WOMEN IN MEDICINE

By JANET K. AITKEN, C.B.E., M.D., F.R.C.P.

It is very agreeable to be asked to write about women in medicine since the earliest days, because on the whole it is a story with which the woman doctor is well satisfied and nowadays she is, or should be, grateful to those women who made her present career possible, and to the majority of her male colleagues who have accepted this break with tradition, some even being most active in giving their assistance.

The London School of Medicine for Women, after its early struggles, had outgrown its quarters, and boldly the Dean, Mrs. Elizabeth Garrett Anderson, and her Council had planned a new building, the first part of which was opened in 1898; but the Council was still much in debt. However, in 1900 Dr. Elizabeth Garrett Anderson writes, 'We have had another splendid donation this week, £5,000 for the School, it is from a kind Mr. Turle, not a very rich man.' Obviously, however, a very sincere sympathizer!

In 1901 the School became one of the colleges of the University of London, and in 1902 students who had qualified from the School got their longed-for opportunity and began to hold resident posts at the Royal Free Hospital. Appointments to the honorary visiting staff followed. The first steps had been taken—a few women doctors were beginning to get the same opportunities for experience as their male colleagues.

It was interesting that in 1908 technical education was made eligible for a Parliamentary grant. No time was lost by the then Dean, Miss Cock, in proving that medical training was technical. Thus the London School of Medicine for Women was the first school to obtain this handsome grant. Other medical schools soon followed suit and the Treasury grant became an important part of the incomes of all the medical schools.

Officially the Edinburgh school was opened in 1869, but the University was not open to students till 1916, though in 1886 they allowed extra-mural teaching and the women could obtain the Scottish Conjoint Diploma. Bristol opened their doors to women in 1891, Durham in 1893, and by 1911 all the Scottish and provincial hospitals were taking women students except Oxford and Cambridge.

None of the London schools, however, took women except, of course, their own special school. Oxford and Cambridge, King's College Hospital and University College Hospital opened during or just after the first world war, and retained a limited number of places open till the present day. Five other hospitals also began to take women students, St. George's, Westminster, St. Mary's, Charing Cross and London, but later they decided not to admit women, St. George's in 1919, so that it was understood that the gesture had been purely a war measure; but the others kept on for a number of years and then decided against the admission of women. One hospital admitted that the reason was because the lessening of the number of male students diminished the number of the pool from which their football team could be chosen! In any case it was a hardship for the women students who had already been taken to belong to a school where women were no longer admitted. The same disability was felt by all the students of the West London which opened as a co-education school in 1937 but which, on the advice of the Goodenough Report to the University of London, closed as an undergraduate teaching hospital and school in 1947. At the same time Guy's, St. Bartholomew's, St. Thomas' and Middlesex, decided to take a limited number of women and the Royal Free Hospital to take men students. At the present time, therefore, in all schools there are an adequate number of places available for women students.

Thus in the fairly early days undergraduate teaching could be obtained with some ease, but post-graduate experience was a different matter. Women students when they had qualified were only gradually admitted to resident house jobs, and the women often felt the need of further experience both for general practice and for specialist work. In fact, of course, it was really impossible to hope for consultant status without further and continued hospital experience. This lack of post-graduate opportunity and the knowledge that an increasing number of patients were clamouring for their services led to great efforts in starting a number of hospitals for women and children staffed by women doctors.

As Elizabeth Garrett had qualified in 1866, she started a dispensary practice in Seymour Place and from the first Dr. Hughlings Jackson and Dr. Broadbent were her consulting physicians and Mr. Critchett, Mr. Thomas Smith and Mr. Norton acted on the surgical side. By 1871, 9,000 patients' names were on the books. By 1872 they had added ten beds, and in 1874 they leased three houses in Marylebone Road because the pressure of work was so great. Two women physicians with Zürich degrees, Miss Morgan and Mrs. Louisa Atkins, joined the staff. By 1888 it was necessary to expand, and the Prince and Princess of Wales opened the New Hospital for Women at 144, Euston Road. It continued to progress and enlarge. At the time of the death of Mrs. Garrett Anderson in 1917, when there was still more building, the name of the hospital was changed to the Elizabeth Garrett Anderson Hospital, familiarly known as the E.G.A. Late in the 1939 war, when taxis were very scarce, the matron and a man hailed a taxi at the same time, the driver asked each where they wanted to go and he chose the matron. She was honoured by this preference and had the fare plus a handsome tip ready, but the driver said, 'On no, my wife was so happy and well cared for at the E.G.A. that I vowed I'd never take a fare from anybody who wanted to go there!'

