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CONTENTS

Some Important Issues of the National Health Service. E. R. C. Walker, M.D., F.R.C.P.Ed. - 181

Central Consultants and Specialists Committee - 183

Scottish Medical Practices Committee - 184

Correspondence - 185

Diary of Central Meetings - 186

Branch and Division Meetings to be Held - 186

Meetings of Branches and Divisions - 186

SOME IMPORTANT ISSUES OF THE NATIONAL HEALTH SERVICE

BY

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Scottish Secretary of the British Medical Association

The office of Scottish Secretary of the British Medical Association carries with it, in its humbler sphere, something of the *ad omnia* responsibilities of the Secretary of State for Scotland, and consequently the opportunity of obtaining a wide overall picture of the working of the National Health Service. It would be impossible to attempt to refer to all the many problems which have arisen during the past four years, and what I have done is to pick out a few of them which seem to me of major importance in its development. Some are clear-cut—as, for example, the framework of administration as defined in the Act. Others, such as the ultimate effects of nationalizing medical provision on the doctor's place and relationships within the community, are less tangible and are recognized as problems of serious significance only by a comparatively small number of people. I propose to say something about four more or less definable issues which demand hard, clear-headed thinking if we are to avoid serious mistakes.

"Adapt or Perish"

First I will refer to one general tendency, fairly widespread—the tendency to accept as permanent the *status quo* and assume that nothing now remains but to run the machine with, perhaps, minor adjustments now and then. So insidious is this tendency that it is observable even among those who have been foremost in demanding amendment of the National Health Service Acts. This indicates a wrong and unscientific attitude towards what all thinking people recognize to be a vast social experiment. Such a situation calls for an alert readiness to change and to adapt. The opposite qualities—rigidity and complacency—are dangerous, for the law of nature "adapt or perish" applies no less to communities than it does to individuals.

It may be said that the form in which the Act was passed—as a so-called "enabling" Act—takes account of this very point. It is interesting to note that much of the criticism levelled at the measure was, and is, that it places too much power in the hands of the Minister and his administration. I suggest that the answer is only theoretically true, and it is at least doubtful whether some of the actual provisions of the Act are the best that could be devised in order "to promote the establishment in Scotland of a comprehensive health service designed to secure improvement in the physical and mental health of the people of Scotland and the prevention, diagnosis, and treatment of illness." Taking both these apparently somewhat conflicting criticisms into consideration, it may be that the statute as it stands gives enabling powers where it should not and does not give them where it should. All I wish to establish is that a *non possumus* attitude is altogether unwarrantable—that attitude which finds expression in the response "but that would mean an amendment of the Act" as a reason for not examining further any proposed alteration in the Service. Any intelligent appreciation of the future needs of this and other social services must necessarily anticipate considerable legislative changes, and if our present legislative arrangements are inadequate or unsuited to this task, then common prudence will require that we overhaul them.

Administrative Issues

Turning to more particular issues, I will start with one already mentioned—the administration of the Service. In a memorandum about five years ago I predicted that the profession might regret that it had not criticized the tripartite system of administration which it could have demonstrated to be related more to considerations of a political nature that to the facts of medical practice. This was not a purely personal view, but a reflection of that expressed to the Cathcart Committee in 1934 by the Scottish Committee of the Association in advocating a single *ad hoc* regional administration of any comprehensive medical service. The Cathcart Committee, although it rejected the *ad hoc* authority, did accept the principle of a common administrative body for all medical services. The committee clearly came to its conclusion after a very careful consideration of the administrative problems involved, and it seems a great pity that this essential feature—namely, unified administration—was ignored by the framers of the Act, and that the opportunity was lost of really rationalizing the organization of the medical services. The Coalition Government's plan of 1944 came nearer to acceptance of

*An abridged version of an address delivered to the Annual Conference of the Scottish Executive Councils Association on September 26, 1952.

the Cathcart view than does the present Act, but what it did was to accept the non-essential part—namely, the transfer of much, but not all, administration to grouped local authorities.

Integration of G.P. and Hospital Services

This conclusion in favour of a single administration was reached on theoretical considerations, and practical people may want to know whether there is evidence that the absence of what the Cathcart Committee thought to be essential has, in practice, given rise to serious difficulties. I would ask you to consider a matter which, ever since 1948, has been much in the minds of everyone concerned with general medical services—the relationship of the general practitioner to the hospital and specialist services. The new hospital authorities, in the exercise of their functions, were soon formulating plans which involved changes in the staffing of a number of the hospitals. Whatever the merits of these changes from the point of view of the hospital and specialist service, they materially affected the working conditions of many general practitioners, and it does not seem to have been the business of any part of the administration to consider these consequential results. So great was the disturbance that in England and Wales the Ministry of Health issued to the hospital authorities a long cautionary memorandum on the subject, and in Scotland the Secretary of State asked his Health Services Council to advise him on what should be the relationships of the practitioner to the hospital services.

