SUPPLEMENT

TO THE

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NOTES OF THE WEEK

DOCTORS AND THE NEW MIDWIFERY SERVICE

As already announced in the *Journal* (September 26th, p. 645) the Minister of Health has issued to local supervising authorities a circular drawing attention to the provisions of the Midwives Act, 1936, and urging these authorities to take immediate steps to formulate their proposals so that a service of salaried midwives may be brought into operation not later than July 30th, 1937. Since it is one of the provisions of the Act that every authority, before submitting its proposals to the Minister, must consult "such local organization (if any) of registered medical practitioners as appears to the authority effectively to represent the opinions of such practitioners practising in that area on the questions to be considered in formulating the proposals," it may be anticipated that during the next few weeks the Branches and Divisions of the British Medical Association will have valuable opportunities of helping to shape local policy in this important matter. Attention is therefore drawn to certain conditions which the Council of the Association regards as essential. The views of the Council have already been expressed to the Ministry, and to some extent are reflected in the present memorandum. It is now the responsibility of Branches and Divisions to use every opportunity of urging these views on the local authorities.

The Act requires that the proposals submitted by an authority shall include "particulars of the number of midwives to be employed by, and the parts of the area of the authority to be served (whether exclusively or jointly) by, the authority, welfare councils, and voluntary organizations respectively, or, if no such arrangements as aforesaid are proposed to be made, of the number of midwives to be employed by the authority." It is hoped that local representatives of the medical profession will do their utmost to secure that the arrangements proposed under this heading shall be such as will enable the patient to have as free a choice of midwife as possible, and to exercise that choice privately by direct communication with the midwife and not through the officer of the authority. In pressing for the policy of free choice of midwife the Association will be supporting a recommendation contained in the Ministry's memorandum. Further, the Council considers it important that the patient, when exercising her choice of midwife, should be encouraged to make at the same time her own choice of the medical practitioner who will be called in should it be decided to seek skilled medical assistance.

Again, it is most desirable, in the Council's view, that the remuneration of midwives should not be so standardized as to prevent individual skill, judgement, and personality from reaping their due reward. It is gratifying to find in the memorandum a footnote which states that "provision may be made, if considered desirable, for a scale of salaries varying with the qualifications and experience of the midwives." This also is a matter in which the local units of the Association should seek to exert their influence; and they might, in this connexion, consider an alternative method to attain a similar end—namely, the fixing of a lower number of cases (say, 70) up to which the midwife should receive a suitable and sufficient salary, with the addition of a further sum per case up to a higher maximum of cases (say, 90).

Some concern has been expressed at the possibility of the institution of a municipal service of midwives causing a reduction in the number of domiciliary cases available for educational purposes. Apparently this apprehension is not shared by the Ministry, for the memorandum suggests that in estimating the number of domiciliary confinements which are likely to be attended in their areas each year (*a*) by midwives, and (*b*) by medical practitioners, the local authorities "will no doubt consider whether the establishment of the new service may not result in a diminution in the number of cases confined in hospital." The local units of the medical profession will no doubt bear this point in mind when they are consulted; and they are asked also to use whatever opportunity arises to urge that all local maternity services should be established in accordance with the Association's Memorandum on a National Maternity Service (*Supplement*, December 7th, 1935, p. 245).

THE ASSOCIATION AND SECRET REMEDIES *

Education of the Public

The education of the public in the dangers of self-diagnosis and self-medication and of the indiscriminate use of advertised remedies has taken a prominent place in the Association's work on the subject of secret remedies, and continuous efforts have been made to persuade the various interests concerned in the sale and advertisement of proprietary remedies and appliances that a scheme of control is necessary for the welfare of the community. Some of the more important steps taken may be mentioned. The medium through which the great majority of patent medicines and appliances are made known is, of course, the daily and periodical lay press, and much of the Association's activity has been directed towards the elimination from these papers of advertisements of preparations which are obviously fraudulent or misleading. Although many newspaper proprietors are loath to take any action which would result in a diminution of the revenue from advertisements of patent medicines and appliances, a considerable measure of success has been achieved with the proprietors of the higher-class newspapers and periodicals. As was pointed out in a leading article in the *Journal* of March 28th, 1936 (p. 646), the Advertising Association possesses machinery for the examination of advertisements submitted for publication in the Press. This body frequently consults the British Medical Association, which is also often approached direct for advice by newspapers and periodicals.