In Edinburgh, meanwhile, Dr. Sophia Jex Blake (who had been in practice since 1878) and others were feeling the same needs, and in 1885 the Edinburgh Hospital and Dispensary for Women and Children came into being. It grew out of possibilities of development on its first site and Bruntsfield Lodge was bought, and in 1903 a new hospital was opened. Meanwhile Dr. Elsie Inglis and others had started a hospice in 1899. Much obstetric work was done here and in 1910 these two pioneer efforts were united administratively. In 1916 the University arranged that some of the obstetric teaching of the women students should be done at the hospice. In 1923 a new hospital was built as a memorial to Dr. Elsie Inglis, who had died after her return from Russia in 1917. Many Scottish graduates are grateful to these Edinburgh hospitals for post-graduate experience, both junior and senior. In Glasgow, too, the women doctors were active. The Glasgow Women's Private Hospital was started in 1902. Only eight patients could be received, but here, as elsewhere, it was soon found that this number was quite inadequate, and in 1924 Redlands Hospital for Women came into being. At this hospital some very well-known women doctors obtained experience to become consultants.

Meanwhile other prospects were being developed by Dr. Helen Boyle and Miss Louisa

Martindale in Brighton. As in London and Edinburgh, the first early effort was a dispensary, in 1898, and then a few beds followed. The first branch to develop in this case was the Lady Chichester Hospital for Women and Children, which later, after the birth of the general hospital, the New Sussex Hospital for Women and Children, was devoted entirely to the treatment of cases of early nervous breakdown. In 1939 the New Sussex Hospital was a most successful hospital for women and children, with 84 beds.

Another interesting enterprise was the opening, in 1901, of the East Anglian Sanatorium, which owed its existence to the zeal and enthusiasm of Dr. Jane Walker. She was one of the first in this country to believe in open air treatment for tuberculosis, and she had great faith in rehabilitation by encouragement in suitable occupation. The purpose of this hospital was a little different from that of some of the other hospitals described, but many women doctors got post-graduate experience at Naylands.

In 1911 Miss Maud Chadburn saw the number of women who had to be turned away from the Elizabeth Garrett Anderson Hospital in London owing to the lack of space and facilities for treatment, and she knew also that the difficulty that women had in gaining postgraduate experience still existed. She made up her mind to start a new hospital on the south bank. In faith the small amount of money available was spent in buying the site and an appeal was launched. The appeal effort was a letter to *The Times*, and this letter evoked an angry and rude reply from a male colleague. The prejudice of the writer caught the eye of a friend of women doctors. A representative called on Miss Chadburn and asked her if it would be certain that the new hospital would admit only women and children and would only be officered by women doctors. On being reassured on this point the whole sum required was promised immediately and anonymously! In all about £100,000 was given—a large sum now, but even more valuable in those days. So this hospital, the South London Hospital for Women and Children, did not gradually develop from small beginnings, though it too outgrew its premises, new departments and buildings being added from time to time. It is now a flourishing hospital of 260 beds.

The next hospital to be started by women doctors, helped by generous sympathizers, was in Manchester. It began with 12 cots in 1914, and Dr. Chisholm was the Chairman of its Medical Committee and continued to remain a strong influence in this hospital. This was one of the first infant hospitals and one of its main objects was to treat nutritional disorders in babies and to train nurses for this work. In 1926 the hospital had

grown and had about 80 cots, and about this time the staff became a mixed staff of male and female. In 1935 21 cots were added and the name changed to the Duchess of York Hospital.

The last women's hospital to be mentioned was the Marie Curie Hospital. In 1925 Dr. Helen Chambers brought before the Committee of the Medical Women's Federation a theory that to make real progress in the knowledge of the best treatment of carcinoma of the cervix it was necessary that a large number of cases should be treated by the same technique. At her suggestion, and under the Chairmanship of Miss M. Chadburn, it was decided to try to carry this out by starting a hospital for the purpose. All the women gynaecologists of the Royal Free Hospital, the Elizabeth Garrett Anderson Hospital, the New Sussex Hospital and the South London Hospital were to co-operate. A director, Dr. Hurdon, was chosen, a distinguished woman whose ability and tact helped the diverse members of the staff to form a united policy and to carry out this interesting experiment. The results were most illuminating.

