisation will be achieved?

MR. JAMES LEWIS, of the General Register Office, spoke of the importance of seeking the aid of, and co-operating with, the British Medical Association for the registration of disease. The substance of his remarks is given at length elsewhere.

Mr. BENSON BAKER proposed the first resolution:—"That in the opinion of this meeting it is desirable that a general registration of all new cases of disease coming under treatment at the public cost in workhouses and Poor-law districts should be established, and that the medical officers of such workhouses and districts, as enjoying the largest opportunities for observing facts prejudicial to the public health, should be intrusted with the duty of making weekly or, in times of epidemic, more frequent returns of cases actually coming under treatment, and of other facts concerning the spread of disease, to the health officers of their respective localities." He thought that the Poor-law medical officers had not only the best knowledge of the state of health of their districts, but also of their sanitary state and of the preventive measures to be adopted, and were thus well qualified to act as deputy health officers. He believed that the Poor-law Board were becoming alive to the necessity of registration. But, even with full knowledge, it was difficult to prevent disease, unless the medical officer had compulsory powers to remove the sick member of a family to an hospital. He was glad to hear from Mr. Lewis that an abstract return was sufficient for the central office; but he considered that the local health officer should be supplied with full details. It ought to be the duty of the medical officer to take note of bad drainage, bad ventilation, and other sanitary defects.

Dr. MAUNSELL, Dispensary Physician of the South Dublin Union, in seconding the resolution, explained the system of registration in operation in Ireland. He stated that each medical officer made a return of the cases of disease occurring in his district, taking special note of any disease unusually prevalent. In Dublin the returns were made up weekly, in outlying districts monthly. A quarterly and an annual return were likewise drawn up.

Dr. BRETT objected to more work being imposed upon the medical officers without more pay. He remarked that the Poor-law medical officers were not interested in preventing all cases of sickness; that was the duty of the state.

Dr. SANSOM insisted upon detailed returns and not mere excerpts. What was wanted was notice of the forerunners of disease. When an epidemic had already gained a footing it was too late.

Dr. BARCLAY (Medical Officer of Health for Chelsea) thought that the returns should be sent to the central office at once, and then be sent back to the health officers. He therefore questioned the advisability of pledging the Association to the plan proposed.

Dr. STALLARD said that the British Medical Association seemed to lay stress upon this point. He was of opinion that the returns ought to be made to the Guardians, and as much in detail as possible. They ought to have as much knowledge as possible of all sanitary defects. A modification of the plan adopted in Ireland would, he thought, be the best. It was advisable also to secure an intelligent, not a mere routine, return. In addition to this, an intelligent appreciation on the part of the public was necessary.

Dr. ALDIS (Medical Officer of St. George's, Hanover Square) advocated the adoption of the plan used by Dr. Ballard. He also paid a tribute to the willingness of the medical officers in his district to supply him with any information for which he asked them.

Dr. LETHEBY said that, as far as his experience went, it was of the greatest advantage that an immediate return should be made to the medical officers of health. What was wanted was a simple and speedy return. He had proposed to his Board to supply the medical officers with paper, stamps, and every facility, so that they might have as little trouble as possible. He considered these officers overworked and underpaid.

Mr. BENSON BAKER explained that, when dispensaries became generally established, the Poor-law medical officers would come under the jurisdiction of the Dispensary Committee.

Dr. LYON PLAYFAIR, M.P., thought it advisable that one remark which had been made by a previous speaker ought not to go forth as the opinion of the Association. He thought it was of the greatest pecuniary interest to the medical officers themselves to prevent disease as much as possible. It was their success in this respect that had made the Irish medical officers so popular. He should be glad to see them better paid; and he was of opinion that the money would not be grudged if the public felt that it was expended upon the plucking out of the seeds of pauperism. They would extricate themselves from their present

* Mr. Griffin's analysis of Lord Elcho's returns showed that in sixteen Union. the stipends of the medical officer ranged from 8d. to 1s. a patient; in 239, from 1s. to 3s.; in 348, from 3s. to 7s.; in 51, from 7s. to 16s. per patient. Salaries in England, with all drugs to find, average £49 only; in Ireland, with nothing to find, £90. Earl Devon, before the Sanitary Commission, asserted that the average salary was £68 a year. This is on the assumption that the whole sum returned in the medical relief column of the Poor-law Board's Report is distributed amongst the medical officers; which, however, is a gross inaccuracy.

