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The Chest=Piece

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"In necessariis unitas, in non-necessariis libertas, in omnibus caritas."

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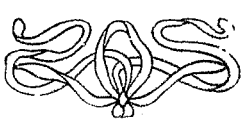

We acknowledge receipt of the following Journals; we apologise for any omissions:

"The British Medical Journal".
"The Practitioner".
"The British Medical Students Journal".
"Scientia".
"Revue Médicale Université de Montréal".
"Journal of Obstetrics and Gynaecology of the British Empire"
"Gazzetta Sanitaria".

EDITORIAL

We make our bow again to our many friends. Need we justify our absence? It was due more to the lack of training in the practical side of journalism amongst the student body than to anything else.

You will all have noticed that the Shakespearean quotation under which previous editorials were written has been dropped. We sail under a different flag now. Not one implying criticism but one of encouragement to each one of our readers to come forward with new ideas, new theories and to share them 'ad majorem populi commoditatem'. The implied criticism of "The fault dear Brutus...." could certainly not have been directed against our predecessors as they inserted it themselves nor will it be against the present generation "unless we fail to do the important things that lie to hand and continue to indulge in an orgy of self-pity and belittlement. We will not succeed if we lose faith in ourselves." (Prof. Topping).

An article on Geriatrics by a student contributor appears elsewhere in this issue. Leonardo da Vinci I believe gave us the first lesson on Preventive Geriatrics in the last lines of his description of the autopsy on the old man he saw dying in the Ospedale di S. Maria Nova at Florence "di si dolce morte". They are still true today: "Acquista cosa nella tua gioventù che ristori il danno della tua vecchezza. E se tu intendi la vecchezza aver per cibo la sapienza, adoprati in tal modo in gioventù che a tal vecchezza non manchi il nutrimento."

This term has seen the enrolement of the greatest number of freshmen in the history of the Faculty. This is indeed a very good sign and we extend a hearty welcome to our young colleagues.

They have entered the ranks of an ancient and noble profession. From this moment demands will be made on your time and your strength that will have to be met. A struggle for survival is now on and will not leave you till you retire. Medicine is all the time changing. Today you will have to keep up-to-date. But always you will be studying. And you will be expected to give of your best all the time. If you don't you may fall on the wayside. You have been warned.

Rumour has it that the curriculum is finally about to be changed to meet the needs of the time. We hope that it will also meet the needs of the various fields our graduates are likely to enter, which are General Practice, the Colonial Service and the R.A.M.C. Up to now the University has turned out very good G.P.s and other Colonial Governments are, or seem to be, happy with the doctors they have from Malta. Could not our School improve on what we have already rather than imitate the younger English schools? Rumour also has it that the Government does not mean to take in more than 20 housemen from among the newly qualified next October. This is unfortunate in view of the present lack of doctors in all the State hospitals. We need not specify. However may we point out that there are no "Junior House Officer" appointments in Pathology, Bacteriology, Radiology, Anaesthesia, Geriatrics and Fevers, and that the departments of Gynaecology, Tuberculosis, Casualty (S.L.H.) and all Out-Patient Clinics could certainly do with more help.

And this before the introduction of a Free Hospital Service.

Roseola Infantum

Report on a case by

E. A. CACHIA M.B., Ch.B. (Manch.), D.C.H. (Lond.)

"In the majority of infants and children between the ages of six months and three years, there occurs a disease in which difficulty of diagnosis for the physician and worry for the parents can hardly be greater during its stormy three to four-day course, and can hardly be less when the rash, diagnosis and end of the disease all happily appear at one and the same time." (1).

On the morning of 10th November 1954 a healthy well-nourished male, (P.M.), 10½ months old, was noticed by his mother to be slightly "off colour". She took his temperature but there was no fever. He took his morning feeds quite well, but refused almost all food in the afternoon. At about 6 p.m. the baby was felt to be hot and a temperature of 102.2°F. (rectal) was recorded. There was no cough or any catarrhal symptom. Examination of the baby did not yield much help towards towards arriving at a diagnosis. The lungs were clear; the spleen not palpable; there were no enlarged lymph-nodes; both ear-drums were normal; the pharynx was very slightly congested; there was no evidence of meningeal irritation; the urine and stools were normal. A provisional diagnosis of an upper respiratory tract infection was made and Penicillin was given by injection that same evening in 8/hourly doses of 500,000 units. The baby passed a restless night and he began to vomit the glucose/saline drinks which were offered to him. Penicillin was continued on the second day of the illness, yet the temperature rose to 105°F (rectal). The baby was now drowsy, but very irritable. The vomiting, however stopped. The baby was again examined but this yielded no concrete results. The Penicillin was discontinued and Tetramycin 150 mgms 6/hourly was given instead.

On the third day of the illness the temperature was 102°F. (rectal) in the morning and 103.2°F. (rectal) in the evening. The baby was still very restless in the morning, but in spite of the fever he began to brighten up in the afternoon. The persistent fever caused some anxiety about possible developments. The morning of the fourth day found the baby afebrile and a good deal happier. There was no critical perspiration during the rapid subsidence of the fever which occurred during the night. In the evening a rash appeared on the abdomen, consisting at first of a few rosered macules 2 to 3 mm. in diameter, which were not elevated above the skin and faded on pressure.

On the following day the eruption spread to cover most of the trunk and neck. There were no macules on the face or extremities. The baby remained well and there was no coming back of the fever. A diagnosis of Roseola infantum was made. The rash faded on the sixth day and there was an uneventful recovery. There was no pigmentation or desquamation. An examination of the blood on the seventh day revealed characteristic cellular changes: —

W.B.Cs . . . 6000 per c.mm.	Polymorphs . . . 11%
	Lymphocytes . . 79%
	Eosinophils . . . 2%
	Monocytes . . . 8%

Comment.

Roseola infantum is very little heard of, but it is probably far more common than is realised. The diagnosis is often missed unless the condition is kept in mind.

The first detailed description was given by Zahorsky (2) in 1910 and 1913, but little attention was given to these papers until

the simultaneous publication of papers by Levy and by Veeder and Hempelmann in 1921. Veeder and Hempelmann first called attention to the characteristic changes in the cellular content of the blood. These have since been corroborated by numerous observers.

The disease is known by a variety of names — Roseola infantum, the Rose-Rash of infants, Exanthema subitum, Exanthema criticum, Pseudorubellla, Critical Pre-eruptive fever, Sixth Disease.

The specific aetiology is unknown. A virus infection is however the most likely cause. Other possibilities put forward are i. allergy and ii. grippe-like infections. (3) Very characteristically, fully 95% of all cases occur in infants under 2½ years of age. 75% of all cases are found in infants between 6 and 18 months old.

The incubation period is 8-14 days, though Garvin puts it at as long as 41 days. The onset is sudden, and quite often fever is the first symptom to be noticed. Vomiting is common. Convulsions may set in initially and this has been observed on several occasions. At this stage Meningitis or Encephalitis may be suspected. The infant is restless, constipation is more frequent than diarrhoea, and often the child may wake up frequently at night with sudden cries of pain, suggesting an acute Otitis.

The fever falls by crisis on the third or fourth day when there appears a rubelliform rash, first on the back and abdomen, later rapidly extending over most of the body, but with remarkably fewer lesions on the extremities and the face. The rash may occur on occasions before the temperature has dropped to normal, but almost never until the temperature has started on it's downward course. There are no important complications or sequelae.

The blood findings are striking. On the first day a slight leucocytosis may be found, but on the second, third and fourth days of the disease a progressive leucopenia develops. The leucocyte count ranges from three to five thousand. The principal feature is a granulocytic leucopenia. The lymphocytes are relatively, if not actually, increased up to 70 or 90%. After the eruption the blood picture rapidly returns to normal. The question of communicability is still uncertain; but several epidemics have now been described. (4) (5) (6).

The diagnosis offers two problems:— (i) the recognition of the disease during the pre-eruptive stage; (ii) the differentiation of the eruption from other exanthemata.

In the pre-eruptive stage diagnosis is based on all clinical manifestations of other common diseases of infancy and early childhood. A blood examination reveals the characteristic picture. The differentiation from Measles and Rubella with which it may be confused is not difficult. The absence of Koplik spots, photophobia, coryza and conjunctivitis, differentiates it from Measles, while the time of appearance of the rash and the lack of enlarged tender lymph-nodes, distinguishes it from Rubella, which is rare in infants.

Treatment is purely symptomatic.

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Advances in medicine are like salesmen knocking at your door. Hear them before you dismiss them.

ANGLO-SAXON MEDICINE

A. J. Bliss M.A. (Oxon), B.Litt.

Among the Anglo-Saxons there were two distinct schools of medicine. The first was based on the traditional pagan lore of the Germanic tribes, brought over by the invaders from the Continent; it relied largely on sympathetic magic, and its remedies were accompanied by incantations and elaborate rituals. The second is derised from Latin translations of the early Greek physicians, and although its practice seems primitive enough from the modern standpoint, it is scientific in so far as the ailments treated are recognized as physical in origin, and the remedies prescribed make use of the physical properties of the substances used.

The traditional pagan medicine is known to us partly from a number of early *Charms*, mostly in verse, and partly from a collection of recipes known as the *Lacnunga* (prescriptions), which, though it is a late compilation, seems to preserve a good deal of early material. The Anglo-Saxons, of course, were nominally Christian from an early date, but there is ample evidence that a body of pagan superstition long survived under a veneer of Christianity; some of the surviving charms are still purely pagan in form, but others have been partially or completely christianized, and invoke the aid of Christ or the Saints instead of that of the Germanic divinities.

