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BRIGHTON

BY

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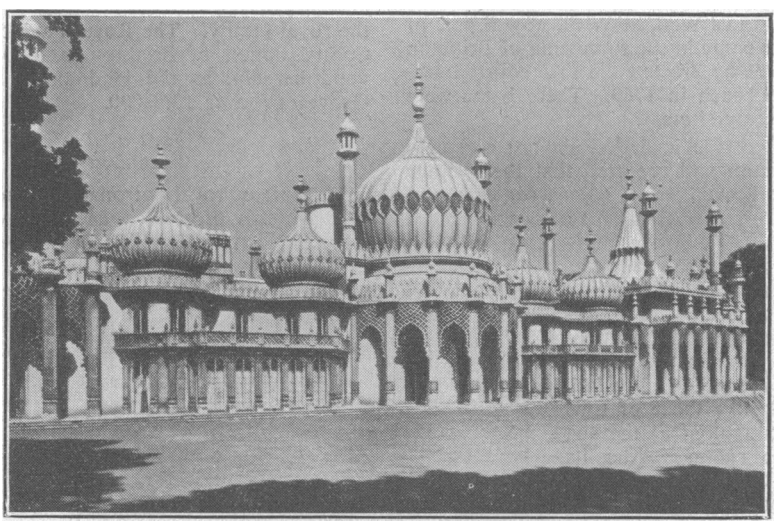
The county borough of Brighton has a population of 151,000 (1951), but its built-up area is continued without a break by that of the municipal borough of Hove, and then by those of the three urban districts of Portslade-by-Sea, Southwick, and Shoreham-by-Sea. These "Five Towns" of central Sussex are geographically but not administratively one town. They share over eight miles of sea front and are together responsible for the welfare of over a quarter of a million persons (263,000 in 1951).



East Front, Royal Pavilion, Brighton.

Brighton, a large village at the time of Domesday, was one of the chief towns in Sussex in the sixteenth and seventeenth centuries. It seems to have declined after suffering much from the encroachment of the sea, and by 1750 the population of Brighthelmston (as it was generally called) numbered fewer than 2,000; yet by 1850 it held 65,000 inhabitants. The causes of the rapid expansion of a small decayed fishing port within the course of a single century were many, but the first stimulus was certainly given by the medical profession.

Use of Sea-Water

The founder of modern Brighton was Dr. Richard Russell (1687–1759). He took his degree of doctor of medicine at the University of Leyden in 1724 and then practised at Lewes, his birthplace. In 1750 he published his famous book *De Tabe Glandulari sive de Usu Aquae Marinae in Morbis Glandularum Dissertatio,* which was first translated into English in 1752 "by an eminent physician," apparently without Russell's sanction, with the title of *Dissertation on the Use of Sea Water in the Diseases of the Glands.* The first Latin edition of Dr. Russell's book was printed at Oxford and bears on its title-page a vignette of the Radcliffe Camera.

Dr. Russell regarded sea-bathing not as a pleasure but as the taking of a medicated bath, and prescribed it for numerous complaints. The peculiar nature of his treatment lay in the fact that he made some of his patients drink sea-water as well as bathe in it. Dr. Russell's discursive volume mainly consists of accounts of his cases in which he explains how his patients had benefited by the external or internal administration of sea-water. On his advice sea-water was drunk instead of spa water, and bottled sea-water, taken from the sea at Brighton, was soon being sold in London.

Some of Dr. Russell's ideas were very modern. He believed in the value of fresh air and did not allow delicate children entrusted to his care to be muffled up in too many clothes. There can be no doubt that the virtue of his treatment in many cases did not lie so much in the sea-water as in the dietetic and hygienic routine which he imposed on his patients in the attractive surroundings of Brighton. Patients came from all over England to take the sea-water cure. Dr. Russell, who was elected F.R.S. in 1752, was still in practice at Lewes, but his Brighton patients became so numerous that in 1753–4 he built himself a new home there on the sea front at the southern end of the Steine.

The sea front at Brighton looking east, with the West (foreground) and Palace Piers.

Russell House was destroyed in 1823 to make way for the Albion Hotel, which now stands on its site.

Dr. Russell's Successors

There was considerable competition among the profession to secure Dr. Russell's flourishing practice. A large part of it was taken over by Dr. Anthony Relhan, who in 1761 wrote a book that can be regarded as the first guide to Brighton. He advertised "the singular healthfulness" of the town, using climatic observations to support his argument. Like Dr. Russell, he also commended the virtues of a chalybeate spring, St. Ann's Well, at Wick, now a part of Hove. The third famous name in the succession of Brighton doctors is John Awsiter, who erected the first covered sea-water baths close to the beach in 1769. These baths were soon to have several competitors.

In 1841 Dr. A. B. Granville inspected six hot and cold sea-water baths at Brighton and reported that the average charge at almost all the houses was a guinea for eight hot baths. Brighton's fame as a watering-place was enhanced still further after Dr. F. A. A. Struve, of Dresden, in 1825, had established his German Spa, south of Queen's Park. This attractive building still survives, but the Regency Society of Brighton and Hove has recently called the attention of Brighton Corporation to the lack of repair into which it has been allowed to fall. Artificial mineral waters, like those of Ems or Carlsbad, were manufactured at the spa and drunk in its pump room. After its patronage by various members of the royal family, including William IV, it became known as the Royal German Spa. Sir James Clerk, physician-in-ordinary to Queen Victoria, sang the praises of Dr. Struve and his spa, while Dr. Granville regarded the spa's existence as "the only reason for sending real patients to Brighton."

Royalty

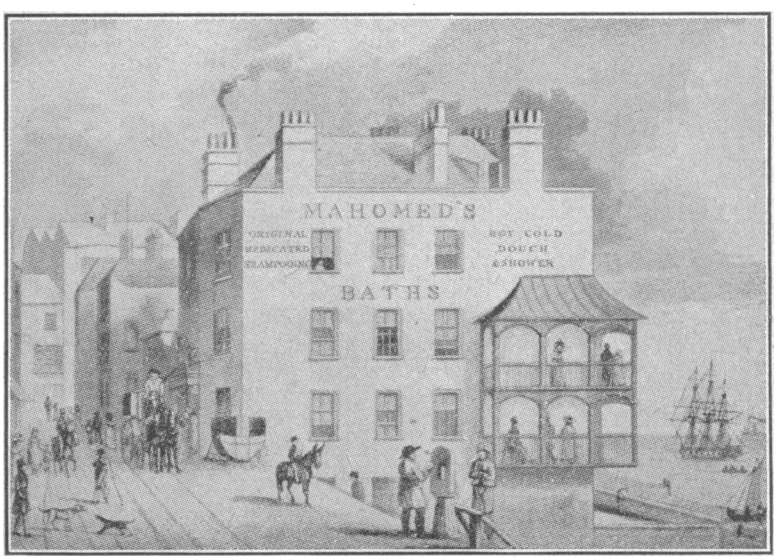
The doctors started the movement to Brighton, but it was accelerated by royalty. In 1783 the Prince of Wales coached to Brighton to visit his uncle, the Duke of Cumberland; he returned in the following year, as he had been advised sea-bathing for the sake of his health. By 1787 the Prince had built his Marine Pavilion, and during the next thirty years he was constantly pulling down and rebuilding this palace until it was completed as we now know it. During the same period Brighton experienced a spate of building. Among the famous crescents, terraces, and squares erected at this time are Royal Crescent (1808), Regency Square (1818–28), Lewes Crescent and Sussex Square (1823–8), and Brunswick Square and Terrace (1824–7). It was during this period of rapid expansion that Brighton also acquired its "Regency reputation for rakishness," a reputation it has never entirely lost. George IV paid his last visit to Brighton in 1827; his long connexion with the town while he was successively Prince, Regent, and King was a principal factor in its growth.

Among George IV's Court officials at the Royal Pavilion was a shampooing surgeon, the post being held by Sake Deen Mahomed, an Indian from Patna, who had had some training as a surgeon. He wore a special Court dress on great occasions. Soon after his arrival in Brighton in 1786, with his pretty Irish wife, he opened a vapour and shampooing bath business. Mahomed's Indian medicated vapour baths were a further addition to Brighton's resources as a watering-place. His patients, after being subjected to great heat and having perspired freely, were next placed in a flannel tent. They were then vigorously massaged by someone outside the tent whose arms alone appeared through its flannel walls. The word "shampooing" was then applied only to the process of massaging the limbs and not to that of washing the hair. Mahomed claimed to have cured many diseases and had a "museum of testimonials" in the shape of crutches, spine-stretchers, head-strainers, bump-dressers, etc., all thrown aside by his patients. Mahomed's baths were on the sea front, where the Queen's Hotel now stands.

The Royal Pavilion was much used by William IV, who made it his winter quarters and added the north gate entrance to the estate. After his death Queen Victoria came several times to Brighton, but she found the Pavilion to be too public as a royal residence. She paid her last visit in 1845 and afterwards purchased Osborne as a seaside home for the royal family. The Royal Pavilion was sold to the Town Commissioners of Brighton in 1850 for £50,000. It was a good bargain, as the land and buildings alone had cost George IV over £356,000.

London by the Sea

The loss of royal patronage did not bring about a decline in Brighton's prosperity, as the completion of the railway from London to Brighton in 1841 more than compensated



Mahomed's Baths, 1822.

A fair invalid at Kemp Town, 1862.

for the desertion of the Pavilion by the Court. After the railway had been built Brighton was reached in two hours in a closed carriage at less expense than that of an outside seat for a coach ride of six hours' duration from London. So Brighton took the place which Margate had once held in the affection of the Cockneys. The rush to the sea helped the growth of Brighton. More visitors of all kinds came for holidays long or short, and the London proletariat was now able to escape to Brighton for at least one day. More workers were needed to cater for the requirements of the growing number of residents, visitors, and trippers. Brighton's population leapt from 46,000 in 1841 to 77,000 in 1861 and to 123,000 in 1901. With the coming of the railway Brighton could rightly be called "the lungs of the great capital."

Climate

The first visitors had come to Brighton because doctors had advised them to bathe in sea or baths and to drink the waters from sea, spring, or spa. In later years the benefits to be derived from the town's salubrious climate received more emphasis from physicians than those to be gained from bathing or drinking waters. From the time of the coming of the railway a succession of doctors wrote of Brighton's climate, generally praising its qualities, but often giving solemn warnings about its dangers for certain classes of patients. In his *Sanative Influence of Climate* (1841) Sir James Clark spoke of Brighton's "dry, elastic, and bracing air," but firmly asserted that the town had more than one climate. Dr. William Kebbell, in his *Climate of Brighton* (1859), described the "sanative properties" of the climate, listing the numerous complaints which the town's bracing air helped to cure, including "the relaxed sore throat, so frequently met with amongst clergymen." Dr. George Corfe, in his *Hints and a Help to Brighton Invalids* (1869), made an elaborate division of the town into three climatic districts, while in 1882 Dr. Alfred Haviland produced a *Health-guide Map for Brighton,* intended to indicate the varying climatic merits of the different parts of the town. Dr. J. Burney Yeo, in his *Climate and Health Resorts* (1885), asserted that Brighton had "a much-too-decided sea climate for many delicate persons, whom it often rendered bilious and dyspeptic."

Amenities

Brighton's hospitals are now under the general direction of the South-East Metropolitan Regional Hospital Board, while local supervision is carried out by the Brighton and Lewes Group Hospital Management Committee, which is responsible for nearly 2,000 beds. Brighton makes notable provision for the blind. The training centre of St. Dunstan's is at Ovingdean, while in 1953 a blind people's garden was opened near Preston Manor; there is a similar garden at Hove.

Brighton has a progressive education authority. It is also the home of two well-known public schools, Brighton College for boys and Roedean for girls. There is now a proposal to establish a University College of Sussex. It is argued that the south-east of England is one of the only regions of the country without a university, and Brighton, with its existing large technical college, is the natural seat for such a university.