† The total number of districts in England and Wales where the acreage and population exceeds the limit of the General Orders of the Poor-law Board is as follows:—

Excess in Acreage.—Above 15,000, 355; above 20,000, 127; above 25,000, 81; above 30,000, 31; above 35,000, 18; above 40,000, 11; above 45,000, 15; above 50,000, 12; above 60,000, 8; above 70,000, 4; above 90,000, 2; above 100,000, 1; total, 665.

Excess in Population.—Above 15,000. 98; above 20,000, 48; above 25,000, 28; above 30,000, 15; above 35,000, 5; above 40,000, 9; above 50,000, 1; above 80,000, 1; total, 205.

anomalous position, and become important public officers by attaching to themselves sanitary duties, as was the case in Ireland.

The resolution was put and carried.

Mr. WICKHAM BARNES proposed the second resolution—"That it was advisable that the workhouse and district medical officers should be appointed deputy health-officers, and be remunerated for the proposed health-returns on a scale to be determined by the central authority."

Dr. BARCLAY seconded the resolution, which was carried.

Dr. BRETT proposed, and Dr. ALDIS seconded, a resolution to the effect that copies of the resolutions should be sent to Mr. Göschen and to the Secretary of the Sanitary Commission.

Dr. DUDFIELD, in supporting the resolution, showed from the statistical returns of Kensington for the last five years how the maintenance of an effective staff of inspectors had been instrumental in reducing the average of mortality; and that, when sanitary inspection was relaxed, the mortality again rose.

The PRESIDENT mentioned a fact that had come to his knowledge within the last two hours. It was to the effect that, in consequence of the many abuses that prevailed under the present system, a general order had been issued in Ireland by which it was determined that medicines and drugs should no longer be purchased by the respective Boards, but that an Apothecary-General should be appointed at a salary of £500 a year, who should purchase the cheapest and best drugs for all the Unions. The importance of this measure would be seen when it was remembered that £32,000 was spent upon medicines. As the same abuses existed in England, Dr. Rogers urged this plan upon the attention of the Poor-law Board for adoption in this metropolis.

With votes of thanks to Dr. Lyon Playfair, Mr. Lewis, and the President, the meeting separated.

CLINICAL SOCIETY OF LONDON.

FRIDAY, NOVEMBER 11TH.

JAMES PAGET, Esq., F.R.S., President, in the Chair.

Skin-grafting. Mr. JOHN CROFT, for Mr. Le Gros Clark, exhibited a patient, who came into Hospital with a large sore on the leg, six inches by four. He was in ill-health. On August 1st a piece of skin, a quarter of an inch in diameter, was snipped from the thigh, and fixed on the sore. On the 11th there was hardly any of it to be seen; but by the 22nd, when Mr. Croft took charge, an island of skin, three-eighths by one-fourth of an inch in size, was visible. This rapidly spread, and the whole was now nearly skinned over.—Mr. F. MASON had operated on about twelve cases. As to the size of the pieces to be grafted, he thought they might be too large, and they might be too small—his own were of the size of canary-seeds. He had failed completely in a case of ulcer of the neck, owing, he thought, to the position and movement of the grafts. His pieces, as a rule, did not disappear, though sometimes the healed portions looked as if they would ulcerate.—Mr. CARTER asked Mr. Lawson (in reference to his paper reported in the JOURNAL of Nov. 19th) if it would not have been better to take the pieces from the other eyelid; they looked buttony now.—Mr. LAWSON said it was not a model to be copied, but rather an experiment. In another case, he would try to do all at once. He would not like to damage a sound eye for the sake of a bad one, and the results of such an operation were seen after entropium.—Mr. GANT wished to know what it was that grew.—Mr. SPENCER WATSON had tried the plan successfully in a boy who had suffered a severe burn on the back. He got one or two pieces to grow.—Mr. ARNOTT had, in a case of keloid in the neck, removed the diseased structures and transplanted some pieces of cuticle. The sore was at the angle of the jaw. One piece slipped, but became adherent at the edge; five others remained fixed, and did well. He had in one instance transplanted a piece of cuticle an inch square in the loin. It seemed to disappear, but after a fortnight a small patch was seen. In the case of a man who had two sloughing ulcers, which after a time improved, he transferred to one three pieces of cuticle, and left the other alone. The pieces did well, and after a time the sore was nearly healed, when he found the other sore, which had not been interfered with, nearly as well. The keloid was removed by deep dissection in August, and had as yet shown no sign of returning.—Mr. REEVES thought it would be well to note that it was the large piece which sloughed.—Mr. DURHAM'S experience had been satisfactory. His method differed somewhat from that generally adopted. A boy aged 12 had suffered from a patch of lupus non exedens on the cheek. He cut it out, and, loosening certain strips of skin from the edges, turned them inwards without cutting through their connections at one end. All adhered, and each became a centre of cicatrisation. In another instance, a little girl had a nævus on the point of her nose. This was removed, and two small pieces were planted. They soon cicatrised. He thought that small pieces were better than large ones.—Mr. CALLENDER said that among Mr. Willett's cases one woman was markedly syphilitic. A portion of the cuticle transplanted to an ulcer on the leg had taken root and done well.—Mr. HEATH asked the age of the sore—was it really syphilitic, or did it only occur in a syphilitic person?—Mr. CALLENDER said it seemed an ordinary tertiary one.—Mr. POLLOCK briefly replied.