A characteristic charm is one which is designed to cure a pain in the side, perhaps what we now call a 'stitch'. The ointment prescribed is compounded of feverfew, red nettle and dock leaves boiled in butter; but the application of the remedy is to be accompanied by a long incantation in verse and a somewhat obscure ritual involving the use of an arrow, a knife, and a number of spears. The pain is attributed to the activity of witches, and the weapons are used for the counter-attack. It is evidently essential that both the source and the site of the pain should be exactly named: so it is attributed in turn to gods, elves and witches, and located in turn in the skin, the flesh and the blood. Finally the pain is banished to the mountain-tops.

The neo-Greek school of medicine is known to us from a number of sources, all from the late tenth or early eleventh centuries. There are two systematic medical treatises, the *Leech-book* and a work known as *Peri Didaxeon*, in which the various diseases are treated according to the part of the body they affect. Two further treatises deal with the *materia medica*: the *Herbarium Apuleii*, attributed to Lucius Apuleius (better known as the author of *The Golden Ass*), but in fact based on a Latin translation of Dioscorides, deals with vegetable remedies; the *Medicina de Quadrupedibus* deals with animal remedies.

Few of the herbs mentioned in the recipes can now be identified with certainty. The English names have mostly passed out of use, and although Latin names are often given as well, the nomenclature of botany has changed so much since the Dark Ages that they are of little use. Not only the remedies but the diseases themselves are often hard to identifh. What is meant, for instance, by 'dry-rot disease'? Perhaps tuberculosis, but there are many other possibilities. Equally obscure are such complaints as 'neck disease' (perhaps goitre) and 'disease in the jowl'. Because both the diseases thmselves and the constituents of the remedies are doubtful, it is impossible to determine whether there is any empirical basis for the prescriptions.

An astonishing feature of the prescriptions, both vegetable and animal, is the wide serviceability of a single ingredient. A herb called *hostriago*, for instance, will cure any kind of unpleasant growth, outbreak or swelling on any part of a man's body. Still more surprising are the uses to

(*continued on page* 25)

THE AUTUMN OF LIFE

Richard Manchè

—*"Does any here know Lear? This is not Lear."* — (SHAKESPEARE)
—*"Science has given us more years in which to live; now physicians must help solve the problem of giving life to those years."* — (STIEGLITZ, 1946)
—*"At the age of fifty beginneth Old Age which containeth all the rest of our lives."* — (LAURENTIUS, 1599.)

Interest in the diseases of the aged started with Aristotle nearly 2000 years ago and we find a definition of eugeria in the Rhetoric (1:5.) In 1635 William Harvey described a post-mortem he performed on a man of circa 152 (!) years, after which interest on-and-off never died. However it was only as late as the nineteenth century that a study of these diseases was made under the heading of gerocomia and the present century has seen a revival which may last. The study of diseases of children having been labled paediatrics, the study of diseases of the aged has been dubbed geriatrics and the study of their causes gerontology.

Geriatrics is not a speciality in the medical sense. It is more an attitude of mind which makes us aware of the processes and results of ageing, senescence and senility. Therefore we may almost say that geriatrics embraces all the specialities.

Geriatrics is concerned with the health and the treatment in illness of the aging and the aged. In many respects the aging are a more important group than the aged and the normal more than the abnormal for geriatrics is more preventive than curative. Geriatrics is as yet an infant science whose future depends on society as well as on scientists and the practice of constructive medicine offers great hope for its future.

The object of geriatrics is to add breadth and depth rather than mere length to life and to assist mankind to realize fully its potentialities.

In general the infirmities of the aged are an accumulation of many conditions. I have attempted, within the limitations of this short paper on so vast a subject, to discuss some aspects of geriatrics and to focus attention on a few problems that present themselves to the geriatrician.

MEDICAL ASPECTS.

Most diseases can and do occur at any time of life, but there are some the frequency of which increases after the peak of maturity is reached and which are the peculiar problem of geriatrics. These are: Circulatory and renal diseases; Metabolic dysfunction; Arthritic disorders and Neoplastic diseases. They are all degenerative disorders the cause of which is obscure; all are of a silent insidious onset and their course is characterized by a long period of increasing disability and invalidism. Diagnosis is made difficult by the overlapping of several progressive abnormalities in the same patient. The obvious conclusion here is to anticipate the diseases before they become apparent by periodic health examination on an annual basis after middle age.

Pain is the next important problem after disease. This is relieved by elevating the pain threshold with the opiates, small amounts of which in the elderly usually serve to relieve pain. Geriatric patients usually present themselves at the clinic complaining of an acute disease which on examination is found to be accompanied by one or more of the chronic diseases. Naturally one does not attempt treatment of the chronic disorder. Furthermore the acute stage may distort and mask the usually quiet chronic complaint so that accurate

evaluation is impossible. But it is important in examining this type of patient that these factors be kept in mind and that search for chronic states be instituted shortly after recovery from the acute illness.

Drugs available to Geriatricians are largely endocrine products such as insulin, adrenal cortical extracts, thyroid and liver extracts, folic acid, pancreatin, estrogens and testosterone. Practically all other drugs available act by ameliorating symptoms such as the vasodilators, sedatives, expectorants, diuretics, analgesics, antispasmodics and the antibiotics which by decreasing the severity of infectious diseases retard the development of certain degenerative disorders. Progress has been made in geriatric drug therapy but has been slow in relation to the importance of the subject.

Other medical aspects include the management of the climateric in women and not uncommonly in the male. The best and most effective is substitution therapy with natural estrogens. There is some diminution in production of androgen as men grow older which may sometimes produce symptoms similar to those of women. Testosterone is here helpful.

SURGICAL ASPECTS.

Following improved techniques and the increased availability of the antibiotics surgical risks in geriatrics are diminishing. Also the advances made in anaesthesia can now face the perilous course of major surgery in the elderly patient.

Treatment of malignacy constituted a large portion of geriatric surgery in the past. Now elective procedures are gaining importance e.g. repair of hernia in older persons (the cause of small bowel obstruction.) Also in cases of arteriosclerotic gangrene use of sympathectomy may forstall amputation. Progress of vascular surgery now offers hope of saving the limb in cases of embolism from cardiac disease. The importance of early diagnosis and surgical removal of the clot is evident. Healing of a painful ulcer may make a bedridden patient ambulatory.

Of course preventive measures will reduce the number of elderly patients attending the fracture clinic. The family of the patient should be taught to appreciate the fact that visual acuity and auditory perception is lessened and that gait and balance are impaired and that therefore rugs on slippery floors should be removed; bathing should be supervised; use of a car should be restricted. All these household hazards to the aged should be removed.

Concerning the operative procedures "an hour of gentleness is safer than ten minutes of trauma" said Rowntree. Vessels are sclerotic, tissues friable, the mesentery tears easily..... and time may be wasted trying to control bleeding caused by rough handling. Blood volume must be adequately maintained and whole blood must be available and replaced as it is lost. Shock ensues quickly and is not recovered from as rapidly as in the younger patients.

The immediate post-operative period in geriatric patients presents its peculiar complications. The benefits of early ambulation cannot be overlooked and patients should be permitted or forced to get out of bed as soon as conditions permit.

NUTRITIONAL ASPECTS

What influence has nutrition on the process of aging? Animal experiments prove that dietary measures induce significant improvement in health and longevity. In man there is direct correlation between life expectancy and nutrition.

Clinical conditions that result from malnutrition are principally the vitamin deficiency states. Obesity, on the other hand results from over-feeding as also do atherosclerosis, diabetes mellitus and senile cataract.

For women, the late fifties and early sixties are most hazardous from a nutritional standpoint. Elderly men may need more calories.

One can approach the problem of nutri-

tion in the elderly by consideration of water. Total intake of beverage fluids should be such that the 24 hour urinary volume is not less than 1500 cc.; fluid intake should vary from 2000 to 3000 cc. Proteins are important since a state of negative nitrogen balance is a common occurence and an intake of 1.4 Gm. per Kg. of bodyweight per day is recommended. Fats should be decreased. The diet vitamins should receive liberal addition. Of the minerals calcium and iron are most likely to be deficient, and anaemia is commonly encountered.

Nutritional therapy should be maintained for long periods as the response of the metabolism of old people to dietary changes is a sluggish one.

PSYCHOSOMATIC ASPECTS.

Mental changes of considerable magnitude occur naturally in the ageing process.

The most common major mental disorders in geriatric patients are senile dementia, psychosis with cerebral arteriosclerosis and involutional melancholia. The key to proper therapy lies in an understanding of the prodromal symptoms of the mental disorders of late life.

The menopausal syndrome including nervous and vasomotor symptoms is common in about 20% of all women. In its development persistent hypochondriacal trends are a warning sign.

Active treatment of actual psychoses is based largely on correction of reversible contributing factors, including circulatory disturbances; on rest and sedation; exercise, occupational and physical therapy and psychotherapy. Other methods include endocrine substitution therapy, use of cerebral stimulants in depressed patients and shock therapy.

Practically any of the neuroses, psychoneuroses and psychoses may occur in elderly patients. Also mental confusion, disorientation, memory defects and unstable emotionalism may follow physical illness fatigue, marked anaemia, long standing nutritional deficiences and congestive heart failure. When encountered in the aged they require special diagnostic and therapeutic skill.