The most valuable of Nature's gifts to Brighton is sunshine. The town enjoys an average of over 1,760 hours per year, about 400–500 hours more than London. Brighton's record of sunshine, its comparative freedom from mists and fogs, and its close proximity to the Sussex countryside and the South Downs are the town's chief natural advantages. To these can be added the architectural attractions of the Royal Pavilion, a unique structure, and of the magnificent sea front, which it shares with Hove, of "Regency" crescents, terraces, and squares. A few yards from this front, and in the centre of the town, are "the lanes," a remnant of old Brighthelmston, and now filled with antique and curiosity shops.

Facilities for amusement and sport in Brighton and Hove, as well as their parks and gardens, are too numerous to describe. It is still true, as Dr. A. L. Wigan remarked in 1834, that even if "Brighton does not agree with the patient it agrees exceedingly well with his wife and family."

The illustration "A Fair Invalid at Kemp Town, 1862," was taken from *Brighton: The Road, The Place, The People* (1862), and that of "Mahomed s Baths, 1822," from S. D. Mahomed, *Shampooing* (1822). Both were included in Professor Gilbert's book *Brighton: Old Ocean's Bauble,* Methuen and Co. Ltd., 1954. The photographs of the Royal Pavilion and the sea front are the copyright of Brighton Corporation.

HOSPITALITY

A few requests have been received from Continental doctors who would like their children to be received as paying guests in medical families in this country, particularly in the London area; one such request is from a Swedish doctor for accommodation near the sea within easy distance of London.

Another Swedish doctor would like his 16-year-old daughter to spend the summer holidays from June 9 to August 25 with a medical family, and in return she offers to take care of children part-time, having had similar experience with a Swedish family last summer.

A Belgian third-year medical student from Antwerp would like to arrange a holiday exchange with a British medical student for one month during August and September.

A number of requests have been received from doctors in Germany for holiday exchanges for their children.

Anyone interested should get in touch with Brigadier H. A. Sandiford, International Medical Visitors' Bureau, B.M.A. House, Tavistock Square, London, W.C.1.

DOMICILIARY NURSING SERVICE FOR INFANTS AND CHILDREN

BY

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The conspicuous success of the Children's Nursing Unit established in Rotherham in 1949[1] encouraged the Council of the Birmingham Institute of Child Health to recommend that a service patterned on similar lines might with advantage be introduced in Birmingham.

In addition to providing the best available nursing services, one of the main purposes considered to be very important in the planning of any service of this character was to promote still further a live integration and close co-operation between general practitioner, local authority, and hospital service, the link being the district nurse. Benefits that it was hoped should accrue in consequence would include avoidance of in-patient treatment in some cases and in others discharge from hospital to home earlier than might otherwise be desirable. Thus, separation of the ill child from his mother and his home would be lessened, and possible psychological trauma minimized.

Experimental Scheme

As any scheme devised would be necessarily in the nature of an experiment, it was considered desirable in the first instance to restrict the service to a relatively small area of the city within the vicinity of the Children's Hospital. Such an arrangement would readily permit the benefits, advantages, and limitations to be more quickly and carefully studied and followed in detail. Any subsequent extension, development, or modification could be considered later in the light of the experience thus gained.

Birmingham Health Committee, the House Committee of the Children's Hospital, the Local Medical Committee, and the Local Executive Council were then approached and invited to give their views on these proposals. Unanimous and warm approval was received, and in consultation with Dr. Matthew Burn (Medical Officer of Health) it was agreed to initiate the scheme within an area containing a population of about 100,000, around the Children's Hospital and two district nursing centres. This deliberately included some of the most densely populated parts of the city, where it was felt the nursing service was most needed.

A nurse from each of the two district nursing centres concerned was appointed specially for this purpose, and before taking up duty they spent some time in the Children's Hospital to familiarize themselves with current in-patient hospital treatment and to meet ward and out-patients hospital nursing staff.

With the co-operation of Birmingham Executive Council a letter was sent to all general practitioners who practised within the defined area, detailing the proposed arrangements and pointing out that nursing services would be available, on request, for their child patients within the agreed area. Attention was drawn to the proposal that the nurses would not only assist the doctors in the care and treatment of the children in their own homes but would also have full and free access to any child admitted to hospital.

First Year's Results

The plan was put into operation in October, 1954, and the first year's working has recently been reviewed. During this period 454 children have been visited in their homes, the number of individual visits totalling 3,295. The age groups of the children were 0 to 1 year, 95; 1 to 5 years, 219; 5 to 14 years, 140. The principal diseases treated were respiratory infections, including tonsillitis and otitis, 271; abscesses and boils, 44; skin conditions, 31; and infectious diseases, 19.

Four hundred and one of these children recovered; 26 required admission to hospital, which included only 2 out of a total of 19 cases of gastro-enteritis. In some of these cases in-patient treatment was required as the mothers were unwilling to have their ill child nursed at home, particularly when they had to go out to work or had large families or lived in overcrowded or inadequate housing. Treatment was terminated for other reasons in 17 cases (including parental objection to injections in 6), and 9 were still under treatment at the time of the review. Only one child died, and this was a hopeless and very severely spastic patient.

One year's working of this scheme has demonstrated that the sought-for co-operation between general practitioners, home nursing, hospital, and local authorities services has been achieved in an eminently smooth and satisfactory manner. Excellent support has been received from the general practitioners, who have warmly commended the nursing services provided by the local authority. The nurses have taken every opportunity to get to know the doctors, and by giving skilled nursing care and often paying several daily visits they have been able to obtain the confidence of the parents. Often the nurses have been called in initially to give an injection of penicillin, etc., but they have always seized this opportunity to teach the mother general nursing care and to advise on diet, clothing, general hygiene, and the like. In some cases cots, hot-water bottles, and clothing have been loaned to the parents for the patient. In particular, evening visits have been found to be most important in allaying the worries and anxieties of the mothers, so that there have been very few emergency calls during the night. The nurses have paid frequent visits to the Children's Hospital to follow up their patients and to discuss other cases with the hospital nursing staff and to acquaint them with the working of the domiciliary service.

Conclusion

These arrangements have operated so successfully that there is every reason to believe that in quite a number of instances the necessity for hospital admission has been avoided. Moreover, a number of children have been discharged from hospital to the care of their general practitioner and the district nurse earlier than previously, in the knowledge that continuity of treatment would be maintained.

In the light of the experience gained in Birmingham during the last twelve months with a pilot scheme for the home nursing of infants and children, it would appear that a very real need is being met. It is hoped that the results herein recorded will encourage the development of similar arrangements in other parts of the country.

REFERENCE

[1] Gillet, J. A., *British Medical Journal*, 1954, 1, 684.

A report has recently been made to the London County Council on its Children's Care Committee service. In addition to giving an account of the service's work during 1955 the report outlines its development over the last ten years. In 1945 there were about 600 voluntary workers in the whole of the county of London; in 1955 the total care committee membership had risen to 2,341. The committees, who are guided by professional social workers, consist of voluntary workers attached to schools, and they are responsible for attending school medical inspections, reporting to school doctors on home conditions, and attempting to see that parents understand and carry out the doctor's recommendations. Friendly co-operation exists between the committees and health visitors. First instituted to carry out the responsibilities of the 1906 Provision of Meals Act, the care committee service is still concerned with provision of free, or reduced-price, meals and clothing for needy children. It also undertakes home visiting and work in connexion with problem children and families. "Above all," the report says, "the members of the care committees aim to become the accepted non-official family friend, ready to help at all times, and knowing where to evoke the right help for each particular problem as it arises."

EMPLOYMENT OF OLDER PERSONS IN INDUSTRY

In 1948 the Representative Body decided to promote the formation of local advisory councils on industrial health representing doctors, employers, and employees. Since then a number of these councils have been formed, and the third annual conference of advisory councils on occupational health was held in B.M.A. House on April 10, with Mr. F. H. MARTIN, of Wolverhampton, presiding.

Dr. I. D. GRANT, Chairman of the Representative Body of the British Medical Association, welcomed the conference in the name of the Association. All doctors were interested, he said, in what happened in industry and in the special subject for discussion. He understood that at the end of last year there were five million people in this country of pensionable age and that in another two decades there would be nine million, which would be a tremendous burden on the working population of the country. Something must be done to enable many of these people to remain at work. At a Glasgow geriatric unit last year 300 people attending were asked whether they thought a compulsory retiring age was a good thing; 7% thought it was a good thing, 6% had no opinion, and the remaining 87% thought it was a very bad thing.

He hoped something concrete might emerge out of the discussions and something be put forward which would have good effects.

Health and Retirement

The first resolution was put forward by Mr. A. J. NIX (Wandsworth), who moved that, having considered the question of the employment of older persons, the conference agreed with the recommendation of the National Advisory Committee on the employment of older men and women that steps should be taken to encourage the employment of older persons in industry. He said the matter was of increasing importance because of full employment. The present pension schemes were devised when these conditions did not exist and it was thought right for the older people to retire to make way for the younger. The question of employment would always be covered by the law of supply and demand.

The motion was carried without discussion, as was a similar motion, with the addition of the proviso that it should be subject to the person's mental and physical fitness and his or her desire to work, which was proposed by Mr. H. RAMSDEN (York).

Dr. R. C. SCOTT (Burton-on-Trent) next moved that the type of work, hours, and working conditions should be adapted to suit the health, physical fitness, and mental capabilities of the individual, due regard being paid to the ordinary physical problems which attend advancing age. He said that there were two main factors involved in the problem of the employment of older people in industry—the economic side and the health side. There had been a great increase in the expectation of life in the last 50 years. While there must be definite pension schemes, there should be adjustments providing for employment after retirement age. In an inquiry by the Ministry of National Insurance among 29,000 persons, six men out of ten wished to stay at work, 54% because they wanted the money, 25% because they were fit and wanted to work, and 20% said that they preferred to work.

With improved health due to medical progress the majority of men and women at the age of 60 and 65 could continue and wished to work, and it was anticipated that health in old age would continue to improve. There was evidence that continuance in employment helped in the retention of health, the break in normal routine caused by compulsory retirement often resulting in physical deterioration.

Dr. S. A. UNDERWOOD (York), supporting the resolution, said there was a tendency to stress the question of retirement too heavily. As an industrial medical officer he knew that the older person could not stand the pace in a modern factory, and that was why the resolution stressed that working conditions should be arranged so as to suit the individual. Dr. G. A. STEELE (Wolverhampton) asked who was to decide what were the health, physical fitness, and mental capabilities of the older worker. It was often his task to try to do this, and it was no light one. The wishes of the individual concerned were not necessarily the best guide. Increasing the proportion of older workers in industry should be linked with increasing medical supervision in industry. Dr. D. C. RENNIE (Southampton) emphasized the need for a regular check on the older worker.

Mr. F. LE GROS CLARK (Nuffield Foundation) agreed with the necessity for medical supervision. In many cases a general practitioner could only suggest light work; it was the industrial medical officer in consultation with supervisory staff and personnel officers who could best solve this problem. In some industries something could be done for the older workers, but not in others where there was a production line.

Mr. RAMSDEN said that employers asked for the older man who would do the "fiddling" jobs which the younger man would not do.

Dr. J. A. L. VAUGHAN JONES (Chairman, Occupational Health Committee) defended the general practitioner who had to prescribe light work for the older man. Industry lacked an essential job analysis, and few people in manufacturing establishments knew how much each job involved. He hoped this would not be approached purely for humanitarian reasons. Older persons should be placed not on sympathetic grounds but in accordance with the work they could do.

Dr. SCOTT, replying to the discussion, said he believed the answer lay with industry and that medical supervision in factories should be much more widely used.

The motion was carried.