Mr. T. SMITH exhibited a patient believed to be the subject of Vaccino-syphilis.—Mr. Callender, Mr. Gascoyen, and Mr. Berkeley Hill were appointed to examine and report on the case.

PATHOLOGICAL SOCIETY OF LONDON.

TUESDAY, NOVEMBER 15TH, 1870.

RICHARD QUAIN, M.D., President, in the Chair.

MR. JAMES E. ADAMS exhibited a specimen of Dislocation of the Wrist. This specimen was taken from the body of an old woman in the dissecting-room of the London Hospital College, and was without any history. All the tendons were normal, lying in healthy synovial sheaths, and there was no sign of any old inflammatory mischief about them or the ligaments. The proximal end of the metacarpal bone of the first finger was of normal shape and size, and fitted into a depression on the inner side of the articular end of the radius. The end of the middle bone of the second finger was opposite to the interval between the radius and ulna, but articulated with a small piece of bone, probably the remains of the os magnum. The fifth metacarpal bone articulated with the unciform, which articulated closely with the inner side of the ulna. On the radial side of the unciform a process of bone reached from the ulna to the base of the fourth metacarpal bone—probably the styloid process of the ulna. On the palmar surface, the unciform process and the pisiform were very close together, and so placed that a line passing through the unciform process and the centre of the pisiform bone had a direction parallel to the long axis of the ulna. The metacarpal bone of the thumb articulated with the remains of the trapezium. A horizontal section showed the scaphoid and the semilunar, and probably the cuneiform, to be fused together, the cancellous texture being continuous. The inferior radio-ulnar articulation was also partially anchylosed.

Dr. SILVER exhibited the Suprarenal Capsules of a man, aged 24, who had died of Addison's disease. The man came under his care at Charing-cross Hospital, in June, and he afterwards became an in-patient. He had been growing dusky for two years; previously to that he had been fair. The cause was rendered obscure by an attack of ague two years before. He was very weak, complained of inability to take a deep breath, and had palpitation. Some time before death he showed cerebral symptoms. He died in the night. After death the vessels of the brain were found to be loaded, the ventricles containing more fluid than ordinary, and the corpora striata softened. The lungs were tolerably healthy, the left apex slightly adherent, and both containing masses of obsolete tubercle. The spleen was normal. The suprarenal capsules were adherent, and completely converted into a calcareous mass on each side. Dr. Silver considered that the case tended to show the connexion between Addison's disease and tuberculosis. He also alluded to two similar cases which he had encountered in visiting country hospitals.

Dr. R. D. POWELL brought forward a series of specimens, and a table of fifteen cases which had occurred at the Brompton Hospital, illustrating the Pathology of Fatal Hæmoptysis in Advanced Phthisis. Specimen 1 consisted of the lung of a man, aged 25, who had died, while under Dr. Powell's care, from exhaustion, three days after his first attack of hæmoptysis. Both lungs were the seat of lobular pneumonic consolidations in all stages of degeneration, and in the right lung there were some old smooth-walled cavities, the largest of which, situated at the base, contained a sacculated aneurism, as large as a small walnut, of a secondary branch of the pulmonary artery. The aneurism had thin, brittle walls, contained few coagular lamina, and had ruptured by a small opening. Specimen 2 showed a small sacculated aneurism situated in the wall of an old indurated quiescent cavity, which had given rise to abruptly fatal hæmoptysis, in a patient of Dr. Symes Thompson, at the Brompton Hospital. This patient had been ill for several years, but had never had hæmoptysis before. Specimen 3 had been removed from a patient under Dr. Powell's care, who had died suddenly of hæmoptysis on October 12, 1870, having had previous attacks of copious hæmoptysis in January and September. This specimen showed a large thin-walled cavity, the surface of which was in a state of active ulceration, which had led to extensive exposure of large vessels, and erosion of their walls. From one of these branches of the pulmonary artery the hæmorrhage had occurred; and on the same vessel, a little higher up, a small aneurism was situated, partially ob-

