to are those which can be posed in a soluble shape; half the difficulty of finding the answer is overcome when the question has been asked in a proper form. He has to learn to be content to answer questions, each one of which is in itself a small thing. The pith of gaining new knowledge is indeed simplification which is the pith of teaching too. Hence it is natural that the two go so easily together. The researcher too has much to gain from the give and take of his colleagues in an active teaching school, and when the time comes, as it surely will, that his productive capacity is in abeyance for a while he can occupy himself with other things and feel that he has earned a good night's sleep. What a miserable time the pure researcher must have when he feels that he is not justifying his salary, and how much bad work such a mood may lead to! And if his fire has died out, as it sometimes will, what is he to turn to? For a restricted life of research, or perhaps I should say a life of restricted research, is no training at all for a teacher. No, teaching and research have natural affinities with one another, and they should not lightly be put asunder, apart from the necessities which I have mentioned. What most teaching schools need is funds for maintaining research which are at their own disposal, and which they can use in their own way; they would make good use of them.

CORRESPONDENCE

RITUAL PURGATION

To the Editor of THE LANCET

SIR,—Doubtless the interesting, amusing, stimulating, and provocative article by my friend Prof. Witts on Ritual Purgation in Modern Medicine will bring a spate of letters to your box. In this iconoclastic lucubration, with which I am largely in agreement, he pays me the doubtful compliment of quoting me in derision. I would ask, is there any physician who has not had the experience of being called to a case of pneumonia on the fourth or fifth day, to find the abdomen grievously distended, and to hear that the bowels have not been properly opened since the beginning of the illness, and to wonder what is the best thing to do?

I am not unduly influenced by the eloquent persuasiveness of a Metchnikoff, or the enthusiasm of an Arbuthnot Lane, but I do think that a loaded colon tends to abdominal distension, and is therefore better emptied at the beginning of an illness. I admit that ritual stuffing with unwanted foodstuffs is a contributory cause of distension, but I must not embark here on a fresh iconoclasm.

I am, Sir, yours faithfully,

F. G. CHANDLER.

Park-square West, N.W., Feb. 22nd.

To the Editor of THE LANCET

SIR,—I was very much interested in Prof. Witts's paper on ritual purgation and in his plea for the avoidance of the bed-pan whenever possible. In this connexion is there any sound reason for insisting on the bed-pan for a healthy woman after a normal confinement? There must be few patients who can survive even a short spell of "bed-pan existence" without losing any normal habit of bowel action which they may have had. To quote an excellent text-book of obstetrics, "a daily aperient will probably be required whilst the patient is in bed," and this is probably a conservative estimate.

If we hope, by forbidding even the daily use of the commode, to avoid strain and such sequelæ as prolapse, surely our results do not justify us. The perineum is quite as likely to be soiled on the bed-pan and, where aperients are given, stools are more liable to be fluid.

It would be interesting to know from what danger we are protecting our patients when we insist in the ritual of bed-pan and frequent purgatives for these normal people.

I am, Sir, yours faithfully,

Oxford, Feb. 23rd. V. SMALLPEICE.

SURGICAL TREATMENT OF CARDIAC ISCHÆMIA

To the Editor of THE LANCET

SIR,—It would indeed have been misleading if cardio-omentopexy had been already performed upon the patients mentioned by Sir Maurice Cassidy in your issue of Feb. 20th. Such a contingency emphasises the new responsibility imposed upon those to whom such patients come for advice. After seeing the cases of cardiac ischæmia treated by omentopexy shown to the clinical section of the Royal Society of Medicine, I find it hard to believe that these patients could be convinced that their improvement was not due to the operation. After all it is natural, though illogical, that a patient who has had the courage to submit to an operation should credit it with his relief from symptoms. Such patients are not likely to stem the spate that Sir Maurice fears. It is surely the duty of the physician to guide the flood into the appropriate channels.

If, as I assume from his quotation of Lord Dawson's words, Sir Maurice holds that recovery from arteriosclerotic heart failure is the result of a compensatory circulation, the physician is faced with the delicate problem of balancing the probabilities of the natural development of this circulation against the hazards of assisting nature's methods by operation, and Mr. O'Shaughnessy has shown convincingly that the operation he has devised can do this.

I am, Sir, yours faithfully,

Hull, Feb. 22nd. HAROLD UPCOTT.

ARTIFICIAL PNEUMOTHORAX ON STATISTICAL TRIAL

To the Editor of THE LANCET

SIR,—Dr. Andrew Morland in his letter in THE LANCET of last week objects to the comparisons made in the inquiry into the value of artificial pneumothorax carried out by the subcommittee of the Joint Tuberculosis Council. His argument is that the control group consisted of patients with a substantially better prognosis when treated conservatively than the A.P. group, and that, therefore, no conclusions could justifiably be based upon the relative survival-rates. Whether that argument in the particular case is just or not is a matter for the authors of the report to discuss. But Dr. Morland passes from this criticism of the particular to a criticism of the general, and says that the investigation "raises the whole question of the applicability of statistics to clinical problems." That question concerns me closely because I am at present endeavouring to show in your columns how simple

statistical methods can be applied with advantage to many clinical problems.