Mr. G. H. MILNER (York) moved that if fit and willing older people were not able to remain at work, or to find work or use their experience and qualifications to the full, there would be considerable hardship to the individuals concerned and a loss of manpower and skill to the country. He said many men and women at 65 were capable of doing a good job of work, particularly in a skilled occupation. Work demanding patience and craftsmanship was ideal for the older worker, and there were many such jobs available. On the point of hardship, a large number of people wished to go on working for the good of their health and their pockets. The habit of regular work should not be suddenly broken, and people should be able to feel that there was a place for them in the community.

Dr. J. N. AGATE (Medical Society for the Care of the Elderly) said that quite a number of old people were maintained in life but not in good health. There had been an emphasis on men, but there were many more women to be considered. In a geriatric unit three patients out of four were women, many of them housewives, who suffered no hardship because they were not employed.

The motion was carried.

Revision of Pension Regulations

A resolution calling for revision of the national pensions schemes and regulations to ensure that those fit and willing to continue at work after pension age should receive the full pension, and thus be encouraged to continue in employment, was put forward by four advisory councils—Brighton, Leeds, Wandsworth, and York.

Mr. T. W. PARSONS (Brighton), moving the resolution, said his council would waive all penalties on earnings over £2 per week which were imposed on pensioners under 70 years of age. They would then be encouraged to take employment suitable to their capabilities. It would help the national exchequer by removing the need for charity or public assistance, besides adding to the pensioners' dignity and pride in continuing to support themselves. This section was bad law; it gave rise to evasive action and created bad citizens. A contributory pension should not be affected by a man's earnings.

Mrs. S. WALLACE (Wandsworth) said that it was impossible for anybody to live on £4 per week. Old people

should be allowed to retain their standard of living, and if people wished to go on working they should be able to do so. This £2 limit should be abolished.

Mr. MILNER said that the Minister of Pensions stated recently that out of 5½m. people of pension age 400,000 were receiving increased pensions, 600,000 were earning the right to increased pensions, and 35,000 were doing sufficient work not to receive any pension at all, so that the number of people affected by this limit was very small, but they should have justice. If a person had contributed to a pension, he was entitled to that pension in addition to his earnings.

Mr. BRIAN STEVENS (Trades Union Congress) said that the earning rule was the yardstick to measure whether a man had retired from his employment. In the 1925 Act pensions were paid at a given age regardless of whether the man or woman had given up work, and the pension rate was below unemployment or sickness pay. During the war, after a comprehensive review, it was decided to abolish the old-age pension, the retirement pension to take its place for those who wished to give up working at a particular age. If the earnings rule was abolished he considered there would be a strong move to increase the minimum age of retirement. The existing level of retirement pension was much too low; the pensioner's life was very wretched in any case, and it was essential to maintain an adequate level of subsistence. This would not be the case if the earnings rule was abolished or was substantially increased. Which was the best thing to do—to try to safeguard the rights of the 5m. existing pensioners who had no other source of income than the pension with public assistance supplement, or get excited about the 35,000 who wished to earn more? One had to think of the greatest good to the greatest number and of getting a decent retirement pension. There was also the risk that if the retirement rule was altered a number of employers would take advantage of it to alter the wage standard.

Mr. PARSONS said that this was something which affected the occupational health of the older workpeople. He had noticed the deterioration which set in when people were too suddenly stopped from working. He believed that the provisions of the present Act were one of the prime causes of that sudden stopping of work, and it was felt that the removal of the earnings limit would be a deterrent to that process. It should be left to the common sense of the workman and the medical officer to decide how quickly or slowly he should bring his working days to a close. A man could draw more than £2 public assistance without losing anything from his pension, whereas the man who worked and earned more than £2 was worse off than if he subsisted on the State. From the point of view of occupational health this was a bad thing and should go.

Dr. A. MACRAE (Secretary, British Medical Association) drew attention to the problem of the blocking of promotion for the younger worker when people stayed on after retiring age.

Mr. A. E. GREGORY (Southampton) said that the main reason for people working after 65 was because they could not afford not to do so. Old craftsmen were unwilling to accept any down-grading, although there was a different feeling in the supervisory grades. Most jobs suitable for older people were filled by the disabled.

Mr. LE GROS CLARK pointed out that with the increasing spread of occupational and industrial pensions a larger proportion of people were able to retire on some kind of superannuation and could take other employment without affecting their pension. It was the man in receipt of the probably much smaller State pension who was penalized.

The resolution was carried.

Selection of Occupation

Dr. MARGUERITE STEWART (Wandsworth) moved a resolution urging that research in universities, in research institutes, and in industries into the effect of industrial conditions on the older worker and into the changes in capacity with increasing age should be continued, extended, and co-ordinated, and that the information gained from these researches should be applied in the selection of occupations suitable for the older worker. She said that ill-health in the elderly worker might have its roots in middle age or earlier, but if morale was high, if there was companionship and interest, the question of health was not so important. Unless there was a right attitude to work frustration would set up a whole chain of reactions. If the motive for work was good the intangible factors affecting health would be good.

Mr. PARSONS said that when a young person went into industry he had to be taken special care of, and there should be a similar service for the elderly worker.

The resolution was carried.

Mr. J. C. POINTON (Wolverhampton) next moved a resolution which noted with approval that some firms made special arrangements for the employment of older workers without segregating them in one part of the factory, and recommended that this method be extended where practicable.

Dr. VAUGHAN JONES asked if the policy of segregating older workers had been generally accepted. Dr. STEELE said that two years ago his advisory council produced a document on the employment of the older worker which recommended segregation, but there were difficulties. The older people in one factory were put into a workshop by themselves and they felt old; in another they were given special facilities, such as later hours of starting, in their normal place of work and were much happier. Dr. UNDERWOOD said that most elderly workers got up early in the morning and should finish work early in the afternoon.

The resolution was carried.

Retraining of the Elderly Worker

Dr. STEELE moved that there was a need for more facilities for the retraining of the older worker. He said it dealt with the point raised by Dr. Macrae with regard to the blocking of promotion. The answer was to regrade the older man to give the younger man his proper chance of promotion. Physical skills disappeared earlier than mental skills, and a man of 65 was not incapable of learning a new skill.

The resolution was carried.

Mr. A. J. BIRCH (Burton-on-Trent) moved that the pensionable age should be elastic from one trade to another, preferably voluntary. He suggested that the present fixed retiring ages of 60 and 65 had been out of date for some time. There was no justification for women retiring earlier than men. Men took a transfer to a different kind of work very well. An older man might be a greater sickness risk, but he had a greater will to work.

Mr. GREGORY opposed the motion. He thought the pensionable age was sufficiently elastic already.

Dr. J. M. ROGAN (Occupational Health Committee) said that one could not have a retirement age which was voluntary.

The resolution was lost.

Local Authorities

Mrs. VIOLET FLETCHER (Wolverhampton) moved that the local authority could assist the employment of the older worker by providing suitable premises and supervision for simple assembly work.

Mr. GREGORY moved an amendment: "That the organization of such premises and supervision should be on a national basis, preferably through Remploy or a similar body." He said that if local authorities started to employ elderly people they would come into conflict with the trade unions, whereas Remploy was in a different position. Remploy was not a commercial firm; it gave a place in life and industry to disabled people, and the job of employing older people could be given to it.

Dr. STEELE spoke against the amendment. Local authorities would not be employers in this matter; they would only provide premises and supervise the work as between industry and the individual. Remploy was heavily committed with the disabled.

Mr. PARSONS opposed the amendment and supported the resolution. He gathered that Wolverhampton had in mind the older people who could not follow their normal employment.

Dr. J. S. G. BURNETT (Society of Medical Officers of Health) said that local authorities had these powers and had experience in these matters, for instance in the provision of workshops for the blind. The work carried on in protected workshops was not employment as it was generally understood. If he understood it aright, the movers of the resolution visualized local authorities setting up protected workshops, but there was the question of providing supervision, of rate subsidies, and of a selling organization. There was the job of finding work which could be done, or looking for jobs in the industries in the town and trying to relate the old people to the jobs with the local authority co-operating to get them into them.

Dr. VAUGHAN JONES said that if industry was properly organized it could deal with many of these older workers in its own ranks. With the best will in the world there was great difficulty in getting a simple assembly job for these people. There were 90 Remploy factories at the present time. Remploy was heavily subsidized, and it was impracticable to set up other factories. He thought the services of the local authorities could be best employed as they were in Buckinghamshire, where the county medical officer had a special scheme for the housebound.

Mr. NIX said the conference had voted against segregation and this motion would lead to segregation.

Mr. STEVENS said that local authorities had the power to grant money to a voluntary association which had as its main purpose the provision of meals or recreation, but he did not know whether that included employment apart from hobby employment.

Mr. LE GROS CLARK said that he could identify local authorities, but what was meant by "industry," and under what legislation would this be imposed? Until these things were defined any discussion about them was vague.

Mr. GREGORY said that the Government grant to Remploy in 1952 was over £1m., so that the number of people in Remploy factories was considerable. Was it suggested that the Government grant to Remploy would be placed on the local authorities if elderly workers were employed there?

Dr. STEELE, in reply, said that there were many equivalents of Darby and Joan Clubs where older persons met together. He believed it was stimulating that they should be doing something while they were there rather than many of the airy-fairy activities found for them. They would feel better if they were making a contribution to industry. A lot of hard work was being done in uncontrolled conditions and there seemed to be a good case for bringing it under control. He thought the local authorities could do it very well.

The amendment was withdrawn.

In reply to a question on what he meant by "employment," Dr. STEELE said he had in mind the sort of work done at home usually on a piecework basis.

The resolution was carried by a narrow majority.

Employers' Pension Rules and Retirement Practices

Dr. UNDERWOOD moved a resolution stating that the Conference considered that employers should be encouraged to organize contributory pension schemes in order to supplement the State retirement pension. He said that few people could save enough for old age; to guarantee a pension of £5 a week by the time he was 65 a man would have to save £3,200. It was not until 1921 that the importance of private pension funds was recognized by the Government, and contributions to such a fund were now regarded as a business expense. Such funds were not to be bettered as a means of saving, and they gave the workers a feeling of security.

Mr. PARSONS seconded the resolution and added that the funds should be transferable, otherwise the tendency to anchor the worker militated against him.

Mr. RAMSDEN said that a pension fund did not prevent people being mobile: they drew out the lump sum and went elsewhere. It would be better, however, if these funds were interchangeable.

The resolution was carried.

A further resolution from York on this subject stated that employers should review and, if necessary, revise pension rules and retirement practices so that fit and willing workers could remain at work after reaching the minimum pension age. This, said Dr. UNDERWOOD, was intended to suggest that if the worker was able to continue at work his pension should be deferred.

Mr. GREGORY said that incremental pension payments should be increased above what they were now. Men were encouraged to defer drawing their State pension until 70, but it took 25 years for them to get back what they had paid towards it.

Mr. PARSONS said that incremental schemes should not be accepted. There should be a revision of these schemes so far as the younger old worker was concerned, who often found it impossible to get other employment because of the impossibility of entering into pension schemes. This had a deleterious effect on the industries and on the occupational health of the younger old worker, who began to worry what was going to happen to him and those who depended on him when he got older.

An amendment to insert the words "and the State" after "employers" was accepted, and as amended the resolution was carried.

Gowers Report

Mr. GREGORY moved:

> That this Conference urges the Government to implement fully those recommendations of the Gowers Report dealing with the employment of juveniles.

He said that up-to-date opinion had gone far beyond the recommendations in the report, particularly with regard to the hours of employment of young persons. The report was not in any way revolutionary; in several aspects it should have gone a lot further than it did, because there was an exploitation of juvenile labour in more than one industry with which the Gowers Committee did not deal.

The resolution was carried without discussion.

Other Business

It was agreed unanimously that Dr. H. Alexander, Chairman of Wandsworth Advisory Council on Occupational Health, should be the Chairman of the next Conference.

