SUPPLEMENT TO THE

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THE SECRETARY REPORTS

PRESTIGE IN GENERAL PRACTICE

Of all the problems which are arising in general practice to-day, apart from remuneration, none is proving of livelier interest than that of prestige. Though it is difficult to be precise in dealing with so intangible a matter, there is a growing feeling that one of the greater dangers in the Health Service is the decline in the standing of the general practitioner and the respect which he enjoys in the community. In the minds of many practitioners this question is tied up with that of the continuance on hospital staffs of general practitioners with special knowledge and experience, and the provision of hospital beds in which general practitioners can treat their own patients. It has been suggested that the ease with which patients can transfer from one doctor to another is a contributing factor. Others complain that there is developing an attitude of mind on the part of patients based on the assumption that, having paid for the Service, patients are entitled to each and every part of it on demand, quite apart from their clinical need. Whatever may be the contributing causes, there is developing the view that this matter of prestige, vague as it is, is one of crucial importance.

Those who have read the Association's report by the special committee presided over by Sir Henry Cohen will have had their attention drawn to the status issue and to a number of long-term proposals for raising the standard of general practice and for its recognition as a special branch of medicine. At its last meeting the Council appointed personnel of the special committee which has been set up to review the present position of general practice, its difficulties and its trends, both generally and with reference to the two years' experience of the National Health Service Acts, and to the Association's Report on "General Practice and the Training of the General Practitioner." It is hoped that Divisions will set up study groups to discuss the proposals in the Cohen Report and to convey their views to this special committee. There is a good deal of apprehension in the public as distinct from the professional mind on this subject, and it is hoped that the outcome of the survey to be conducted by the special committee will be an authoritative statement with recommendations on the whole subject of general practice and its future.

Vacancies in General Practice

It cannot be pretended that the machinery set up under the Act for facilitating the entrance of practitioners to general practice is without its snags. Here is an example. A vacancy occurs and it is decided to fill it. The procedure of advertisement, interview, and selection is followed, and Dr. A is successful. But in the meantime it has been necessary to employ a locum, Dr. B, for the care of the patients of the retired or deceased practitioner. The locum buys the house from which the practice is conducted, the area being one not designated a "closed area." Because of the character of the area the locum is entitled to automatic inclusion in the list on application. The solution of this problem is not easy to see, but representatives of the General Medical Services and the Medical Practices Committees are shortly to discuss the whole question with the Ministry in an endeavour to find a solution.

Another problem has now been solved. It was created by the fact that under the Act selection of the practitioner for inclusion in the list rested with the Medical Practices Committee, while the decision as to the practitioner on whose list the patient would be placed remained with the local executive council. It was clearly necessary that these two decisions should be made by one and the same body if only to avoid the position which might possibly arise with one practitioner being selected by the Medical Practices Committee and another by the local executive council. This difficulty has been solved by requiring the local executive council to make the transfer of the practitioner selected by the Medical Practices Committee.

Vaccination

An odd point has arisen in connexion with the vaccination arrangements. After protracted negotiations the fee was agreed for vaccination covering the report submitted by a practitioner to a local authority. But it is now clear that the agreed fee is payable only in respect of people on doctors' lists and only to a doctor in the Service in respect of a patient on his own list. This would seem to be contrary to the intention of the Act, which states that every local authority shall make arrangements with medical practitioners for vaccination, and that the local health authority shall give every medical practitioner in the N.H.S. an opportunity of providing this service. It does not say that the service should be limited to patients taking advantage of the N.H.S. or patients on the doctor's list.

The public interest would seem to demand that the vaccination arrangements, including the fee, should cover all practitioners whether in the Service or not and all citizens whether opting to use the Service or not. It cannot be expected that the virus of smallpox will have much regard to whether the patient is using the Service or not, or whether the patient is on any doctor's list. The General Medical Services Committee is taking this matter up with the Ministry.

S.H.M.O.s

Consultants will be wondering when there is to be an announcement on the field in which appointments in the grade of senior hospital medical officer will and will not be made in the future. Discussions with the Ministry on the form of words defining the limited field of future S.H.M.O. appointments have been going on for almost a year, and at long last it seems likely that the final stage has been reached. A draft will come before the Joint Committee at its meeting on July 11.

I hope to devote this column next week to a report on the work of the Joint Committee generally.

British Medical Association

PROCEEDINGS OF COUNCIL

Wednesday, May 31, 1950

A meeting of the Council of the British Medical Association was held at Headquarters on Wednesday, May 31. As the Chairman of Council, Dr. Gregg, was attending the Australasian Medical Congress at Brisbane, Dr. H. GUY DAIN was voted to the chair.

The Late Dr. Gordon

The CHAIRMAN referred to the severe loss which the Council had sustained since its last meeting by the death of Dr. R. G. Gordon. Dr. Gordon had carried out a great deal of work for the Association, centrally and locally, over many years. In connexion with the reorganization of the business arrangements of the *Journal* some years ago he was the principal figure, and always a most assiduous member of Council.

Dr. O. C. CARTER, chairman of the Journal Committee, said that the magnitude of the loss which the Council and the Association had sustained might not be appreciated for some little time to come. Dr. Gordon had guided the work of the Journal Committee with great knowledge and wisdom, and in addition he was prominent in the work of many other committees. Although a senior member, he was perhaps not well known to the rank-and-file, for his was a reserved nature, and he had always a preoccupied mind. No one was a greater lover of the Association, and he had left behind a great example which would not be readily forgotten.

The members stood in silence.

Affiliation with the Indian Medical Association

Dr. F. GRAY, chairman of the Committee on the Constitutional Position of Branches, brought forward a proposal for an agreement to be entered into with the Indian Medical Association for affiliation with the B.M.A. A draft agreement, based largely on the South African model, had been submitted for consideration in India. The draft contained three important provisos: that the agreement be limited to members of the I.M.A. who held a registrable qualification—that is, excluding licentiates; that it should apply to members of the I.M.A. visiting, or temporarily resident in, Great Britain or Ireland, and that the Association would dissolve its Branches in India except where (as in Assam) the majority had expressed a desire to continue as a Branch. The I.M.A., however, had expressed the view that it would not be possible to differentiate between graduates and licentiates, and after discussion it had been agreed that affiliation should apply to both. Certain overseas Branches had raised objections, but these appeared to be based on a misunderstanding, and letters of explanation had been sent.

The CHAIRMAN reminded the Council that if it took this step it was doing something which had not been done before—namely, affiliating with an association a large number of members of which did not hold a registrable qualification. The Secretary, in reply to a question, said that India, having become a Dominion, was anxious to follow the example of Canada and South Africa and to achieve full equality in this as in other respects. If the affiliation went through, it meant that Indian practitioners of the licentiate class, not in our sense registered practitioners, would on coming to this country become for the time being, with certain reservations, members of the B.M.A. and entitled to the facilities of the House.

It was pointed out that there was no question of such licentiates being allowed to take up practice in this country; most of those who visited Great Britain would be here to take post-graduate courses.

After discussion the recommendation for affiliation was agreed to, and the terms of the proposed agreement were approved.

Patenting in the Medical Field

Dr. R. FORBES, chairman of the Committee on Patenting in the Medical Field, introduced a report on this question. He said that the Association's policy formulated in 1932 broadly opposed patenting by members of the medical profession in the absence of a system whereby patents might be dedicated to the use of the public. The conditions when this policy was settled were markedly different from those obtaining to-day. Further, in pursuance of the Development of Inventions Act, 1948, a central body had been set up, known as the National Research Development Corporation, to which patents might be dedicated; this body gave assistance, financial and technical, in the development of inventions to ensure that their development was in the best interests of the nation. His committee came to the conclusion that the problem of patenting in the medical field might be satisfactorily solved by members of the profession making use of the machinery of this Corporation for the dedication of patents. He accordingly moved that the Representative Body be recommended to approve and urge the adoption of the policy of patenting, provided the patents were assigned to the Corporation to secure that the inventions and discoveries to which they related were made available, developed, and exploited in the best interests of the public.

Dr. N. E. WATERFIELD asked whether it would be within the discretion of the Corporation to make any payment to the individual who had largely contributed to a discovery. It ought to be ensured that in addition to the satisfaction attendant upon having done a good piece of work, and the fame it brought, some tangible reward was available. Dr. J. C. ARTHUR asked whether there would be any objection to the inventor receiving some form of royalty. Dr. H. B. MORGAN drew attention to one paragraph in the report which stated that the Corporation could not enter into financial arrangements with another man's servant, and that therefore no payment by way of reward could be made, for instance, to a Crown servant, who in any event would be precluded by his contract from deriving any benefit from his inventions. He urged that the matter be given further consideration before a decision was reached. The inventor would be continually penalized by receiving no reward for his work.

Dr. FORBES pointed out that there were now very few sole workers engaged in research; they were a disappearing class. Most of the work was done by whole-time paid employees of large manufacturing organizations or under the surveillance of a university. These whole-time employees would be under contract under which they bound themselves not to acquire a patent in respect of any discovery made in their laboratories, and into this contract they would have entered quite voluntarily. He added that the proposal now made was not a new one. In the discussions which took place years ago the Association had always wanted a dedicatory system.

Dr. WATERFIELD supported Dr. Morgan's proposal to refer back for further consideration. He felt that research workers should in some way get a reward for their genius, even if they were under some sort of contract. During the war the Government gave prizes to inventors.

Mr. LAWRENCE ABEL said that surely an inventor might make his terms for assigning his invention to the Corporation. There was nothing in the proposed arrangement to suggest an unfair deal.

The motion to refer back was lost, and the Council agreed to recommend the Representative Body to approve the policy of patenting in the medical field by assignment to the Corporation. It was pointed out that there was no compulsion about it.

General Medical Services

Dr. S. WAND, chairman of the General Medical Services Committee, presented a report covering the various matters already referred to in the report of the meeting of that Committee in the *Supplement* of May 27 (p. 233). He said that no reply had been received from the Ministry as yet to the resolutions on the remuneration issue which the Committee had forwarded. The temper of the profession was rising, and there was no doubt that in the minds of many general practitioners there was great resentment at the long delay in meeting their just claims. One thing which was becoming very interesting at the present juncture was that it was not only the Spens position which was causing anxiety but the prestige position. The whole subject would be discussed at a Special Conference of Local Medical Committees called for June 29.

Mr. LAWRENCE ABEL, on the question of the representation of general practitioners on regional hospital boards and hospital management committees, asked whether the question of general practitioners on boards of governors of teaching hospitals had also been considered. Dr. WAND replied that that was a matter which would be taken up by the Central Consultants and Specialists Committee and from that body would go to the Joint Committee. Mr. R. L. NEWELL, chairman of the Consultants and Specialists Committee, said that that was a matter which would be discussed by his committee on the following day. He agreed with Dr. Dain that the case for having the general practitioner on the board of governors of a teaching hospital was just as strong as that for having him on regional boards and management committees, but there were legal difficulties.

Autonomous Bodies

Dr. C. METCALFE BROWN presented a report of the committee which had been set up to consider the relationship of autonomous bodies to the Association. The lengthy report before the Council was prepared for eventual submission to the Representative Body. He would not attempt to summarize it—it would appear in the *Supplement*. His committee felt that the present system, at least for the time being, should not be disturbed, but that in not more than three years' time the position should be reviewed in the light of experience. He added that on the public health side the Public Health Committee, of which he was chairman, neither had autonomy nor wanted it. The position of that committee gave rise to no difficulty under its working arrangement with the Society of Medical Officers of Health.

Dr. HALE-WHITE thought that the position of the autonomous bodies should be reviewed every year, but the CHAIRMAN suggested that this would not necessarily be an advantage.

Dr. GORSKY said that he was satisfied that the situation was now under control. The thing that was worrying him, however, was the Whitley Council machinery, which in some cases was not working too satisfactorily. If the situation was to depend on the Whitley Council machinery he was certain that the matter would be reviewed before three years were ended.

Mr. LAWRENCE ABEL referred to the composition of the Joint Committee. There was no reference in the report to the requirement, on which some stress had been laid, that non-teachers should form at least 50% of the representation of the Royal Colleges and Corporations on that body.

The report was approved for submission to the Representative Body, with the recommendation that the present arrangements continue but that in not more than three years' time the position of the autonomous bodies be re-examined in the light of experience. The CHAIRMAN pointed out that there was nothing in this to prevent the opening up of the question before the expiry of this term should the situation seem to require it.

Reorganization of the Council

Dr. J. A. PRIDHAM, chairman of the Organization Committee, brought forward a recommendation to amend the appropriate by-law so as to provide that in the election of the 39 members of the Council every candidate should be a member of a Branch or group of Branches or Division or group of Divisions comprising the constituency for which he was standing. He reminded the Council that at the recent Special Representative Meeting a proposal to this effect was carried but not by a sufficient majority to become effective. The reason why it did not get a sufficient majority was the feeling abroad that having increased the size of the Council and lessened the size of the constituencies the opportunities for election in a particular area had been altered and in some respects limited and that it might be wise to throw the matter open and allow an electoral area to elect to the Council a member who did not necessarily live or practise there. The recommendation was brought forward again in the interests of uniformity. At present in the case of a Branch a candidate must be a member of the Branch, but there was no similar provision when the constituency comprised a Division or group of Divisions.

Mr. ABEL thought the proposal a retrograde step. Every member of the Association wherever he lived should be eligible for election for any constituency, just in the same way as a candidate for Parliament.

After some further discussion the Organization Committee's recommendation was agreed to, the words "by 'member' is included 'visiting member'" being added in parentheses.

Representation of Scottish Branches

Dr. PRIDHAM next brought forward the question of Scottish representation on the Council. At the Special Representative Meeting, by some oversight, the membership of Group 30 was given as 1,597, whereas it was 1,757. A group membership of over 1,600 entitles the group to an additional member of Council, and accordingly the Stirling Branch, which was concerned in these figures, now claimed, with the approval of the Scottish Committee, that an additional seat should be accorded to the group. Dr. Pridham pointed out that Scotland as a whole had six members of Council. As it had 5,611 electors, this gave 935 for each Council seat. In England there was one seat to every 1,034 members. If seven seats were accorded to Scotland there would be one for each 800 members. The Organization Committee was of opinion that it would not be an equitable position between members in England on the one hand and in Scotland on the other if Scotland were given an additional seat; Scotland should be entitled to elect only six members of Council, and if the number of members directly elected were to be increased from four to five, as proposed by Stirling, the number to be elected by the representatives of the constituencies in Scotland should be reduced by one.

Dr. I. D. GRANT, chairman of the Scottish Committee, said that Scotland did feel it had a grievance. Every English group of more than 1,600 members had two seats on the Council, and under the new arrangement the English membership of the Council was increased by ten. The group in question included the English county of Cumberland with some 170 members. Dr. JOPE pointed out as a further argument for additional Scottish representation the inequality of areas; in England there were 64 doctors for every 100 square miles, and in Scotland, 19. Dr. KNOX said that the Representative Body was under a misapprehension when it decided on six members for Scotland; it had been given wrong figures for one Scottish area.

By 25 votes to 11 the Council approved the Organization Committee's opinion, and agreed that a report embodying it should be included in the Supplementary Report of Council.

Association Finance

Mr. A. M. A. MOORE, Treasurer, gave a report on Association finance for the period January to March. Subscription revenue had increased by nearly £28,000 as compared with the corresponding period in 1949. There was also a largely increased income from advertisements. He gave an analysis of the incomes and expenditures and the reasons for increases and decreases.

The Treasurer also stated that the Finance Committee had considered the possibility of a subsistence allowance being made in addition to travelling expenses to members of the staff side attending meetings of the Medical Whitley Council and its three committees, but, in view of the recent decision of the Representative Body concerning subsistence allowances to members attending B.M.A. meetings, had decided to take no action.

Dr. VAUGHAN JONES moved that subsistence allowances be paid to members of the staff side attending meetings of the Whitley Council. The work of the Whitley Council was in the nature of a business job, had to be done regularly, and called for a large amount of time. It was the practice of organizations to pay subsistence allowances both on the staff and on the employers' side. This proposal was supported by Dr. GRANT and Dr. HUTCHINSON. Dr. WAND said that in attending Whitley Councils they were just doing another piece of Association work. There was no payment for attending other meetings of the Association, and it would be difficult to pay for Whitley and not pay for anything else.

Dr. Vaughan Jones's motion was lost.

The Association Buildings

Mr. DOUGAL CALLANDER, chairman of the Building Committee, brought forward a report concerning various matters in the Association building—the seating of the council chamber, the alterations to the Great Hall and to the Hastings Hall, the paving of the council garden, and the progress of the new south wing. The report was approved.

On a recommendation from the Scottish Committee approval was given to the renting of premises in St. Vincent Street, Glasgow—a suite of four rooms—for the purposes of the Glasgow Regional Office of the Association.

Dr. H. R. FREDERICK, chairman of the Welsh Committee, reported that negotiations were proceeding satisfactorily for the purchase of a property in Cardiff in which to establish a B.M.A. House in Wales. The house that was being purchased was in Newport Road, Cardiff.