On occasion action has been directed towards a particular type of publication. During the years 1923 and 1924, for instance, the Association's attention was drawn to the objectionable advertisements of patent medicines appearing in Church magazines. Certain religious organizations were approached, and as a result the Guild of St. Luke agreed to issue to clergymen of the Church of England a pamphlet on the harmful effects of patent medicines and a warning against the publication of patent medicines in Church magazines. The Association has also been disturbed by the appearance of advertisements of patent medicines and appliances in some Government publications—for example, in books of stamps—because the nature of the medium is liable to suggest that the products advertised have received some sort of approval by the Government. A promise has been obtained from the Department chiefly concerned that remedies or appliances claiming to have beneficial effects in certain diseases shall not be advertised in its publications, but not all undesirable advertisements are being refused. Direct publicity for the Association's views has been secured by the occasional insertion of articles addressed to the lay public in publications of such organizations as the Hospital Saving Association.

The Association's Work on the 1936 Bill

The conferences of interested organizations held under the auspices of the Parliamentary Committee on Food and Health in connexion with the drafting of the recent Bill gave the Association an excellent opportunity of gauging the extent to which a scheme of control would be acceptable. The representatives of the patent medicine trade declined to support any Bill on the lines of the report of the Select Committee, and the measure of control proposed by the 1931 Bill was not acceptable to other representative organizations. The British Medical Association, in its determination to secure an agreed measure which should have a reasonably good prospect of reaching the Statute Book, acquiesced in reduction after reduction of its original proposals in the hope that, if control were introduced step by step, its benefits might gradually be appreciated and a complete scheme eventually become acceptable to all concerned. The 1936 Bill, which proposed merely to prohibit the offer or supply of medicines and appliances for the treatment of a group of serious diseases and conditions, and the publication of invitations to diagnose or treat certain ailments by correspondence, may be regarded as an expression of the extent to which control would be accepted at the present time by the various interests involved.

The nature of the support commanded by the draft Bill is illustrated by the following list of organizations which co-operated with the Parliamentary Committee on Food and Health, and all of which signified their agreement: the British Medical Association, the Proprietary Association of Great Britain, the Retail Pharmacists Union, the Wholesale Drug and Trade Association, the Association of Wholesale Druggists and Manufacturers of Medicinal Preparations, the Pharmaceutical Society of Great Britain, the Advertising Association, the Institute of Incorporated Practitioners in Advertising, the Newspaper Society, the Periodical Trade Press and Weekly Newspaper Proprietors Association Ltd., the National Pharmaceutical Union, the Surgical Instrument Manufacturers Association, the Society of Medical Officers of Health, the County Councils Association, the National Association of Insurance Committees, the Association of Municipal Corporations, and the Parliamentary Medical Committee.

Legislation Abroad

That there are no insuperable difficulties inherent in a scheme of control is shown by the efficacy of legislation abroad. The laws of one country are not, of course, usually suitable for reproduction in other countries, but it as at least interesting to see how an evil which has appeared in various forms throughout the world has been dealt with by other communities. The summary of foreign methods included in the Select Committee's report shows that the general method of regulation is to prohibit the sale of proprietary medicines the formulae of which have not been communicated to the appropriate Government Department, and that in some cases this provision is supplemented by supervision of the claims made in advertisements or by penalties for false or exaggerated statements. In France the sale of secret remedies is prohibited, while in Italy and Belgium the formula must be approved by the recognized authority and must be supplied with every package sold. In Czechoslovakia the process of manufacture, as well as the composition, must be disclosed. In the United States the penalties for "misbranding" under the Food and Drugs Act apply to the inaccurate description of the contents of any preparation and its therapeutic effects.

