SUPPLEMENT
TO THE
BRITISH MEDICAL JOURNAL.

LONDON, SATURDAY, JULY 27TH, 1929.

CONTENTS.

British Medical Association: Annual Meeting, Manchester, 1929.

ANNUAL REPRESENTATIVE MEETING.

Friday, July 19th.

THE Annual Representative Meeting opened at the Milton Hall, Deansgate, Manchester, on Friday morning. Dr. C. O. HAWTHORNE, Chairman of the Representative Body, presided, supported by the President (Sir Ewen Maclean), the Chairman of Council (Dr. H. B. Brackenbury), the Treasurer (Mr. Bishop Harman), and the officials of the Association. The agenda paper contained 145 motions and amendments, and in view of the large programme a paper was placed before each representative, giving suggestions by the Chairman for the expedition of business, and hinting at the possibility of late sittings.

The meeting opened promptly at 9.30 a.m.

After the returns of representatives and deputy representatives had been received, the new members of the Representative Body, numbering about 85, were invited to sign the permanent record book.

The standing orders, with some slight amendments proposed from the chair, were adopted, and the report of the Agenda Committee was received. This report made one innovation on the practice of previous years—namely, that only motions by Divisions and Branches strictly relevant to the several paragraphs of the Annual and Supplementary Reports of Council should be considered with such paragraphs, and that other motions should be considered only after general approval had been given to the reports. It was also proposed to take the agenda under "Overseas Branches," followed by "Naval and Military," as the first business of the afternoon session on Monday, and to make the official votes of thanks the first business on Tuesday morning. Certain amendments to vary the procedure by bringing forward later independent motions so that they could be discussed in connexion with the Annual Report were lost.

ANNUAL REPORT OF COUNCIL.

The CHAIRMAN OF COUNCIL moved the reception of the Annual Report of Council and the associated documents, and this was agreed to.

Election of Sir Robert Philip as a Vice-President.

The CHAIRMAN moved as a recommendation of Council the election of Sir Robert Philip as a Vice-President of the Association in recognition of his services as President during the year 1927–28. The members of the Association, he said, had already taken such opportunities as they had been able to secure to express their personal regard for Sir Robert Philip, and their appreciation of the services he had rendered the Association; these sentiments had been expressed both on the occasion of his retirement from the chair and when he was entertained as the guest of the Association at the Autumn Dinner in London. The Association had now an opportunity of recording its good will and gratitude to Sir Robert in a more enduring and official manner by electing him one of the Vice-Presidents.

The motion was received and carried with acclamation.

The CHAIRMAN OF COUNCIL, in moving the reception of the Report under "Preliminary," said that this contained the usual congratulations in respect of honours received by members of the Association and, unfortunately, the usual regrets at the decease of members. He drew the attention of the representatives particularly to two gifts to the Association—one made by the Honorary Treasurer and one by the President. The first was an official symbolic staff for the Association, for use on appropriate occasions, and the second was a Past-President's badge, which also would be very useful and convenient. Although at the Annual Meeting of the Association, to be held on Tuesday afternoon, July 23rd, there would be an opportunity to present the staff, he felt sure the representatives would like him, in moving the reception of the Report under "Preliminary," to express their appreciation and thanks to the donors. ("Hear, hear," and applause.)

The report under "Preliminary" was approved.

Annual Meeting, 1930.

The CHAIRMAN OF COUNCIL moved that the Annual Representative Meeting, 1930, be held at the British Medical Association House, London, to commence on Friday, July 18th. It would be well to bear in mind, he said, that if the proposal was adopted the Representative Meeting would be held a few weeks before the Annual Meeting at Winnipeg, and at the former certain matters, such as the election of officers, would have to be dealt with. That had certain constitutional as well as certain personal bearings. The Representative Meeting next July would not be of an ordinary character, because it would not be followed immediately by the Annual Meeting.

The motion was adopted.

Dr. E. R. FOTHERGILL (Brighton) said it had been decided by the Council that the President, the Chairman of the Representative Body, the Chairman of the Council, and the Treasurer should be chosen to represent the Association at the Winnipeg meeting. Possibly some of the representatives would not understand the hint which Dr. Brackenbury had thrown out in this connexion. As soon as the Representative Body concluded its work its Chairman went out of office and his successor took over, and that would happen next July. It was true he could be re-elected, but as a rule it was felt that when anyone had held that office for three years he should retire. In the early days of the Representative Body that position arose in regard to a meeting in Canada, and Sir Victor Horsley, who had held office for three years, was elected for a fourth, so that he might represent the Association there. He hoped the representatives would bear that in mind next year, when the question of who should be Chairman of the Representative Body and go to Canada in that capacity arose. Whoever went would not know until two or three weeks before whether to book a berth, or whether he would be going in a private or an official capacity. The same position arose in regard to the Treasurer. He urged the representatives to remember that the present Chairman of the Representative Body, Chairman of Council, and Treasurer had done all the hard work of the Association for some years, and he suggested that, whoever else went, they certainly ought to go.

The PRESIDENT-ELECT (Professor A. H. Burgess) at this point came on to the platform to offer a welcome to the representatives. He was accompanied by Professor W. Harvey Smith, who will be President of the meeting at Winnipeg in 1930.

The PRESIDENT-ELECT said he wished to express the great pleasure it gave him to have the members visit Manchester. He was particularly pleased to see present so many representatives from overseas, and especially Dr. Harvey Smith. (Applause.) Though he met Dr. Harvey Smith for the first time the previous evening, he and his charming wife had so impressed him that he was sure the Winnipeg meeting would be a great success.

Dr. HARVEY SMITH, who was received with applause, thanked the members for the great honour they had done him. He was present, he said, not only as holding an official position in the Association, but as one of the fraternal delegates from the Canadian Medical Association, bringing their greetings and good will. Next year he hoped to see all the members in Winnipeg, where a hearty welcome awaited them. (Applause.)

CIVIC WELCOME.

The Lord Mayor of Manchester (Colonel George Westcott) entered the hall to welcome the Association to the city.

The LORD MAYOR expressed the hope that this great gathering of the medical profession would be highly successful. Every public man could not but have the highest regard for a calling which was in such intimate contact with the people. While he was not unmindful of the valuable services that doctors performed in their private practice, as Lord Mayor he would lay stress on the public work the profession was so excellently carrying out on behalf of the community. In a city like Manchester the conditions of life were governed by the city's industrial and commercial pursuits, and the municipality was bound to lean on the medical profession in acquiring information to guide it in devising schemes to make life more healthy and secure. One could easily recall how widespread and prevalent were diseases which to-day had been very largely lessened in their incidence, but the public still looked with anxiety to certain scourges which remained to assail mankind. He wished every success to the deliberations of the meeting, and, as Lord Mayor, if there was anything he could do to further its objects he would have great pleasure in doing it. (Loud applause.)

The CHAIRMAN expressed gratitude to the Lord Mayor for the courteous and cordial welcome he had given the Association on behalf of the city of Manchester, and which he had extended so generously. The gratitude of the Association to the Lord Mayor was enhanced by the fact that, in spite of the numerous and pressing claims of his important office, the Lord Mayor had taken the trouble to attend the meeting in person to assure the Association of the good will of the great municipality over which, by the votes of his fellow citizens, and as chief magistrate, he had been called upon to preside. The Chairman asked the Lord Mayor to accept from the meeting an assurance of the Association's appreciation and gratitude, for he was convinced that those sentiments would be approved by the 35,000 members of the Association. Professional brethren in Manchester and Salford had left no doubt in the minds of the members of the Association that the invitation they had extended to the Association was extended with the cordial approval of their fellow citizens and of the municipal and academic authorities, and the Association appreciated highly the Lord Mayor's personal approval and official endorsement of the proposal that the year 1929 should be distinguished in the annals of the Association by the experience of the generous hospitality of the city of Manchester. Manchester, of course, had its own appeal—or rather, it had many appeals. By medical practitioners it was perhaps mainly noted as the city of a famous university which had made great contributions to scientific knowledge and to effective medical and surgical practice. Naturally, also, medical men were greatly interested in the hospitals and kindred institutions and in the public health services, the reputation of which was well known to them, and they hoped to receive some measure of both instruction and inspiration from these various sources during their visit to Manchester. They were well aware, too, of other achievements which stood to the credit of Manchester—municipal and educational achievements, commercial enterprises which touched all quarters of the globe, a daily press of great influence and distinction, and the foresight, courage and patience, and determination which had transformed Manchester from an inland city to a port open to the seven seas. Last, but by no means least, they desired to recall the practical and affectionate devotion which was paid in Manchester to the culture and expression of art in all its various forms. Some of the problems to be discussed by the British Medical Association during its meeting in Manchester were necessarily of a professional and technical nature, but there were others—he hoped many—which would engage the general interest of the citizens. The medical profession welcomed public interest in medical affairs, because the more fully the aims and methods of medicine were understood, the better would the

profession be able to play its important part in the promotion of the health, happiness, and welfare of the community. He understood that the Lord Mayor and his colleagues had been good enough to make preparations for the entertainment and for the refreshment and recreation of the members of the Association, and the members welcomed these as a pleasing contrast to the more severe exercises they were bound to cultivate in the meeting hall. They looked forward to meeting his Lordship and his colleagues and fellow citizens on a somewhat less formal platform than that on which the representatives were met that day. In conclusion, the Chairman repeated his expression of gratitude to the Lord Mayor and the citizens of Manchester for the message of welcome and good will extended to the Association.

At this stage of the programme a photograph was taken of the meeting; the centre of the platform was occupied by the Lord Mayor and the Chairman.

The Lord Mayor then withdrew.

HOSPITAL POLICY.

The Question of a Separate Middle Class Policy.

The meeting then turned to the question of revision of the Association's Hospital Policy, on which there were a large number of motions and amendments.

Sir RICHARD LUCE, chairman of the Hospitals Committee, moved on behalf of the Council:

> That it is not desirable to formulate a separate middle-class hospital policy, as suggested in a resolution of the Annual Representative Meeting, 1927, but that the position be met by amending the Voluntary Hospital Policy (United Kingdom).

The question had, he said, been considered by the Hospitals Committee, and a special subcommittee was set up to investigate it, and went into it very thoroughly. At first it seemed a little difficult to define what exactly was meant by "middle class." The term was a very elastic one, but the conclusion was reached that the lower limit should correspond to the income limit above which it had been decided that people could not be treated in hospitals otherwise than as private patients. The lower limit was therefore fixed by the scale already laid down in the Hospitals Policy. The fixing of an upper limit would, it was felt, be very difficult, and was really unnecessary from the point of view of the medical profession, so long as it was understood that every patient who was going to be treated otherwise than as under the income limit already in existence should be charged according to his means, and according to an arrangement fixed by the doctor in agreement with the patient. If that was granted, it seemed unnecessary to form any definite upper limit to the middle class. They had come to the conclusion that what was meant by "middle class" was practically what was already laid down in the policy of the Association as paying patients, and that the policy covered all the main points. The aspects from which the matter had been considered were four: first, the question of the middle-class or paying patients; secondly, their method of treatment in special hospitals; thirdly, the development of new accommodation in hospitals for that class; and, fourthly, the question of contributory schemes for paying patients. With regard to the first point, the committee had come to the conclusion that, with certain modifications to be put forward in the following motion, the matter was definitely dealt with in the Hospital Policy; that with regard to special hospitals the policy was not complete, and that a new section should be added. With regard to the development of further accommodation, it had appeared that there was a very great demand by the profession for further facilities for institutional treatment for private patients. That had been dealt with in the report, and it was also being dealt with by a special resolution, proposed by Kensington, which the committee desired to accept. That question was dealt with in para. 96 of the Annual Report. The problem of contributory schemes was already dealt with in Section G of the Hospital Policy, and there appeared to be no need to alter that section. The committee considered that its report in its present form brought the Hospital Policy to a state in which it definitely provided a middle-class Hospital Policy for the Association in a form which could be easily understood by the public and the profession, and much better so than by introducing an entirely new scheme for the middle class. He noticed that there was an amendment asking for that question to be more explicitly put, but he hoped he had said enough to show that the matter had been fully considered; that the Council considered it was dealt with in the existing Policy; and that it would be useless to add anything beyond what the committee proposed to add in subsequent motions.

The CHAIRMAN pointed out that Sir Richard Luce's proposal was practically that the Council had carried out its instructions to prepare a middle-class Hospital Policy when it had presented the scheme included in Appendix VI (*Supplement*, April 20th, p. 126). An amendment by Newcastle asked the meeting to conclude that a scheme of middle-class hospital policy could not be considered until the Council had defined the principles upon which such a scheme could be based. His conclusion was, therefore, that if the Newcastle amendment was carried the whole of the rest of the scheme was suspended till the Council had come back to the Representative Meeting and presented the principles upon which the middle-class hospital policy could be founded.

Sir ROBERT BOLAM (Newcastle-on-Tyne) then moved his amendment, which was to request the Council to present a report showing the principles on which middle-class hospital policy is based as a preliminary to the incorporation of such principles in the Voluntary Hospital Policy of the Association. His Division had no desire to hold up the consideration of matters of hospital policy in which the meeting was interested. What his Division was anxious to ascertain was where exactly the line was drawn in regard to "middle class." He observed that a category termed "aided patients" had been inserted between the free patient and the tariff patient. If he understood Sir Richard Luce aright, a tariff patient would include those people who were below the income limit of £200. Therefore the "aided patient" was some class of patient intermediate between the free patient and the tariff patient. That it was below the tariff patient he was assured by the chairman of the Hospitals Committee. Therefore it would follow that every industrial patient, practically, would come within the aided class if he was not in the tariff class. Dr. Fothergill apparently did not agree.

Dr. FOTHERGILL (Brighton) said he did not agree. The Chairman of the Hospitals Committee, he added, had no right to utter such a dictum.

Sir ROBERT BOLAM, continuing, said his Division must then be amply justified in asking for an explanation. As he read it, one passed from the free to the aided, then to the tariff, and then to the private, and he understood from what the Chairman had said that in the term "private patient" came all the middle class. His difficulty was one which was felt not only in Newcastle but in every industrial area in the land. All the people who were in the industrial class could claim, under the policy, to be regarded as aided patients. ("No, no.") They had simply to say they were unable to pay the full tariff. What was there to prevent what was actually happening, where men contributed not 2d. or 3d. a week to a contributory scheme so that they could pay the tariff charges, but ¼d. or ½d. a week for membership, and used the charitable funds to make up the difference between what they paid and what they ought to pay under tariff? What he wanted was to elicit an answer to the questions: What are the tariff patients? What are the middle-class patients? If the middle-class patients were above the tariff grade, then he failed to see the necessity for "aided" at all. The patient should either be free, or, if he was of the industrial class, there was nothing to prevent him entering a satisfactory contributory scheme and paying the low tariff charges. If he were satisfied on that point he would be prepared to withdraw his amendment.

The CHAIRMAN OF COUNCIL suggested that Sir Robert Bolam's point came more properly on a later amendment in the name of Newcastle. The Representative Body last year asked the Council as a matter of urgency to produce a middle-class hospital policy. The Council had done this, in what it considered to be the best way, by amendments and additions to that portion of the Hospital Policy which referred to paying patients. He was sure that neither

Newcastle nor its representative wished to delay for a whole year the consideration of a problem which was said last year to be urgent, and which the Council had done its best to incorporate in the various motions before the present meeting.

The CHAIRMAN pointed out clearly to the meeting the implications of the committee's proposal and of the Newcastle amendment. All the meeting was asked to do at the moment was to say whether it thought discussion should proceed on the scheme which the Hospitals Committee had prepared.

Sir ROBERT BOLAM, on an assurance given by the chairman of the Hospitals Committee that the middle-class patient was a patient above the tariff class, begged leave to withdraw his amendment.

The original motion proposed by Sir Richard Luce was adopted.

Revision of Hospital Policy.

Sir RICHARD LUCE next moved the adoption of the new or amended paragraphs Nos. 16 to 30 sent out in Appendix VI to Annual Report of Council (*Supplement*, April 20th, p. 126). He said that with the proposed new paragraphs the committee began to consider the points which were helpful in illustrating the question of the existing Hospital Policy in regard to the voluntary hospital, and it seemed to them an opportunity to try and bring the Hospital Policy a little bit more up to the actual conditions of the present day. They were perhaps bold men to attempt to tamper with the existing Hospital Policy, and those who went through the discussion five years ago would realize this particularly. But there were points in the policy which were not quite in accordance with the realities of the case at the present time. The proposals did not, however, in any sense alter any vital point of the Hospital Policy. The question around which most of the amendments centred was as to the categories into which hospital patients were to be divided. The old divisions were free or indigent patients, tariff patients, and private patients. On the question of free patients he did not think there would be any difference of opinion; the profession had always agreed that those unable to pay should be treated by the profession free of charge. That class had been for years, fortunately, a diminishing one. These patients remained, as a matter of principle, pledged to the charity of the nation, and also to the charity of the profession. The tariff class included the vast majority of all patients treated in voluntary hospitals. There were two different sections of the community, between which there was a very definite difference. There was a considerable class of hospital patients in no sense objects of charity, either to the hospital or to the medical profession. They were people for whom there was some corporate or other kind of body responsible for their medical treatment. This class of patient included ex-service men (for whose treatment the Government was responsible); those sent to the hospitals by educational authorities, and patients sent by municipal authorities and by Poor Law authorities. It was right that those responsible for that class of patient should pay the whole cost incurred by the hospitals, coupled with a definite proportion or amount to the medical profession, for their treatment. There was also a definite class of patients who, although they had had paid for them, or had themselves paid, a certain proportion of the cost of their medical treatment, were still reckoned by the community, and he maintained they were still reckoned by the medical profession, as partially objects of charity. Supposing the contributory schemes increased, so that the members of contributory schemes wished no longer to be objects of charity, but wished to pay the whole cost of their treatment in hospital, then that second class of patient would cease to exist. The old policy in the matter of the need for some remuneration for the medical staff was unaffected. The clauses in the existing policy—31 and 35—which dealt with the remuneration of the staff by means of a staff fund or honoraria were unaltered, and this applied, as before, both to the aided and to the tariff class. No revolutionary changes in hospital policy were proposed, but simply a differentiation of patients into two distinct classes: those who were the object of some charity (though paying something themselves), and those who were not the objects of charity at all and in regard to whom the whole proportion should be paid to the staff for the treatment they received in hospital. That seemed to the Hospitals Committee and to the Council a sensible and reasonable alteration. The amendments which had been put down, and which objected to this differentiation, must be based, he thought, either on a misunderstanding of what was intended or on a fear that the division would stereotype people into the lower class. He did not think that was likely to happen. The bulk of the medical profession wanted the hospitals to remain voluntary, both in the matter of management and in the matter of receiving contributions from the charitably disposed. It seemed likely, therefore, that there would always be a considerable class who, while able to pay something towards the cost of their maintenance and treatment, would be objects of charity to the rest of the community as long as the charitably disposed were willing to contribute to their support. No change was proposed in the income limit which allowed people to be treated in hospital as tariff or as aided patients, and it would be for the profession to insist on having some voice in deciding to whom they should give some charity and to whom they should not. The main alterations in the clauses dealing with private patients were introduced to meet the desire of a large body of the profession that the private practitioner should be in closer touch with, and have a larger share in, the treatment of his private patients when they were in a hospital of any class. According to the old policy, private patients were divided into those in nursing homes attached to hospitals and those in the hospitals themselves. The first alteration made was to alter the order of those two. In almost all hospitals ordinary patients were treated by the hospital staff. The next grade was for those who were treated in private wards in those hospitals, and there a modification had been made to meet the views of the general practitioners to which he had referred. Hospitals with private wards had been divided into two classes, the first comprising those which had a consulting staff in the ordinary way to look after the patients in the ordinary wards, and had also a resident medical staff. For that class it was felt impossible, on administrative grounds and because it would be taking away from the staffs of those hospitals a privilege they at present enjoyed, completely to open the private wards to any practitioner who had a patient therein. The private patient, it was decided, would still be under the direct charge of a member of the staff of the hospital, but a proviso was added to the following effect:

"(*a*) If the hospital has a resident medical officer or officers and also a staff of consultants who are ordinarily responsible for the care of all patients in the public wards—the patient should be under the responsible care of a member of the visiting staff, in association with the private practitioner of the patient who should have free access to the patient and should have such share of responsibility and treatment of the patient as may be agreed upon, unless in the case of any such hospital arrangements have been made by the governing body to permit the access of practitioners not on the staff to have responsible care of their own patients, when the provisions of para. 30 should apply."

That was a concession to the general practitioner who wished to have closer touch with his patient in a general hospital. The second group was where there was not a definite consulting staff in charge of the patients in the ordinary wards, as in hospitals of the cottage hospital type, where there was an open staff. There the patient would have free choice of doctor and free choice of consultant. Then came the group of private patients treated in annexes or homes in connexion with hospitals. Very little alteration was proposed there. The patient would have free choice of doctor and of consultant. That type of hospital was not common, but there were certain hospitals in London which had annexes of that type. A change was proposed there which had been proposed the previous year and referred back to the Council for further consideration. The question was whether anyone undertaking special treatment in such annexes should be required to show that he had the skill and experience requisite for such treatment. The Council had reconsidered the matter, and had come to the conclusion that it was only fair to the hospital that they should have the right to ask for such an assurance. It was therefore laid down that those giving such treatment might be required to satisfy "one or more

of the following conditions," those conditions being the ones laid down last year. The treatment of patients in special hospitals was dealt with in a separate resolution, to which an amendment had been put down. The matter had been given very careful consideration, and the conclusion arrived at was that the term "consulting staff" should not be interpreted too narrowly. It did not mean that the consultants who had charge of the hospital should be pure consultants; they might be general practitioners outside, but it should be recognized by the general body of the profession that they were consultants in that particular area.

Conditions Governing Admission.

Dr. R. RICHARDS (Aberdeen) moved an amendment to retain existing paragraph 17, which runs:

> "Some means of investigation into the circumstances of the applicants for relief, by means of an almoner or other agent, should be employed in all medical charities."

(This is omitted from the amended proposals.) It was desired to retain this paragraph, as it was specially applicable to Scotland.

Sir RICHARD LUCE said he was willing to accept the amendment.

The amendment was agreed to.

Categories of Patients.

Sir ROBERT BOLAM (Newcastle) moved to refer back the new paragraphs dealing with categories of patients, free patients, and aided patients (paras. 17-21). He hoped the position would be left as it was for another twelve months. Throughout the country men had been working for years to get a definite Hospital Policy for the large industrial class, which constituted from 80 to 85 per cent. of the people using the hospitals. The actual free or indigent population in hospitals varied between 10 and 15 per cent., and the remainder of the number were of a class which should not be in a voluntary hospital but in a private annexe. In Newcastle he had recently induced the house committee to try a scheme which was, in effect, an industrial tariff scheme. Liverpool also, he believed, had been able to do that. If the meeting allowed the formation of an aided class, why should any industrial worker bother to join a contributory scheme and pay his 2d. or 3d. a week and become a tariff patient? If the Meeting stuck out for the industrial class to be put in the tariff class, then the Association could negotiate with a free hand. In one county which he knew very well it was possible to ascertain the exact number of workmen in a particular industry, and in ordinary times they were well able to pay 2d. or 3d. a week for hospital services in addition to their other off-takes. In fact, it had been ascertained they were only paying ¼d. a week—about £5 a year. The contributory schemes must be made adequate; the contribution must be 2d. or 3d. a week. That would cover the ordinary provincial costs, and there was nothing to prevent the average working man paying that. As an independent person he would be willing to do it, and would be glad to make some small recognition of the medical services, though realizing that it was not full payment for those services. If the "aided" class was allowed to remain scheduled, nobody would introduce a proper contributory scheme. He appealed to the Meeting to give those who were working for the desired end another year's opportunity to complete their work.

Mr. BISHOP HARMAN said, on behalf of Marylebone, he wished to support the resolution put forward by Newcastle-upon-Tyne. There were existing at the present time large numbers of patients—in fact, nearly the majority—who came into the category of aided patients. They were the people who had not prepared for themselves the means of meeting the cost of hospital treatment when such an occasion arose, they being only able to pay for a portion of the cost of their treatment. Those patients were aided by the charitable funds of the hospital, and the new clauses were principally designed to cover those persons. He submitted that it was not wise to frame the categories or the policy so as to cover exceptions which were recognized in practice but which in policy were disadvantageous. The Association would never succeed in attaining their ideal of getting people to provide for themselves under present-day conditions. He hoped they would follow Newcastle's lead for the remission of the proposal for another year until they had had time to consider the matter.

Dr. J. C. MATTHEWS (Liverpool) said he desired to support the amendment from Newcastle from the point of view of himself and his colleagues who had had to work out the details of a very large contributory scheme on Merseyside. This attempt or suggestion by the Hospitals Committee to emphasize the distinction, which he admitted to a certain extent existed, was unnecessary, and was also in some respects dangerous. It was unnecessary because patients were treated in the same way whether "aided" or "tariff." It was dangerous because it would allow the development of an idea which had been in existence in some centres that the only "tariff" patients were those for whom the full cost of maintenance was being paid. Throughout the years that had gone by this Association had stuck out for recognition of the hospital staff on account of all patients for whom payment was being made either by authority or by a contributory scheme. In Liverpool they had obtained that financial recognition of staff. A lump sum was being paid to the hospital staff in Liverpool, representing 10 per cent. He said that had this emphasis on a distinction between "tariff" and "aided" patients been in existence during the last year, he hardly dared contemplate the difficulties and endless tasks which would have arisen. He therefore joined with Sir Robert Bolam in saying that those who were doing the actual spadework should leave the matter as it stood for another year.

Dr. E. R. FOTHERGILL said he would like to amplify the word "aided." It did not mean State-aided. He thought the word "aided" was misleading by itself. They had four groups: they had the "free" group, for which neither the staff nor the hospital got anything; then they had the other extreme, the private patient; from the voluntary "aided" the staff got a share, and from the "tariff" they got a certain percentage. The voluntary schemes which existed at the present moment never paid the hospitals in full. Were they to wait until Liverpool and Newcastle had well-developed schemes and then bring the matter up again? They must make a distinction between those aided by the hospitals and those who were aided by voluntary contributory schemes.

Mr. MCADAM ECCLES supported the Hospitals Committee in the proposal that there should be a definite "aided" group under "Contributory patients." There were aided patients of this particular category at present in the country, not only in the south, but also in the north, and he did not think any representative could deny the presence of that group. So long as there were these aided patients they must, in the opinion of the majority of the Hospitals Committee and the Council, be kept separate from the tariff patients, and they were certainly not private patients. Aided patients would become fewer and fewer, but until they disappeared the Representative Body should recognize them, and when they disappeared delete this category. For the South he could not accept Sir Robert Bolam's percentages, and even if they were accepted for the North there still remained a small percentage—5 to 10 per cent.—which came under this "aided" category, including the indigent poor. Then if they had, and desired to have, all patients under tariff—which he thought most of them did—there would be a time when they could delete the "aided"; but that time had not yet come.

Dr. PETER MACDONALD (York) supported the Newcastle amendment. He gave the experience of York, where he had been able to persuade the staff of the hospital with which he was associated to accept the contributory scheme in full, and, further, to persuade the governing body of the hospital to accept the Association's contributory policy. For the moment 20 per cent. had been established as the proper contribution to the staff fund. The working people's hospital fund were desirous of converting their fund into a contributory scheme, and had accepted the full implications of the Association's model scheme. Officially they were free patients, but practically they were not. All the hospitals demanded contributions, but the fact that these were nominally free patients, so far from being a deterrent, would be used by the hospitals themselves to induce them to become tariff patients and

members of contributory schemes. It would be much better not to have an aided class. He hoped the Newcastle amendment would go through.

Dr. F. A. ROPER (Exeter) said that those who had to deal with hospital committees experienced one of their greatest difficulties in negotiating with regard to patients of precisely this aided class—the class aided in part only by public or other funds—and therefore it was his very definite opinion that, for clarity of thought, this aided class should be differentiated clearly into a separate category. It was probably the largest of all the classes.

Dr. R. C. BUIST (Dundee) urged the meeting to accept the amendment. The questions involved, he said, were very much more serious than seemed to be realized. The matter under discussion was that of hospital policy; was it a policy for the future or for the past? If it were a policy for the past they should take the historical view that certain things existed; if a policy for the future, they must try to exclude those things they did not want.

Sir RICHARD LUCE suggested that the opposition were traversing a good deal of ground unnecessarily. The speeches delivered so far in favour of the amendment had been made with the object of introducing a policy which would provide only for the new traiff provisions, and of eliminating altogether those other than tariff patients. It must be remembered, however, that the present policy allowed for both types perfectly evenly. By differentiating they would be setting up an ideal, so that those who did not wish to be objects of charity should have a definite chance to join schemes to provide for the payment of the whole of the cost of their treatment. They were trying to establish a definite class into which these could be included. Newcastle and Liverpool were simply trying to put forward a scheme by which all people would belong to that new tariff class. As had been stated, however, in many parts of the country the people would not pay the cost of their treatment; they had systems by which they paid certain contributions per week for their actual treatment in the hospitals while they were in the hospitals, and did not make provision through a system of insurance. Those people would never pay the full cost of their treatment. So long as that system existed they must always be considered as belonging to the aided class. That being so, it did seem to him that it would represent a great advance to have one class which would be completely free from charity, as well as the other, which latter was diminishing, and perhaps would be eliminated suddenly some day as the result of State intervention. It would be a great advance to establish an ideal tariff system as opposed to the un-ideal system relating to the aided class.

Sir ROBERT BOLAM said the representatives were all at one in desiring that the class of patient under discussion should be in the tariff schedule. Sir Richard Luce had said that there were individuals in this country who would always arrange to pay the hospital costs only when the emergency arose. Would those people ever pay the full costs? Never! Those were the very people who, by means of a small payment regularly under a contributory scheme, could place themselves in a position to provide for the payment of the tariff charges from the funds of that scheme, but they never would join a contributory scheme unless it was made imperative that they should do so. Under the old policy we could progress to that end; under the new proposals of the Hospitals Committee we should stereotype and crystallize once and for all this aided class, and the people in that class would remain in their present position and would make no provision for the future. Which should we have?

The amendment to refer back the paragraphs was carried by a large majority.

Private Patients in Private Wards.

Dr. D. F. TODD (Sunderland) moved to delete from new paragraph 29 (*a*) the two references to "a staff of consultants" and to substitute the words "visiting staff." This amendment, he said, was quite a common-sense one. As in the case of the amendment proposed by Newcastle, it was put forward as the result of practical experience, and he submitted that the meeting would, by accepting it, be doing something in an effective way which would be of benefit to those concerned. Refusal to accept it would be a retrograde step.

Sir RICHARD LUCE had no objection to the amendment, which was accepted.

Dr. D. F. TODD (Sunderland) moved to delete the suggested new paragraph 29 (*a*), and to substitute the following:

> (*a*) If the hospital has a resident medical officer, or officers, and also a visiting staff which is ordinarily responsible for the care of all the patients in the public wards, the patient should be allowed to select any available registered medical practitioner as his attendant, but, if the treatment of the patient at any time involves the application of special skill or experience, then the practitioner undertaking that treatment should be a member of the visiting staff of the hospital.

Practical experience in the North of England, he said, led practitioners there to think the amendment would result in a satisfactory solution of the difficulty, whereas what was suggested by the committee was impracticable and unworkmanlike.

Dr. FOTHERGILL said that large numbers of hospitals had a visiting medical staff, which was appointed by the board. The board, having appointed that staff and assured itself of their qualifications and capabilities, freed itself from any legal liability for consequences to the patients. That, he suggested, was important. According to the amendment, any practitioner in the area should be allowed to take full responsibility for attending his patients in the hospital, regardless of any co-operation with a member of the visiting staff. He would like to hear what the law was on that. He could not conceive any governing body allowing a practitioner to come in and attend his patients without having satisfied itself that that practitioner was, in its view, competent. If Dr. Todd could get over that difficulty, personally he would be very pleased. Visiting staffs of hospitals said, "You bring your patients to the hospital, and we will attend to them." The other group—and this was Dr. Todd's position—said, "We will bring our patients in, and if we want the help of the visiting staff we will have it." Those were the two extremes. The committee came to its decision in view of the legal position, and because it was thought to represent a fair compromise. Dr. Todd gave no indication of how a governing body, knowing the legal position, could get over its liability for an action brought by a patient for what in the patient's view was the consequence of maltreatment committed in its building. He submitted that an action would lie against the governing body for allowing a practitioner to treat a patient without satisfying itself as to his competence.