CONVALESCENCE.

The time required for convalescence increases with age. Changes in the capacity of tissues to repair after traumatic, toxic or metabolic injury are both quantitative and qualitative. Old tissues heal well but more slowly, and there can be no question that the nutritional status of the patient plays a very major role in repair. Despite the logic of the facts it is often immensely more difficult for the physician to guide the geriatric patient through convalescence than through an acute illness; yet the importance of permitting adequate time for convalescence cannot be over-stressed. A recognition by physicians of the situation in which old people find themselves is of first importance. Patients must be taught that the world still needs them and that they should not deplore too much the loss of some of their powers but should be thankful for those that remain and continue to make use of them. In institutions, doctors and nurses using sympathy, tact and good common sense are of untold help to these patients during convalescence from diseases.

THE G.P. AND THE ELDERLY PATIENT.

It has been seen that the treatment for old age resolves itself into the early care of troubles which become chronic if neglected, and advice to those already old on how best to adjust themselves to a different way of living. No elaborate equipment or skilled manipulations are necessary, and who is better able to give the required advice than the G.P. with his knowledge of the family and of the patients, past history? He is uniquely fitted to look after the elderly patient. Here Aristotle's rule of moderation in all things should be the guiding principle in giving these people advice.

ECONOMIC ASPECTS.

Shifting in the age structure of the population with an increasing proportion of middle-aged and elderly persons cannot but create serious economic problems. The expectation of life in these last 50 years has risen from 49.2 to 68 years. As the birth-rate tends to fall and emigration is increased our population structure continues to shift. According to reliable estimates, by the year 2000 approximately 40% of Americans will be 45 or older and 13% will be over 65. Nobody has as yet estimated the future situation in Malta. Nor do we know how important the part played by the elderly will be in our national economy, consequently.

If through medical care and health-education the volume of invalidism from the affections of old age could be reduced the productive capacity of the country would no doubt be increased.

However, the greater the success of medicine and social agencies in prolonging the lives of the aged, the heavier will be the burden on the tax-payer of providing pensions, small houses, communal homes and hospital accommodation. With ruthless realism Ffranycon Roberts asks: "Are we justified in spending millions on prolonging by a few months or weeks the lives of old people suffering from incurable disease, while people who are merely suffering from old age are inadequately housed and cared for?" Part of the answer is to be found in the recent discovery that old people deemed to be suffering from incurable disease or senility are often capable of mental and physical rehabilitation. Length of years does not mean for everyone diminshed capability, for did not Cato learn Greek, Sophocles write his *Oedipus* and Goethe complete *Faust* when in their eighties? In our time we have Churchill, Toscanini, and G. B. Shaw.

CONCLUSION.

Study of the problems of aging and a practical programme for enabling men and women to use and enjoy the added years of life is a challenge, not to the medical profession alone but to all mankind. The physician's approach must change from passive defence to active attack and confidence and age must be rated by health and ability rather than by time.

Physicians can do a lot to guide geriatric patients towards continued and improved health and efficiency, but they cannot supply motivation for the effort required on the part of the patient. As Stieglitz points out: "We are entering upon an Age of age. Let us make the best of it. If further ageing comes to mean continued growth, we will succeed in enriching life immeasurably. If aging is permitted to mean arrest of progress and stagnation, the second forty years mean rust and rotting. Life is change and one of the changes is that of aging. Aging is living. The time to start building health and happiness into the later years is now."

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APPENDIX I.

Table showing mortality in decennial age groups by sex for 1952 (Malta & Gozo)

	55-64	65-74	75-84	85-94	95—	
M	262	350	276	53	2	Malta
F	208	326	307	90	2	
M	22	42	42	18	—	Gozo
F	25	34	46	19	—	

APPENDIX II.

Table showing the movement of the patient population at St. Vincent de Paule Hospital for the Aged.

	Remaining on 31.12.51	Admitted in 1952	Discharged	Deaths	Remaining on 31.12.52
Males	375	163	33	108	375
Females	352	135	23	123	333
Total	727	298	56	231	708

APPENDIX III.

Table showing comparative Birth and Death Rates. — Malta and Gozo

	Births				Death-Rate.	
Year	Live	Rate /1000 Population	Still	Rate /100 total births	Infant Mortality Rate	Total Death Rate
1933	8321	33.04	206	2.4	258.26	20.21
1939	8930	33.08	309	3.3	226.98	19.95
1941	7352	27.09	240	3.1	303.45	23.74
1942	6768	25.15	227	3.3	345.15	31.97
1943	8452	31.06	293	3.3	210.00	20.49
1944	10963	39.26	334	2.9	116.30	13.25
1947	11612	38.20	304	2.5	120.30	12.62
1950	10281	32.95	280	2.6	88.51	10.33
1951	9511	30.38	205	2.2	99.78	11.10
1952	9226	29.30	221	2.3	71.75	10.69

*Appendices by courtesy of the C.G.M.O., Malta.

AN INTERVIEW WITH SIR ERIC PRIDIE
Director of the Colonial Medical Service

During the recent visit to Malta of Sir Eric Pride the BMSA had an opportunity to discuss with him the Colonial Medical Service in a brief interview. In the past several Maltese doctors have entered this service, and a report of this interview may be of interest to those of the present medical students who are inclined to do likewise.

The interview with Sir Eric Pridie was by no means comprehensive and all it did was to touch on a few points of interest in connection with the Colonial Medical Service. Those who require full information on the subject will find it elsewhere in this issue.

Before entering the service it is essential that a doctor must have passed a pre-registration year in a hospital recognised for the purpose. In addition to this it is useful, but not essential, to obtain the Diploma in Tropical Medicine and Hygiene. Other qualifications such as the DPH are of value to the doctor as they usually carry with them a better post and a higher salary.

On entering the service the doctor chooses a country of preference and if fortunate may be sent to that country but this cannot be guaranteed. Sir Eric Pridie pointed out that the Medical Service in each country was a separate independent entity and that in effect the doctor was employed by the Government concerned and not by the Colonial Office.

The Colonial medical service was only a central organisation to distribute doctors to the various countries. When asked about transfer from one area to another Sir Eric said that though there was no automatic transfer arrangement, if a doctor wished to transfer to a certain area and a post fitting his seniority was vacant in that area the transfer could usually be arranged. He added that in actual fact few transfers were requested.

It was possible to enter the service either on a permanent basis or on a short term one. It seemed that the short term was becoming increasingly popular.

Sir Eric Pridie was then asked what provisions were made for those doctors who suddenly found that their services were no longer required by a territory that had acquired self-government. It was felt that this was a question of great importance. Sir Eric replied that there was no scheme of incorporation in the National Health Service. He pointed out, however, that such an eventuality was most unlikely to occur for nobody would wish to get rid of doctors, and in fact it was more usual to wish to increase them. In the past when a territory became self-governing what usually happened was that the new government offered the doctors a choice of either remaining in their employ or of receiving compensation in the form of a gratuity. In the case of the Sudan the government had found that the gratuity (£8,000) was so generous that they were in a serious danger of losing all their doctors! The terms of compensation were the concern of the particular government involved but it was inconceivable that a doctor should find himself out of work through an acquisition of self-government or without compensation. It was not unlikely that self-government would actually increase the doctors' remuneration.

In conclusion Sir Eric Pridie said that many Maltese doctors seemed to find Northern Nigeria congenial, perhaps because it was only a short flight from Malta. He said that the climate was pleasant and the work most interesting.

E.F.D.

Catholic Ethics

Contraception.

"....a few words intended as counsel to all those who are interested in this question, especially students in medicine and doctors. We are fully aware that birth-control is at present being practised in practically every nation and unfortunately our islands have not been able to exclude themselves from the sordid company. Hence, some women may come to you asking for advice or directions as to how contraception could be affected. These women express unashamedly their desire of being relieved from the fears, responsibilities and discomforts of pregnancy. They will enquire about the instruments or about operations performed abroad for the purpose of contraception; they will appeal to your sympathy and understanding because they already have too many children or because their husband's salary is not sufficient.

Gentlemen, if you are aware of your noble mission and responsibilities, if you believe in God, if you are good practising Catholics, you should not only refuse to co-operate with such pessimists and these tempters of Divine Providence but it is your supreme duty before the Almighty to point out the evil they would be incurring if they carried out their desires. Let them know that you are physicians and not vile practitioners in things that are immoral and wrong. Above all be kind and patient and try to win these lost souls over to your sides by pointing out the evil and wrong of contra-ception. Later, if they have been convinced, they will return to thank and bless you for your sound and fatherly advice." — (*Tabone, the Rev. Prof. Paul, Human Sterilization — a paper read at the University on 13th January* 1950)

The Etiquette of Medicine!

An injunction of Hippocrates from the Arabic work "Lives of Physicians," written by Iben Abi Usaybia, who died in 1269.

Saith Hippocrates, "The student of Medicine should be gentle by birth, excellent by nature, young in years, of moderate stature and symmetrical limbs, of good understanding and pleasant conversation, sound in judgment when consulted, chaste, and courageous, no lover of money, self controlled when angered, not apt to lose his temper even under severe provocation, and not slow of understanding.

He should be sympathetic and kind with the sick and a faithful guardian of secrets, because many patients tell us about diseases in themselves which they do not wish to be known to others. He should be patient of insults, because many mad and melancholic persons meet us with such, wherein we should bear with them, knowing that such conduct does not proceed from them but is really caused by a disease external to their proper nature.