The field of work which lay in India and other Eastern countries, especially among the missionaries, has always attracted many women doctors. They knew, of course, that among certain groups, such as women in purdah, they and they only could give medical help. The first women to help their own sex who could not avail themselves of male medical care were missionaries who were so impressed with the desperate plight of some poor souls that they tried to train themselves to give elementary medical care. The first qualified women doctors in India were American, but one cannot think of such work without mentioning Dame Mary Scharlieb. Just before the turn of the century an American, Mr. Kitteredge, in Bombay, wrote, 'I am convinced that for success in India women must be recognized as the equals of men in the medical care of their own sex.' He and a Mr. Sorabjee Shapurjee Bengalees and others formed a fund, 'The Medical Women for India Fund.' Meanwhile, Mr. Pestonjee Hormusjee Cama offered a huge sum to the Bombay Government for a hospital on condition that the Government provided a site and maintained it, and provided it were turned over to the charge of women doctors. The Government, though they had the example of the excellent work of the women pioneers, objected to the second proviso, saying, 'We will willingly agree to utilize the services of competent medical women acting under the instruction and guidance of the male superior staff, when such services are available!' Finally, however, Dr. Edith Pechey did become the first woman superintendent.

In 1927 there were 183 women's hospitals staffed by women, as well as numerous women's wards in district and municipal hospitals under the care of women assistant surgeons. The women doctors trained nurses and helped in the training of men and women students. They worked very hard but they could never feel that their work was not needed; in fact, they had the satisfaction of knowing that much of it could only be done by women trained in medicine.

Soon after the turn of the century women doctors began to be employed in the ministries and by the municipal authorities. These public bodies had a tendency to hope that women doctors would accept lower salaries. Fortunately, on the whole, the women listened to the advice of the pioneers and insisted on equal work for equal pay. In 1907, Dame Janet Campbell was offered an important post as assistant to the Chief Medical Officer to the Medical Department of the Board of Education, but she refused because the salary was inadequate. However, in the following year, Dr. Newman (later Sir George Newman), the medical officer concerned, insisted on equal pay, and Dame Janet was appointed and the precedent of the same salary for men and women was established. Later, in 1918, when the Ministry of Health was formed, Dame Janet was put in charge of the Maternity and Child Welfare Division. In the early days it may have been wise to segregate women M.O.s in the one division, but the practise of the Ministry at that time in this matter was followed by the local authorities, and has largely prevented women M.O.s from qualifying themselves for work other than maternity and child welfare and the School Medical Service. This was probably one of the reasons why, for many years, no woman M.O.H. was appointed. However there are quite a few women who are now in other branches of public work.

In August 1914, the prevailing idea was that war was man's business and the women doctors were told that their services would not be required. Some of the women doctors themselves, however, felt that it was their duty to do anything they could to help. There were the well-known Scottish Women's Hospital Units, the various small units that were formed and sent to Antwerp and France and Serbia. There was the Malta contingent of women and the Endell Street Military Hospital. When Queen Mary's Army Auxiliary Corps was formed they had women medical officers. Still later there were women medical officers to the W.R.N.S.

After the outbreak of war Dr. Elsie Inglis realized what an all important part women could take in the war and she started to collect money to train and equip the Scottish Women's Hospitals.

She went to London to offer the services of herself and her women colleagues, but was told, 'My good lady, go home and sit still.' She did not sit still and with astonishing rapidity the first two units were ready, one for Serbia and one for France. The French one was under the care of Miss Ivens of Liverpool, and its work at Royaumont became famous. The name of Dr. Elsie Inglis herself will be linked for ever with that of Serbia, where it was remembered with something of legendary veneration. Covering a period of four to five years, 14 hospitals were staffed and operated in five countries!

Three privately financed hospital units, also considered redundant by the British Army, were sent overseas, the first to Antwerp, the second to Tourlaville near Cherbourg, and the last to Serbia in 1915. Miss Stoney, the proud possessor of a new X-ray Coolidge tube, was in charge of the first. They had to retreat of course, got home dirty and tired out, but with no casualties. They formed again and set off for the Chateau de Tourlaville, where they did good work tending the French and Belgian wounded. Meanwhile the French Red Cross had received cordially an offer of a fully-equipped surgical unit composed of women doctors and trained nurses under Dr. Louisa Garrett Anderson and Dr. Flora Murray. In *The Times*, 1915, was published the following statement by Sir Alfred Keogh, D.M.S.:—he had received numbers of unsolicited letters from Paris and Boulogne which stated that the work of the women doctors at the Front was beyond all praise. So impressed had he been that he had asked two of the staff from Paris to come here and take bigger work. He had asked them to take charge of a hospital of 500 beds and, if they pleased, a hospital of 1,000 beds. This was the start of the Endell Street Hospital. In 1918 Sir Alfred wrote to Dr. Garrett Anderson, 'It has always been to me a great pride to know how successful you have been.'