Dr. C. E. S. FLEMMING (Council) asked what the position of the governing body of a cottage hospital would be if Dr. Fothergill was right in contending that the governing body of a hospital was responsible for what happened in its building. According to the Association's policy, membership of the medical staff of a cottage hospital should be open to all practitioners in the district from which the hospital drew its patients. The position of the governing body of such a hospital would, if Dr. Fothergill was right, be a very serious and indeed almost impossible one.

Mr. N. E. WATERFIELD (Oxford) thought the motion proposed by the Chairman of the Hospitals Committee was more likely to be for the benefit of the patients and staff of the smaller hospitals than was the amendment. In many instances the staffs of the smaller hospitals did not pretend to be a consulting staff. The amendment seemed to imply that any outside practitioner could attend a patient in the hospital and call in any outside consultant he chose. According to the proposal of the Hospitals Committee, however, the staff itself would be responsible for the treatment of the patient, in conjunction with the general practitioner, and that seemed to be a much more satisfactory arrangement, because then (in conjunction, if necessary) it would be much easier to call in what he might describe as the real consultant, possibly of one of the bigger hospitals, without interfering with the right of the member of the staff ordinarily in attendance on the patient.

Dr. R. D. MOTHERSOLE (Bolton) thought the amendment was open to two grave objections. First of all, with regard

to special treatment requiring special skill or experience, the difficulty would arise as to who was to decide when such treatment was required. The practitioner in attendance might not be aware of it. Secondly, the amendment did not cover the point that the practitioner attending the patient might have special experience on the particular point arising which was greater than that of any member of the staff of the hospital.

Sir R. LUCE said he could not accept the amendment, which was contrary to the view arrived at, after a great deal of discussion, that in the majority of hospitals of the kind in question which had a definite visiting staff the number of beds available in private wards of the type mentioned was very small, and to open those at the present time to any practitioner to have complete charge would be administratively impossible. It would be extremely difficult for anyone but a definite member of the staff to have charge of the patients in such wards, though they might, of course, share that charge with the private practitioner. Where there was a separate administrative block with possibly a separate resident, a separate staff of nurses, and a separate theatre, the case was different. The fact that those beds were few meant they were practically a vested interest of the members of the staff for their cases. The amendment would be objected to by the staffs of practically every hospital which had wards of the type in question; it would lead to administrative difficulties, and therefore he could not accept it.

Dr. TODD, in reply, suggested that the legal attitude Dr. Fothergill assumed was entirely wrong. He would like to have the Solicitor's opinion.

Dr. C. F. T. SCOTT asked that the Solicitor should give his opinion as to the legal responsibility of the governing body of a hospital.

Dr. FOTHERGILL said his opinion was based on Stone's *Manual*. The hospital appointed a staff; they considered the credentials of each candidate, and, having satisfied themselves that the applicant was a satisfactory person to be appointed, they had done all they were called upon to do with regard to the patient. The doctor was not a servant of the hospital; he was a "contractor." He carried out his duty as he thought fit.

The SOLICITOR (Mr. Oswald Hempson) said the question was difficult to answer, particularly if he was to answer it in the light of the Sunderland amendment, because that amendment gave considerable protection to the hospital by leaving it to the patient to select the practitioner. The patient, therefore, by taking on himself the selection, assumed the responsibility that might otherwise attach to the hospital in the appointment of the medical officer.

The Sunderland amendment was lost.

Dr. FOTHERGILL moved to insert in paragraph 29 (*a*) the words "between the member of the visiting staff and the private practitioner," so that it would read: ". . . the private practitioner of the patient . . . should have such share of responsibility and treatment of the patient as may be agreed upon between the member of the visiting staff and the private practitioner."

Sir R. LUCE said this was not the intention of the Hospitals Committee. The position of the hospital must come into the question, and he could not accept the proposition that it should be an agreement only between the consultant and the practitioner.

Dr. FOTHERGILL said he must fight the chairman of the committee. (Laughter.)

The CHAIRMAN OF COUNCIL expressed disagreement with the view of Sir Richard Luce, and supported Dr. Fothergill's amendment, which expressed his understanding of the intentions of the committee.

Sir R. LUCE thought that the hospital must be allowed to have some say as to whether there should be a share. It might be the policy of the Association that there should be agreement, and that a share should be given, but the possibility of a share being given, and the type of share that should be given, must be agreed to to some extent by the authorities of the hospital.

Dr. FOTHERGILL said that, having appointed a member of the visiting staff, the governing body authorized that person to act on his discretion, and did not need to be consulted as to the amount of work he should delegate to his colleague.

Dr. Fothergill's amendment was carried.

Private Patients in Public Wards.

Dr. F. A. ROPER (Exeter) moved to amend the new paragraph 27 with regard to the conditions under which private patients might be admitted into the public ward; he wanted to introduce words which would ensure that in the case of these patients as in the case of tariff patients the ordinary hospital routine of admission, transference, and discharge should not be modified, nor should any preferential treatment be given to them. Not only as a matter of tactics, but also as a matter of plain justice, it was advisable, he thought, to emphasize that para. 25 applied also to private patients. It made the Hospital Policy more unassailable, and in that way might add to its prestige. Private patients in a public ward should, he thought, have no preferential treatment whatever, and that was merely the intention of his Division in bringing forward its amendment.

Sir R. LUCE said in the last remarks of Dr. Roper he had stated that private patients might be in a public ward; they should only be there as a temporary measure. The committee's proposals were that private patients should not be admitted into general wards except as a matter of urgency. He took it that this amendment would make the question of special facilities being given to private patients impossible except in a private ward. The committee came to the conclusion that it was the general practice in most hospitals that private patients should have certain facilities given to them. In most hospitals they were given different diet. There were, of course, differences in the question of admission; in the routine method of admission there was bound to be a difference.

The amendment was lost.

Mr. BISHOP HARMAN moved that consequent upon the referring back of paragraphs 17–21 the new paragraphs 22–25 also stand referred back. Sir R. LUCE agreed. The motion was agreed to.

The CHAIRMAN said that the recommendation of the Chairman of the Hospitals Committee was that paragraphs 26–30 be approved.

The recommendation was agreed to.

Separate Institutions for Paying Patients.

Sir RICHARD LUCE next moved on behalf of the Council the adoption of the policy and rules for private patients admitted into separate hospitals or institutions (not connected with voluntary hospitals). These form Appendix VII to Annual Report of Council (*Supplement*, April 20th, p. 128). He said the arrangements were clear and definite, and there was added also a set of suggested rules for the formation of the governing body of hospitals of this kind. It was to be representative of the medical profession, and to have a medical committee to which would be referred all matters concerning the medical administration of such a home.

Dr. FOTHERGILL (Brighton) moved to amend the heading of the Appendix so that it read, "private patients admitted under the care of their personal medical advisers, etc."

The Brighton amendment was lost, and the original motion was carried.

Cottage Hospitals.

Sir R. LUCE then moved the adoption of the new paragraphs in Appendix VIII of the Annual Report, dealing with Hospital Policy as applied to cottage hospitals, in substitution for the present paragraphs of the Policy. The committee had come to the conclusion, he said, that there were two contingencies which were not met by the policy as laid down at present. In the case of cottage hospitals which received payments from contributory schemes, if there were a staff fund from such schemes it was obvious that a doctor could not charge a private patient and receive also a proportion of the payment from the contributory scheme. It was essential, therefore, that if there were such schemes it should be laid down either that the amount

of the contribution should not cover any payment to the staff, or that, if the scheme did cover payment to the staff, then the practitioner should not be entitled to charge private fees as well. The second contingency was that there existed, contrary to the Association's present policy, many cottage hospitals which had not completely open staffs, as the Association would like. If a cottage hospital had a closed staff it did not seem to be right that the members of that staff should be able to charge patients of their own who were treated at the hospital; they would not be able, of course, to charge for other people's patients whom they were treating there. Therefore, if a hospital had a closed staff, it seemed to be essential that the staff should be paid on the ordinary system, by means of an honorarium, or should receive a proportion of the payment made through the contributory scheme, just as should be done in the larger hospitals with closed staffs.

The motion was carried, without discussion.

Industrial Accidents and Hospitals.

Sir R. LUCE moved as a recommendation of Council:

> That there are two ways by which industrial accidents need not be a charge on voluntary hospitals or on the services of the medical staff—namely, by (1) making a charge on industry, which would require legislation, and (2) the development of contributory schemes in connexion with which the services of the medical staffs are recognized in accordance with the policy of the Association.
>
> Further, that the following paragraphs of the Hospital Policy apply to this position:
>
> 9. Contributions to hospitals by employers of labour or massed or periodical contributions by employees should be considered as contributions for services rendered or to be rendered.
>
> 32. Where the board of management of a voluntary hospital accepts contributions for patients from an approved society, insurance company, contributory scheme, employer of labour, and/or by massed or periodical payments by employees, the members of the visiting medical staff should receive recognition of their services either in the form of an agreed honorarium, or by means of a percentage of all such payments being passed into a special fund. Such honorarium or fund can be allocated in any manner which the visiting medical staff may determine.

This resolution, he said, dealt with the question referred to at last year's Representative Meeting, when the Council had been asked to consider the problems of industrial accidents. The Council had come to the conclusion that there were two possibilities. Under the present system in this country industrial accidents were covered, so far as they were covered at all, by the donations and contributions of the employers, who, as a rule, subscribed something to the funds of hospitals for the benefit of employees—not directly, but indirectly. If there were to be any other system by which the employers were to be made responsible for industrial accidents, or were to pay a definite proportion of the benefits or the cost of treatment rendered necessary by such accidents, fresh legislation would be necessary. It was extremely unlikely that the necessary legislative measures could be obtained under present circumstances, and the Council considered there was only one alternative—namely, that the staffs should be given a proper remuneration under existing contributory schemes. It was not the business of the Association to look after the interests of the hospitals. All that it was necessary for it to do in its policy was to ensure that the medical profession was not exploited, and if it could ensure that the members of the profession received a reasonable proportion of the funds paid through contributory schemes in respect of the services rendered, then it would have protected them against exploitation.

Mr. F. C. PYBUS (Newcastle) said that when the voluntary hospitals were first started they were poor, and it was never anticipated they would have to deal with the class of people they were compelled to deal with at present. Nor was it ever realized that industrial accidents would form so considerable a part of hospital work. The number of industrial accident cases, especially in industrial areas, had led to abuse not only of the services of the staff but of the charitable funds of the hospitals. In some cases their cost was partly met by contributions from firms or from the employees themselves, but in others the works provided an ambulance to convey their cases to hospital, and after that took no further trouble. At his own hospital the total contribution received from employers barely covered the actual maintenance cost of accident cases, the remainder, presumably, being borne by charity. One colliery which sent its accidents to the hospital refused to contribute anything beyond what it received in the shape of small fines from its workpeople. To give a concrete example, a certain firm gave £250 a year. At first sight that seemed a very handsome contribution, but the number of accidents amounted to some five hundred a year, and the subscription did not cover their cost. On one occasion he had been able to save that firm £500 by restoring one of their workmen to full mechanical ability, whereas previously they had practically agreed to compensate him for permanent partial injury to the tune of £500. A fatal accident might cost a firm or an insurance company about £600; large sums were paid weekly as compensation, and lump sums for permanent or partial disability; and this showed the value of the work the hospitals did. The chairman of the Hospitals Committee had said the only method of dealing with those cases was to admit them as tariff patients, but there was an alternative—namely, to consider them as private patients. If a serious accident case, requiring blood transfusion, was admitted to hospital, and most of the evening spent in dealing with it—the case might be fatal in the end—under the tariff scheme the hospital would receive something like eight shillings, of which the medical staff got about two shillings. If a patient had a fractured skull or limb and recovered, and was sent out in a week or ten days, the hospital received three or four guineas and the staff about £1. An alternative which should be considered was that such patients should be admitted to private wards, and in the case of hospitals with private wards, and especially where a reduced charge was made, they might very well be admitted to them rather than come under the heading of tariff patients. The question of whether the payment at present received was sufficient deserved serious consideration, and practitioners should consider whether such patients should not be treated as private patients.

Mr. N. E. WATERFIELD (Oxford) pointed out that motoring accidents were very numerous, and the policy which protected the subject of the accident agreed in nearly every case to pay the medical expenses of the sufferer. When such patients were admitted to the general ward of a hospital the medical officer in attendance lost all right to charge any fee, and the insurance company escaped the liability it had accepted. If, as had been suggested, such accidents were admitted as private cases, the doctor's fee would be guaranteed by the insurance company which undertook the risk. He thought the suggestion that those cases should be treated as private cases was therefore a reasonable one, and valuable from the point of view of the doctor.

The motion was carried.

Hospital Policy for Radiological Services.

Sir RICHARD LUCE next moved the adoption of the memorandum on the interpretation of the Hospital Policy for Radiological Services (Appendix X to Annual Report of Council). The matter, he said, arose out of an appeal by the British Institute of Radiology, which had for some time been asking that its members on the staffs of voluntary hospitals should be put on a definite basis, and that a policy should be laid down with regard to them. They were prepared to receive a proportion of the fees usually charged for similar work in the district. Another point was that radiologists should have the right to have their own department in the hospital if they so desired. It was often the rule that cases could be referred to the radiologists only by other members of the staff, and the radiologists wanted the right to have cases sent to them direct. That had been agreed to by the Council.

Dr. FOTHERGILL (Brighton) moved to amend paragraph 4 of the memorandum, which stated that a hospital might arrange a schedule of modified charges for patients within the scale of income limits; he desired the omission of the ensuing words—namely: "based upon the average of one-half the fees commonly charged for similar private work in the district." It was felt undesirable, he said, that radiologists in any area should have the basis on which their fees should be charged clearly defined; it would be better to leave them a free hand.

Mr. BISHOP HARMAN said he had conducted the negotiations with the radiologists in regard to the matter under discussion. He had discussed the amendment with them, and their view was that they desired the protection afforded by the words the amendment proposed to delete. They did not want any fee-cutting by the hospital authorities; they did not want the fees at such a low level as would prevent them doing any private work, or at such a high level that private work would be removed from them and attracted to the hospital. The careful wording suggested was fair in both cases. He hoped the amendment would be rejected unanimously.

The Brighton amendment was lost.

Dr. PETER MACDONALD (York) said he was concerned by para. 8 of Appendix X, which is as follows:

> The normal approach to the radiologist is through the medical officers of other departments of the hospital, but in exceptional circumstances cases may be referred direct to the radiologist by private practitioners.
>
> (Case sheets and records of patients treated in hospitals, including *x*-ray plates and prints, should remain in the custody of the hospital; they must be regarded as confidential documents, and access to them allowed solely to the members of the visiting staff of the hospital.)

A great many hospitals, including his own, had laid it down that approach to the radiologist should be only through the other departments. The paragraph in question meant that the Association would be adopting a policy which was favoured by one section of the profession but was held in strong disfavour by another very considerable section of the profession. He had not distinctly heard what the chairman of the committee had said, but gathered that he was advocating rather more than exceptional approach to the radiologist.

Sir R. LUCE said he was not a party to the actual negotiations on the matter, but he understood from the committee that it was one of their very vital points. There were many parts of the country where radiologists were not at present granted permission to have direct access from outside to patients in the hospitals. The radiologists made a great point of that, and if the Representative Body turned down the clause, it would undoubtedly break the agreement with the radiologists.

The CHAIRMAN OF COUNCIL asked the meeting to allow the paragraph to stand, as it was an integral part of the whole scheme. He thought it possible that the chairman of the committee had indicated that the door was opened rather more widely than was actually the case within the meaning of the wording of the paragraph. It was only in exceptional cases that the patient might be referred direct to the radiologist by private practitioners.

The CHAIRMAN asked how the position appealed to the representatives of Marylebone and of Newcastle in reference to the classification of patients shown in para. 2 of the Appendix as "Free," "Aided," "Tariff," and "Private." In an earlier discussion the Representative Body had referred back the consideration of that classification of patients, so that the present policy of the Association remained—namely, free patients, tariff patients, and private patients.

Mr. BISHOP HARMAN moved that all the reference to the different classes of patients in para. 2 of the Appendix be deleted, and Sir ROBERT BOLAM seconded. The CHAIRMAN announced that the representatives of Newcastle and Marylebone accepted this proposal.

The memorandum, as amended, was adopted.

Model Contributory Scheme for Hospital Benefit.

Sir RICHARD LUCE moved approval of para. 95 of the Annual Report of Council, relating to the model scheme prepared by the Council enunciating the fundamental principles of the Association in regard to contributory schemes. This was done in order to assist medical staffs of hospitals in their consideration of such schemes. It had been thought desirable to draw up a model contributory scheme for the benefit of those members of hospital staffs where arrangements for contributory schemes were being made, and that model was set out in Appendix IX. There was practically nothing new in it. It conformed with the other parts of the policy.

Dr. FOTHERGILL (Brighton), in regard to the opening sentence of the model contributory scheme, which read that its purpose was to enable wage-earners and others "*by means of an organized system of regular contributions to give assistance*" to hospitals, desired to substitute the phrase "payments to hospitals." The payments under a contributory scheme ought to be payments in full. He submitted that the question whether the payments were adequate or inadequate did not arise on the scheme, and it was dangerous to put in the words "give assistance," because the whole scheme was thereby given away. He thought Sir Robert Bolam would agree that the contributions should definitely finance the schemes. He therefore moved the amendment.

Dr. FOTHERGILL withdrew his amendment in favour of the following wording of the opening paragraph of Appendix IX as follows, moved by Mr. BISHOP HARMAN:

> "The . . . contributory scheme for hospital benefit enables wage-earners and others within definite income limits to provide hospital benefit for themselves and their dependants by means of an organized system of regular contributions in return for which those persons will be relieved from all hospital charges when receiving hospital treatment. Benefit, etc."

Dr. FOTHERGILL seconded, and the amendment was carried.

Mr. HARMAN moved further to revise the first part of the paragraph headed "Eligibility for Membership" in Appendix IX, so that it would read:

> All persons, whether insured under the National Health Insurance Acts or not, whose income from all sources does not exceed a specified scale, are eligible for hospital benefit under this scheme, the hospital reserving its right to refuse admission. (The following maximum scale is suggested, subject to economic and local variation and periodic revision.)

Dr. GOODBODY seconded this motion.

Dr. BRACKENBURY thought that Mr. Bishop Harman had overlooked the fact that this was a paragraph of a model contributory scheme. His amendment was in the wrong form. The figures in this paragraph ought to be left blank, with a footnote to the effect that they should not be filled in beyond a certain maximum. If Mr. Harman thought this was an essential alteration to be made it should be made in that form.

Mr. BISHOP HARMAN asked leave to withdraw his amendment, in view of the remarks of the Chairman of Council.

The CHAIRMAN OF COUNCIL replied that he would prefer that the amendment be put to the meeting as altered in accordance with his own suggestions. This meant that the paragraph relating to "Eligibility for Membership" should remain unaltered, and that a footnote should be added that the figures to be entered in the blank spaces should not exceed a certain maximum for each of the three classes.

Mr. HARMAN added that he was not sure that the ages should not be deleted also, but it was not essential. It was important that the actual income should not be stereotyped; that was against the policy of the Association.

Mr. MCADAM ECCLES opposed the amendment, for two reasons. In the first place, the Representative Meeting, he said, had reached the most important point in regard to the Association's Hospital Policy. It was agreed that before long most of the patients in the hospitals should be under the tariff scheme, and this was the first time the Association would be putting forward a model contributory scheme for hospital benefit. It ought to have done so two or three years ago, because schemes had been cropping up all over the country which were not "model," according to the Association's policy. If there were to be model schemes in the future, and if other schemes were to be remodelled, the Association must put down categorically what it really meant, and if it omitted to state the figures in the scheme, and was satisfied to have them included in a rider at the end, it would have itself to blame if those responsible for the various schemes altered the figures to suit their own ideas. Secondly, the Hospitals Committee—thanks to a large extent to Dr. Anderson—had put in figures which represented a slight modification of the policy of the Association, though only to the extent that the figure in the first instance was £8 per year more than was stated in the Hospital Policy. Most of the people to be catered for were industrial workers, and their wages were paid weekly, and those who drew up contributory schemes had a less difficult task set them when the

amounts paid were referred to as weekly contributions rather than as annual contributions.

Sir ROBERT BOLAM proposed a further amendment, to the effect that the reference to Classes I, II, and III be removed to a footnote, and that it should be preceded by the words, "The following maximum scale is suggested, subject to economic and local variations and to periodic revision." He suggested that that would meet the point made by Mr. Eccles, and felt sure that Mr. Harman would accept it.

The amendment proposed by Mr. Harman was put to the meeting, and lost.

The amendment proposed by Sir R. Bolam was seconded by Mr. Eccles, and carried by a large majority.

Dr. FOTHERGILL (Brighton) also moved to add to the model contributory scheme a paragraph embodying the present policy of the Association in the matter, namely:

> "Where arrangements for consultations or specialist services for tariff patients are made under some contributory scheme or otherwise, such arrangements should provide that these services shall be given so far as is possible and consistent with the best interests of the patients by a private practitioner at his consulting rooms or at the patient's own home and not at the out-patient department of the voluntary hospital."

It did not follow at all, said Dr. Fothergill, that because the family doctor was unable himself to render the services required by a patient, there was no other course possible but for that patient to go into hospital. He emphasized that, besides the hospital staffs, there were others who were equally well trained and equally capable of rendering the services required, and they should be paid direct from the funds of the contributory schemes for so doing. The hospital should be the last resort of a patient. The principle he was advocating was not acknowledged in the Association's model scheme, and it was not acknowledged in the various schemes existing throughout the country. It might be difficult to get the principle adopted in the various schemes, because it would cost more money, but the Association must be consistent in its policy. If any specialist, or any private practitioner with special knowledge of the particular branch of medicine involved, was able to render the service required (provided it was in the best interests of the patient) either at his own house or at his patient's house, he should have the opportunity, the experience, and the pay. For the Association to set up a scheme for application throughout the country which did not acknowledge that principle would be disastrous.

Dr. H. G. DAIN, speaking against the amendment, said that whilst he was sure the whole medical profession would sympathize with the desire that the private practitioner should take his proper share in regard to patients treated under contributory schemes, he did not see how, in a model contributory scheme for *hospital* benefit, one could provide that the private practitioner could take some of the money. It seemed illogical, and he did not think the Representative Meeting would have the courage to pass the amendment. In a model contributory scheme for hospital benefit it would be out of place to have an additional paragraph such as Dr. Fothergill suggested.

The CHAIRMAN OF COUNCIL pointed out that paragraph 8 of the Hospital Policy of the Association was headed "Contributory Schemes," whereas the meeting was now discussing Appendix IX, "Model Contributory Scheme for Hospital Benefit." There was therefore no inconsistency but every advantage in not mixing up what one might like to have as a paragraph in one kind of contributory scheme with the paragraphs which must necessarily appear in a contributory scheme dealing with hospitals only.

Dr. FOTHERGILL said he appreciated the arguments of the last two speakers so far as drafting was concerned, but they did not convince him, and he hoped they would not convince the profession generally, that in any scheme sent out to the public for adoption the whole of the practice beyond the family doctor's ordinary practice should be sent to the hospital. Whether his amendment was carried or not, it must be understood that contributory schemes should not finance the hospitals at the expense of the practitioners who could give the same services at the patients' homes or in their own homes. In the ophthalmic scheme it was recognized the service should be given at the house of the ophthalmic specialist and at a reduced fee. There were other branches of medicine besides panel work where that principle should be recognized.

The amendment was lost.

Sir RICHARD LUCE, in moving the remainder of the report under "Hospitals," said there was very little in it which had not already been dealt with by special resolutions. One of the questions not so far referred to was that of assistance to staffs of hospitals, and arose out of a resolution by the conference of members of staffs of hospitals held last year. On that the Council decided that, while it and the central staff would do everything in their power to assist the members of hospital staffs to enforce the policy of the British Medical Association in every way possible, it did not think the time was yet ripe for making the policy of the Association absolutely binding. The other point not so far dealt with was the necessity for further beds. The Hospitals Committee fully realized the need for further beds, especially for the treatment of patients by their own doctors, and was ready to do all it could to help the matter forward. It was in negotiation with King Edward's Fund in London, and was trying to persuade it to devote its energies to providing further beds in London where patients would be treated by their own doctors. The Fund had not yet replied to a deputation which met it on that point, though it said it was prepared to consider it.

The remainder of the report under "Hospitals" was approved.

Pay-Bed Accommodation.

Dr. CHRISTINE MURRELL (Kensington) moved to add to the relevant paragraph in the Annual Report that the Annual Representative Meeting wished to emphasize its conviction that pay-bed accommodation was wanted, not only for those patients who required operative or specialist treatment, but also for those whose need for such accommodation was due to the fact that they could not receive suitable nursing and domestic attention in their own homes whilst still remaining under the medical care of their own private practitioner. The question was very largely, she said, one of emphasis. Its urgency differed in different areas. In areas supplied by cottage hospitals the matter was generally dealt with quite simply; and where there were non-teaching hospitals it could often be suitably adjusted. It was, however, urgent in the large cities, of which London was the outstanding example, and where the question of hospital accommodation for the middle classes was extremely important. Middle-class patients were not always, for the whole of their illness, in need of specialist or surgical treatment, and the authorities dealing with the subject should be urged to supply accommodation for patients who were not in need of such services. In London the Pay-Beds Committee of the King Edward's Hospital Fund had reported in favour of the extension of pay beds in connexion with hospitals for specialist services, and had also quite clearly stated that the alternative arrangement might be available at the same time. It said:

> "Your committee desires to emphasize its opinion that the future trend of development in regard to the provision of accommodation for the paying patient should run along the lines of the provision of specially built and equipped private hospitals and homes and of the extension of the paying-ward system at existing hospitals."

It also said that the separate hospital might be a development of the nursing home; there was nothing, it said, administratively impossible in the provision of all the usual hospital facilities in such an institution. If the medical profession considered it was going to affect their patients and their practice (put very definitely in that order) they should stress the importance of having such accommodation for those of their patients who wished to remain under their care, and who could, with the greatest benefit to themselves, do so, but who yet required some middle-class pay-bed accommodation.

Sir RICHARD LUCE heartily supported the motion.

Mr. H. S. SOUTTAR (London) also supported the Kensington motion. He had recently had an opportunity of visiting in Sweden eighteen of the finest hospitals in Europe, and arrangements were made in them by which the medical practitioners of the country could make use of them for the service of their patients; and that, surely,

was what was wanted for this country. It was wholly impossible to provide such hospitals as those which he had seen in Sweden without direct contributions from public sources. He did not think there existed in this country x-ray apparatus comparable with the best he had seen in Sweden. It was for the Association to see that the hospitals were absolutely up to date, that the whole of the public had admission to them, and that the whole of the profession should be able to serve its patients there. (Applause.)

Mr. McADAM ECCLES supported the Kensington motion. He emphasized the need for more paying beds in hospitals at the periphery of the large towns, where the local practitioner should be admitted as the doctor in the case. The King Edward's Hospital Fund for London had considered the matter with very close attention, and had realized the importance of hospitals at the periphery. The difficulties were how to raise the capital to build and equip such hospitals, and to arrange for patients to be able to afford moderate hospital accommodation fees. The first difficulty could be overcome by millionaires coming forward and providing money for the good of the community at large—as, indeed, they were doing. The other difficulty might be surmounted by some type of insurance scheme whereby prospective patients should pay a small amount—£10, £20, or £30—towards the capital expenditure, not in the hope that they might go into the hospital, but in view of the possibility of going there.

Dr. R. D. MOTHERSOLE (Bolton) also supported the motion. He suggested that, to make the meaning clearer, after the word "homes" the words "so that they may receive the attention they require while still remaining under the medical care of their own private practitioner" should be substituted for the remaining words of the motion.

Dr. CHRISTINE MURRELL (Kensington) agreed to accept this alteration.

The Kensington motion, as thus amended, was carried *nem. con.*

Definition of Hospital Benefit.

Dr. R. C. BUIST (Dundee) moved to ask the Council to present a definition of hospital benefit in accordance with the Association's policy. Without such a definition they were largely at sea. Surely, from the medical side, some guidance could be given on this subject. It was important for lay people who had to interpret the policy that some definition should be given by the Council.

Dr. FOTHERGILL seconded the motion, which was carried.

This concluded the discussion on the revision of Hospital Policy, which had occupied the greater part of the day.

THE FINANCE OF THE ASSOCIATION.

The Treasurer (Mr. N. BISHOP HARMAN), in moving approval of the Annual Report of Council under "Finance," said there were certain differences in the accounts as between this year and last. For the several years during which he had had the honour of presenting these accounts there had been a credit balance, but this year there was a debit balance, though it amounted to only £265. This was due to the fact that the Association had met certain items of expenditure as they had arisen instead of putting them aside and calling them "assets," and carrying them forward year after year. Commenting on the income and expenditure account, he referred to the items of £1,141, representing the balance paid to Sir Edwin Lutyens in respect of the main building and of £3,200 paid to the present architect, Mr. Wontner Smith, on account of the work he had done in connexion with the extensions. It would have been quite open to the Association, as in the case of any business company, to include these fees as an essential cost of the building, in which case there would have been shown a handsome credit balance to be carried forward; but since that expenditure was non-recurring, and was of a type that could never be recouped, it seemed better to wipe it off at once as current expenditure. Redecorations were being carried out at the Association's House in London, and money in reserve was being spent in that direction. The reserve account amounted to £39,000, whereas the investments shown in the reserve account amounted to £23,000—the £16,000 representing the difference between those two figures was in the bank. The policy of the Association with regard to its reserve fund had been considered by the Council, and it had been decided to keep it in its present state. In December last the investments represented by the figure of £23,000 were worth £25,000, so that there had been an advance in the value of investments. On the other hand, there was advantage in keeping a certain proportion of the assets of the Association in a fluid state, so that they could be realized and turned into cash at any time and at the shortest notice. Commenting on the growth of the Association's income and expenditure, he said that in 1926 the income was £136,000, in 1927 it was £143,000, and in 1928 it was £151,000; the expenditure for those three years was £134,000, £141,000, and £151,000 respectively. The amount of the subscriptions received had increased by £3,000 as between 1927 and 1928, and the receipts on the *Journal* account had also increased. With regard to the general Association expenses, he pointed to the fact that the Council had paid its subscription to the Association Professionnelle Internationale des Médecins. As to the central premises expenses, the housekeeping accounts were fairly well stabilized. The expenditure on coal, coke, wood, and oil in 1928 was about £100 less than in 1927, that decrease being due to the installation of an oil-fired furnace for the boilers. There had, however, been a very small increase in the cost of electricity and gas. The Library expenses were mounting, and they would continue to mount. The Library account, of course, included only a small portion of the money actually expended on the Library; it did not include overhead and standing charges or the large sums the Association had invested in the new Library stores. The accounts relating to the *Archives of Disease in Childhood* and the *Journal of Neurology and Psychopathology* were separate banking accounts for the two journals run by the Association. There was a small charge upon the Association's funds for their maintenance, but it was agreed by all that the expenditure was proper and justifiable. With regard to the Office Staff Superannuation Fund, he was happy to be able to say that the investments stood very well, especially the later ones. In conclusion, the Treasurer asked the Representative Meeting to approve the bold policy of the Council in wiping off the debts incurred for special services of architects in respect of the B.M.A. House.

Expenditure by Association on Advancement of Science.

Dr. W. GRIFFITH (Marylebone) asked what moneys were expended annually by the Association on the advancement of medical science.