Medical Ethics

Dr. R. FORBES presented, on behalf of the Central Ethical Committee, the draft rules as to the ethics of medical consultations. These draft rules had been before the Council already, and one rule in particular had been amended in the light of discussions. This now read:

"If for any reason the practitioner consulted and the attending practitioner cannot examine the patient together, the attending practitioner should send to the practitioner consulted a brief history of the case. After examining the patient the practitioner consulted shall forward his opinion, together with any advice as to treatment he may advise, in a sealed envelope addressed to the attending practitioner and he may give to the patient or to the patient's representatives such information as he judges appropriate to the position. . . . "

This was to meet the numerous cases in which the attending practitioner and the consultant did not examine the patient in consultation together.

The draft rules were approved.

The Committee had also reconsidered the International Code of Ethics in the light of criticisms passed upon it at a previous meeting of Council and had redrafted it to meet objections.

Dr. PRIDHAM took exception to the redrafting of one of the clauses which now read: "A doctor shall not in any circumstances do, authorize to be done, or condone anything that would weaken the physical or mental resistance of a human being, except from strictly therapeutic or prophylactic indications imposed in the interest of the patient." He objected to the word "imposed."

A looser wording " . . . except for the purpose of treating or preventing disease" was agreed to.

The Declaration of Geneva again came forward in the light of the doubts expressed as to the use of the word "freely" in the last clause—"I make these promises solemnly, *freely*, and upon my honour." The Committee thought it would be preferable to make the Declaration compulsory for the new graduate, and therefore the word "freely" should be omitted.

Dr. J. G. M. HAMILTON spoke strongly in favour of the retention of the word, and Dr. WAND and Dr. PRIDHAM spoke to the same effect.

The proposal to omit the word "freely" was lost by a large majority. It was agreed that the Declaration be submitted to universities and licensing bodies as appropriate for adoption as part of the formalities of qualification. The inclusion of the word "freely," of course, deprived it of any compulsory character, but it was thought that it was the kind of declaration which the new graduate might be expected to take.

Association Prizes

Dr. JANET AITKEN brought forward a report of the Science Committee with recommendations for awards of the Association prizes and scholarships as follows:

Nathaniel Bishop Harman Prize.—Dr. C. H. C. Toussaint (London).

Prizes for Nurses: Four Categories.—(i) 1st Prize, Miss E. J. Creamer (London), 2nd Prize, Miss J. A. Sauer (Godalming); (ii) 1st Prize, Miss F. Payne (Cambridge), 2nd Prize, Miss A. Schensnovitch (Banbury); (iii) 1st Prize, Miss G. Kenneth (Malvern), 2nd Prize, Miss P. Peart (Scunthorpe); (iv) 1st Prize, Mr. T. J. Tapp (Bristol), 2nd Prize, Miss J. P. J. Smith (Grange-over-Sands).

Ernest Hart Memorial Scholarship.—Dr. R. M. McGregor (Hawick).

Walter Dixon Memorial Scholarship.—Dr. H. J. C. Swan (London).

Ordinary Scholarships.—Dr. R. Dallachy (Paisley), Dr. E. L. Feinmann (Salford), Dr. N. E. France (London), Dr. W. K. Metcalf (Bristol).

The recommendations were approved.

On the report of the Science Committee a proposal was also considered that instead of the suggested establishment of a Founder's Memorial Lectureship, there being already a Sir Charles Hastings Lecture, a festival in honour of the Founder of the Association be held in May, 1951. The idea was approved and certain preliminary details discussed.

Pay of Industrial Medical Officers

Dr. J. A. L. VAUGHAN JONES, chairman of the Occupational Health Committee, brought forward proposals for the remuneration of whole-time and part-time industrial medical officers. The proposals differed chiefly from those now existing in stipulating that there should be regular annual increments of specified amounts and in laying down a range of maximum salaries corresponding with the range of starting salaries. After full consideration of the matter in the light of other scales the Committee suggested that starting salaries should range from £1,000 to £1,800, a medical officer in charge starting at not less than £1,200, and that, normally, the maximum salary should range from £1,800 to £2,700. So far as part-time work was concerned, the Committee had confined its attention to the scale based on the number of hours per week and suggested an improved scale on the same basis.

It was agreed that the revised scales be recommended to the Representative Body.

Fees for Police Calls

The only recommendation of the Private Practice Committee, presented by Dr. I. D. GRANT, was a scale of fees for payment to practitioners called in by the police.

After discussion, Dr. Grant agreed to take back the recommendation.

Medical Officers in the Armed Forces

To fill a vacancy in the Service representation on the Council it was proposed and warmly approved that Surgeon Vice-Admiral Sir Sheldon Dudley be elected as the representative of the Medical Branch of the Royal Navy.

Sir PERCY TOMLINSON, chairman of the Armed Forces Committee, speaking on the remuneration of medical officers in the armed Forces, said that although further discussions had taken place with the Defence Departments they had been restricted in scope and no indication had been received of any intention on the part of the Departments to make remuneration more attractive to volunteers. A full statement of the position was published in the *Supplement* of May 20 (p. 223). The position was thoroughly unsatisfactory and he moved on behalf of his committee that advertisements of civilian specialist appointments with the armed Forces at salaries in excess of pay received by Service specialists be not accepted for publication in the *Journal*. The excess, taking allowances into consideration, was between £400 and £500, and there was great resentment in the Services.

The recommendation was agreed to. A further recommendation was agreed to, protesting strongly to the War Office against a recent Army Council instruction by virtue of which applications to resign from the Service submitted by medical officers in the R.A.M.C. will not normally be approved, except where an officer can be released without detriment to the Service or strong compassionate grounds exist.

With the memory of a former contest in mind, Sir Percy Tomlinson congratulated women doctors in the Medical Services on being granted commissions in the R.A.M.C. and medical Branch of the R.A.F., and receiving the same rank and titles as men. Dr. JANET AITKEN made a suitable acknowledgment.

Health Centres

A recommendation of the Health Centre Committee which was deferred at the last meeting of Council was now moved by Dr. HUTCHINSON—namely, that when the report on health centres came to be circulated to local authorities it should be accompanied by a letter stating that, while the report represented the Association's policy, it was realized that in existing conditions a comprehensive health-centre programme was impracticable and that the Association was considering what steps could be taken to facilitate the provision of a full health-centre service when building and other difficulties were removed.

It was agreed first to send the report to local medical committees and to reserve its issue to local authorities until the views of such committees were known.

Present Position of General Practice

The Council agreed at its previous meeting that a special committee should be set up to review the present position of general practice, its difficulties, and its trends, both generally and with reference to N.H.S. experience and to the Association report on "General Practice and the Training of the General Practitioner."

The CHAIRMAN suggested that in making nominations for the Committee care should be taken to include representatives of various types of general practice, as well as specialists and general-practitioner specialists. In addition to the President and President-elect, the Chairmen of Council and of the Representative Body, and the Treasurer, the following names were proposed:

Dr. G. O. Barber
Dr. Lindsey Batten
Dr. Alexander Brown
Dr. C. Metcalfe Brown
Mr. Zachary Cope
Dr. H. Guy Dain
Dr. Annis Gillie
Mr. A. Staveley Gough
Dr. I. D. Grant
Dr. David Hughes
Dr. G. W. Ireland
Dr. J. A. L. Vaughan Jones
Dr. W. Jope
Professor Hilda Lloyd
Dr. John Milne
Dr. John Revans
Dr. A. Talbot Rogers
Dr. J. G. Thwaites
Dr. C. W. Walker
Dr. S. Wand

Merit Awards and Specialist Grading

Earlier in the day the Council had learned incidentally from its Northern Ireland member that merit awards were being made in Northern Ireland. Mr. LAWRENCE ABEL now moved that the attention of the Minister of Health be drawn to the delay in the allocation of merit awards and upgrading of S.H.M.O.s in Great Britain, and that he be urged to fulfil his promises. Dr. S. F. L. DAHNE seconded.

The resolution was carried without dissent.

The Medical Bill

The Council had before it a memorandum on the Medical Bill, 1950, interpreting certain points. It was stated that all the important changes which the Association had sought had been made during the passage of the Bill in the House of Lords.

Dr. H. B. MORGAN said that the Bill would not have an uncontested passage through the Commons.

Dr. H. R. FREDERICK said that the Bill as drafted made no separate provision for the election to the General Medical Council of a representative or representatives for Wales. The attention of the Association's G.M.C. Committee was drawn to this, and it was with great gratification in Wales that they found an amendment to this effect had been embodied in the Bill. He wished to express grateful appreciation for the part the Committee had played in the matter.

Other Business

The Council sent a telegram timed so as to reach Brisbane during the dinner of the Australasian Medical Congress conveying the greetings and good wishes of the Council.

The report of the Public Health Committee, presented by Dr. C. METCALFE BROWN, contained matters already reported in the *Supplement*. Dr. J. M. GIBSON was appointed in place of Dr. R. H. H. JOLLY, who had resigned, on Committee C of the Whitley Council.

In presenting a report of the Charities Committee Dr. JANET AITKEN mentioned that the year marked the 25th anniversary of the establishment of the B.M.A. Charities Trust Fund and of the first allocations from that Fund to the Royal Medical Benevolent Fund and the Royal Medical Foundation of Epsom College. Both these bodies had expressed their warm thanks for the great assistance they had received from the Trust Fund over this period.

On the report of the Film Committee, presented by Dr. R. P. LISTON, it was agreed that the Association should be represented by the chairman of the committee at a one-day film session of the International Medical Congress at Verona in July, when the B.M.A. film on "Infections of the Hand," now in the final stages of production, would be shown.

In presenting the report of the Journal Committee, Dr. O. C. CARTER said that inquiry had been made into the feasibility of the suggestion that an air mail edition of the *Journal* should be posted to overseas members. There were 18,530 such members, and the weekly additional cost of sending them the *Journal* by air mail, printed on india paper, would be £3,221, which put the proposition out of court. Inquiries were being made as to the feasibility of sending a number of copies by air mail to addresses on a selected list.

The report of the Colonies and Dependencies Committee, presented by Dr. H. B. MORGAN, was concerned, among other matters, with the arrangements for a Caribbean Conference, when the main item on the agenda would be the unification of the medical services in the British West Indies. On Dr. Dain's suggestion, Dr. Morgan was invited to accompany Dr. Dain on his visit to the West Indies.

The Committee on Psychiatry and the Law reported that the preparation of a memorandum on the adolescent delinquent boy was proceeding.

Appointment of Delegates

The Council invited Lord Horder to represent the Association at the forthcoming fifth post-war annual conference of the Cremation Society.

Dr. Clark Trotter was appointed Association delegate to attend the annual conference of the National Smoke Abatement Society.

At the request of the Civil Service Medical Officers Joint Committee for two nominations for the Chancellor's consideration for a medical representative on the Civil Service Medical Officers Joint Committee (the Barlow Committee), Dr. Frank Gray and Dr. D. F. Hutchinson were nominated.

Mr. L. Dougal Callander and Dr. F. Gray were appointed members of the Publishing Subcommittee to fill the vacancies created by the death of Dr. R. G. Gordon and the resignation of Dr. R. W. Cockshut. It was announced that Dr. Cockshut's resignation was due to ill-health and the Council sent him a sympathetic message.

The Council again nominated Dr. H. Guy Dain as co-opted member of the Council of the Royal College of Surgeons of England.

Appointments to Staff

The Council, after interviewing three candidates on a short "leet" presented by the Scottish Committee, appointed Dr. J. T. McCutcheon, of Glasgow, as Assistant Scottish Secretary.

On the recommendation of the Journal Committee, and after hearing short statements from the candidates, the Council appointed Dr. J. L. Crammer and Dr. M. Ware as Assistant Editors of the *British Medical Journal*, and Dr. C. B. M. Swan as Medical Assistant Editor of the popular health journal.

GENERAL MEDICAL COUNCIL

REPORTS OF COMMITTEES

A report of the Examination Committee was presented to the Council by the Chairman, Dr. Brocklehurst. It included a summary of the annual returns of professional examinations held in 1949.

The Public Health Committee, under the chairmanship of Sir Andrew Davidson, presented a summary of the annual returns of the results of examinations held by licensing bodies and by the English Conjoint Board in 1949 for diplomas and certificates in public health. The number of passes for diplomas was 172 and of rejections 13. For certificates the number of passes was 182 and of rejections 29.

The Pharmacopoeia Committee, under the chairmanship of Mr. Dilling, embodied a report of the British Pharmacopoeia Commission, chiefly relating to the Addendum to the *British Pharmacopoeia, 1948*, which will shortly be published and will become official before the end of the present year. The Addendum will contain new monographs dealing with the antibiotic group of substances, synthetic drugs, and hormones, also human blood and preparations of it. The report also stated:

"The Commission has been informed of the intention of the World Health Organization to publish in the near future an *International Pharmacopoeia*. This will be issued to the member Governments of the Organization with the recommendation that its provisions be included in the national pharmacopoeias after the adoption of the said provisions by the authorities responsible for the pharmacopoeias.

"The Commission recommends that the provisions of the *International Pharmacopoeia* be adopted for the *British Pharmacopoeia*, subject to a reservation in terms similar to those of the reservation appended to the ratification of the existing international agreement for the unification of pharmacopoeial formulae for potent drugs: 'To reserve the right of introducing such modifications in detail as established usage in medical and pharmaceutical practice renders expedient and the progress of medical and pharmaceutical science may from time to time render necessary.'"

DISCIPLINARY CASES

The Council on May 25 and 26 considered the case of Dr. Eric Allan Peter Sutherland-Rawlings, registered as of Burwood Place, London, W.2, who was summoned on the charge that he had committed adultery with Gwyneth Lyons, of which adultery he had been found guilty by the decree of the Divorce Court dated July 22, 1949, and made absolute on December 17, 1949, in the case of Sutherland-Rawlings *v.* Sutherland-Rawlings, in which he was the respondent; and that he had stood in professional relationship with the said Gwyneth Lyons at all material times.

After hearing the case the Council found that it had not been proved to its satisfaction that there was professional relationship at all material times, and therefore the case was dismissed.

The Council next considered the case of Dr. Reginald Frank Stubbs, registered as of Hale, Cheshire, who was summoned on the charge of having committed adultery with Freda Rose Mitchell, a married woman, of which adultery he had been found guilty by decree of the Divorce Division dated June 27, 1949, and made absolute on August 10, 1949, in the case of Mitchell *v.* Mitchell and Stubbs, in which he was the co-respondent, and that he had stood in professional relationship with the same Freda Rose Mitchell at all material times.

After hearing the case the Council found that it was not satisfied that the part of the charge concerning adultery had been proved, and accordingly dismissed the case.

Cases Following Convictions

The four remaining cases on the Council programme were consequent upon court convictions.

Dr. Peter Augustine Smyth, registered as of Lillie Road, London, S.W.6, had been convicted in 1947 at Marylebone of being in charge of a motor vehicle while under the influence of drink, and in 1949 at London quarter sessions of driving a car while under the influence of drink and in a manner dangerous to the public. The Council found the convictions proved, but postponed judgment for 12 months.

Dr. Garden Hepburn Swapp, registered as of Stonehaven, Kincardineshire, appeared following two convictions at Aberdeen in 1949 and one in 1945 of being in charge of a motor-car whilst under the influence of drink. In this case also the Council postponed judgment for 12 months.

Dr. Thomas Dunbar, registered as of Finlay Drive, Glasgow, was summoned following convictions at Glasgow, in 1949, of being in charge of a motor vehicle while under the influence of drink, and in 1950 of a similar offence. The practitioner did not appear, but sent a letter explaining the circumstances and giving his assurances for the future. Here again the Council postponed judgment for 12 months.

All the above practitioners were required to appear at the 1951 May session, and to bring testimonials from their professional colleagues as to their conduct in the meantime.

The Council considered in private a complaint against Dr. Bronislaw Ciszewski, registered as of Bristol, Med. Dip. U. Warsaw, consequent upon a conviction for misdemeanour. It was afterwards announced in public that the Council had found the conviction proved, but did not see fit to erase the name.

The final act of the Council was to agree to present an address of congratulation to the Royal College of Surgeons of England on the forthcoming celebration of the 150th anniversary of its incorpation by royal charter.

Questions Answered

Examining H.M.C. Employees

Q.—*I am a medical registrar (senior grade) and have been directed by the hospital management committee to carry out medical examinations without fee on employees of the committee for superannuation purposes. Is a fee payable for this service?*

A.—Although in general the examination of employees for superannuation purposes (at the request of the employer) is outside the scope of the hospital and specialist services, and therefore may be undertaken for payment by members of hospital medical staffs, it is clear from the wording of paragraph (*a*) (iv) of Category II of paragraph 14 of the "Terms of Service" that, where the person to be examined is the employee of the hospital board or hospital management committee at the hospital where the practitioner is employed, the work is within the scope of his contract, to be performed without additional payment.

British Medical Association

SUPPLEMENTARY ANNUAL REPORT OF COUNCIL, 1949-50

Every member is asked to keep this Supplement, with the earlier one of April 22, until the subjects have been discussed by his Division

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PRELIMINARY

Representation of Medical Branch, Royal Navy, on the Council

184. A vacancy exists on the Council owing to the resignation of C. H. M. Gimlette, the representative of the Medical Branch of the Royal Navy.

Recommendation: That Surgeon Vice-Admiral Sir Sheldon Dudley, K.C.B., O.B.E., M.D., F.R.C.P., F.R.S., be elected as the representative of the Medical Branch of the Royal Navy on the Council to fill the vacancy caused by the resignation of Surgeon Rear-Admiral C. H. M. Gimlette for the remaining period of the latter's term of office, 1949–52.

