characterized by the consideration of the living being as an integrated unit. The biological thinking of Hunter and Darwin had been carried on by such physiologists as Gaskell, Sherrington, Haldane, and the "clinicians of the whole man," maintaining in medicine the Hippocratic spirit. The development of sex was now better understood, and therefore disturbances in that development resulting in intersex became clearer. It was shown how sometimes, in the normal mechanism of sex development, the sexoformic impulse was deflected at a certain stage, and development then continued according to the opposite sex. This deflection could occur at various phases; the earlier it occurred the fewer organs differentiated, and therefore the more marked was the intersex. It proceeded from two groups of factors: hereditary weakness of the genetic impulse and factors of environment, the latter including education, imitation, and social *milieu*.

Sex was not a fixed feature; it was the result of an evolution, which continued. The lower beings remained at the stage of asexualism. Later sexual characters appeared, but coexisted in the same being (namely, plants and some lower animals); later still the sexes separated, and complete unisexuality could not be conceived at this, the human, stage of evolution.

In passing, the lecturer noted one differentiation between the sexes. Feminism in men—for example, in the male castrate—was regarded as a retrogression, but certain male features acquired by women were regarded as not abnormal but as perfecting the woman. He instanced Lady Hester Stanhope, the niece of William Pitt, a mild adrenal gynandroid, whose features and build were masculine, and whose courage, behaviour, and domineering tendencies were traits associated with the male sex, and yet she was admired, and had some sentimental and even physical adventures.

The Basis of Sex

The ovary and testis were not the basis of sex, but merely manifestations or results of the initial genetic sexoformic impulse, which in human beings was either male or female and never bisexual. A female was not the appendage of her ovaries, to use Virchow's phrase, but had ovaries because she was female. A male was not male because he had testes; he had testes because he was male. There was neither absolute male nor absolute female. Every male had more or less latent female features, and vice versa. Intensification of this normal intersexualism characterized the disease hermaphroditism, and all degrees were encountered.

As intersexualism was biologically a disease of the whole individual, not merely a disease of a particular endocrine gland, any treatment must be directed to the whole constitution. Had we any right to punish an individual who showed the homosexual form of intersexualism? Theoretically we had no such right. A male homosexual of intersexual origin was in fact an intersex who wanted to be a female. On the other hand, a homosexual was a focus of infection. Such a boy at school infected others, causing sex reversal through psychological factors, and handicapping them for life. The duty of society to such persons was to cure them or to prevent them from harming others.

Finally Dr. Cawadias touched on adrenal virilism, a special problem by itself. When it was due to a tumour, the indication for operation was the tumour, not the intersexual state. When it arose as an adrenocortical hyperplasia the problem was more complex. In adult cases no demasculinizing adrenalectomy should be performed if the patient wished to remain male. But the principle of sex choice should not be pushed so far as to withhold adrenalectomy in infantile cases of adrenal virilism, for the results of the operation were so brilliant that it was not justifiable to risk for these subjects the persistence of an intersexual state which, notwithstanding the predominance of one sex, was always a handicap.

The Ministry of Health has now issued in Circular 2395B the promised list of special clinics outside the Emergency Hospital Scheme which are to function as additional Fracture Clinics "C" (*Journal*, August 23, p. 290). Instructions on the method of referring cases to these clinics are being sent to all hospitals in the E.M.S.

HOSPITALS IN THE POST-WAR WORLD

INTERNATIONAL CONFERENCE IN LONDON

An international gathering filled the Great Hall of the British Medical Association House in London on November 25 when a conference was summoned by the United Kingdom Council of the International Hospital Association to consider the position of hospitals the world over at the dawn of peace. King Haakon of Norway, the Grand-Duchess of Luxemburg, and Dr. Benes, lately President of Czechoslovakia, attended, together with the Prime Minister of the Netherlands, the Belgian Ambassador, the Ministers of Norway, Venezuela, and Colombia, and official or other representatives of Poland, Yugoslavia, Greece, Palestine, Iraq, Egypt, Abyssinia, India, and China. The British Red Cross and the St. John Ambulance Association, the American Red Cross, and the Czech and the Netherlands Red Cross sent representatives, and there was a representative of the Free French Medical Corps. The Agents-General of several Australian States were present, as well as Sir Earle Page, the envoy of the Australian Government.