Dealing with administrative arrangements, the report of the Health Services Council says: "We think it right, however, to record our view that, unless a full measure of integration is achieved through the existing machinery, serious consideration will have to be given to changes in the administrative framework." The reference to "existing machinery" relates, amongst other things, to the liaison or co-ordination committees set up under Section 30 of the Act. For my part, I find it difficult to believe that this machinery can contribute effectively to the "full measure of integration" which the Health Services Council rightly calls for. Even if it could and did, is this not rather a clumsy and cumbersome way of achieving the end in view? Would it not really be simpler to eliminate the *need* for co-ordination by the straightforward process of making one administration responsible for all the medical services? If this had been done it seems to me highly probable that many mistakes would have been avoided, for the probable effect on the working of the other parts of the Service would necessarily have been taken into consideration in the early and formative stages of planning for any one of them. It has been suggested that there should be a regional planning body parallel to the administrative bodies, which would be left as they are. I think the consensus of opinion of those experienced in administration is that, although it may in certain circumstances be advisable, it is usually undesirable to divorce planning from executive functions. In any case, this too would seem to involve unnecessary complication and the risk of friction.

I should like to cite one further quotation, this time from the Coalition White Paper of 1944, which says: "There is a certain danger in making personal health the subject of a National Service at all. It is the danger of over-organization, of letting the machine designed to ensure a better service itself stifle the chances of getting one." Would it not be wise to take stock soon and see whether we have altogether avoided this danger?

The Medical Administrator

The next issue concerns the place of the medical administrator in the Health Service, particularly that of the medical superintendent of the hospital. I raise this issue because it is not widely recognized that there is a real danger that a distinctive feature of our Scottish hospitals may before long disappear, not because of any proved demerit but for extraneous and largely irrelevant reasons. There have evolved two fairly distinct systems of hospital management. They are sometimes called "the parallel" and "the hierarchical." In the former, the management body has a lay executive functionary and obtains its technical advice from a medical committee; in the latter, the executive functionary is a medical man and, consequently, qualified also as a technical adviser. Broadly speaking, the former has become the predominant system in England and the latter in Scotland, and this probably for historical reasons. The famous teaching hospitals in London were mostly developed from religious foundations, and the house-governor can be regarded as a sort of lineal descendant of the abbot. In Scotland our great teaching infirmaries were designed specifically for the treatment of the sick, and from their foundation in the eighteenth and nineteenth centuries have employed a medically qualified person to superintend, on behalf of the managing body, the day-to-day running of the institution.

I wish to speak now of the possible outcome if present trends continue unaltered. Developments since 1948 make it clear that the purely administrative superintendent will disappear as a feature of hospital management in England. It is the declared objective of the Ministry of Health "to reduce to a minimum the time to be given by medical staff to administrative duties," whilst a recent report by the Institute of Hospital Administrators on "The Administration of the Hospital Service," in advocating the continuance in England of the "parallel" system, significantly adds, "Even although the system in Scotland cannot immediately be brought into line with that advocated in England and Wales, the latter is the long-term objective in all parts of Great Britain." This declaration is made despite the fact that the views expressed are not supported by the Scottish division of the Institute. Official pronouncements of the Scottish administration indicate that their policy is to continue the traditional system. To apply disincentive terms of service as an economic substitute for the firing squad may be a rational enough procedure for dealing with an obsolescent group. To do so, however, with those whose services it is the policy to retain must obviously jeopardize the chances of that policy proving effective. It would be all to the good that there should be the experiment of running concurrently the two systems in the two countries, but the chances of one of them will be prejudiced from the start if the present indeterminate attitude and shirking of the real issue persist.

"Section 70"

The next issue on my list has come to be known as the "Section 70" issue. This section provides that "Section 166 of the Public Health (Scotland) Act, 1897 [which relates to the protection of local authorities and their officers] shall apply in relation to a regional hospital board, board of management, a local health authority, and an executive council, in like manner as the said section applies in relation to a local authority. . . ." What are the implications of this provision in relation to the legal liabilities of medical men in contract with the administrative bodies in the Service? So far discussions have been confined to such implications in the hospital field, but you will note that executive councils are specifically mentioned.