GENERAL MEDICAL SERVICES

Remuneration

(Continuation of para. 12 of Annual Report)

185. At the interview with the Minister of Health on April 3 the G.M.S. Committee's representatives drew attention to the long delay in settling the general practitioners' claims in regard to the size of the Central Pool and to the comparisons which were being made between the remuneration of general practitioners and that enjoyed by other professions in the National Health Service.

The Minister, while not unsympathetic with the general practitioners' case, stated that the Government's "wage freeze" policy could not be disregarded, and he was not prepared to increase the Central Pool on the facts submitted to him. He wished, however, to have the co-operation of the profession in undertaking certain further inquiries relating to (1) actual payments from National Health Service sources to each general practitioner in the year ending March 31, 1950, and (2) the practice expenses of general practitioners under a full year's working of the new Service. Having obtained this information, by the autumn of 1950, the Minister would consider, with the G.M.S. Committee's representatives, the implications in the light of conditions then obtaining.

After careful consideration the Committee passed the following resolutions, which were sent to the Ministry:

"That the General Medical Services Committee—despite its deep disappointment at the Minister's repeated refusals to increase general-practitioner remuneration—is willing, subject to agreement on detail, to accept the Minister's invitation to collaborate with him in the collection of fresh information on general practitioners' incomes from the Service, provided that the Minister agrees

"1. That these studies and investigations are completed by November 1, 1950.

"2. That the Spens Report on general-practitioner remuneration, accepted by both the Minister and general practitioners, remains the basis of general-practitioner remuneration until, after appropriate notice, any new basis is agreed between the Minister and the profession's representatives.

"3. That if the investigations reveal inadequacy of general-practitioner remuneration or an excessive margin between their remuneration and that of other comparable professions within the National Health Service and other appropriate branches of the medical profession, the Minister will make available to general practitioners any money necessary to remedy the inadequacy or to narrow the margin.

"That the G.M.S. Committee informs the Minister of its willingness to collaborate in a search for reasonable and prudent economies in the National Health Service."

The Ministry's reply included the following statement on the second proviso:

"(2) The Minister agrees that the Spens Report remains the basis of the remuneration of general medical practitioners until such time as after the usual consultations some other basis is substituted."

This was not considered to be satisfactory and an assurance is being sought that the Spens Report will remain the basis of the remuneration of general medical practitioners until after the full Whitley procedure has been followed, including, if necessary, such recourse to arbitration or independent inquiry as is provided for in the Whitley Constitution. The G.M.S. Committee is anxious that the machinery laid down shall not be short-circuited by arbitrary one-sided action by the Minister.

Reports from a number of local medical committees indicate a desire for a Special Conference of Representatives of L.M.C.s at which the whole subject of remuneration can be discussed. It has been decided, therefore, to convene such a Conference, to be held on June 29.

Mileage

(Continuation of para. 12 of Annual Report)

186. Following the decision not to implement the new proposals for distributing the Central Mileage Fund pending the receipt of further information on "walking" units, discussions have taken place with officers of the Ministry. These discussions and a subsequent examination of the problem have shown that many of the present inequalities are due to the lack of any proper basis for the allocation of the Reserve portion of the Fund.

The original grants from the Reserve portion were determined by a Ministry of Health Committee after a comprehensive survey some twenty-five years ago. With subsequent increases in the Mileage Fund, the present size and distribution of the Reserve portion appears to bear little relation to the difficulties of access actually involved. Furthermore, the method of classifying practices for the purpose of compiling returns which govern the distribution of the Ordinary portion of the Fund is some twenty-five years old and takes no account of changed conditions.

It is therefore clear that the factors on which the Committee's proposals are based would not necessarily lead to an equitable distribution of the Fund, and the remedy appears to be the appointment of a Government Committee to review the whole mileage problem afresh. The Ministry has been asked to take this course, but, as some time will elapse before a new scheme can be evolved, it has been decided, as an interim measure, to implement the new proposals as soon as administratively possible in order to reduce some of the more obvious inequalities.

Central Practitioners' Fund—Basis of Calculation

187. In 1948 it was agreed that the population factor in the calculation of the Central Practitioners' Fund—95% of the population in Great Britain—should hold good for two years. Discussions are taking place with the Ministry of Health in order to determine what modifications are necessary in the light of changed conditions.

Vaccination and Immunization

(Continuation of para. 18 of Annual Report)

188. Reports received from various parts of the country show that some local authorities are paying medical practitioners the agreed fee of 5s. for a report of successful vaccination or diphtheria immunization only in respect of patients on their N.H.S. lists. There would appear to be no justification for this discrimination, and the Ministry of Health is being asked to take appropriate action.

Standard Dressings

(Continuation of para. 27 of Annual Report)

189. Agreement has been reached with the Ministry on the revision of the component parts of the standard dressing laid down in the Drug Tariff. It has been agreed that the new standard dressing shall consist of: three 2-in. bandages, one square yard of gauze, and 1 oz. of cotton-wool.

Medicines and Appliances for Doctors' Surgeries

190. Discussions have taken place between representatives of the G.M.S. Committee and of the chemists on a suggestion that doctors should be allowed to order on official prescription forms stocks of medicines and dressings for emergency use in surgeries. General agreement has been reached on the lists of medicines and dressings which may be ordered in this way, and the list is being presented to the Ministry by representative doctors and chemists acting together.

Prescribing of Preparations which are not Drugs or Medicines

191. The Ministry has recently issued to executive councils the first report of the Joint Subcommittee of the Standing Medical and Pharmaceutical and General Practitioner Advisory Committee, which has been reviewing a number of borderline preparations held by the Department not to be drugs.

Dental Haemorrhages

(Continuation of para. 30 of Annual Report)

192. Representatives of the G.M.S. Committee and the British Dental Association are to make a joint approach to the Ministry with a proposal that a doctor should be regarded as a dentist's deputy when giving emergency treatment arising from a dental operation, thus enabling the doctor to claim a fee from the dental "pool."

Change of Doctor

(Continuation of para. 32 of Annual Report)

193. Following representations made by the Committee, the Ministry of Health has submitted a proposal the effect of which is to require a patient who wishes to transfer to another doctor to give a fortnight's written notice of his intention to the executive council. This proposal is satisfactory so far as it goes, but the Ministry is being asked to provide, in addition, for immediate change of doctor with the consent of both doctors concerned.

Representation of General Practitioners on Regional Hospital Boards and Hospital Management Committees

(Continuation of para. 38 of Annual Report)

194. Discussions have taken place with the Ministry on the desirability of securing representation of general practitioners on regional hospital boards and hospital management committees.

Appointment of members of R.H.B.s is in the hands of the Minister, who is obliged to consult "such organizations as he may recognize as representative of the profession in the area or generally." In practice, the Minister has invited the Association (centrally) to make nominations, and, since the establishment of the Central Consultants and Specialists Committee with its regional organization, the matter has been dealt with through that Committee. Regional consultants and specialists committees have been advised to consult local medical committees in the region before submitting names. This procedure, as a result of the difficulties involved, has, in practice, not had the desired effect so far as general practitioners are concerned. At the same time, it is noticeable that there has been a continuing tendency to reduce the medical representatives on R.H.B.s, and the appointments made by the Minister in March last show that in eight cases medical members have been replaced by laymen. It is proposed that, in future, the Association will submit separate lists of consultants and specialists and general practitioners.

Some concern was felt at the limitation placed by the Ministry on the sources from which names for vacancies for medical members of Hospital Management Committees may come. In the Ministry's circular R.H.B. (49) 143 it is stated that "medical and dental members should normally be derived as implied by the Act, from names proposed by the hospital staffs and not from other sources." No such inference as that indicated can be drawn from the Act, and it was pointed out to the Ministry that this limitation for practical purposes prevents general practitioners from finding their way to H.M.C.s. The Ministry has agreed to issue a clarifying circular before the next annual elections to H.M.C.s take place, in the light of the Committee's recommendation.

Definition of Medical Treatment

195. General approval has been given to the following definition of "medical treatment," prepared by the Ministry of Health:

"Medical treatment consists in the employment of the professional skill of the medical profession to alleviate suffering, to restore normal functions, to maintain health, and to prevent disease or other conditions harmful to health.

"The word 'health' here refers to the mental as well as to the physical state."

Petrol Tax

196. Immediately following the announcement that the Chancellor of the Exchequer proposed to increase the tax on petrol by ninepence a gallon, representations were made to the Ministry of Health, on the ground that the increased tax constituted a net reduction of general-practitioner remuneration, falling heaviest on those who travel the greatest number of miles. Subsequently, the Ministry stated that this was a matter for the Treasury to deal with, and a request was made to the Chancellor to receive a small deputation. The reply on behalf of the Chancellor was a reference to questions and answers in Parliament to the effect (*a*) that it was impracticable to relieve doctors of the increase in petrol duty, and (*b*) that the imposition of a new tax could not be regarded as constituting grounds for an addition to remuneration. In the circumstances, the Chancellor felt that no useful purpose would be served by his receiving a deputation.

CONSULTANTS AND SPECIALISTS

Merit Awards: Grading of Hospital Staffs

197. The following resolutions of the Council have been communicated to the Ministry of Health:

"1. That the Council of the British Medical Association deplores the delay in the payment of merit awards to specialists in England, Wales, and Scotland, and requests that immediate steps be taken to expedite the payment of this overdue remuneration.

"2. That the Council again draws attention to the widespread dissatisfaction at inequalities and injustices in the grading of hospital staffs and urges that a national review of such gradings be instituted forthwith."

Salaries of Medically Qualified Teachers and Research Workers

197*a*. In February, 1949, the Council appointed a special committee to consider the best methods of securing the application of the recommendations of the Spens Committee to full-time medically qualified teachers and research workers.

Shortly after the committee began its task the University Grants Committee, recognizing the implications of the Spens Committee Report, informed universities that provision would be made in the 1949–50 financial estimates to enable them to readjust the salaries of the holders of whole-time posts in medical and dental schools within certain limits. The various universities subsequently implemented new salary scales within the maxima recommended by the University Grants Committee, operative in the case of the holders of clinical posts with effect from April 1, 1949, and in the case of non-clinical teachers from October 1, 1949. It was learned that the Medical Research Council also had introduced new salary scales for its medically qualified research staff with effect from April 1, 1949.

The committee accordingly reviewed the terms and conditions of service of medically qualified teachers and research workers in the light not only of the Spens Committee Report but of the action which had already been taken. After a full examination of the position it reached the conclusion that, although the improvements effected had gone a long way towards reaching terms of service for university medical teaching staff and research workers comparable with those obtaining in the hospital and specialist service, further adjustments were desirable, particularly with a view to securing uniformity as between the different universities and for securing that the U.G.C.'s recommendations were fully implemented.

Discussions have therefore taken place with the U.G.C. and the M.R.C. on these facts.

Income Tax

197*b*. As members of hospitals medical staff are now receiving arrears of salary retrospective to July 5, 1948, on the basis of the terms of service, it is of interest to record that counsel's opinion has been obtained to the effect that these payments should be regarded for tax purposes as income of the year in which it was earned, whether the practitioner is assessed under Schedule D or under the PAYE provisions of Schedule E. The same consideration should apply to surtax.

OCCUPATIONAL HEALTH

Remuneration of Industrial Medical Officers

(Continuation of para. 81 of Annual Report)

198. The scale of remuneration for industrial medical officers approved by the Council in 1948 has been reviewed in relation to the remuneration already arranged, or now being claimed, in other branches of medical work. Particular attention has been paid to the position in general practice and the proposed salary scales for public health medical officers and medical officers in the Civil Service. The Council has reached the conclusion that the scale for industrial medical officers now requires revision. The Council's revised proposals differ mainly from the existing proposals in stipulating that there should be regular annual increments and in laying down a range of maximum salaries corresponding with the range of starting salaries.

Since the appointment of assistant medical officer is often held for many years, the Council considers that such medical officers should have the benefit of an incremental scale. It therefore proposes that there should be a single salary, applicable to all whole-time industrial medical officers, including those who work under the immediate supervision of senior medical officers.

In regard to part-time industrial medical officers the Council proposes that the scale of salaries should be based on the number of hours per week.

The Council recommends:

Recommendation: That the Representative Body approve the revised scales of salaries for industrial medical officers as follows:

A. Whole-time Officers

1. A whole-time industrial medical officer who has had three years' experience in the practice of his profession after obtaining a registrable qualification should receive, when first appointed, a starting salary within the range of £1,000 to £1,800 per annum, according to the degree of responsibility entailed by the appointment; provided that

(1) a whole-time industrial medical officer who holds a higher professional qualification or has had special postgraduate training in industrial medicine or more than three years' professional experience should receive, when first appointed, a starting salary at a suitable incremental point above the minimum which would otherwise be appropriate;

(2) a whole-time industrial medical officer *in charge* should receive, when first appointed, a starting salary not less than £1,200 per annum.

2. The starting salary should be increased by regular annual increments, each increment being not less than 6% of the existing salary.

3. The annual increments should be continued until the salary reaches a maximum normally within the range of £1,800 to £2,700; provided that a maximum salary in excess of £2,700 should be paid when the appointment entails exceptional responsibilities.

4. The introduction of this salary scale should in no circumstances result in the reduction of the existing salary of any industrial medical officer already appointed.

Note.—The description "medical officer in charge" refers to the medical officer who has charge of the medical services of a firm or (in the case of a large firm) of one of its constituent units.

B. Part-time Officers

1. Part-time industrial medical officers should receive annual salaries, based on the average number of hours' work per week, at rates not lower than those set out in the following table:

Hours per week	Minimum Annual Salary
Up to 1 hour	£75
1 „ 2 hours	£150
2 „ 3 „	£225
3 „ 4 „	£300
4 „ 5 „	£350
5 „ 6 „	£400
6 „ 7 „	£450
7 „ 8 „	£500
8 „ 9 „	£550
9 „ 10 „	£600
10 „ 11 „	£650
11 „ 12 „	£700
12 „ 13 „	£750
13 „ 14 „	£800
14 „ 15 „	£850
15 „ 16 „	£900
16 „ 18 „	£950
18 „ 20 „	£1,000

2. The above scale is intended to include work inside and outside the industrial establishment and covers not only routine work but also telephone consultations, preparation of memoranda, advice on Government publications, etc.

3. Where a part-time industrial medical officer is required to travel beyond a radius of two miles in the course of his duties a mileage rate of 1s. a mile each way should be paid.

Manual of Industrial First Aid

199. In 1948 representatives of the Association attended a conference at the Royal College of Nursing to discuss a syllabus of training for industrial first-aid attendants. The syllabus approved at that conference was subsequently submitted to the St. John Ambulance Association for the purpose of preparing a *Manual of Industrial First Aid*. The draft manual which has been produced has been submitted to a number of organizations, including the B.M.A., for their comments before it is finally printed and is being considered by the Council.

MEDICAL ETHICS

Rules for Medical Consultations

(Continuation of para. 101 of Annual Report)

200. The Council has now completed the revision of the Rules as to the Ethics of Medical Consultations in Practice, Other Intra-professional Obligations, Guidance for Professional Conduct in Relation to Dentists, and Examining Medical Officers.

The Council submits in Appendix IV the revised rules for approval.

Recommendation: That the following rules be approved:

(*a*) Rules as to the Ethics of Medical Consultations in Practice,

(*b*) Other Intra-professional Obligations,

(*c*) Guidance for Professional Conduct in Relation to Dentists,

(*d*) Examining Medical Officers' Ethical Rules.

PRIVATE PRACTICE

Medical Officers of Approved Schools

(Continuation of para. 108 of Annual Report)

201. The impression that the present scale of remuneration for medical officers of approved schools is only adequate where there are a large number of pupils has been confirmed by the replies received to a circular sent to the medical officers of several approved schools of various sizes. The Council has decided to press the Home Office to increase the minimum salary to £52 per annum for all schools.

Allowances to Medical Witnesses

(Continuation of para. 111 of Annual Report)

202. An unsatisfactory reply has been received from the Home Office to representations that a fixed scale of fees should be laid down for payment to medical witnesses in criminal courts. The recommendations dealing with the payment of allowances to professional witnesses at county courts, contained in a report issued by the Committee on County Court Procedure, are also regarded as unsatisfactory. Further action is proceeding.

Air Ministry—Examination of Volunteers for the R.A.F.V.R.

203. Following the agreement reached with the War Office for the payment of a fee of £1 1s. for the examination of recruits to the Territorial Army, representations were made to the Air Ministry that a similar fee should be paid for the examination of recruits for ground duties in the R.A.F. Auxiliary and Reserve Forces. These representations have been successful and the increased fee came into effect as from April 25, 1950. The fee previously paid was 10s. 6d.

204. The Council is pressing for the removal of the overriding daily maxima of £4 4s. for the first 3 days in each week and £3 3s. for subsequent days, which are still being applied to the increased fee.

Air Ministry—Examination of Personnel for Fitness to Fly

205. For many months the Council has been pressing the Air Ministry to increase from £1 1s. to £1 11s. 6d. the fee payable for the examination of personnel for fitness to fly. The Air Ministry has now informed the Council that the number of occasions on which a civilian medical practitioner is engaged by the Department to undertake these examinations has become rare, but that where such arrangements are made in the future the fee will be £1 11s. 6d.