The TREASURER said he was very glad he had had previous notice of the question. It had been asked about two years ago in a rather challenging way, with a hint that for a "wealthy corporation" like the Association very little was so spent. He proposed to indicate the cost to the Association in 1928 of those items which could be ear-marked as being directly expended on the advancement of medical science. First of all, on direct research work, the subsidizing of individual research workers, the Association spent in scientific grants, research scholarships, and on various other grants and prizes, the sum of £1,430. No scientific society, moreover, could live without a library; it was part of the necessary equipment of the research worker. The cost of the Library was £1,825. No scientific society could live without circulating information among its members and publishing the results of the work it did and of the work done by others in other fields, and therefore the Association maintained a *Journal*. The costs of the *British Medical Journal* had been divided according to whether they represented pure medical science, the social side, or the organization side of the Association's work. The *Journal* expenditure amounted to £60,000, of which £28,580 was directly attributable to the advancement of medical science. Some of his colleagues had demurred at the smallness of that estimate, but he preferred to be on the safe side. The Association undertook some collective work represented by such organizations as the International Medical Sea Code Committee and even, he might add, the Psycho-analysis Committee, and those committees for the advancement of medical science cost the Association £705 net for direct expenses, excluding over-

head charges. The Branches and Divisions did good work in teaching and spreading the knowledge of medical science, and the head office subsidized lecturers to go out into the highways and byways and spread knowledge. If £1,000 were credited to the Branches and Divisions, and £450 added for the British Medical Association Lectures, one obtained a total of £1,450. The two specialist journals already mentioned were issued at a cost of £144. The Association subscribed to other scientific societies and sent some of its members as delegates, and that entailed a small cost. Altogether, the Association spent at least £35,000 every year from its income in the direct cause of the advancement of science. That £35,000 did not include the necessary cost of maintaining the House and staff. If such things were added, it would mean the Association, year by year, spent wellnigh half its income on the advancement of medical science. (Applause.)

Dr. F. C. MARTLEY (Kensington) congratulated the Treasurer on the excellent result he had shown, and thoroughly endorsed the way in which he had paid his debts, instead of saying he had £5,000 in his pocket which was not really there. At the same time he thought what the Treasurer had introduced was open to a certain amount of friendly criticism. The report gave a full account of what had happened in 1928, and, for purposes of comparison, a résumé of the position in 1927, which, however, did not altogether agree with the accounts for 1927 as passed at the Representative Meeting the previous year. No doubt the Treasurer could give a satisfactory explanation, but to say the 1927 accounts as printed this year represented the accounts as passed in 1927 was wrong, and he hoped in future that would not occur. A second point was that the Association paid £1,000 a year to some insurance company in order to receive a lump sum in so many years' time. That was bad finance. It brought in about 3¼ per cent. compound interest, whereas if the money were put into good loans or securities maturing about the time when the money was wanted, 4 per cent. could be obtained. That would make a difference in interest of about £8 a year, but it grew every year. In five years the Association would have lost £100, and in ten years £400. He noticed the Office Committee received fees to the amount of £94 10s. He thought the sums received by members of the Council should be stated somewhere. While not objecting to their receiving the money, he thought it would be a safer policy if no committee was paid. Alternatively, if one was paid, they should all be; but it was preferable to have no payment at all to members of committees.

Mr. E. B. TURNER, referring to the payment of the Office Committee, said it was on his proposal (which was carried almost unanimously by the Representative Meeting some years ago) that it was started. The Association rejoiced, and had always rejoiced, at the enormous amount of voluntary, unpaid work that was done for it, but the Office Committee was in a different position from the others. It was thought the headquarters work of the Association would proceed more smoothly and efficiently if a committee were appointed which would take in hand the co-ordination of that work, and which would act in much the same way as the directors of a commercial organization. It was not thought right, however, that gentlemen who were already giving an enormous amount of their time voluntarily to the Association should put in extra and responsible work, which would conduce to the good of the Association and be for its pecuniary benefit, without receiving some small honorarium which would compensate them to some slight extent for the additional time and trouble they were spending. The work of the committee had expanded greatly since then, and in his opinion they were even now most inadequately paid for their attendances.

The TREASURER pointed out that at the Representative Meeting of last year it was intimated that the members of the Office Committee, apart from the senior permanent officials (who received no fees for this work), were quite willing to relinquish the fees if the meeting so desired, but the Representative Body had declined to take that course. The cost of the committee's work had fallen from £284 in 1920 to £94 10s. last year. With regard to the sinking fund, he thought Dr. Martley had overlooked the question of income tax—3½ per cent. without deduction of income tax was better than 4 per cent. less tax. The reason why the accounts for the present year did not agree with those for the previous year was that the figures in light type had been made comparable with the current year's figures. The details were shown in the third abstract in Abstract B. It had been rightly pointed out to him that in his estimate of the scientific expenditure he had omitted to add in the figures for the sum expended upon the scientific sections of the Annual Meeting, which was no small amount.

The motion was carried *nem. con.*

"BRITISH MEDICAL JOURNAL."

Sir ROBERT BOLAM, chairman of the Journal Committee, brought forward the Report of Council under that heading (*Supplement*, June 29th, p. 250). In moving its approval he pointed out that there had been a steady increase in the popularity of the *Journal*, in spite of criticisms which were naturally made from time to time. He would not anticipate a motion to be put forward by Edinburgh and Leith. The present was the first full year in which the *British Medical Journal* had been working under its new Editor. The *Journal* had not lost its position, but had distinctly and steadily gained. (Applause.) It was no small achievement for the present Editor to have been able to maintain the position reached by Sir Dawson Williams, with all his years of accumulated wisdom and experience, and with all his vast personal influence. That was a matter of great congratulation to the Association and to Dr. Horner. (Applause.) There had been certain changes with regard to the editoral staff. These had not yet been stabilized, but it was hoped to present a definite plan with regard to the staffing of the *Journal* by next year. Efforts had been steadily made to improve the quality of the periodical, but there were difficulties which no doubt his friend from Edinburgh would emphasize. One most gratifying feature was the way in which the advertisement revenue had expanded. That was the department which Mr. Ferris-Scott particularly looked after, and was a criterion of the success in the eyes of the public of a journal of that kind. The revenue from advertisements was unequalled by that of any other periodical of a similar type. Another indication of the popularity of the *British Medical Journal* was the volume and the intensity of the correspondence evoked by the material published in its pages. He was certain that the number of men who carefully read the *Journal* had increased out of all recognition in the last fifteen years. They read not only the literary matter, but the advertisements as well, and frequently called to task those responsible for publishing many of them. An increasing effort was being made to exercise supervision over the kind of advertisement inserted and over the nature of the claims made by the advertisers. Steadily, slowly, carefully, the censorship was being tightened. The subsidiary journals were gradually improving their position, and as they became more popular he trusted that the Association would authorize more and more expenditure until they attained a perfection such as the men who conducted those special journals desired. (Applause.)

The motion was carried.

Mr. DAVID LEES (Edinburgh and Leith) moved that steps be taken to improve the illustrations to scientific articles in the *British Medical Journal*, and also to make the *Epitome of Current Medical Literature* more extensive and comprehensive. He was of opinion that the illustrations in the *Journal* fell short when compared with some other publications. It might be said that the *Journal* got many more contributions than it could publish, but he believed that a better type of article and more variety would be forthcoming if the illustrations were better produced and the paper was better. Better paper would cost more, but the cost would be well worth while. From figures given in the financial report he gathered that on the average each member paid every year £2 7s. 11d. to the Association. In 1927 8s. 2d. per head was allocated to *Journal* expenses, and in 1928, 7s. The *Journal* was sold at 1s. 3d. a copy to non-members. Rather more expenditure on the *Journal* would be well worth while. It would attract the newly fledged graduates to the Association. Medical practice

every year became less an art and more a science, and to keep abreast of science was almost impossible, but here members looked to a first-class journal for assistance. He suggested ways in which a more comprehensive Epitome might be obtained.

Dr. C. E. DOUGLAS endorsed these remarks. He felt, on a comparison of the *Journal* with some other medical periodicals of the world, that there was room for improvement in respect to format, type of paper, and quality of illustrations. The great importance of this matter was that it was the *Journal* which helped most of all to maintain the Association. The average general practitioner perhaps took little interest in the general work of the Association; his interest was in the *Journal*, which he read and studied. He was entitled to a better *Journal*, which could be produced if money were spent upon it.

Dr. R. K. FORD (Preston) said that the *Journal* was one of which the Association might genuinely be proud, but with regard to the Epitome, he felt that this might be more complete, and for his part he was inclined to go beyond this motion, and to ask that the Epitome be published annually as a small pamphlet at a price sufficient to cover the cost. Members often wanted to look up things. What he would like to have, if possible, would be an annual publication of the Epitome, with an exhaustive index, in order that one might follow the subjects of importance from year to year and not have to depend upon memory. In conclusion he said he would like to thank those responsible for speeding up publication of the reports of the scientific sections which was promised last year at Cardiff.

Sir ROBERT BOLAM, in reply, said that if the Representative Body would be satisfied, and Mr. Lees would be satisfied, with putting the resolution in a slightly less mandatory form, then he thought there would be no difficulty on the part of anyone accepting it. If they were to pass it in its present form they were telling the Journal Committee, through the Council, to do certain things without having quite all the data in front of them; without knowing, in fact, whether those things were entirely possible, or, if possible, entirely advisable. The committee welcomed the criticism that had been made, but he would like to put before the meeting one or two points. They published every week roughly 40,000 journals. If they were to have their *Journal* every week at the appointed time, it was necessary that the 40,000 copies be run off at great speed. The *Journal* had to go to press at a certain hour every week, and within a very short time indeed they had to get the journals into the post to reach the subscribers in every part of the country. The production of 40,000 copies was a very different matter from the production of 8,000 or 9,000. If the circulation of the *Journal* were only 8,000 or 9,000 it could be printed upon flat-bed machines, on different paper, and the illustrations could be improved. It was necessary to use rapid rotary printing machines, and to print from stereotype plates. For this purpose the best machinery possible was used, and the best and most expensive ink recommended by the expert, and the best quality of the only type of paper which could be used in these machines. Those difficulties could not be overcome. It might, of course, be possible to issue a supplement dealing with current matters, and also to issue for other matter something like the journals which had a much smaller circulation; this could be printed on material approaching the quality of art paper, with the best illustrations. But it would not be the *British Medical Journal* as it was known at present. It was necessary to hold the balance between providing current material *plus* scientific matter to a very large number of subscribers in a definite time, so that it would not be behind its competitors, and providing a highly polished publication which would meet the requirements of everybody who wanted their scientific material nicely printed and nicely illustrated. The *Journal*, as provided in years past, had been an ephemeral publication; it was not a periodical of the type that the majority of people would bind and keep for certain articles that it contained. How many of the members of the Association could really bind and keep the *Journal* in their houses continuously? They could not treat it as they would treat, for instance, the journals of bacteriology or physiology or pathology, which were printed at leisure on the best paper, and contained the best illustrations. The Association's *Journal* represented a compromise. With regard to its contents, members had pleaded eloquently—and they had his sympathy—for a more excellent Epitome. The Epitome consisted usually of four pages, but at intervals it extended to six, and it could be extended further, but if that were done, quite a large number of members would say, "We are not really interested in the Epitome; what we want are the original full articles," or "What we are interested in is the *Supplement*, and we would rather have that than anything else." The Journal Committee catered for an extraordinary variety of opinion in regard to the contents of the *Journal*, and the members of the committee were doing their best to hold the balance. They welcomed the criticism that had been made. If Mr. Lees, however, would agree to alter the wording of his motion, to provide that the matter be referred to the Council for consideration and report, Sir Robert Bolam felt sure that the meeting would vote for it.

Mr. DAVID LEES, expressing his readiness to adopt this last suggestion, said the motion was put forward simply out of a desire to raise the *Journal* to a higher pinnacle than that which it occupied at present.

The motion by Edinburgh and Leith, modified in the manner suggested, was carried, and the report under "*British Medical Journal*" was approved.

THE ASSOCIATION'S BUILDING.

Sir ROBERT BOLAM (Chairman of the Building Committee) moved on behalf of the Council that the Supplementary Report of Council under "Building" (*Supplement*, June 29th, p. 257, para. 202) be approved. He pointed out that considerable progress had been made with regard to the new building since the report was drawn up, and at the time of speaking the completion of the centre block was within measurable distance; indeed, in the course of about six weeks the builders would have completed their task, and the Association would have a dignified and worthy building which, in the course of time, would house any of its own extended activities or those of kindred and affiliated bodies, and which in the meantime, he trusted, would provide a return on the capital expended in the way of rents for spaces let to approved bodies. He believed it would be agreed that the Association had spent its money wisely and well. It could safely be said that the architect who was entrusted with the drawing up of the plans had designed a very handsome structure; even in its unfinished condition it had been the subject of very gratifying comment. In conclusion, he invited criticism or questions.

Dr. F. J. BAILDON asked if there were photographs or illustrations available for inspection, particularly for the benefit of those who did not live in London. Sir ROBERT BOLAM replied that there were in Manchester certain photographs showing the progress made up to the present time, and these were to be shown at the Exhibition.

Dr. GOODBODY asked whether a fire which had occurred a few days ago at the building had caused much damage. Sir R. BOLAM replied that the fire had originated from a tarpaulin, used by the sculptors on the face of the building to prevent the stone chippings falling into the street below; this was ignited by a spirit stove used by the men for cooking, and there was an extraordinary blaze within a few seconds. The cornice had been blackened, and until it was cleaned the extent of the damage could not be determined. One split had been discovered, but under the terms of the insurance the Association would be able to restore that, so that eventually there would be nothing noticeable.

SALARIES OF WHOLE-TIME PUBLIC HEALTH OFFICERS.

Sir ROBERT BOLAM gave a report on the conclusions reached in the series of conferences between representatives of the British Medical Association (on whose panel there were included representatives of the Society of Medical Officers of Health) on the one part, and of local authorities on the other. Under Lord Askwith, who had

acted as independent chairman, certain recommendations had been agreed to for presentation to the Representative Body and to the associations of the various local authorities. The terms of the agreement are published in the *Supplement* this week at page 71; they were arrived at too late for inclusion in the Supplementary Report of Council. Explaining the course of events, Sir R. Bolam said that a good many years ago the Association had endeavoured to agree with local authorities on a scale of remuneration for medical officers who worked in the public health service. The first attitude of the local authorities throughout the country had been, "We are masters in our own houses, we dispense the salaries of the public health servants, and we will be the arbiters of the salaries and conditions of service of these gentlemen." That, of course, was a very laudable ambition, but there was such a thing as a market—the supply which followed a reasonable demand—and the Association had approached the local authorities with a suggestion that they would get better service, and a more contented staff, if they would put into writing the terms and conditions under which they were inviting medical men to serve. If such a schedule were arranged, and the Association felt that it could honestly recommend such conditions of service to the profession, then the local authorities would get a better supply of better men. If the conditions were not such as could honestly be recommended to young graduates desirous of entering the public health service there were many other avenues in the profession which they could enter, and local authorities would not get the type of people the Association thought the public health service ought to command. The local authorities did not see eye to eye with the Association in the matter, and after a considerable number of discussions only one body—the Association of Municipal Authorities—really felt that what was suggested was reasonable. The Ministry of Health also supported the British Medical Association and the Society of Medical Officers of Health. For some years the Association had been working under an agreement which the Ministry, the Association of Municipal Authorities, and the B.M.A. itself thought was a fit thing to recommend, and most of those who took an interest in the subject knew the terms that were suggested. At first some of the other local authorities did not agree to the scale and conditions suggested, and the Association had to combat their prejudices, and to show them that if they would not offer reasonable terms they could not get the proper men, and, indeed, would have difficulty in getting anyone at all. That had in fact proved to be the case. Little by little the authorities had found out that if they wished to have an adequate supply of suitable people they must give something in the nature of the terms the Association suggested. Those terms were arrived at by a consideration of the general earning capacity of medical men and the special conditions of the service, and it was thought that they were reasonable; otherwise they would never have been put forward. Last year the Association was approached by various types of authority outside the municipal authorities, and asked to confer again on the matter to see if agreement could be reached and conflict of opinion avoided, so that all might work to the same end, in the interests of the community, to fill these posts with the best people available for the public service. The Ministry of Health said it would not intervene, and suggested the selection of an independent chairman. The conference had now been sitting for a considerable time, on the one side a panel of the British Medical Association (half of which consisted of members of the Society of Medical Officers of Health), and on the other a panel representative of all the various types of public authorities employing medical men, and under the presidency of Lord Askwith as a neutral chairman. Little by little an agreement had been thrashed out, and the two panels—the medical profession on the one side and the local authorities on the other—had agreed to send to the appointing bodies—the B.M.A. and the various authorities—a document which they thought should meet with general acceptance. Good will on both sides would be needed, of course, but it was thought to represent a reasonable compromise. The various authorities had now this document before them. It had gone to the associations of local authorities, and from them in course of time would go, and had already gone in some cases, to the constituent authorities throughout the country. The Association thought it might reasonably be accepted by them all—not only by municipal authorities and county councils, but in particular by education authorities, which had not been very accommodating in the past. It was also something which enabled the Association to suggest that young men might consider very carefully the advantages of such a service. It was not pretended that the agreement represented the millennium for those entering the public health service. Both the Association and the local authorities asked for a good many things they did not succeed in getting; it was, as he said, essentially a compromise. In putting it forward now he suggested that those who had special knowledge of the subject should criticize it. Those who conducted the negotiations, though they tried to get specialized knowledge, might not have been able to grasp every difficulty that would arise in the course of working such an agreement. He hoped, therefore, the members would point out anything they had failed to achieve and which ought reasonably to be obtained. Having done that, he suggested a general mandate be given to the Council to negotiate on the basis of the document. If a resolution were passed giving general approval of the document and authorizing the Council to continue the negotiations for its ratification, it might be the Council would be able to achieve certain of the things the members might desire, or in any case they would know where the difficulties arose, and the Advisory Committee which it was hoped, under the agreement, to set up might be able to settle matters satisfactorily. In the course of the conference the support of a number of members who took no part in the speaking was of considerable value to those who had to do the talking. Many members came most regularly and gave their support and the benefit of their opinion, men who were not specifically interested in the public health service but who were interested in the balance of affairs in the profession generally. He particularly appreciated the assistance of the members of the Society of Medical Officers of Health, who brought to the conference expert knowledge. The Association was there as holding the balance for the medical profession, and seeing that the public health service obtained its proper place in employment by public authorities, and did not attain a place which was out of proportion to that held by other ranks of the profession. He trusted the meeting would give its general approval to what had been done, and allow the negotiations with the public authorities to be continued, in the hope of getting the document ratified very much in its present form.

Dr. FOTHERGILL pointed out that the document had only been in the hands of members for two or three days, and asked whether the Association's representatives at the conference were in a position to consider the suggestions he had put forward, and other points which might emerge in the discussion.

The CHAIRMAN expressed sympathy with the difficulty felt by Dr. Fothergill. He drew attention to the procedure indicated on the agenda paper. Clearly there must be some further indication of what was to be proposed in the document. If the motion actually before the meeting were carried, all that was adopted was to be found in the short paragraph at the top of the second column on page 253 of the *Supplement* for June 29th. He would suggest that Sir Robert Bolam be asked to consider what further proposal he desired to make by the next morning. He was sure that no member would desire to propose any question which would embarrass Sir Robert, to whom the profession owed a debt which could never be paid. (Applause.)

Dr. CHALMERS asked whether the committee had in view the position in Scotland in consequence of the new Act.

Sir ROBERT BOLAM said that he was in a difficult position technically. If the resolution on the agenda were passed the meeting would in fact have passed the document. But in substance what he would move on the morrow was a simple resolution that the agreement set out in the document be accepted.

The CHAIRMAN thought this would make the position perfectly clear.

The session concluded at 6.30 p.m.

Saturday, July 20th.

The meeting resumed at 9.30 a.m., Dr. HAWTHORNE again in the chair.

The discussion on the report of the conference on the salaries of whole-time public health medical officers was resumed.

Sir ROBERT BOLAM moved the following:

That the agreement set out in the document before the meeting be accepted.

Dr. FOTHERGILL wanted it to be "generally approved" rather than accepted. Sir R. BOLAM said he feared that that method could not be adopted. This was an agreement which had been arrived at after long discussion with the local authorities. It must be either accepted or rejected. It could not be tinkered. It was competent for any representative to make comments or criticisms, and he would do his best to meet such. He must ask representatives to keep to the position taken up by those negotiating on their side in the conference. The negotiators had said, "We are empowered by our Association to come, if possible, to an agreement with you." They had done so, and he must press the meeting to accept the agreement as it stood. Many of the criticisms could be met by explanation from those who had been in the deliberations from the beginning.

Dr. D. F. TODD (Sunderland) said that in his own area a whole-time medical officer was appointed and took on the duties of a workhouse and hospital, and they were warned about the salary laid down; then the Council said that it did not come under that heading. Would such appointments as that come under the comprehensive salaries laid down here?

The CHAIRMAN said it was manifest that the document was presented either for acceptance or rejection, and therefore he was obliged to rule that amendments seeking to alter the terms contained in the document would not be in order.

Mr. E. W. G. MASTERMAN (Camberwell) considered that a great debt of gratitude was due to the committee and to Sir Robert Bolam in particular. Certain medical officers—he was speaking now particularly about hospital work—had a greatly improved position. They had not only got an agreement to give them a salary above what had been offered for similar positions, but, what was so extremely good, there was an undertaking that on April 1st those below that salary were going to be brought up to it, and if that agreement was carried out it was an unexpectedly satisfactory thing. At the same time there were one or two points of criticism. Men in charge of the smaller hospitals were much more favourably placed than before—£750 working up to £1,100 was quite a good minimum—but there was a ragged end to this arrangement, and that was with regard to those who had the largest type of hospital, from 750 beds upwards. These men, unlike the others, had no promise of increase whatever. All the men below that were promised an increase of £50 every two years until they worked up, in the case of the men with smaller salaries, to 25 per cent. above their beginning salary. The man who began with the largest type of hospital—750 beds and upwards—and started at £1,100, had no promise of increase until after four years, when he might apply to the local authority. The speaker did not think that was quite just, and it was very discouraging to the man in that position because, after all, these increments were things which made the positions most attractive—though, perhaps, if he came under a local authority he would not commence with that minimum salary at all. Another point not allowed for in the scale was the extra duties over and above the hospital superintendent's appointment. When the scale was considered years ago it was stated that extra duties should be paid for. In London most of the superintendents, in addition to their own hospitals, would have institutions converted into infirmaries for the chronic sick. This was not mentioned at all in the scheme. There was another curious point, which he did not wish by any means to be thrown out, that the medical superintendents were to have a salary with housing accommodation "and board." The number of medical superintendents who got board must be very few. He would suggest that the words "board or its equivalent" be added. He thought they should all be pleased with the arrangements for the assistant medical officers.

Dr. MIDDLETON MARTIN (Gloucestershire) said he knew the attitude of the County Councils Association very well, and he could not but think that to achieve an agreed document of the kind the members had before them was a marvellous piece of work on the part of any conference. There was one point to which Mr. Masterman had referred which was of the greatest importance to himself and colleagues, and that was the provision made for the existing medical officers of health in a way never done before. He was convinced that Sir Robert Bolam was absolutely right in pressing the members to accept the agreed document. It could not be altered in any way, because it had been circulated among the local authorities. If there was any dotting of the "i's" or crossing of the "t's" it would probably prejudice the position with these bodies.

Dr. J. T. D'EWART (Manchester) said he stood on the platform in a position he had never occupied before, and that was to praise the Council. (Laughter and applause.) Some of the members who had been to the Association's meetings in years gone by would know that on various occasions it had been his painful duty to point out to the Council its deficiencies. (Laughter.) He would like to take an opportunity of thanking the Council for the good work it had done; but the work was not yet finished, it had only begun. He was sure the representatives were extremely grateful that all the junior members and the lower paid members of the hospital and public health services were being put on a salary basis which could be considered an adequate commencing one. That was an enormous improvement. He was glad that the junior members were to receive an adequate reward for their services at the commencement of their service. He could only express the hope that, before some of them quite reached the sere and yellow leaf they might likewise receive the consideration which their junior brethren had attained. The members were very grateful to the negotiators for the way they had handled an extraordinarily difficult subject; only those who had had anything to do with it knew how difficult the work had been. He looked to them with gratitude for favours to come.

Dr. A. K. CHALMERS (Glasgow North-Eastern) said no other medical officers had the opportunity of appreciating the work of Sir Robert Bolam's Committee so much as those in Scotland. From their point of view the report was to be heartily approved. But the important point to keep in view was that the report dealt with a condition of things which was rapidly changing, more especially in view of the prospective application of the Local Government Acts of both countries. There were many illustrations in England of education authorities being completely detached from public health organizations, and probably relatively more in Scotland. While in both countries the Poor Law medical service was completely detached at the moment from public health, in the future all that would be changed. He thought that, while approving the present report, the committee should be asked to keep a watching brief on such additions to the public health services as the bill contemplated. If the public were to get full advantage of recent advances in medical science it could only be through a very considerable extension of hospital accommodation, and unless the new legislation materialized in that direction in the future the public would lose a great part of what the Local Government Act contemplated. He said that Dr. Brackenbury had drawn his attention to the fact that this matter had already been under consideration by the committee [vide Section X, paragraph (3), of the report]: "The Advisory Committee shall not be precluded from considering the cases of chief medical officers of counties and county boroughs whose duties and conditions of service may be altered materially as the result of legislation." This contemplated the very thing that he had been asking.

Dr. H. W. POOLER (Chesterfield) asked what was exactly the difference between a resident medical officer (in Section I) and a medical superintendent (in Section IV). It seemed to him that there were certain types of medical officers in

Poor Law infirmaries of the smaller class who might be called, by public authorities, either medical officers or medical superintendents, according to whether the public authorities intended to pay them good salaries or not. To illustrate the point, he recalled that about three years ago the Chesterfield Division had had to deal with an appointment at the Chesterfield Workhouse Infirmary, which contains just over 100 beds. Previously it had been officered by a visiting medical officer—one of the local practitioners—at a salary, he believed, of about £150 a year. Owing to a dispute, however, the visiting medical officer had resigned, the practitioners of the town had resolved not to take the appointment, and the guardians, therefore, had been forced to consider the appointment of a whole-time resident officer. They had advertised the post, and the Division was called upon to decide whether this was a position for which a medical practitioner ought to apply. Headquarters were advised both as to the position and the salary; they had seen no reason why the position should not be filled, but were unable to give any help with regard to the salary because at that time there was no agreed scale. Eventually the guardians had offered the post at a salary of £450 a year, with board and lodging, and it was adequately filled. The medical officer appointed was in the infirmary alone; he had full charge, he could operate if he liked—as a matter of fact he was sending patients for major operations into the local hospital. Was he a resident medical officer (under Section I) or a medical superintendent (under Section IV)? In order to decide in a case such as that a little more elucidation was necessary.

Dr. H. KERR (Public Health Service representative) paid a tribute to the work done by the Council in negotiating this extremely good arrangement. It did not by any means embody all that the whole-time medical service would like to see, but it looked for further favours to come. To Sir Robert Bolam particularly he offered thanks. His diplomacy and finesse had evidently established that confidence with the local authorities' representatives which he inspired in all negotiations. There were two classes of medical officer, continued Dr. Kerr, whom he did not think had been referred to. The first class embodied the medical officers of sanatoriums of less than 150 beds; these men were not only physicians, but also administrators, and their administrative duties were even more pressing than their other duties. Their duties were difficult and trying, and they were in every sense of the phrase whole-time servants, because they were on duty from early morning until early morning, and were never free from worry and anxiety. He urged that particular attention should be devoted to their interests in any negotiations entered into under Section 10. The other class to which he drew particular attention was the class of district medical officers of the Poor Law who might be appointed as whole-timers, and presumably they would be appointed by the health departments and would come within the category of "medical officers employed in departments." The tendency was to appoint such men at very miserable salaries indeed, and to make them the district medical officers under the existing boards of guardians. Dr. Kerr urged that these also should be remembered particularly.

Dr. J. R. GILLESPIE (Belfast) joined with previous speakers in thanking the Association for the work it had done to improve the position of whole-time medical officers. He was employed by a county council, and the council was offering a salary of £450 a year to an assistant for him. He asked whether, if this Representative Meeting approved of the recommendations contained in the report, it would be proper for him to inform his council that it could advertise within the terms of this agreement.

Dr. T. EUSTACE HILL (Public Health Service representative) also acknowledged the valuable assistance given by Sir Robert Bolam in connexion with the negotiations. Not only had Sir Robert exercised extraordinary tact and persuasive powers in dealing with the opposition of the local authorities, but also in dealing with certain of the medical officers of health, who had presented perhaps an even more difficult problem. His difficulties had been very great indeed, because, as had been stated, the Society of Medical Officers of Health, as a body, was not absolutely satisfied with the results, though it realized that very great progress had been made towards the end which its members so much desired. The difficulty with regard to medical officers of sanatoriums was one of the most serious blots in regard to the results of the negotiations, because the officer in charge of a sanatorium with less than 100 beds apparently came within the first section, and might be appointed at £350, with emoluments. In Durham there were two sanatoriums, each of 80 beds, and they were paying approximately £800 a year. The officer in charge had to run the whole sanatorium, and was responsible for the administrative work; in a sense he was more responsible than a medical superintendent of a larger sanatorium having one or two assistants. Dr. Hill hoped that in time that position would be rectified. He also expressed thanks to the Scottish members for having arrived at a scale of from £500 to £700 for assistant medical officers; that was better than starting at £600, with no prospects of anything more. It had been adopted academically in Scotland, and he hoped the Scottish representatives would see that it was applied definitely there. The medical officers of health were grateful to the Association for the active part it had played in the negotiations, which had resulted in very satisfactory progress being made. He hoped there would be no serious amendments to the report as it stood; the job was a very ticklish one; some of the associations concerned with salaries were by no means convinced that they had achieved what they ought to achieve, and there would still be opposition, and if serious amendments were made to the report new problems would arise which would render the final solution more difficult.

The CHAIRMAN OF COUNCIL said the agreement, as it stood, had to be accepted not only by the Association, but by several associations and local authorities, and if there were a chorus of approval of too pronounced a character at this meeting it might be regarded as an indication that the other authorities had made a bad bargain and had again been beaten by the British Medical Association, whereas, as a matter of fact, this document was essentially a compromise document, giving the results of negotiations in which the representatives of the Association had done the best they could and had secured all that could be secured. The same would be said on the other side, and it must be recognized that, although he hoped the meeting would be satisfied to adopt the agreement unanimously as an agreement negotiated in those circumstances, it would not do to leave the impression on the minds of local authorities that it was an agreement which the members of the Association would wish to have if they had had their own way. Secondly, he pointed out that the position with regard to the particular class of medical officers in sanatoriums of less than 100 beds had been argued very definitely, and the effort had been made to have their case dealt with specifically in the agreement. In the result, however, it had been necessary to take note of the admissions on the other side, and it was one of the matters which would go before the Advisory Committee, with the sympathetic consideration of the local authority representatives on that committee. The Association could not at the time get a specific clause in the agreement which covered exactly all the points. He was surprised to find Dr. Kerr had mentioned district medical officers in connexion with the proposed scale. It was true that in some half-dozen places there were whole-time district medical officers under boards of guardians, but the Representative Meeting last year laid it down emphatically that district medical officers doing domiciliary work should in no circumstances be whole-time officers, and therefore it should not be suggested that they might come under the scale in question.

Dr. G. CLARK TROTTER (Council) paid a tribute to the excellent work done by the committee, but called attention to a weakness in paragraph (3) of Section VI, which reads:

"No scale of periodic increments for Medical Officers of Health has been formulated, on the understanding that employing local authorities will give suitable increases for capability and length of service."

That was in the nature of a pious hope, and required strengthening. In the case of medical officers of health

who started below the scale but had now reached it there would be a tendency for the scale to be regarded as a maximum and for them to get no further increments, whereas those who began at the minimum shown would probably receive such increments.

Dr. D. KIRKHOPE (North Middlesex) said the Local Government Act, which came into operation next April, enabled county boroughs and county councils to delegate a great many of their powers in health matters to subordinate authorities. Paragraph (3) of Section X of the Agreement reserved to the Advisory Committee the power to recommend that the case of chief medical officers of counties and county boroughs should receive consideration in the event of their duties being increased. He thought it desirable that the medical officers of subordinate authorities to whom health functions were delegated should also receive adequate consideration.

Dr. J. HUDSON (Newcastle) thought the tendency to have whole-time men doing domiciliary work was increasing, and instanced the case of a young man in his area who, starting by spending half his time in a district and half in hospital, had lately taken on a second district and might, if a third district fell vacant, take that over too. The Association had recommended in a half-hearted way that that sort of thing was undesirable, but he did not think any penalties against it had been provided. So far his Division had done nothing in the case of the young man to whom he had referred, but he suggested it would be well for them to condemn the practice in question.