I think I can best bring out the point which is exercising us by quoting from an excellent short article by Mr. Robert Moore entitled, "The Hospital Authority and the Doctor," which appeared in the *Lancet* about a year ago. Mr. Moore writes: "Judgments given in legal actions since the introduction of the National Health Service have stimulated discussion of the responsibilities of hospital authorities towards their patients. In England the courts are now emphasizing that the hospital authorities may be held liable for negligence, not only on the part of their servants who undertake ordinary day-to-day management and routine duties, but also on the part of their medical staffs in the exercise of professional skill and care. This has not happened in Scotland, where the distinction between those members of the staff who are servants of the hospital and those who perform services for the hospital is still observed

and the hospital authorities are absolved from liability for negligence by their professional staffs."

It might be expected that doctors would prefer the position which is being established in the English courts. But let me again quote Mr. Moore: "If a hospital authority is now responsible, not just for providing hospitals where patients may meet with doctors, but for seeing that the patient receives the measure of reasonable professional skill and care to which he is entitled, how is it possible for it to discharge that responsibility? Radical changes in the relation of hospital authorities to their medical staffs may be in prospect." And, one might add, radical consequential changes in the relations of those doctors to their patients. It does not need fanciful imagination to appreciate that these changes might be in a most undesirable direction. The relationship between a physician and his patient has always been regarded as an essentially personal one, and, as a corollary, doctors have always accepted absolute responsibility for their actions. The Common Law provides safeguards against any dangers that may be inherent in this relationship. If this responsibility is now to be shifted to, or shared by, the administrative authority, does it not seem inevitable that this authority, which in effect means the State, will become a directly interested party in the doctor–patient relationship? I feel morally certain that it was not the intention either of the framers of the Act or of Parliament that it should. Yet the first steps in this direction have already been taken, and this, so far as one can judge, is the logical consequence of the provisions of Section 70 of the Act.

"Peculiar to Scotland"

I now come to the last of my four issues. Medicine is rightly regarded as a universal art and science knowing no national boundaries. Nevertheless, differences of custom, method, and tradition in its practice have evolved in response to the needs of different communities. For this reason it was wise legislative provision that there is a separate and distinct statute and administration for the Health Service in Scotland. I am not sure, however, whether the wisdom, or even the existence, of this arrangement is always appreciated on the other side of the border—or, indeed, in some quarters on this side.

Inevitably both Government and professional organizations must think in terms applicable to our much larger southern neighbour, and it is hardly surprising that there is sometimes impatience over matters "peculiar to Scotland," as the somewhat invidious phrase goes. The danger is all too obvious that in these circumstances the sacred name of uniformity will be invoked as the excuse for effecting changes in the Service in Scotland which would not occur as a result of natural and organic evolution, or—what is equally important—for preventing changes which would. Such an outcome would, in my submission, be disadvantageous for us all.

Much of what I have said has been in critical vein, but I hope it has been recognized as the criticism of someone closely concerned in the success of the enterprise. My profession, and the Association which I represent, had for two decades before the inauguration of the present Service been strongly advocating the expansion, extension, and improvement of the nation's medical services. I should like to conclude, therefore, on a note of faith and optimism, and to urge that we should try to recapture something of the mood and spirit in which we met the challenge in the inter-war years. It has always seemed to me that few of us have ever really grasped the immense possibilities of an effective health service. It is indeed difficult to conceive of any directive steps in the affairs of a community so fraught with possibilities for good as the inauguration of a sound health policy, or one likely to add more to the sum of its welfare. I think I would now be inclined to add that in these days of threatened economic and political danger it may be that how we come through what lies ahead of us will depend closely on our ability to realize these possibilities.

CENTRAL CONSULTANTS AND SPECIALISTS COMMITTEE

The first meeting of the session of the Central Consultants and Specialists Committee was held at B.M.A. House on October 30. Dr. T. Rowland Hill was re-elected chairman and Mr. T. Holmes Sellors deputy chairman. Mr. C. E. Kindersley and Mr. H. J. McCurrich were co-opted as members. On a ballot an Executive Committee was set up, consisting of the chairman and deputy chairman *ex officio*, Dr. A. H. Imrie (representing Scotland), together with the following: Professor P. C. P. Cloake, Dr. A. A. Cunningham, Dr. Peter Edwards, Professor S. J. Hartfall, Mr. H. H. Langston, Dr. J. R. Nicholson-Lailey, Mr. D. W. C. Northfield, Dr. S. Cochrane Shanks, and Professor G. I. Strachan. From this number, by a further ballot, the Committee elected Professor Cloake, Mr. Langston, and Mr. Northfield as members of the Joint Committee, with Dr. Rowland Hill, Mr. Holmes Sellors, and Dr. Imrie *ex officio*.