A vote of thanks to the Chairman, Mr. F. H. Martin, was accorded by applause, and the conference concluded.

SELF-EMPLOYED AND THE BUDGET

TAX RELIEF ON DEFERRED ANNUITIES

[FROM AN INCOME-TAX CONSULTANT]

The Chancellor of the Exchequer in his budget speech announced his intention of giving income-tax and surtax relief on premiums paid by self-employed persons for deferred annuities on retirement. This is in accordance with a recommendation of the Millard-Tucker Committee.

This proposal may benefit some members of the medical profession, but at this stage the position is far from clear and obviously subject to limitations because of the operation of the National Health Service Superannuation Regulations and other terms of service. In any event, details cannot be known before the Finance Bill becomes law, which is unlikely to be before August, and even then certain provisions may be subject to Regulations. The Association is no doubt following other interested bodies in obtaining further information. In general medical men would be wise not to commit themselves at this stage to any insurance schemes purporting to take advantage of the Budget proposal. A policy of "wait and see" is recommended.

GENERAL MEDICAL SERVICES COMMITTEE

The General Medical Services Committee met for the whole day on Thursday, April 19, at B.M.A. House, with Dr. A. TALBOT ROGERS in the chair.

Tributes to the Late Dr. A. Campbell

The CHAIRMAN said that the death of Dr. Campbell, of Lancashire, was a special loss to the Committee. He personally held him in considerable affection; they sat together for a number of years and got to know each other very well and to appreciate each other's point of view. Dr. Campbell, despite his quite severe physical handicaps, served his Committees in Lancashire and this Committee without stint.

Dr. F. M. ROSE also spoke in appreciative terms of Dr. Campbell, whom he had known since his student days in Edinburgh and with whom he again came into contact when he joined the Lancashire Medical Committee in 1939. During the years he had come increasingly to appreciate and respect this rather turbulent front bencher. He had outstanding qualities as a medical practitioner, and he could take a problem which seemed to be very complex and pick the heart out of it right away. In his own town, of which he was a former mayor, he was widely respected, and his local authority's housing policy, for which he was largely responsible, was admired all over the north of England. The Committee would be the poorer for his loss.

The members stood in silence for a few moments in tribute to Dr. Campbell.

In view of the nearness of the elections to the Committee for the new session it had been decided by Lancashire not to fill Dr. Campbell's place for the time being.

Remuneration

It was reported that expressions of support for the action being taken with regard to remuneration had been received from many Branches and Divisions of the Association, and particular pleasure had been voiced that negotiations were being conducted jointly on behalf of general practitioners and consultants and not separately. The Chairman said the preparation of the case to be put forward was now well in hand.

The Gold-headed Cane

The Committee next considered an item on the agenda, which was a letter from the London Local Medical Committee asking that a resolution of that committee should be laid before the G.M.S. Committee. The resolution was as follows:

> That the General Medical Services Committee be informed that the committee deprecates the leading article in the *British Medical Journal* of April 7, 1956—"The Gold-headed Cane."

The Chairman pointed out that the affairs of the *B.M.J.* were matters for the Council, and it was not appropriate that any resolution should be sent from the Committee to the Council asking for action on this matter.

Dr. F. GRAY said that he did not wish to refer any more than was necessary to the leading article. He wanted to question whether it was at any time suitable for one medical body to attack another, and in particular to attack its president. He thought the leading article was most regrettable. The Committee was vitally concerned in the matter; it had made a joint approach to the Ministry with the consultants, and the atmosphere of the Negotiating Committee had been most harmonious. The leader chosen by the consultants was Sir Russell Brain, the President of the Royal College of Physicians, and Dr. Gray could only say that he regarded the leading article as an attack on Sir Russell Brain and on the Royal College of Physicians—an article which was looked upon by laymen as coming from the B.M.A., and was so regarded by the *Daily Telegraph*. It was deplorable to bring disunity into the profession at a moment when, above all, unity was needed and when unity was being achieved. That was the unanimous opinion of all the members of his committee and that was why they passed the resolution.

Dr. F. M. ROSE, while agreeing with everything that Dr. Gray had said, thought that, as this was a matter which was likely to be raised in the Council, nothing would be gained in having a prolonged discussion now.

Dr. H. H. D. SUTHERLAND regretted the article in the *Journal* because it was an attack on a friend, and a personal friend of his, which might sabotage the efforts which had been made by the Committee, as representing general practitioners, with the Royal College of Physicians.

Dr. A. BEAUCHAMP agreed entirely with what Dr. Gray and Dr. Sutherland said, but in his view this was an attack on the policy of the G.M.S. Committee, and in the following week's *Journal* there had been another article attacking the Minister on the question of poliomyelitis. It seemed to Dr. Beauchamp that both these articles were singularly ill-timed and that both were maladroit.

The CHAIRMAN said that he did not think they wanted to have a prolonged debate, but he wanted to say that he hoped that nothing would be allowed to jeopardize any confidence in continuing to work co-operatively with the Royal College of Physicians in joint negotiations, and he felt sure that Sir Russell Brain felt the same.

After further discussion it was agreed that it should be reported to the Council that the Committee had discussed the matter and reaffirmed its confidence in the joint negotiations and in the Negotiating Committee.

Proposed Amendments to the N.H.S. Regulations

The Committee considered draft amendments to the National Health Service (General Medical and Pharmaceutical Services) Regulations. All of these had been agreed with the Association except for one or two minor provisions. Among them was a provision for keeping up to date the names of pupils and other inmates of residential schools and institutions on the list of a general practitioner. Another amendment would make a deputy who was on the list of the same executive council as the doctor for whom he was deputizing responsible for his own acts, and still another would make consent to employ an assistant subject to periodical review. If the consent was withdrawn the practitioner would have the right of appeal to the Medical Practices Committee. Under another amendment an error in the amount paid to a practitioner in any quarter would have to be adjusted in the next quarter. An amendment to the Fifth Schedule to the regulations, which prescribes a list of medical certificates a doctor is required to issue to his patients, inserted the words "establish pregnancy or other medical grounds for the purpose of obtaining extra coal or welfare foods" in place of the existing words.

Arising out of recent cases of appeals by doctors against penalties imposed upon them, Dr. H. G. DAIN pointed out that there was a loophole in the regulations which enabled the Minister to by-pass his Medical Advisory Committee and he thought this loophole should be closed in the amending regulations now under consideration. Also widely differing penalties were inflicted for the same type of offence, and it was agreed that consideration should be given to working out what would be appropriate machinery for dealing with these matters.

Admission to the Medical List

The Committee considered for some time the position which arose when, after a doctor's name was erased from the *Medical Register*, a vacancy was declared and a successor appointed to the practice. When his name was restored the practitioner made application to return to his former area of practice and the position of the successor was seriously jeopardized. In one instance quoted, the doctor appointed to the practice had lost a substantial number of patients. Concern was expressed because the regulations provided for a period of only twelve months during which the practitioner would be prohibited from

recommencing practice at his former surgery address. Another case was quoted in which the major portion of the patients transferred back to the old doctor, leaving the appointed doctor in dire straits. Although a local medical committee might inform the executive council that it did not recommend the doctor's reappointment to the list, the executive council had little option in the matter. No one wished to impose an additional punishment upon these doctors, but the point of view of the doctor appointed to the vacancy was an important factor in the situation. The matter was remitted to the Young Practitioners Subcommittee for consideration.

Group Practice Loans

Dr. A. BROWN reported that the Group Practice Loans Committee had approved 73 applications for loans (in respect of 268 doctors) in principle, 78 were rejected, 19 were withdrawn, and 18 were still under consideration at the end of the year. No application was approved without a visit to the group. The total amount approved in principle was £329,722, the total amount actually advanced was £185,409, and the total amount repaid was £10,593 16s. 2d. There was on December 31, 1955, £89,184 in the fund, and it was expected that a further £88,000 would be contributed from the central pool in April this year. Dr. Brown added that at the rate at which applications were coming in the Committee would run out of money by July next.

Dispensing of Proprietary Preparations

Concern having been expressed at the amount of publicity material included with the packaging of many preparations prescribed under the Health Service, the Committee asked a small deputation to meet the Association of British Pharmaceutical Industry. The DEPUTY SECRETARY, reporting on the meeting, said that the A.B.P.I. representatives stated that they believed that the retail pharmacists would co-operate by removing leaflets intended solely for the medical or pharmaceutical professions, but it was helpful to the public and the profession to include general instructions in new preparations. The Committee's representatives said that it was no part of the duty of the pharmaceutical industry to communicate advertising matter to the patients nor to take over what was essentially the obligation of the doctor, but the A.B.P.I. said that they were anxious to ensure that full instructions were available with every package, complaints having been made by coroners that warnings had not been made sufficiently clear.

It was suggested that the Committee might ask retail chemists to delete or remove advertising material unless the doctor asked that it should be retained. It was agreed that the discussions should continue.

Emergency Call Service

A matter which aroused discussion was the provision of an emergency call service in the London area which stated that it provided a staff of registered medical practitioners who would deputize on night calls for subscribing general practitioners and that every duty doctor was provided with a car equipped with two-way radio so that he was in constant touch with a control room so that emergency calls could be relayed instantly to him.

After some discussion the opinion was expressed that the scheme was undesirable and that there were two problems, ethical and legal, which might create difficult complications.

In view of the importance of the matter, it was decided to seek legal advice and to consider the matter again at the next meeting.

Other Matters

During the day the Committee turned itself into a meeting of the Defence Trustees to receive and approve the accounts. It was reported that, after the circulation of Counsel's opinion, a sum of money had been transferred to the British Medical Guild for subsequent transmission to Malta to assist, if necessary, the doctors there who were in dispute with the Government.

Some consideration was given to a resolution from the Public Health Committee relating to the reference of a child by the school medical officer for specialist treatment. In the policy agreed between the Association and the Society of Medical Officers of Health it was agreed that the general practitioner should be informed in all cases, except in regard to ophthalmic treatment. The Ophthalmological Group Committee had expressed the view that this restriction should be removed, and the Public Health Committee put forward a recommendation that the phrase "other than an ophthalmic examination" should be replaced by the phrase "other than an examination for refraction."

It was agreed to support the view of the Ophthalmic Group Committee.

RADIOLOGISTS GROUP

A meeting of the Radiologists Group, the first to be held for two years, took place at B.M.A. House, London, on April 19. Dr. S. WHATELY DAVIDSON (Newcastle) was elected chairman. A message of good wishes was sent to Dr. G. L. Buckley (Bournemouth), who was unable to attend owing to illness.

Co-ordinators in Radiology

The report of the Group Committee was presented by its chairman, Dr. J. W. D. BULL (London). The appointment of co-ordinators in radiology in the south-western region was considered and the fact that the regional hospital board had insisted that their choice must be a matter for the sole discretion of the board. Dr. ROBINSON THOMAS (Newton Abbot) stated that radiologists had had clinical directives sent to them. Dr. C. WROTH (Exeter), who said that he had been a co-ordinator, had resigned because in his view the co-ordinators served no useful purpose.

In discussion it was agreed that there should be some means of conveying the needs of radiologists to the board through their own advisory committee; it was mentioned that in one region the board was being advised on the purchase of *x*-ray equipment by an engineer and a lay official. In the Oxford region, it was stated, there was a central radiological committee composed of chairmen of local area committees elected by the radiologists, though the chairman of the central committee was appointed by the board.

It was reported that the Joint Consultants Committee had no comment to make on the recommendation, passed at the last Group meeting, that when only one consultant was in charge of a department he should be in administrative charge, and that when there was more than one consultant the selection of the consultant in administrative charge should be determined on the basis of his seniority and experience, provided that in each case this procedure was not contrary to the ascertained wishes of the radiologists concerned. Dr. ROBINSON THOMAS pointed out that the Group's view was contrary to the section on medical administration in the memorandum of the Central Consultants and Specialists Committee appended to the Council's report (*Supplement*, April 7, p. 161).