I am inclined to agree with Dr. Morland that in assessing the value of A.P. it may be very difficult *now* to find two equivalent groups of patients, one so treated, the other not, which are the requirements for an effective comparison (the subject was ably discussed by F. J. Bentley in his report on the L.C.C. experience published in the *Spec. Rep. Ser. med. Res. Coun., Lond.* No. 215, 1936). But was it *always* so difficult? In the early days of the treatment it was certainly not universally applied to all those patients who to-day might be regarded as suitable subjects. Some clinicians would in those early days have induced an A.P. where others would not. If while the treatment were in that experimental stage, the clinical trials had been efficiently planned and organised, then, I believe, a measure of its value would have been obtained. The statistical method (like any other method) must fail if it has to be applied to faulty material; but faulty material is the product of a faulty experiment. The time for a test of a new method of treatment is clearly in its early days when opinions upon it differ, and equivalent patients, treated and untreated, are available for study. Too often that critical moment is lost and we fall back later upon second-best comparisons.

Dr. Morland says that there is now "a relatively small group of patients in whom pneumothorax is tried without delay as experience has taught us that their prognosis will be much improved thereby." That conclusion is itself statistical even though it is not given numerical expression. It must be based upon a mental, subjective, comparison, of similar types of patients to whom A.P.T. was applied or not applied. The two groups must have existed; the clinician must have been able to define them as of similar type to reach the conclusion; is it too much to believe that if the critical moment had been seized an objective, numerical assessment could have been obtained by suitable statistical methods?

I am, Sir, yours faithfully,

A. BRADFORD HILL.

London School of Hygiene and Tropical Medicine, Keppel-street, W.C., Feb. 22nd.

MEDICAL PRIVILEGE

To the Editor of THE LANCET

SIR,—The introduction into the House of Commons of Sir Ernest Graham-Little's Bill for the protection of medical practitioners has brought to public notice a very important question—namely, the position of doctors as regards the secrecy of communications with their patients.

The Bill was rejected on two main grounds: first there was no statement as to whose privilege the privilege claimed should be; and secondly there was no definition of such privilege. I think it is very important that the matter should not be lost sight of and that it should be brought up again as soon as possible. I should suggest that the new Bill should be settled after careful legal consultation and should provide: (1) that the privilege should be the privilege of the patient; and (2) that the patient should have as regards his medical attendant the same privilege as a client has in regard to his solicitor. I think this mode of dealing with the matter would get over a considerable amount of difficulty in the way of definition.

I am, Sir, yours faithfully,

JOHN J. WITHERS.

Howard House, Arundel-street, Strand, W.C., Feb. 23rd.

TREATMENT OF FRACTURE OF THE NECK OF THE FEMUR

To the Editor of THE LANCET

SIR,—May I reply through your columns to some of the points raised by Mr. Gissane in his friendly criticism of the technique I described for the introduction of a Smith-Petersen nail?

Mr. Gissane agrees that traction in a Thomas splint should be the routine method of preliminary treatment and can effect accurate reduction. When this is so, therefore, it seems a thousand pities to undo this good work by removing the extension and starting all over again with an orthopædic table if an alternative "bed procedure" can be offered, which is satisfactory. Accepting the criterion of satisfaction as (1) accuracy of reduction, and (2) maintenance of this reduction until the nail is in position, the bed technique described fulfils these two requirements. Accuracy of reduction must, of course, be controlled by radiograms in two planes, and may be confirmed with advantage immediately prior to operation after the spinal anæsthetic has been given. Within five minutes of this the guiding wire can be in position, and as no disturbance of the weight extension has taken place, there is no reason to suppose that the simple introduction of a wire can have caused displacement. At this stage, however, there is nothing to prevent as close a radiological control as the surgeon desires, given a good portable X ray apparatus, and lateral radiograms could be taken until sufficient experience of cases gives conviction that the instrument does in itself ensure complete control.

In introducing the nail over the wire inserted right through into the head of the femur, I find it difficult to conceive that the head fragment lying in the acetabulum can move. Any movement that could occur must surely be on the part of the proximal fragment of neck, and attached femur with it, and the immobility of this is guaranteed by the weight extension supplemented by the wire. Maintenance of reduction is thus sustained until the nail is in position.

Finally, if the experience of others should prove the same as my own, they will find that the elderly patients have no fear of what is to them a "bedside treatment" compared with a visit to the theatre for an "operation," where events that may be no worse than tedium for the surgeon and his assistants are no less than an ordeal for the patient.

I am, Sir, yours faithfully,

E. T. BAILEY.

St. Leonard's Hospital, Hoxton-street, N., Feb. 20th.

THE SERVICES

ROYAL NAVAL MEDICAL SERVICE

Surg. Capts. K. H. Hole, O.B.E., to *Drake* for R.N. Hosp., Plymouth; and G. G. Vickery, O.B.E., to *Victory*.

Surg. Comdr. R. G. Anthony lent to N.Z. Division for three years.

Surg. Comdrs. A. J. Tozer to *Wildfire*; H. Hurst to *Lucia*; D. M. Beaton to R.N. Hosp., Plymouth; and A. W. Cocking to *Pembroke* for R.N.B.

Surg. Comdr. (D) H. J. Luck to *Victory*.

Surg. Lt.-Comdr. (Royal Australian Navy) C. A. Downward to *President* for course.

Surg. Lt.-Comdrs. C. T. Hyatt to *Drake* for Devonport Dockyard; F. Dolan and F. W. Besley to *Drake* for R.N.B.; T. L. Cleave and T. G. B. Crawford to *Pembroke* for R.N.B.; and J. J. Keevil and D. A. Newbery to *Victory* for R.N.B.