Senior Registrar Establishment

A recommendation from the Executive Committee came before the main body concerning the position of those senior registrars who are likely to be displaced as a result of the reduction in hospital establishments. The recommendation was that the automatic termination of the appointment of senior registrars at the end of four years should cease, and that, subject to annual review as to their fitness, senior registrars should be allowed to continue in their appointments (or to obtain other appointments in the grade) until consultant vacancies were available.

Dr. R. M. Forrester, a representative of the registrars on the Committee, pleaded for a slow run-down of the present registrar establishment, so far as this was necessary, instead of a sudden cut-off. While the termination of appointment at the end of four years should be automatic there should be provision for application for reappointment in competition with others. Another member urged that the Joint Committee should try to make the best of a difficult position. The ultimate solution, he said, was more consultant posts. If a supply of registrars was to be maintained there must be a fair and equal opportunity for promotion, and those in non-teaching hospitals should have an equal chance with those in teaching ones. Mr. A. Staveley Gough said that for general surgery appointments, at least in the south, there were 50 applicants for any one job. He had an uncomfortable feeling that at the end of this arrangement there would be a number of men left over, adequately trained for consultant posts, and not suitably trained to make good general practitioners.

The recommendation of the Executive was carried. The Chairman said that the Joint Committee would not be merely negative in this matter, and the Ministry officials now seemed inclined to take it more seriously and to investigate it with the Joint Committee.

On a further recommendation it was agreed that the Joint Committee be asked to reopen the question of the procedure for appointment of hospital medical staff in the light of a consideration of the main defects of the present system. These main defects were that the local senior hospital staff had insufficient voice in the appointments, and that the advisory appointments committee usually recommended one candidate only, so that the appointment by the board was largely a formality.

Junior Hospital Staffing

Mr. Staveley Gough asked the Committee to consider carefully the position of the junior staff officer in hospitals. What he had in mind was the house officer who was continually required to undertake extra duties owing to a shortage of staff. Some house officers had these extra duties thrust upon them for as long as three months, and received no extra remuneration or compensatory time off.

Dr. Talbot Rogers pointed out that the only way to meet the situation was by the further employment of general practitioners in hospital.

After further discussion, the Chairman said that the junior staffing problem was an urgent one, and representations should be made to the Ministry on the subject. This course was agreed to.

Other recommendations from the Executive which were agreed to were that the Joint Committee should be asked to raise with the Ministry the question of the starting salary of S.H.M.O.s regraded as consultants ; that the proposals of the Department of Health for Scotland for the introduction of a new senior grade in the structure of hospital medical staffing be opposed ; and that the Joint Committee be asked to continue to resist the imposition upon consultants of cases referred to hospital by Government departments for examination and report.

The Obstetric Service

The Council had referred to the Central Committee for its comments a proposal that the organization of the obstetric service under the National Health Service be examined, especially with a view to the number of different authorities which are responsible for it.

A Subcommittee under Professor Strachan had considered this matter. Professor Strachan said that it was felt from the first that the division of authority was undesirable. The best or only way to proceed in the matter, while avoiding confusion and ill feeling, was to go by stages. In Glasgow recently local-authority clinics had been linked up with the corresponding hospital maternity units. This was a purely unofficial and friendly agreement, and it was reported that the liaison was working well. It was not their desire that the general practitioners practising midwifery should think that they were going to be absorbed and overwhelmed by institutional administration, and it was thought wise to have in the first place as great an integration as possible between the maternity services of the hospitals and the local-authority maternity clinics. That would reduce the number of authorities from three to two, and when that had been brought about they could turn to the relationship between the new body and those practising domiciliary midwifery. A fuller report from the subcommittee concerned would come forward at a later date.

Dr. D. F. Hutchinson said that it would be better to get the three authorities together at the start.

It was agreed to await the more considered report.

Work of Joint Committee

The Chairman gave the following report on the work of the Joint Committee and of Committee " B " of the Medical Whitley Council.

He said that one of the fundamental points of policy in the Joint Committee work at the present time is to develop, in conjunction with the Ministry of Health, sound medical advisory machinery throughout the Hospital Service so that the profession, through its own chosen representatives, can advise at hospital, regional board, and ministerial level upon the policy and development of the hospital services. A large measure of agreement had now been reached on these matters with the Ministry of Health, but the implementation of this agreement is awaiting the comments of the standing Medical Advisory Committee of the Central Health Services Council, whose views upon the matter are also desired by the Ministry of Health.