structing a bronchus. Specimen 4 was removed from a patient of Dr. Pollock's, who had died from rapid tubercular phthisis, but had never had any important hæmoptysis. This specimen, like the preceding, showed a large cavity in a state of active ulceration, leading to extensive exposure and erosion of vessels. It illustrated the long-continuing patency of large vessels in the walls of cavities, and the formation of fibrinous coagula in them, attached to the side first exposed, and invaded by the ulceration, and the subsequent removal by the same process of the vessel-wall, leaving the coagulum bare while the vessel still remained patent. Of the fifteen cases of fatal hæmoptysis in the table (including three of the above cases), twelve had resulted from rupture of the pulmonary artery in a cavity, preceded in eleven by dilatation (five sacculated, six varicose), and in one case from ulcerative erosion. In three cases the source could not be discovered. Dr. Powell regarded old-standing unilateral cases of phthisis with quiescent cavities as most favourable for the formation of aneurisms or ectasias of branches of the pulmonary artery; cavities in a state of active ulceration as most liable to cause fatal hæmorrhage by erosion of the vessel. In both these cases the artery was invaded on one side only, the other being still in connexion with living tissue. When a vessel was surrounded by pneumonic consolidations it was more likely to become obliterated. Dr. Powell referred to a paper by Dr. Rasmussen, in which eight cases of fatal hæmoptysis were related—four from sacculated aneurisms, and four from dilatation of pulmonary branches.—Dr. C. T. WILLIAMS had seen the vessels sometimes dilated and thin-walled—sometimes almost calcareous. Was there any change in the vessels in early consolidation?—Dr. BASTIAN thought it was not difficult to account for fibroid change in the coats of the vessels. In the brain, this was generally so. With an old cavity and chronic induration, he could understand the vessels partaking of the change, and dilating or giving way where there was no support.—Dr. MOXON had failed entirely in discovering the source of hæmorrhage in two suddenly fatal cases. One was a girl who died in five minutes; yet he could find consolidation merely. It was a matter of surprise that Dr. Powell's cases should be of the kind they were, as in such it was usual for the vessels to contract. He would rather expect to find such change in rapidly fatal cases.—In reply to Mr. Arnott, Dr. MOXON said he had pursued his search for the source of the hæmorrhage systematically till the lung was reduced to exceedingly small pieces.

Mr. DAVY exhibited two Hip-joints from patients of Mr. Holt and Mr. Holthouse. One was an example of the destructive form of disease, with general erosion and abscess in the pelvis; the other, of bony ankylosis, the result of a fractured neck of the thigh-bone, taking place long ago, and ending in a stiff joint.

Mr. DAVY also exhibited the Ruptured Stomach of a Dog which had been run over in the streets. There was no external injury, yet the stomach was traversed by a large rent.—Mr. ARNOTT had no idea that these cases were rare or he would have brought some before the Society. In one case a little boy fell from a ladder; there was no external mark, yet there was a large rupture of the stomach. At University College Hospital, a man came complaining of colicky pains. He had already been supplied with diarrhœa medicine; while there, he was taken very ill and speedily died. The day before he had had a fall and hurt his side, but he walked home and partook of a meal as well as of the physic. There was a large rent in the wall of his stomach, and its contents were lying in the peritoneal cavity.—Dr. MURCHISON had seen as many as three in one day, the result of a railway accident, the passengers' stomachs being full.—Mr. HULKE had seen a case where the stomach formed part of the contents of an umbilical hernia, and, in forcible attempts at reduction, a rent four or five inches long was made in its wall.—Dr. MOXON had seen the stomach of a boy run over by a carriage, where the vertebral column seemed to have cut the stomach like a knife.—Mr. ARNOTT alluded to another case of a young man playing at football, who had received a blow from an elbow; death followed on the second day. There was a large opening in the jejunum.