The system that most nearly approaches the scheme which the British Medical Association would like to see in operation in this country is that of Canada, and it may be of interest to describe more fully the provisions of the Canadian Act. The Proprietary or Patent Medicine Act, which came into force in 1908 and was amended in 1919, relates only to patent medicines, not appliances, and its administration is vested in the Minister of Health. A patent medicine is defined as any artificial remedy or prescription manufactured for the internal or external use of man which is not to be found in the usual pharmacopoeias and formularies, or any artificial remedy upon which is not printed the true formula or list of ingredients contained in it. All such medicines manufactured in Canada or imported and sold in Canada must be registered with the Minister of Health, and the manufacturer is required to obtain an annual licence to sell them. He is also required to furnish the Minister with a statement of the quantity of any scheduled potent drug present in the medicine, and to include on every package sold a label containing the name and number under which the medicine is registered. Applications for the registration of medicines containing ingredients of unknown action or use are rejected. The statement of composition is made under oath, and is treated as confidential by the Ministry, which must be notified of any change in the formula or name. No patent medicine may be offered for sale if it contains certain defined drugs or alcohol in excess of a prescribed

* This is the conclusion of the article on this subject which appeared in last week's *Supplement* at page 182.

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proportion, or if it is represented as a cure for any disease, or if false or misleading claims for it are made either on the label or in any advertisement. Distribution of samples of medicines from door to door or through the post is prohibited. An Advisory Committee appointed under the Act is composed of men eminently qualified in therapeutics, pharmacology, pharmacy, and chemistry, and the necessary inspection is undertaken by the inspectors appointed under the Food and Drugs Act. The Act also empowers the Minister to make regulations, and one of the directions in which he has exercised this power is the rejection of applications for the registration of remedies for cancer, tuberculosis, gall-stones, goitre, appendicitis, diabetes, and other conditions which should be treated only under skilled supervision. Claims for such remedies are regarded as misleading and exaggerated, and therefore contrary to the spirit of the Act. Persons committing offences under the Act are liable to fine or imprisonment or both.

The Association sought from an authoritative source an opinion on the efficacy of the Canadian Act. This authority believed that the Act afforded a very considerable degree of protection to the Canadian public and that it was giving general satisfaction. Very little difficulty had been experienced with Canadian manufacturers in the deposit with the Minister of Health of the formulae of their medicines. The cost of the scheme is said not to be prohibitive, the estimate given being 60,000 dollars annually. It appears to the Association that this Act is achieving in Canada the kind of control that the Select Committee thought desirable for this country, and that it provides a valuable answer to those who contend that such a scheme is impracticable.

Stamp Duty

It has already been reported in the *Journal* (July 18th, 1936, p. 159) that the House of Commons has appointed a Select Committee "to consider the duties of excise chargeable under the Medicines Stamp Act, 1802, the Stamp Act, 1804, and the Medicines Stamp Act, 1812, and any enactment amending those Acts, and to report thereon and make such recommendations for the alteration of those duties or otherwise as they think fit, with a view to reforming the law relating thereto." Apart from the objection that the appearance of a Government stamp on a package of medicine tends to create the impression that the remedy itself has received some sort of Government approval, the present state of the administration of these Acts constitutes, in the words of a witness to the Select Committee on Patent Medicines, "a financial and legal chaos." The scale of duties has remained unchanged since 1804, and some curious anomalies have grown up during the application of the Acts. Since 1902, for instance, the Commissioners of Inland Revenue have required a duty to be paid on medicines in connexion with which the name of the ailment is mentioned, but if no ailment but only the organ of the body which is the seat of the ailment is mentioned no duty is payable. Thus "headache powder" is dutiable, but "head powder" is not; "cough mixture" is dutiable, but "chest mixture" is not. The Select Committee on Patent Medicines recommended the consolidation of the Stamp Acts and the removal of anomalies, and it also advised the prohibition of any reference in advertising matter to the Government stamp and of the printing on the stamp of the name of a proprietor or firm.