The CHAIRMAN said that though, *pace* his ruling already given, Dr. Fothergill could not move certain amendments, copies of which he had sent in, there was nothing to preclude him from basing arguments upon them for the acceptance or rejection of the report, and he wished to apologize for not calling on Dr. Fothergill earlier.

Dr. FOTHERGILL said he felt somewhat diffident about criticizing the agreement, as it was said that the medical officers' service liked it; but there were some points to which he wished to draw attention. Paragraph (3) of Section II, for example, provided that the salary of medical officers employed in departments should be brought into line with the new scale, and he would like to know why the other groups of medical officers were not similarly favoured. Secondly, there were notes at the end of Sections I and III which he thought should be embodied in the conditions as paragraphs, and not printed in the form of notes. Council members would appreciate the point. It seemed to him that paragraph (3) of Section IX placed a medical officer who was married in a peculiarly good position as against his colleagues who were not. It provided that if the authority wished to get rid of him in future for any lapse of conduct, that must be stated in the original advertisement on which he was engaged. He had ventured to put forward a new draft for that paragraph. Section X, paragraph (3), said "The Advisory Committee shall not be precluded from considering the cases of chief medical officers of counties and county boroughs," etc. He did not see why they should be precluded from considering the case of the medical officer of any area if occasion arose. As a member of Council he had seen two great troubles looming before the profession. One had been what might almost be described as the animosity between general practitioner and public medical officer, and the other was the unfair treatment of the public medical officer by the State. His experience during the last few months, not only in his own area, but by reports which reached him from all over the country, was that an extraordinary spirit of sympathy and co-operation was developing between the public medical officer and the general practitioner under these schemes. That was for the good both of the profession and of the public. He welcomed the scheme as providing equitable and fair treatment for that part of the profession with which it dealt, and he thought it would be for the good of the public health generally.

Dr. R. K. FORD (Preston) reiterated certain questions asked by Drs. Masterman and D'Ewart. One applied to the extra duties which were likely to accrue to a medical superintendent of one of the transferred hospitals. Under the larger authorities the additional duties would probably be comparatively light, but under the smaller authorities there would be considerable numbers of duties additional to the institutional work. Thus the medical superintendents of the present Poor Law institutions, which would become State hospitals if the law came into force, would also probably have to be medical officers of children's homes and other institutions, and would have to undertake other duties of an advisory nature. One question, therefore, which he wished to press was whether those other duties were to be remunerated or not. A second point on which he was not clear was that there appeared to be no provision for people who were getting the minimum scale of £750 a year for considerably higher duties. He cited the case (imaginary, he hoped) of a man with a hospital of 500 or 600 beds who was getting just the minimum salary of £750. He was not clear that the agreement provided for any more than his commencing his increments at once, provided he had not had an increment for more than two years. He appealed to the Divisions to take more interest, not only personally but medico-politically, in that kind of work. He had had a hospital with over 170 beds some years ago. There he had had the house, the mental cases in addition, and a district built up by the abolition of four part-time districts comprising twenty-seven square miles and a county borough in the middle and a rural district round. He had received £500 a year and a house of a not very elaborate nature, and he did not even get a travelling allowance for a car. That kind of thing was absolute slavery, and he asked the body of the Association to back the Council up with the agreement in trying to get it enforced in the Divisions. (Applause.)

Sir ROBERT BOLAM, in reply, said that Dr. Brackenbury had dealt with one or two matters in regard to the district medical officers in a way which solved the questions put in that regard. Dr. Todd's query was really solved by certain resolutions of policy which appeared in the *Handbook* on pages 154 and 155, to the effect that no medical officer of health or school medical officer should accept a new appointment involving fresh duties unless adequate remuneration was added to that he previously had, and that it was inadvisable that the medico-legal work or other duties not concerned directly with the duties of whole-time health medical officers should be accepted by them, and also that the new legislation would remove a great deal of the possibilities in the direction where Dr. Todd feared trouble. The position represented by Mr. Masterman on behalf of the officers of some of the larger institutions was not quite so simple. Still, it seemed perfectly clear that if, in fact, a medical officer in any one of those classes was shown to be doing things not strictly applicable to the definition of his class, obviously that was a case which might be represented to the Advisory Committee and thrashed out with the local authorities, and he felt that any reasonable local authority would do what was right. Beyond that he did not think they could go. Dr. Ford had also put a special case of much the same nature, and the same reply, he thought, would suffice for him. If it were shown that there were duties outside any particular schedule it would be a matter for investigation and discussion. That was the great benefit of the Advisory Committee which they had managed to obtain. As to Dr. Chalmers's query in regard to the changes made by the 1929 Act, that was adequately answered by the reference which Dr. Brackenbury had made. The question of the sanatorium officer was one which he had pleaded with all the force at his command before the local authorities, but it was so difficult that all that could be obtained was that there should be the power of reference and discussion, and in order not to hold up the other sections of the agreement the negotiators had been forced to consent merely to the reference to an Advisory Committee, and it was hoped that that reference would have a successful issue. Several members had raised the question of emoluments for those who were in office, as to why the clause which applied to the junior officer should not have been applied in its entirety to all classes. The answer was that they had been beaten absolutely on the question of applying to every class such a clause as Dr. Fothergill desired, and there was undoubtedly some reason behind the contention of the authorities that on the appointed day to raise all

salaries, sometimes by extraordinary amounts, was an inconceivable thing to them. It had been a fight all the way through. He did not pretend that the issue was to his satisfaction, or that he had achieved all he had hoped. But there was something to be said for cultivating an atmosphere in the public interest between the authorities and the profession, and to achieve that he was willing, and he was sure the officers of the public health service had shown themselves willing, to agree to something less than ought to be obtained, in order to get on peacefully with the work at a time when that huge legislative enactment, the Local Government Act, 1929, was beginning to make itself felt in the land. He was sure that the public health service would be fully employed in dealing with the contingencies that arose under the new enactments. There would be many points which the Advisory Committee would be called upon to discuss, and in order to get elbow-room and peace to discuss those things they had given away perhaps something in the way of conditions of service and remuneration for a complete scheme in order to attract young good men and women to the service and to try and do good work for the public. It was on those lines that they had tried to achieve agreement. There were one or two points in regard to Dr. Fothergill's criticism. The speaker and his colleagues had fought hard to have put in front of the Advisory Committee everything that might arise, even to the smallest contingency from the legislation which had just been passed and from legislation which might come in the future. The authorities did not want to be continually revising the agreement in essential points. The members of the committee agreed on behalf of the Association that they should be bound for five years, and that the only matters to be discussed were matters of major importance which legislation might bring about in regard to the terms and conditions of a man's service; and that was the utmost the committee had been able to get an agreement for. Dr. Fothergill would appreciate that, in putting down those paragraphs, they had had particular thought to the case of the woman practitioner who married while in the public health service. It was not likely that local authorities would seek to enforce a penalty on a man who married whilst in the public health service, although it was quite possible in the terms of the wording to bring something of that kind about. He thought if any authority was foolish enough to do that it would receive sufficient castigation at the hands of its own community. It was done in the interest of those women practitioners who in some cases, when they married, had received hard treatment at the hands of local authorities. In answer to Dr. Kirkhope's point, he did not think there was any real case of delegation such as he anticipated; he did not think the contingency would come about. In conclusion, he said the position was perfectly clear. He thought they were ratifying an agreement with the members' approval—not unqualified by reservations in their own minds as to its propriety—which on balance would give peace and quietness, and furnish them with an opportunity to see whether in the next five or six years the terms were such that it would give this country a public health service such as it ought to have. He hoped in that mood they would remit it to the Council, setting their seal upon it, and if the local authorities saw fit to accept it in the same spirit then the Association might set to work to do good business. (Applause.)

Dr. GILLESPIE asked whether Sir Robert Bolam had answered the question he had raised.

The CHAIRMAN OF COUNCIL said the point was whether, now they had given this agreement their approval, the ordinary office procedure of important notices and disciplinary procedure was to continue. This agreement had been accepted by the Association, but it had not yet been accepted by the local authorities. The existing state of affairs remained in force until April 1st next, and even then would stand if the present agreement was not accepted by the other parties to it. As to whether, in those circumstances, it would be advisable to take disciplinary measures would be for each Division to determine for itself.

The motion before the meeting: "That the Supplementary Report of Council under 'Conference *re* Salaries of Whole-time Public Health Medical Officers' be approved, and that the agreement set out in the document before the meeting be accepted," was carried with two dissentient votes.

MEDICO-POLITICAL.

Preservation of Infant Life Bill.

Dr. J. W. BONE (Chairman of the Medico-Political Committee) brought forward the report under that heading. The first matter to which there was attached a recommendation was with regard to the Preservation of Infant Life Bill, as sent from the House of Lords to the House of Commons. He moved the approval of Clause 1 (1) of that bill, which was set out in the Annual Report of Council (*Supplement*, April 20th, p. 106). He said that this was a matter in which the Association had been interested for many years. The alteration made to the measure by the House of Lords contained a form of words which, the Council thought, was all that was needed.

The motion was carried without dissent.

Medical Practitioners and Road Accidents.

Dr. BONE next moved as a recommendation of Council:

> That the Representative Body is of opinion that, failing the creation of a central fund by some extra tax on motorists or some system of compulsory insurance, including a priority for charges for medical attendance on any claims made, either of which methods would require legislation, probably highly contentious in nature, no satisfactory solution can be devised of the difficulty experienced by doctors in recovering the amount of their charges for treatment rendered to patients meeting with accidents on the road; further, the Representative Body is of opinion that no greater case can be made out for dealing specially with the non-payment of fees incurred by persons involved in road accidents than for those incurred in the treatment of the victims of any form of accident.

This, he said, was a question raised first of all by the Buckinghamshire Division, which was anxious, as they all were, that doctors should receive fees for treating this emergency. It was a misfortune for a medical man to live in the neighbourhood of a great public road in the country, because he was called upon, by day and night, to attend serious motor accidents, and seldom received payment for his services. It was still more unfortunate if he happened to be on the staff of a local hospital, for the injured person might be sent there and remain for weeks or months, and the staff got no remuneration. There were two ways in which the position might be remedied: by an extra tax on motorists, or some system of compulsory insurance, but this was hardly a matter for a body of doctors to initiate.

Dr. C. FORBES (Aberdeen) moved to refer back the recommendation for consideration. The Council had confused the issue by a reference to other kinds of accidents. It had said that road accidents were on a level with all other kinds of accidents, such as domestic or industrial accidents; but in these latter cases he had never, or rarely, had any difficulty in collecting fees. But in road accidents no one was held responsible. He asked the Council to give some more thought to the question.

Dr. J. B. MILLER (Lanarkshire) said he had been asked by his Division to support the amendment put forward by Aberdeen; indeed, the Lanarkshire Division had sent in an amendment on similar lines. This matter was a hardy annual, and this year the Lanarkshire Division was rather astounded at the recommendations of the Council—at least, in so far as they could understand them. (Laughter.) The phraseology was involved, and two hypothetical solutions were put forward, but these were so hedged about with qualifications and safeguards that they were strangled at birth. Indeed, his Division, after reading the recommendations, had felt that the Council had shelved the matter in an avalanche of words. (Laughter.) The problem was a source of annoyance to most practitioners, and the Division felt—particularly after reading the last paragraph—that the Council did not quite appreciate the situation. There was no comparison between a road accident and an accident which occurred in any other place. In an accident other than a road accident one was at least sure of finding an injured person. Describing what often happened in the case of a road accident, he said that the doctor received intimation that an accident had occurred, and that his services were required immediately, but in about 50 per cent. of the cases—and this was no exaggera-

tion—when he arrived on the scene of the accident he found the smiling face of the countryside unchanged. Either the topographical knowledge of the messenger had been at fault, and the doctor had been sent to the wrong place, or the injuries received had been so slight that the motorist had gone home, or perhaps he had been taken to hospital by another motorist. If, however, the patient was still on the scene of the accident when the doctor arrived, the doctor had to attend to him in very difficult circumstances, usually before a crowd, and after he had finished dressing the wounds a constable, who hitherto had remained unobtrusively in the background, would come forward for a full statement of the facts, the reason for the constable's previous modesty being that if he himself had sent for the doctor the police would have been liable for the fee. It had been suggested that the only remedy was legislation; whatever was the remedy, surely it was the duty of the Council to initiate the proper steps rather than to shelve the matter. In the great majority of cases legislation was not necessary. Where motorists had insured against third-party risks, could not some arrangement be come to with the insurance companies to pay the doctors' fees direct to the doctors and not to the patients? In this connexion Dr. Miller pointed out that fire insurances were so arranged that, if the salvage corps were called to the scene of a fire, their fee was paid direct by the insurance company. Another possible method was to make the police force responsible for collecting the doctors' fees. If the roadway or a telegraph post were damaged by a road accident, the police would at least assist in collecting the money to repair that damage on behalf of the county council or the Government, as the case might be. Therefore, why should not the police be responsible for the collection of the doctors' fees, whether the doctors were summoned by the police or not? It could hardly be pretended that this matter was one of the first importance, but it was a pinprick which was a source of annoyance to country practitioners, all of whom were anxious that the question should be kept open, and that every possible step should be taken by the Council of the Association to get it cleared up.

Dr. BONE said there were none more anxious than he to ensure that doctors summoned to attend people injured in road accidents should be paid for their services, but he hoped the meeting would not refer this matter back in the manner suggested. No constructive suggestions had been made by either of the previous speakers as to what should be done—(this remark gave rise to some protest from the meeting)—except, he added, that there should be found some method by which a doctor should be paid for a particular service. Dr. Miller had stated that in 50 per cent. of cases the injured person was absent when the doctor arrived. Clearly, whatever the Council might do, in such cases the doctor's fee also would not be forthcoming, because one could not obtain a fee for a service which had not been rendered. With regard to the other 50 per cent. of cases, it was suggested that a bargain should be come to with the insurance companies so that they would pay the fees direct to the doctors concerned, or that legislation should be promoted. Did Dr. Miller wish the Council to introduce a bill into Parliament in order to achieve this very laudable object? His third suggestion was to put the screw on the police force, and to impose upon the police the duty of obtaining the doctor's fee. The circumstances with regard to road accidents, however, were somewhat different from those applying to other accidents. The police were seldom on the scene of a road accident at an early stage: very often the doctor was there long before the police. All these difficulties had been considered at length, and Dr. Bone urged the meeting to consider the matter most carefully before deciding to refer it back for further consideration, because the Association would have to expend a great deal of money and a great deal of time in order to do anything really effective. The great motoring organizations were the proper bodies to deal with the matter. The question was one for motorists long before it was a question for doctors. (Cries of "No.") He thought the meeting should hesitate before imposing on the Council what would be a long, difficult, and expensive task.

Dr. J. B. CANDLER-HOPE (Scarborough) thought it evident that Dr. Bone did not appreciate the position in the country. He said that if the body was not there there could be no payment, but that was not so. Where a person was called in for emergency treatment under the Insurance Acts payment by mileage was allowed for. Only the previous week the Panel Committee in his district had before it a case where two doctors were called to the same accident. One arrived sooner than the other, but the committee decided to pay the fees of both. The fact that the injured person might no longer be there when one arrived at the scene of an accident was not an insurmountable difficulty.

Dr. H. G. DAIN (Birmingham) thought that Dr. Miller had offered a constructive suggestion—namely, that the Association should get in touch with the insurance companies and see if some arrangement could not be come to on the lines suggested by him. Dr. Bone himself had made a constructive suggestion—that the Association should get in touch with the motoring organizations, the R.A.C. and the A.A., to see if some arrangement could not be arrived at by which the doctor's risk could be met. On both these grounds there was substantial reason for asking the Council to reconsider the subject and put before the Representative Meeting next year some constructive policy on a matter which, while it did not involve a great deal of money, caused a tremendous amount of irritation.

Dr. R. M. MANWARING-WHITE (Mid-Cheshire) held that the general practitioner had a very real grievance with regard to motor accidents, which had of late years enormously increased in number. The attitude of the Council appeared to be "This is a difficult question, and therefore we will shelve it." It did not usually let the Association down in that way, and he hoped the present case would not constitute a precedent; the more difficult a matter was, the more reason there was for the Council to deal with it. In some areas the police had instructions not to send for the doctor, because if they did it was their responsibility. They were told to send someone in the crowd, and get out of the difficulty in that way. Dr. Bone had said that if a doctor travelled miles, at great inconvenience, to the scene of an accident and found the case had been treated by someone else or removed to hospital, he had rendered no service. Personally, he did not agree with that view; if a private patient sent for him, and when he arrived told him he was not needed, he charged a fee, and that should be the practice also in the case under discussion. Where the injured person and not the motorist was responsible for an accident, the insurance company, under the terms of its policy, had no responsibility. He thought that was wrong. The doctor rendered service to the injured person apart from any question of responsibility for the accident, and somebody should be responsible for the doctor's fee. He strongly supported the amendment to refer the question back to the Council to see if it could not take some useful action. Personally, he thought it could.

Dr. BONE said he had been so convinced by the arguments put before him that he was quite prepared to say, on behalf of the Council, that it would reconsider the matter. This statement was received with applause.

Road Vehicles Regulation Bill.

Dr. BONE moved the following:

> That although it is unsatisfactory that fitness for driving a mechanically propelled vehicle should, as at present it is, be ignored entirely in the granting of a driving licence, the practical difficulties in regard to the position, including that of obtaining a consensus of opinion as to what the disabilities should be, are such that it is inadvisable for the Association at present to make a pronouncement in the matter; further, that no scheme so far proposed is free from great practical difficulties.

This question was, he said, in many ways similar to the previous one. It was now coming into the field of practical politics, though he doubted if it was yet ripe for settlement. In this country and in France no legal restrictions with regard to health were placed on the driver of an ordinary motor car; the only restriction was with regard to age. A boy might drive a motor cycle at 15 and a car at 17 years of age, which, he believed, were the lowest minima in Europe. Many Continental countries required a medical examination before issuing a licence; this was

the case in Germany, Bulgaria, Denmark, Danzig, Luxembourg, Norway, Poland, Sweden, Switzerland, and Yugoslavia, etc. In London the only people who were subjected to such an examination were those who drove certain types of public vehicles, and particularly motor omnibuses. The questions to be considered with regard to the setting up of such an examination were very numerous. There was the question of an upper limit of age, of whether a man over 65, for instance, should be allowed to drive a motor car. That was the sort of thing one was asking for in suggesting a medical examination for fitness to drive a motor car. (Cries of "No.") Then there was the question whether a deaf man should be allowed to drive, or, with regard to eyesight, whether a man with some refractive error, or who could not distinguish red from green, or who suffered from cataract (and if so, to what extent) should be allowed to do so. It was obvious an epileptic should not be allowed to drive, but how was one to find out a man was an epileptic? Then there was the question of high blood pressure, or a tendency to apoplexy, or heart conditions. There was also the question of the need for some sort of psychical examination. A man might have a perfect physique and respond normally to all the usual tests but react very badly to the conditions met with in driving, and so be an unsafe driver. The French had a psycho-technique test, particularly for tram and omnibus drivers. He did not know what the nature of it was, but probably it was similar to those to which would-be airmen were subjected before being allowed to fly. The next difficulty was how often the examination should be made. In some European countries it was at five-year, and in others at three-year, intervals. Then there was the question of who should conduct the examination. He thought there would be general agreement that it should not be the family doctor, who might tend to be too complaisant or, if he was not, might soon have very few patients left. That seemed to point to the setting up of a body of official examiners, and as anyone they turned down must have the right of appeal, there would probably have to be a body of official referees also. The whole question was involved and difficult, and the view of his committee was that it was not ripe for settlement.

Dr. C. FORBES (Aberdeen) moved to refer this back also. He was sure that all present realized the difficulties of the problem, but the difficulty of diagnosing a disability was no reason why it should not be tackled. Dr. Bone was belittling his own ability and that of the Council when he said they could not solve problems which had already been solved by other countries. The Association had a public duty to perform. They knew the evils that resulted from the licensing of the halt, the maim, and the blind to drive cars. He therefore confidently submitted his amendment asking that the matter be sent back for further consideration. (Applause.)

Dr. DAIN (Birmingham) supported the amendment. The Association was not concerned with the regulation side of the matter, but it ought to be prepared with some sort of idea of the maximum disabilities which should be allowed to a person licensed to drive a motor car when powers of control were sought by a local authority. It would be too late to wait until such powers were actually acquired.

Dr. H. C. BRISTOWE (Bristol) foresaw the difficulty that would arise if certificates of fitness were given on account of the possibility that a man who was fit one week might not be fit the next week or the next month. For what period could such certificates be issued?

Dr. C. H. HALL (Watford) asked whether it was the committee's opinion that some standard of fitness was required, and whether Dr. Bone would make a declaration to that effect. Upon the answer he would like to move an amendment. (Laughter.)

Dr. BONE replied that the statement in the motion, that it was unsatisfactory that fitness should be ignored entirely in the granting of a driving licence, covered the question—that is, the committee did think there should be a standard of fitness. He was not prepared to go further than that. That was the opinion of the committee.

Mr. BISHOP HARMAN suggested that the Medico-Political Committee was not the competent authority of the Association to set up a standard of fitness, as that was a scientific matter. Such a standard, if arrived at, should be dealt with by a scientific committee appointed *ad hoc* by the Council; and therefore, whether the amendment was carried or lost, he would propose another amendment, that the Council be requested to appoint an *ad hoc* committee to consider what, if any, standard of fitness should be required of private automobile drivers.

Dr. R. FORBES (Gateshead) expressed the hope that the matter would not be referred back in the non-committal manner suggested by Aberdeen. Before the Association could safely move, it was necessary to educate public opinion. The users of motor vehicles formed a very large and influential portion of the community, and it was dangerous for the Association to risk antagonizing that body of opinion. He therefore proposed, as an alternative amendment:

> That the Representative Body definitely lays it down as its opinion that a standard of medical fitness should be prescribed as the minimum possession of every applicant for a licence to drive a mechanically propelled vehicle, but considers that the necessary qualifications of an applicant can only be determined by a conference of all the interests involved.

The CHAIRMAN OF COUNCIL said the Council wanted to be in a position to take such steps as the Representative Body desired. The first amendment was that the matter should be referred to the Council. Another suggestion was that the Council, in taking it back, should appoint an *ad hoc* committee to examine and report upon the standard of fitness which should be required. The third amendment was that the Council, in taking it back, should take steps, in co-operation with other bodies, to examine the position and report thereupon. He was bound to say that since it had been agreed, as set out in the resolution of the Council, that some standard of fitness ought to be set up, he hoped, on behalf of the Council, that the meeting would accept Dr. R. Forbes's suggestion, because quite clearly it was not a matter for the Medico-Political Committee to settle, neither did he think it was a matter for the Council of the Association to set up a standard. But if the meeting asked the Council of the Association to take this matter into consideration in view of the declaration that a standard should be set up, then the meeting would instruct the Council to go to an appropriate body and seek direction. If that were done he thought they would know what the situation was, and he understood that to be what Dr. R. Forbes had proposed. Speaking as Chairman of Council, the body which received instructions and carried them into effect, that method of action would probably produce the best results and be within the sphere in which the Council had to move.

Mr. H. M. STRATFORD (Kensington) said there would be great difficulties in examining everybody who wished to take out a licence for driving. A special service of medical men would have to be provided to undertake it. He thought that anyone who had got into the courts in connexion with an accident and had his licence withdrawn should be examined before the licence was returned. By doing that a person, after his first accident, would possibly be prevented from creating further damage. He threw that out as a suggestion for the Council, and at the same time supported the member from Aberdeen in asking to have the motion referred back.

Dr. C. FORBES asked Dr. Bone and the Chairman of Council whether, in view of fresh facts, they were not prepared to take the matter back for reconsideration.

The CHAIRMAN: You persist in your amendment, Dr. Forbes?
Dr. FORBES: Yes.

The motion to refer back was carried.

MATERNAL MORTALITY INQUIRY.

Dr. BONE next moved as a recommendation of Council:

> That, as the giving of information to the medical investigator who will fill up the form of inquiry into maternal mortality issued by the Departmental Committee on Maternal Mortality is regarded by the Association as a voluntary contribution on the part of the medical profession to a scientific inquiry on a question of pressing public importance, the Association is of opinion that no fee should be charged for the service and none accepted if offered.

He said that so far as he knew practitioners had cheerfully accepted the duties that would fall upon them in connexion with those inquiries. The Council recommended that there

should be no fee received in connexion with such services which might be rendered, and no fee accepted if it was offered.

Dr. H. R. FREDERICK (Swansea) moved to amend the last phrase of the resolution so that it should read: "The Association is of opinion that no fee should be charged for this particular service." He said that the general practitioner had been too long the whipping-boy in connexion with maternal mortality. It should be clearly laid down that this service was rendered as an act of public duty, and that the non-acceptance of a fee could not be taken as a precedent. They had nothing to hide in the matter.

Dr. R. BOYD (Manchester) said there were limits to professional altruism, and this was one of them. What they did now out of good will would become a public duty later on. It would be found that the information given on the form was tantamount to putting a noose round their necks. The information would be very useful in a court of law to "hang" one, although the Ministry of Health had given its assurance that the information would not be used against a practitioner. In spite of that assurance a practitioner could be subpoenaed by a court of law. A fee should be charged, and such fee might be handed over as subscription to the Medical Defence Union.

The CHAIRMAN OF COUNCIL said that as soon as a duty was imposed upon the profession by public authorities it became the duty of those authorities to pay a fee for the service rendered; but when the profession was asked voluntarily to contribute to a scientific investigation in a situation in which the public was gravely concerned, then the Council felt that the more generously the profession volunteered such services as it could render the better it would be for the profession, and it was only in harmony with the general traditions and character of the profession that anything it could do in a voluntary way for the public good it should do. In this voluntary service, which no practitioner need enter into unless he wished, it was better that no fee should be expected or charged.

Dr. A. B. MURRAY (Banff) said the meeting was being misled. He was astonished at the statements made by those in authority. He begged the meeting to take his advice; his advice was generally good. (Laughter.) "Do nothing for nothing. What is worth doing is worth being paid for, and what is not worth being paid for is not worth doing." ("Oh," and laughter.)

Dr. C. FORBES (Aberdeen) said that the profession had been asked to give voluntary help in an investigation to be carried out by a Government department, or a body appointed by a Government department, in an exceedingly difficult matter about which very much more information than was at present available was required, and he urged that it was the duty of the profession to assist. Incidentally, he felt sure that a detailed scientific inquiry would prove that certain criticisms of general practitioners were unfounded in fact. He wished to urge, as a general practitioner, that it was the duty of the profession to assist, and, even if offered a fee, to refuse to accept it. The fear had been expressed that this voluntary offer of assistance without payment would be used against them when they came to consider terms and conditions of service under Government departments, but he had no fear of that.

The amendment was lost by a considerable majority, and the original motion was carried.

Contract Rates for Juvenile Oddfellows.

Dr. KATHLEEN HARDING (St. Pancras) had an amendment expressing disagreement with the view put forward in the Annual Report of Council that while the Association was precluded (by the fact that a two-thirds majority was not secured for the resolution of last year) from making a national arrangement for the treatment of juvenile oddfellows at 8s. 8d. per head per year, the Divisions and Branches were permitted to make local arrangements on the lines suggested in last year's resolution without contravening the policy of the Association. The St. Pancras Division, said Dr. Harding, considered that a rate less than 8s. 8d. per head should not be considered in any circumstances.

Dr. CANDLER-HOPE contended that this discussion was out of order, because it related, not to the Council's report, but to a matter which had been discussed at the Representative Meeting last year. The CHAIRMAN, however, ruled that it was in order, inasmuch as it related to an actual paragraph in the Council's report.

Dr. E. WARD (Torquay) pointed out that para. 70 of the Annual Report entailed a reversal of the decision arrived at last year at the Representative Meeting after a very full discussion. His Division thought the Representative Body should not give its approval to any such departure. It regarded para. 70 as an attempt to achieve by a circuitous route what the meeting tried to escape from last year.

Dr. A. T. JONES asked whether the paragraph meant that when circumstances arose in any particular area a case must be made out and submitted for the consideration of the Council, as to whether the Council advised the acceptance of a lower fee.

The CHAIRMAN explained that it was merely the interpretation the Council put on a vote taken in the Representative Body the previous year. That vote was technically a rejection of the proposal to reach an agreement between the central authority of the Association and a particular friendly society. The Council interpreted that as meaning that while the Council was not competent to come to such an agreement, local arrangements between units of the Association and units of the friendly society were not interfered with. It was open to the meeting to disagree with that view, and the amendment proposed that the meeting should disagree with it.

Dr. R. K. FORD (Preston) said that in his Division the antagonism to the Association aroused at the time of the original arrangements under the National Insurance Acts had not yet been entirely eradicated. In his Division club practice (except in the case of certain clubs connected with the Roman Catholic Church) had been completely stamped out, and the view was taken that contract practice provided a lever for negotiations in the future concerning the terms of service under the Insurance Acts, and that such terms of service as were embodied in the resolution dealt with last year would constitute a strong argument for a lower capitation fee. His Division desired him to emphasize that point very strongly.

Dr. E. E. BRIERLEY (Cardiff) said the question of what should be paid for juvenile members was fought out with the friendly societies in Cardiff some years ago, and it was only with great difficulty that the societies were prevailed upon to agree to a fee of 8s. 8d. It would be a great pity if Divisions and Branches were permitted to make local arrangements at a lower figure than that.

The CHAIRMAN OF COUNCIL thought some members of the Representative Body had great difficulty in understanding the real position. There was no question of reopening what was decided last year. The Council was faced with the position, however, that many Divisions had for years had an arrangement with the Oddfellows Society at fees which in some cases did not amount to nearly 8s. 8d. When the resolution moved last year failed to obtain the necessary two-thirds majority, it left standing the policy of the Association as it then was—namely, that such local arrangements were permitted. The Council therefore considered that although they were precluded from entering into the national bargain which had been proposed to them by a particular society, the policy of the Association remained in force, and under it local agreements were legitimate, even if undesirable. If the meeting adopted the amendment proposed by St. Pancras, and disagreed with that interpretation, it meant that all these local agreements, which the Representative Body had tolerated for many years, would have to be scrapped, and that anyone who worked under them would be liable to such disciplinary action as the Association and its Divisions could take. That would be a disastrous situation. Such agreements had been in existence for a long time, and a great many reputable members of the Association had been working under them; they were, moreover, consistent with the present policy of the Association. If the Council's view of the situation was held to be wrong, disciplinary action would have to be taken against the hundreds and possibly thousands of members who were working under such agreements.

Dr. H. W. POOLER (Chesterfield) said that until Dr. Brackenbury spoke the meeting had heard only one side of the question, from members representing Divisions which appeared to scorn club practice and wanted to have nothing to do with it. He (the speaker) represented a Division where club practice was all-important, and where the fees for juveniles were definitely lower than 8s. 8d., and he was not the only representative present from a Division where such fees were taken, fees which were properly authorized by the Association. He urged the meeting not to cut the ground from under their feet by passing the amendment, for to do so would lead to great confusion in Divisions such as he represented, and cause great dissatisfaction.

Dr. J. LIVINGSTON (Furness) said he came from what might be called a distressed area, and one where juvenile clubs existed, and he contended that what had been done there could be done elsewhere. They ran a panel for juveniles on which every man could go. The panel rate was 10s. a head per annum, excluding night-work, serums, operations, etc. The amount received was distributed by the secretary, not by the clubs, and even at 10s. only 60 to 70 per cent. of the fees charged (moderate fees of 2s. 6d. a visit) was received.

Dr. BONE pointed out that the paragraph under discussion did not reopen the whole question of contract fees for juveniles, but was merely a statement of the position which resulted from what happened a year ago. The final paragraph of para. 70 represented the considered opinion of the Council, arrived at after consultation with the Association's solicitor. To disagree with it would be to put the Council in a difficult position.

The amendment was rejected.

Dangerous Drugs: Heroin.