It was agreed unanimously that the Committee should raise this matter again.

Manpower Shortage

The question of shortage of radiologists had been investigated by the Committee. There was evidence that some senior vacancies had been filled by making use of the S.H.M.O. grade. It was felt that the consultant establishment in radiology was not sufficient to ensure reasonable prospects for those taking up this field of medicine as a career. The Committee proposed more training facilities, the inclusion of the teaching of radiology in the medical curriculum as a means of stimulating interest, and an adequate establishment of consultant posts.

The CHAIRMAN said that without doubt there was also a nation-wide shortage of radiographers, although this was not admitted by the Society of Radiographers. A suggestion by the Committee was that in view of the time taken for examination results to come through, although suitable candidates were available in the meantime to take up duties, radiographers might be appointed temporarily under some other designation pending publication of the examination results.

Dr. H. R. C. HAY (Sevenoaks) suggested that the question of fees for domiciliary visits, which had not been revised since 1948, should be discussed. This view was generally supported by the meeting, which referred the matter to the Committee. Doubts were expressed on whether all domiciliary visits were really necessary.

Implications of the suggestion that tuberculosis clinics and hospitals should deal with all diseases of the chest were raised by Dr. R. A. ROBERTS (Port Talbot). The CHAIRMAN said that the Joint Tuberculosis Council had put forward propositions which were being dealt with by another body. There was a move to take in industrial examinations and charge fees, which he thought would be detrimental to the right of radiologists to private practice. The Group Committee was asked to look into this matter.

The meeting expressed sympathy with the views of Dr. J. P. BRACKEN (Bromley) on the need for a revision of the remuneration of locumtenents; radiologists and pathologists, he said, were particularly affected by this. This was also sent to the Committee.

Dr. GRACE BATTEN (London) wrote suggesting that the Group should press for an increase in the salaries of radiographers. It was pointed out that the Group could hardly take action in this matter, because it was already being considered under the Whitley machinery.

A further matter which the Group considered was the designation of *x*-ray and pathological departments. Dr. ROBINSON THOMAS expressed dislike of the term "ancillary," as inferring inferior status, and the meeting agreed with him. The word "special" was thought to be more suitable and was in use in some areas.

PRIVATE PRACTICE COMMITTEE

The Private Practice Committee met on Wednesday, April 18, at B.M.A. House, with Dr. A. BROWN in the chair.

Mobile Radio for Doctors

A representative of the General Post Office Radio Department attended the meeting to explain the position with regard to the use of mobile radio by doctors. The Committee had felt that an exclusive channel for this service should be retained for the purposes of the profession, in contrast to the recommendation of the subcommittee on frequency special allocations that ambulance and medical-practitioner allocations should be combined. The representative of the Post Office explained that this did not necessarily mean that doctors would have to share a frequency with ambulance services operating in the same area. Under the revised arrangements a number of channels would be available for ambulance and medical services, and, so far as practical, allocations would be made to avoid interference between the two services. This would be done by allocating a channel used by a doctor or an ambulance service to the other category of user in an area some distance away, so that any interfering signal would be much weaker than the required signal. These arrangements would give the Post Office more flexibility in the allocation of channels to members of the medical profession.

By its very nature this kind of communication could not be secret, but in general people would not wish to listen to what was going on. The effective range of the service was 25 to 30 miles; beyond that distance the signal was very weak indeed. The range would be less in mountainous areas. Asked if it would be possible for the ambulance transmitter to be used for communicating with a doctor, the Post Office representative said that this could be done. It was hoped that mobile radio for these services would be used reasonably, and that if there was an emergency, and a priority call was given, silence would ensue. This was done in the shipping world already. It was hoped ultimately to have operating 17 channels for medical and ambulance services, which would include 11 channels for county ambulance schemes in the low band and six channels in the high band for county boroughs.

At present the extent of the medical need for this facility is not known. It was felt that there was a definite need for it in the more isolated parts of the country. One general practitioner who was known to have such a radio fitted to his car had stated that the arrangements worked very well.

The Committee agreed to set up a subcommittee which would consider the matter in all its aspects and make a report. The Committee felt that the Post Office had demonstrated that the medical profession was at present adequately protected.

Fees in Forensic and Other Branches of Practice

The Forensic Subcommittee had reviewed the question of the salary of a whole-time consultant chief medical officer of police in a large city, and recommended that it should not be less than £2,750 per annum, a recommendation with which the Committee agreed. The Council had questioned the appropriate fee for examinations for the police lasting an hour or more, and as most of the examinations lasted a little more than an hour the Council thought that the higher fees would apply to almost all examinations. The Forensic Subcommittee recommended that "including taking of notes and entering in police books or police forms" should be deleted from the wording of the scale of fees, and that a footnote should be included instead explaining that an examination implied the taking of notes relative to the circumstances. With regard to fees for examinations, the subcommittee proposed that there should not be any alteration; the average time taken for examinations was less than one hour and many would not qualify for the higher fee.

The question of who should pay the fee for a medical examination in respect of application for public service vehicle driving licences was again brought forward. It had been suggested in some quarters that the medical report should be sent direct to the licensing authority, who should pay for it. If this was done it might mean that the licensing authority would select a limited number of general practitioners to do the work instead of accepting reports from any general practitioner. The CHAIRMAN commented that before a man could obtain a passenger service vehicle licence he had to have a special medical certificate. It was a condition of his employment and the certificate was his personal property. The Committee agreed that the fee should be paid by the patient, and should be a matter of arrangement between the doctor and patient.

Arising out of consideration of fees paid by one or two insurance offices and other organizations for examinations, the Committee expressed the opinion that it would be helpful and save a good deal of explanation if the amount of the fee to be paid by the examinee was stated on the form which had to be completed.

Administrative Tribunals

The Committee considered matters under the heading of "Private Practice" in the draft memorandum of evidence to be given to the Government Committee on Administrative Tribunals, as well as notes submitted by Dr. I. M. JONES on the medical membership of a medical appeals tribunal and with the constitution of local appeals tribunals considering claims of special hardship allowance under the Industrial Injuries Act. Dr. Jones suggested that, wherever possible, the medical members should be one specialist in the type of case under consideration and either a general surgeon, a general physician, or a general practitioner, each with

extensive experience as a chairman of medical boards. With regard to local tribunals, Dr. Jones suggested that their constitution should be modified by appointing a medical chairman, or by the appointment of at least one medical member, or by the obligatory inclusion of a medical assessor.

Parking of Cars

A suggestion was received from a correspondent that the Association should give evidence on behalf of the profession to the Committee set up by the Minister of Transport to make a survey of car parking facilities in inner London. It was said that the position was becoming acute in many areas. It was agreed that the opinion of the Metropolitan Counties Branch should be obtained and that representations should be made.

Dangerous Drug Booklet

It was reported that the Home Office had prepared a revised edition of the Booklet D.D. 101 concerning the responsibility of those using dangerous drugs in medical practice. The Ministry of Health was arranging to send copies to executive councils for distribution to the doctors on their lists. The Committee has had considerable correspondence with the Home Office during the revision of the booklet, and several amendments were made in it on the suggestion of the committee. It would soon be available for purchase from H.M. Stationery Office.

Age Limit

The Committee had protested to the Ministry of Pensions against its proposal to apply an age limit of 72 to doctors employed as examining medical officers and medical officers on part-time administrative duties, but a letter had been received from the Ministry reiterating its determination to do this. It was felt that a protest should be made again. and strongly.

Drugs for Private Patients

The Chairman stated that a joint deputation consisting of representatives of the Private Practice Committee and the G.M.S. Committee had interviewed the Minister of Health. The deputation emphasized the importance which the Association attaches to this matter and sought an amendment of the Act at the earliest opportunity to allow private patients to receive drugs under the N.H.S. A statement of the Minister's views was awaited.

AGREEMENT IN MALTA

COMMISSION TO REVIEW MEDICAL SERVICE

A settlement has been reached in the dispute between the Government and medical profession of Malta (see *Supplement,* January 21, p. 19, and April 21, p. 206). An agreement, which each party hopes " will firmly establish a climate of good will for the future " and will lead to " a notable advance in the development of the medical services in Malta," was signed on April 24 by Dr. Hyzler, Minister of Health, and Dr. V. Tabone, president of the Medical Officers Union.

The agreement provides for the appointment of a commission " to undertake a comprehensive review of the medical service and to submit recommendations for the future organization and terms and conditions of employment." The members of the commission, to be approved by both sides, are to be from the United Kingdom and will consist of a chairman of legal status and two members nominated by the Royal College of Physicians and the Royal College of Surgeons respectively. Its report is to be made known to the Medical Officers Union as soon as it is made known to the Government.

Meanwhile the Union has agreed to withdraw all letters of resignation and to restore immediately the normal medical service. It has pledged not to take action under the bond which exists between its members until the commission submits its report. The Government has promised to reinstate all doctors and will not take any disciplinary measures for political views expressed by them while not on duty ; but no political activities will be tolerated during official business. As a gesture of good will the Government has undertaken to re-employ the five doctors whose recent discharge had been under discussion, and, pending the commission's report, no doctor enjoying private practice will be transferred, nor will any action be taken to fill the previously advertised medical posts in the island of Gozo or any similar posts in Malta. The Minister of Health has authorized the Medical Officers Union to state that in a speech which he made to the Legislative Assembly he never accused the medical profession of dishonesty and parasitism.

Under the terms of the agreement the doctors of Malta, with the backing of the British Medical Association, have gained their principal objectives. On April 17 Dr. Tabone and Professor V. Vassallo, past-president of the Malta Branch, visited B.M.A. House and remained in London for two days, and Mr. J. L. Gilks, chairman of the Association's Overseas Committee, arrived in Malta on April 25. It is reported that the emergency medical service organized by the doctors functioned smoothly for the nine days until the dispute was settled. One hundred thousand leaflets in the Maltese language were distributed to the public expounding briefly the profession's case. The reaction of the public is believed on the whole to have been favourable to the doctors, although a minor demonstration against the profession took place in Valletta on April 22.

Scottish News

AYRSHIRE DIVISION

DINNER TO HONORARY SECRETARY

A complimentary dinner to Dr. BRYCE R. NISBET, organized by the Ayrshire Division, was held in Ayr on April 6. Mr. A. H. SANGSTER, the chairman of the Division, presided, and about 50 members were present. Dr. Nisbet has just completed 25 years as honorary secretary of the Division.

Tribute was paid by Mr. SANGSTER to Dr. Nisbet's work over such a long period, and Dr. H. STRATHERN, vice-chairman, on behalf of the Division, presented Dr. Nisbet with a pair of binoculars and a cheque in appreciation of the valuable service he had given. Dr. Nisbet thanked the members for their great kindness, and expressed the pleasure he had derived as a result of being the honorary secretary for the Division. Dr. T. C. FRAME proposed the toast of "The British Medical Association," and Dr. E. R. C. WALKER, Scottish Secretary, replied.

Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Drugs for Private Patients

SIR,—There are said to be some 700 family doctors in this island wholly engaged in private practice. I am one such, and I write first to say that, whatever may prove to be its disadvantages, it has become for us a vital necessity to be able to order essential drugs for our patients out of national funds. It is not, for us, a question of more or fewer private patients, as in a mixed practice. " Patients " and " private patients " are, for us, synonymous ; our whole practice, all our patients, are involved.

The injustice done to these patients is, of course, flagrant, and it is a scandal that successive governments have not redressed it. They pay their weekly contributions and, more to the point, as fee-paying patients they are almost *ipso facto* substantial taxpayers. In round terms, they have already paid once for their medicines ; they should not

have to pay twice. It is said, truly enough, that the private patient pays twice for his medical advice. He does; but he has chosen to do so; he has not chosen to pay twice for his medicines. It is, I believe, also argued that the N.H.S. drugs are an integral part of the practitioner service and cannot be separated from it. Prescriber and prescription are indissolubly linked. You cannot have the second without the first.