PROBLEMS IN PRACTICE

(These columns are devoted to matters of general interest on which individual members have sought the advice of the Head Office of the British Medical Association)

NOTIFICATION OF BIRTHS

A correspondent has been good enough to draw attention to a misleading statement in the paragraph on notification of births which appeared in these columns on September 19th (p. 163). It was there suggested that the doctor need not notify the birth if he has definitely ascertained that the father has done so. Actually, although the Association has taken the view that the doctor should not be responsible for notification, the strict legal position is that he is responsible, provided that he was in attendance upon the mother at the time of, or within six hours after, the birth. It is true that a person who fails to give notice of a birth in accordance with the legal requirements will not be liable to a penalty if he satisfies the court that he had reasonable grounds to believe that notice had been duly given by some other person. Merely to be summoned to the court, however, may be a more serious matter than to be called upon to pay the comparatively moderate penalty, "not exceeding twenty shillings" required by the Act; and only by notifying the birth himself can the doctor secure certain protection from the attentions of the legal authorities.

ETHICS OF MEDICAL CONSULTATIONS

In the last two issues of the *Supplement* (September 26th, p. 172; October 3rd, p. 183) reference has been made to intraprofessional obligations in private practice where the relationship of two doctors is not strictly that of consultant and attending practitioner. The rules approved by the Representative Body as to the ethics of medical consultations strictly so-called are as follows:

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

2. It is the duty of an attending practitioner to accept the opportunity of consultation in obscure and difficult cases, or when consultation is desired by the patient or by persons authorized to act on the patient's behalf.

3. In the following circumstances it is especially desirable that the attending practitioner, while dealing with an emergency when this exists, should endeavour to secure consultation with a colleague:

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

(*b*) When operative procedures involving the death of the foetus or of an unborn child are contemplated, especially if labour has not commenced;

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

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

4. The attending practitioner should nominate the practitioner to be consulted and advise accordingly, but he ought not to refuse to meet a practitioner selected by the patient or the patient's representative, although he is entitled, if such is his opinion, to urge that the practitioner selected has not the qualifications or the experience which the particular demands of the case require.

5. The arrangements for consultation should be made by the attending practitioner.

6. The following procedure in consultations conducted at the patient's residence is generally adopted and should be observed, unless in any particular instance there is substantial reason for departing from it:

(*a*) The attending practitioner should ascertain in advance the amount of the fee to be paid to the practitioner consulted, and should inform the patient or his representatives that this should be paid at the time of the consultation;

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

(*c*) On entering the room of the patient the attending practitioner should precede the practitioner consulted, and after the examination the attending practitioner should be the last to leave the room ;

(*d*) The diagnosis, prognosis, and treatment should be discussed by the practitioner consulted and the attending practitioner in private ;

(*e*) The opinion on the case and the treatment as agreed should be communicated to the patient or the patient's friends by the practitioner consulted in the presence of the attending practitioner ;

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

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

8. The arrangements for any future consultation (if required) shall be left to the initiative of the attending practitioner.

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

10. It is the duty of the attending practitioner loyally to carry out the measures agreed at, or subsequent to, the consultation ; he should refrain from making any radical alteration in these measures except upon urgent grounds or after adequate trial, and should carefully avoid any remark or suggestion which would seem to disparage the skill or judgement of the practitioner consulted.

11. The practitioner consulted shall not supersede the attending practitioner during the illness with which the consultation was concerned, nor shall he act as attending practitioner to the patient in any subsequent illness except after an explanation given to his former colleague, unless circumstances should make this latter course impracticable.

PUBLIC HEALTH NOTES

POLLUTED SHELLFISH

In the Section of Public Health at the Annual Meeting of the British Medical Association at Oxford Dr. R. W. Dodgson, Director of Shellfish Services, Ministry of Agriculture and Fisheries, in a paper on shellfish and public health, pointed out that had we set out to devise a method of ensuring the continued existence of typhoid fever in this country we could hardly have thought out a better plan than that of turning out the crude sewage from large centres of population on to a shellfish bed and then distributing such shellfish all over the country. He concluded that the only alternative to officially banning molluscan shellfish as a whole as dirty and dangerous food was the application of a satisfactory system of purification under conditions which would ensure the elimination of breakdown through carelessness and evasion. Dr. Cyril Banks, medical officer of health for Nottingham, in his annual report for the year 1935, reporting the occurrence of three cases of typhoid fever in the city, two being associated with the first, which was due to the ingestion of mussels, states: "Precautions are taken with many oyster supplies, and oysters now are not as dangerous as they used to be. With mussels it is different, and mussels polluted by sewage are frequently on the market, and owing to the peculiarities of this trade it is not easy for health authorities to ensure that such foully polluted mussels are kept from sale. In my opinion the matter is one which ought to be taken up nationally rather than locally, and it should be made a punishable offence to sell any mussels at all unless they have been subjected to a system of purification such as is carried out at Conway."