Medical Examination of Migrants

(Continuation of para. 114 of Annual Report)

206. Following further negotiations with representatives of the Australian Government, the Council has obtained an increase in the fees recommended for the examination of migrants. Prospective migrants will now be informed by the Australian Immigration Authorities that the appropriate fee for the examination and report on adults and unaccompanied children is £1 1s., and that for the examination and report on accompanied children under 16 years of age the appropriate fee is 7s. 6d. Previously, the recommended fees were 10s. 6d. and 5s. respectively. Representations are now being made to the Canadian Authorities that similar fees should be recommended for the examination of migrants to Canada.

"BRITISH MEDICAL JOURNAL"

Popular Health Journal

207. The Annual Representative Meeting in 1949 adopted the recommendation of Council that the Association undertake the publication of a popular health journal, when it should be published to be decided subsequently by the Council. When the Council met on April 5 this year it approved the project, and the new journal will therefore appear early next year, being published monthly.

Dr. I. Harvey Flack, Assistant Editor of the *British Medical Journal*, has been appointed Editor of the popular health journal. Other staff appointments have also been made.

FINANCE

Subscription to the Association

(Continuation of para. 123 of Annual Report)

208. The Council has given further consideration to the question of the subscription to the Association of medical officers in the public health service. The Council was informed that public health medical officers wished to be regarded as full members of the Association and did not seek any advantage over other members. It appeared to the Public Health Committee that the difficulty to which reference was made at the last Annual Representative Meeting should be resolved not by means of seeking a reduction in membership subscription but rather by seeking adequate scales of remuneration.

The Council has decided in the light of the views expressed by the Public Health Committee to take no further action.

SCIENCE

ASSOCIATION PRIZES

(Continuation of para. 125 of Annual Report)

Nathaniel Bishop Harman Prize

209. The Nathaniel Bishop Harman Prize was established for the promotion of systematic observation and research among consultant members of the staffs of hospitals who are not attached to recognized medical schools. It consists of a certificate and a cheque for £100.

The 1950 prize has been awarded to Dr. C. H. C. Toussaint, London, for an essay on Domiciliary Management of Pulmonary Tuberculosis.

Prizes for Nurses

The Association's Prizes for Nurses have been awarded as follows:

Student Nurses (category (i))	First Prize to Miss Enid J. Creamer, Highlands Hospital, London, N.21. Second Prize to Miss Janna A. Sauer, St. Thomas's Hospital, Hydestile, Godalming.
State Registered Nurses working in a hospital (category (ii))	First Prize to Miss Frances Payne, Addenbrooke's Hospital, Cambridge. Second Prize to Miss Anna Schensnovitch, Horton General Hospital, Banbury.
State Registered Nurses not working in a hospital (category (iii))	First Prize to Miss Grace Kenneth, Malvern. Second Prize to Miss Phyllis Peart, Scunthorpe.
State-enrolled Assistant Nurses (category (iv))	First Prize to Mr. Theodore J. Tapp, Bristol. Second Prize to Miss Joyce P. J. Smith, Grange-over-Sands, Lancs.

Acknowledgments

The Council thanks the following, who have assisted in judging the entries for the Association Prizes awarded in 1950:

Dr. Janet Aitken, Dr. G. O. Barber, Mr. V. Zachary Cope, Miss M. H. Cordiner, Professor C. F. W. Illingworth, Dr. J. C. Matthews, Miss E. J. Merry, Dr. C. G. Newman, Dr. T. E. Osmond, Miss Agnes Pavey, Miss Joan Price, Dr. Marjory Warren.

The Council also thanks those who have visited and reported on the Association's 1949–50 Research Scholars—namely:

Dr. D. Evan Bedford, Professor A. Haddow, Professor T. F. Hewer, Professor Sir James Learmonth, Dr. G. N. Orpwood Price, Professor W. W. D. Thomson, Professor F. G. Young.

Founders' Festival

210. The Council has decided to hold in Worcester, in 1951, a festival in honour of Sir Charles Hastings, the Founder of the Association. It is probable that the festival will take the form of a memorial service in Worcester Cathedral, followed by the "Founder's Lecture." The details of the festival will be arranged by the Worcester and Bromsgrove Division.

The Mackenzie Industrial Health Lecture

211. The 1950 Mackenzie Industrial Health Lecture is being arranged in conjunction with the Association of Industrial Medical Officers. The Lecture will be delivered by Professor Ronald E. Lane (Nuffield Professor of Occupational Health, University of Manchester) at Birmingham on June 28. The title of the lecture will be "Education and Industrial Health."

CRIMINAL RESPONSIBILITY OF PERSONS CHARGED WITH MURDER

(Continuation of para. 138 of Annual Report)

212. At the request of the Royal Commission on Capital Punishment the Council has prepared a brief Supplementary Memorandum of Evidence, which is set out below, on the advisability of the Judge or the prosecution being permitted to raise the issue of insanity at any stage during the trial—as is already the procedure under Scottish Law—when the prisoner appears to be mad but refuses to allow the defence to plead insanity on his behalf:

1. In Paragraph 25 of its previous memorandum the Association recommended that it should not be necessary for a court to consider or a Judge to direct the jury as to irresponsibility or diminished responsibility resulting from disease of the mind unless one or other of these matters has been raised specifically on behalf of the accused. The witnesses who appeared before the Commission made it clear that the adoption of this recommendation would leave the Judge free to raise the issue of insanity, although he would be under no obligation to do this if he thought it unnecessary.

2. At the request of the Royal Commission, the Association has again considered whether it is desirable that the Judge or the prosecution should be empowered to introduce the question of the prisoner's mental condition at any stage of the trial when the prisoner appears to be mentally abnormal but refuses to plead insanity or diminished responsibility.

3. An advantage of this change in the law would be a reduction of the proportion of cases in which persons charged with murder are found guilty, sentenced to death, and later reprieved as a result of a statutory inquiry. The procedure of the statutory inquiry would still be necessary, but the Judge would less often be obliged to pronounce the capital sentence in cases in which it is highly probable, if not certain, that the sentence will not be carried out.

4. After further study of the problem, however, the Association thinks that there would be some danger in allowing the prosecution, at any stage of the trial, to raise the issue of insanity in the teeth of opposition from the defence. In a case in which the prisoner denied having committed the act charged against him, evidence of insanity might make the jury disposed to assume the prisoner's guilt and to disregard his denial. The suggested change in the law would affect trials for lesser crimes as well as trials for murder, and there might be many cases in which the prisoner's chance of acquittal, in the absence of conclusive evidence of guilt, would be prejudiced owing to bias in the minds of the jury resulting from evidence of the prisoner's mental abnormality.

5. The problem is perhaps one for lawyers rather than for doctors, but the Association, having been asked for its views, offers the suggestion that the solution may be found in the suitable timing of the intervention by the prosecution. When the jury, having considered the facts of the case without regard to the prisoner's state of mind, is satisfied that the prisoner committed the act with which he is charged, there may then be no objection to the prosecution raising the issue of insanity or diminished responsibility and the jury being required to give a second verdict—as to the prisoner's responsibility at the time of the crime—before sentence is passed.

6. This procedure of a two-stage verdict would be facilitated by the adoption of the Association's recommendation, in Paragraph 38 of the earlier memorandum, that the verdict "Guilty but insane" should be replaced by the verdict proposed by the Atkin Committee: "That the accused did the act (or made the omission) charged, but is not guilty on the ground that he was insane so as not to be responsible, according to law, at the time." The jury having given its verdict on the facts of the case, the Judge might then ask counsel for the prosecution whether there was any other matter that he wished to raise, thus giving him an opportunity of suggesting an inquiry as to the prisoner's mental condition. In most cases this would be only a formal question to which counsel would give a negative answer, and the Judge would then immediately pronounce sentence. There would seem, however, to be no objection to the Judge himself, if he has any doubt as to the prisoner's responsibility, raising the issue of insanity or diminished responsibility at this stage of the trial, even if counsel for the prosecution has not thought it necessary to avail himself of the opportunity of doing so.

7. If, in accordance with this suggested procedure, the question of insanity or diminished responsibility were raised either by the prosecution or by the Judge, the defence might wish to contest the matter, especially in cases of minor crimes. It would therefore be desirable that both the prosecution and the defence should have a full opportunity of calling expert medical evidence as to the prisoner's mental state. In short, the method of assisting the jury in determining the responsibility of the prisoner at the time of the crime should be the same as that adopted at present when insanity is pleaded on behalf of the prisoner by the defence.

ARMED FORCES

Rates of Pay of Service Medical Officers

(Continuation of para. 139 of Annual Report)

213. Although further discussions have taken place with the Defence Departments in an endeavour to secure improved rates of pay for medical officers in the armed Forces, they have been restricted in scope and the Council regrets to report that no indication has been received of any intention on the part of the Departments to make remuneration more attractive to volunteers.

A full statement of the position was published in the *British Medical Journal* on May 20.

Meanwhile advertisements are being received for publication in the *Journal* of appointments for civilian specialists to serve with the R.A.M.C. at salaries considerably higher than the combined pay and emoluments of Army specialists. The publication of these advertisements gives rise to strong resentment on the part of regular specialists, who are at present not

permitted to leave the Service to seek more attractive employment elsewhere. The Council has decided, therefore, that in these circumstances the advertisements cannot be accepted.

Resignation from R.A.M.C.

214. Reference is made in the preceding paragraph to the fact that medical officers may not leave the R.A.M.C. This is the result of an Army Council Instruction introduced earlier this year which stipulates that the Army Council will not normally approve applications to resign from the Service submitted by medical officers in the R.A.M.C. (or dental officers in the R.A.D.C.) except where an officer can be released without detriment to the Service or where strong compassionate grounds exist.

It is understood that no similar regulation applies to officers in other branches of the Army, and the Council has protested strongly to the War Office against this discrimination and has requested that the Instruction be cancelled.

Women Medical Officers

215. The Council is pleased to report that in future women doctors in the medical Services will be granted commissions in the R.A.M.C. and the Medical Branch of the R.A.F. instead of being commissioned for service with the R.A.M.C. and the Medical Branch, R.A.F. Women medical officers will also receive the same rank titles as men.

ORGANIZATION

Provisions of By-law 60

216. By-law 60 provides—

No person shall be eligible for election as a Member of Council to represent a Branch or Group of Branches in Great Britain or Northern Ireland (whether the election be by the Branch or Group or by the Representatives of Constituencies) unless at the time of his election he shall be a Member of that Branch or of a Branch comprised in that Group.

A proposal was submitted to the Special Representative Meeting in March that the By-law "should be amended to provide that every candidate for election to Council for any constituency shall be a member of one of the Divisions in that constituency," but the resolution, not being carried by the requisite majority, did not become effective.

The present position appears to be that, whereas in the case of a Branch or Group of Branches the candidate for election to the Council under By-law 60 must be a member of that Branch or Group, there is no similar provision where the constituency comprises a group of Divisions or a single Division. In these latter cases it would appear to be open for the name of any member of the Association to be submitted for election to the Council by the members of the constituency. In the Council's view it should be impossible to differentiate between two classes of constituency, and By-law 60 should accordingly be amended to provide that, in the election of the thirty-nine members of Council, every candidate shall be a member of a Branch or group of Branches or Division or group of Divisions comprising the constituency.

Representation of Scottish Branches on the Council

217. A proposal has been submitted by the Stirling Branch that Group 30, which has 1,757 members, should be entitled to elect two members to the Council, and that the number of directly elected members should be increased from 39 to 40. This proposal has arisen because of an error in the Council's Report to the Special Representative Meeting. In that report it was indicated that the membership of Group 30 was 1,597, whereas in point of fact it was 1,757.

The contention is that as the membership of Group 30 is now over 1,600, which was the figure above which a Group in England was allowed to elect an additional member, the Scottish Group should be entitled to one additional representative. The effect of the proposal would be to increase the number of members of Council elected for Scotland from 6 to 7. The existing position is that the members in England elect by the direct method 31 members of Council, and the members in Scotland elect by the direct method four members of Council, in addition to which the Scottish representatives in the Representative Body elect two members of Council. There is now no similar provision for the election of members of Council by representatives of Constituencies in England.

The following table shows the present position:

	Membership	*No. of Members of Council*	*No. of Members of Council on a Membership Basis*
England (excluding Shropshire) ..	32,077	31	1,034
Scotland	5,611	6	935

If Scotland elects 7 members of Council as is proposed by Stirling it will lead to the following result:

England 1 member for 1,034
Scotland 1 member for 801

The Council is of opinion—

(1) That it would not be an equitable position as between the members in England on the one hand and in Scotland on the other if Scotland were given an additional seat on the Council as is proposed by the Stirling Branch;

(2) that Scotland should be entitled to elect only six members to the Council;

(3) that if the number of members directly elected is to be increased from four to five as is proposed by the Stirling Branch the number of members to be elected by the representatives of constituencies in Scotland should be reduced to one.

Affiliation with the Indian Medical Association

218. The Council proposes to take steps to reach an agreement with the Indian Medical Association for affiliation between the two bodies. All members of the Indian Medical Association whether graduates or licentiates will participate in the benefits of affiliation.

If an agreement on affiliation with the Indian Medical Association is concluded the existing Branches of the Association in India, with the exception of the Assam Branch, will be dissolved, but special arrangements will, of course, be made for members of the Association in India to continue as "unattached" members.

SCOTLAND

Assistant Scottish Secretary

(Continuation of para. 153 of Annual Report)

219. The Council has appointed Dr. J. T. McCutcheon, of Glasgow, as Assistant Scottish Secretary.

Glasgow Regional Office

220. Arrangements are well advanced for the establishment of a Regional Office of the Association in Glasgow at 234, St. Vincent Street. It is believed that the secretarial and clerical facilities thus made available will enhance the value of the Association to the large number of its members who live in or near Glasgow and to the profession as a whole in the West of Scotland.

Relationship of General Practitioners to the Hospital and Specialist Service

(Continuation of para. 156 of Annual Report)

221. On behalf of the Council the Scottish Committee has presented to the Joint Subcommittee of three of the Standing Advisory Committees of the Scottish Health Services Council an interim report on the relationship of general practitioners to the Hospital and Specialist Service under the National Health Service. This report was considered by the Joint Subcommittee on May 25, when oral evidence on behalf of the Association was also heard.

The interim report is based on three assumptions: (*a*) That there is a widespread feeling among general practitioners that the status of general practice both in the profession itself and in the Health Service generally is threatened by the present trend of developments; (*b*) that there is uncertainty and dissatisfaction amongst hospital staffs, particularly among the younger members of them, over questions of grading and the prospects of employment within permanent establishments; and (*c*) that the profession in Scotland remains of the opinion, expressed practically unanimously to the Cathcart Committee in 1934, that the primary requirement of an efficient, comprehensive medical service is good general practice. It advocates as a solution of the problems which now face both hospital administrators and general practitioners the proper employment of the latter within the hospital service. To this end a reversal of the policy of closing cottage hospitals to general practitioners and the development of general practitioner hospitals or general practitioner blocks in hospitals is strongly recommended, and also the employment of appropriately qualified practitioners within the specialist establishment.

Constitution of Public Health Subcommittee

(*Continuation of para. 160 of Annual Report*)

222. The Council has approved a revision of the reference and constitution of the Public Health Subcommittee of the Scottish Committee. The Subcommittee will now have power to confer with appropriate Government Departments in Scotland and to report its findings not only to the Scottish Committee but also to the Society of Medical Officers of Health and in certain cases direct to the Standing Public Health Committee of the Association. The alteration has been made in order to give the Subcommittee greater freedom of action in dealing speedily with questions of conditions of service in their relation to Scotland.

Arrangements at Hospitals for the Reception and Welfare of In-patients

223. The Scottish Committee, on behalf of the Council, has accepted an invitation to prepare evidence for submission to a Subcommittee of the Standing Advisory Committee on Hospital and Specialist Services of the Scottish Health Services Council, which is considering the arrangements at hospitals in the National Health Service for the reception and welfare of in-patients.

Maternity Services under the National Health Service

224. An approach is being made to the Department of Health for Scotland with the object of standardizing maternity record keeping throughout Scotland and the issue of a maternity record form for use by practitioners. Further representations in favour of the establishment in each executive council area in Scotland of permanent liaison machinery in respect of maternity services between the three administrative bodies concerned are also being made to the Department of Health.

General Medical Services

(*Continuation of para. 158 of Annual Report*)

225. Since the Annual Report of the Council the General Medical Services Subcommittee (Scotland) has had further discussions with the Department of Health on matters connected with applications for inducement payments and the consideration of claims for inducement payment on account of hardship arising from the introduction of the National Health Service. The Subcommittee has also discussed with the Department the right of freedom of choice of doctor by aged and chronic invalids in institutions; the provision of standard maternity packs; and the reinstatement on doctor's lists of persons whose names have been removed automatically on going abroad. The Subcommittee has expressed its approval of a memorandum by the Scottish Education Committee to Scottish Education Authorities, clarifying the position in respect of the issue of medical certificates for children absent from school. It is considering the question of allocation of partnership shares from the point of view of (*a*) the salaried partner and (*b*) concealed sale, and it proposes to discuss with the Department of Health the question of the increasing tendency on the part of regional hospital boards and boards of management of hospitals to exclude general practitioners from their membership. The Colliery Practitioners Subcommittee is discussing with representatives of the National Coal Board the question of *ex-gratia* payments for emergency calls in mine accidents, death and disablement benefits, and fees for services rendered on behalf of the National Coal Board. It is also discussing with the Mine Workers Union arrangements for attendance of medical practitioners at mine accidents. Discussions with the local authority associations in Scotland on the question of fees for part-time services rendered by general practitioners are to be resumed.