Several motions were down relating to para. 60 of the Annual Report of Council, dealing with the Dangerous Drugs Acts and Regulations. The first taken was by Dr. JOHN STEVENS (Edinburgh and Leith), who had a resolution strongly supporting the Council in its effort to obtain amendment of Section 3 of the 1925 Act, and recommending that heroin should come under the same conditions as morphine and its salts. He submitted that there was no need whatsoever for the extension of the restrictions to heroin, a most valuable drug for which there was no thoroughly adequate substitute. Every member of the Association was, of course, warmly in support of any well-directed effort to stop drug addiction, but extreme restrictions, instead of doing good, were more likely to do harm. He hoped the meeting would show the Council that it had the full support of the members in pursuing the subject, and in endeavouring to secure some improvement in the position. The Regulations constituted a serious and unnecesary interference with the work of the profession, and note should also be taken of the heavy penalties involved.

The representative of Lanarkshire, who had an amendment on the paper, was content to accept the Edinburgh motion.

Dr. MANWARING-WHITE (Mid-Cheshire), believing the provisions relating to heroin to be quite unnecessary, moved to instruct the Council to take steps to secure the removal of heroin from the provisions. In moving this as an amendment, he said that in the opinion of a large number of general practitioners heroin was the most useful drug in the *Pharmacopoeia* for certain conditions, particularly for the dry, irritable cough of influenza, which caused strain on the bronchial tubes, which was often followed by bronchial pneumonia. The history of the restriction originated in Geneva in the Conference of 1925. Sir Malcolm Delevingne had stated that the British Medical Association had been consulted, and had agreed to the regulations. That statement had appeared in the *Supplement* over Sir Malcolm Delevingne's signature. Yet the Association said they had made strong protests against the restrictions, but that, owing to lack of support in the profession, those protests had been of no avail. That he understood to be the reply of the Council. Yet in the *Journal* during the year 1928 he thought there was not to be found one word regarding the restrictions on heroin: at any rate, he had failed to find any such word. If all those protests had been made, surely something would have been said in the *Journal*, but the profession knew nothing of the negotiations, although they were now told that the Council was protesting. Why should not heroin have the same status as morphine? Lord Cecil had said that the restrictions on morphine were working satisfactorily, so why should heroin remain under a cloud? It was stated that there were practically no heroin addicts in this country. A large number, however, had been found in America and China. He was afraid that at the present time the number of heroin addicts in America was greater than ever, due, possibly, to the fact that the restriction on the medicinal use of heroin had thrown a large amount on the market on which they were, unhappily, "feeding." He desired the Council to be instructed from that meeting to take measures to get rid of mischievous legislation. If the profession could not be defended by the Council in this respect, to whom were they to look?

Dr. BONE observed that Dr. Manwaring-White had not spoken to his own amendment. His speech was an appeal to put heroin on the same footing as morphine. He was with him so far as his speech went, but he opposed him on his amendment. Dr. MANWARING-WHITE replied that he would be quite satisfied if heroin had the same status as morphine.

The Mid-Cheshire amendment was lost by a large majority, and the meeting then resumed consideration of the original motion by Edinburgh and Leith.

Dr. MANWARING-WHITE desired to explain that he did not intend to convey, by anything he had said, that if a doctor considered it necessary to prescribe heroin for a patient he would be deterred from doing so by the restrictions imposed by the Act.

The Dangerous Drugs Regulations: Statement by Dr. Bone.

Dr. BONE said that a number of letters had been published in the *Supplement* calling the Council to account for what it had failed to do in connexion with the Regulations under the Dangerous Drugs Acts, and he had expected to have to meet a storm of criticism that day from those who thought that the Council had failed in its duty to keep an eye on the Regulations and to see that they were in accordance with the wishes of the profession. There had been very little such criticism, however, and what little he had heard he considered to be ill informed. The principal criticism made at the meeting was that there were some restrictions on the use of these particular drugs. As a matter of fact, however, there were no restrictions whatever on the use of any drug in any of the Dangerous Drugs Regulations, except that in certain instances records had to be kept. The idea that somebody was going to die because he could not get heroin in this country was a huge fallacy, and he would leave it to the meeting to suggest how to deal with the doctor who allowed his patient to die because he was too lazy to record the fact that he had given that patient heroin. In order to dispose of the misconceptions that had arisen in connexion with the Regulations, Dr. Bone reviewed the position. There were three Dangerous Drugs Acts in force in this country. The first was passed in 1920, and was the principal Act referring to these matters. The Regulations it was sought to impose under that first Act had met with very great opposition from the British Medical Association, and the Association had succeeded in rousing members of Parliament to such an extent that fifty-four members of Parliament had met together in one of the committee rooms of the House to consider the matter. In consequence of the report of that meeting a committee was set up, under the chairmanship of Mr. Chester Jones, which had obtained evidence from the Association and from other interested bodies, and had produced a report which embodied practically everything the Association had sought to obtain from it in connexion with the Dangerous Drugs Regulations. The Regulations issued subsequently were accepted by the Association, and he believed they were accepted cheerfully by the whole of the profession as representing a solution of a very difficult and awkward problem. Under those Regulations the profession had worked quite happily, and he did not think that in the circumstances they were unduly

onerous, or represented more than was requisite. They applied to four groups of drugs—morphine, cocaine, heroin, and the various preparations of opium. In the case of morphine it was necessary to record anything over 0.1 per cent., and in the case of cocaine it was necessary to record anything over 0.2 per cent.; quantities of heroin of more than 0.1 per cent., and of opium of more than 0.2 per cent. had to be recorded. In 1924 a new position had arisen. The Ministry of Health had informed the Association that the Home Office had received a letter from the general secretary of the League of Nations, asking the Government—as other Governments had been asked—to express their views as to the advisability of the total suppression of the manufacture of heroin, or of its limitation to the minimum amount required. That letter was forwarded to the Association, and, after consulting some of those interested, a reply had been sent that the drug had a legitimate use in medicine, and, that being the case, the Association could not agree that its manufacture should be prohibited, but that it would have no objection to such limitation of the manufacture or supply of the drug as would not interfere with its legitimate use either then or in the future. Afterwards that was submitted to the Council and to the Representative Body, and that had been the policy of the Association thenceforward; the Council had never varied it in any respect. In December, 1924, the Home Office had inquired again whether the medical profession would be likely to object strongly if the Dangerous Drugs Regulations were applied to all preparations of morphine and heroin, and the Association had stated that it was not in agreement with that proposal. Prior to that—on September 30th, 1924—the Minister of Health had appointed a small departmental committee, under the chairmanship of Sir Humphry Rolleston, to consider the problem of morphine and heroin addiction, and on February 12th, 1925, that committee had sought an extension of its terms of reference to enable it to "consider and advise whether it is expedient that any or all preparations which contain morphine or heroin of a percentage lower than that specified in the Dangerous Drugs Act should be brought within the provisions of the Regulations, and, if so, under what conditions." On February 19th, 1925, a convention was signed by the British plenipotentiary at Geneva—only one week after the extension of the terms of reference of the committee of doctors who had been requested by the Government to look into this matter. Article 6 of the Convention said that the contracting parties should control all persons manufacturing, importing, selling, distributing, or exporting the substances to which that chapter of the Convention applied. In June the Council of the Association set up a small committee on drug addiction, and on July 3rd it was reported to that committee that the Geneva Convention had been signed, and that in consequence all preparations of heroin, whatever their strength, would be brought within the scope of the Dangerous Drugs legislation. That was reported to the Council of the Association on July 20th, and to the Representative Body immediately after the Council meeting, so that both those bodies were aware in 1925 that we had been pledged as a nation to agree to the application of the Dangerous Drugs Regulations to all mixtures containing heroin. When that committee reported, which it did on January 21st, 1926, it said definitely that, "Since this reference was received the committee was informed that at Geneva this country assented to an international agreement to bring within the scope of the Dangerous Drugs legislation all preparations of heroin without distinction of percentage. We have therefore thought it unnecessary to consider preparations of heroin under our reference." It was idle, therefore, to allege, as did so many people who wrote to the *Journal*, that the profession knew nothing about these things. At the time he made himself most objectionable to all those with whom he came in contact on the various committees by trying to get rid of the obligation in regard to heroin, until he found no one would take any interest in the question, and he dropped it. The Dangerous Drugs Act was passed in the latter part of 1925, but by one of its later clauses it did not become operative except by order of His Majesty in Council. The necessary Order in Council was not issued until September, 1928, and the new Regulations did not come into force until January 1st, 1929; and then it suddenly dawned on the profession, or on some members of it, that in future, if they wished to use heroin in any strength at all, they must keep records of its use. Personally, he thought that was an oppressive restriction on the medical profession. He had been saying so ever since 1925, and at last he had found that some members of the profession agreed with him. There was not, and never had been, any heroin addiction to speak of in this country. The Association had been, and was still, in correspondence with the Home Office with a view to getting rid of the restriction in question, and he thought Sir Malcolm Delevingne's principal argument was that he could not break away from an international agreement. In the Convention, however, there was a proviso to the effect that the requirement to enter the quantities manufactured, imports, exports, sales, and all other distribution of the substances dealt with "shall not necessarily apply either to supplies dispensed by medical practitioners or to sales by duly authorized chemists." Sir Malcolm might quite well make use of that proviso to exempt doctors from entering those particulars in their books, provided their prescriptions were filed and preserved, so that the Home Office could trace how they had dealt with their supplies of heroin. The proviso in the Convention was in fact inserted for that purpose. Unfortunately the Dangerous Drugs Act of 1925, which applied the Convention, did not contain that proviso, but contained the definite requirement that any strength of heroin should be recorded. He hoped the Edinburgh motion, which objected to that, would be passed, and perhaps the meeting might go a little further and suggest that legislation to amend the Dangerous Drugs Act of 1925, in the sense he had indicated, should be encouraged. It was commonly said, and had been said freely in the *Journal*, that this was the only country which had honourably tried to give effect to the Convention signed at Geneva, and that other countries, and particularly America, had taken no steps to ratify it. Dr. Cox had spent much time and thought in writing to correspondents in the United States to find out what the position there really was. It was, in fact, most confused, because doctors there were subject to both Federal and State law, and the laws in regard to dangerous drugs were in an extremely complicated state. Elaborate steps had been taken in America, however, to deal with heroin addiction. Under the Harrison Law the importation of morphine for the manufacture of heroin was forbidden; in some States the use of heroin was prohibited, and in all the object was to cut heroin out of the *Pharmacopoeia* of the American doctor. Heroin addiction was a big problem in America, which accounted for the drastic measures taken. But because America had heroin addiction, and therefore had to prohibit the use of the drug, that was no reason why this country should give up employing what many doctors considered a useful substance. (Applause.)

DR. TEMPLE GRAY proposed, and DR. D. ROXBURGH seconded, as an addition to the Edinburgh and Leith amendment, the following:

> Also that the Council should, on all possible occasions, urge the Government not to enter into international conventions involving medical questions until the opinion of the medical profession has been ascertained.

DR. STEVENS accepted the addition.

DR. TEMPLE GRAY, in support of his proposal, said the question was whether the *British Pharmacopoeia* was to be settled in Geneva or not. He spoke with no hostility to the League of Nations, which was an excellent idea; but since it was a human institution run by human beings, it was necessary to pay close attention to its actions. Everyone must admire the energy the Council had displayed in the matter, but the information Dr. Bone had given came a little too late to be of use. International conventions could be put into force only by national enactments, which as a rule modified their terms; but in the present instance our legislation had gone further than the Convention itself required, and it was a pity that had not appeared in the report. The line the Council should take was to urge the legislature to repeal the section which went beyond the Geneva Convention.

Dr. STEVENS thanked Dr. Bone for the instructive statement he had given ("Hear, hear"), which was really in support of the motion he had proposed, and he hoped that motion would be carried unanimously. He thanked Dr. Bone also for the hard work he had done during the past years, and added, "Be not weary in well-doing."

The motion of Edinburgh was carried.

Inspection of Drugs.

Dr. STEVENS (Edinburgh and Leith) further drew attention to the Home Office memorandum as to the duties of doctors and dentists (DD 101/3), and to the impossibility of a doctor or dentist having his stock of dangerous drugs under lock and key and at the same time having them available for inspection by any duly authorized person in his absence.

Dr. BONE said that the drugs could be kept under lock and key and the records left open for inspection. Any inspector would be prepared to call at a time when the drugs could conveniently be inspected; and, moreover, during ordinary hours there would be someone in charge of the key who could produce the drugs even in the doctor's absence.

A motion on the lines of Dr. Stevens's remarks was lost.

Dr. STEVENS also had an amendment affirming that in the same Home Office document the reference to "in his presence" was an unnecessary hardship on the doctor and the patient, and should read "to supply them to his patients by personal administration or by administration under his authority given to a nurse or other responsible person."

Dr. BONE suggested that this amendment was submitted under a misapprehension of the true position. If the drug was administered under the personal supervision of the doctor there was no need to keep a record; if administered otherwise, then a record must be kept.

Mr. DAVID LEES (Edinburgh) disagreed with what Dr. Bone had said; but a doctor had the power to prescribe fifty or a hundred tablets in a prescription and send them to a nursing home, and they could be used *ad lib.* by the patient, who could thus get outside the Dangerous Drugs Act. Would it not be advisable that the doctor should have power only to authorize the limited supply required during the night, as Dr. Stevens had suggested?

Dr. BONE said it was not correct to say that fifty or a hundred tablets could be prescribed, and if that was being done in Edinburgh it was irregular, and was not in accordance with the Regulations.

Dr. F. RADCLIFFE (Council) said he was sorry not to be able to agree with Dr. Bone. He had taken a great deal of trouble to try to find out where things were as regards the "personally or in his presence" clause. He had with him a document from H.M. Stationery Office, dated January 31st, 1929, entitled "A memorandum as to the duties of doctors and dentists regarding the Dangerous Drugs Act," which stated that a new edition would follow. He was still waiting for that, and had been unable to obtain it. He had written to one of the chief regional medical officers asking exactly what his duties were, and he had been told that he need not enter in his prescription book every time a nurse administered a quarter of a grain of morphine in the night. He had not been informed, however, where that statement came from, as his informant did not know. He had been told also that if a nurse administered a quarter of a grain of morphine hypodermically and initialled the entry, that would cover what he had ordered by lots of fifty or a hundred tablets, provided that before another supply was got the entries tallied. Whether that information was correct or not he could not say, but that was his information. To make doubly sure he had been advised to instruct a second nurse to countersign the entry. This did not appear to agree with what Dr. Bone had said.

Dr. BONE said he had the memorandum to which Dr. Radcliffe had referred, and, what was much more important, the Regulations on which it was based. The exempting clause showing the circumstances in which a record need not be kept said that for the purpose of the Regulation a drug or preparation administered by or under the direct supervision and in the presence of a duly qualified medical practitioner should not be deemed to have been "supplied" by him, and when a drug was deemed not to have been supplied, a record need not be kept. In short, if a doctor gave a patient a hypodermic injection of morphine he need not keep a record; but if he told a nurse to give the hypodermic injection of morphine in his absence a record must be kept. In reply to a member, who asked "By whom?" Dr. BONE said it must be kept by the only person who could keep it—namely, the nurse. Asked whether every private house must keep a register, Dr. Bone replied in the negative.

The CHAIRMAN said he was afraid the meeting was going outside the borders of the motion. Dr. Bone had paid special attention to the matter, and was informed on all the technicalities of the subject, and had therefore been good enough to intervene between remarks made by other speakers; but clearly there must be a limit to questions shouted from various parts of the hall.

Dr. BONE said that, of course, the doctor kept his own record if he had sent a supply of drugs to his patient; and in a hospital it was kept by the hospital, and every nursing home purchasing or using the drugs must have a register if it was carrying out the Regulations.

The CHAIRMAN thought there would be general agreement with the position set out by Dr. Bone.

The Edinburgh and Leith amendment was lost by a large majority.

Abatement of Unnecessary Noise.

Dr. GRACE GRIFFITH (West Suffolk) moved to instruct the Council to take steps to secure the abatement of unnecessary noise. She stated that her amendment was intended to reopen the question of the noise nuisance, and not leave it where it was in the Annual Report of Council. At the Representative Meeting last year the subject was discussed, but the Report of Council suggested that the matter had now been dropped, and nothing further could be done. West Suffolk wished her to reopen this matter by pointing out one or two ways in which legislation might be made to deal with the noise nuisance. The last paragraph, for instance, suggested that those noises were more a matter for the Ministry of Transport; and that conveyed the idea that they were chiefly the noises of traffic, trains, and other means of transport. But they in West Suffolk did not feel that all those noises were only matters for the Ministry of Transport. One of the special noises was that made by a mechanical pig feeder; a West Suffolk member had a patient who was extremely upset in his nerves because in a neighbouring field a farmer kept a large number of pigs who were thus fed. Another form of nuisance to them, which perhaps did not obtain in other districts, was the noise which emanated from the exhausts of oil engines used for the making of electric light. In this case it was remarkable that, while a passing motor car must have a silencer on it, it was not necessary to provide a silencer on oil engine exhausts. At the present moment the only remedy was to take steps in the High Court, which was very expensive and uncertain in its result, the case being tried in London and requiring expensive witnesses on both sides. It seemed that there should be provided some inexpensive and easy method of disposal of such cases. When the great Public Health Charter was inaugurated in 1875 the relationship of germs to disease had not been discovered, and effluvia were regarded as the cause of fevers and other similar disorders, and for that reason nuisances arising from effluvia were provided for. Section 91 enumerated seven nuisances which could be dealt with summarily under this Act. She suggested, therefore, that there should be added to the list of nuisances which could be dealt with any offensive and unnecessary noise. Section 105 allowed for a complaint to a justice of the peace on account of a nuisance under this Act, and Section 106 enabled the police to take action in any case of noise nuisance which was not dealt with by the Act. If powers of this kind were given to the sanitary authority it was certain that they would never be likely to be abused, and, as many of those noises were industrial, there would be a tendency for the bench to side with the defendant. At the same time it ought to be easy for a local authority to take proceedings, and it should not be necessary for the complainant to come out in the open and to make his complaint himself. This method of procedure was at present

followed in the case of other nuisances dealt with by the local authority, but it was difficult for a man to make a complaint against his landlord, his employer, his neighbour, or his friend. Therefore, in West Suffolk they desired to have this subject reopened in order that they might have further legislation on it.

Dr. BONE said that this was an instruction to the Council to take steps to secure legislation for a certain purpose. It had already received instructions to take steps to promote legislation for all sorts of purposes, and the meeting apparently considered that the promotion of legislation was a very easy matter for the Council. The problem of the abatement of unnecessary noise was one which had his very deepest sympathy, and one in which the Council had always been interested, and last year it had taken what he considered to be every possible means it could to have the matter dealt with by those responsible. The suggestion made by Dr. Grace Griffith was not new to the Council, and it had tried to get unnecessary noise scheduled as a nuisance under the Public Health Act. It had seemed to the Council, however, that the only way to do this was to approach the Minister of Health, and to try to persuade him that unnecessary noise was a danger to health. That was really the only thing that the Association, as a body of medical men, could do; it was no use their saying that they did not like noise and wished to abolish it. The Minister had received a deputation, which was considered to be a strong deputation—it included Dr. Dan McKenzie, who had written and spoken a great deal about noise abatement, and Dr. Nasmyth, of Edinburgh, who was one of those who had brought this matter before the Representative Body. At the same time, the Minister received a very influential deputation from the People's League of Health. The deputations had put to the Minister as strong a case as possible in support of the contention that noises were injurious to health, but it appeared that they had not succeeded. The late Minister of Health (Mr. Neville Chamberlain) was a very astute man, and he had asked some very awkward questions indeed; he had wanted to know what proofs there were that particular noises actually injured health, what statistics were available, which particular classes of people were injuriously affected, and so on. The speakers had done their best to answer those questions, but it was obvious to those who were merely observers that Mr. Chamberlain was not convinced that they had made out a case for his intervention as Minister of Health. He had stated that, while he was in sympathy with the objects of the deputations, this matter was one for the Minister of Transport rather than for the Minister of Health, and he had proposed to hand over to the Minister of Transport the reports and statements made by the deputations. In the face of that experience, the Association had done all it could, and Dr. Bone expressed the hope that, however much the Representative Body might favour the object of the amendment, it would not load the Council with instructions to promote legislation in regard to it.

Dr. WALLACE HENRY: May I suggest that if we could not do it in the dry wood, we may do it in the Greenwood? (Laughter.)

On the motion of the CHAIRMAN OF COUNCIL, it was decided to pass to the next business.

NATIONAL MATERNITY SERVICE SCHEME.

Dr. H. G. DAIN moved, as a recommendation of Council, that the memorandum contained in Appendix I to Supplementary Report of Council (*Supplement*, June 29th, p. 258) be adopted as a contribution on lines acceptable to the profession towards the establishment of a national maternity service scheme for England and Wales. Speaking particularly as chairman of the committee which had drawn up the scheme, he said that, whilst it might not contain all that some members would like to see in it, the committee submitted it as being a very practical and practicable solution of a burning question. The health departments, not only of this country but of other countries, were much exercised by reason of maternal mortality, and by the fact that it had not diminished in recent years as had the mortality from some diseases. At the last Annual Representative Meeting the Committee on the Causation of Maternal Mortality had presented a report containing some very striking observations, and one of the instructions given by the Representative Body to the Council was:

"No such ideal can be accomplished without full and cordial co-operation between doctor and midwife. There is here a field for team work comprising ante-natal examination by the doctor in the patient's home or at the clinic, the confinement being carried out by the doctor or midwife or both, with the specialist and bacteriologist available in cases of special difficulty, and, in certain cases, institutional treatment."

On those instructions the Council had appointed a committee, which had now presented a scheme. It seemed fortunate and particularly appropriate that at a meeting at which there was available the report of another committee dealing with the inroads into private practice, the committee dealing with maternal mortality should be able to put forward a report showing that, to the great advantage of the public, more use ought to be made of the services of the private practitioner. That was one of the great features of this particular scheme. It proposed the better use and organization of the practising doctors in connexion with the maternity service and in connexion with midwives, and was based on the conviction that such a scheme would produce better results in the reduction of maternal mortality. The striking feature of the report made last year was the fact that in certain areas where maternity services were organized, especially in connexion with schools for medical practitioners or midwives, there had been a tremendous diminution of maternal mortality as compared with the country at large. The committee had examined the essential features of those services, and had attempted, in the scheme now put forward, to reproduce for the whole country what it regarded as the essential features of those services which were giving such excellent results. The scheme was based on three principles. The first was a very important one—namely, that the normal case could safely be treated at home. Modern teaching had been rather in the direction of showing that increased safety was to be obtained by sending cases of all sorts, including normal cases, to institutions for confinement. Figures obtained from all sorts of cities and slum areas, however, showed that this was not necessarily true, and that the normal unassisted delivery could take place as safely in a poor home as in an institution. This could only be effective where certain other conditions held, and the committee regarded as one of the essential conditions that all maternity cases were effectively examined ante-natally at the appropriate time, in order that all cases might be classified into those which might safely be attended at home either (*a*) by a midwife, or (*b*) by a midwife and doctor, and those which should enter an institution for the confinement. The scheme made use of the existing practitioners, and provided for one of the cardinal points for which the Association stood—namely, free choice. There was free choice of doctor and of midwife. It apportioned responsibility between them in a way which would lead to no misunderstanding. It provided that the doctor who saw the case at the beginning should see it through, and it was thus a great advance on any of the schemes for ante-natal clinics and service at present in existence, which in most instances provided for an examination by a doctor who would have no opportunity of seeing a case through. There were certain initial difficulties and disadvantages which had to be faced, and which were largely due to the human element on both sides. There were many doctors who were not fully alive to the importance of efficient ante-natal examination at the proper moment, and there were others who had not familiarized themselves with modern methods of ante-natal examination; but all that, when properly understood, could be rapidly corrected. With regard to midwives, there was at present in many areas a considerable shortage of properly trained midwives. The scheme made it essential that every woman should have the services of a trained and registered midwife; the amateur midwife disappeared from the scene altogether, and no real progress could be made until that happened. If the material conditions for midwives were greatly improved the service should attract a better and more educated type of woman, and should soon provide the country with an efficient midwifery service. The scheme was one to be put into operation as quickly as possible, but it largely provided for future development and for the

generations of doctors and midwives who would carry on in the future. The medical schools of to-day were turning out doctors better equipped in that respect than many of their predecessors were when they started in practice, and this was the moment for the Association to step in and say that a national service could and should be organized which would give the country extremely good results. The scheme was not intended to cut across the work of the teaching schools. By their reputation and in their districts they would still attract a sufficient number of normal cases for teaching purposes. The condition, desired by many doctors, of every confinement being attended by a doctor was not asked for by the scheme. A doctor was provided for every case where, by examination, it was discovered he was likely to be necessary, and also in every case where at the confinement the nurse found it necessary to call him in. With regard to institutional treatment, an examination of the needs showed that under the scheme a much smaller number of beds would be required than was commonly supposed; the number of abnormal cases needing to go into hospital for confinement was less than was generally realized. A maternity hospital in South London (not quoted in the report) which undertook to take in all maternity cases requiring institutional treatment for medical reasons over a large area, and which did in fact receive some two thousand cases a year, did not take in more than forty a year on account of abnormal midwifery needs. The committee had gone to the length of making suggestions as to the cost of the scheme and methods of finance. In para. 49 it said: "An additional contribution on behalf of the employer and worker together of 0.46d. per week for each insured person, with 0.23d. per week by the State, would provide all the money." The figures should, in fact, be 0.4d. and 0.2d., so that the cost would be less than was there suggested. The criticism had been made that there was no provision for the payment of a consultant for services given in an institution, but it would be found that certain fees were set apart to be paid to institutions to which patients were admitted, and certain doctors' fees would be saved and would follow those patients to the institution, and from those sources a fund could be provided from which the fees for consultants doing major operations such as Caesarean section could properly be met. Certain departmental committees were dealing with the subject, and one reason for bringing up the proposal this year was that it might go forward as the opinion of the Association to a committee which was now sitting, and which would be very glad to have the view of the profession before issuing its report. (Applause.)

Dr. B. H. PAIN (Tunbridge Wells) moved as an amendment:

> That in any future scheme of midwifery work a general practitioner and midwife be available for all women requiring ante-natal, natal, or post-natal treatment, and not simply in cases referred to the medical practitioner at the discretion of the midwife.

He had discussed the amendment, he said, with Dr. Brackenbury, and Dr. Brackenbury had parried all his arguments; it was as if he were an early Briton with a club tackling a triple-armoured tank. (Laughter.) He consoled himself by thinking, however, that in the Representative Meeting he would find a more responsive audience. The aim of the scheme, as stated in the *Supplement* of June 22nd (p. 239), was "to provide every pregnant woman with the services of a midwife and a doctor, the latter taking responsibility, ante-natal, natal, and post-natal, and attending the confinement if necessary or desirable." When the scheme was discussed by the Council, Dr. Dain, in reply to criticism, said: "If the patient in a normal confinement desired the presence of a doctor as well as a midwife, or if anaesthetics were given in a normal case, these would be extra expenditures to be met by the patient herself. They were not included in a national scheme." He read in the *Supplement* that it was agreed to recommend the scheme to the Representative Body as "a contribution on lines acceptable to the profession." Possibly it was the midwifery profession that was meant; he did not think it would be acceptable to the medical profession. The amendment he moved was passed as a resolution by the Tunbridge Wells Division eight weeks before the publication of the scheme. That explained why the wording did not fit in very well with the scheme he was criticizing. His Division felt strongly that no national scheme should prevent a woman having a doctor in attendance at the confinement, if she so desired and the doctor was willing to attend. The scheme said that if she wanted a doctor she must pay him herself, and many poor women would be deprived of a doctor on that account. A midwifery practice among normal, straightforward cases was helpful, if not essential, for obtaining the experience required to deal with one difficult case. (Applause.) It was necessary to watch the evolution of a normal labour so as to be alert to an abnormal labour. The scheme made provision for no such thing, and without it was a mere endowment to midwives in normal cases. If acted on it would not add a single midwifery case to the number attended by the doctors to-day. About 70 per cent. of confinements in this country were attended by midwives only, and the scheme would not affect that position; it might even mean that doctors would attend fewer cases than at present. Ante-natal, natal, and post-natal work should be in the hands of a general practitioner, who should have an opportunity under any efficient scheme of attending normal confinements. In Tunbridge Wells they had learnt their lesson. They saw all their midwifery work and the subsequent attendance on the children passing out of their hands and going to the midwife, then to the health visitor, and then to the school medical officer, and their private practice from those sources lessening every day. The Association's scheme did nothing to alter that state of affairs; in fact, it increased the midwife's stranglehold on the doctor's private practice. In the *Journal* of November 3rd, 1928, there was an account of a meeting on maternity services and local authorities, addressed by the late Minister of Health and by Dr. C. E. S. Flemming. Dr. Flemming was reported to have said: "The division of work between doctor and midwife was not quite so easy as it might appear, and until there was a sufficient supply of thoroughly qualified midwives, there would have to be some system of supervision by the medical man in ante-natal work." This was the exact opposite of what ought to have been said. His Division would prefer to say that until there was a sufficient supply of thoroughly qualified doctors, there would have to be ante-natal work done by midwives. The doctors in Kent were prepared to do ante-natal work forthwith, and he hoped the meeting would see to it that the Association scheme assured to them the opportunity, not only of ante-natal work, but of natal work as well. With regard to private practice, the interim report said:

> "The Association, it will be remembered, in its evidence before the Royal Commission on National Health Insurance, advised an extension of the medical service under that system which would supply a doctor and a nurse, *or* a midwife, to all insured women and the wives of insured men. Such an organized service would *of course* guarantee to all concerned ante-natal supervision and would eliminate the need for ante-natal clinics, for there is nothing medical done there that cannot be equally well done in the doctor's consulting room."

He had not yet met a midwife who got £2 10s. a case; more often she got 30s. or 35s. She was to get 50s. under the scheme. He was not saying a word against that, but comparing it with the doctor's fees he was to get pre-war fees and no increase at all. The scheme was really an endowment scheme for midwives, and the general practitioner was simply not in it at all. When he showed the scheme to a midwife her mouth had expanded into a huge smile; she saw untold wealth dangling before her eyes. The scheme was obviously not a general practitioner's scheme. The medical officer of health had his midwives working under him. Under the scheme he not only had the midwives, but the doctors too. The M.O.H. wanted better midwives, and to get them he must arrange that they should be better paid. The scheme did that excellently. The M.O.H. must see that the new midwives were subsidized; those who could not make a living because they had too few cases must get more than the agreed tariff; the scheme gave it to them. This was all very well, but the general practitioner willing to throw himself heart and soul into the new life-saving campaign was told in the scheme that he must look to the slender purse of the mother for his fees at her confinement. This was wrong, inhumane, and unfair not only to the general practitioner, but to the insured person and to the approved

societies, who would not endorse the scheme when they came to examine it. A rich woman had at her confinement a doctor and a nurse, and if she wanted an anaesthetic she had it. The working man's wife should have these advantages also, and she could afford to have them by a system of insurance, but not the insurance system of the proposed scheme. According to the scheme 450,000 of the 500,000 patients were still to be without a doctor, and were to be attended by midwives alone. He could understand the scheme being presented by a committee of the Central Midwives Board, or by a committee of the Society of Medical Officers of Health; but for the British Medical Association, which had always stood for the rights of the general practitioner, to bring forward such a scheme was to him most disappointing. (Loud applause.)

Dr. D. ROXBURGH (Marylebone) laid emphasis on the fact that the Association had not, under the scheme proposed, secured the one thing which he considered important—namely, that some medical man should be responsible for the cases. If the maternal morbidity had gone up seriously in the past thirty years, to his mind it must be due to the change in midwifery practice which had resulted during those years. The change caused by the Midwives Act had permitted the responsibility to devolve upon individuals whose education made them incapable of supporting it. In former days the value of a practice was decided by the midwifery. The older practitioner perhaps attended a thousand cases without a single death. But nowadays he was a wise practitioner who declared that he would not take any midwifery at all, and for this reason, that instead of getting a hundred cases a year, rough and smooth, simple and difficult, he was asked to take only ten cases, all of them difficult. Such was the influence of the Midwives Act upon men in general practice.