Yet my written word can obtain for my patient his citizen's share of hospital services, a blood-count, an *x*-ray. My signature, no less than my N.H.S. colleague's, gives him his passport to the oculist, his share of the cost of his glasses, his certificate for sickness-benefit. All these are easily uncoupled from the N.H.S. practitioner; why not prescriptions too? These arguments are, of course, transparent sophistry and special pleading. Any unbiased child could see where justice lies. The effect—I fear the intended effect—of this discrimination is to press, almost to compel, the citizen of small or moderate means (but not the rich) to rely on a Service practitioner, whether he wants to or not. It powerfully discourages free choice and powerfully encourages State monopoly of medical services—an obvious step towards that whole-time salaried service the profession has until now consistently opposed.

That the N.H.S., the State, the citizen, and the medical profession, if they were wise and clear-headed, would one and all welcome and encourage a body of independent practitioners ought not to need restating. It is quite clearly in all their interests. The profession has, to do it justice, several times pronounced in favour of drugs for private patients at the cost of the N.H.S. A recommendation to that effect was passed by the R.B. only last year; yet a section of the Council considers, in that fine familiar phrase, that "the time is inopportune," the time being nearly eight years past the appointed day.

I think the time is not "inopportune" but over-ripe. The political party in power has declared itself "not opposed to the principle." I agree with Mr. C. E. Beare and Dr. William Russell (*Supplement*, April 21, p. 207) that a private practice committee consisting predominantly of private practitioners might well be able to press successfully for an overdue reform which has the support of the Representative Body.—I am, etc.,

London, N.W.3. LINDSEY W. BATTEN.

SIR,—In slightly more than half a page Dr. John Swan (*Supplement*, April 21, p. 206) exposes the sad state of the "doctor–patient relationship" so far as he is concerned. With all sympathy for him in his failure to establish that degree of confidence and friendliness which is the whole basis of private medical practice, I must, nevertheless, confute his arguments. Nobody gets "free" drugs. N.H.S. patients pay for them through their National Insurance contributions and through taxation. Private patients pay for them similarly but do not get them. They are denied their rights.

Because patients on his list want their rights and are sometimes a little exigent in their demands, Dr. Swan is irritated. He says he was in private general practice for a year prior to the appointed day. Why did he not remain in it? Was it, perhaps, because he hoped to get the best of two worlds—the guaranteed income from the pool and the supplement from private fees? Those of us in wholly private practice resent the injustice done to our patients, for whom we cannot write out a prescription for drugs already paid for by them, and of which they can only get delivery by paying again in cash.

I have a feeling that Dr. Swan would be happier in a whole-time salaried service in which he could dictate to his patients. He has made it quite clear that he is not a private practitioner but—to use his own words—"a principal in a large general N.H.S. practice" who has "a little private as well." I submit that his views are entirely irrelevant to the issue, which is that of common justice to people who, having paid their dues to society, still wish to have a private contract with their doctor. Why should they be penalized on that account? Surely it is up to us to support their claim to drugs for which they have paid and will continue to pay. I have been 35 years in private practice and have no fear for the continuance of a friendly respectful "doctor–patient relationship" without loss of prestige if I am allowed to give my patients their right by prescribing what I consider necessary for them on an E.C.10.

I might also add for the information of Dr. Swan and others, who may possibly hold similar views, that we private practitioners have intimated our willingness to accept reasonable disciplinary action by the Ministry for over-prescribing or other breaches of the Drug Regulations. I find it difficult to reconcile the suggestion in the final paragraph of Dr. Swan's letter with the general tenor of his argument. Neither the public nor the profession could possibly accept this half-a-loaf compromise.—I am, etc.,

London, N.W.3. J. KENNEDY.

Drugs on the Market

SIR,—As I have been travelling by land and sea since December 6 last year until February 1, it has not been easy to catch up with my *Journals*, and I have only now read the *Journal* of April 14. A leading article, "Drugs on the Market" (p. 849) interested me, and I unhesitatingly corroborate the "therapeutic dictatorship" which you speak of, though you do not accord capital letters to the caption, which are deserved.

I have had almost three years' experience in a small country hospital away in the burning bush of Australia, in Queensland, where each quarterly indent for drugs and appliances was usually subjected to a searching catechism by the advisory committee on drugs and appliances for hospitals (I think I have the designation correct), a very discouraging exercise and worse than anything I ever experienced in British military hospital administration for over 34 years. The system is ultimately, for one not used to it, one of attrition and exhaustion and hardly progressive. In Queensland lint was totally banned where I was, and no amount of writing or appealing could convert the advisory committee as to its real need. At first the shock was so great that I purchased a small supply for the hospital, pending, as I had hoped, conversion of the advisory committee, but, as this could not be kept up indefinitely at my own expense, one had to have recourse to old and torn-up bedsheets, etc., which one referred to as the bag of treasured rags. The case for lint was mercilessly thrown overboard. As for people having to pay for "cotton-wool, the lint, the purgative, and the pills for headaches and hangovers," where I was everything was free. This appeared to me an awful drain on public money, as almost everyone was earning and could afford to pay for such things. The money, instead, went to the publican, and I remember having written a letter to the *Medical Journal of Australia* about this in 1952. The extravagance in hospital dieting and equipment, etc., for which there were no authorized scales or tables. was striking, nor was there any control by audit. This was a typical case of "swallowing a camel and straining at a gnat."

I understand that neither in- nor out-patient treatment in other Australian states is free, and it was observed that people were coming into Queensland from New South Wales for the benefit of free treatment. So what, Sir?—I am, etc.,

London, S.W.19. B. J. BOUCHÉ.

Remuneration of Medical Teachers

SIR,—Your correspondents, Drs. H. de C. Baker and J. P. Smith (*Supplement*, April 14, p. 197), discussing the desirability of vigorous action in order that medical teachers' salaries should be revised in time for the commencement of the next quinquennium, agree that the Non-professorial Medical Teachers and Research Workers Group of the B.M.A. is the body best fitted to represent them and ask for evidence of a vigorous and effective policy from the Group Committee.

The policy of the B.M.A. regarding remuneration of medical teachers and research workers was formulated soon

after the commencement of the N.H.S. by a special committee consisting of the President of the B.M.A. (Sir Lionel Whitby), the Chairman of Council, the Secretary of the B.M.A., and other members of Council, together with representatives of the Group Committee, and including the joint secretaries of the Conference of Non-clinical Professors. This special committee drew up salary scales which were approved by Council and published in the *Journal*. Deputations from this special committee were received by the Universities Grants Committee and by the M.R.C., but it was not possible to arrange a meeting with the Committee of Vice-chancellors and Principals.

While the negotiations were under way the Chancellor of the Exchequer made available money to the University Grants Committee, and as a result university salaries in general were raised, though not uniformly and not to the level asked for in the B.M.A. scale. Since then another general increase in salaries has taken place, and, as was pointed out (*Supplement*, February 5, 1955, p. 42), the position is deteriorating as far as the medical teachers are concerned.

The Group Committee, in dealing with the problem of remuneration, have always had a sense of frustration in that they have had no opposite number with which to deal. The U.G.C., while always willing to listen sympathetically, can only make recommendations to the various universities regarding salary scales, and, as a result of the universities' understandable and desirable wish to retain as much control over their finances as possible, there is no uniformity and anomalies inevitably arise. With this lack of negotiating machinery in mind, the Group Committee made representations to the Hamilton Committee on Association Policy regarding Medical Remuneration, and it is interesting to note that the following recommendation of that Committee has been approved by Council for submission to the Representative Body : "That the Association take all possible steps to promote an effective system of negotiation whereby decisions reached upon appropriate salary ranges for medical teachers will be binding upon the universities concerned."

One of these steps may very well be that the Council of the Association should make an approach to the U.G.C. to urge them to make provision in their estimates for the next quinquennium for adequate remuneration of medical teachers, so that the standard of teaching in the medical schools shall not fall.—I am, etc.,

I. RANNIE,
Chairman of the Non-Professorial Medical Teachers and Research Workers Group Committee.

Newcastle-upon-Tyne.

Defence of the Middle Classes

SIR,—It is generally agreed that the professions in particular, and the middle classes in general, are the least organized politically, and in consequence the most heavily taxed. As the majority of your readers belong to this politically inarticulate group, they may be interested in an attempt to form an organization for the defence of the middle classes which has been inaugurated by Mr. H. A. Price, M.P.

Among the suggested aims of this organization are : (1) to represent the middle classes in all matters of common interest, and to strive to restore its pre-war status and dignity ; (2) to encourage thrift, industry, and independence, and to ensure that these virtues are not deprived of their just reward ; (3) to oppose monopolistic and restrictive practices in all their forms ; (4) to ensure that subsidies go to those who need them and not to those who do not ; (5) to oppose the growth of bureaucracy and protect the rights of individuals ; (6) to expose abuses of the Welfare State ; (7) to re-establish, and to encourage acceptance of, the principle that "he who pays the piper calls the tune."

A membership of at least 500,000 is considered necessary to ensure its voice being heeded, and I would urge all who, irrespective of their political persuasion, believe in the survival of a middle class to write to Mr. Price at the House of Commons.—I am, etc.,

Northampton. J. LEAHY TAYLOR.

Salaried Service

SIR,—The arguments put forward by Dr. B. Hirsh (*Supplement*, April 21, p. 208) in favour of salaried service are simply fantastic. Either Dr. Hirsh is a comparative newcomer to general practice or has very little experience of general practice.

To say that the drug bill and the sick-pay bill would be greatly reduced by merely introducing salaried service is just like living in a fool's paradise. The majority of doctors prescribe what is good for the patient, and not what the patient demands. If a patient comes to the doctor and says he is not feeling well, no matter how he may look, the examination may not prove anything ; can any doctor on these grounds decide the patient is fit for work ? The more reasonable course would be to give the patient the benefit of the doubt, at least for the time being. If a patient says he has a headache, backache, or tummy-ache, can anyone prove that he is lying ?

In the National Health Service a doctor in general practice is the only person who has some freedom left—for example, he can prescribe whatever he thinks is necessary for his patient, irrespective of the category of the drug as decided by the Joint Committee on Prescribing. It is possible to maintain a high standard of medical practice and reduce the cost of drugs in the present system. With the introduction of salaried service neither would be possible. What is more, the individual freedom of the doctor would be lost. This is proved by the correspondence by doctors in other medical services in the *Journal* in the past.—I am, etc.,

Liverpool. H. J. PRATAP.

Cost of N.H.S.

SIR,—(1) Capsules 250 mg. : 16, 48s. 3d. ; 100, 290s. 3d. (2) Tablets 250 mg. : 16, 48s. 3d. ; 100, 290s. 3d. These are the published prices of two separate, distinct therapeutic substances manufactured by two separate firms in two widely separated factories. They are, indeed, wonder drugs ; and I and my patients are grateful for the skill and organization which must go into their production. In the hands of medical practitioners these and many other costly substances made a considerable contribution to the national health.

But what of the economics behind all this ? I remember a phase when some drug manufacturers, as and when their expensively produced new preparations went into mass production, the medical profession having adopted them for general use, were pleased to announce price reductions. This almost amounted to a gentleman's agreement. Have those days passed ? The national drug bill is rising steeply. As an all-dispensing doctor I have seen my total drug bill more than double itself in the past two years. Have I become extravagant ? Or am I simply making use to the best of my knowledge and ability of the magnificent and highly expensive armamentarium which is now at my disposal ?