Central Consultants and Specialists Committee (Scotland)

(*Continuation of para. 159 of Annual Report*)

226. The Tuberculosis Subcommittee has completed its report on Tuberculosis Health Services under the National Health Service. The Committee has referred to the Scottish Joint Committee for Consultants and Specialists the problem of salary anomalies among university laboratory staff who undertake work for regional hospital boards, with a request that the attention of the Department of Health for Scotland be drawn to the difficulties which are resulting therefrom throughout the Scottish Regions. The Committee has discussed with the Department of Health the question of the retrospective payment of Registrars and agreed that retrospective payments should be made except in those cases where the practitioner now appointed to a registrar post has previously held a Class III appointment which was essentially not a substantive one. The question of the policy to be adopted in respect of senior hospital medical officer advertisements from Scottish regional hospital boards is the subject of discussion with the Scottish Joint Committee for Consultants and Specialists and with the Central Consultants and Specialists Committee.

WALES

227. The Welsh Committee, which meets in Shrewsbury under the chairmanship of Dr. H. R. Frederick, has considered a number of other matters of importance to Welsh practitioners. It has made representations in regard to the provisions of the Medical Bill in order to ensure the election by practitioners resident in Wales of a direct representative for Wales on the General Medical Council, and the Council is glad to note that in the Committee stage of the Bill provision has been made for the election of a direct representative by the practitioners in Wales. The question of mileage allowances for rural practitioners and the financial position of certain Welsh practitioners under the National Health Service have also been discussed.

OVERSEAS

British West Indies

(*Continuation of para. 167 of Annual Report*)

228. The Council has appointed Dr. H. Guy Dain to preside over the B.M.A. Caribbean Conference, and he will be accompanied by Dr. H. B. Morgan, the representative of the West Indian Branches on the Council.

Salaries in East and Central Africa

(*Continuation of para. 166 of Annual Report*)

229. In addition to the proposals for Medical Officers' and Senior Administrative Medical Officers' salaries which have been agreed with the Colonial Office for recommendation to the East and Central African Governments, agreement has now been reached on the salaries to be recommended to those Governments for Clinical Specialists and for a new grade of Medical Officer with higher qualifications.

RELATIONSHIP OF AUTONOMOUS BODIES TO THE ASSOCIATION

230. The Council has re-examined the constitutional position of the autonomous committees in relation to the Council and Representative Body. The autonomous bodies which the Council had in mind are the bodies recognized by the Government as representing general practitioners and consultants and specialists engaged in the National Health Service—viz., the General Medical Services Committee and the Central Consultants and Specialists Committee. The problems of the third main group of the profession, those engaged in the public health services, are dealt with by the Association through its Public Health Committee in conformity with an agreement with the Society of Medical Officers of Health under which medico-political activities in this field are undertaken by the Association. This committee, like the General Medical Services Committee and the Central Consultants and Specialists Committee, is a Standing Committee of the Council.

The Council and the Representative Body have delegated to the General Medical Services and Central Consultants and Specialists Committees certain powers the effect of which is to give them a measure of autonomy beyond that enjoyed by other Standing Committees of the Association. The reasons for this delegation of power to these two committees within their respective fields are discussed later in this report. Whatever the merits or demerits of the policy which has been adopted to adjust the Association's committee structure to changing needs, the underlying reason for this review of the position is the apprehension which has arisen in some quarters that this autonomy may become prejudicial to the interests of the Association.

It will be convenient at this stage to consider exactly what is involved by the autonomy which the general practitioner and consultant and specialist bodies enjoy.

The General Medical Services Committee

Taking the General Medical Services Committee first, so far as its autonomy finds expression in the Association's By-laws its duties and powers are

"To deal with all matters affecting practitioners providing general medical services under the National Health Service Acts and any Act amending or consolidating the same and to watch the interests of those practitioners in relation to those Acts."

The Committee, although a Standing Committee of the Association, is also the executive organ of a body which finds no place in the written constitution of the Association—the Conference of Local Medical Committees (except to the extent that the membership of the Committee includes six members appointed by the Conference).

Local medical committees are statutory bodies recognized by the Minister under Section 32 of the National Health Service Act, 1946 (or by the Secretary of State under Section 33 of the National Health Service (Scotland) Act, 1947), as representative of the members of the profession in Executive Council areas. These committees are not local units of the Association and their membership is open to non-members of the Association.

In any examination of the present distribution of powers and functions there are certain facts to be borne in mind:

1. The Government recognizes the statutory local medical committees as the local bodies representative of medical practitioners for the purposes of the National Health Service.

2. Any body which purports to voice the views of the general practitioner to the Government must be representative of local medical committees.

3. The local medical committees are elected by and representative of the whole profession in their areas, irrespective of membership of the British Medical Association or other associations.

4. Any central body which aims to be representative of local medical committees must, therefore, be responsible to local medical committees. The Conference of representatives of local medical committees has been devised for pooling the views of these committees and for presenting those views to the body which represents the Conference in discussions with the Government—i.e., the General Medical Services Committee.

5. From the practical point of view the question arises whether it is an advantage for the Association to have the General Medical Services Committee as one of its committees, though that body takes its instructions from, and is also responsible to, the Conference of local medical committees. However illogical this may appear from the limited viewpoint of the written constitution, it is clear that the advantages of associating the General Medical Services Committee with the Standing Committees of the Council outweigh the disadvantages that would accrue if that committee had to be disassociated from the Council.

6. The source from which the General Medical Services Committee springs is the Local Medical Committee, which technically is not a part of the Association's structure, although in practice it bears a close relationship to the Association's local unit. It is difficult to contemplate any departure from the position that the local medical committees should use their annual conference as the means of expressing their collective views to their executive—the General Medical Services Committee.

If these premises be accepted, it follows that the association of the General Medical Services Committee with the Representative Body as one of the Standing Committees of the Council will profit rather than prejudice the interests of the Association's members, if only for the reason that the liaison and interchange of membership which this achieves is more profitable than detrimental to all the interests concerned.

These considerations apart, in practice the General Medical Services Committee and the Conference of Local Medical Committees are just as closely related to the Association as were the old Insurance Acts Committee and Conference of Local Medical and Panel Committees. The experience of the past 35 years shows that during the whole of the time that these bodies have acted autonomously no practical difficulty has arisen between the Insurance Acts Committee and the Council and between the Panel Conference and the Representative Body. It is true that in theory the General Medical Services Committee (and the old Insurance Acts Committee) could be composed predominantly of non-members of the Association, but this has not happened. An overwhelming majority of the members of the Committee have been simultaneously members of the Association and many of them also have been members of the Council. The position to-day remains as it was in the days of the old Insurance Acts Committee—that the committee dealing with general practice exercises autonomy within its own field, recognizing that when its activities extend outside that field to matters affecting other sections of the profession the convenient and acknowledged forum for the discussion of such matters is the Representative Body. The liaison has the further advantage that, if and when the General Medical Services Committee needs the support of the whole profession on an issue within its own sphere, the channel through which that support may be obtained is the Council and the Representative Body. Conversely, any recommendation of the Council or of the Representative Body is regarded as having the greatest possible force in the deliberations of the General Medical Services Committee and the Conference of Local Medical Committees. None of these considerations need affect the overall supremacy of the Representative Body on issues which are common to the whole profession. Whatever the technicalities of the constitutional position, the plain fact is that the General Medical Services Committee is regarded as an integral component of the Association's machinery and despite its somewhat illogical position the Committee is generally accepted as a really effective part of that machinery.

The Council, in the light of these considerations, has reached the conclusion that no useful purpose would be served by seeking to disturb the present arrangement.

The Central Consultants and Specialists Committee

As regards the Central Consultants and Specialists Committee, the autonomy of this body has been defined rather more explicitly. The Association's By-laws prescribe its duties and powers:

"To consider and to act on matters affecting those engaged in consultant and specialist practice, including matters arising under the National Health Service Acts and any Act amending or consolidating the same and to watch the interests of consultants and specialists in relation to those Acts."

The Committee's position, however, is more clearly expressed in the following resolution passed by the Representative Body at Harrogate in 1949:

"The Central Consultants and Specialists Committee shall be an autonomous body with full powers to determine policy and action on consulting and specialist and hospital matters through the administrative machinery of the Association. The decisions of the Committee within that sphere shall not be subject to approval of the Council or the Representative Body."

It has been contended that this Committee has been given an independence which is *ultra vires* the Articles and By-laws of the Association and in particular By-law 83, which provides that all Standing Committees should report to and act under the instructions of the Council. To appreciate the implications of this somewhat complex position it is necessary to retrace, step by step, its historical development. Before the National Health Service there were two Standing Committees of the Council in this field, the Consultants and Specialists Committee (previously Special Practice Committee) and the Hospitals Committee—dealing respectively with problems affecting consultants and specialists and hospitals. With the introduction of the National Health Service and the consequent formation of Regional Hospital Boards to administer the country's hospital and specialist services the Council considered whether, and if so to what extent, the existing machinery of the Association could be adapted to meet the problems arising under the new service. The Council submitted its findings to the Representative Body at Cambridge in 1948. In brief, the Council recommended that in the area of each Regional Hospital Board there should be set up a committee on somewhat parallel lines to the local medical committee to represent the views of the profession on hospital and consultant and specialist services. There was no statutory provision for such regional professional committees, and to this extent the position differed materially from that which applied in the field of general practice, where the Act made provision for the formation and recognition by the Minister of committees representing the profession in local areas. To provide a really parallel body at the periphery the Council reached the conclusion that, if the new Regional Committees were to represent the general body of consultants and specialists in each area, they should be elected irrespective of membership of the Association. As in the general-practitioner field, it was at the periphery that a new functional body was established which, though closely related to the Association, was not an integral part of its constitution.

At the same time a new Central Consultants and Specialists Committee was established in the place of the old Consultants and Specialists and Hospitals Committees, to secure effective co-ordination of the work of the Regional Committees. The Central Committee was conceived as a Standing Committee of the Association in the full sense of the term, except that non-members of the Association would participate in the election of the Regional Committees from the representatives of which the Central Committee's membership was predominantly drawn. But the Council's proposals were not accepted by the Representative Body in that form. An amendment was carried by the Representative Body at Cambridge that the Central Consultants and Specialists Committee should be an autonomous body with full powers to determine policy on consultant and specialist and hospital matters and action, through the administrative machinery of the Association, the decisions of the Committee not to be subject to approval of the Council or the Representative Body except in so far as they might affect other forms of practice or other aspects of the policy or activities of the Association.

A number of consultants and specialists felt at that time that the Association concerned itself mainly with the interests of general practitioners and insisted that any body set up by the Association to represent consultants and specialists should have complete power of action within its own field. Although the proposal for an autonomous body was accepted by the Representative Body further problems and difficulties arose. The Regional Committees were important bodies, jealous of their autonomy and in their early days even suspicious of the Association. Their views were reflected in the deliberations of the Central Committee to the extent that some doubts were created whether the decision of the Cambridge Representative Body had in fact given it complete autonomy within its own sphere. To remove those doubts the Committee submitted a further modification of its remit to the Representative Body at Harrogate in 1949, the effect of which was to state in unequivocal terms that the decisions of the Committee within its own sphere shall not be subject to approval by the Council or the Representative Body. The Representative Body approved this modification.

An even more significant factor, however, was the position of the Royal Colleges. In July, 1948, when the National Health Service came into operation, exploratory discussions began with representatives of the Royal Colleges and the Royal Scottish Corporations which eventually led to the establishment of the Joint Committee for Consultants. At that time it was apparent that the Central Consultants and Specialists Committee was the only body representative of consultants democratically elected and having the peripheral organization necessary to obtain the views of consultants generally. But, notwithstanding its claims on these grounds to represent the consultant profession, it was clear that by reason of prestige and status—as well as good will—it would be wise that the Royal Colleges and the Royal Scottish Corporations should participate in any negotiations with the Minister. To ensure that there should be one channel, and one channel only, for the presentation of the views of consultants and specialists to the Minister, the Joint Committee was established in December, 1948, with the following terms of reference:

(*a*) to represent consultants and specialists in the impending negotiations with the Government on matters arising out of the National Health Service Acts and the report of the Spens Committee on the Remuneration of Consultants and Specialists;

(*b*) to prepare and to submit for the consideration of its constituent bodies a scheme, including terms and reference, for the future work of the Committee.

The composition of the Joint Committee was agreed on the following basis:

Royal College of Physicians	3
Royal College of Surgeons	3
Royal College of Obstetricians and Gynaecologists ..	2
Royal College of Physicians, Edinburgh	1
Royal College of Surgeons, Edinburgh	1
Royal Faculty of Physicians and Surgeons, Glasgow ..	1
Central Consultants and Specialists Committee	6

The dominant reason for this joint arrangement, however illogical it may appear in relation to the Association's constitution, was the paramount necessity that in the interests of consultants there should be a single mouthpiece for the purpose of their negotiations with the Government. The Joint Committee under Sir Lionel Whitby's chairmanship has achieved that object. Though its constitution provides that, where one of the constituent bodies disagrees with the view of the Joint Committee, that body shall be entitled to convey its views direct to the Government, it is significant that not one of the constituent bodies has yet invoked this procedure.

Liaison

Although the autonomous bodies reviewed in this report have been subject to criticism because of their autonomy, provision has been made for inter-representation which provides an effective liaison between the three groups of the profession concerned. At the periphery there is provision for representation on the regional consultants committees of general practitioners nominated by the local medical committees. More recently steps have been taken to advise that representation is afforded to general-practitioner specialists by inviting the practitioners in this category in each region to elect two of their number to serve on the Regional Committee. Similarly, the Regional Committee includes provision in its constitution for the representation of the Public Health Service.

The constitution of local medical committees provides for representation of consultants and specialists appointed by the

Regional Committees, and representation is also given to the local Medical Officer of Health or his nominee.

At the centre the Central Consultants and Specialists Committee, the General Medical Services Committee, and the Public Health Committee each include representation of the other two groups of the profession concerned.

Conclusion

In the general-practitioner field the Council, in an earlier paragraph, has expressed the view that no useful purpose would be served by seeking to disturb the present arrangement.

In the consultant and specialist field the Council is fully aware that criticisms on constitutional grounds can be levelled against the present administrative structure. At the same time the Council's considered opinion is that it would be wise to continue the present arrangements to ensure that the views of consultants shall be presented to the Government through one mouthpiece. The National Health Service Whitley machinery is now beginning its work and a Medical Functional Council has been appointed, the staff side of which consists of seven representatives of each of the Joint Committee, the General Medical Services Committee, and the Public Health Committee. The Medical Functional Council has appointed committees to deal with the general-practitioner, consultant and specialist, and public health services respectively. How the Whitley machinery will work remains to be seen, but in the Council's opinion it would be inopportune to disturb the constituent parts of the present structure for the time being.

The position of the Public Health Committee gives rise to no difficulty under its working agreement with the Society of Medical Officers of Health.

In view of the considerations referred to in this report, the Council recommends that the present arrangements should continue, but that, in the light of the experience which will then be available, the position of the autonomous bodies be re-examined in not more than three years' time.

PATENTING IN THE MEDICAL FIELD

231. The Association's policy as approved by the Representative Body in 1932 broadly opposes patenting by members of the medical profession in the absence of a system whereby patents can be dedicated to the use of the public.

The Council felt that this policy should be reviewed, and appointed a special committee to look into the general question of patenting in its relation to the medical profession. That Committee has fully investigated the problem and in so doing has had the assistance of a number of research workers (of whom all except one were medical).

Having considered the Report of the Committee, which is set out in Appendix V, the Council takes the view that the conditions obtaining when the 1932 policy was laid down were markedly different from those obtaining to-day. Furthermore, it will be seen that a central body has now been set up, in pursuance of the Development of Inventions Act, 1948, known as the National Research Development Corporation, to which patents may be dedicated. This organization is able to give assistance, both financial and technical, in the development of inventions to ensure their development in the best interests of the nation as a whole. The Council is satisfied that the problem of patenting in the medical field would be satisfactorily solved by members of the profession making use of the machinery offered by the National Research Development Corporation for the dedication of patents.

The Council recommends:

Recommendation: That the Representative Body approves and urges the adoption of the policy of patenting in the medical field by members of the profession, provided the patients are assigned to the National Research Development Corporation to secure that the inventions and discoveries to which they relate are made available, developed, and exploited in the best interests of the public.