Dr. WHIPHAM exhibited a specimen of Diseased Tricuspid Valves, the left side being healthy. The patient, a male, had symptoms of pneumonia, and had suffered from hæmoptysis. He gradually sank, when it was found that the right lung in its lower lobe was hepatised, and that the pleura had given way. All the valves of the heart were healthy, except the tricuspid, which was ulcerated, and some of its chordal tendons were broken across. There was no apparent cause for this, and no pyæmia. Dr. Anstie had recorded a case where there was pus under the aortic valves, which seemed to resemble this.

Dr. KELLY showed a specimen of Malformed Heart in a case of Cyanosis. The heart was taken from a child, aged three months. The pulmonary artery arose from the left ventricle and the aorta from the right ventricle. The only communication between the systemic and pulmonary systems was through the patent foramen ovale; the ductus arteriosus was closed. There was no malformation in any other organ. The child was not cyanotic until five weeks after birth: it then became rather livid, and every morning had slight convulsive attacks, probably brought on by impure blood passing through the nervous centres. During life a loud systolic bruit could be heard nearly all over the thorax, but most distinctly at the apex. Another child in the same family had previously died of a similar affection.

Dr. KELLY also showed a Malformed Heart, taken from a child, aged 6, who died in King's College Hospital of renal dropsy after scarlet fever. There were no symptoms of heart-disease during life, with the exception of a systolic bruit between the base and apex of the heart. The septum between the ventricles was defective above, so that there was an oval communication between the right auricle and the two ventricles. The adjacent portions of the tricuspid and mitral valves were intimately adherent.

Dr. KELLY showed a specimen of Necrosis of the Patella, taken from a girl, aged 7, under the care of Mr. Wood. She ran a dirty fork into her left forefinger last August, and shortly afterwards symptoms of pyæmia came on; there were shivering, and a fluctuating range of temperature, and swelling of the left knee-joint, which was very painful. The joint was opened and some pus escaped. In a few weeks it was again opened, and a good deal of pus came away. The girl then began to improve in health; and, one morning last October, when the wound was being dressed, the patella was found lying loose, and was removed by forceps. The bone was yellow, and somewhat destroyed on its lower and posterior aspect. It weighed, when dry, 1·485 grammes. The finger at this time was nearly healed. Both wounds had been treated with carbolic acid, according to Mr. Wood's method. The child soon made an excellent recovery, and left the Hospital in November.—Mr. WOOD said the case was really one of pyæmia. An abscess had formed over the metacarpal bone and destroyed it. The pus was let out, but a swelling of the knee-joint followed, and an opening had to be made to allow the matter to escape; another had also been required after a time. He had used McDougall's powder as a disinfectant.—In reply to Mr. HULKE, it was stated to be too early to look for repair.

Dr. PAYNE exhibited a specimen of Cancer of the Thyroid in an elderly lady who had suffered for years from goître. Latterly she had bronchitis, dyspnœa, and loss of voice, supposed to be due to a thoracic tumour. After death, it was found that the left lobe of the thyroid had pressed on the recurrent laryngeal, and was converted into a thick-walled cavity containing creamy material like medullary cancer, also isolated nodules containing multiple nucleated cells. The mass really consisted of two structures—ordinary goître, and cancer.

Mr. ARNOTT exhibited a specimen of Concurrent Myxoma from the gluteal region. The patient was a middle-aged woman, and a similar tumour had been removed twelve months before. It apparently sprang from the periosteum, and was soft, lobulated, and jelly-like.—Referred, along with Dr. Payne's specimen, to the Morbid Growth Committee.

Mr. J. D. HILL exhibited a Tumour that day removed from the Scapula, having been attached to its under surface and costa. It pressed on the vessels and nerves, and was of rapid growth. It had not been examined.

ASSOCIATION INTELLIGENCE.

BIRMINGHAM AND MIDLAND COUNTIES BRANCH.

THE next meeting of the above Branch will be held in the Council Room of the Midland Institute, on Thursday, December 8th. The Chair will be taken at 3 P.M. precisely.

Members are invited to exhibit pathological specimens at the commencement of the meeting.

T. H. BARTLEET, *Honorary Secretary.*

Birmingham, November 1870.

BATH AND BRISTOL BRANCH.

THE second ordinary meeting of the session will be held at the York House, Bath, on Thursday, December 15th, at 7 P.M.; CHARLES BLEECK, Esq., President.

R. S. FOWLER, E. C. BOARD, } *Honorary Secretaries.*

6, Belmont, Bath, November 1870.