His hair should be cut neatly and symmetrically and he should neither shave it nor suffer it to grow too luxuriantly. He should neither cut his fingernails closely, nor suffer them to overgrow the tips of his fingers. His clothes should be white, clean, and soft in texture. He should not walk hastily, for this is a sign of levity, nor slowly, for this indicates faint heartedness. When summoned to a patient he should sit cross-legged, and question him about his condition with becoming gravity and deliberation, not in a distracted or agitated manner.

In my opinion this way, fashion and order are indeed better than any other."

SEMEIOTICS

— A scheme for methodical physical examination.

1 Temperature.

2 Pulse rate.

3 Respiratory rate.

4 General appearance: physical development — nutrition — decubitus — posture — gait.

5 Skin: colour — texture — moisture — eruptions — other lesions.

6 Head: appearance — size — shape — hair (distribution, character) — scalp.

7 Face: appearance — colour — tenderness — abnormal movements.

8 Eyes: brows—lids—eyeballs (movements, prominence, tension) — conjuctivae — sclerae — cornea — iris — pupils (size, shape, regularity, reactions. fundi).

9 Ears: appearance — hearing — discharge — tenderness — postauricular swelling or tenderness (drums, canals).

10 Nose: appearance—discharge—movements — Nasal cavity — septum — transillumination.

11 Mouth: breath — lips (colour, fissures, lesions) — tongue (tremor, deviation, colour, moisture, texture, lesions) — gingivae (colour, texture, pus) — teeth (number, condition, denture) — buccal mucosa (colour, eruptions, lesions).

12 Throat: palate and uvula — pillars — tonsils — posterior phranx — larynx.

13 Neck: lymph nodes — scars — thyroid — salivary glands — position — movements — veins — pulsations — oedema — trachea.

14 Shoulder girdle: deformity — swelling — tenderness — movements — muscle spasm.

15 Arms and hands: position — deformities — tenderness — abnormal movements — joints — oedema — temperature — moisture — local swellings — vessels — fingers — nails — reflexes.

16 Breasts: size — contour — masses — nipples.

17 Axillae: skin — hair — lymph nodes.

18 Back: movements — deformities — skin — swellings — tenderness scapulae — muscle spasm — oedema (especially over sacrum).

19 Chest: shape — swelling — pulsation —respiratory movements.

20 Heart: Apex beat (location, character, rate, thrill).
Measurements (right border, left border, supracradiac dullness, mid-clavicular line).
Sounds (rate. rhythm, intensity, quality).
Murmurs.
Pulses (equality, character, condition of temporal, brachial, radial vessels).
Blood pressure.

21 Lungs: fremitus — resonance — breath sounds — spoken voice sounds —rales.

22 Abdomen: size — shape — tenderness — spasm — masses — pulsation —percussion note — Liver (dullness, edge, tenderness) — Spleen — Kidneys — costovertebral tenderness — berinae — peristalsis (audible, visible) — inguinal lymph nodes.

23 Legs and feet: position — deformities —tenderness — abnormal movements — joints — oedema — temperature — —moisture — local swellings — ulcerations — vessels — shins — arches — ankle jerk — plantar reflex — clonus —Kernig's sign — Romberg's sign.

24 Male genitalia: scrotum — testicles — penis.

25 Female genitalia: perineum — vulva — vagina — cervix — fundus — vaults.

26 Rectum: anal orifice — fissures — haemorrhoids.
Internal: (obstruction, masses, tenderness, prostate).

(By courtesy of Professor Debono).

PHARMACY UNDER THREE QUEENS

(reproduced from "The British and Overseas Pharmacist, March 1952)

The first Elizabeth, Anne and Victoria were all styled "good." Now while we welcome our new young Queen "Elizabeth the Second" perhaps we may take a glance backward and see what pharmacy and medicine accomplished in previous reigns.

When "Good Queen Bess" came to the throne, nearly 400 years ago, medical art and practice had already reached a turning point. Political broils had disrupted the monasteries and abolished their hospitals and charities, which for so long had given food, medicine and treatment to the sick and needy. During centuries learned men among the brethren had imported knowledge, translated foreign manuscripts, and carried out scientific experiments, hopeful to enrich both the soul and body of mankind. Roger Bacon is a front rank example.

Monastic herb gardens were famous; many monastic pharmacies, we are told, were magnificently appointed. Those well-staffed infirmaries provided the health service of that period, and it was a free service, provided without cost to the national exchequer. Doctors were available to those who could pay, for the College of Physicians had been incorporated under Henry VIII; but the common people must look elsewhere for relief. Something had to be done.

Fortunately the art of printing had come to a head and was seized to promote home doctoring. In modern phraseology "everybody got cracking." Herbals were printed, housewives collected recipes for family use, new drugs rolled in from America and the East. The first London *Pharmacopoeia*, issued in 1618, was on its way. Its aggregate of 1,028 simples and 932 compounds reflects the standard pharmacology of that period; only 17 of these items were chemicals.

The next hundred years marked progress of sorts and brought the accession of "Good Queen Anne," the last English Sovereign to "touch" for scrofula—the "King's Evil." Doctor Johnson was one of her patients.

The fourth London *Pharmacopoeia* was in preparation under the guidance of Sir Hans Sloane. It registered marked changes from its predecessors; old things were passing, but all things had not yet become new. Many more books were issued, notably Fuller's *Pharmacopoeia Bateana* and Quincy's *Compleat English Dispensatory*. As a guide to the state of medicine early in the eighteenth century, the latter work is a useful possession, and one which repays perusal. In Anne's regin, too, the somewhat earlier works of Glauber and Culpepper gained popularity, a pointer surely to the coming fusion of chemists and druggists.

It is difficult to epitomise the great Victorian epoch, to set down a mountain of progress within a few written lines. Science surged forward, carrying medicine and pharmacy with it. Hospital layout assumed a departmental character, giving scope to specialised clinical and surgical treatment, to the checking of infection and to prevention of disease.

Where and to what results will the reign of Elizabeth II take us? The kaleidoscope of pharmaceutical achievement will keep on turning, the pictures can be seen only as they fall into shape. In an early design we saw preponderance of plant drugs and few chemicals, a condition that is now reversed. Turn again and we see the picture of the discovery of Glauber's Salts, a lonely chemical flanked by vegetable remedies; now the plant product, penicillin, shines amid a host of chemicals. The tale of the future, therefore, is probably one of reversions, re-formations, new figures — an everchanging tableau and progress ever hurries us forward to unimagined goals.

AVICENNA

"The Prince of Physicians"

Nearly 1,000 years have now passed since the life-time of the great Arabian physician and philosopher Avicenna (Ibn Síná, the Son of Síná). Born near Bokhara in 980. A.D., he spent most of his life in Persia where he died in 1037. Although the intervening millenium has witnessed an enormous extension of human knowledge, Avicenna's fame has increased rather than diminished, for his greatness was based not only on his eminence as a physician and on his contributions to medicine, but above all on his universal genius. Like Aristotle and Leonardo da Vinci, Avicenna had a command of the entire range of knowledge of his day.

Even as a child Avicenna attracted attention by his insatiable thirst for knowledge and the early maturity of his mental powers. At the age of 18 he wrote a comprehensive work embracing the whole of the scientific knowledge of his day. By this time, he had already gained a reputation as a successful physician. His writings include nearly 100 books on theology, metaphysics, astronomy, natural philosophy, political questions and medicine. His "Canon of Medicine", a treatise in 5 volumes, remained a standard work for centuries, and as late as the 17th century it was still used as a text-book at the Universities of Montpellier and Louvain. In this work, Avicenna did not merely record the teachings of Hippocrates and Galen, as is often disparagingly claimed, but also attempted to reconcile his own experience and ideas with their writings. His personal contributions to the "Canon" show that he was a keen observer and did not shrink from replacing traditional teachings by his own observations. Thus, he recognized that the retina is the part of the eye principally concerned in vision, whereas formerly the lens was held responsible for this function; he also emphasized the connection between emotions and physical symptoms, differentiated between the principal forms of icterus, and drew attention to the transmission of certain infections across the placental barrier.

Although a tireless worker, who devoted himself to his writings even when travelling, Avicenna also valued the lighter side of life and enjoyed good company, poetry and music. He died at the age of fifty-seven in Hamadan, where a large mausoleum was recently erected over his grave in honour of his memory. Avicenna was known during his lifetime as "The Prince of Physicians", and certainly the universal nature of his genius has earned him a place among the sages in the annals of mankind.

T.

The facts of today were fancies yesterday and will be memories tomorrow. Practically every deed was once a dream; every invention once an imagination.