Oyster Purification

The report for 1935 of the Port of London medical officer of health, Dr. C. F. White, contains the following account of the oyster purification station at Brightlingsea, the only station of its kind in this country:

The principle is the same as that employed for mussels at the Shellfish Research Station of the Ministry of Agriculture and Fisheries at Conway—namely, to cleanse the shells and then let the shellfish cleanse themselves by leaving them submerged in a tank of sterile sea-water for a sufficient period. The main difference in practice is that in the case of oysters in cold weather the water in the tank must be warmed to about 56° F., whereas with mussels this refinement is not necessary.

The procedure of cleansing is as follows: The oysters are brought to the station and laid not more than two deep on wooden gratings in concrete tanks (45 feet by 35 feet by 2 feet 6 inches). They are then hosed with powerful jets of sterilized sea-water from a specially designed rake with which the double layer of oysters is turned over so that all are thoroughly washed. The sea-water is sterilized by the addition of the necessary amount of a solution of bleaching powder. The tanks are sloped towards a channel at one end and the dirty water escapes through a drain at the lowest point. The tank is then filled with sterilized sea-water and emptied again, thus flushing away all the dirt that has been washed off the shells.

The next stage is to get the oysters themselves washed. This is done by filling the tank with sterile sea-water, sufficient of a solution of sodium thiosulphate being allowed to drip into the water as it enters the tank to neutralize any residual chlorine. The submerged oysters open and pass the sterile water through their shells as they naturally do in breathing and feeding, thus washing themselves clean. They are left submerged overnight, and the next morning the tank is drained and the oysters are again hosed to wash away everything they have excreted. Then for a second time the tank is filled with sterile sea-water and the oysters remain submerged for a second night. The tank is then drained, the oysters hosed, and all excreta flushed away.

The last stage is to give the oysters a shallow bath for one hour in sea-water to which sufficient bleaching powder has been added to give two parts per million of residual chlorine. In this bath the oysters do not open, the object being finally to sterilize the shells. The oysters are then taken from the tank and may either be packed at once in receptacles (bags or baskets), which have been sterilized by immersion in water treated with bleaching powder so as to contain ten parts per million of residual chlorine, or they may be stored for not more than one week and not more than six deep in sterile sea-water, which is changed every day.

The plant comprises two outdoor treatment tanks for use in summer and four smaller covered ones for use in the winter, when it is necessary to warm the water to about 56° F., the optimum temperature for the cleansing process."

The Court of Common Council made an Order under the Public Health (Shellfish) Regulations, 1934, by virtue of which:

A person shall not sell or expose or distribute or offer for sale or have in his possession for the purpose of sale for human consumption any oysters, mussels, or other

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molluscan shellfish taken from within the prescribed area unless such oysters, mussels, or other molluscan shellfish have been:

1. Subjected to a satisfactory process of cleansing at an establishment which is for the time being approved by the Minister of Health for the purpose ; or

2. Relaid in pure water for such period and in such places as may from time to time be approved for the purpose by the said port sanitary authority ; or

3. Subjected to a process of sterilization by steam under pressure for at least six minutes in an apparatus which is for the time being approved by the said port sanitary authority.