Through his representatives in Tavistock Square the doctor is asking for a fair standard of remuneration. What of differentials as between, say, the unnegotiated reward received by the drug manufacturer for his skill and care and that received by the doctor for his skill and care in administering the drug ? The latter has to go cap in hand to a Minister for his just reward. The Minister pays both of them. And what sort of economics is it, anyway, when a dear old female pensioner of 84, having but one day left to live, swallows 72s. worth of one of the above-mentioned wonder drugs, and is now destined to draw her pension for, quite possibly, a further two years ? My ingrained sense of ethics would not allow me to think of withholding this silken life-line from her. But to what a shocking inflationary spiral have I, hand in hand with the drug manufacturer, thus contributed.

And still I feel that I ought to receive my just reward for my skill and devotion—until such time as some monetary nuclear fissional explosion covers you and me and the drug manufacturer with its impoverishing dust and allows us all to start again from zero.—I am, etc.,

March, Cambs. G. L. MCCULLOCH.

Doctors' Remuneration

SIR,—I hope there are not many who have interpreted my letter (*Supplement*, February 25, p. 64) as a hard-luck story. I recommend those who have to read it more closely. From the personal details supplied, the discerning reader must surely have grasped the inference that if it is difficult to make ends meet on the better prospects then how impossible it must be for the less fortunate. I am well aware of the position of such groups as G.P. assistants, junior hospital staff, medical teachers, and those employed by local authority. Those in such circumstances should, in all fairness, weigh in the balance any advantages which they may enjoy, such as regular hours, freedom from rising expenses (apart from the effects of inflation), and freedom from the frustrations afforded by regular contact with the more irresponsible and feckless members of the public. Only those with experience of working a large list can fully appreciate the significance of these points. I refute any suggestion that the B.M.A. is interested only in one section of the profession. The Diary of Central Meetings for April (*Supplement*, April 7, p. 184) lists a wide range of activities of various committees, among them the Subcommittee on Remuneration of Whole-time Medical Teachers, meeting on April 23.

Expenses vary from practice to practice, and no generalization can be taken as representative, nor can the figure of £2,222 net remuneration be regarded as universal. This is underlined in the admirable letter from Dr. Bruce Cardew (*Supplement*, April 7, p. 183). My own net figure falls far below this amount, owing mainly to the heavy expenses. My view is that income is payment for services rendered, not just to meet expenses, and if, as a result of those expenses rising, the income is declining, then appropriate adjustment should be made. I submit that £1,700 is a more realistic average in general practice, and when one adds to this approximately £1,200 expenses it represents a good many fourpences, which, as Dr. T. S. Eimerl has pointed out in a subsequent letter (*Supplement*, March 10, p. 83), is our average remuneration per head per week. This figure is shown to be even more ridiculous by comparison with such charges as 25s. for servicing a typewriter, refrigerator, or television set, none of them life-or-death matters.

The call is still to support the Negotiating Committee, for in the face of an increased national income the claim is obviously justified, and there is no reason why it should be prejudiced by extravagance and thriftlessness which has taken place on a national scale.—I am, etc.,

Sowerby Bridge, Yorks. E. A. HUMPHREY.

SIR,—There appeared recently in certain newspapers a statement giving the figure of £2,222 as the net income of the average general practitioner. I am informed that this sum was arrived at by a leading statistician. In spite of this, I maintain that, in fact, this amount is a gross overstatement of our net incomes. In allowing it to receive publicity in the press, the public has been seriously misinformed as to the amount their doctors earn.

Several of my patients have been delighted to know that I was so well off when, in actual fact, I find the greatest difficulty in making both ends meet. I have a list of over 3,000 patients, a small private practice, numerous temporary residents, and the other usual minor sources of income. My net income is well under the given figure, and I know that the average practitioner does not have over 3,000 patients. If the claim for an increase in remuneration to cover the increase in the cost of living since 1950 is to meet with any sympathy from the powers that be and the general public, a fresh announcement should be made more in keeping with the facts.

I have discussed this matter with several practitioners and we are all agreed that statistics can give a false impression of the facts, as they appear to have done in this instance. The average general practitioner just does not receive a net income of £2,222 per annum.—I am, etc.,

Blackpool. A. C. FERGUSON.

SIR,—Like most of the writers to the *Journal*, I am strongly of the opinion that we deserve increased remuneration and that this is overdue. We cannot expect unanimity about this, as we appear to number more idealists in our profession than almost any other. But also there are so many classes in medicine and such varied remuneration, and there must be many who are doing nicely.

My main point, however, is that since 1945 I have had no faith in our negotiators, being medical men. I think we should have well-paid professional negotiators. I attended a representative conference of the B.M.A. in 1945 to discuss a National Health Service, and was positively nauseated by the lack of fervour and belief in our own cause shown by the several members of the negotiating committee who spoke from the platform. They spoke more like impartial judges than the protagonists we were then and again now are so much in need of. I had a sinking feeling that with such representation we would have little success against people who had the will to win, as we all knew the Government of that time had. I have no faith that a few of the newer generation plus some experience will do much to toughen the body. Coming as it will at the tail end of a long string of wage-increase demands, coupled with the tendency to make deflation a strong argument when it suits the Government, there seems to me little doubt that only clear-cut and copious facts and figures, coupled with a strong belief in our cause and the will to win, can gain us anything at all. Surely lawyers and business men, from mere experience and habit of thought, must be more suitable for this type of contest than doctors.

It would seem to me imperative that, before any negotiating is commenced, as many facts and figures as possible should be taken from a wide cross-section of the profession. Yet I have heard of no such step being taken. The B.M.A., of course, may be able to find out as many gross incomes as it needs, but I am only too well aware that what determines our standard of living is chiefly practice expenses, and these can vary from a moderate sum to one so relatively large as to entail real hardship.—I am, etc.,

Middlesbrough. J. DURIE.

SIR,—May I suggest to the General Medical Services Committee that in their forthcoming discussion with the Government regarding the "betterment factor" the closely related subject of compensation money be put on the agenda? Many have watched with dismay the gradual dwindling in value of our compensation award since 1948. The retention of our compensation money is indefensible, and we now have a golden opportunity to correct this grave injustice.—I am, etc.,

Northolt, Middx. J. M. GREEN.

SIR,—The *Daily Mail* of April 5 reveals that 77 dustmen in Derby earn £14 19s. 10s. each per week (certainly not bad for utterly unskilled work). When one ponders the fact that these earnings are £200 to £300 more per year than the average wage of a house-surgeon liable at any time to charges of negligence by the general public, one wonders why some doctors have the temerity to suggest that the Negotiating Committee should not press on with our just wage claims.

The system of reward for the type of work done is now becoming ridiculous, and if we do not ask the Committee to look to our laurels we shall soon become the laughing-stock of the country.—I am, etc.,

Slough, Bucks. N. C. HYPHER.

SIR,—In view of the intended claim for revision of remuneration may I suggest that, in my opinion, the greatest injustice lies in distribution of the expenses factor? This, being strictly attached to capitation fee, wrongs the small- and medium-list practitioner as much as it favours the big-list doctor. Every practitioner, independent of the size of his list, has got the same burden of keeping and using his surgery and waiting-room, of having it cleaned, lighted, and heated in the same way. He has to pay the same basic telephone rates, garage, car registration rate, and insurance,

whether he has 500 or 3,500 persons on his list. Apart from difference in wages of a secretary and in car mileage, basic expenses are the same for all.

These minimum basic expenses should be returned in full to every doctor on the N.H.S. list. There is almost no private practice nowadays and we keep our surgery nearly exclusively for N.H.S. patients. Why should a big-list practitioner be privileged in drawing an excessive expense factor from the common pool at the cost of his small- and medium-list colleague, as happens now when this factor is attached as additional to capitation fee?

If this matter were revised and justly settled, the rather complicated assistance for the small-list practitioner, granted now in the form of supplementary payment, could easily be abolished.—I am, etc.,

London, S.W.17. M. MOHR.

Prescribing

SIR,—What ludicrous situations can now arise over prescribing. I have a patient, aged 70, who suffers from diabetes mellitus, steatorrhoea, and "chronic senile chest." His diabetes is controlled by diet alone, as he proved unstable on insulin treatment and suffered hypoglycaemic symptoms frequently, with coma on two occasions. His carbohydrate intake is therefore restricted. His steatorrhoea virtually precludes fat from his diet. His chest flares up each winter and bronchopneumonia is no new experience for him.

A consultant physician suggested that he should be given one of the concentrated protein products ("casilan"), and this seemed to me to be sound preventive medicine, and likely to help him combat his chest condition. I accordingly prescribed it. In due course I heard that the executive council decided that they were not bound to supply this "food," and my case was considered by the local medical committee, who decided I should have to foot the bill. On principle I exercised my privilege of appealing to the Minister, and some weeks later appeared before three referees who had travelled to my home town for the occasion—a barrister-at-law, a professor of pharmacology, and another medical man—to state my case. During the short hearing, the question arose of the possibility of my patient buying the casilan himself. I pointed out that he had only his old-age pension, and had to pay for his lodgings, and was told that he could surely apply for assistance. "Where," I asked, "does the money come from?" "Oh," was the reply, "it comes from the same source, but through different channels." I ask you. My reply to that (which unfortunately did not come to mind at the time) should have been: "How much more in keeping with human dignity to let me prescribe it for him, instead of making him beg for it."

There will be recovered from me, Sir, 4s. 10d., the cost of the food I prescribed. This will go a long way, no doubt, to paying the travelling expenses and subsistence allowances of the eminent gentlemen who came here to hear the reference—but that money will come easily enough through yet another channel from the same source.—I am, etc.,

Bedford. BRIAN V. I. GREENISH.

Present State of Practice

SIR,—The *Daily Express* featured a leading article on Friday, April 20. The article quoted from a speech in the Commons by the Financial Secretary to the Treasury, Mr. Henry Brooke. In his speech Mr. Brooke was referring to the effort or drive which is to be made to get more work done by fewer people in the Civil Service. Said Mr. Brooke: "Virtually the whole of the service is now working regular and continuous overtime and that makes neither for efficiency nor economy." Mr. Brooke could not, of course, be more correct; let the Treasury take careful note of these wise words.

Medical practitioners are now working anything from 70 to 90 and sometimes more hours per week, and only a few can afford the luxury of an annual holiday away from home, or indeed a holiday at all. In the event of any illness, either of an infective nature or mental illness due to sheer stress of overwork, the doctor has personally to pay out of his totally inadequate remuneration £25 per week for a locum, this sum including a car allowance and his personal keep.

Would Mr. Henry Brooke consider that this state of affairs promoted and encouraged efficiency among the medical personnel of the country, upon whose efficiency, skill, and diagnostic acumen depend the health and happiness of the rest of the community?—I am, etc.,

Enfield, Middx. N. GRAHAM.

Correction.—A correspondent recently made reference to "linguets" in a letter in the *Supplement* (April 21, p. 206). We are informed by Ciba Laboratories Limited that Ciba Limited, Basle, are the registered proprietors of the trade mark "linguets," which is registered in the United Kingdom and abroad in the pharmaceutical class.

B.M.A. LIBRARY

The Library service is available to all members of the Association resident in Great Britain and Northern Ireland (and by special arrangement to members of the Irish Medical Association). A copy of the Library Rules will be forwarded on application to the Librarian at B.M.A. House.