Dr. JAMES YOUNG (Edinburgh) said that if the remarks of the previous speaker (Dr. Roxburgh) were accepted they might seriously distort the course of the discussion. It was necessary to recognize that the object of this scheme was to reduce maternal morbidity and mortality. It was by no means true that these things were increasing, and when that was remembered a great deal of the argument advanced by the previous speaker fell to the ground. That argument could also be countered by reviewing the only figures available relating to the work of midwives, such as the splendid record of the Queen Victoria Jubilee Institute for Nurses, which dealt with, roughly, about 50,000 cases a year, with a mortality rate of from 1.3 to 1.5 per 1,000, roughly about one-third of the mortality in these cases in the community generally. As a matter of fact, if the scheme was read carefully from beginning to end he failed to see how any impartial student could refuse to accept the fact that it embodied machinery by which a satisfactory and efficient midwifery might be obtained in a way never before possible. At the present moment the ante-natal clinics which were at work throughout the country failed to accomplish this because of the curious and illogical position that the doctor who looked after the woman during her ante-natal period was not necessarily responsible for attention during her confinement.

Dr. C. M. STEVENSON (Cambridge) said that this was not intended as a scheme for the financial benefit of the medical profession. When he himself started practice midwives did 40 per cent. of the midwifery, now they did 70 per cent.; soon they would be doing 80 per cent., and he believed it possible for them to do 90 or 95 per cent. There were two reasons for this: they did it more cheaply, and they did it as well as, if not better than, the medical practitioners. The midwife could do a great deal more for her patient than the doctor—for example, she washed the baby. He urged acceptance of this scheme, which gave the practitioner his proper and appointed role in midwifery work.

Mr. N. E. WATERFIELD (Oxford) thought the scheme really meant an enormous advance in the practice of midwifery; but he did not feel satisfied about the provision that if a woman in normal labour wanted a doctor she must pay for him herself.

Dr. R. K. FORD (Preston) had found many practitioners keeping on midwifery—although saying it did not pay them—because they were afraid of losing the patient and her family. He was superintendent of a maternity home run by a local authority, where doctors sending patients had a right to attend them themselves if they desired, but this they rarely did, preferring to ring him up and ask him to see to the case. The medical profession must make up its mind as to what it wanted. If it did want to take a definite part in maternity work this scheme afforded it the opportunity, and he congratulated the committee on what it had achieved.

Dr. A. M. STUART (Walsall) asked whether the ante-natal fee of 10s. 6d. in the scheme applied to insured women and to those in receipt of parish relief, because these women were already being paid for, and were entitled to ante-natal and post-natal examination, and the Government was not likely to be persuaded to pay twice for the same service.

Dr. C. FORBES (Aberdeen) asked if the Council contemplated the application of a similar scheme to Scotland. The CHAIRMAN said he understood the intention was to apply the scheme, if possible, to England and Wales.

The CHAIRMAN OF COUNCIL, opposing the Tunbridge Wells amendment, said it confined itself to the statement that in any scheme there ought to be provision for a doctor as well as a midwife throughout every case. He recalled that Mr. Baldwin, in his election programme, had stated that if his party were returned to power a scheme for a national maternity service would be produced; no doubt the present Minister of Health was no less anxious than his predecessor to do something in that direction. There was a popular demand for it, and it had figured very largely in the speeches of all the parties during the last general election campaign. There was in existence—it had just completed its work—a Departmental Committee on which at any rate two members of the Representative Body had had places. It had put forward its ideas as to the arrangements which should be made in a maternity scheme, and its report was about to be considered. It was imperative that the Council, in pursuance of resolutions passed on more than one occasion by the Representative Body, should take this matter up, and at this opportune moment should present a scheme which would be in line with the wishes of the medical profession. He emphasized that a national maternity scheme must be made possible from the financial point of view, and must do for the women of the country all that it was necessary to do for them—though it was not required to provide them with everything that was convenient or desirable in all circumstances—out of the national funds. All the nation had to do was to ensure that every woman in pregnancy and labour was as safe as she could be made, and a scheme on the lines of the wishes of the profession, provided its application was not out of the question financially, was likely to be in the running with other schemes put forward, and to receive favourable consideration. It was of no use the Association putting forward a scheme which would cost two or three times as much as other schemes which were considered. There could be no doubt that a national scheme which provided, at the national expense, or at the expense of the compulsory insurance funds, the services of a doctor as well as a midwife, and made it necessary for that doctor to be, not merely in responsible charge of the case, but present at every confinement, would be financially out of the running. Although some members wished to wipe out all the legislation of the last thirty years, and to pretend there were no midwives at all, and that the nation did not want any, that would not be accepted. The Government might ask if it were really necessary for a doctor as well as a midwife to be present on every occasion, and for provision to be made for a doctor's fee in every case. Clearly it was not. This scheme was based on the fact that normal midwifery might safely be attended to at home, and general practitioners needed to emphasize that. They wanted to be in association with this maternity business, and to be responsible for the cases from an early stage until they were over; it was not necessary, on the one hand, that every case should go into an institution, nor, on the other hand, that the practitioner should sit by the bedside and watch the patient throughout the whole of her confinement, or anything like it. Figures proved that where cases were attended in the homes of the patients by midwives, however bad those homes might be—

and the midwives could call in the doctor in cases of abnormality—the conduct of that midwifery had been extraordinarily successful. The East End Maternity Hospital had had 11,196 deliveries in the homes of the women during ten years, and there were only two deaths. In the case of the Queen Victoria Jubilee Institute for Nurses there were over 53,000 deliveries, and only six deaths. The General Lying-in Hospital had attended over 16,500 cases, and there had been only three deaths; and in the case of the Edinburgh Maternity Hospital, out of 5,000 cases there were only two deaths. In the face of those figures it could not be pretended that it was necessary to have a national scheme which would make financial provision for a doctor's fee in every case. Therefore, whatever the Representative Body did with regard to the rest of the scheme—and he hoped it would adopt it in the end without dissent, because it was very urgent—he urged that this amendment should be defeated, because it made the impossible demand that in any scheme put forward by the Association that which was unnecessary for the public health and impossible for the public purse should be made a *sine qua non*.

Dr. C. E. S. FLEMMING said he did not believe that the members of the profession generally wished to attend to all deliveries, certainly not under the unsatisfactory conditions existing up to the present time. In the advertisements of practices for sale there were frequently such statements as "no midwifery," "very little night work," and so on. Whenever the question was raised at the Representative Meeting there was great applause at the idea that doctors were going to get more work to do, or cries of "Shame" when they were told that midwives were going to do more. When the night bell rang, however, their opinions were very different. (Laughter.) The conditions which would apply under this proposed scheme were very much more satisfactory; they would have opportunities such as were not now available for showing their skill, and would be able to produce satisfactory results with much less fatigue. But the problem of payment was a very important one. It had been stated that at present practitioners were attending only 30 per cent. of the cases. Assuming an average fee of £2 2s., that meant that they received only 60 guineas for each 100 cases. Under the new scheme, whether they had to attend at the confinement or not—and it could be assumed that in about 10 per cent. of cases that would be necessary—they would get £107 in respect of every 100 cases, and the work would be much less irksome. The object of the promoters of the scheme was to reduce mortality, and experience showed that where properly trained midwives were employed this could be achieved with great success, particularly where the doctor was called in for an ante-natal examination, and for the confinement when found necessary, and where the midwife was under his supervision, as was proposed in the scheme under discussion.

Dr. DAIN congratulated Dr. Pain on his speech, and the meeting on the discovery of a new speaker of great ability. On Dr. Pain's point of the need for a doctor in every case Dr. Brackenbury had come to his (the present speaker's) assistance, and there was little he need add. The scheme did not provide for a doctor for every case, partly on the ground of expense, and partly because the public neither asked for nor required it, and he thought most doctors would agree it was not necessary. It did provide what was not available at present, but what was very necessary—namely, medical supervision from beginning to end—and, as Dr. Flemming had pointed out, supervision in much more satisfactory circumstances. One of the points in favour of the scheme, when it was put before the public, was that it was not a scheme for the endowment of the medical profession. The subject had been approached from the point of view of reducing maternal mortality—from the point of view of the mothers of the country; so long as the doctor was properly paid for the services it was considered absolutely necessary he should render he hoped the Association would not seek to go further. The scheme had been called one for the endowment of midwives, but everyone recognized that the profession of midwifery was not all it should be because the conditions of the service were poor, and if that state of things could be altered it would be highly desirable that it should. The midwife, as at present, would call in the doctor when necessary. His own area had been more fortunate than that of a previous speaker. Either Birmingham women were not so insistent or Birmingham midwives were more adamant, but the 5s. insurance fee in Birmingham did provide a doctor whenever the midwife considered it necessary, without the patient being called on by the municipality or the doctor to find any fee, and the fees were paid on the statutory scale. He hoped the scheme would appeal to the members as being sufficient. He was satisfied no injustice was done to the woman who felt she would like a doctor present and was willing to pay for the amenities his presence might afford even in a normal confinement, for it was urged that the maternity benefit should be retained, and if every insured woman or wife of an insured man received £2 or more as maternity benefit she could afford to pay for what she desired.

Dr. PAIN, in replying, said that if 450,000 women were to be attended by midwives alone it was difficult to see where doctors would get the necessary experience to enable them to attend difficult cases. He had never asked for a general practitioner scheme so that doctors could make a lot of money out of it. A general practitioner was out to help his patients, and, although doctor and nurse could find no abnormality, if a woman was nervous it was cruel to tell her that if she wanted a doctor she must pay for him herself. Everyone would have read the interesting article on maternity mortality and insured childbirth by Sir Henry Simson in the *Journal* of May 11th last, in which the author said, "I have been forced to the conclusion that in primiparae at any rate a normal labour is not a common occurrence." He would like to know how that affected the financing of the proposed scheme. While the midwife was to obtain an increase of 60 to 80 per cent. in her fees, all that a doctor obtained who had to administer an anaesthetic for a colleague was a guinea; the doctor's fees were on a pre-war basis. The conditions regarding the maternity benefit should be altered so that the money went to the proper channels; it might go into a fund to be used as required. Dr. Brackenbury was rather misleading when he said the amendment advocated that a doctor should go to every case. The intention was simply that if a woman was anxious, even though there was no abnormality, she should have a doctor without having to pay for it out of her own pocket.

Dr. Pain's amendment was rejected.

An amendment on behalf of Brighton was moved, in the absence of the representative, with reference to the paragraph in the scheme dealing with the training of the midwife, that in order that satisfactory arrangements could be made for midwives to obtain post-certification instruction it was desirable that the local authorities should provide the necessary assistance.

Dr. DAIN considered that this was not necessary in view of what was done or projected already.

It was agreed to pass to the next business.

Institutional Treatment by General Practitioners.

Dr. GRACE GRIFFITH (West Suffolk), with reference to the memorandum outlining the scheme, moved:

> That institutional treatment by general practitioners is impracticable except in institutions specially arranged for the purpose.

Her Division wished merely to emphasize that it was impracticable that private practitioners should follow their cases into the general hospitals.

Dr. DAIN said he was unable to accept the amendment. It cut into another part of the policy of the Association with regard to the admission of general practitioners into hospitals to treat their patients. At the moment it was perhaps impossible for practitioners to go into the general wards of hospitals, but there was no insuperable difficulty in a doctor following his own case into the maternity ward, and the committee was strongly in favour of the man who started the ante-natal work having every opportunity to attend the case not only in the patient's home, but also—where it was not a case for a major operation—into the maternity hospital itself.

The West Suffolk amendment was lost.

An amendment by Newcastle-upon-Tyne to insert in the paragraph dealing with the scope and provisions of the

scheme, "That a supply of obstetric dressings should be available in every case," was accepted by the chairman of the committee, and was carried without discussion.

The Midwife and her Duties.

Dr. F. E. BRIERLEY (Cardiff) moved:

> That it is not desirable, as contemplated in para. 17 of the memorandum outlining the scheme, that the midwife should engage the doctor on behalf of the expectant mother.

His Division desired to bring forward the amendment because when a midwife was tired she was naturally inclined to call in a doctor to get the case over as rapidly as possible. That was not best for the patient, and it was preferable for the mother to engage her own doctor.

Dr. W. N. WEST WATSON (Bradford) supported the motion for the reason given by Dr. Brierley, and also because it often happened that a midwife sent all her cases to a particular doctor for whom she had a liking, who was frequently not the family doctor of the patient.

Dr. DAIN said he keenly appreciated the points covered by this and other amendments. The same view had been advocated in a recent letter to the *Journal*, which letter had made a very practical suggestion. He asked the permission of the meeting to redraft para. 17 in the sense of these two motions and of that letter, the letter suggesting that a more practical way of doing it would be for the prospective mother to engage first with the authority controlling the scheme. That seemed to do away with a good many difficulties.

Dr. BRACKENBURY, on a point of order, observed that this matter, involving an alteration in a committee report, should be referred to the Council for approval, and it was decided that a draft should be submitted to the Council for its approval on Monday morning, which draft could be subsequently presented to the Representative Meeting.

Capitation Fee for Ante-natal Work.

Dr. GRACE GRIFFITH (West Suffolk) moved that the question of a capitation fee for ante-natal work be considered. Her Division did not decide on a definite fee, but wanted to have one fee for the whole of the ante-natal supervision. Most of them in their private practice charged one fee for ante-natal and natal work if they attended right through. Another omission from the scheme was any allowance for the conveyance of patients to hospital.

Dr. DAIN said that any proper scheme should, of course, provide for the transport of the patient. The outline scheme he had presented did not pretend to provide for every detail. With regard to the capitation fee, it would mean merely a restatement of para. 43 (*a*). He had no objection to amend the paragraph by allowing of a capitation fee as an alternative.

The amendment was accepted.

The CHAIRMAN said that a proposal had been received from Walsall and Lichfield that the minimum fee in the maternity service for attendance on a confinement should be three guineas. This was a proposition which in other circumstances might be discussed by the Representative Meeting, but it was not in order under the schedule attached to the scheme, and he therefore ruled that it could not be proposed.

The Value of the National Scheme.

The PRESIDENT (Sir Ewen Maclean), speaking on the original motion to adopt the memorandum, said that he had looked forward to this discussion as one which directly concerned a most important branch of medical practice, and one which, he knew, must have engaged the widespread interest of the public, and he thought Dr. Dain would say that the discussion had proceeded on very gratifying lines. The speaker had desired to gather from the discussion what was likely to be the attitude of the men and women on whom the responsibility must depend. No scheme would be successful unless it engaged the active sympathy and good will of the general practitioners. These were more than the first line of defence; they were those who had the duty of carrying the scheme forward in its further development. For it was obvious that we were only at the commencement of a very great readjustment of this branch of practice. It had been said that such a scheme as this would tend further to diminish the proportion of cases to be attended by doctors. ("Hear, hear.") He entirely disagreed. If he felt that this was to be the case he would not support it. It seemed to him that here was an opportunity for the profession to regain lost ground; he was convinced that the proportion of cases to be attended by the general practitioner under such a scheme must steadily increase. With regard to the wonderful and gratifying figures quoted in relation to certain extern midwifery institutions, he suggested it was unfair to quote them by way of comparison with the cases attended by midwives who were not working in connexion with such institutions. The institutions were guided and incited to do their best work by medical practitioners, whereas the practice of the midwives outside those institutions was not so guided and inspired. Discussing finance, the President repeated what he had said when the scheme was placed before the Council—namely, that he would deeply regret that it should be recommended to the public authorities or to the Government of the day because it was cheap. There ought to be more money in the scheme. During the last General Election campaign every political party had claimed to be directly and keenly interested in the problem of maternal mortality; therefore he claimed that those in authority must be expected to pay the reasonable costs of such a scheme, and he added that, whatever might be the cost at the start, any scheme with the same objective must in the course of time cost more and more. With the development of ante-natal work, morbidity and mortality from midwifery cases must necessarily diminish, and that was a matter which must be borne in mind with regard to the provision of beds to back any such scheme. All concerned must agree that any such scheme which was not backed up by an appropriate number of institutional beds was likely to fall short of success. He did not imply, however, that any institution was good because it had the beds; every institution was good or bad according to the manner in which it was administered. He hoped profoundly that the Representative Body would agree that this scheme, with all its defects—and it had some—represented a fair contribution to the solution of a great national problem, and would approve it, with the proviso that, if and when the Government committees now working on the subject submitted in their reports certain recommendations which could not well be accommodated to the scheme, the Council of the Association should be empowered, and indeed instructed, to ensure that before the recommendations were put into operation regard should be paid to the general feeling of the Representative Body, representing the general practitioners throughout the country. (Applause.)

Dr. C. E. S. FLEMMING, congratulating the committee which had produced this excellent scheme, said it was practicable to work, and, he believed, economically sound. Its operation might cost more than the figure set out, but that was not a very serious matter. It allowed all concerned to give more time to their work, and made for efficiency of the work done under it. Another important aspect was that it served to bring medical men generally into closer contact with the midwifery services of the country, and there was no principle in it which in any way transgressed the policy of the Association. The discussion had been extremely useful, in that it had served to draw attention to certain weaknesses and certain points in regard to which the scheme might be improved, and no doubt attention would be drawn to other such points in time. The important thing was that the Representative Body should accept it as a contribution to the solution of the problem of preventing maternal mortality and morbidity, and that it should be placed in the hands of the Government, who alone could make it effective. It was important that the Government Departments concerned should be acquainted with the views of the medical profession, and especially with the views of the general practitioners, who must be intimately concerned in the working of any scheme the purpose of which was to reduce maternal mortality and morbidity. Whether or not any scheme of this sort was to be really effective must depend to a large extent on the general practitioner, and he hoped that the scheme would be passed by the Representative Body so that

it might be considered by the Government Departments concerned. If defects became apparent in the future he felt sure that it would only be necessary for the Association to make representations to the Government, and that the Government would be only too glad to consult a body such as this.

Dr. DAIN said the committee which had drawn up the scheme would be gratified by the discussion and by the reception it had received. It embodied no principle to which the Representative Meeting had not already given its assent, and in that respect it might have been unnecessary to submit it to the meeting; but when put together as a complete whole it afforded the representatives an opportunity of reviewing their policy as expressed in its separate items. He was grateful to the President for suggesting that, if it was true that much less than 70 per cent. of the cases of midwifery were normal, then, under the scheme, a doctor would attend more midwifery cases and not less. There were two points the President mentioned to which he wished to refer, and regarding which he desired to tender his apologies, for if he had misled the President he must have misled the meeting also. The figures quoted with regard to the good work done by certain maternity services and teaching schools were not put forward as a reflection on the practice in the rest of the country, nor for purposes of comparison, but as an ideal which it was hoped the new scheme would attain. The present figures were the outcome of present circumstances, and it was confidently anticipated that by the adoption of the scheme they could be improved. Secondly, figures were quoted to show that the scheme would not be expensive, but it would not be in the ordinary meaning of the word a "cheap" scheme. The President used the word "cheap." He apologized if he had given the idea it would be a cheap scheme; it would be efficient and economical, but not cheap.

The motion to adopt the memorandum as a contribution on lines acceptable to the profession towards the establishment of a national maternity service scheme was carried.

PSYCHO-ANALYSIS.

The Report of the Special Committee.

Just before six o'clock the CHAIRMAN called upon Dr. Langdon-Down to bring forward the report under "Psycho-analysis." Several representatives expressed a wish that the discussion on this subject should not be taken at that late hour of the sitting. Dr. J. T. D'EWART moved that the discussion be deferred until Monday morning, and that "Medical Benevolence" be taken during the last half-hour; Dr. L. A. PARRY seconded, pointing out that all the representatives were tired. The CHAIRMAN OF COUNCIL said that if he was tired he would rather take psycho-analysis than medical benevolence! The motion to adjourn the discussion was lost.

Dr. LANGDON-DOWN moved approval of the report under "Psycho-Analysis" (*Supplement*, June 29th, p. 256), and also that the report of the committee as submitted to the Council be accepted as discharging the instructions given to the Council. There were probably, he said, some members present who also attended the 1926 meeting at which the Psycho-Analysis Committee originated, but there would be others who were not present on that occasion. When the subject was then propounded by the Council as a matter for investigation, various views were expressed deprecating the formation of such a committee, for the most part for two reasons: the nature of the subject, which it was held rendered it an undesirable one for such consideration, it being a matter of developing theory on which there was a great absence of common ground, and on which it would be difficult to lay down any unified conclusions, and the inevitable difficulties which must arise between the members of such a committee. The Representative Meeting, however, far from accepting those as reasons for not appointing a committee, considered them good grounds for its appointment, and accordingly the Council was instructed to appoint it. Difficulties did appear to some extent, but he did not think they were as great as had been anticipated. The subject-matter was a very difficult one, and that had inevitably governed the nature of the report. The Council was to be congratulated on having secured the adhesion and support of a very distinguished company to discuss the matter, a vital necessity because on such a matter the best opinion obtainable in the country must be taken. The committee was very varied in its attitude and experience; it worked most thoroughly, and the thoroughness with which its work was done justified the time and expense involved. The personnel worked very well together, though strong opinions were expressed on both sides. An immense amount of valuable work was done by Dr. R. G. Gordon, who accepted the post of honorary secretary. After the first year's work the permission of the Council was obtained to co-opt two specialists in the branch of study in question—Dr. Godwin Baynes and Dr. Ernest Jones. Dr. Godwin Baynes was absent from this country for most of the time, but immense assistance of the highest expert quality was obtained from Dr. Ernest Jones. Dr. Langdon-Down paid a tribute also to the valuable assistance given by the Chairman of the Representative Body, Dr. Hawthorne, in the final phraseology of the report. The general line followed by the committee was that laid down by the Representative Body in 1926, that it was to investigate the matter from the point of view of a report which might be useful to the ordinary practitioner. It was impossible to summarize the literature on the subject, or to give a handbook so that the general practitioner could start undertaking practice in psycho-analysis, or, again, to lay down a dogma as to the rights or wrongs of the matter. At an early stage it was found necessary to define the subject of the report, and it was accepted that psycho-analysis was the doctrine and practice of Freud and his followers. There were many differences of opinion, and not more than two members of either school of thought agreed with each other. It was inevitable that the report should be an open one, and that was desirable from the point of view of the Association, which had always regarded it as dangerous to attempt to lay down the law to medical practitioners on questions of medical treatment, of theory, or of technical methods of diagnosis, and had taken the view that a qualified doctor must follow his own bent. The committee, therefore, asked the Representative Body to accept the report as the discharge of the instructions it had given to the Council.

Dr. L. A. PARRY (Isle of Wight) moved:

> That the Representative Body, while accepting the report of the Psycho-Analysis Committee, and thanking the members of that committee for their services, regrets that more emphasis has not been laid on the very real and serious dangers, especially to children and adolescents, of any system of mental therapy which postulates a sexual basis as the sole or preponderating cause of nearly all neuroses and pathological mental conditions.

In doing so he remarked that it was unnecessary for him to utter an apology for moving the amendment, as it had been inevitable from the beginning. Four years ago he had felt that there were very grave potential dangers in the theory and practice of psycho-analysis, and as the result of attending an enormous number of meetings, listening to psychologists of every school of thought, and reading a great deal on psycho-therapy and psycho-analysis, he was more than ever convinced of those dangers. Instead of bringing him nearer to the other school of thought, it had driven him further away. The whole theory of that system of psycho-analysis was based on one thing, and one thing only: that sex, used in no esoteric sense, but in the ordinary sense, was at the basis of every neurosis and every departure from normal conduct; and that was the thing he objected to. The theory was that the basis of all neuroses, of all alterations of conduct in babies in arms, young children, adolescents, and grown-up people, was the sexual basis—what they called, in a euphemistic term, the Oedipus complex—the incestuous love of a boy for his mother and the girl for her father being the basis of all abnormal conduct. Even such things as head-nodding, thumb-sucking, and so forth were all said to be due to the fact that the Oedipus complex was dominating their subconscious minds. That was the thing of which he wanted the Representative Meeting to express disapproval. To treat young children on that assumption led to obvious dangers. This was not his own view merely. The amendment was down in his own name, but it was upheld by two Divisions and one Branch. It was not based on hostile criticism of the committee; he recognized the good work it had done. There was much that he could say, but he

did not think it desirable to say it in public. If the theory of the Oedipus complex was not true, then psycho-analysis had no reality. He simply asked the meeting to state that this—to use a mild word—unpleasant, and he believed wholly untrue, basis for the psychology of life was objectionable and attended by serious dangers. (Applause.)

Dr. M. G. BIGGS (Wandsworth) objected to the amendment because it savoured of prejudice or intolerance, which should have no part in a scientific discussion. The only criterion was truth or falsehood. There was scarcely any branch of science the strangling of which in its early stages had not been attempted either on the ground that it was against morals or against religion. He was not himself a psycho-analyst, but he believed the psycho-analysts were doing a real work. If, of course, it was proposed to issue small books for children and adolescents telling them all about it, then he would be with Dr. Parry. But he felt that the only way in which to settle a question of this kind was by asking whether it was true or not true. (Applause.)

Mr. E. B. TURNER (Kensington) said that when psycho-analysis was sprung upon the world some thirty years ago he found that, either without his advice or against it, a good many children and adolescents of his acquaintance were psycho-analysed, with the result that in subsequent years he had had to clean up a great deal of very unpleasant material. He would be told that probably they were not psycho-analysed in the right way or by the right people, and it was possible that some of these children were treated by pretenders to the art. But they had also been told that it was not for them to say whether these things should be done or not. He held, on the contrary, that it was the duty of responsible medical men, if they saw dangers ahead, to point them out. There was no doubt that psycho-analysis was founded, in the great majority of cases, absolutely on the sexual basis as explanatory of everything, and he had to deal with those who had suffered moral, and in some cases physical, damage from this teaching. It made young people think of things they never dreamed of, and dream of things they never thought of. (Applause.)

Dr. R. G. GORDON (Bath) opposed Dr. Parry's amendment, but at the same time paid a tribute to Dr. Parry himself. He had stated that he was convinced that everything connected with psycho-analysis must be wrong. Those who were well versed in theological questions knew that an article of faith required no proof, and in most cases was incapable of proof. For two years Dr. Parry had maintained the same article of faith, and in the face of persuasive arguments, jeers, and even of insults he had maintained the same urbanity and good temper that his colleagues always associated with him, because he had been firm in his faith. (Applause.) Dr. Gordon submitted, however, that a scientific report could have nothing to do with articles of faith; what was needed was proof. During two years no case had been brought before the committee which could be substantiated in favour of Dr. Parry's proposition; the cases brought forward had been found to be unsubstantiated in their evidence, or were such that they had nothing to do with psycho-analysis as defined by the committee. Of course, in the early days of any system of treatment there were many people who thought they knew all about it directly they had read the name, and there was no doubt that much harm had been done in the name of psycho-analysis. He was certain that all the members of the committee were agreed on that point. The members of the committee who emphasized that point particularly were the psycho-analysts themselves; indeed, that was stated in the report. It was not fair to condemn psycho-analysis because certain wrong things had been done in its name; he did not believe that all the findings of psycho-analysts were correct, but it was necessary to be fair, and Dr. Parry's amendment was not fair. He had stated that "psycho-analysts postulate a sexual basis for all their neuroses." The evidence before the committee, however, was to the effect that they did not postulate it, but that by examination they always found it. That was a different thing from postulating it. It was not the business of this committee to adjudicate, unless it had very strong evidence, that any system of treatment was necessarily wrong simply because mistakes, and even disasters, had occurred. For instance, in all forms of surgery, in the early stages, mistakes occurred owing to insufficient knowledge and inadequate technique. If one point were emphasized strongly in the report it was that there was great need for better instruction in psychology, not only for those undertaking psycho-therapy, but for the whole body of medical practitioners. Therefore, in spite of the great weight of Mr. Turner's opinion, he felt that the cases Mr. Turner had cited had not been subjected to proper criticism, and the experience of the committee was that when cases had been subjected to such criticism the fault could not be laid at the door of the psycho-analysts. (Applause.)

At this point the discussion was adjourned.

ELECTIONS.

Chairman and Deputy Chairman of Representative Body.

The MEDICAL SECRETARY announced, amid loud applause, that Dr. C. O. Hawthorne had been re-elected Chairman, and Dr. A. Lyndon, Deputy Chairman, of the Representative Body, in each case without a contest.

Twelve Members of Council.

The election of twelve members of Council by grouped representatives resulted as follows:

Group I.—North of England and Yorkshire—Dr. ROBERT FORBES.

Group II.—Lancashire and Cheshire, and North Lancashire and South Westmorland—Dr. F. J. BAILDON.

Group III.—Cambridge and Huntingdon, East Yorks and North Lincs, Essex, Midland, Norfolk, South Midland, and Suffolk—Dr. J. W. BONE.

Group IV.—Birmingham, North Wales, Shropshire and Mid-Wales, South Wales and Monmouthshire, and Staffordshire—Dr. J. R. PRYTHERCH.

Group V.—Metropolitan Counties, Inner—Mr. E. B. TURNER.

Group VI.—Metropolitan Counties, Outer—Dr. H. S. BEADLES.

Group VII.—Bath and Bristol, Dorset and West Hants, Gloucestershire, South-Western, West Somerset, Wiltshire and Worcestershire, and Herefordshire—Dr. H. C. BRISTOWE.

Group VIII.—Kent, Oxford and Reading, Southern, Surrey, and Sussex—Dr. C. G. C. SCUDAMORE.

Group IX.—Aberdeen, Dundee, Edinburgh, Fife, Northern Counties, and Perth—Dr. JOHN STEVENS.

Group X.—Border Counties, Glasgow and West of Scotland, and Stirling—Dr. J. B. MILLER.

Group XI.—Connaught, Leinster, Munster, and South-Eastern of Ireland—Sir WILLIAM I. DE C. WHEELER.

Group XII.—Ulster.—Dr. R. W. LESLIE.

There were contests in Groups I, VII, VIII, and IX.

Colonel A. E. HAMERTON, G.M.G., D.S.O., late R.A.M.C.(ret.), and Group Captain N. J. ROCHE, O.B.E., R.A.F.M.S.(ret.), were elected to the Council, the former to represent the A.M.S., and the latter the R.A.F.M.S.

The meeting adjourned at 6.30 p.m.

Monday, July 22nd.

REPORT ON PSYCHO-ANALYSIS.

(Discussion Resumed.)

THE discussion of the report under "Psycho-Analysis," which was opened shortly before Saturday's adjournment, was the first business taken when the meeting reassembled at 10 a.m. with Dr. HAWTHORNE in the chair. The motion by Dr. Parry was before the meeting—namely:

> That the Representative Body, while accepting the report of the Psycho-Analysis Committee, and thanking the members of that committee for their services, regrets that more emphasis has not been laid on the very real and serious dangers, especially to children and adolescents, of any system of mental therapy which postulates a sexual basis as the sole or preponderating cause of nearly all neuroses and pathological mental conditions.

Dr. C. E. DOUGLAS (Council) said he desired to speak on the general report, and asked that the five-minutes rule should be relaxed in view of the importance of the subject. ("No, no.")

The CHAIRMAN pointed out that members would have an opportunity of speaking twice on the subject, first on the

amendment and secondly on the original motion, or on the amendment as a substantive motion if carried, and therefore he did not feel authorized, without the express direction of the meeting, to relax the rule.

Dr. DOUGLAS, continuing, said the report throughout took up an attitude as if no one had ever dealt with the subject before, but if Freud had asked any Roman Catholic priest at any time during the last thousand years he would have been told that in the confessional something like 90 per cent. of all the confessions made dealt with sexual subjects. It was an old story, and the only new thing that Freud had brought up was that it was also to be met with in childhood. The report also seemed to deal with the subject of the unconscious mind as if it were a new thing; yet in metaphysics and in philosophy they had known that subject for thirty or forty years. Schopenhauer dealt with it; von Hartmann, in his *Philosophy of the Unconscious*, dealt with it in three volumes. William James had dealt with it in his *Varieties of Religious Experience*, of which his (the speaker's) own copy was dated as long ago as 1904. The psycho-analysts came along and said they had discovered these matters. They had not. The only difference was that in James the threshold of the subliminal consciousness was a clean threshold; the subliminal consciousness of Freud was a threshold muddied by dirty little footmarks. ("Hear, hear.") It was stated in one of the criticisms given in the report that "Some critics hold that the directing of a patient's thoughts to sexual matters must be harmful morally," and so on. The reply furnished was an example of the sort of arrogance with which the psycho-analysts seemed to deal with all objections raised against them: "If one has to take this criticism seriously . . ." Of course one had to take it seriously; it was the very gravamen of the whole story, that it was a bad thing morally to direct a patient's thoughts to matters sexual—

> "If one has to take this criticism seriously one is compelled to point out that, as is indicated by the one-sided and tendentiously misleading allusion to psycho-analysis in its wording, and still more by the far stronger expressions and accusations which the committee does not quote, the criticism is founded on a combination of ignorance and prejudice."