ADULTERATION OF FOOD

Some of the reports of medical officers of health for 1935 contain references to proceedings taken under the Food and Drugs Adulteration Act and to food contamination. Dr. J. N. Mackintosh, county medical officer of health for Northamptonshire, states that two samples purporting to be of chocolate Swiss roll were purchased for analysis. One, labelled "choclait," contained 1 per cent. of cocoa material, and the second sample, labelled "chocolate," contained even less cocoa—namely, 0.10 per cent.—and had neither the taste nor smell of chocolate, but was dyed to give it a chocolate colour. As the shopkeeper relied on the warranty, it was agreed to take a further sample in the course of delivery. The analytical result was similar, and proceedings were taken against the manufacturers for (1) giving a label which falsely described the article sold, and (2) giving to the purchaser a false warranty. The case attracted considerable notice throughout the confectionery and grocery trades, witnesses being brought from a considerable distance to testify for the defence the impossibility of successfully manufacturing a chocolate Swiss roll with the amount of cocoa—a minimum of 4 per cent. fat-free cocoa material—suggested by the prosecution. As there is no statutory standard of the amount of cocoa to be used in making chocolate Swiss rolls, the justices had to decide the case on the evidence, and fines of £2 10s. in each case were inflicted, with the addition of £10 towards the costs.

One satisfactory feature of this case is that as a result of the proceedings the confectionery trade has been advised to increase the percentage of cocoa in chocolate Swiss rolls, and it is of interest to note that a later sample taken in this county contained 4.2 per cent. of dry fat-free cocoa material.

The report of Dr. G. MacDonald, medical officer of health for the metropolitan borough of Battersea, contains the following case.

Two samples of "cream sandwich" were certified by the public analyst to contain a white filling which was practically devoid of cream and which respectively contained 48.2 and 51 per cent. of fat, of which not less than 95 per cent. was fat not derived from milk. The two samples had been sold to the council's inspector as cream sandwich. Following the hearing of the case the magistrate delivered the following judgement:

"The question that I have to decide is whether, when a cream sandwich is asked for and an article supplied in which the so-called cream contains 95 per cent. of fat not derived from milk, this constitutes a breach of S. 2 of the Food and Drugs (Adulteration) Act, 1928. It was common ground between the parties that the Artificial Cream Act, 1929, does not affect my decision. Various dictionary definitions of the word cream were submitted to me, but even without them I should hold that cream does not necessarily mean a product of the cow, as is shown in the names face cream, cold cream, etc. As applied to confectionery, evidence was called by the defence that various substances are used in the trade as fillings that do not emanate from the cow. I accept this evidence as representing the general position. The witness for the prosecution, while urging that dairy cream ought to be used, admitted that it frequently was not. I hold that the article which in this case the purchaser could reasonably expect to receive was the article supplied, and that therefore the purchaser was not prejudiced.

The summons was dismissed and the prosecutors ordered to pay three guineas costs.

Dr. C. F. White, medical officer of health for the Port of London, states that at the beginning of the year twelve tins were drawn from a consignment of sardines, and each month the contents of one tin were analysed with a view to ascertaining whether the degree of lead contamination was affected by the period of storage. Previous experience had shown that if a number of tins are taken from one consignment and the contents of each tin are analysed separately the degree of lead contamination will be found to vary considerably. For example, in May, 1934, six tins taken from one consignment gave respectively the following results: 13, 18, 32, 24, and 58 parts per 1,000,000 of lead. For this reason, and because it is believed that the contamination takes place principally during the preparation of the sardines before they are put into the tins, it was not expected that this investigation would show that storage had any effect on the lead content of the fish. This proved to be the case, the results in parts per 1,000,000 of lead over the twelve months consecutively were 14, 13, 20, 14, 25, 25, 20, 21, 18, 15, 14, and 17. These figures are well within the limits of variation found when a number of tins are examined at the time of arrival of a consignment, and there is obviously no relation between the lead content of the fish and the period of storage.

PUBLIC HEALTH MEDICAL SERVICE

The following changes have recently been made in public health medical staffs.

APPOINTMENTS

Dr. I. G. Davies, to be deputy medical officer of health for Bristol.

Dr. D. Desmond, to be assistant medical officer for Bury.

RESIGNATION

Dr. N. B. M. Blackham, medical officer of health for Loughborough, will retire in December next.

THE INSURANCE MEDICAL SERVICE WEEK BY WEEK

Pregnancy and Incapacity

Further inquiries on this subject have been received as follows: (1) Can a married woman who is in domestic service and who is dismissed probably at six or seven months demand a certificate, as she certainly cannot get her usual work? (2) Can a woman who is doing work outside her home, and is unable to continue on account of ordinary uncomplicated pregnancy, but quite able to do her own housework, demand a certificate?