———— :O: ————

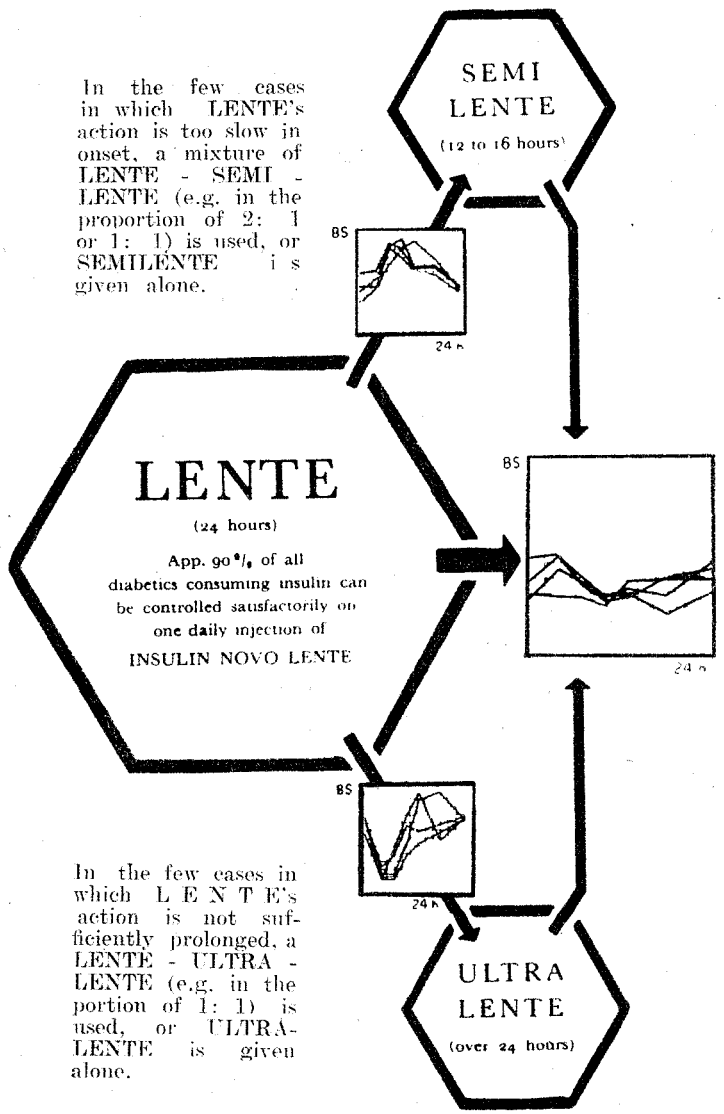
Tests may be time-consuming; they are life-saving.

———— :O: ————

Sleep is a reservoir of strength, an escape from care and worry, a restorer of hope, an opportunity for dreams.

———— :O: ————

ONE INJECTION PER DAY WITH THE "NOVO" LENTE INSULINS



The ever increasing use of "NOVO" LENTE INSULINS in private practice and the supply of 30.000 vials of 10 cc. each (300.000 does of 1 cc.) of NOVO LENTE INSULINS to the Medical & Health Department for use in government hospitals and dispensaries in Malta and Gozo provide convincing evidence of their effectiveness in the treatment of diabetes.

MALTA AND THE I.F.M.S.A

Peter Fenech

Honorary Treasurer, B.M.S.A.

A delegation from Malta attended for the first time the General Assembly of the International Federation of Medical Student Associations, which was held in Rome from October 1—5. The four members of the Malta Branch of the British Medical Student's Association were:—

Mr. Edward Debono, President, Mr. Joe Demartino, Vice-President, Mr. Anthony Jaccarini, Honorary Secretary, and myself. The passage to and from Rome was financed by the Malta Government whilst individuals and various organisations also contributed a share of the expenses.

In the opening session of the Assembly Malta had the honour to be unanimously accepted as a full member. Others accepted were Italy, Switzerland and Turkey. The next business before the Assembly was of a peculiarly critical character. The International Union of Students had sent an observer to attend the I.F.M.S.A. Assembly, without having had an invitation. Owing to the political nature of the I.U.S. the Assembly adopted the British proposal that the I.U.S. man should leave the hall straight away. Mr. Debono agreed with the British proposal and addressed the Assembly accordingly.

However, more important than the general meetings of the Assembly, were the standing committees. In fact the main activities of I.F.M.S.A. are controlled by these committees. Thus Mr. Debono attended the committees on International Relationship and on Student Health; Mr. Demartino attended the Committee on Professional Exchange; Mr. Jaccarini that on Medical Education and I attended the one on Publications.

At the last sitting of the Assembly, held in the evening of the 5th October, the delegate from Turkey was elected Chairman of the Standing Committee on Publications and Malta was offered Delegation responsibility of the Advertising Committee, with the task of writing to drug houses for possible advertising and sending any adverts to the "COSEC" in Holland. Owing to the fact that this was our first international meeting and chiefly because of our geographical position, we felt we could not accept this. This was then offered to Switzerland.

Strong efforts should be made by all concerned so that at least two delegates from our Branch of the B.M.S.A. shall attend the annual assemblies of I.F.M.S.A. Before, Malta was just a name or even not that. Our contact with the delegates served to show them what Malta is. There were two delegates who did not know that a place called Malta existed in the world. I sincerely hope that Professional Exchange will be got going in our island.

By this exchange, foreign students will be able not only to see our island but also to notice our high academical studies. On the other hand, our students will likewise benefit by going abroad.

A personal impression is that our medical education is one of the best and compares favourably with the majority; what we lack is clinical practice; all delegates told us that they start attending hospitals right from their first year. One last point is that all countries, except Sweden and Yugoslavia, have a surplus of doctors.

The organization of the Assembly was well-nigh perfect, and the Italian Medical Students' Union organized a full-day excursion to Naples and Pompei, whilst a first-class reception was held in honour of Dr. Lench, Treasurer of the World Medical Association. At this party distinguished members of the Italian medical profession as well as of elsewhere were present.

CAREERS

1. THE ROYAL ARMY MEDICAL CORPS.

The R.A.M.C. provides a life career with service on the active list up to the age of 57. After retirement employment as a retired officer is up to 65.

Fully registered medical practitioners who are British Subjects and whose parents are British Subjects are eligible for regular commissions if they are under 33.

PROMOTION. Selected candidates who have no former service join in the rank of Lieutenant and are promoted Captain after one year; to Major after 8 years service; to Lieut-Colonel by selection at about their 17th year and to Colonel about their 23rd. year of service.

INCOME. A) Basic Pay: Lieut.: £483 — Captain: £593-803.
Maj.: £1003-1277. — Lt. Col.: £1332-1600.
Col.: £1733-1898.
B) Allowances: After one year, a gratuity of £1500 called a "Regular Commission Grant".

RATIONS: Officers are entitled to standard rations or to 4s.4d. per diem in lieu.

LODGING: All single officers are required to live in an Officers' Mess. When this is not available a daily allowance of 11s. is made in lieu.

MARRIAGE ALLOWANCE: Over 25 years: Lieuts., Capts., Majors: 18s.6d. per diem. — Lt. Cols. and Colonels: 21s. (Taxable).

Under 25 years: Lieuts., Capts., Majors: 8s.-

An Overseas allowance is given which varies proportionately with the cost of living in the overseas station.

OUTFIT AND TROPICAL KIT:

Initial: £124. 10s. — Tropical kit: £67. 10s. (Tax free).

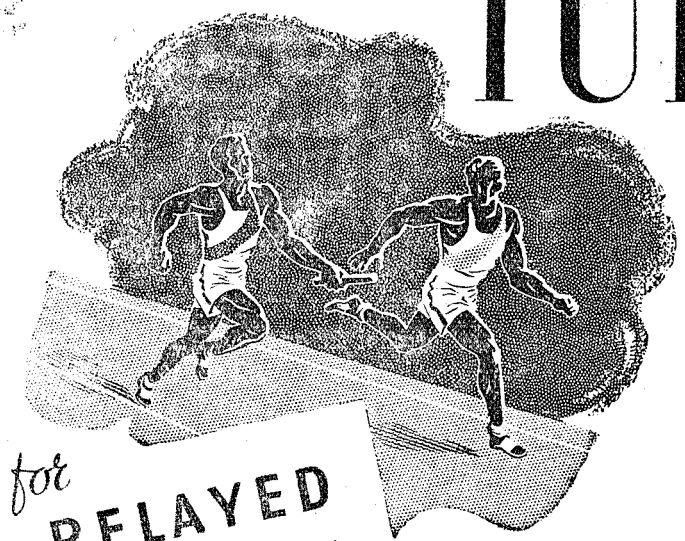
TOTAL INCOME:

	Single.		Married.
	Mess:	Outside:	
Lieut.:	£483	£762.	£900.
Capt.:	£593-803	£872-1082	£1009-1292
Maj.:	£1003-1496	£1282-1775	£1420-1913
Lt. Col.:	£1332-1825	£1666-2159	£1794-2287
Col.:	£1833-1898	£2167-2232	£2296-2305

SHORT SERVICE COMMISSIONS:

These provide a short career for men and women followed by retirement with gratuity. Basic commission of eight years of which any period can be spent

TUINAL



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'Pulvules' brand Filled Capsules Tuinal 1½ grs. (No. 303) and 3 grs. (No. 304) are supplied in bottles of 40, 100, and 500.

Literature on Request.

Lilly TRADE MARK

in the active list, the balance being spent in the Regular Army Reserve of Officers. The Reserve entails no annual training but merely the liability for recall in an emergency.

WORK:

The R.A.M.C. is responsible for the full medical care of all officers and men of the British Army and their wives and children in the U.K. and Overseas. About 75% are young male adults, 10% are between 35-60 and 15% are women and children.