The Minister of Health (Mr. Ernest Brown) and the Secretary of State for Scotland (Mr. T. Johnston) attended, as did the Chief Medical Officer (Sir Wilson Jameson) and several officers of the Ministry, the President of the Royal College of Surgeons (Sir Alfred Webb-Johnson), the Chairman of Council of the British Medical Association (Mr. H. S. Souttar), and the representatives of many other bodies concerned with medicine, hospital administration, and social welfare.

Mr. W. McADAM ECCLES, chairman of the United Kingdom Council, presided over this assembly. At the outset a message was sent to the King, expressing gratitude for the interest he and the Queen have taken in the work of hospitals and the hope that with the swift coming of peace there may be freedom to continue and foster the healing art in every hospital in the world. Before the conference ended a gracious reply was received. A cable of greeting was also sent to the President of the International Association, Dr. MacEachern of Chicago.

International Hospital Collaboration

Dr. A. T. JURASZ, dean of the Polish Medical Faculty in the University of Edinburgh, opened a debate on the collaboration which must follow the war, a collaboration which must extend to all nations prepared to work together on a basis of honesty and friendliness. He suggested a greater interchange of personnel, both lay and medical; a six-months residence in the larger hospitals for graduates of different countries on a principle of international exchange, and an extension of post-graduate teaching. Prof. J. LOEWY (Czechoslovakia) followed with the suggestion for a "Health Union" among European countries, the basis of which would be the curative resources of each country, such as mountain sunshine or medicinal springs, and the distribution of patients without regard to national boundaries. Dr. GEORGE H. H. WOO (China) repeated the description of recent hospital progress in China which he gave to the China Institute the other day. Dr. KARL EVANG (Norwegian Minister of Social Welfare) said that in his country of three million inhabitants there was one hospital bed to every hundred of population. He believed that after the war the same system of hospital provision, based on sickness insurance, would continue. Dr. E. J. BIGWOOD (chairman of the Belgian Commission for the Study of Post-war Conditions) said that the Governments of the Allied countries at present in London had already considered a plan of action, both for immediate relief after the war and also for long-term development.

Hospitals in English-speaking Countries

Mr. McADAM ECCLES introduced a discussion on the special problems of English-speaking countries. It was not too early, he said, to consider problems that would arise as soon as peace was declared. He suggested that in any area the total number of beds required for in-patient treatment and the expected number of out-patients should be computed, the approximate annual cost per bed and per out-patient ascertained, allowance being made for some kind of sinking fund for the purchase of

new equipment and future rebuilding, and then on the basis of this annual budget it would be possible to announce the amount necessary from the local community for the support of their hospitals, and he did not doubt that the money would be afforded voluntarily.

Mr. H. S. SOUTTAR referred to the sweeping away of divisions between classes of hospitals. He had been a member of the staff of a voluntary hospital, but at present he was taking charge of an L.C.C. hospital under the control of the Ministry of Health. He referred to the work of the Medical Planning Commission as a kind of "Brains Trust" to determine the character of the after-war service, but, of course, the International Hospital Association, along its own lines, had a still wider purview.

Voluntaryism and State Aid

Lord GIFFORD, who has been associated with a hospital in Sydney, said that that hospital preserved its voluntary character although 60% of its income came from the State. More than half its board were State-appointed, but once they took their seats they were indistinguishable from other members. Voluntary hospitals would ask a great deal more aid from the State, and yet he believed that they could preserve their democratic character. Sir EARLE PAGE also said that in Australia they had endeavoured to incorporate the voluntary system with the maximum amount of State aid. Sir WILLIAM GOSCHEN (London Hospital) spoke of the need for a scheme which would bring the voluntary and municipal hospitals together. Mr. CARUS WILSON (St. Bartholomew's) said that the doubts which had been expressed as to the survival of voluntary hospitals after the war were also expressed during the last war, but voluntary hospitals continued then, and they would continue now. But they must look to such organizations as the Hospital Saving Association for augmentation of their income.

Among other speakers were representatives of the British Dental Association and the Royal College of Nursing, and the discussion was closed by Dr. ANDREW DAVIDSON (Chief Medical Officer for Scotland), who said that although the Committee on Scottish Health Services found a shortage of 3,600 beds, this had been more than made up by the Emergency Hospital Service. There was also now available for the first time in Scotland a comprehensive orthopaedic scheme.