In 1917 the War Office woke up to the fact that many duties could suitably be undertaken by women, and the Queen Mary's Army Auxiliary Corps was formed. Dr. Mona Chalmers Watson was appointed as administrator, though not in any medical capacity. The doctors in the Corps formed an auxiliary part of the R.A.M.C., but it was considered impossible that they should be given commissions.

Thus, though many women doctors saw active service, most of their efforts were unofficial and their units scattered.

When the war was over the Medical Women's Federation realized that the position of women doctors in the Services should be clarified. They made efforts to get the War Office to agree to dis-

cuss the matter, but were unsuccessful. The matter was dropped as, after all, one did have a hope at that time that the war to end war had just been concluded.

Nothing was done until 1938 when the question of the status of the women doctors was again raised. If one has not worked in a service it is difficult to appreciate the importance of 'status.' I had not understood it myself until the consequences of lack of status were explained to me. I imagine that, before going abroad to serve, the women doctors in the first war shared this innocent point of view. In any case they made no attempt to argue about their status—they found out about its importance later. For instance, women doctors abroad sometimes had to travel disguised as soldiers' wives or as V.A.D.s; the doctors had no status, therefore a pass could not be given; the wives and the V.A.D.s had got status, so a pass could be given!

Again in this war, as in the last, the women doctors were told they would not be wanted. Again the Services changed their mind and decided that they did want women doctors after all. In both cases this new decision was taken at a time when the fortunes of the country were at such a low ebb that it was impossible to protest very strongly against conditions of service. In this war, however, women doctors were given the same pay, promotion and so on as their male colleagues, but they were not members of the medical services, they only worked with these services. In point of fact it worked well, largely, we believe, for two reasons; firstly, many doctors of either sex did not know that there was any difference, and secondly, there was real goodwill in high places and a determination to smooth out the situation. It was obvious, however, that the position was fundamentally unsatisfactory.

After 1945 the Medical Women's Federation felt that though the financial terms were now satisfactory, the question of status was still outstanding. Women doctors were in a position quite different from anyone else. They were not in any service at all, that is to say they had not the protection of a service; they were only working alongside the male medical services. It had always been said that women could not legally hold land forces' commissions; this, however, turned out to be a myth. The Medical Women's Federation appealed to the British Medical Association and were successful in getting unanimous support from all except their Armed Forces' Standing Committee, who argued that women doctors could not be put in the front line and were therefore different from their male colleagues. The Medical Women's Federation agreed that the Army might not want to have women in the front line (though, i

of course, in emergency anything may happen), but it was pointed out that many of the men doctors were in categories which made them not only unfit or unsuitable (i.e. consultant surgeons and physicians) for the front line, but some of them were even unfit for service abroad.

It was finally agreed, in 1950, that medical women would in future be commissioned in the R.A.M.C. and the R.A.F.M.B. in exactly the same way as their men colleagues, and that they would hold the same rank titles. The Medical Women's Federation was happy to be able to report that it had gained all its objectives.

In 1944 the Interdepartmental Committee on Medical Schools (known as the Goodenough Committee) produced a report on medical education in general, including, of course, that of women. The Medical Women's Federation was asked for a memorandum. This needed much consideration, for women doctors have always felt that their aim was to arrive at a state of mind, in the profession and outside it, when the question of the sex of the doctor did not primarily arise—a doctor to be a doctor, and only secondarily it might turn out that the doctor be a man or a woman. In such conditions all opportunities would be open and a woman would be appointed to any position in the profession, provided always that the individual woman was the best doctor available. In such circumstances special training schools and special hospitals for women would be redundant. Had such a moment arrived? The Council of the Medical Women's Federation knew that it had not arrived to the full extent. For instance, there was the medical school which had taken women students for several decades and had never given one of these students any post-graduate experience by appointing her to a resident job in the teaching hospital until 1939—not a good story. In another, the woman gold medalist of the University of London could not get anything higher than a first house job. In the public health service it was, and still is, difficult for a woman to be appointed to any of the senior positions. The Federation felt, however, that the moment had come to take the plunge, to risk something so that their aim that there should be no differentiation between men and women should gradually be accomplished. They recommended, therefore, that all schools should be co-educational (which meant, naturally, that the London (Royal Free Hospital) School of Medicine for Women should be included), provided always that the schools accepted post-graduate as well as undergraduate education as their responsibility. The Goodenough Committee reported in accordance with this memorandum, and its advice has been accepted. The Royal Free Hospital, which took women students