A. The R.A.M.C. has 12 large hospitals in U.K. and 14 overseas (200-600 beds); certain of these have been recognised by the Council of the Royal Colleges as follows:
   1. The Queen Alexandra Military Hosp. Millbank for Final F.R.C.S. in general surgery and for training for the D.M.R.D., D.A., and D.L.O.
   2. The Cambridge Military Hosp., Aldershot for F.R.C.S. and D.A.
   3. The Louise Margaret Hosp., Aldershot for M.R.C.O.G. and D.R.C.O.G.
   4. The Royal Victoria Hosp., Netley for D.P.M.
   5. The R.A.M.C. College, London, SW1, for Dip.Path.

B. It keeps also smaller hospitals (50-200 beds) 5 in U.K. and 20 overseas.

C. Medical Reception Stations where there is no hospital.

D. Medical Centres in all army units.

PROGRESS IN AN OFFICER'S CAREER.

On joining an officer spends two weeks at Depot and Training Establishment, Aldershot, for clothing, equipping and for training in military subjects. One week at Field Training School for training in Field Medical duties. One week at the Army School of Health. Normally officers who are granted regular commissions for 4 years or more are required to undergo professional duties at the R.A.M.C. College, Millbank, SW1., for ten weeks. Other officers for 14 days only.

LEAVE: If in U.K., 42 days annually on full pay and allowances with free travel warrants. If Overseas for 3 years, a maximum of 75 days "including disembarcation leave can be earned".

MEDICAL TREATMENT is free.

RETIRING AGES.

Rank	*Max. rate of retired pay.*	*No. of years service.*	*Compulsory retiring age*
Lts., Capts.	£400	20	53
Majors	£500	22	53
Lt. Col.	£675	24	55
Colonel	£875	26	57

A lump sum terminal grant is also payable to an officer retiring on retired pay. Grant at rate of £1000 where 20 or more years service has been rendered or proportionately less if with less service.

PENSIONS FOR WIDOWS. Rates are as below provided the deceased has served for a minimum of 20 years or 10 years if he is invalided or dies whilst serving :

Rank of husband	*Rate.*
Capt. or Lt.	£110 p.a.
Major	£140
Lt. Col.	£180.
Colonel	£220.

METHOD OF OBTAINING REGULAR COMMISSION. By direct entry from civil life. Applications to be addressed to the A.D.M.S., H.Q. Troops, Malta, or to the Medical Director General of the Army, The War Office, by whom final acceptance is made.

GENERAL DUTIES MEDICAL OFFICERS. About 40% of regular and 80% of short service officers are employed in general duty. The majority of junior officers are employed on work analogous to the general practitioner, consisting of day to day doctoring of officers, men, women and children in their homes, in hospitals, medical centres or reception stations. As a general duties medical officer in a hospital he is given charge of a ward and accepts full responsibility for the treatment of his patients until fit for discharge; he is also required to lecture to nursing orderlies in professional subjects, to understand man management and to gain experience in the administration of the unit which includes a knowledge of pay, regimental funds, running of messes; instruction of other ranks in current affairs and leadership. A minority are employed in field ambulances. On becoming more senior he will be given command of units for which he has received training during his service.

SPECIALISTS. Opportunities to specialize are excellent. At present 40% of regulars and 20% of short service officers are specialists.

Grades : Senior. Has qualified at least 7 years and been employed wholetime 5 years and higher qualification.

Junior. Has qualified at least 3 years and been employed wholetime 2 years.

Subjects : Anaesthesia, Army Health, Dermatology, Medicine, Obstetrics, Ophthalmology, Orthopoedics, E.N.T., Pathology, Physical Medicine, Physiology, Psychiatry, Radiology and Surgery.

COUNTRIES in which officers are liable to serve :

Home Stations : Aldershot, Chester, Catterick, Colchester, Glasgow, Hindhead, London, Netley (Nr. Southampton), Oxford, Shorncliffe, Tidworth, York, N. Ireland, Germany and Austria.

Overseas : Gibraltar, Nigeria, Gold Coast, Sierra Leone, Tripoli, Cyrenaica, Malta, Cyprus, Suez, East-Africa, Korea, Honk Kong, Singapore, Malaja, Japan, Jamaica.

* This information is given for guidance of prospective applicants by courtesy of the A.D.M.S., H.Q. Troops, Malta.

2. THE COLONIAL MEDICAL SERVICE

1. It is difficult for those who have had no personal experience of the Colonies to grasp what an enormous task faces Colonial Medical Departments in their endeavour to raise the standard of health of the Colonial peoples. Many of the latter are still primitive and illiterate and unable on their own to get the better of the famine, drought, poverty and pestilence which surround them. Tropical diseases are widespread; malaria, sleeping sickness, filariasis, helminthiasis, yellow fever, yaws, the dysenteries, leprosy. Besides these so-called tropical diseases there are tuberculosis, venereal disease and malnutrition. The process of improperly controlled urbanisation has further complicated the public health problem. On the clinical side all the diseases commonly met with in the United Kingdom have also to be catered for.

Nonetheless because of the work of Colonial Medical Departments progress during the last 20 years has been appreciable and in some instances remarkable; yellow fever has been controlled and in certain areas malaria has been virtually eradicated. There is generally a much deeper insight into the aetiology of tropical diseases and their epidemiology. Substantial advances in therapeutics and prophylaxis enable individual problems to be approached more scientifically. Research, preventive and social medicine, mass survey and treatment of community wide diseases, increased provision for medical treatment, intensified training of local staff for posts in all grades of the medical services and the fullest possible co-operation between neighbouring Colonies are the main lines on which further advances are going to be made.

The Colonial Medical Service in conformity with the general trend of health administration throughout the world is much more specialised than it used to be; there are specialist appointments in curative and preventive medicine, and highly technical branches have been developed. But the underlying rule of the Service remains what it has always been; to deal scientifically with the host of killing and debilitating endemic diseases in the Colonies and to combat the mass ill-health of the Colonial peoples.

There are at present in the Colonial Medical Service some 800 administrative, public health and clinical posts for officers who hold a qualification registrable in the United Kingdom. Of these about 50 are filled by or are available for women medical officers. To make up the body of a comprehensive medical service there are nursing sisters, health inspectors, pharmacists and other technical personnel from overseas, and there is a large and invaluable complement of locally trained doctors nurses, medical orderlies and subordinate health and technical staff.

The organisation of medical departments varies according to the size of each Colony. But the general principles are the same in all. Except in the smaller Colonies where direct administrative control of deparmental activities is possible, there is a system of decentralisation from the Medical Directorate through regional or provincial administrative systems to the districts. Provincial or Senior Medical Officers are usually engaged full-time on administrative duties. In the Districts, the ultimate responsibility for the hospital and rural health

work rests personally with the District Medical Officer who holds, therefore, an assignment of considerable variety and interest.

Specialist posts exist in most Colonies.

Pathological laboratory services are, where the resources of the Colony permit, established as separate units serving the specialised laboratory requirements of the whole Colony and acting as a training centre for technical staffs for clinical laboratories in hospitals in other parts of the Colony. In several instances these laboratories have become research institutes of high professional standing. They are staffed by officers of the Service who have specialised in this branch of medicine.

Medical Schools now exist in West Africa, East Africa, Malaya, the West Indies and Fiji. Most of the teaching staffs of these Medical Schools have so far come from within the Medical Service. Some of these schools already train students to the standard of a qualification registrable in the United Kingdom and others are progressing towards that standard.

Officers of the Colonial Medical Service are employed so far as circumstances allow on clinical, public health, specialist, teaching or other duties according to their personal bent and suitability.

The Colonial Medical Service maintains close contact with scientific advances and the trend of medical opinion in the United Kingdom and other parts of the world. In one direction this is achieved by giving officers study—leave for recognised post — graduate courses, and by sending them to conferences and scientific congresses which have a bearing on medical problems in the Colonies. In the reverse direction provision is now made for specialists in various branches of medicine and public health in the United Kingdom to visit the Colonies and discuss their particular problems with medical officers on the spot.

2. *Selection Dates.*

There is no annual selection : vacancies are filled as circumstances require. Completed forms of application may therefore be sent to the Director of Recruitment at any time of the year.

3. *Age Limit.*

The normal rule is that candidates should be under 40, but candidates over this age may sometimes be considered.

4. *Qualifications.*

A medical qualification registrable in the United Kingdom with at least one year's post-graduate hospital experience.

5. *Salaries.*

West Africa	...	...	...	£950-1850
East Africa	...	...	...	£865-1590
Malaya	...	...	...	£1156-2044
Hong Kong	...	...	...	£1147-1911

6. *Training after Selection.*

Selected candidates may be required either on selection or after their first tour overseas to take the course for the Diploma in Tropical Medicine and

To provide enough of all the essential protective factors and at the same time to avoid unnecessary excess is the aim in prescribing for pregnancy. Supplementation is needed to maintain full health and to guard against such complications as, for example, toxaemia, premature births, hypochromic anaemia, inability to breast feed and dental caries.

By combining in one preparation all the factors needed to ensure adequacy, not only is economy effected but the patient is not burdened by excessive medication.

FORMULA: The daily dose provides, at time of manufacture:

liq. vitamin A conc., B.P. (40mg.)	2,000 *i.u.*	*ferr. sulph. exsic., B.P.*	60 *mg.*
liq. vitamin D conc., B.P. (30mg.)	300 *i.u.*	*calc. phosph., B.P.*	480 *mg.*
vitamin B_1, B.P.	0.6 *mg.*	*pot. iod., B.P. not less than*	15 *p.p.m.*
vitamin C, B.P.	20 *mg.*	*cupr. sulph., B.P.*	not less than 40 *p.p.m.*
tocoph. acet., B.P.C. (*vitamin E*)	1 *mg.*	*mang. sulph., B.P.C.*	
nicotinamide, B.P.	25 *mg.*		

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LITERATURE & TRADE ENQUIRIES:

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43, Lascaris Wharf — Valletta.