Negotiations with the Ministry of Health to obtain some improvement in private bed organization in hospitals and upon pay-bed regulations have not progressed very far owing to the fact that new legislation would be necessary to implement any agreement, and the Joint Committee is informed that there is little prospect of any fresh Health Service legislation for the next two years.

The Joint Committee is aware that there are advantages and disadvantages in accepting the new mileage allowance arrangements for staff in the hospital service. These new arrangements were agreed between the Management Side and the Staff Side of the Health Service in the General Whitley Council for the Health Services. The Staff Side of Whitley Committee " B " felt, on balance, that these new mileage allowances carried with them for the majority of hospital staff more advantages than disadvantages. Being unable to get any alteration made, it felt it best to accept them, but under protest with regard to the clause which prevents whole-time officers obtaining home-to-hospital mileage payments. This particular clause is being raised in the General Whitley Council again, and it is understood that other sections of hospital staff, apart from medical members, are lodging the same objection. It is hoped that in due course modification of this clause may be possible.

Part-time Consultants' Contracts

The Chairman said the Joint Committee is finding it necessary to keep under constant observation the safety of part-time consultants' contracts. It has agreed with the Ministry the terms of a circular that is being sent out emphasizing to boards that part-time contracts must be kept under a continuing review to make sure that they are accurate. At the same time every possible step is being taken to ensure that part-time consultants' contracts shall not be subjected to sudden and unnecessary changes.

A circular recently issued by the Ministry of Health permitting the appointment by boards of administrative heads to certain departments in hospitals was agreed with the Joint Committee for issue, and it is satisfactory that the consultant placed in administrative charge will not have clinical control over his consultant colleagues, and that the appointment will be made only where it is necessary in certain departments for the supervision of apparatus or of numerous subordinate staff.

Whitley Committee " B " has succeeded in obtaining for S.H.M.O.s the same rights of appeal to the Chief Medical Officer's appeal committee as consultants have.

SCOTTISH MEDICAL PRACTICES COMMITTEE

CRITERIA FOR INITIAL PRACTICE ALLOWANCES

It has been agreed that the Scottish Medical Practices Committee will confer initially, and from time to time, with the General Medical Services Subcommittee (Scotland) and the Department of Health for Scotland about the criteria to be applied in determining applications for initial practice allowances. Preliminary discussions have taken place, and the Scottish Medical Practices Committee has recently submitted to the General Medical Services Subcommittee (Scotland) its proposals in this connexion. The Subcommittee, before commenting on these proposals, has referred them to local medical committees for their observations. It is hoped to resume discussions on this subject early in December.

Fourth Report

The Scottish Medical Practices Committee has just issued its fourth report, and the following are some points from it.

The population of Scotland is now 5,111,231, of whom 1,917,500 live in the four cities. The numbers of doctors providing general medical services at July 1, 1952, and, in parentheses, the corresponding number at July 1, 1951, were: (*a*) doctors providing general medical services including maternity medical services, 2,127 (2,063) ; (*b*) doctors providing general medical services only, 252 (265) ; (*c*) doctors providing maternity medical services only, 3 (3) ;

(*d*) doctors on medical lists for limited purposes, 42 (71). This shows an increase of 51 doctors. There has again been an increase in the number of doctors in industrial areas.

During the year the Committee granted 148 applications for admission to medical lists for the purpose of providing general medical services. The number of doctors entering practice by way of partnerships supports the Committee in its view that, in many areas, the likeliest method for a young doctor to establish himself in general practice is to be assumed into partnership, preferably after an initial period of assistantship.

The Committee has again been impressed by the consistently high average number of applicants. During the year over 500 applications were received by executive councils for the 25 advertised vacancies. This does not, of course, indicate the number of doctors seeking to be established, since many doctors were applicants for more than one vacancy, but the Committee has been concerned to note the difficulty still experienced by many doctors anxious to become settled as principals. Roughly 50% of the applicants were engaged as assistants, 20% were principals in general practice who wished to change the type or locality of practice, 10% were hospital doctors who wished to enter general practice, 10% were acting as locumtenents, and 10% were employed in public health, Government medical services, etc.

TRADE UNION MEMBERSHIP

The following is a list of local authorities which are understood to require employees to be members of a trade union or other organization:

Metropolitan Borough Councils.—Fulham, Southwark.
Non-County Borough Councils.—Crewe.
Urban District Councils.—Houghton-le-Spring.

Correspondence

Because of the present high cost of producing the Journal, and the great pressure on our space, correspondents are asked to keep their letters short.