E.M.S. Hospitals

Mr. ERNEST BROWN, Minister of Health, mentioned the close relation between Great Britain and the United States in connexion with the Emergency Medical Service. The U.S.A. not only had given material help but had lent medical and nursing personnel. The E.M.S. was not designed as a pattern for future development, but it had nevertheless proved a very useful experimental ground from which lessons of long-term value had been learned. It was organized to cope with the expected casualties of war, but in practice it had assumed a shape which made possible the adaptation to war needs of all kinds of existing hospitals and services. It had yielded experience with regard to the relation of hospitals one to another which would greatly influence the peacetime situation.

A HOMESTEAD SCHEME FOR MOTHERS AND CHILDREN

The family unit is the first casualty in war. If the nucleus of the State is the family—the living unity of father, mother, and children—then by some means the family should be enabled to maintain its status and fulfil its function, in spite of the disruptions caused by the war. The family unit was the basic idea of that great social venture, the Pioneer Health Centre at Peckham, whose work is now largely suspended because so much of the population it served has migrated. But the ideas which animated the Centre go on, and some of them are ably put forward in a memorandum addressed to the Ministry of Health and other Departments over the signature of Dr. Innes Pearse, the medical director.

Dr. Pearse proposes a homestead scheme, which will provide a reasonably healthy and useful life for the wives and children of mobilized men. She wants to see the evacuated women and children introduced into a society of people like themselves, of which they would become an integral and significant part. If the family is to function the mother and child must not be separated, as they would be if the former went into one of the auxiliary services or into "munitions." Perhaps one-third of the mother's working day must be given to the young child, but the remainder could be devoted to work of national importance, most obviously food production. The running of a mixed farm and garden—a homestead—on an estate of thirty or fifty acres, of which there are many in this country, should be within the capacity of a group of twenty-five to thirty women with two-thirds of a day's work to give on the spot where they are living. Under the guidance of advisers and with the help of a nursery-school worker, the mothers in such a colony would be able to undertake useful self-supporting work on the land, they would take their turn in household duty, they and their children would live in relative safety and under optimum health conditions, and, what is of equal importance, the fathers, to their own great benefit, could rejoin them on the farm during their periods of leave. Dr. Pearse begs the Government to set up a voluntary service of young mothers with children under 5, to begin with, to be called "The Mothers' Auxiliary Yeomen Service." The health overhaul, which was another idea of the Peckham Centre, could be undertaken by a visiting doctor and nurse-laboratory attendant travelling in a motor van to each of a batch of homesteads, and they would also supervise the diet and general hygiene and assure antenatal and post-natal care and child welfare. It is not pretended that such a scheme could do more than touch the fringe of the vast evacuation problem; but it would at least provide that a certain number of women, made familiar with the land and having had their resourcefulness and initiative developed and their health reinforced, would be ready to stand with their men on the return of the latter from the war, a reconstituted family unit in wholesome surroundings, better able to meet the demands of the new world.

Local News

ENGLAND AND WALES

London's Wartime Hospital Needs

Mr. Charles M. Power, house-governor and secretary, reports that the Ministry of Health has placed at the disposal of the Westminster Hospital 100 beds at an emergency hospital near London. To these beds civilian patients are now being transferred, after initial treatment in the London wards of the hospital. Here, also, out-patient children needing operations for the removal of tonsils and adenoids are being sent. The Westminster Hospital has been able to reopen some forty beds for the accommodation of contributory middle-class patients. The Ministry of Health, at the request of the National Radium Commission, is providing a centre to contain 120 beds for patients needing radium and *x*-ray treatment. Five of the London hospitals will share the beds. It is hoped that these beds may be the means of avoiding delay which has occurred during recent months, and that the treatment of these distressing cases will not again be interrupted should air raids on London be resumed.

Emergency X-ray Service for Hospitals

A fleet of fifteen *x*-ray vans now stands ready to answer calls for assistance from hospitals enrolled in the Ministry of Health's Emergency Hospital Service. These mobile vans, fitted with the latest type of equipment, have been presented by the War Organization of the British Red Cross and Order of St. John of Jerusalem. They will be stationed at selected hospitals in London and the Provinces so that calls from any part of the country can be answered. It is not intended to use them for routine work, but they will constitute reserve sets for an emergency caused either by raid damage or by unexpected demands on