Telephone Central 5138.

Hygiene at either London, Liverpool or Edinburgh Universities. At present the course is usually taken after the 1st tour overseas.

3. THE ROYAL NAVY.

Entry into the Naval Medical Service as Acting Surgeon Lieutenant will in the 1st instance be on Short Service basis and appointments will be made under the following regulations :— Qualifications.

To be registered under the Medical Act as qualified to practise Medicine and Surgery in Great Britain and Ireland.

To be recommended by the Deans of their Schools (this recommendation will be obtained by the M.D.G. and need not be obtained by the candidates).

To produce another certificate of good character.

Age — preferable 24—28.

Candidates will be interviewed by the Medical Director-General and their physical fitness for general duties as a Naval Medical Officer, determined by a Board of Medical Officers at the Admiralty.

1. *Visual Standard on Entry.*

Both eyes to be healthy, the vision to be correctable to 6/6; 6/24 or to 6/12; 6/12 at least. The candidate should be able to read Jaeger 2 with either eye. There should be no history of asthenopia.

The refractive error should not exceed :

(a) 7 dioptres of hypermetropia or of compound hypermetropic astigmatism under homatropine in the meridian of greater error in either eye.

(b) 7 dioptres of myopia or of compound myopic astigmatism under homatropine in the meridian of greater error in either eye.

The fields of vision should be full.

Colour perception. The minimum standard of Colour Perception is Grade III.

An alternating squint with small deviation (not exceeding 15 degrees) will be permitted provided that the vision shall be correctable to at least 6/24 in the worse eye.

Candidates who are accepted with a distant visual acuity of less than 6/60, 6/60 and whose vision does not correct up to 6/12 or better in either eye are to have this fact noted in their Medical History Documents and are to be examined by a Naval Ophthalmic Specialist should they later apply for a Permanent Commission.

The candidate's teeth must be in a healthy condition and adequate for the efficient mastication of food. Any defects must be remedied at the Candidate's expense prior to entry. The wearing of artificial dentures, provided they are well-fitting, will not necessarily disqualify a candidate who is fit and suitable in every other respect

Candidates must be British subjects and the sons of persons who are British subjects at the time of the candidate's entry. In doubtful cases the burden of clear proof will rest upon the candidates who, if they are in any doubt should seek the opinion of the Admiralty at the earliest opportunity. Candidates who possess a foreign, as well as British nationality may, in certain cases, be regarded as ineligible for entry as Medical Officers, R.N. Prospective candidates possessing double nationality are therefore advised to seek an early decision from the Admiralty as to their eligibility for entry.

A cash grant towards the provision of the necessary outfit of uniform is payable in addition to a free issue of certain articles of clothing, subject to certain conditions of refund in the event of an officer failing to serve for certain prescribed periods from date entry.

MESSING. Officers will be allowed the ordinary ship's rations when attached to ships in commision, but will have to pay about 2/- a day towards the maintenance of their Mess as Ward Room Officers.

CONDITIONS OF SERVICE. Officers will be entered for a period of four years, except ex-holders of Kitchener Medical Services Scholarships who will be entered for 5 years full pay service. Officers who leave the Service at the end of the Short Service engagement will be eligible for gratuities.

To serve when and where required. A course of instruction on Naval Regulations and procedure, Tropical Diseases, Naval Hygiene, etc., is given to each Short Service Officer on entry.

TRANSFER TO PERMANENT LIST. Officers, including ex-holders of Kitchener Medical Services Scholarships, may be transferred to the Permanent List at the discretion of the Admiralty and in determining the number to be transferred regard will be paid by the Admiralty to the number of higher appointments available from time to time for Officers on the Permanent List.

Promotion is made to rank of Surgeon Lieutenant-Commander on attaining seven years seniority as confirmed Surgeon Lieutenant including at least two years sea service from date of entry. Promotion to rank of Surgeon Commander and above is by selection, subject to completion of such periods of service and sea service and subject to such other conditions as may be specified from time to time. The general regulations governing promotion to the above ranks and higher ranks are included in the King's Regulations and Admiralty Instructions.

Pensions for widows of Permanent Officers are granted subject to certain conditions in cases of Officers dying from causes not attributable to the Services.

RATES OF PAY.

Rank	*Single*	*Married*
Acting Surgeon Lieutenant	£483	£821
Surgeon Lieutenant	£593-876	£930-1213
Surgeon Lieutenant-Commander	£1003-1277	£1341-1615
Surgeon Commander	£1332-1606	£1715-1989
Surgeon Captain	£1733-2007	£2117-2436
Surgeon Rear-Admiral	£2190	£2664

ALLOWANCES.

Travelling Expenses :— The expense of first joining the Service is not allowable as a charge to public funds; but Officers travelling on duty are entitled to travel at the public expense.

Subsistence Allowance :— When travelling on short periods of detached duty on shore Officers are, in the absence of Service accommodation and victualling, eligible to be paid subsistence allowance.

Lodging Allowance :— Lodging Allowance at the rate of 11/- a day for Surgeon Lieutenant-Commander and below, and 14/- a day for Surgeon Commander is payable to single Officers who are not actually provided, or who cannot be provided with sleeping accommodation in any vessel or in a Naval Establishment or in Service premises of any description.

Ration Allowance :— Officers in full pay appointments are entitled to Service victualling, but may be paid an allowance (at present 4/4d. a day) in lieu of the prescribed rates if they cannot be victualled owing to the nature of their duties.

Marriage Allowance :— Rates of marriage allowance for Officers over 25 years of age are :—

Surgeon Commander — 21/- a day (£383-5s.-0d p.a.)
Surgeon Lieutenant-Commander
and below — 18/6d. a day £337-12s.-6d. p.a.)

Marriage allowance for Officers under the age of 25 years is 50/- a week.

Permanent Commission Grant :— Officers who transfer to permanent Commissiones after a minimum of one year's service will be paid a grant of £1,500 (taxable).

4. THE R.A.F.

THE ROYAL AIR FORCE offers a medical career that is both attractive and interesting. Much of the work brings officers into close contact with aviation medicine, flying duties, and the carrying of sick and wounded by air, as well as with the medical treatment of families. Suitable male medical officers may be selected for piloting duties as flying personnel medical officers.

APPLICATIONS.

The age on first appointment is normally below 33, but candidates who are above the age will be considered.

Candidates may apply during their period of provisional registration but will not be appointed to commissions until they are fully registered by the General Medical Council.

Candidates must be British subjects or citizens of the Irish Republic. Candidates with dual nationality or either of whose parents is (or was at the time of death) of foreign nationality may possibly be regarded as ineligible.

Application must be made on Air Ministry Form 1842 (A.M. Form 1842W for women), to be obtained from the A.O.C., R.A.F. H.Q., Malta.

Nominations to commissions are made by the Air Council after candidates have been interviewed and medically examined. Candidates who are not selected for an interview are informed accordingly. No appeal against the decision of the Air Council will be considered nor can the Air Ministry undertake to give reasons for the rejection of a candidate.

Candidates are examined for medical fitness by a Royal Air Force medical board held in London, normally on the same day as the interview. A third-class railway return warrant will be provided for candidates attending for an interview or for medical examination where the cost of the third-class return fare exceeds five shillings. No other expenses are admissible.

Candidates report on duty at the Medical Training Establishment, R.A.F. Station, Lytham St. Anne's Lancs., where they will attend a short orientation

course. They will not be entitled to a refund of any expenses incurred on first joining for duty.

Short service officers may choose to serve for three, four or five years on the Active List, followed by four years in the Royal Air Force Reserve of Officers. The period on the Active List originally chosen may, on application by the officer, be extended to complete any period of years up to a maximum of eight years at the discretion of the Air Council. The reserve liability remains at four years. While on the Active List officers are liable for service in any part of the world, and, if required, to fly in service aircraft as passengers. The normal length of a tour of duty overseas is 2½ years.

Rank on Appointment. Officers will normally be commissioned in the rank of Flying Officer.

Promotion. Officers of the Medical Branch are eligible for time promotion as folows:—

(a) To the rank of Flight Lieutenant after 12 months' reckonable service.

(b) To the rank of Squadron Leader after 8 years' reckonable service.

Promotion within the establishment to and above the rank of Wing Commander is by selection and not by time.

No distinction is made between officers on short service and on permanent commissions for the purposes of rank and command.

Officers' Messes. Every officer is a member of the officers' mess of his station. Married officers may be given permission to live out, becoming non-dining members of the mess, at the discretion of the commanding officer. Officers pay mess subscriptions (which do not exceed half a day's pay per month) and contribution to library sports, and other funds.

Leave. The leave entitlement for officers is 30 days a year. An additional 12 days yearly may be given at the discretion of commanding officers. Embarkation and disembarkation leave is also granted in connection with service abroad. Terminal leave of 28 days is given at the end of the short service engagement and is normally arranged so that the last day of leave coincides with the last of service on the Active List. If in exceptional circumstances terminal leave canot be completed by that the period of service will be extended to allow the period of terminal leave due to be taken, but such extensions will not qualify for any addition to the gratuity. Commanding officers may permit absence from duty for period of up to 48 hours. These do not count against the annual leave entitlement.