first and then took women as resident doctors and finally gave some of them staff appointments, became co-educational. Before that, the students were all women, but the patients and the honorary staff were mixed; now the students are young men as well as young women. All the schools which had been exclusively male agreed to take a limited number of women students.

The special hospitals are a little different, as in this case the needs of the patients have to be considered, and there are still a large number of women who like to go to a women's hospital where they know they will be treated by a woman. However, under the National Health Service most of these hospitals are now part of a larger group and as such are not isolated.

There are doctors, even women doctors, who while agreeing presumably that the special women's efforts, including their special women's associations, were necessary in the early days, have thought for many years that they were unnecessary and even harmful to women as they stressed the question of the sex of the doctors. I feel a certain sympathy with this point of view, but I feel sure that it was wrong with regard to the past. I think it is noticeable that the status of women doctors is higher where these special hospitals exist. This is perhaps not surprising, for why should our colleagues accept that women are capable of being efficient in any branch of medicine until they have proved themselves so to be? In general practice this was possible; it was the patient only on whom the success of the G.P. was dependent, and a great many women doctors have been highly successful in standing this test. But as far as other branches were concerned, appointments had to be made, and women could not prove their worth unless they were given some of these positions. The special women's hospitals gave consultants these opportunities. In the public health service it is still difficult to reach the top. It is not only in certain areas in this country that it is noticeable that women who have not proven their worth in a women's hospital are not so readily appointed to higher positions. In many other countries women doctors do not feel in any sense that they have equal opportunities, and in these countries it is often the case that women doctors have not shown the same corporate enterprise as in this country.

With regard to the future, we are all hoping that the fact that the special hospitals are being merged into other groups will certainly benefit these hospitals and will not be harmful to women doctors individually. With regard to their special organisation I and many others believe that the Medical Women's Federation should remain in being for the present.

The idea of it was born in 1915, and the prime

mover was Dr. Jane Walker. It was a union of various women's organizations over the British Isles, and it aimed at giving, as far as possible, local autonomy to all its constituent local associations. To this day, though the offices are in London, about half the Council meetings are held elsewhere. The Federation was actually formed in 1917.

All women doctors would probably agree that such an association was necessary in the past, but what about the present and the future? Women in medicine are in a minority, and it is generally agreed that it is wise for minorities to have a special organization so that the minority view may be kept before the majority, which may have nothing but goodwill towards the minority but which, being composed of human beings, is apt to put its own views in the forefront. However, are there still occasions when this minority view is not identical with that of the majority? Yes, there are. For instance, at most meetings women doctors are in a minority and it would seem natural that this limits their chance of election to administrative committees, limits it out of proportion to their lesser numbers. This happens indeed to such an extent that the Council of the British Medical Association had to point out that they felt, at times, the need of a woman on their Council who was knowledgeable and experienced in women's affairs, and could give them such specialized advice. They suggested, therefore, that such a woman should be elected by the women doctors in the same way that they already had two public health officers, these doctors also being insufficiently represented on the Council on account of their minority position. The Federation accepted the B.M.A. suggestion with some trepidation, as they did not want this one woman to prevent the election of women through the ordinary channels.

As the British Medical Association has had in its constitution for many years 'There shall be no differentiation solely on account of sex,' are there still any special women's problems? Yes, there are. As already pointed out, it is only just the other day, for instance, that the problem of the position of women in the medical services of the Crown reached a satisfactory conclusion.

The British Medical Association helped the Medical Women's Federation in its efforts to achieve this, and the latter published the following in its journal:—

'We are most grateful to the British Medical Association for its valuable and, indeed, vital support. It is important to realize that it was because the Federation was able to speak through the women members' representative on the Council of the B.M.A. that this complicated subject at last became to be so completely understood and

appreciated by that body. The importance of the support of the B.M.A. cannot be stressed too strongly. It is another instance of the Association's willing co-operation when an organization can place before it convincing evidence of the rightness of its cause.'