MEDICAL BENEVOLENCE

232. The sum of £10,170 7s. 9d. was received during the year 1949 by the Charities Trust Fund of the Association for medical charities, and the following statement shows the amounts collected and distributed during the 12 months:

	1948 £ s. d.	1949 £ s. d.
To: Subscriptions and Donations collected for:—		
(*a*) Distribution at the discretion of B.M.A. Charities Trust Fund	4,455 19 2	4,296 14 3
(*b*) Royal Medical Benevolent Fund	3,573 8 8	3,437 11 8
(*c*) Royal Medical Foundation of Epsom College	880 3 0	840 3 0
(*d*) Royal Medical Benevolent Fund Society of Ireland	62 19 6	50 2 0
Bequests received and allocated to Existing Medical Charities		1,545 16 10
	£8,972 10 4	£10,170 7 9

	1948 £ s. d.		1949 £ s. d.		1949 £ s. d.
By: Amounts distributed to:—					
(*a*) Royal Medical Benevolent Fund—					
(1) Allocated from B.M.A. Charities Trust Fund for General Fund			2,106 2 8		
(2) Allocated from Bequests			772 18 5		
(3) Earmarked for Fund			3,437 11 8		
	5,740 2 11				6,316 12 9
(*b*) Royal Medical Foundation of Epsom College—					
(1) Allocated from B.M.A. Charities Trust Fund for General Fund			1,894 12 6		
(2) Allocated from Bequests			772 18 5		
(3) Allocated from B.M.A. Charities Trust Fund for Sherman Bigg Fund			211 10 3		
(4) Earmarked for General Fund			815 17 0		
(5) Earmarked for Sherman Bigg Fund			24 6 0		
	3,046 17 2				3,719 4 2
(*c*) Royal Medical Benevolent Fund Society of Ireland—					
Earmarked for Fund	62 19 6				50 2 0
(*d*) Sir Charles Hastings Fund	122 10 9				84 8 10
	£8,972 10 4				£10,170 7 9

The above figures show a slight falling off in subscriptions and donations collected for the medical charities, but this has been more than offset by sums received in bequests.

The year 1950 marks the twenty-fifth anniversary of the establishment of the "B.M.A. Charities Trust Fund," although before this the Association acted as a collecting agency for subscriptions to the Royal Medical Benevolent Fund and Epsom College. The annual sums collected have increased in this period from some £450 in 1925 to over £4,250 in 1950, which the Council considers is most gratifying. At the same time demands on the funds are constantly increasing, and the Council hopes that members of the profession will do all they can to help.

OTHER ASSOCIATION ACTIVITIES

Committee on Psychiatry and the Law

233. The Council has received from the Joint Committee of the Association and the Magistrates' Association a report that a memorandum is being prepared on the problem of the Adolescent Delinquent Boy.

This Committee has decided that it will deal with the Law in Relation to the Illegitimate Child as the subject of its next report.

E. A. GREGG,
Chairman.

APPENDIX IV

I.—RULES AS TO THE ETHICS OF MEDICAL CONSULTATIONS IN PRACTICE

1. In these Rules a practitioner consulted is a practitioner who, with the acquiescence of the practitioner already in attendance, examines a patient under this practitioner's care and, either at a meeting of the two practitioners or by correspondence, co-operates in the formulation of diagnosis, prognosis, and treatment of the case. The term "consultation" means such a co-operation between practitioners.

2. It is the duty of an Attending Practitioner to accept the opportunity of consultation in obscure and difficult cases, or

to acquiesce in any reasonable request for consultation expressed by the patient or his representatives.

3. The Attending Practitioner should nominate the practitioner to be consulted, and should advise accordingly, but he ought not to refuse to meet a registered medical practitioner selected by the patient or by the patient's representative, although he is entitled, if such is his opinion, to urge that the practitioner selected has not the qualifications or the experience demanded by the particular requirements of the case.

4. The arrangements for consultation should be made or initiated by the Attending Practitioner. The Attending Practitioner should ascertain in advance the amount of the fee, if any, to be paid to the practitioner consulted, and should inform the patient or his representatives that this should be paid at the time of the consultation.

5. In cases where the Consultant and the Attending Practitioner meet and personally examine the patient together, the following procedure is generally adopted and should be observed, unless in any particular instance there is substantial reason for departing from it.

(*a*) All parties meeting in consultation should be punctual, and if the Attending Practitioner fails to keep the appointment the practitioner consulted, after a reasonable time, may examine the patient, and should communicate his conclusions to the Attending Practitioner in writing and in a sealed envelope.

(*b*) If the consultation takes place at the patient's residence, the Attending Practitioner should, on entering the room of the patient, precede the practitioner consulted, and after the examination the Attending Practitioner should be the last to leave the room.

(*c*) The diagnosis, prognosis, and treatment should be discussed by the practitioner consulted and the Attending Practitioner in private.

(*d*) The opinion on the case and the treatment as agreed should be communicated to the patient or the patient's representatives where practicable by the practitioner consulted in the presence of the Attending Practitioner.

(*e*) It is the duty of the Attending Practitioner loyally to carry out the measures agreed at, or subsequently to, the consultation. He should refrain from making any radical alteration in these measures except upon urgent grounds or after adequate trial.

6. If for any reason the practitioner consulted and the Attending Practitioner cannot examine the patient together, the Attending Practitioner should send to the practitioner consulted a brief history of the case. After examining the patient, the practitioner consulted shall forward his opinion, together with any advice as to treatment he may advise, in a sealed envelope addressed to the Attending Practitioner, and he may give to the patient or to the patient's representatives such information as he judges appropriate to the position.

In cases where the Attending Practitioner accepts the opinion and advice of the practitioner consulted he should carry out the measures recommended as in the event of agreement (Rule 5): where, however, the Attending Practitioner finds he is in disagreement with the opinion and advice of the practitioner consulted he should by suitable means communicate his disagreement to the practitioner consulted.

7. Except in emergency, the arrangements for any future or other consultation or additional investigation shall be left to the initiative of the Attending Practitioner.

8. The practitioner consulted shall not attempt to secure for himself the care of a patient seen in consultation. It is his duty to avoid any word or action which might disturb the confidence of the patient in the Attending Practitioner. The practitioner consulted should not communicate with the patient or the patient's representative subsequent to the consultation except through the Attending Practitioner.

9. The Attending Practitioner should carefully avoid any remark or suggestion which would seem to disparage the skill or judgment of the practitioner consulted.

10. Except by mutual consent the practitioner consulted shall neither supersede the Attending Practitioner during the illness with which the consultation was concerned, nor shall he act as Attending Practitioner to the patient in any subsequent illness.

11. Should the practitioner consulted and the Attending Practitioner hold divergent views, either on the diagnosis or on the treatment of the case, and should the Attending Practitioner be unwilling to pursue the course of action advised by the practitioner consulted, this difference of opinion should be communicated to the patient or his representatives by the practitioner consulted and the Attending Practitioner jointly, and the patient or his representatives shall then be advised either to choose one or other of the suggested alternatives or to obtain further professional advice.

Note.—In the following circumstances it is especially desirable that the Attending Practitioner should endeavour to secure consultation with a colleague:

(*a*) When the propriety has to be considered of performing an operation or of adopting some course of treatment which may involve considerable risk to the life of the patient or may permanently prejudice his activities or capacities and particularly when the condition which it is sought to relieve by this treatment is not itself dangerous to life;

(*b*) When any procedure likely to result in death of the foetus or of an unborn child is contemplated, especially if labour has not commenced;

(*c*) When continued administration of any drug of addiction is deemed desirable in the case of a person who does not need it otherwise than for the relief of symptoms of addiction;

(*d*) When there is reason to suspect that the patient (i) has been subjected to an illegal operation, or (ii) is the victim of suspected criminal poisoning.

II.—OTHER INTRA-PROFESSIONAL OBLIGATIONS

Under the code of ethics of the profession a practitioner ought not to accept as his patient (except with the consent of the colleague concerned),

1. Any patient or member of a patient's household whom he has previously attended either as a consulting practitioner or as a deputy for a colleague.

2. Any patient or member of the patient's household whom he has attended within the previous five years in the capacity of assistant or locum tenens.

3. Any patient who at the time of the application is under the active care of a colleague, unless he is personally satisfied that the colleague concerned has been notified by the patient or his representatives that his services are no longer required.

4. Any patient who so applies because his regular medical attendant is temporarily unavailable. In such case he should render whatever treatment may for the time be required, and should subsequently notify the patient's regular attendant of the steps he has taken.

5. Notwithstanding Rule 3 above, when a practitioner in whatever form of practice is asked for advice or treatment by a patient and has reason to believe that the patient is already under medical care and that the request is made without the knowledge of the attending practitioner, it is the duty of the practitioner so approached to urge the patient to permit him to communicate with the attending practitioner. Should the patient refuse this proposal and *if the circumstances are exceptional* the practitioner is at liberty to examine the patient and to tell the patient his findings and conclusions, but, save for any emergency which exists, he shall not accept the patient for treatment.

III.—GUIDANCE FOR PROFESSIONAL CONDUCT IN RELATION TO DENTISTS

Rules Governing Consultations

(As agreed with the British Dental Association)

(1) Where a patient, in the opinion of his medical attendant, needs simple dental treatment, the patient should be referred in all but exceptional circumstances to his own dentist. In the event of the patient having no regular dentist, there is no objection to a doctor recommending a dentist of his own choice.

(2) Where a doctor (for the benefit of one of his patients) requires to consult a dentist, the doctor should communicate in the first instance with the patient's own dentist. In the event of the patient having no regular dentist there is no objection to the doctor consulting the dentist of his own choice.

(3) Where, for any reason, the patient's doctor considers that the patient should be sent to a dentist other than his own, or where a further dental opinion is sought, the patient's usual dentist should be informed.

Note.—Apart from simple dental treatment—i.e., in the presence of a dental condition which might affect the general health of the patient or necessitate a major dental operation—the dentist should consult the patient's doctor before carrying out such treatment.

Anaesthetics

Where an anaesthetic is advised by the dentist, it is competent for him to select the anaesthetist, but, if such anaesthetist is not the patient's doctor, no objection should be taken to the patient inviting his doctor to be present. Where the operation proposed is a major one, or if it is known to the dentist that the patient is under medical care, the dentist should consult the patient's doctor upon the operation proposed and should invite him to be present if the patient so desires. Similarly, where the patient is under dental care and the doctor advises operative or other major treatment arising from the patient's dental condition, the dentist should be consulted.

On the completion of any dental operation, and especially if there is any reason to think that post-operative complications may ensue, the patient should be advised to consult the dentist immediately if such complications arise and the dentist should take all reasonable steps to facilitate such consultation.

IV.—EXAMINING MEDICAL OFFICERS

Ethical Rules

For the purpose of these Rules an examining medical officer is a practitioner undertaking the examination of a patient of another practitioner at the request of a third party with the exception of examinations under statutory requirements. Rules 2 and 3 do not apply to examinations in connexion with superannuation, pre-employment, or proposals for life or sickness assurance.

(1) An Examining Practitioner must be satisfied that the individual to be examined consents, personally or through his legal representative, to submit to medical examination and understands the reason for it.

(2) When the individual to be examined is under medical care, the Examining Practitioner shall cause the Attending Practitioner to be given such notice of the time, place, and purpose of his examination as will enable the Attending Practitioner to be present should he or the patient so desire.

(Preferably such notice should be sent to the Attending Practitioner through the post, or by telephone, but in certain circumstances a communication might properly be conveyed by the patient.)

Exceptions to this are:

(*a*) When circumstances justify a surprise visit.

(*b*) When circumstances necessitate a visit within a period which does not afford time for notification.

Where the Examining Practitioner has acted under (*a*) or (*b*) he shall promptly inform the Attending Practitioner of the fact of his visit and the reason for his action.

(3) If the Attending Practitioner fails to attend at the time arranged the Examining Practitioner shall be at liberty to proceed with the examination.

(4) An Examining Practitioner must avoid any word or action which might disturb the confidence of the patient in the Attending Practitioner and must not, without the consent of the Attending Practitioner, do anything which involves interference with the treatment of the patient.

(5) An Examining Practitioner shall confine himself strictly to such investigation and examination as are necessary for the purpose of submitting an adequate report.

(6) Any proposal or suggestion which an Examining Practitioner may wish to put forward regarding treatment shall be first discussed with the Attending Practitioner either personally or by correspondence.

(7) When in the course of an examination there come to light material clinical findings, of which the Attending Practitioner is believed to be unaware, the Examining Practitioner shall, with the consent of the patient, inform the Attending Practitioner of the relevant details.

(8) An Examining Practitioner shall not utilize his position to influence the person examined to choose him as his medical attendant.

(9) When the terms of contract with his employing body interfere with the free application of these rules, a Medical Officer shall make honest endeavour to obtain the necessary alteration of his contract either individually or through the British Medical Association.

APPENDIX V

PATENTING IN ITS RELATION TO THE MEDICAL PROFESSION

The aim of the patent system in this country is to encourage industry and commerce by granting temporary monopolies to persons responsible for inventions.

The subject of this temporary monopoly, or patent, must be a "manufacture"—that is to say, a manufacture process or a product of manufacture. Chemical and medical inventions are not excluded, but grants of patents in respect of substances intended for food or medicine or surgical or curative devices are made subject to the provision that the Comptroller of Patents shall license any applicant interested to work the invention on such terms as the Comptroller thinks fit. The terms under which licences are granted are such that the product shall be made available at the lowest price consistent with due reward to the inventor.

In this country the application of the system to industry has been satisfactory. The medical profession, however, has made little use of the facilities for patenting.

Policy of Association

The Central Ethical Committee in 1903 and 1920 respectively passed the following resolutions:

That it is undesirable for a medical man who has invented a device intended for medical purposes to take out a patent for the purpose of deriving from such patent the financial results of a monopoly.

That it is contrary to the ethics of the medical profession to attempt to secure a monopoly in the sale of any article used in the treatment of disease, and especially by patenting any such article in the name of a medical practitioner whose name would necessarily be used in its advertisement.

The objections of the profession to patents in the medical field derived from a desire to eliminate secrecy or monopoly, with the resultant limitation of the application of an invention and its exploitation by the inventor at the expense of mankind. Medical research in this country is founded on free exchange of information and discoveries. A new discovery or invention is made known to the profession as a whole.

Further, a medical invention is seldom the work of one person. The final results depend largely on previous contributions of a number of individual observers. It would be unfair that the worker who is fortunate enough to add the finishing touch to a series of discoveries should deprive his fellow workers of their reward by patenting the invention.

Until about 1930 these objections were regarded as axiomatic throughout the profession in this country. The rapid progress of medical and biological research during recent years and the free use of British patents by foreign workers and commercial organizations, often to the detriment of British medicine, have indicated the need for a reorientation of the attitude of the profession towards medical patents. The foreign patentee, whose invention is often merely the addition of the final stage to the prolonged research of the British worker, robs the latter of the reward of his labour and maybe the right to use his discovery.

The granting of patents and monopolies to certain commercial firms has been recognized to be advantageous in that it makes worth while the installation of special plant. This was shown, for example, in the early days of insulin.

In the absence of international agreement the manufacturers have said that the abolition of patents would hinder the development of industry and depress its productive capacity. If research workers of industrial firms were not protected by patent law there would be a real danger of a resort to secret operations and remedies.

Some attempts have been made by research workers to protect their discoveries by patenting while denying themselves any private financial gain. The Drs. Dick patented their scarlet fever toxin and antitoxin but delegated their rights to a special committee. The patent for Sir Frederick Banting's process for the preparation of insulin was taken out in the name of the University of Toronto, but the British patent rights were vested in the Medical Research Council, which used them to prevent

exploitation and to ensure the maintenance of a high standard until the Therapeutic Substances Act, 1925, rendered their surveillance unnecessary. But the delegation of patent rights to universities does not always effectually prevent exploitation.

A British patent was granted to a university for a process at a stage when knowledge of the subject-matter was imperfect, but it was drawn in such wide terms that it covered work of greater importance conducted by other persons, who, both before and after the granting of the patent, were seeking to achieve the same objective. The patentee is consequently able to claim control over all application of knowledge to this particular subject even though that knowledge be of independent origin. In an instance of this sort there is also the danger that while the research worker himself forgoes any personal profits the university concerned may be tempted to use the rights for the promotion of its own interests or for purposes unconnected with the invention patented.

The Association submitted a Memorandum of Evidence to the Departmental Committee of the Board of Trade set up in 1929 to consider the Patents and Designs Acts and the practice of the Patent Office.

Two possible methods of overcoming the above difficulties were considered. The first was the abolition of medical patents. This could be effective only if adopted by all countries. Such has proved to be unattainable.

The second was the introduction of a system of dedication of patents to the public, with utilization of funds accruing from the sale of licences for promotion of further research with or without some reward to the inventor.

In its Memorandum of Evidence the Association suggested that a dedicatory scheme was worthy of careful examination.

Objection to the scheme was voiced by the Representative Body in 1930 on the ground that it was not acceptable to the majority of the profession, research workers, and others; that it would not achieve the objects desired and that there was no sound ethical distinction between the direct remuneration of a medical research worker by way of royalties under the patent law and that of the clinician by way of patient's fees.

In 1931 the Representative Body adopted the following resolution:

> That the Association approves the traditional professional usage in accordance with which it is unethical for any medical practitioner who discovers or invents any substance, process, apparatus, or principle likely to be of value in the treatment of patients to act against the public interest by unduly restricting the use and knowledge of such discovery or invention for his own personal advantage.

Conferences were held in conjunction with representatives of the Royal Colleges of Physicians and of Surgeons and the Medical Research Council for the purpose of a further exploration of the subject. The members of these conferences formulated a policy which was reported to the Representative Body in 1932, when the adoption of the following recommendations was moved:

1. That the granting of further patents in the medical field is undesirable in the public interest, and the Association would welcome any action to prevent or regulate such further grant by international agreement.

2. That experience has shown that research and discovery have been hindered rather than promoted by the granting of patents for inventions dealing with the following classes of substances used in therapeutics and practical dietetics: sera, toxins, antigens, viruses, bacteriological products, active principles natural to the animal body, vitamins. The Association considers it desirable, in the interests of medical science and practice, that no further patents should be granted for inventions dealing with the manufacture of such substances for use in medicine or dietetics. If patents are granted for methods of manufacturing such substances for other uses it considers that manufacture for use in medicine should be exempted from the operation of such patents. The Association would urge amendment of the law to secure these ends.