RATES OF PAY.

Rank	*Single*	*Married*
Flying Officer	£484	£822
Flight Lieutenant	£593-876	£931-1,214
Squadron Leader	£1,004-1,277	£1,342-1615
Wing Commander	£1,332-1,606	£1,715-1989
Group Captain	£1,734-1,898	£2,117-2,281
Air Commodore	£2,007	£2,436
Air Vice-Marshal	£2,190	£2,664
Air Marshal	£2,737	£3,211.

(*continued on page 26*)

The British Medical Association.

At innumerable gatherings of final-year students and the newly qualified the advice is given to do two things on qualification: (1) to join the British Medical Association, and (2) to join a defence society.

The British Medical Association, with which the Canadian Medical Association is affiliated and the Medical Association of South Africa is shortly to be affiliated, has a membership of over 52,500. Medical practitioners are elected to membership by the Council of the Branch in the area in which they reside, or, if not resident within the area of a Branch (e.g., serving with H.M. Forces), by the Council of the Association. The ordinary subscription for members resident in Great Britain and Northern Ireland is 3 gns., but there are remissions of part of the subscription in certain cases and newly qualified practitioners admitted to membership within the first two years of their registration pay only 1½ gns. until the end of their fourth year. For members not resident in Great Britain and Northern Ireland the subscription is ordinarily 1½ gns., and for medical officers serving with the Forces (apart from the above concession to newly qualified practitioners) the subscription is 2 gns. Forms of application are obtainable from the Hon. Secretary of the Division or Branch or from the Secretary, B.M.A. House, Tavistock Square, W.C.1.

The privileges of a member include participation in all the activities of the Association, local and central, the receipt weekly of the *British Medical Journal* and its *Supplement*, participation in the government of the Association and in the formulation of its policy, the use of the houses of the Association, with, at the London house, library and common room, and the advice and help of the central staff in professional matters.

ANSWERS TO QUIZ.

1. A hospital official who looks after the social well-being of patients.
2. Truth.
3. W. Somerset Maugham, who began his career as a physician celebrated his 80th. birthday on January 25th.
4. Round the waist, on the shin, on the head, on the breast, on the arm.

ANGLO-SAXON MEDICINE

(*continued from page 4*)

which the body of a fox can be put. An ointment made from a fox's fat will cure both headache and earache; broth from a fox's lung or liver cures pains in the spleen; an emulsion compounded from a fox's muscles cures sore jaws; the gall-bladder cures dimness of the eyes; and the whole carcase stewed cures rheumatism.

It may seem that the Anglo-Saxons were exceptionally superstitious and credulous; but it is well to remember that remedies no less curious than theirs were still current as recently as the seventeenth century. John Aubrey quotes a method of curing the thrush: 'Take a living frog, and hold it in a cloth, that it does not go down into the child's mouth; and put the head into the child's mouth 'till it is dead; and then take another frog and do the same.' Or again, a cure for the tooth-ache: 'Take a new nail, and make the gum bleed with it, and then drive it into an oak. This did cure William Neal's son, a very stout gentleman, when he was almost mad with the pain, and had a mind to have pistolled himself.'

WORLD HEALTH

Few doctors realise as yet what the World Health Organisation is and what it does. This body is not the League of Nations Health Committee under a new name; in conception, structure and scope it is both wider and sounder. In all that concerned health the League had an honourable record; its statistical services many times repaid their cost. This past experience, carefully indexed, will be placed at the disposal of the future.

There are more signatories to the constitution of the W.H.O. than any previous international body of this kind could muster; and the new machinery has not only size, it has teeth. The Health Committee of the League, it will be remembered, was made up of experts appointed in a personal capacity who were not representatives of their governments. They had thus only advisory powers, and it speaks well for their status that their pronouncements were so widely regarded. Delegates to W.H.O., on the other hand, are representatives of national governments, and they attend the meetings in the full knowledge that their governments have accepted in advance definite responsibilities and obligations. The World Health Assembly, has the power to make regulations which will come into force automatically for all member states, in the absence of specifically notified reservations. Fears have been expressed that too complicated or unrealistic safeguards may be promulgated. On the contrary, as uniform health standards are enacted and enforced, it may be possible to lighten certain regulations. Increasing confidence will prevent panic legislation at one extreme as well as slipshod indifference at the other. All the indications are that international good sense will be seen at its best in the world health services now in being.

———— :O: ————

CAREERS

(*continued from page* 24)

R.A.F. Specialists. Officers (other than National Service officers) may, within the limits of the requirement of the Service, be recognized as R.A.F. specialists by the Director General of Medical Services on the advice of the consultant. To be considered for such recognition officers are expected to have the appropriate higher qualifications and the requisite experience in their branch of medicine.

Uniform Allowance. Officers are required to provide themselves on entry with the uniform of their rank. When an officer has joined for duty an allowance will be paid to cover the cost of items of the prescribed uniform which cannot be issued free of charge from service stock. Special rates apply to officers who within 4 years previous to their appointment held a commission in the Royal Air Force, the Royal Air Force Reserve of Officers, the Royal Auxiliary Air Force, or the Royal Air Force Volunteer Reserve.

Further information can be obtained from the office of the University or directly from Service H.Qs. in Malta.

———— :O: ————

The statistician deals with averages; the physician with individuals.

fiat mistura...

A friend of mine once spoke to a don of an Oxford College from which an undergraduate was being carried in his coffin. My friend made some commonplace remark about the tragedy of the occasion, on which the don remarked, "Yes, it is no doubt sad; but in any case the poor fellow would have had to leave the college, for he had twice failed in pass moderations." — *Pages from a Lawyer's Notebooks, by E. S. P. Haynes (Watta).*

———— :O: ————

The heart of a fool is in his mouth and the mouth of a wise man is in his heart. — *Arabic Proverb.*

———— :O: ————

Extract from Philatelic Magazine:

Mr. J. B. wishes to deny that he attributes his mental and physical abilities to stamps as stated in this column on 15 Dec. He attributes them to rowing!

———— :O: ————

Advertisement in Personal Column of a Canbridge Univ. paper:—

Wanted: by undergradute; female short-hand typist, 18-21, evenings only. Knowledge of short-hand and typing not essentul.

———— :O: ————

A young boy asked his father: "Hey, Pop, how does electricity go through wires?

"Don't know, son. It's always been a mysteryto me."

"Then, Pop, can you tell me what makes thunder and lightning?"

"Tell the truth, son, never did understand thething myself."

"Hey Pop," said the son after a little thought.. "Oh well, never mind."

"Go ahead, son," cried the father. "Ask questios. Ask plenty of questions. How else are you going to learn." — *The Communue.*

First chess player: Your move.

Second chess player: My move? Well, why didn't you say so this morning.

A student asked in his 'viva' to describe the symptoms of phosphorous poisoning could think of nothing to say until in a moment of inspiration he blurted out: "The stools are luminous, Sir." Said the examiner: "Is that a flash in the pan?" — *Trephine.*

Club Bore: "....so I've definitely made up my mind, be cremated."

Member: "Right. I'll call you a taxi." — *Punch.*

QUIZ

1. What is the work of an almoner?
2. "It sits upon the lips of dying men" (Mathew Arnold)?
3. Two famous writers were 80 this year. One is Churchill the other was a medical student at one time in his youth and is known as "The Gentlemen of Cap Ferrat". Who is he?
4. Where would you wear the following: a chatêlaine, a eave, a beaver, a plastron, a brassard?

NOTES AND NEWS

B. M. S. A. Committee

The Committee of the B.M.S.A. for the current academic year has been constituted as follows :—

Hon. President : The Vice-Chancellor.
Director : Prof. Xuereb, Dean of Medicine.
President : Mr. J. Demartino, *Vice-President* : Mr. E. Debono, *Hon. Treasurer* : Mr. Casaletto, *Hon. Secretary* : Mr. P. Fenech, *Asst. Hon. Secretary* : Mr. Mangion.
Members : Mr. Luis Vassallo (Librarian), Mr. Hamilton, Mr. A. Jaccarini, Mr. Briffa, Mr. Richard Manche' (ex officio).

* * *

LEDERLE SCHOLARSHIP

Following on the news of the Vice-Chancellor's visit to the LEDERLE office in New York and the donation of £1700 worth of ACHROMYCIN to the Medical Department at St. Luke's comes the news that a fellowship plan is being worked out in order to enable a number of capable physicians from every corner of the earth to study and practice medicin in the U.S.A. for one year. Mr. DeGiorgio the local representative is trying his best to secure at least one for Malta. It may be of interest to point out that Mr. Carlo DeGiorgio has founded the LEDERLE PRIZE for Nurses at St. Luke's and is in the act of foundin the DEGIORGIO PRIZE for the best student in THERAPEUTICS in the Pharmacy Course. He has also been instrumental in obtaining from the LEDERLE £120 p.a. as a subsidy for our fellow journ THE PHARMACIST, a subsidy which THE CHEST-PIECE reluctantly had to turn down for obvious reasons. Still we did appreciate the thought and think it most kind and would like to say We done Mr. Degiorgio and Thank-you.

* * *

Visitors to the School have been numerous and distinguished including H.E. the Governor and Lady Laycock, Lady Mountbatten of Burma, and Sir Eric Pridie. Next month sees the arrival of Mr Wylie McKissock of the National Hospital, Queen's Square, W.C.1 who is Visiting Surgeon to the H.M.D., Attard.