A Trend in State Medicine

SIR,—Mr. Michael Harmer (*Supplement*, October 25, p. 174) expresses a fear that "direction" in clinical work may be creeping into the nationalized hospital service, as he himself experienced in the armed Forces. As a profession we are at times both obstinate and covetous.

The progressive strength of the letters which Mr. Harmer quotes, suggesting that children suffering from skeletal tuberculosis should not be retained in a general hospital, is, after all, perfectly reasonable. Mr. Harmer refers to malignant disease, but patients with malignant disease rarely require education—they do not live long enough. The main purpose of segregation of children with surgical tuberculosis is that their education may continue. There are very few of the younger consultant general surgeons who have handled *any* cases of surgical tuberculosis in childhood, except in courses for the F.R.C.S. Among the orthopaedic surgeons it is a rarity to find a registrar or senior registrar (and he it is who is left to put on the plaster) who has had a satisfactory resident period in an institution dealing particularly with childhood tuberculosis. If surgeons are so stupid as to want to retain the odd cases of bone tuberculosis in a child, then it may well be that traditional freedom should give place to common sense.

Mr. Harmer has chosen a bad illustration. Behind many of the suggestions for the segregation of special cases one has found the personal ambition of a consultant, or a group of consultants who have managed to sway the administration. We used to call it "Empire-building." Some months ago a hospital group in which I work received a proposed establishment which included a "senior group paediatrician." I would be whole-hearted in the support of Mr. Harmer if he is out to annihilate clinical gauleiters, but we need have no fear in the case of children with tuberculosis. Their interests are paramount.—I am, etc.,

Dulwich, S.E.19. D. F. ELLISON NASH.

Criticism of the Working Party's Scheme

SIR,—We, assembled in Oxford for the purpose of considering the injustice of the Working Party's scheme, wish to draw attention to the very important correspondence in your columns last week.

Dr. A. C. E. Breach, a man of great probity of speech and conduct, has thought fit to write you a letter (October 25, p. 173) at the end of which he announces his resignation from the General Medical Services Committee. He points out that it was at a personal interview he sought, in company with Dr. B. S. Grant, of East Horsley, with the Secretary that it became apparent that the footnote the Secretary had written (to Dr. Grant's letter), denying that any pressure had been exerted from Headquarters, was written in good faith, after due consultation with the "appropriate authorities," the Secretary not having been present at the relevant meeting of the G.M.S. Committee. Furthermore, the suggestion Dr. Breach then made to the "appropriate authorities" that they should issue a frank statement was not acted upon. Indeed, not until Dr. Breach's letter was published did the G.M.S. Committee think fit to make any statement at all, and that statement cannot be called frank. It consists of a letter (October 25, p. 173) from Dr. A. Talbot Rogers to yourself, and it contains no denial of the "surmise"—to put it at its mildest—that pressure was exerted at meetings. Dr. Talbot Rogers disregards Dr. Breach's specific statement that "the plan has a number of grave faults; in particular that it fails to implement the agreed terms of reference of the Working Party"; and he remains silent at the very serious statement "that the measures taken by the G.M.S. Committee to influence doctors and secure their acceptance of the plan were so gravely objectionable" in Dr. Breach's view that he announced his withdrawal from the Committee.

In an endeavour to placate small-list practitioners, Dr. Talbot Rogers offers the hope that "all doctors in active unrestricted single-handed practice may be assured of being able on application automatically to receive any help to which they may be entitled."

Sir, we feel that a bare recital of the facts shows that the conduct of affairs has not been creditable to the "appropriate authorities," and that the time has arrived when they should give way to a less evasive body so that the small-list doctor will be able to claim as of right, not "help," but his proper due—the implementation of the term of reference "to bring about a relative improvement in the position of those practitioners least favourably placed under the present plan of distribution."—We are, etc.,

C. K. BROWN (Oxford)
C. H. BARBER (Thame)
O. F. CONOLEY (Princes Risborough)
PETER DAWES (Feckenham, Redditch)
BERNARD DAWES (Feckenham, Redditch)
A. E. GLANVILL (Chard, Somerset)
K. H. GILL (Eastbourne)
B. S. GRANT (East Horsley)
W. J. GRANT (Shrewsbury)
S. L. HENDERSON (West Sussex)
H. N. HORNIBROOK (Gerrards Cross)
L. G. JACKSON (Barnet)
G. A. JACKSON (Reading)
H. M. KELSEY (West Sussex)
F. W. KEMP (Walsall)
L. PENHALL PHILLIPS (Radlett)
W. G. SHAKESPEARE (West Malvern)
B. C. SEKAR (Wembley)
C. I. SCHIFF (London)

Oxford.