Was that a sound criticism of the objection? He urged that it was not. The objection which had been made had not been answered, and, therefore, the question arose as to whether doctors in general practice could take the responsibility for subjecting their patients to such a revolting treatment.

Dr. J. S. MANSON (Warrington) said that when he received the agenda paper and noticed the motion by Dr. Parry, containing its reference to the very real and serious dangers of this matter, he had said, "Here is this old subject turning up again." He considered that the appeal Dr. Parry was making was not an appeal made to the Representative Body as members of a scientific profession, but as ordinary human beings; he was making an appeal to their prejudices—(cries of "No")—to those hostile emotions which were always associated with breaches of, or antagonisms to, traditional or conventional habits of thought, and, as had been stated by Dr. Biggs, it was a fallacious appeal. If this theory of the sexual basis of the neuroses were true, then, whether the members of the profession liked it or not, they must accept it; that was the attitude which the profession must adopt towards this subject. No doubt there were abuses of this process—("Hear, hear")—and no doubt there were people practising who had not been trained, or who had not studied the question; but that was not the subject of the report that had been brought before the Representative Body. The members of the profession must treat the matter seriously. They must avoid a fallacious sense of repugnance. New things had often been repugnant, but had been accepted subsequently. On those grounds he asked the Representative Body to say that the appeal made to it was a fallacious appeal, and to reject the motion.

Dr. C. M. STEVENSON (Cambridge), urging the Representative Body to abandon this "heresy hunt," asked if it had ever done any good by heresy hunting. His answer was that it had done the profession harm. Again, was the present discussion doing the profession any good in the eyes of the general public, who could not really understand it? They should read history, and refresh their memories as to what had happened as the result of past heresy hunts. There were members of the Representative Body who were sufficiently old that it was not necessary for them to read history, because they knew everything from personal experience, but there were others who were not in that position. The only way to deal with a matter such as this was to give their opponents plenty of rope, and they would either hang themselves or would justify their statements. Posterity would judge, twenty or thirty years hence, as to which side was right.

Dr. J. T. D'EWART (Manchester) asked if the Representative Body believed for a moment that Dr. Parry had put forward his resolution without having given due thought to it, or that he did not recognize, as most of the representatives did, that there were dangers in this problem. Dr. Manson, of all people, had said that Dr. Parry had appealed to the prejudices of the representatives, and Dr. Stevenson had said that they were heresy hunting. That was not so. They were out to protect certain members of the public—their patients. What must be thought of a man who dared to stand on that platform and say that he was appealing to posterity? What about the present generation? Their patients were not posterity, and the doctors were not responsible for posterity. Let them stick to their patients. Had any one of Dr. Parry's opponents stated that no harm was being done? Had not Dr. Gordon—whose word they were prepared to accept implicitly—skated over that very gently? He (Dr. D'Ewart) knew that there were people who were suffering from these so-called psycho-analysts. It had been said that the practitioners were not properly psycho-analysts, but the trouble was that they were working under the flag of psycho-analysis and calling themselves psycho-analysts, and surely Dr. Gordon did not wish to defend them. It was the duty of the profession to protect their patients against them. This Association had attained for itself a position in the public affairs of this nation which it could not afford to lose. It was working in the public interest, contrary to which it must not go. He urged the members of the Representative Body to think carefully about this matter, and not to be swayed by statements that an appeal was being made to their prejudices. Did anyone present dare to say that there was no public danger? If they dare not, they must not vote against Dr. Parry's motion.

Dr. F. H. BODMAN (Bristol) said the meeting was not a court of morals or manners, and when it discussed a scientific report should treat it in a scientific way. Having read most of Freud's translated works, as well as many papers by English authors on the subject, he thought there was a body of scientific evidence to support both the principles and the application of psycho-analytical technique; nor had he come across a juster or more lucid explanation of the question than was contained in the report under discussion. The matters revealed by psycho-analysis were often painful and repugnant, but the issue should not be shirked on that account. The Representative Body would create an unfortunate and unworthy precedent if it did not support the report of the committee and reject Dr. Parry's motion.

Dr. PETER MACDONALD (York) said that, while he might not be able to take up Dr. D'Ewart's challenge precisely in the form in which it was made, he could do so in part. While feeling great sympathy with Dr. Parry, he hoped the meeting would reject his motion. Personally, he had attended twenty-one out of the twenty-two meetings of the committee, and had endeavoured to consider the question without that prejudice which Dr. Parry evidently had maintained throughout the proceedings, for prejudice was a bad guide to conduct. He himself at the beginning knew nothing about the subject and was in a fog, and he was still more or less in a fog, because psycho-analysts talked a language he did not understand; but two things did become clear to him in the course of the proceedings. One was that real psycho-analysts were not charlatans, and the other was that proof of the asserted dangers of psycho-analysis seemed to disappear under investigation. Dr. Parry asked the meeting to vote for a motion which implied there was a serious danger, especially to children

and adolescents, in any system of mental therapy which postulated a sexual basis, the Oedipus complex. The committee had gone into that question more thoroughly, perhaps, than into any other. Personally, he did not know whether what Dr. Parry said was correct or not, but he was certain the Representative Body was in an even worse position to know than he was, and he begged it not to commit itself on a scientific subject to such a statement as that, when it did not know, and knew it did not know. He hoped it would reject the motion. He wished to associate himself with what the chairman of the committee had said as to the splendid work done by Dr. Gordon, and to add that the Association was indebted to the chairman, Dr. Langdon-Down, to an almost equal extent.

Dr. L. W. BATTEN (Hampstead) pointed out that, while it had been said the Representative Body was asked to condemn people who were not proper psycho-analysts and who harmed their patients by trying to carry out what they believed to be the Freudian doctrine, as a matter of fact what the motion did was to condemn not particular people but a system, and to condemn it not only because it was said to be untrue and harmful, but because, as Dr. Parry had almost put it, nothing so unpleasant could possibly be true. That was a very dangerous doctrine. There were people to whom experiments on animals were as repugnant as was this subject to Dr. Parry, and who, because they thought them so unpleasant, came to believe that no good had resulted or could result from them. Doctors must not fall victims to that kind of mental affectation, and say that because a doctrine was unpleasant it must be untrue.

Dr. D. CLOW (Gloucestershire) thought many members might well doubt the wisdom of the question being raised in the Representative Meeting for some sort of solution, but there could be no two opinions about the patience, the sincerity, and the discretion with which it had been investigated. To go back to the genesis and development of the controversy, it arose four years ago at Bath, when Dr. Parry put before the meeting three cases of alleged gross abuse through psycho-analysis. The Representative Body wisely decided to refer the matter to the Council for investigation, and the Council, after receiving all the evidence Dr. Parry could put before it at the time, decided to take no further action. Three years ago, at Nottingham, Dr. Parry raised the question again, and said all he wanted was an impartial investigation into psycho-analysis and its place in medicine. That investigation had now been carried out, and Dr. Parry had had ample opportunity to place before the committee all the evidence he could get. Nevertheless, the committee was not satisfied from the evidence put before it that any gross abuses had arisen from this practice. Dr. Parry, however, still came forward and said, in effect, "I could a tale unfold whose lightest word would harrow up thy soul." It was not unreasonable to suggest, therefore, that what had been desired was not a full and impartial investigation, but that the Representative Body, and through it the Association, should make some sort of pontifical pronouncement which would have the effect of discrediting or discouraging the practice of psycho-analysis. This matter was one of the worst on which it could so pronounce, because, in the admirable phrase of Dr. Langdon-Down, this thing was at the growing point of medical theory, and he hoped the meeting would turn down this amendment. If the amendment was carried in the way Dr. Parry wished it to be carried, it would have very wide repercussions; it would be seized upon, and the British Medical Association would be thrown up in a very lurid light.

Dr. E. K. LE FLEMING (Council) said he hoped the meeting would pass this report without any amendment whatever. ("Hear, hear.") He believed this report was issued by a committee which was set up in consequence of certain statements which had been made at a Representative Meeting, to enlighten, as far as possible, what he would call the general practitioner of the country as to what could be proved against psycho-analysis. All would feel satisfied that the inquiry which had been made was exhaustive, and was made in the best possible way. A more difficult subject to investigate could hardly be imagined, and he felt sure that no other body could have produced a more enlightening report than this one. He had himself been keenly interested, as a general practitioner with no knowledge whatever on the subject, to keep in touch with the views of those who were serving on this committee, and he looked at the report to see how far the views that he obtained from these people were represented in the report. He studied with special interest paragraphs 27 to 36, which helped him greatly in his work as a general practitioner. He was convinced on the two points which Dr. Peter Macdonald laid stress on, that psycho-analysts as defined in this memorandum were genuine workers, believing in what they professed to believe, and working along the lines which they believed to be honest. He was not satisfied that the allegations which had so upset some members of the conference had been proved. If they had been as abundant as had been suggested by Mr. Turner, and perhaps by other speakers, surely one or more incidents would have been brought before the committee to substantiate them. He held an open mind; he believed every practitioner who was anxious to get the best knowledge on this subject must hold an open mind. Whatever was true on this subject could not be suppressed, but would become more evident in course of time. Whatever was false would fade away and disappear. At one time he was inclined airily to dismiss such subjects as spiritualism, water-divining, and so forth, but now he had learned to preserve an open mind on those matters. It was the only reasonable attitude for a scientific man. A favourite quotation of his was: "Oh, what a dusty answer gets the soul hot-foot for certainty in this our life."

Dr. LANGDON-DOWN desired to congratulate the meeting on the high level which the debate had reached. Almost all the points had been touched on, but he would like to review the matter. Dr. D'Ewart had tried to persuade the meeting that the psycho-analysts were the people who were led by emotion, that he and his friends were the placid scientific people, and he tried to confuse his hearers by disregarding what was meant in the report by psycho-analysis and psycho-analysts without any fundamental coherent argument at all. Coming to the motion by Dr. Parry, those present would see that it was a complicated farrago of implications to which, if passed, the Association would be committed. Dr. Gordon said that the psycho-analysts had postulated a certain theory as to the origin of the neuroses. That was not correct. The psycho-analysts had built up a theory based on their investigation of the data presented to them. The implication of the motion was that by rejecting that theory one set up an axiom of one's own based upon one's instincts and traditional teaching; that that theory, however it was obtained, was false. This ran directly counter to the proposition which he, the speaker, put before the meeting in his opening remarks—that nothing could be more unwise than for that body to lay down dicta or dogma on questions of that kind. Coming back to a point a little earlier in the motion, Dr. Parry had led his hearers to suppose that the dangers of psycho-analysis depended on the theory at the basis of the neuroses. Anything more absurd could scarcely be imagined. The dangers which Dr. D'Ewart challenged were admittedly there, but they did not depend in any degree on the truth or falsity of any theory which might be propounded as to the causes of the neuroses. The dangers lay in any form of exploratory mental therapy, whatever theory was at the basis. He would go a little further into the question of these dangers. What made the danger? It was not the theory which might lie at the basis of the psychology; it was the nature of the mind itself, working, as it did, in a complicated civilized structure. Who were the best guardians against these dangers? No one had more clearly pointed out the dangers than the psycho-analysts themselves. The committee had stressed very strongly the dangers which were inevitable. The very appointment of the committee was sufficient to refute the suggestion that the Association had neglected those dangers. He hoped the arguments he had used would persuade the meeting to reject the motion of Dr. Parry.

Dr. PARRY, in reply, said that Dr. Biggs had accused him of intolerance. He had been not at all intolerant.

All he was asking the Representative Body to do was to point out the dangers and abuses of a certain system of psycho-analysis, just as a French committee a hundred years ago had pointed out the dangers of morphine. Mr. Turner, in his vigorous speech, had pointed out the dangers ahead. He recognized those dangers, but he also recognized the present dangers, and it was against those that he was asking the meeting to vote. Dr. Gordon had referred to the two years of "insults" he (Dr. Parry) had had to endure. He could assure the meeting that if he never had anything worse to endure than those pleasant gibes of Dr. Gordon and his colleagues on the Psycho-Analysis Committee he would not resent them very much; he was not so thin-skinned as that. Dr. Gordon had said that all his (the speaker's) opinions were matters of faith and not of proof. He did not agree, but, after all, faith was something. It was impossible to bring patients and doctors and psycho-analysts before the committee and cross-examine them to prove the dangers to which he had alluded. It was impossible to prove them, but there was such a thing as deductive reasoning. If he handed a small boy a tin of gunpowder and a box of matches, must he produce the charred body of the boy to prove the danger? (Laughter.) Dr. Douglas had referred to psycho-analysis as being no new discovery. He did not think the Roman Catholic priests would like the slight reference to sex matters which must occur in the confessional to be confused with the references to sex matters made by the psycho-analysts. There was no comparison. Dr. Manson had said he (the speaker) was appealing to the prejudices of members. He denied that *in toto*. He was asking them to use their good common sense, for which they were noted, and to vote with him on his motion. Dr. Manson had also said that if the theory of psycho-analysis was true, it would have to be accepted. Of course, that was so, but his four years of study, in which he had listened to all the protagonists of the psycho-analytic school, had not produced one fact which convinced him that there was any truth in it. Dr. Stevenson had referred to "heresy hunting." Surely that was a big term for his resolution. All he was asking the meeting to do was to express by a vote that there were grave dangers in the system of psycho-analysis. He thanked Dr. D'Ewart for his vigorous support, which had helped him considerably. Dr. Peter Macdonald had offered his sympathy; but he would rather have his vote. (Laughter.) He had not time to deal with the arguments of Dr. Langdon-Down, but he wanted the meeting to say that if the system of psycho-analysis was allowed to go on uncontrolled, there were not only grave and definite dangers to patients, but a very grave and definite danger of bringing considerable discredit on the profession. (Applause.)

Dr. Parry's motion was lost.

Dr. J. S. MANSON (Warrington) moved that the Representative Body, "in accepting the report of the Psycho-Analysis Committee, thanks the committee for their services."

Dr. WALLACE HENRY asked whether the representative of Warrington desired to whittle down the approval to the mere acceptance and receiving.

The CHAIRMAN said that the interpretation of the word "acceptance" was entirely a matter of opinion.

Dr. LANGDON-DOWN said he was naturally unwilling to disclaim the thanks tendered to his fellow members of the committee, but would regret that the actual form of words in which his original resolution was couched should not be adhered to.

Dr. C. E. S. FLEMMING asked whether Dr. Manson would accept his amendment as a rider to the motion.

Dr. MANSON replied affirmatively.

Dr. BUIST pointed out, as a matter of order, that the proper form for an amendment was that certain words be removed from the motion and others added or substituted.

The CHAIRMAN agreed, and ruled that the amendment was in order.

Dr. LANGDON-DOWN moved to proceed to the next business.

The CHAIRMAN said he could not accept this motion in discussion of the work of a committee which had sat for two and a half years. ("Hear, hear.")

The CHAIRMAN OF COUNCIL pointed out that the difference between the motion and the amendment was that the motion merely accepted the report as discharging the committee, while the amendment said that the report be accepted and the members be thanked for their work. He preferred the amendment, because it was stronger.

Dr. FORBES asked for the Chairman's ruling as to whether the word "acceptance" meant "approval." ("No, no.")

The CHAIRMAN said two things prevented him from doing that. One was that he had lived too long, and the other was that he had been the Chairman of the Representative Body too long. (Laughter.) He recognized that it was not his business to provide definitions for words in the English language. Those were to be interpreted by reference first of all to the dictionary, and secondly, to the custom and genius of the English tongue. He could only tell the meeting what the word was; what the understanding of the meeting was, was beyond him. (Laughter and applause.) He thought it was high time the meeting came to a decision.

Dr. FORBES pressed his question as to whether the acceptance of the report was to be interpreted as meaning approval of it.

The CHAIRMAN replied that he could not put his own interpretation on the wording of a motion by any constituent body, and that whether the word "accepted" was interpreted as meaning approval was a matter of purely academic concern.

In response to a request to read the motion and the proposed amendment, the CHAIRMAN said the only modification to the motion for the acceptance of the report was the addition of the words "and thanks the members of the committee for their services."

Sir JENNER VERRALL said that that appealed to him as much the best form.

Dr. MANSON and Dr. LANGDON-DOWN intimated their acceptance, and the motion was put to the meeting that the report of the Psycho-Analysis Committee, as submitted by the Council, be accepted as discharging the instruction given to the Council in the resolution of the Annual Representative Meeting, 1926, and that the Annual Representative Meeting, 1929, thanks the members of that committee for their services.

The motion was carried *nem. con.*

Dr. FOTHERGILL suggested that the Council be asked to have the report published and offered for sale, in view of its great value.

The CHAIRMAN OF COUNCIL intimated that unless the Representative Body passed a resolution to the effect that any particular report of the Council was not to be published, it was within the Council's rights to direct its publication.

(*To be continued.*)

APPENDIX TO REPORT OF ANNUAL REPRESENTATIVE MEETING.

CONFERENCE ON SALARIES OF WHOLE-TIME PUBLIC HEALTH MEDICAL OFFICERS.

A SERIES of conferences between representatives of the British Medical Association on the one part and of Local Authorities on the other has been held since the beginning of the year to discuss salaries of whole-time medical officers in public health services. On the panel of the Association there were included representatives of the Society of Medical Officers of Health, whilst the panel of the Local Authorities, in addition to those from County, County Borough, Urban and Rural District, London County and Metropolitan Borough Authorities, included also representatives of the Associations of Education Committees and of Mental Hospitals. Lord Askwith accepted the unanimous invitation of the parties to act as independent chairman. In the end the subjoined recommendations were agreed for presentation to the Representative Body of the British Medical Association[1] and to the Associations of the various Local Authorities.

[1] See report of discussion at page 49 of this *Supplement*.

AGREEMENT.

Memorandum of Recommendations agreed to at Conferences held at the Ministry of Health on February 14th, March 6th, April 22nd, June 4th, and June 24th, 1929, at which representatives of the County Councils Association, the Association of Municipal Corporations, the Urban District Councils Association, the Rural District Councils Association, the London County Council, the Association of Education Committees, the Mental Hospitals Association, the Metropolitan Boroughs Standing Joint Committee, and the British Medical Association were present.

I.—*Resident Medical Officers.*

(1) These are Officers employed in Hospitals, Sanatoria, or other Institutions, without the responsibility for the work of other Medical Officers.

(2) The minimum commencing salary of an officer in this class shall be £350, rising by annual increments of £25 to £450 per annum, with emoluments which shall include board, lodging, laundry, and attendance.

(3) All officers in this class receiving less than £350 per annum at present to be raised to that salary on the appointed day, and such salary shall be regarded as the commencing salary.

(4) All officers in this class who are on the appointed day receiving £350 or more and who have had at least two years' service without increment, shall receive their first increment as from the appointed day.

(5) After the expiry of four and not later than five years after the date on which an officer in this class reaches his maximum in the scale, the employing local authority shall consider whether in his case the salary should be increased to an amount in advance of that maximum.

Note.—Where the Appointing Authority limits the appointment to a term not exceeding one year and not renewable, this salary shall not apply, nor shall it apply to officers without previous professional experience.

II.—*Medical Officers employed in Departments.*

(1) These are officers without responsibility for the work of other Medical Officers who should have had at least three years' experience in the practice of their profession subsequent to obtaining a registrable qualification.

(2) Medical Officers comprised in the above defined class shall be remunerated on a scale of salary commencing at £500 per annum and rising by annual increments of £25 to a maximum of £700.

(3) In any case in which an officer in this class is in receipt of a salary at a rate less than that which would have been payable had the scale been in force and applied to him during the whole period of his service in this class, the salary shall be increased to an amount according with the scale.

(4) On and after the appointed day, service in this class under a local authority (whether prior to or subsequent to that date) shall be reckoned in calculating the appropriate salary of an officer transferring to another authority to fill a post in the same class.

(5) After the expiry of four years and not later than five years after the date on which an officer in this class reaches his maximum in the scale the employing local authority shall consider whether in his case the salary should be increased to an amount in advance of that maximum.

III.—*Senior Medical Officers.*

(1) These are Medical Officers (not being Medical Officers of Health) in charge of Services or Departments (for example: Port Sanitation, School Medical Service, Tuberculosis, Mental Deficiency, Maternity and Child Welfare, Venereal Disease, or any other similar service or department or combination thereof).

Note.—It is understood that in the case of the Tuberculosis and Venereal Disease Services the present practice in some County areas is to appoint not a Senior Medical Officer with Assistants under him, but a number of Assistants of equal standing whose clinical work in the areas assigned to them is not subject to supervision by any Chief Officer and who act in a consultant capacity in relation to medical practitioners. Such Officers must be regarded as Senior Medical Officers and paid as such.

(2) *Salaries:* Minimum commencing salary £750 to £1,100 according to responsibility and scope of department, regard being had to the relation of the Officer's salary to that of the Medical Officer of Health.

(3) All Officers in this class receiving less than £750 per annum at present to be raised to that salary on the appointed day, and such salary shall be regarded as the commencing salary for the purpose of paragraph (4) below.

(4) All Officers in this class shall, every two years commencing from the appointed day, receive an increment of £50 up to a maximum of 25 per cent. above their commencing salary; but no salary in this class shall exceed £1,100 per annum, except in manner provided in paragraph (6) below.

(5) All Officers in this class who are on the appointed day receiving £750 or more, and who have had at least two years' service without increment, shall receive their first increment as from the appointed day.

(6) After the expiry of four and not later than five years after the date on which an Officer in this class reaches his maximum in the scale, the employing local authority shall consider whether in his case the salary should be increased to an amount in advance of that maximum.

IV.—*Medical Superintendents of Institutions, other than Mental Hospitals.*

(1) When a hospital, sanatorium, or other institution with over 100 beds employs a whole-time medical officer in charge of the institution such officer shall be considered for purposes of salary a Medical Superintendent.

Note.—The Advisory Committee referred to in Section X of these recommendations may, upon application being made to them in the manner prescribed in paragraph (2) of that section, consider the cases of Medical Superintendents in charge of institutions (other than mental hospitals) containing not more than 100 beds.

(2) Salaries shall be on the following scale:

No. of Beds in Institution.	Minimum commencing Salary.
	£
Not exceeding 150	750
151–200	800
201–300	850
301–400	900
401–500	950
501–600	1,000
601–750	1,050
Exceeding 750	1,100

(All salaries in this class are inclusive of the value of emoluments—for example, housing accommodation and board.)

(3) All Officers in this class receiving less than £750 per annum at present to be raised to that salary on the appointed day, and such salary shall be regarded as the commencing salary for the purpose of paragraph (4) below.

(4) All Officers in this class shall, every two years commencing from the appointed day, receive an increment of £50 up to a maximum of 25 per cent. above their commencing salary; but no salary in this class shall exceed £1,100 per annum, except in manner provided in paragraph (6) below.

(5) All Officers in this class who are on the appointed day receiving £750 or more, and who have had at least two years' service without increment, shall receive their first increment as from the appointed day.

(6) After the expiry of four, and not later than five, years after the date on which an Officer in this class reaches his maximum in the scale, the employing local authority shall consider whether in his case the salary should be increased to an amount in advance of that maximum.

V.—*Deputy or Chief Assistant Medical Officers of Health.*

(1) These are Medical Officers duly appointed as Deputy or Chief Assistant Medical Officers of Health in the general administration of the Health Department and the carrying out of the various Acts, by-laws, orders, rules, regulations, etc., required to be or usually administered by the Medical Officer of Health.

(2) The salary of such an Officer shall be 60 per cent. of the appropriate minimum commencing salary of the scale for Medical Officers of Health.

(3) On the appointed day all Deputy or Chief Assistant Medical Officers of Health who are receiving less than the minimum commencing salary appropriate to their office shall receive an immediate increment of £50 and increments of £50 annually thereafter until the appropriate figure has been reached.

(4) No scale of periodic increments for Deputy or Chief Assistant Medical Officers of Health has been formulated, on the understanding that employing local authorities will give suitable increases for capability and length of service.

(5) Where no Deputy or Chief Assistant Medical Officer of Health has been appointed it is recommended that, in the absence of the Medical Officer of Health for a prolonged period, the question of the recognition of the special services of the Officer who acts in his place shall be considered.

VI.—*Medical Officers of Health.*

(1) The minimum commencing salaries shall be on the following scale:

Population.	County Boroughs and Metropolitan Boroughs and those Boroughs and Urban Districts which are both Education and Maternity and Child Welfare Authorities.	County Councils, Rural and Combined Districts, and those Boroughs and Urban Districts which are not both Education and Maternity and Child Welfare Authorities.
	£	£
Not exceeding 50,000 ...	800	800
,, ,, 75,000 ...	900	
,, ,, 100,000 ...	1,000	900
,, ,, 150,000 ...	1,100	1,000
,, ,, 250,000 ...	1,200	1,100
,, ,, 500,000 ...	1,400	1,200
,, ,, 750,000 ...	1,600	1,400
Exceeding 750,000 ...	1,800	1,600

(2) On the appointed day all Medical Officers of Health who are receiving less than the minimum commencing salary shown in the

scale as appropriate to their office shall receive an immediate increment of £50 and increments of £50 annually thereafter until the appropriate figure in the scale has been reached.

(3) No scale of periodic increments for Medical Officers of Health has been formulated, on the understanding that employing local authorities will give suitable increases for capability and length of service.

VII.—*Salaries for Combined Posts.*

Where an Assistant Medical Officer under a County Council acts as a District Medical Officer (either for a single or combined district) for a definite proportion of his time, such Officer shall receive by way of total salary not less than the minimum commencing salary of a whole-time Medical Officer of Health, as indicated by the population of the district or combined district. Such Officer shall not in any case receive a salary of less than £800 per annum, and paragraphs (2) and (3) of Section VI. shall apply to these posts.

VIII.—*Assistant Medical Officers to Mental Hospitals.*

(1) The minimum commencing salary of an Assistant Medical Officer to a Mental Hospital shall be £350, rising by annual increments of £25 to £450 per annum, with emoluments which shall include board, lodging, laundry, and attendance. It is desirable that suitable provision should be made at or in connexion with every Mental Hospital for the accommodation of married Assistant Medical Officers.

(2) All Officers in this class receiving less than £350 per annum at present to be raised to that salary on the appointed day, and such salary shall be regarded as the commencing salary.

(3) All Officers in this class who are on the appointed day receiving £350 or more and who have had at least two years' service without increment, shall receive their first increment as from the appointed day.

(4) After the expiry of four, and not later than five, years after the date on which an officer in this class reaches his maximum in the scale, the employing authority shall consider whether in his case the salary should be increased to an amount in advance of that maximum.

(5) Those Assistant Medical Officers to Mental Hospitals who possess a diploma in psychological medicine shall receive an additional £50 per annum, and all such Officers shall be encouraged to obtain this diploma. Those Assistant Medical Officers who, in the opinion of the Superintendent of the Mental Hospital, do not take advantage of the opportunities offered to them to obtain the diploma, shall not receive any increment beyond the first.

(6) Temporary Medical Officers should not be employed on the staffs of Mental Hospitals for more than twelve months, except as relief during holidays, or when a member of the permanent medical staff is incapacitated through illness or has been seconded for any purpose.

(7) Clinical Assistants in Mental Hospitals should not be appointed to undertake the responsible duties of Junior Assistant Medical Officers.

(8) Practitioners engaged in the work of continuous attendance on patients in Mental Hospitals should have at least four weeks' leave each year, and wherever possible they should not be obliged to take more than two weeks of this leave consecutively.

Note.—For the purposes of this section any reference to "local authority" in Sections IX and X shall be interpreted to mean "Visiting Committee."

IX.—*General Conditions Applying to All Appointments.*

(1) Travelling expenses and other reasonable expenses properly incurred in the performance of the duties to be paid in addition to salary.

(2) The operation of the scales of salaries shall not in any circumstances result in reducing the salary of any Medical Officer serving at the appointed day.

(3) Where a local authority either intends to dismiss the holder of a medical appointment who marries, or desires to reserve the right so to do, a specific statement should be inserted in the advertisement relating to the appointment.

(4) No differentiation of salary shall be made on account of sex.

(5) Population means population at the latest annual report of the Registrar-General.

X.—*Advisory Committee.*

(1) An Advisory Committee, constituted in accordance with paragraph (5) shall be appointed to consider, upon such application as is mentioned in paragraph (2) below: (*a*) the merits of any case in which a local authority proposes to employ an officer at a salary or on conditions not in accordance with this agreement; and (*b*) any difficulties which may arise in the application of this agreement; and to report its recommendations thereon to the parties concerned.

(2) Applications to the Advisory Committee may be made by the Ministry of Health, by the British Medical Association, by any Association of Local Authorities which is a party to this agreement, or by any individual local authority.

(3) The Advisory Committee shall not be precluded from considering the cases of Chief Medical Officers of Counties and County Boroughs whose duties and conditions of service may be altered materially as the result of legislation.

(4) It shall be competent to the Advisory Committee to invite a representative of the Board of Education or the Board of Control to attend a particular meeting, but without power to vote.

(5) The Advisory Committee shall consist of 17 representatives, one, who shall act as Chairman, to be appointed by the Minister of Health, one each to be appointed by the County Councils Association, the Association of Municipal Corporations, the Urban District Councils Association, the Rural District Councils Association, the London County Council, the Association of Education Committees, the Mental Hospitals Association, and the Metropolitan Boroughs Standing Joint Committee, and eight by the British Medical Association.

(6) The Advisory Committee shall formulate its own rules of procedure, subject to the condition that, whatever arrangements may be made for the attendance of members at the hearing of applications no case shall be considered or determined in the absence of a representative of the Association representing the local authority or class of local authorities concerned.

XI.—*Duration of Agreement.*

This agreement shall come into force on the 1st April, 1930, hereinbefore referred to as the "appointed day"; and remain in force for five years and thereafter from year to year, subject to notice of one year from any of the bodies mentioned in paragraph (5) of Section X.

(Signed) ASKWITH,
Chairman of the Conference, on behalf of the parties to the foregoing recommendations.

V. L. HARKNESS,
Secretary.
June 24th, 1929.

BRITISH MEDICAL ASSOCIATION,
B.M.A. HOUSE, TAVISTOCK SQUARE,
LONDON, W.C.1.

ANNUAL GENERAL MEETING.

THE statutory Annual General Meeting of the Association was held in the Milton Hall, Manchester, on Tuesday, July 23rd. The retiring President, Sir EWEN MACLEAN, occupied the chair during the first part of the proceedings.

The minutes of the meeting held at Cardiff on July 24th, 1928, were approved and signed.

Induction of New President.

Sir EWEN MACLEAN inducted into the chair as President, 1929–30, Professor Arthur H. Burgess, and invested him with the Presidential Badge of Office. In doing so he said: I do not think the British Medical Association could have been more fortunate in its choice of President for this year of its Manchester meeting. Professor Burgess is a man of outstanding distinction in his own branch of medicine, which is that of general surgery. More than that, his works of charity and kindliness have made him a notable figure in the whole of this wide and populous area. He has also taken very great interest in matters that are medico-political. In every respect he is one whom this Association is proud to have as its titular head for the ensuing year. There are others who will speak of Professor Burgess's qualities, and I envy them the task, because it is a very pleasant one. But my immediate duty is to transform Professor Burgess, or to transmute him, from President-Elect to President of this Association. Before I do that, however, I would draw his attention to the fact that the Presidential Badge, which is symbolic of his transmutation, has certain clasps upon it which demonstrate the fact that the British Medical Association, in its boundaries, is coterminous with the British Empire, and therefore our Association is one upon which the sun never sets. I am convinced, if only by the proceedings of the Representative Body this year, that there is another sense in which the sun will never set upon the British Medical Association. The general tenor of its debates and the resolutions arrived at suggest that the Association will go on from strength to strength, dominated by the highest principle—namely, that of seeking the public good.

Professor BURGESS, who was received with loud applause, said: I wish to express my thanks to the members of the Representative Body, and through them to all the members of the Association, for the very great honour they have done me in electing me to this position, which I am very proud to hold, inasmuch as it is the highest in the medical

world. Though I accept it with feelings of gratitude, I am at the same time conscious that it carries with it very great responsibilities. Until twelve months ago, when I was appointed President-Elect, I had no idea whatever how great those responsibilities are, but I have learned a good deal during the past twelve months, and I have lived to appreciate as I never did before what a very high position the British Medical Association occupies. There is no other body to which the Government and the Ministry of Health will listen with anything like the attention it gives to this Association; that being so, a very great responsibility rests upon its officers. I should like to add that I have just received a message—and it is a pleasant augury for the future—from the President of the American College of Surgeons (Dr. Franklin Martin) wishing success to our meeting and to myself personally on entering upon my year of office. (Applause.) Again I thank you all for the very great honour you have done me.