The following books have been added to the Library:

Adriani, J.: Selection of Anesthesia. 1955.
Baker, D. M.: Cardiac Symptoms in the Neuroses. Second edition. 1955.
Brain, Sir R.: Diseases of the Nervous System. Fifth edition. 1955.
Convegno Medico dell'Amicizia Italo-Svizzera, Bologna, 6-7-8 Settembre, 1953. 1955.
Critchley, M. (Editor): James Parkinson (1755-1824). 1955.
Diethelm, O.: Treatment in Psychiatry. Third edition. 1955.
Drinker, P., and Hatch, T.: Industrial Dust. Second edition. 1954.
Fraenkel, M., and Erhardt, C. L.: Morbidity in the Municipal Hospitals of the City of New York. 1955.
Haex, A. J. C., and Van Beek, C.: Tuberculosis and Aspiration Liver Biopsy. 1955.
Harry, R. G.: Principles and Practice of Modern Cosmetics. Volume I: Modern Cosmeticology. Fourth edition. 1955.
Henderson, G.: Bible and Stethoscope in India. 1954.
Herdan, G.: Statistics of Therapeutic Trials. 1955.
Houssay, B. A., *et al.*: Human Physiology. Second edition. 1955.
Hyman, H. T.: Handbook of Treatment. 1955.
Lyle, D. J.: Neuro-ophthalmology. 1954.
McCarthy, D. J., and Corrin, K. M.: Medical Treatment of Mental Diseases. 1955.
Martin, G. J.: Ion Exchange and Adsorption Agents in Medicine. 1955.
Ritvo, M.: Bone and Joint *X*-ray Diagnosis. 1955.
Ryff, W. H.: Omnium Humani Corporis Partium Descriptio (Facsimile edition). 1951.
Sainsbury, P.: Suicide in London: An Ecological Study. 1955.
Selman, J.: Fundamentals of *X*-ray and Radium Physics. 1954.
Shearer's Manual of Human Dissection. Third edition, edited by Charles E. Tobin. 1955.
Singer, M., and Yakovlev, P. I.: Human Brain in Sagittal Section. 1954.
Sociedad Española de Ciencias Fisiologicas, Primer Reunion Nacional, Abril de 1953, Madrid. 1955.
Squire, J. R., *et al.*: Dextran: Its Properties and Use in Medicine. 1955.
Stallworthy, K. R.: Manual of Psychiatry. Third edition. 1955.
Standard, S., and Nathan, H. (Editors): Should the Patient Know the Truth? 1955.
Statland, H.: Fluid and Electrolytes in Practice. 1954.
Tuberculosis in Ireland: Report of the National Tuberculosis Survey (1950-53). 1954.
Turner, G. D.: General Endocrinology. Second edition. 1955.
Walker, B. S., *et al.*: Biochemistry and Human Metabolism. Second edition. 1954.
Weinstein, E. A., and Kahn, R. L.: Denial of Illness: Symbolic and Physiological Aspects. 1955.
Wells, K. F.: Kinesiology. Second edition. 1955.
Welt, L. G.: Clinical Disorders of Hydration and Acid-base Equilibrium. 1955.
Wertham, F.: Seduction of the Innocent. 1955.
White, P. R.: Cultivation of Animal and Plant Cells. 1955.
Wilder, L.: The Mayo Clinic. Second edition. 1955.

HER MAJESTY'S OVERSEA CIVIL SERVICE

The following appointments have been announced: I. N. Anastassiades, M.B., District Medical Officer, Cyprus; F. C. Harris, M.R.C.S., L.R.C.P., D.C.P., Specialist Pathologist, Gold Coast; L. G. G. Jones, M.R.C.P.Ed., Medical Officer, Grade A (Venereologist), Trinidad; P. C. Kothari, M.B., Medical Officer, Sierra Leone; A. D. Low, M.R.C.S., L.R.C.P., District Medical Officer, St. Lucia; Katherine P. Prendiville, L.R.C.P. and S.I., Assistant Medical Officer, Bahamas; M. J. C. Thomson, L.M.S.S.A., Resident Medical Officer, Uganda; B. Voulich, M.D., Medical Officer, Northern Region, Nigeria; Sylvia J. Darke, M.B., Ch.B., Medical Research Officer, Grade III, East Africa High Commission.

Association Notices

A.R.M. MOTIONS INVOLVING SPECIAL EXPENDITURE

The following motions involving special expenditure have been submitted for inclusion in the A.R.M. Agenda:

Cornwall: That, the principle having long been approved as the policy of the Association, the time has arrived when subsistence allowances should become payable to members when attending centrally arranged meetings for which they have been elected.

North Middlesex: That this Meeting resolves that members who are elected by their Divisions to act as their Representatives at the Annual Representative Meetings should be wholly or at least partially reimbursed by the B.M.A. toward the general expenses incurred in attending such meetings.

Derby: That Branches and Divisions should, at their discretion, be permitted to expend some portion of their annual grants in helping to defray expenses of their members attending meetings in the interests of the Association.

These motions have been referred to the Finance Committee and to the Council in order that the Council may report on them to the Representative Body in accordance with Standing Order 8 relative to business at Representative Meetings, which reads as follows:

8. *Resolutions Involving Special Expenditure.*—The Meeting shall not proceed on any motion involving special expenditure which has not previously been considered by the Finance Committee. The Council shall report to the Representative Body on all motions involving special expenditure, of which not less than two months' notice has been given in the *Journal*.

A.R.M. MOTION INVOLVING RESCISSION OF A PREVIOUS RESOLUTION

The following motion has been submitted by the North Middlesex Division for inclusion in the A.R.M. Agenda:

That this Meeting believes that the right of buying and selling the goodwill of practices should be restored.

The following motion was adopted by the A.R.M. in 1954:

That this Meeting considers that the restoration of the right to buy and sell goodwill of medical practices in the National Health Service is impracticable.

The North Middlesex motion is now published in accordance with Standing Order 30 relative to business at Representative Meetings, which reads as follows:

30. *Rescission of Resolutions.*—No motion to rescind any resolution of a Representative Meeting shall be in order at any subsequent Representative Meeting, unless at least two months' notice of such proposed motion shall have been given to the Divisions through the *Supplement* to the *Journal*.

Diary of Central Meetings

MAY

8	Tues.	Alternative Edition Subcommittee, Joint Formulary Committee, 11 a.m.
8	Tues.	Subcommittee on Service Committees and Tribunal Regulations, G.M.S. Committee 11 a.m.
9	Wed.	Editorial Subcommittee, Joint Formulary Committee, 11 a.m.
10	Thurs.	Guillebaud Subcommittee, Central Consultants and Specialists Committee, 11 a.m.
10	Thurs.	Conference of Regional Officers, 12 noon.
11	Fri.	Conference of Honorary Secretaries, 10.30 a.m.
11	Fri.	Chest Services Subcommittee, Central Consultants and Specialists Committee, 2 p.m.
17	Thurs.	G.M.S. Committee, 10.30 a.m.
17	Thurs.	Organization Subcommittee, Central Consultants and Specialists Committee, 2.30 p.m.

JUNE

1	Fri.	Ophthalmic Group Committee, 10.30 a.m.
1	Fri.	Ophthalmic Qualifications Committee, following Ophthalmic Group Committee.
1	Fri.	Subcommittee on Future of Ophthalmic Services, Ophthalmic Group Committee and Faculty of Ophthalmologists, 2 p.m.
20	Wed.	Maritime Subcommittee, Private Practice Committee, 2 p.m.

JULY

5	Thurs.	**Annual Representative Meeting** (at Brighton), 10 a.m.
6	Fri.	**Annual Representative Meeting** (at Brighton), 9.30 a.m.
7	Sat.	**Council** (at Brighton), 9 a.m.
7	Sat.	**Annual Representative Meeting** (at Brighton), 10 a.m.
9	Mon.	**Annual Representative Meeting** (at Brighton), 10 a.m.
9	Mon.	**Council** (at Brighton), at conclusion of A.R.M.
9	Mon.	**Annual General Meeting** (at Brighton), 12.30 p.m.
9	Mon.	**Adjourned Annual General Meeting and President's Address** (at Brighton), at 8.15 p.m.

Branch and Division Meetings to be Held

BUCKINGHAMSHIRE DIVISION.—At King's Head Hotel, Aylesbury, Friday, May 11, 8.30 p.m., meeting. Dr. G. W. Knight: "Poliomyelitis Vaccine."

CROYDON DIVISION.—At 43, Wellesley Road, Croydon, Tuesday, May 8, 8.30 p.m., annual general meeting, followed by films: (1) "Thrombosis and Embolism"; (2) "Mitral Valvotomy," by Sir Russell Brock.

EAST HERTS DIVISION.—At Shire Hall, Hertford, Friday, May 11, 9 p.m. to 1.30 a.m., annual supper dance.

EAST KENT DIVISION.—At Chez Laurie Restaurant, Thanet Way, Herne Bay, Thursday, May 10, 7.30 p.m., dinner; 8.45 p.m., general meeting, followed by annual general meeting.

HALIFAX DIVISION.—At Board Room, Royal Halifax Infirmary, Wednesday, May 9, 8.30 p.m., annual general meeting. Address by Dr. W. P. Sweetnam: "The Changing Face of Paediatrics."

HENDON DIVISION.—At Hendon Hall Hotel, N.W., Monday, May 7, 8.45 p.m., annual general meeting.

KESTEVEN DIVISION.—At Nurses' Recreation Hall, Grantham and Kesteven General Hospital, Sunday, May 6, 10.30 a.m., meeting.

KINGSTON-ON-THAMES DIVISION.—At Nurses' Home, Kingston Hospital, Wolverton Avenue, Kingston, Tuesday, May 8, 8.30 p.m., annual meeting. Address by Dr. W. H. Bradley: "Possibilities of Immunization Against Poliomyelitis."

NORTH-EAST ESSEX DIVISION.—At George Hotel, Colchester, Wednesday, May 9, 8.15 p.m., joint meeting with Colchester Medical Society. Dinner, followed by lecture by Dr. F. Dudley Hart: "Clinical Use of Cortisone and its Derivatives."

RICHMOND DIVISION.—At Reception Room, Mortlake Brewery, S.W., Friday, May 11, 9 p.m., annual meeting.

SCARBOROUGH DIVISION.—At Scarborough Hospital, Monday, May 7, 8.30 p.m., general meeting.

SHEFFIELD DIVISION.—At Medical Library, Sheffield University, Tuesday, May 8, 8.30 p.m., general meeting.

SOUTH-EAST ESSEX DIVISION.—At Southend General Hospital, Friday, May 11, 8.30 p.m., annual general meeting.

SOUTH ESSEX DIVISION.—At Masonic Hall, Hutton, Saturday, May 12, 7.30 p.m., dinner.

SOUTH STAFFS DIVISION.—Thursday, May 10, 3.30 p.m., tour of Pottery Works of Messrs. Josiah Wedgwood and Sons Ltd., Barlaston, meeting at works.

SOUTH-WEST WALES DIVISION.—At St. David's Hospital, Carmarthen, Sunday, May 6, 3 p.m., annual meeting.

SWINDON DIVISION.—At Victoria Hospital, Swindon, Friday, May 11, 8.30 p.m., annual general meeting.

WEST SUSSEX DIVISION.—At 2, Longfellow Road, Worthing, Sunday, May 13, 4 p.m., annual general meeting.

WINCHESTER DIVISION.—At Board Room, Royal Hampshire County Hospital, Winchester, Wednesday, May 9, 8.45 p.m., general meeting.

Meetings of Branches and Divisions

AYRSHIRE DIVISION

A meeting was held at Kilmarnock Infirmary on March 11, 1956, to ascertain members' feelings on the question of increased remuneration; 52 members attended. Resolutions were passed that the question of negotiation of salaries should be made jointly for all branches of the profession, and that this was the proper time to go ahead for a betterment factor.

RUGBY DIVISION

Some 20 members were present at the Grand Hotel on March 16, 1956, to hear the B.M.A. Lecture given by Dr. R. M. B. MacKenna on "Common Problems in Dermatology."

WEST SUFFOLK DIVISION

The annual general meeting was held at Everard's Hotel, Bury St. Edmunds, on March 13, 1956. Dr. H. W. Bradford took the chair and 29 members were present. Mr. D. J. Martin gave a talk on remuneration of general practitioners and hospital medical staffs. The following officers were elected for the coming year:

Chairman.—Dr. T. C. Kirkpatrick.
Deputy Chairman.—Dr. H. W. Bradford.
Honorary Secretary.—Dr. J. W. E. Cory.
Assistant Secretary.—Dr. R. S. Blaxland.