3. That the Association is not convinced that the granting of patents for the synthetic preparation of new substances, for use in therapeutics, has been similarly detrimental. It further appreciates the possibility that a one-sided and purely national abolition of such patents might unjustly penalize commercial enterprise in this country. It would gladly see a mechanism established by which patents for inventions in the medical field, other than those specified in para. 2 of this recommendation, could be dedicated to the use of the public in this country, while affording the requisite priority of action in other countries.

4. That until some such dedicatory system is established the special position held by medical men in the community renders it undesirable that they should apply for patents in the medical field.

These recommendations gave rise to a prolonged discussion, which disclosed considerable differences of opinion on the subject. Eventually, when it had been made clear that the recommendations were not to be regarded as the final conclusions of the Association on the subject and that a practitioner who did not strictly observe them was not to be considered guilty of unethical conduct, the following amendment was carried without dissent:

> That the Representative Body adopts the Report of the Council under the heading "Patenting in the Medical Field" with its suggestions for the guidance of registered medical practitioners, and asks the Council to continue consideration of the subject.

Attempts were made to obtain agreement with professional associations in foreign countries, but practice differed widely and very little interest was shown. It was found impossible to find common ground for agreement, and as late as 1937 it was considered that the profession in this country must continue to frame its policy on the assumption that the abolition of medical patents by international agreement was impracticable.

In 1944 the Board of Trade appointed a Departmental Committee to consider and report whether any, and if so what, changes were desirable in the Patents and Designs Acts. The Association in giving evidence to that Committee again expressed the view that it would be advantageous to have a central body to whom medical patents could be dedicated by a patentee who wished that his invention should be developed for the benefit of the public.

The ethics of the medical profession require that the results of medical research should be dedicated to and for the benefit of humanity, while patent law and practice entail the emergence of a temporary and conditional monopoly. Such a monopoly is not necessarily unethical in its operation.

Change in Situation

The "no patenting" rule was framed in circumstances differing materially from those that obtain at the present day. The situation has changed rapidly in recent years. Patentable medical discoveries are made not by clinicians but by research workers, and a large majority of these are not qualified medical practitioners. Chemists, physicists, and engineers work in the field of medical research as well as doctors. An increasing number of non-medical specialists are drawn within the orbit of medical ethics. There immediately arises the possibility of a moral obligation upon the non-medical specialist to avoid patenting where formerly he would have patented, and it may be incumbent upon the medical profession to make concessions in departing from the custom that formerly prevailed.

Another change is noted in the nature of the subject-matter. Many medical products nowadays are chemotherapeutic substances produced by a large industry as opposed to preparations from naturally occurring substances and by-products. There is no longer a valid separation between biological and chemical substances.

Whereas in the old days the granting of a patent would usually have meant that a doctor was receiving financial benefit relating to a natural therapeutic agent, the only advantage being to the doctor, the situation is now quite different and it is necessary to control the manufacture of therapeutic substances in the public interest. Where an invention is not protected by a patent a manufacturer would normally refuse to handle it; in the absence of a patent others would be able to copy it and to reap the benefit from his outlay of time and money. It is desirable that patents should be taken out and licences granted, so that a substance is manufactured to meet the public need. The question is not so much whether a medical man should take out a patent and benefit financially from an invention as how to ensure that the public benefit to the greatest

possible extent from the invention and that the interests of British research workers are not prejudiced by foreign activities.

To meet this new position the concept of a central trustee or dedicatory body has been advanced. The operative need in patenting is not the possession of a prescriptive patent but the creation of a patent field wherein the inventor or his assignee(s) holds the initially dominating but a gradually diminishing control and interest.

Marginal patents are granted for different parts of the field and it is undesirable that the central position should be vacated, since if that happened the marginal patentees could operate the whole field in an undesirable manner. The strategic centre must be held if humanitarian interests are to be safeguarded.

This strategic centre may be vacated in a number of ways:

(*a*) By failure to occupy in the first instance—i.e., failure to take out a patent.

(*b*) By publication prior to a patent application—i.e., failure to obtain the grant of a valid patent.

(*c*) By abandoning the patent position for which application has been made.

(*d*) By "dedicating" the patent to the public on terms whereby all can use it, royalty free, or on terms settled by the Comptroller of Patents.

In many cases vacation of the centre has caused regrettable situations to develop. Examples of this are stilboestrol and sex hormones. The rings of marginal contributors who operated these during the war had to be broken by the U.S. Government.

The result of there being no central patentee of penicillin has led to the deplorable position whereby the British consumer pays royalties to American firms for penicillin manufactured in the United Kingdom.

Other similar experiences can be quoted. For example, a firm holds a patent for the manufacture of a preparation by partial synthesis and its position is such that it can dictate the conditions relating to the sale and manufacture of this important form of treatment for many years to come. Unless a reversal of policy is accepted by the medical profession, a discovery in the field of this biological product would become the property of the firm for its financial exploitation.

Conception of a Central Trustee

If the principle be accepted that the proprietary rights of the public in discoveries made by the taxpayers' money shall be safeguarded by means of patents, then someone or some body must act as trustees for these holdings. The burden of responsibility is clearly too great to be carried by the individual inventor.

The National Research Development Corporation as Trustee

To help solve this problem the Government passed the Development of Inventions Act, 1948, as a non-party measure. The Act set up the National Research Development Corporation as an independent body, with a board of business men and scientists, to undertake work of the character described above.

Assignment to the Corporation of patents in the medical field was contemplated from its inception. On introducing the Bill the President of the Board of Trade said: "In the absence of reciprocal arrangements with overseas countries for the free use of medical inventions, it does not seem right that this country should sacrifice the very valuable returns which may be obtained from overseas exploitation, and the Bill offers some solution to these difficulties. The M.R.C. are not only willing but most anxious to co-operate, and they are agreeing to the establishment of a body of suitable trustees prepared to accept patents dedicated to them and administer them in the best interests of the public as a whole. This is the part which the Corporation, in co-operation with them, will be playing."*

*It is understood that the M.R.C. are already making it normal practice to hand over any patents they hold to the N.R.D.C.

It is important at this point not to confuse two distinct issues. The N.R.D.C. is a proper recipient for medical patents; that is accepted in principle by all parties to its formation. Its existence as a proper recipient, however, does not thereby oblige anyone either to take out a patent in a field of discovery or to assign a patent to the N.R.D.C.

The N.R.D.C. does, and will be at all times, ready to disclaim any desire to interfere with the academic, clinical, or technical freedom of medical and other research workers and in particular:

(i) Will always leave the last word on publication with the research worker or workers concerned with a particular invention.

(ii) Will give sympathetic consideration to any personal desires that academic workers may express with regard to methods of exploitation.

(iii) Will always recognize and attempt to reward any real initiative taken by, or help given to, academic workers by commercial firms collaborating over an invention.

Position of Inventor in the Matter of Reward

The view of the National Research Development Corporation is that it cannot enter into financial arrangements with another man's servant. No payment by way of reward would, therefore, be made to a Crown servant, for instance, who in any event would be precluded under his contract from deriving any benefit from his inventions. He has, however, the right to claim, but no actual right to receive, an award from the Departmental Awards Committee.

The relationship between the Corporation and a sole worker not employed by an organization, who desired to assign a patent and claim a reward, would be one of buyer and seller—a matter for negotiation—but in the case of a medical man the Corporation would not take any action that would conflict with a policy laid down by the profession as a whole.

Conclusion

As already indicated the Representative Body in 1932 approved the Council's statement that the establishment of a system of dedication of patents in the medical field to the use of the public would be welcomed; and that until some such dedicatory system was established the special position held by medical men in the community rendered it undesirable that they should apply for patents in the medical field.

As a system of the kind envisaged by the Council has been established by the National Research Development Corporation, it now seems appropriate that the Association should state its policy in relation thereto.

In the opinion of the Association there is no longer any objection to the patenting of inventions for which members of the medical profession are responsible, provided such patents are assigned to the National Research Development Corporation with a view to their administration in the best interests of the public as a whole.

H.M. Forces Appointments

TERRITORIAL ARMY

ROYAL ARMY MEDICAL CORPS

Major R. A. Read to be acting Lieutenant-Colonel.
Lieutenant H. C. Sims to be acting Major.

COLONIAL MEDICAL SERVICE

The following appointments have been announced: P. W. Dill Russell, M.R.C.S., L.R.C.P., Deputy Director of Medical Services, Nyasaland; L. A. P. Slinger, M.B., D.P.H., Senior Medical Officer, British Honduras; H. D. Sutherland, M.B., B.A.O., Senior Medical Officer, Northern Rhodesia; F. R. S. Kellett, M.B., Medical Officer, Grade C, Trinidad; L. F. E. Lewis, M.R.C.P., D.P.M., Medical Officer, Grade A, Trinidad; G. C. Galea, M.D., Medical Officer, Nigeria; A. M. Ozimek, M.D., Medical Officer, North Borneo; J. L. Hardman, M.R.C.S., L.R.C.P., Medical Officer, Nyasaland; A. D. Ross, M.B., Ch.B., Medical Officer, Somaliland Protectorate; K. Sperber, O.B.E., M.D., D.P.H., Medical Officer, Seychelles.

SIGHT-TESTING BY OPHTHALMIC OPTICIANS

The report of a Working Party (chairman, Mr. W. Penman) appointed by the Minister of Health and the Secretary of State for Scotland to ascertain the average time taken to test sight by ophthalmic opticians under the Supplementary Ophthalmic Services has now been published (H.M.S.O., 1s. 3d.). Its main conclusion is that 36.16 minutes is the time taken for testing sight, including the writing of letters to general practitioners, filling up forms, and covering losses due to broken appointments.

A sample of 329 ophthalmic opticians was drawn from the 6,225 on the lists in England, Scotland, and Wales, and 194 of these took part effectively in the inquiry. The Working Party considers that the sample was adequate, and that the replies were honest records.

It found no evidence of widespread overwork. The average time taken by principals and partners was about 36 minutes, and by managing opticians and assistants about 35 minutes. There was no appreciable difference between the times taken by whole-time and part-time ophthalmic opticians. On the average the greater the number of tests made the shorter was the time spent on them. Letters were written to general practitioners in about one-twelfth of the completed tests.

Many ophthalmic opticians expressed the opinion that the zenith of sight-testing has been passed.

In May, 1949, opticians' fees for sight-testing and for dispensing glasses were reduced, the revised fees being paid pending the results of this inquiry.

A second part of the report will be issued later showing the average time taken by ophthalmic opticians and by dispensing opticians to fit and supply glasses.

The report of the Working Party on the time taken to test sight by ophthalmic medical practitioners was summarized in the *Supplement* of March 11 (p. 75). The average time for sight-testing, including paper work, was found to be 27.4 minutes.

SUBSCRIPTIONS TO ASSOCIATIONS

The National Health Service (Authorization of Subscriptions) Regulations, 1950, empower regional hospital boards, boards of governors, and hospital management committees to subscribe such sums as may be approved by the Minister as subscriptions to funds of any associations whose objects are approved by him. The Minister has so far approved the following associations: The Association of Hospital Management Committees, the Teaching Hospitals Association, and the International Hospital Federation. The Minister will consider extending this list if asked to do so, but in the meantime any board or committee which is subscribing from Exchequer funds to any organization not on the approved list should cease to do so.

LECTURES TO NURSES

Although student nurses are trained chiefly by members of hospital medical staffs, this work does not come within the scope of their terms of service, which specifically provide that (whether whole-time or part-time) they may retain fees received for this purpose.

Although this is not challenged, at least one regional hospital board has suggested that there is no obligation on the board or hospital management committee to pay fees to medical practitioners for training nurses or giving lectures to them in the ordinary course of the medical practitioners' duties. In other words, although the practitioner is entitled to ask a fee for his work, neither regional boards nor hospital management committees have any responsibility in the matter of payment.

The Nurses Act, 1949, will change the arrangements for the general oversight of nurse training and for defraying expenditure incurred in this connexion. Pending the introduction of the provisions of this Act in September, 1950, it would be reasonable to argue that, when a hospital has been recognized as a nurses' training school, the administrative body of the hospital has an obligation to see that the training is provided, and this would seem to cover the payment of any necessary fees for lectures. The expenditure ought therefore to be borne by the hospital board or committee.

MILEAGE PAYMENTS

SOME CHANGES PROPOSED

The B.M.A. has sent to secretaries of local medical committees in England and Wales a statement on some changes in the distribution of the Mileage Fund proposed by the Rural Practitioners' Subcommittee of the General Medical Services Committee. The subcommittee has recently investigated the problem, and its statement begins by pointing out that the present method of distributing mileage payments, which is substantially the same as under National Health Insurance, has revealed a number of discrepancies. Under the present method, which has been in use since January 1, 1937, the Mileage Fund is divided into two parts, "ordinary" and "reserve," the latter portion amounting to approximately £207,000 out of a total of £1,570,000 in the Mileage Fund for England and Wales. The ordinary portion of the Fund is distributed on the following basis:

(1) One unit is allowed for each mile or part of a mile over two miles from the doctor's residence to the patient's address.

(2) Practices are then classified into (A) rural, (B) semi-rural, and (C) urban by dividing the total number of persons on the doctor's list by the total number of mileage units credited to him. If this calculation results in a figure of less than 0.75, the practice is classified as rural, if between 0.75 and 2.5 semi-rural, and if over 2.5 urban.

(3) The units claimed for rural practices are then increased by 25%, and urban claims are reduced by 10%.

(4) The ordinary part of the Fund is then distributed between areas in accordance with the total number of units claimed, after adjustment as in (3) above.

The reserve portion of the Fund is distributed among areas where special difficulties exist by allocations which were determined by a Ministry of Health committee after a comprehensive survey of the Mileage Fund some 25 years ago. Subsequently, when the Fund was increased with the introduction of the National Health Service and later by the addition of £700,000, the reserve portion was increased *pro rata*. In consequence, in many areas the present distribution of the reserve fund bears little relation to existing conditions. For example, the payments made to specially difficult areas have increased proportionately without regard to any change in the character of the areas concerned and are based on a variety of local criteria which may now well be obsolete.

Similarly, the ordinary portion of the Fund, although distributed on returns which have been obtained since the inception of the new Service, is based on a method of classifying practices which is many years old and which takes no account of vastly changed conditions—e.g., the shift of population—which have substantially affected many areas.

The Subcommittee therefore feels that without a comprehensive survey of the country involving, if necessary, a detailed examination of every practice, it is difficult, if not impossible, to secure an equitable distribution of the Fund. As a result, the Ministry of Health has been asked to appoint a Government Committee, on which rural practitioners are adequately represented, to undertake such an examination with a view to evolving a fair method of allocating the mileage money between areas.

Interim Scheme

Since it will be some time before a committee can carry out this task, the Ministry has been asked to introduce a revised scheme for distributing the ordinary part of the Fund based on principles evolved by the Insurance Acts Committee in 1948 and subsequently approved by the Annual Conference of Local Medical Committees. The basis of the distribution is substantially the same as that obtaining under the present

scheme—i.e., units are claimed on the same standard basis and practices classified by the same method. A material alteration has, however, been made to the weightings for each class of practice. While the units claimed by "urban" practices are left undisturbed, the units claimed by rural and semi-rural practices are weighted by 100% and 50% respectively.

As a step towards implementing these proposals, the Ministry of Health asked local executive councils where mileage schemes operate to make returns of units claimed on the standard basis, to classify practices, and to apply the revised weightings. Statements were then submitted to the subcommittee showing the effect of adopting the new scheme.

Some considerable redistribution of the mileage moneys resulted from the adoption of these new weightings. In particular, the areas which gain under the new scheme appeared to be mainly those where the nature of the country makes it difficult for a practitioner to have a large list of patients and where mileage payments perform their primary function of compensating the practitioner for this disadvantage and the consequent loss of remunerative time. The adjustments to be made in consequence of the new proposals range from a gain of £14,623 in one area to a reduction of £11,654 in another. The reserve portion of the Mileage Fund will, in the absence of any reliable data, continue to be distributed on the present basis.

When submitting these figures the Ministry suggested the exclusion of a number of areas which *prima facie* are urban in character with little justification for continuing to receive moneys from the Mileage Fund. The subcommittee agrees that these areas should be excluded in the absence of any further supporting evidence to the contrary. Their exclusion will necessitate a slight adjustment to the figures which the Ministry has prepared and will make additional moneys available for distribution to all areas, particularly those which have been underpaid in the past.

Attempt at Fair Distribution

The subcommittee considers that the merits of the interim scheme should not be judged by the adjustments which result from its application. The present distribution is known to be inequitable, and existing allocations to areas cannot fairly be used as a basis for comparison. The result of adopting these proposals will be to redistribute approximately £90,000 out of a total of £1,570,000 in the Mileage Fund for England and Wales, and the effect on the areas whose mileage grants are lowered will be to reduce the additional benefit which they have enjoyed from the increase of £700,000 made to the Fund. But all areas throughout the country will continue to benefit from the balance of the increase in the Fund to the extent of about £610,000. Moreover, £200,000 of the overall increase in the Mileage Fund comes from the Special Inducement Fund, the main purpose of which is to provide additional remuneration for practices in difficult or unattractive areas. Areas where mileage problems are known to be the most acute come within this category, and it is not unreasonable to regard money taken from the Special Inducement Fund as being applicable to this type of practice. In short, the amount which will be redistributed can properly be regarded as coming out of the £200,000 taken from the Special Inducement Fund.