Past-President's Badge.

The CHAIRMAN OF COUNCIL (Dr. Brackenbury), who then invested Sir Ewen Maclean with the Past-President's badge, said: We have not had a Past-President's badge hitherto, so that this is the first occasion on which this ceremony has taken place. That we had not thought of having a Past-President's badge before is remarkable. Sir Ewen Maclean himself thought of it—(laughter)—and Sir Ewen has himself presented the badge to us. I do not think anything could have been more happy or more appropriate. ("Hear, hear.") We are all pleased to think that this will be a permanent memorial, passing on from Past-President to Past-President as the years go by, and also that it is a symbol which will be carried by our immediate Past-President, Sir Ewen Maclean, on Saturday next, when he leaves this country to represent us in Australia and other parts of the world. (Applause.)

Appointment of Auditors.

The PRESIDENT (Professor Burgess) moved, and it was agreed:

That Messrs. Price, Waterhouse and Co. be and they are hereby reappointed Auditors of the British Medical Association until the next Annual General Meeting, at a remuneration of three hundred guineas.

The President-Elect.

The PRESIDENT, in formally reporting that the Representative Body had elected Dr. W. Harvey Smith, professor of ophthalmology, Manitoba Medical College, as President of the Association for the year 1930–31, said: Occasionally the British Medical Association holds its Annual Meeting outside our own country. We have met at Montreal, and our last meeting abroad was at Toronto in 1907. It has been decided that our next shall be at Winnipeg in 1930, and Professor Harvey Smith will be President. It would be invidious for me to speak of his abilities as an opthalmologist, and so on. I have known of him for long, but it is only in the past two or three days that I have enjoyed the pleasure of his personal acquaintance. He has shown that he is one of the best of good fellows, and I am sure he will be in every way as successful as his predecessors have been. And I may say that in the short time that Mrs. Harvey Smith has been in this city we have all been impressed by her manifold charms and graces. She has gained the golden opinion of all those with whom she has come into contact. I am sure that in the hands of Professor and Mrs. Harvey Smith the meeting at Winnipeg will be a tremendous success, and that all those who may have the good fortune to go will have the time of their lives.

Professor HARVEY SMITH, who was very cordially received, said: Mr. President, ladies, and gentlemen, I thank you from the bottom of my heart for your kind words. And I thank the Association for their kindness in appointing me to this great office to carry on the affairs at Winnipeg next year. Though I have been connected with many American enterprises, nothing I have ever undertaken has given me greater pleasure, or provided me with a greater interest than the work which now lies before me. In this connexion I acknowledge, with very great thanks, our indebtedness to the officers of the Association, especially to my good friend Dr. Alfred Cox, who has been "a lamp unto my feet and a light unto my path." I have written him numberless letters, on all sorts of topics, and he has been patience personified; he has never failed me. The first invitation which was extended for the Association to meet in Winnipeg was thirty-three years ago, which seems a long time to wait, but ultimately this great reward has come to us. Need I say how welcome you will be in every portion of Canada? It is more than a scientific meeting; it is a gathering together of brethren of the British Empire. Thank you again for your kindness. (Applause.)

Vote of Thanks to Retiring President.

The CHAIRMAN OF COUNCIL moved:

That the hearty thanks of this Annual General Meeting of the Association be given to the retiring President, Sir Ewen Maclean, for his services as President, 1928–29.

When, at Edinburgh (he said), Sir Ewen Maclean became our President-Elect you will remember he promised that in the following year, at Cardiff, we should receive a warm Welsh welcome. It was in the atmosphere of that warm Welsh welcome that Sir Ewen Maclean began his presidency, and the warmth and cordiality which he has shown to us, and which we have felt for him ever since, has not failed in the slightest degree. (Applause.) We value very highly the wise statesmanship which his previous experience as Chairman of the Representative Body has enabled him to increase, and which has filled us with admiration. We feel for him, indeed, a warmth of admiration and affection which it is difficult to express. (Applause.)

The motion was carried by general acclamation.

Sir EWEN MACLEAN said: I think a word is due from me to this meeting as to this Badge which I have the honour to wear. It is a strange coincidence that I should be the first receiver of the Badge which it has been my honour and privilege to give to the Association. It seems to me this is the only occasion on which I can express my deep sense of gratitude to all those who have helped me, and who have preserved me from errors during my year of office. The evidences are growing everywhere that the power and status of the British Medical Association, great though it is, is relatively only at its early stage. Therefore it is very important that its titular head should be guarded and guided by wise advice from those eminently fitted to give it. I am greatly indebted to Dr. Hawthorne for his help, to Dr. Brackenbury for his kindness, to Dr. Cox for his sterling worth and help, and to Dr. Anderson, without whom it would be difficult to avoid making mistakes. I also want to mention friends—though only acquaintances for a year—on the clerical staff, some of them represented here, for their faithful and strenuous service, which is beyond all aknowledgement. There is not a single member of the Association who is not deeply indebted to them. And, above all those to whom I am indebted is one, a lady, who is on the platform, my sister. The success which attended the Cardiff meeting was largely attributable to her; all my efforts have been greatly aided by Miss Maclean. (Applause.)

Symbolic Staff of the Association.

The TREASURER (Mr. Bishop Harman) formally presented the Staff given by him to the Association. A description of this beautiful piece of symbolism appeared in the *Supplement*, April 13th (p. 85) on the occasion when it was shown to the Council at its April meeting. The Treasurer, addressing the President, said: I have the honour to ask you, the President of the British Medical Association, to accept this standard, which bears the Badge of the Association and those letters, familiar throughout the world, which are the initial letters of its name. Our Association lives and moves and has its being in the deeds of its members. Those deeds need no symbol. A symbol will not advance them, just as a wedding ring does not of necessity make a happy marriage. Yet as the wedding ring is the symbol of much happiness in human life, so this standard may serve as a sign of the wisdom and beneficence of the British Medical Association. I beg to be allowed to offer this standard to the Association.

The members expressed in an enthusiastic manner their admiration for the Staff and their thanks for the gift.

The PRESIDENT said: I am expressing the feeling of every member when I say how very much we appreciate this latest expression of Mr. Bishop Harman's kindly interest in the welfare of our Association. He has also presented a golf cup, and his wife the Katherine Bishop Harman Prize. In connexion with the new extension of the House he has been, next to Sir Robert Bolam, the moving spirit. He has been always willing to lend a hand at any job, and he has guarded the funds of the Association in a masterly and masterful fashion. I have the very greatest pleasure in accepting on behalf of the Association this beautiful Staff; it will last as long as the Association itself lasts, and I am proud to be the first President to walk immediately in its wake. (Applause.)

The meeting then adjourned until 8 p.m. at the Free Trade Hall.

ADJOURNED ANNUAL GENERAL MEETING.

THE Adjourned General Meeting took place on the evening of Tuesday in the Free Trade Hall, Manchester, when the President, Professor ARTHUR H. BURGESS, D.L., F.R.C.S., M.Sc., delivered his Address from the chair.

The distinguished company on the platform included: The Lord Mayor of Manchester (Colonel G. Westcott), the Lord Bishop of Manchester (the Right Rev. Guy Warman), the Dean (the Very Rev. Hewlett Johnson), the Vice-Chancellor and professors of the University, the Mayor of Salford, and other prominent citizens, Sir Ewen Maclean (Past-President) and Miss Maclean, Professor W. Harvey Smith (President-Elect) and Mrs. Harvey Smith, Dr. H. B. Brackenbury (Chairman of Council), Dr. C. O. Hawthorne (Chairman of Representative Body), and Mr. N. Bishop Harman (Treasurer). Members of the Council and officials of the Association and members of the local Executive Committee also occupied seats behind the President. The area and galleries of the spacious hall were almost filled with members of the Association and their guests.

INTRODUCTION OF DELEGATES.

The CHAIRMAN OF COUNCIL introduced to the President the following delegates from kindred associations:

Canadian Medical Association: Dr. A. T. Bazin, Dr. H. S. Birkett, C.B., Dr. G. S. Fahrni, Dr. J. G. FitzGerald, Professor A. Primrose, C.B., F.R.C.S., Dr. George A. Ramsay, and Professor W. Harvey Smith.

American Medical Association: Dr. Dean Lewis and Dr. Willard J. Stone.

The following foreign delegates were next introduced:

Austria: Professor Martin Haudek (Vienna).
Denmark: Dr. Svend Lomholt (Copenhagen).
Holland: Dr. J. L. L. Muskens (Amsterdam).
Sweden: Professor Essen-Möller (Lund).
Switzerland: Dr. L. Carozzi (Geneva).
United States: Dr. T. S. Cullen (Baltimore), Dr. Wells P. Eagleton (Newark, N.J.), Dr. Maurice Fishberg (New York), Dr. W. A. Hudson (Detroit), Dr. Hans Jarré (Detroit), Dr. F. A. Kelly (Detroit), Dr. Charles H. Mayo and Dr. W. J. Mayo (Rochester), Dr. G. P. Pitkin (Hackensack, N.J.), Dr. F. L. Richardson (Boston), Dr. A. G. Swartz (New York), and Professor A. S. Warthin (Michigan).

Finally came the introduction of the representatives and delegates from Branches in the Oversea Dominions:

Africa: Dr. G. J. C. Smyth (Border), Dr. J. L. Connacher (Cape Midland), Mr. J. L. Gilks, F.R.C.S. (Kenya), Dr. T. Edygar Jones (Griqualand West), Dr. J. Leggate, Dr. A. P. Martin, and Dr. G. R. Ross (Mashonaland), Dr. H. B. Savage (Northern Transvaal), Dr. A. B. Black (Southern Transvaal), Dr. J. C. S. McDouall, O.B.E. (Sierra Leone), and Dr. R. Y. Stones, M.C. (Uganda).

Australasia: Dr. H. Huff Johnston (New South Wales), Dr. E. Gordon Anderson, Dr. I. C. Fraser, Dr. A. W. Izard, O.B.E., Dr. N. H. Prior, M.C., and Dr. Russell I. Ritchie (New Zealand), Dr. A. Breinl, Dr. C. F. A. de Monchaux and Dr. Eustace Russell (Queensland), Dr. F. J. Stansfield (Tasmanian), Dr. L. S. Kidd, Mr. W. Sloss, F.R.C.S., and Mr. H. Douglas Stephens, M.S. (Victorian), and Dr. F. J. Clark (Western Australian).

India: Dr. C. G. Terrell and Dr. W. F. Whaley (Assam), Dr. A. S. Erulkar (Bombay), Lieut.-Colonel S. T. Crump and Lieut.-Colonel R. Kelsall, D.S.O. (Burma), Lieut.-Colonel J. A. Shorten (Calcutta), Dr. A. Nell (Ceylon), Lieut.-Colonel V. M. Anderson, C.I.E. (Hyderabad), Captain S. N. Hayes and Dr. N. C. Sikri (Punjab), and Lieut.-Colonel E. W. C. Bradfield, C.I.E., O.B.E. (South India and Madras).

Mesopotamia: Dr. H. C. Sinderson.

British West Indies: Dr. A. G. Bancroft (Barbados), Dr. D. B. B. Hughes (Grenada), and Dr. G. C. Strathairn (Jamaica).

PRESENTATION OF PRIZES.

The following Association prizes were then presented to the recipients by the President:

The Sir Charles Hastings Clinical Prize to Dr. Arthur Crook (Norwich) for his clinical study entitled "Albumin in the urine in association with pregnancy and childbirth." (This prize was established to encourage research in general practice, and consists of a certificate and a cheque for 50 guineas.)

The Hempson Prize to Dr. A. C. T. Perkins (Bury St. Edmunds) for the study submitted by him on "The problems presented by school preventive medicine in rural areas."* (This prize was offered by Mr. W. E. Hempson upon the occasion of his retirement as Solicitor to the Association for the best essay or treatise on some phase or branch of public health work. It consists of a certificate and a cheque for 25 guineas.)

The Middlemore Prize to Mr. W. S. Duke-Elder, F.R.C.S. (London), for his essay on "The clinical study of the vitreous body, its swellings, contractions, opacities, and reactions to toxic invasions; with special reference to glaucoma and detached retina." (The prize consists of a certificate and a cheque for £50, and was established to encourage research in ophthalmic medicine or surgery.)

PRESIDENT'S ADDRESS.

Professor BURGESS then delivered his Presidential Address, which is printed in full at page 131 of this week's *Journal*. An ovation was given to the President at the close.

Dr. C. O. HAWTHORNE, in moving a vote of thanks, said he imagined that in this great and impressive audience, assembled as it was in the famous Free Trade Hall of the city of Manchester, there must needs be not a few Manchester citizens who recognized in the person of the newly elected President of the British Medical Association a quite familiar figure—Professor of Clinical Surgery in the University, one of Manchester's leaders of the medical profession, and a devoted and distinguished citizen of this enterprising city. Doubtless to his fellow citizens the election of Professor Burgess to a position of dignity and responsibility would seem to be in strict accord with the eternal fitness of things. (Applause.) Hence when to-night they saw the President honoured by his professional colleagues, both their feelings of personal regard for him and their civic pride would experience a sensation of pleasure entirely unqualified by the element of surprise. It was obvious, from the reception which had been given to that address, that this anticipation had suffered no degree of disappointment. Naturally, therefore, he concluded that it would be desired that in the official record of this evening's proceedings an expression of gratitude and appreciation should be entered in appropriate terms. (Applause.) There was, however, another aspect of this proposal. Some of those present could not claim the distinction of Manchester citizenship. They had their points, however. (Laughter.) Yet all admired Manchester's municipal, educational, commercial, journalistic, academic, and artistic distinction. But, when all was said and done, those he referred to were not of the household of Manchester. It was in the name of the whole 35,000 members of the Association, many of them from distant parts, that he expressed good will to the new President. By a seemly and well-established tradition, nothing in the shape of criticism or comment was allowed on the Presidential Address. The topic of the Address was the close association between the advance of science on the one hand and that of surgery on the other, and there was added a charming personal note. There could be no doubt that in due time the end would crown the work; and in the meantime those present welcomed Professor Burgess to a year of cordial comradeship.

*An abstract of Dr. Perkins's essay was printed in the *British Medical Journal* of July 20th (p. 95).

The VICE-CHANCELLOR OF THE UNIVERSITY (Dr. Moberly), in seconding the vote of thanks, said he imagined that he was allowed to support the resolution as a representative of that part of this great audience which had contact with surgery only as furnishing the "vile body" on which experiments had to be made. (Laughter.) He eulogized the President as a characteristic and highly popular Manchester institution. One was not wrong in carrying away as the lesson of the Address what in a more restricted field Lord Dawson referred to the other day when he said that the work of the doctors and nurses attending the King was a great example of team work. The moral of the Address was the importance of team work over the widest field. He had tried to speculate how many of the audience were physicians and how many were surgeons, but he had gathered from the applause that, whether one or the other, they were convinced of the value of team work and ready to appreciate the work done in fields other than their own. As a citizen of Manchester, a colleague of Professor Burgess, and one who knew how highly his kindly and genial leadership was valued in the Medical Faculty, he had the greatest pleasure in seconding the vote of thanks. (Applause.)

The PRESIDENT, in responding, said that the sympathetic atmosphere of his audience, the kindly faces of old friends, the presence of fellow citizens on the platform, and of so many of his old teachers and senior colleagues, and of almost a record number of oversea medical men—all these facts conspired together to render this moment the proudest and happiest of his life, with one exception—the exception being the moment when, thirty-two years ago, he received to a time-honoured question an affirmative answer from one who had been the mainspring of his inspiration and happiness. (Loud applause.)

At the conclusion of the proceedings the members attended a reception by the President and local executive at the University.

OPENING OF THE ANNUAL EXHIBITION.

THE exhibition of surgical instruments and appliances, drugs, foods, and books, housed in the City Exhibition Hall, Deansgate, was opened by Professor A. H. BURGESS (President-Elect) on Tuesday morning in the presence of a large gathering of members of the Association and of exhibitors. Dr. C. O. HAWTHORNE, Chairman of the Representative Body, said that the Council regarded the exhibition as an essential part of the Annual Meeting. Medicine and surgery were arts which were continually entering new fields and striving to make more efficient those already occupied. In this they had to rely on help from the inventor, the pharmacist, the chemist, and the mechanical and electrical engineer. Science had to be translated into efficient forms of art, and there was in this exhibition an opportunity for members of the profession to see in a convenient and compressed form the most recent developments in all these departments. The authorities of the Association wished to indicate the importance which they attached to the exhibition by asking the President formally to open it. Professor BURGESS, before declaring the exhibition open, said that as a resident of Manchester he had attended many exhibitions in that hall, but he could truly say that he had never seen one which to him, as a medical man, had been anywhere near so beautiful and artistic as the present one, which might indeed be described as a medical paradise. The exhibition had now become an essential part of the British Medical Association Annual Meeting. He himself considered that it was one of the most instructive parts; in his own experience he had often learned from a visit to the stalls as much as he had been able to gather from the meetings of the scientific sections. The medical profession was most willing to acknowledge the great debt it owed to the manufacturers of drugs, instruments, and other articles. The statement had often been made that bad workmen were apt to quarrel with their tools, but it was obvious that even the very best of workmen could not produce their best and most creative work unless they had efficient implements. The beauty and elegance of the pharmaceutical preparations in the exhibition might almost make visitors wish that they could have the disease for which these products were designed, while the ingenuity manifested similarly by the surgical instruments was such that those who saw them must desire to have them thrust into their bodies forthwith! Manufacturers of medical and surgical appliances were just as essential factors in the progress of medical science as were medical practitioners themselves. It was very interesting to find, as time went on, how British enterprise was improving in this matter; nowadays practically everything essential to medical work could be produced entirely by British manufacturers. Being himself a Manchester product, Professor Burgess added, he was naturally very delighted to see the excellent stalls of local origin. Whenever he had had occasion to require anything new, local firms had always met him with the very greatest assistance. The experience of most people who designed instruments was that when they came to work them out, the trained staff of the instrument maker could always improve the design. The traders had an advantage over the medical profession in this respect, that they were allowed to advertise. He hoped that the amount expended on advertisement in connexion with the exhibition would be repaid by the very close attention which the members and visitors would undoubtedly give to the exhibits.

VISIT TO CHESTER.

OVER four hundred members of the Representative Body, and the ladies accompanying them, made an excursion by road to Chester on Sunday, July 21st, and were given a civic welcome by the mayor, Lieut.-Colonel W. CHURTON, D.S.O. The mayor suggested that the difference between Manchester and Chester could be expressed as a contrast in black and white. Dr. HAWTHORNE, Chairman of the Representative Body, in replying, said that the prophets of gloom who had foretold less kindly weather in Manchester and Chester than elsewhere, stood utterly abashed and confounded. These cities, far from being devoted to gloom and depression, were the homes of benevolent and beneficent radio-activity.

The party afterwards attended a special service in the Cathedral, at which the Bishop of Chester, himself the son of a surgeon (Sir James Paget) gave a brief address, in which he said that they had come together in the unity of a close brotherhood to acknowledge God, the giver of all good gifts, as a fellow-worker. They were there to offer Him the free use of their skill, and were met to thank God for the success that again and again came to them. They still found opposed to them ignorance and carelessness, which were apt to make what they did of little effect. There were places where the municipal authorities undervalued them and their work; where their reports were unread, their warnings unheard, and expenditure on the health of the people was grudged as a waste of money.

In the afternoon the party travelled by motor cars and steam launches to Eaton Hall, where tea was served and a short organ recital given by Mr. A. H. Robinson, organist to the Duke of Westminster.

Naval and Military Appointments.

ROYAL NAVAL MEDICAL SERVICE.

Surgeon Commander H. M. Langdale is placed on the retired list with the rank of Surgeon Captain.

Surgeon Commanders A. A. Sanders, O.B.E., and R. J. G. Parnell to the *Pembroke* for R.N. Hospital, Chatham.

Surgeon Lieutenant Commander N. B. de M. Greenstreet to the *President* for post-graduate course.

Surgeon Lieutenants A. J. Burden to the *Cockchafer*; J. K. G. Way to the *Victory* for R.N. Barracks, Portsmouth; D. Duncan to the *Cambrian*.

ROYAL NAVAL VOLUNTEER RESERVE.

Surgeon Lieutenant T. C. Stevenson to the *Victory* for R.N. Hospital, Haslar, for training.

Probationary Surgeon Sublieutenant F. W. Chippindale to the *Victory* for R.N. Hospital, Haslar, for training.

ROYAL ARMY MEDICAL CORPS.

Captain I. F. Mackenzie, late R.A.M.C. Special Reserve, to be temporary Captain, and temporarily relinquishes the rank of Captain.

Lieutenant (on probation) R. R. Leaning, from the seconded list, is restored to the establishment.

Donald A'Brook to be Lieutenant on probation, and is seconded under the provisions of Article 205, Royal Warrant for Pay and Promotion, 1926.

ROYAL AIR FORCE MEDICAL SERVICE.

Flight Lieutenant J. Twohill is transferred to the Reserve, Class Dii.

Flight Lieutenant A. Harvey to R.A.F. Hospital, Cranwell.

H. C. S. Pimblett is granted a short-service commission as a Flying Officer for three years on the Active List.

The short-service commission of Flying Officer C. Crowley is antedated to July 2nd, 1928, and he ceases to be seconded to the Manor House Hospital, Golders Green.

INDIAN MEDICAL SERVICE.

Colonel R. F. Baird has retired from the service.

Lieut.-Colonel W. J. Simpson is posted as Chief Medical Officer in Central India, and Residency Surgeon, Indore, with effect from June 14th, 1929.

Lieut.-Colonel H. E. Stanger-Leathes, Assistant Director of Public Health, Delhi, is appointed Deputy Director-General, Indian Medical Service, with effect from July 5th, or the date on which he assumes charge of the post.

On return from leave the services of Major J. M. R. Hennessy are placed at the disposal of the Government of India in the Department of Education, Health and Lands.

Lieutenant Mohan Lal Ahuja to be Captain.

TERRITORIAL ARMY.

ROYAL ARMY MEDICAL CORPS.

Lieut.-Colonel J. S. Y. Rogers, D.S.O., T.D., having attained the age limit, retires and retains his rank with permission to wear the prescribed uniform.

Lieutenants A. Barr and F. W. Bury to be Captains.

Honorary Second Lieutenant B. Reid (late R.A.F.) to be Lieutenant.

Supernumerary for Service with O.T.C.—A. J. Parer to be Lieutenant, supernumerary for service with Medical Unit, University of London Contingent, Senior Division, O.T.C.

TERRITORIAL ARMY RESERVE OF OFFICERS.

ROYAL ARMY MEDICAL CORPS.

Captain C. Shaw-Crisp, from Active List, to be Captain.

VACANCIES.

ABERDEEN COUNTY: PUBLIC HEALTH DEPARTMENT.—Junior Assistant Medical Officer of Health. Salary at the rate of £500 per annum.

ASHTON-UNDER-LYNE: DISTRICT INFIRMARY.—Assistant Radiologist. Salary £500 per annum.

BIRKENHEAD GENERAL HOSPITAL.—Casualty Surgeon (male). Salary £100 per annum.

BIRMINGHAM: CHILDREN'S HOSPITAL.—Resident Medical Officer. Salary at the rate of £175 per annum.

BIRMINGHAM CITY.—Medical Superintendent at the Mental Deficiency Institution. Salary £700 per annum.

BIRMINGHAM AND MIDLAND EYE HOSPITAL, Church Street, Birmingham.—(1) Resident Surgical Officer; salary £150 per annum. (2) Two House-Surgeons; salary £110 per annum.

BRADFORD CHILDREN'S HOSPITAL.—(1) House-Surgeon. (2) House-Physician. Salary £120 per annum each.

CROYDON MENTAL HOSPITAL, Upper Warlingham.—Second Assistant Medical Officer. Salary £350 per annum, rising to £450.

DURHAM COUNTY AND SUNDERLAND EYE INFIRMARY, Sunderland.—Locumtenent for August and September.

EGYPTIAN UNIVERSITY.—Professor of Clinical Pathology. Salary £E.1,500 a year.

EXETER: ROYAL DEVON AND EXETER HOSPITAL.—Assistant House-Surgeon (male). Salary at the rate of £100 per annum.

GREAT YARMOUTH: GENERAL HOSPITAL.—(1) Senior House-Surgeon. (2) Junior House-Surgeon. Salary £150 and £100 per annum respectively.

HUDDERSFIELD ROYAL INFIRMARY.—Junior House-Surgeon. Salary £150 per annum.

HULL ROYAL INFIRMARY.—Casualty House-Surgeon (male). Salary at the rate of £130 per annum.

INFANTS HOSPITAL, Vincent Square, Westminster.—House-Physician (female). Salary at the rate of £75 per annum.

LIVERPOOL COUNTY BOROUGH.—Junior Assistant School Medical Officer. Salary £600 per annum.

LIVERPOOL OPEN-AIR HOSPITAL FOR CHILDREN, Leasowe.—Junior Resident Medical Officer. Salary £200.

LONDON HOMOEOPATHIC HOSPITAL, Great Ormond Street and Queen Square, W.C.1.—Assistant Surgeon for Diseases of the Eye.

LONDON TEMPERANCE HOSPITAL, Hampstead Road, N.W.1.—Casualty Officer. Salary £120 per annum.

LONGTON HOSPITAL.—House-Surgeon. Salary £120 per annum.

LOWESTOFT AND NORTH SUFFOLK HOSPITAL.—House-Surgeon (male). Salary £120 per annum.

MANCHESTER ROYAL INFIRMARY.—Junior Assistant Medical Officer in Radiological Department. Salary at the rate of £350 per annum.

NEWPORT, MON.: ROYAL GWENT HOSPITAL.—Junior Resident Medical Officer. Salary £125 per annum.

NOTTINGHAM EDUCATION COMMITTEE.—Senior Assistant Medical Officer. Salary £600, rising to £800, per annum.

NOTTS COUNTY MENTAL HOSPITAL, Radcliffe-on-Trent.—Senior Assistant Medical Officer and Deputy Medical Superintendent. Salary £520 per annum, rising to £620.

PLYMOUTH.—(1) Assistant Medical Officer of Health. Salary at the rate of £600 per annum. (2) Resident Medical Officer (male) at Udal Torre Sanatorium, Yelverton. Salary at the rate of £450 per annum.

QUEEN MARY'S HOSPITAL FOR THE EAST END, E.15.—Honorary Assistant Radiologist.

ROCHDALE COUNTY BOROUGH.—Assistant Maternity and Child Welfare Medical Officer (lady). Salary at the rate of £600 per annum.

ST. JOHN'S HOSPITAL, Lewisham, S.E.13.—Resident House Appointment (male). Salary £100 per annum.

SALISBURY, SOUTHERN RHODESIA.—Medical Officer of Health. Salary £900 per annum.

SHEFFIELD: ROYAL INFIRMARY.—(1) Surgical Registrar. (2) Assistant Casualty Officer. (3) House-Surgeon. (4) Ophthalmic House-Surgeon. (5) Assistant Ophthalmic House-Surgeon. Salary for (1) £200 per annum, and for (2-5) £80 per annum each.

TYNEMOUTH VICTORIA JUBILEE INFIRMARY.—Two House-Surgeons (male or female). Salary £100 per annum.

WEST DERBY UNION.—Resident Assistant Medical Officer (male) at the Alder Hey Children's Hospital, West Derby, Liverpool. Salary at the rate of £200 per annum.

WEST HERTS HOSPITAL, Hemel Hempstead.—(1) Senior Resident Medical Officer. (2) Junior Resident Medical Officer. Salary £150 and £100 per annum respectively.

CERTIFYING FACTORY SURGEON.—The appointment at Colwyn Bay (Denbighshire) is vacant. Applications to the Chief Inspector of Factories, Home Office, Whitehall, S.W.1.

This list of vacancies is compiled from our advertisement columns, where full particulars will be found. To ensure notice in this column advertisements must be received not later than the first post on Tuesday morning.

British Medical Association.

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IRISH MEDICAL SECRETARY: 16, South Frederick Street, Dublin. (Telegrams: Bacillus, Dublin. Tel.: 4737 Dublin.)

APPOINTMENTS.

BAKER, Doris M., M.D., M.R.C.P., M.R.C.S., Assistant Physician to the South London Hospital for Women, Clapham Common.

FLETCHER, T., M.B., Ch.B., Certifying Factory Surgeon for the Kirkcowan District, Wigtown.

LIVERPOOL HEART HOSPITAL.—*Maurice Stern Research Fellowship*. R. Howard Mole, M.D. *Honorary Assistant Physician:* Maurice Newman, M.D., M.R.C.P. *Honorary Medical Officer in charge of Cardio-neurosis Department:* C. Rankin, M.D. *Honorary Medical Officer in charge of Biochemistry Department:* I. J. Lipkin, M.D., D.P.H., D.T.M. *Honorary Medical Officer in charge of X-Ray Department:* F. Swanson Hawks, L.M.S.S.A.

CERTIFYING FACTORY SURGEONS.—J. Mowat, M.B., Ch.B.Glas., for the Chapel-en-le-Frith District (Derby), and M. F. Hendron, M.B., Ch.B. Q.U.Belf., for the Croston District (Lancashire).

POST-GRADUATE COURSES AND LECTURES.

FELLOWSHIP OF MEDICINE AND POST-GRADUATE MEDICAL ASSOCIATION, 1, Wimpole Street, London, W.1.—*All Saints' Hospital*, Vauxhall Bridge Road, S.W.1: Special Course in Urology, afternoons and evenings; duration of course one month; fee £2 12s. 6d.

NORTH-EAST LONDON POST-GRADUATE COLLEGE, Prince of Wales's General Hospital, Tottenham, N.15.—Mon., 2.30 to 5 p.m., Medical, Surgical, and Gynaecological Clinics; Operations. Tues., 2.30 to 5 p.m., Medical, Surgical, Throat, Nose, and Ear Clinics; Operations. Wed., 2.30 to 5 p.m., Medical, Skin, and Eye Clinics; Operations. Thurs., 11.30 a.m., Dental Clinics; 2.30 to 5 p.m., Medical, Surgical, and Ear, Nose, and Throat Clinics; Operations. Fri., 10.30 a.m., Throat, Nose, and Ear Clinics; 2.30 to 5 p.m., Surgical, Medical, and Children's Diseases Clinics; Operations.

LIVERPOOL UNIVERSITY CLINICAL SCHOOL ANTE-NATAL CLINICS.—Royal Infirmary: Mon. and Thurs., 10.30 a.m. Maternity Hospital: Mon., Tues., Wed., Thurs., and Fri., 11.30 a.m.

BIRTHS, MARRIAGES, AND DEATHS.

The charge for inserting announcement of Births, Marriages, and Deaths is 9s., which sum should be forwarded with the notice not later than the first post on Tuesday morning, in order to ensure insertion in the current issue.

BIRTH.

TOWERS.—At Mount Vernon Lodge, Nottingham, on July 23rd, to Edith Sherriff Towers (*née* Watson), wife of Frank Towers, B.A.(Mod.), M.B., Ch.B., a daughter.

MARRIAGE.

LYON–CHALMERS.—On July 10th, at St. Matthias, Richmond, Dr. Louis Carlyle Lyon, of 415, Prince's Gardens, West Acton, W.3, third son of Mr. and Mrs. J. J. Lyon, St. Ann's Bay, Jamaica, B.W.I., to Elmina, elder daughter of Mr. and Mrs. Haigh Chalmers, East Sheen, S.W.14.

DEATHS.

BEALE.—On July 12th, at Roman Tower, Broadstone, Dorset, Hanway Richard Beale, M.D.Lond., M.B., M.R.C.S., L.R.C.P., D.P.H.Sheffield, of Bridgegate House, Retford, Notts.

WHITTON.—At a nursing home, Aberdeen, on July 19th, Dr. Whitton of Towie House, Turriff, and late of Aberchirder.

Printed and published by the British Medical Association, at their Office, Tavistock Square, in the Parish of St. Pancras, in the County of London.