Again, during the war, a cost-of-living bonus different for men and women was given. This was also put right with the help of the B.M.A., but only after the Medical Women's Federation had produced facts and figures proving that this contravened their principle of equal pay.

Several other smaller injustices occurred in the war, all put right after the Medical Women's Federation had brought forward their existence, but the B.M.A. agree that it would have been difficult to focus enough attention on the problems had it not been for the perseverance of the Medical Women's Federation. In the Colonial Service differentiation is apt to occur unless the position is kept under review.

I feel certain that for some years at any rate there will be much work for the Federation to do. As in the past, it will work with the British Medical Association. There has been, and I feel sure there will be in the future, absolutely no antagonism between the two bodies.

I believe that with the coming of the Health Service there will be many problems for the Medical Women's Federation to face. On the central committees women have been appointed not as representatives of the Federation (none of the members are representatives), but largely on the advice of the Federation. There are, however, many regional and local executive committees which have no women members or an insufficient number of women members, and though equal opportunities have been promised, I fear that we may find that difficulties will arise, not from ill will but from ignorance. There are the peculiarly woman's questions such as the work and opportunities of the married woman, part-time and partnership problems, etc. There are medical advisory committees, regional and hospital management boards, some members of which have never met, let alone worked with, a woman consultant. It will take them some time to get used to the idea that a woman might be appointed. I am quite certain that it is due to the existence of the Medical Women's Federation that even the limited number of the appointments of women in the service have been made. I feel, however, that women doctors are near the achievement of complete equality of opportunity, though they have not yet reached it. The position is now that there are many women doctors in successful general practice all over the country. In the early days it was almost impossible for a woman to buy a practice. They

were obliged to set up a plate and very gradually build up their practices. This they usually did without much difficulty. We must hope that the executive committees (on which women doctors are not really adequately represented), now that they have some say in the matter, will protect their interests.

In public health and the ministries there are a number of women and some are in very responsible positions; women are doing research and there are many women consultants all over the country, though it is noticeable that in certain areas large hospitals, especially non-teaching hospitals, have no women on the staff. It is, I think, the first step which counts; once a woman has been appointed, if she is a wise woman and good at her work, our male colleagues get used to the idea and the next time a woman applies she is more or less considered on her merits. The first woman to be appointed anywhere has a great responsibility, as if she is not found to be a good colleague the

pendulum swings back and another chance is not given for some time.

There are several professors in the big teaching schools, there are women doctors in the higher academic positions and the big main administrative councils, and there is one of whom we are particularly proud, Professor Hilda Lloyd, President of the Royal College of Obstetricians and Gynaecologists.

On reading over this article it appears that I have given the impression that women doctors have had a fairly smooth path to follow, suggesting that they have progressed from none to ample opportunities without stress and strain. This is not, of course, the case; but in remembering, with gratitude, all that the pioneers have done for us, I expect it is wise to remember that all pioneers, in no matter what direction, are apt to meet with the same obstructions. They are not like us; they are 'naturally of the stuff that martyrs are made of.'

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The Editor,
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SIR,

I was much interested in the report of clinico-pathological conference No. 14 held at the Postgraduate Medical School, Hammersmith Hospital (July 1951).

The case discussed, fulminating meningococcal septicaemia with adrenal haemorrhage contracted on the tenth day of life, may possibly be the youngest on record. Under the age of six months I know of no recovery from this syndrome.

As was pointed out, whole adrenal cortical extract in the dosage usually given is relatively inactive. Faloon, *et al.* (1951), controlled the treatment of a case, aged 17 years, by the eosinophil count and found that dosage of 20 cc. intravenously followed by 10 cc. every hour for six

hours and then three-hourly for some days was necessary to keep the eosinophil count below 15 per cmm. The suggestion that cortisone may be more effective than eucortone is a valuable one, and the drug should be made immediately available for this type of case.

Prof. Dible mentioned that he did not know whether there was specific localization of meningococci to the adrenal in this type of case. I can answer this question in the affirmative. The evidence is clear from sections prepared from a similar case (child of three years; illness 13 hours' duration) by Dr. E. H. Bailey of the Southern Group Laboratory, Park Hospital. They clearly show capillaries stuffed with meningococci among the degenerated cells of the adrenal cortex. As far as I know this evidence has not been published elsewhere than in 'Modern Practice in Infectious Fevers,' Butterworth, London, page 317, Figs. 77 and 78.

Yours sincerely,

H. STANLEY BANKS.

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