At present some areas are receiving more than their fair share of the Mileage Fund in relation to their mileage commitments, while others are receiving sums far short of their real needs. It is to remedy this unsatisfactory situation that the revised scheme has been evolved, but the subcommittee emphasizes that these proposals are of an interim nature to attempt to overcome some of the more obvious inequalities of the present scheme and should be regarded only as a temporary arrangement until the detailed investigations being undertaken by a Government committee are completed.

Proposals for redistributing the Mileage Fund for Scotland on a similar basis would necessitate adjustments of a like nature to the present allocations between areas from the Central Mileage Fund. Here again, any adjustments should be regarded as coming from the portion which Scotland receives of the mileage moneys derived from the Special Inducement Fund. A special mileage subcommittee of the Scottish Committee is now studying this and other aspects of the mileage problem.

In many areas local subcommittees have been formed to deal with problems affecting rural practitioners. These subcommittees have proved extremely useful in presenting the views of the rural practitioner and ventilating grievances. In the opinion of the Rural Practitioners Subcommittee the formation of similar subcommittees should be encouraged.

ANNUAL MEETING OF THE B.M.A., SOUTH AFRICA, 1951

Many members have given provisional notice of their intention to visit South Africa and attend the Joint Meeting of the B.M.A. and the S.A.M.A. in Johannesburg in July, 1951, and the choice of route—i.e., by sea or air both ways, or by sea outwards and air return, or vice versa—has been indicated.

The air lines are providing full facilities to the Association, and, provided the planes can be filled, times of departure and return can be arranged to suit the convenience of the travellers. In the case of the sea journey, however, as the B.M.A. party will not be able to charter a vessel for its exclusive use the routes and dates of sailing will be those arranged by the shipping companies for their normal passenger services to South Africa. Members who propose to make the journey, therefore, are urged to indicate their intentions to the Secretary, B.M.A. House, at the earliest moment, in order that provisional reservations may be made out of the limited accommodation which is being placed at the disposal of the Association.

The Arrangements Committee will be meeting on June 23 to nominate officers of the Scientific Sections, and will take into consideration the names of members who have indicated their intention to be present at the meeting.

Air Travel

For the journey to Johannesburg the B.O.A.C. are flying the new Hermes machines, which will be operating on the South African route at the time of the Joint Annual Meeting. These planes, which are taking the place of the Sunderland flying boats, accommodate forty passengers in deep-seated comfort, and are sound-proofed and air-conditioned on the ground as well as in the air. The height at which they operate is in the neighbourhood of 8,000 feet.

The itinerary suggested is as follows:—July 10: Arrive Catania in Sicily, where the late afternoon and evening will be spent and good accommodation provided at the B.O.A.C. Headquarters at Augusta. July 11: Departure from Augusta will be at about 9 a.m., Cairo reached at about 2 p.m. For the rest of the day the party will be at liberty in the Egyptian capital and the night spent in the B.O.A.C. hotel. July 12: Leave Cairo at about 9 a.m., reaching Nairobi between 3 and 4 p.m. July 13: Depart Nairobi in the morning for Livingstone, where ample time will be provided to convey the party to Victoria Falls. It is hoped that accommodation will be provided at the Victoria Falls Hotel. July 14: The party will be driven to Livingstone and will continue the flight to Johannesburg, arriving in the city between 1 and 2 p.m. July 15: This will be a free day. July 16–21: Covers the period of the Meeting. During and after the Congress excursions will be arranged to the Kruger National Park, Pretoria, and, for those who wish to go further afield, Durban and Capetown. July 31: Expected date of departure from Johannesburg. August 1: The plane will leave Livingstone early in order that a whole day may be spent in Nairobi. August 2: The plane will leave Nairobi around midday, reaching Cairo in the evening. August 3: Cairo to Rome. August 4: Rome to London airport, arriving back between 5 and 6 p.m.

The cost of the air journey, including all meals, the stop-over at hotels, gratuities, provision of passports, necessary endorsements, etc., will be £305 per person. This does not include the excursions in South Africa nor the cost of hotel accommodation during that time.

Sea Journey

Both the Union Castle Line and the Holland Africa Line have undertaken to convey parties to South Africa. It is hoped that the main group will leave on the Union Castle boat *Pretoria Castle* on June 21 and will arrive at Capetown after calling at Madeira on July 7. A smaller party taking the same West Coast route, but calling at Teneriffe, will leave by the Holland Africa boat, the *Bloemfontein,* on June 19, and will be due at Capetown on July 8.

These two parties will combine at Capetown and remain there five days. During this time the opportunity will be given to members and their friends to join organized tours to places of interest within reasonable access of Capetown. The party will then proceed to Johannesburg by the South African Railway route, arriving on July 15 in time for the Meeting, which opens on the following day. The present arrangements provide for a stay in Johannesburg for two or three days after the Meeting to enable members to visit the Kruger National Park.

The first party returning by the sea route will leave Johannesburg on July 24 for Durban and Capetown, and taking the same route as the outgoing will leave South Africa at the end of the month, arriving back in England on or about August 15.

The first-class return fare by boat and the rail journey to Johannesburg will be approximately £317, but will vary according to the cost of the cabin. As in the case of the fare quoted for the air travel, this does not include the cost of excursions taken in South Africa, nor the cost of hotel accommodation during that time.

ANNUAL MEETING

THE DAWSON WILLIAMS LECTURE

Professor A. A. Moncrieff will deliver the Dawson Williams Prize Lecture, entitled "Child Health and the Future," on Thursday, July 20, at 4 p.m., in the Chemistry Theatre, Gossage Buildings, Liverpool. This will form part of the programme of the Section on Child Health, and is additional to that already published in the Annual Meeting Programme (*Supplement,* May 27, p. 238). It is hoped that all those interested in child health and its relation to public health will attend.

Correspondence

Certificates from Unregistered Practitioners

SIR,

"The time has come," the Walrus said,
"To talk of many things:
—Of ships—and shoes—and sealing wax—
Of cabbages and kings—
And why the sea is boiling hot—
And whether pigs have wings."

I feel certain that the spirit of Lewis Carroll will forgive me if I ask your readers to substitute for "cabbages" general practitioners and for "kings" Ministers and Government Departments.

The assiduous secretary of the South Essex Division, Dr. E. Anthony, in his letter in the *Journal* of May 6 (p. 1077) laments that something has gone wrong in general practice to-day and wonders why this situation has arisen. Professor Sir Henry Cohen assures the general practitioner that his committee on "the General Practitioner and his Training" does not desire to place further burdens on him but to *raise his status* in the eyes of the profession and the public.

"Curiouser and curiouser!" cried Alice. The general secretary of the Medical Practitioners' Union in his May Newsletter is concerned with the same thing—the status of the G.P. Permit me, Sir, to quote him: "Subtly, in a dozen different ways, the status and prestige of the G.P. has been undermined during the last two years and it is vital that this process should be checked forthwith. We owe it to ourselves and to the future generations of medical men and women, not only to check, but to reverse the trend. . . . We recognize that no easy solution is in sight."

We have lost our status because we have lost our liberty and freedom. In order to create the Welfare State the legislature has intervened to secure a greater measure of economic liberty so that certain sections of the community shall not have their lives restricted by poverty, insecurity, and overwork. But this intervention has now extended to such an extent that other sections of the community have been disregarded where their personal liberty is concerned. To-day political considerations are more apt than usual to intrude into the administration of the law. A supremacy of political principles has developed which supersedes all established logical and technical principles of legal interpretation. Mr. Lloyd George once said, "Liberty is not merely a privilege to be conferred: it is a habit to be acquired." It is a habit that the G.P. appears to have lost because we have relaxed our vigilance. A great Irish orator emphasized this in the following words: "The condition upon which God hath given liberty to man is eternal vigilance, which condition, if he break, servitude is at once the consequence of his crime and the punishment of his guilt." It is vital that we reinforce and reassert our observance of that condition of vigilance if we wish to retain what we have left and to recover what we have lost of professional liberty.

It is timely and opportune to quote and emphasize the words above. You, Sir, have drawn attention in "Medical Notes in Parliament" (*Journal,* June 3, p. 1324) to a question put to the Minister of National Insurance on May 23 by Mr. Reader Harris and have noted the Minister's reply. The matter raised by Mr. Reader Harris, M.P., is one of serious import to the G.P. as one which affects his already lowered status. I have already commented on the powers of the Minister of Health in a contribution to the *Journal* of April 24, 1948 (p. 796), on "The National Health Service Tribunal: the Legal Aspects." Some two years later a deputation of the G.M.S. Committee went to the Ministry to put forward proposals for changes in the Service Committees and Tribunal Regulations.

Before commenting on the legal aspects of medical certification may I quote from the Memorandum by the Government Actuary, Appendix A to the Beveridge Report, November, 1942, para. 22: "Past experience of sickness insurance—both State and voluntary—leads to the conclusion that, even with the support of a satisfactory system of medical certification and adequate measures of control by sick visiting and by medical referees, these high benefits will result in materially increased claim rates, especially in respect of prolonged incapacity . . . and there will be less incentive than in the past to return to work owing to loss of income. . . . The position is definitely speculative, but it is clear to me that the realization of a level of incapacity as low as that which I have adopted can only be achieved with a full appreciation of their responsibilities on the part of all concerned—that is to say, the active co-operation of the insured persons together with a high standard both of medical certification and of administrative supervision."

Section 37 of the Medical Act, 1858, states that "No certificate required by any Act from any physician, surgeon, licentiate in medicine and surgery, or other medical practitioner, is valid unless the person signing the certificate is a registered medical practitioner." This section has not been repealed in the Ninth Schedule of the National Insurance Act, 1946, and therefore any certificate for the purposes of claiming sickness benefit must be given by a registered medical practitioner. S.I. 1948 No. 1175 is cited as the National Insurance (Medical Certification) Regulations, 1948.

Section 2 (1) of S.I. 1948 No. 1175 reads as follows: "Every person claiming sickness benefit shall furnish evidence of incapacity, in respect of the days for which the claim is made, by means of a certificate given by a registered medical practitioner in accordance with the rules for medical certification set out in Part I of the Schedule to these regulations in the form appropriate to the circumstances of the case, as set out in that Part, or by such other means as the determining

authority may accept as sufficient in the circumstances of any particular case or class of cases."

"The determining authority" means, as the case may require, an insurance officer, a local tribunal, the National Insurance Commissioner, a Deputy Commissioner, or a tribunal presided over by the National Insurance Commissioner, or a Deputy Commissioner appointed or constituted in accordance with the National Insurance (Determination of Claims and Questions) Regulations, 1948.

The Minister has given power to these officials to accept evidence from persons other than registered medical practitioners for the purpose of obtaining sickness benefits, and in my considered opinion this is *ultra vires* the Minister's powers, as it is repugnant to the wording of Section 37 of the Medical Act of 1858, which is still in force.

"The rule of interpretation is that if subordinate legislation is directly repugnant to the general purpose of the Act which authorizes it, or indeed is repugnant to any well-established principle of statute (*in this case the Medical Act, 1858, Section 37*—the italics are mine) or Common Law, it is either *ultra vires* altogether or must, if possible, be so interpreted as not to create an antinomy" (Professor Carleton Allen, *Law and Orders*, p. 133). Antinomy is defined in the *Oxford Dictionary* as "a contradiction in law or between two equally binding laws."

I quote two other rules of interpretation from Halsbury's *Laws of England* (Hailsham Edition): (1) Words are primarily to be construed in their popular sense, and as they would have been understood the day after the statute was passed, it being irrelevant to consider how a branch of the public may understand the meaning, unless such a construction would lead to a manifest and gross absurdity. (2) Words in a statute must be taken to be used correctly and exactly, not loosely and inexactly.

Let me reiterate the operative words again of the National Insurance (Medical Certification) Regulations, 1948. By rule 1 above medical certification in the popular sense means a certificate issued for the purposes of the National Insurance Act in accordance with Section 37 of the Medical Act, 1858, by a registered medical practitioner and none other. The Minister is therefore acting *ultra vires* in delegating powers to "determining authorities" to accept evidence other than the certificate of a registered medical practitioner for sickness benefit claims.

Medical registration confers on doctors a status with which are associated privileges and rights, but those rights impose a correlative duty or obligation. A breach of those duties or obligations may bring us within Section 13 of S.I. 1948 No. 507, Section 42 of the National Health Service Act, and the G.M.C., whose duty it is to administer the Medical Acts. Surely, Sir, it is of paramount importance to those of us who do the routine work of the medical profession to demand that our status shall be safeguarded and not lowered to the standards of unorthodox practice.

This is a matter which concerns not only the Council of the B.M.A., the G.M.S. Committee, and the Conference of Local Medical Committees, but the defence societies as well.—I am, etc.,

London, S.W.1 J. ARTHUR GORSKY.

Association Notices

ELECTION OF TWO MEMBERS OF COUNCIL BY THE NORTHERN IRELAND BRANCH

Notice is hereby given that nomination of candidates for election as members of Council, 1950–1, by the Northern Ireland Branch must be forwarded in writing so as to reach me not later than June 24, 1950.

The nominations must be on the prescribed forms, copies of which can be obtained on application to me.

CHARLES HILL,
Secretary.

ADJUSTMENT OF AREAS OF EXETER AND TORQUAY DIVISIONS

Notice is hereby given that the Council has transferred Chudleigh and Moretonhampstead from the area of the Torquay Division to that of the Exeter Division.

CHARLES HILL,
Secretary.

Diary of Central Meetings

JUNE

13	Tues.	Occupational Health Committee, 2 p.m.
14	Wed.	Dental Subcommittee, 11 a.m.
15	Thurs.	Dermatologists Group Committee, 10.30 a.m.
15	Thurs.	Dermatologists Group—Annual meeting, 2.15 p.m.
20	Tues.	British Medical Guild Executive, 11 a.m.
20	Tues.	Publishing Subcommittee, 11 a.m. (*Change of date.*)
20	Tues.	Tuberculosis Group Committee, 2 p.m.
21	Wed.	General Medical Services Committee, 11 a.m.
23	Fri.	Interim Executive Committee, 2 p.m.
29	Thurs.	Special conference of representatives of Local Medical Committees, 10 a.m.
30	Fri.	Staff Side, Committee "C," 10 a.m.
30	Fri.	Committee "C," 2 p.m.

Branch and Division Meetings to be Held

FURNESS DIVISION.—At Orthopaedic Out-patients' Department, North Lonsdale Hospital, Tuesday, June 13, 8 p.m., annual general meeting.

HENDON DIVISION.—At Hendon Hall Hotel, Friday, June 16, 8.45 p.m., medico-political meeting.

LANCASTER DIVISION.—At Royal King's Arms Hotel, Lancaster, Tuesday, June 13, 8.30 p.m., annual meeting; to be followed by meeting of all medical practitioners in the area of the Division to form local organization of British Medical Guild.

METROPOLITAN COUNTIES BRANCH.—At B.M.A. House, Tavistock Square, London, W.C., Tuesday, July 4, 2.30 p.m., annual general meeting. Presidential address by Dr. Frank Gray.

NORTH LANCASHIRE AND WESTMORLAND BRANCH.—At Preston, Thursday, June 15, inaugural meeting of the Branch, 12.30 for 1 p.m., lunch at Bull and Royal Hotel, Fishergate, Preston, after which Sir Henry Cohen will install the first president of the Branch, Dr. F. M. Rose. The presidential address will follow.

SOUTH WALES AND MONMOUTHSHIRE BRANCH.—At Adelina Patti Hospital, Craig-y-nos, Abercrave, Swansea, Thursday, June 15, 3 p.m., social meeting.

SOUTH-WEST ESSEX DIVISION.—At Clinic Hall, Thorpe Coombe Maternity Hospital, Walthamstow, E., Wednesday, June 14, 8.30 p.m., Discussion: "The Medical Witness in Court," to be opened by His Honour Judge Earengay, K.C., LL.D., and Mr. Ivor Back.

TOWER HAMLETS DIVISION.—At Mile End Hospital, Bancroft Road, London, E., Friday, June 16, 3 p.m., clinical meeting.

WEST BROMWICH AND SMETHWICK DIVISION.—At West Bromwich and District General Hospital, Sunday, June 11, 11 a.m., meeting.

WEST MIDDLESEX DIVISION.—At Park Royal Hotel, Western Avenue, Ealing, W., Friday, June 16, 8.30 p.m., annual general meeting.

B.M.A. CAR BADGE

Some members who have received their car badge have found difficulty in attaching it to the car, particularly to the radiator grill. The badges are pierced for bumper-bar fixing, but it is possible by means of a slight alteration to attach the badge to the radiator by piercing holes large enough to take 2 in. 4BA screws. The badge can be kept in place by means of threaded fixing bars inserted through the radiator grill, through which the screws can be passed. In this case the lower part of the fixing plate below the initials "B.M.A." is unnecessary and can be cut off. This can be carried out by most garages, and many members are having it done. The Association is having badges prepared for fixing in this way, but they may not be available until the end of June. Members may, if they wish, exchange their badges for one of the alternative type.

Orders are being dealt with in rotation as supplies are received from the manufacturers. Members who have not received their badges are assured that every effort is being made to obtain them and dispatch them before the end of June.