SIR,—I have hesitated to add to the correspondence on the distribution scheme, but I venture to put forward one aspect which appears to have escaped notice.

During the last four years it has been frequently stated that remuneration of the general practitioner should be in

proportion to responsibility undertaken. This principle does not seem to be implemented in the case of doctors with lists up to 500, who are not entitled to I.P.A. or other special grant under the new scheme. If there were no loading, and the new moneys were used to increase the capitation payment *pro rata*, these doctors would be in a much better financial position. May I suggest that any doctor not receiving I.P.A. or inducement payment should be given the option of an increased capitation payment (at the rate indicated above) in lieu of loading? This would be no more than a just reward for work undertaken.—I am, etc.,

Stanmore. H. BARBARA WOODHOUSE.

SIR,—I have carefully read and re-read Dr. A. C. E. Breach's letter (*Supplement*, October 25, p. 173) and I can find no sentence in which he challenged the motives of the G.M.S. Committee as stated by Dr. A. Talbot Rogers (p. 173). In case others are equally obtuse, the Chairman of the G.M.S. Committee might be willing to point out the words which he thus interprets.

On the other hand, Dr. Talbot Rogers categorically states that "... pressure ... was due not so much to any advocacy by members of my Committee, but to the general pressure of events." As the case was presented to us in the Plymouth Division we were warned that the Danckwerts award was disliked by all political parties to such an extent that the whole thing would be "thrown back into the melting-pot" again if we failed to approve the Working Party's proposals. We were most solemnly warned, after due inquiry had been made as to the presence or absence of the Press, that we could not afford to suggest any change or modification whatever. There was, of course, some discussion, but how fertile could that be with such a dire threat held out to us?

I am one of those who will benefit to the maximum extent by the Working Party's decisions, but that fact does not blind me to the strong element of coercion with which they were foisted on the profession. As methods similar to those used in Plymouth appear to have been used in nearly all Divisions, it seems reasonable to assume that they had a common source and inspiration in the G.M.S. Committee. —I am, etc.,

Launceston, Cornwall. DONALD M. O'CONNOR.

Association Notices

Diary of Central Meetings

NOVEMBER

11	Tues.	D.I.H./D.P.H. Subcommittee, Occupational Health Committee, 2.15 p.m.
12	Wed	Remuneration Subcommittee, Occupational Health Committee, 11 a.m.
12	Wed.	Joint Subcommittee *re* National Coal Board Medical Officers, Private Practice and Occupational Health Committees, 2 p.m.
12	Wed.	Subcommittee to Consider the Special Conference Rider, G.M.S. Committee, 2 p.m.
14	Fri.	Special Meeting of Public Health Committee, 2 p.m.
18	Tues.	Joint Meeting of Representatives of Occupational Health and Public Health Committees, 2 p.m.
19	Wed.	Coroners Subcommittee, Private Practice Committee, 11 a.m.
19	Wed.	Medical Witnesses Subcommittee, Private Practice Committee, 2 p.m.
20	Thurs.	G.M.S. Committee, 10.30 a.m.
20	Thurs.	Radiologists Group Committee, 2 p.m.
24	Mon.	Armed Forces Committee, 2 p.m. (*date changed from November 7*).
26	Wed.	Pathology Subcommittee, Alcohol and Road Accidents Committee, 2 p.m.
28	Fri.	Venereologists Group Committee, 2.30 p.m. (*date changed from October 31*).

DECEMBER

3	Wed.	Film Committee, 2 p.m.
4	Thurs.	Rural Practices Subcommittee, G.M.S. Committee, 2 p.m.
5	Fri.	Joint Committee of B.M.A. and the Magistrates' Association, 11 a.m.
12	Fri.	Physical Medicine Group Committee, 2 p.m.

Branch and Division Meetings to be Held

BLACKBURN DIVISION.—At Swan and Royal Hotel, Clitheroe, Thursday, November 13, 8 p.m. to 1 a.m., annual dance.

BORDER COUNTIES BRANCH.—At County Hall, Carlisle, Thursday, November 13, buffet-dance.

BOURNEMOUTH DIVISION.—At Royal Bath Hotel, Friday, November 14, 7.30 for 8 p.m., dinner dance.

BRIGHTON DIVISION.—At Dudley Hotel, Thursday, November 13, 8.30 p.m., conjoint meeting with Brighton Dental Association. Address by Dr. Keith Simpson: "Crime Reconstruction."

BURTON-ON-TRENT DIVISION.—At Burton Golf Club, Tuesday, November 11, 7.45 p.m., dinner. Lecture by Professor J. C. Moir: "Haemorrhage in Obstetrics."

CROYDON DIVISION.—At 43, Wellesley Road, West Croydon, Tuesday, November 11, 8.30 p.m., meeting. Address by Dr. J. N. O'Reilly: "Vomiting in Childhood."

EAST KENT DIVISION.—At Chez Laurie Restaurant, Thanet Way, Herne Bay, Thursday, November 13, 7.30 p.m., dinner; 8.45 p.m., meeting. Address by Mr. V. Zachary Cope: "The Golden Age of Medicine."

EAST YORKSHIRE BRANCH.—At Beverley Arms Hotel, Beverley, Wednesday, November 12, 8 p.m., annual dinner.

GUILDFORD DIVISION.—At Farnham Hospital, Hale Road, Farnham, Thursday, November 13, 8 p.m., clinical meeting.

HENDON DIVISION.—At Hendon Hall Hotel, London, N.W., Tuesday, November 11, 8.45 p.m., clinical meeting. Dr. Evan Bedford: "Indications for Cardiac Surgery."

KENSINGTON AND HAMMERSMITH DIVISION.—At Postgraduate Medical School of London, Hammersmith Hospital, Ducane Road, W., Wednesday, November 12, 2 p.m., Special Ward Visit for General Practitioners by Dr. C. L. Cope.

KESTEVEN DIVISION.—At George Hotel, Grantham, Thursday, November 13, 7 for 7.30 p.m., dinner; talk by Mr. Rodney Maingot: "The Management of the Chronic Gastric and Duodenal Ulcer" (illustrated by slides).

MIDLAND BRANCH.—At Medical Institute, 154, Great Charles Street, Birmingham, Thursday, November 13, 3 p.m., 91st annual meeting. Paper by retiring President: "The Integration of Medical Practice."

ROCHDALE DIVISION.—At Red Lion Hotel, Rochdale, Monday, November 10, 8.30 p.m., clinical meeting. Mr. A. S. Coupe: "The Coroner and the Medical Profession."

SOUTH-EAST ESSEX DIVISION.—At Southend General Hospital, Friday, November 14, 8.30 p.m., meeting. Mr. R. C. Percival: "Obstetrics in General Practice," including film on Breech Delivery.

TOWER HAMLETS DIVISION.—At Mile End Hospital, Bancroft Road, London, E., Friday, November 14, 3 p.m., clinical meeting.

WEST DENBIGH AND FLINT DIVISION.—At Royal Alexandra Hospital, Rhyl, Tuesday, November 11, 3 p.m., clinical meeting. Cases will be presented by Dr. D. E. Meredith and Dr. Ivor Lewis.

WEST SOMERSET DIVISION.—At Empire Hall, County Hotel, Taunton, Thursday, November 13, dinner and dance

WEST SUSSEX DIVISION.—At Burlington Hotel, Worthing, Wednesday, November 12, 7 for 7.30 p.m., dinner; 8.30 p.m., meeting. Address by Dr. A. T. Richardson: "Electrodiagnosis."

WIGAN DIVISION.—At Lewis' Restaurant, Wallgate, Wigan, Thursday, November 13, 8.15 p.m., clinical meeting. 8.45 p.m., supper; 9.20 p.m., sound and colour film: "Senile Obliterative Arteritis of the Legs."

Meetings of Branches and Divisions

COVENTRY DIVISION

The first ordinary general meeting of the session was held at the Pilot Hotel on October 7, 1952. With Dr. T. B. Kenderdine in the chair, there were 50 members present. The chairman delivered an inaugural address on "The Feminine Monarchie," which related to his hobby of bee-keeping.

MATABELELAND BRANCH

A meeting was held at the hospital, Bulawayo, on August 21, 1952. With Dr. M. H. Webster in the chair there were 14 members present. The following delegates to the Medical Association of Southern Rhodesia for 1952–4 were elected by vote: Drs. G. A. Jamieson, H. J. Morris, and J. Wakeford, with the chairman *ex officio*.

MOMBASA DIVISION

A meeting of the Mombasa Division was held at the Pandya Memorial Clinic on June 23, 1952. With Dr. Bartlett in the chair, there were 14 members present. The meeting concluded with an interesting talk by Mr. Michael Wood on "Some Recent Advances in the Treatment of Fractures."

SOUTH-EASTERN COUNTIES DIVISION

A meeting was held at St. Boswells on July 20, 1952, with Dr. W. Davidson in the chair. There were 22 members present. Dr. Macgregor, the Division's representative, gave a report of the Annual Representative Meeting in Dublin. A committee was formed to keep the whole question of future divisional activities under consideration.