We may perhaps remind correspondents of one or two things which have already been stated on this question of pregnancy and incapacity. The practitioner's responsibility is to determine according to established principles whether a patient, as the result wholly or partly of pregnancy, is actually incapable of work ; he is not directly concerned with the economic consequences. It has been formally decided, as stated in these columns on September 19th (p. 164), that where a pregnant woman is incapable of following her normal occupation, but might be capable of doing work of a lighter description, a certificate of incapacity may properly be issued, as it is unreasonable to expect her in such circumstances to seek for or obtain some new form of employment. In such cases, however, the certificate should state, in addition to pregnancy, either the disabling associated condition, or where the pregnancy is normal, the period of pregnancy and the nature of the employment. Where, as in the first question, a married woman is dismissed from her domestic employment, it would clearly be unreasonable to expect her, in her condition, to obtain other paid domestic service ; the practitioner might take this into account in

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certifying incapacity, at the same time stating the facts of the case for the information of the woman's society. It must always be remembered that it is for the society to determine whether to pay benefit, and that machinery exists for referring the case to referees. The important matter when a doctor is certifying incapacity, with some reservation in his mind as to whether the insured person is actually incapable of work in the narrowest construction of the term, is that he should add for the information of the society the facts of the case as known to him, which have guided him in addition to the view he has formed as the result of the examination of the patient.

Laboratory and Diagnostic Facilities

In the report of the executive committee of the Scottish Association of Insurance Committees presented at the annual conference at Greenock on October 2nd, an important statement appears with regard to laboratory and diagnostic facilities. The following is a substantial extract from the report:

"For many years the Scottish Association of Insurance Committees has been pressing the central authority to secure to medical practitioners providing treatment under the national health insurance scheme extended laboratory and diagnostic facilities. The executive committee has been much impressed with the representations made from time to time that no real improvement can be looked for in the medical service until the practitioner has available to him the laboratory and diagnostic facilities on which modern medicine increasingly relies. There are certain administrative difficulties in providing such facilities for a section of the population, but the Department is very sympathetic to the view that every encouragement should be given to raise the standard of service, and has from time to time encouraged the association to believe that, while in the main extensions must wait until the insurance scheme is recast and widened, it ought to be possible under present conditions to secure a large measure of the necessary facilities. At a meeting with the Department nine months ago the association agreed to ascertain what laboratory and diagnostic facilities were available throughout Scotland, and accordingly an inquiry has been directed to all committees. It was suggested to each committee that consultations might properly be held with the local Panel Committee so as to obtain reliable information. The majority of committees have now replied, and it is hoped that a full report will be completed and submitted to the Department before the end of the year. Generally speaking, within reasonable reach of the large hospitals or where the public health department has established suitable services, practitioners report that they are satisfied with the provision made —although even in such cases it is occasionally found that there are delays which are undesirable, for expedition in such a service would double its value. Some parts of the country are exceedingly well served, but there are others where the difficulties are great and where the service is admittedly inadequate. It would certainly appear that in the larger rural areas some assistance is necessary to bring within the reach of the practitioner modern methods of scientific diagnosis. Whether this can always be done under the existing machinery is doubtful, but certain pressure by committees, with the encouragement of the central Department, should in many cases assist towards the provision by the local authority of a substantial measure of the required facilities. The executive committee therefore suggests that each Insurance Committee, unless thoroughly satisfied with the report of the Panel Committee, should discuss with the latter how far any gaps might be filled and further provision made."

There follows a reference to the fact that the movement towards increased provision of these facilities is one which has been taken up in a wider sphere, and to the conferences called in London to discuss the demand for the provision of expert medical advice and treatment and laboratory services to supplement and render more effective the medical services for the insured, having in view the recommendation of the Royal Commission on National Health Insurance as follows:

"That the extended services should be provided not by way of development of the out-patient work of the hospitals, but through an independent scheme organized under the general protection of the Ministry throughout the whole country by the Insurance Committees (or their successors) as an integral part of medical benefit."

These conferences are the subject of a report to be made to the Annual Conference of Local Medical and Panel Committees.

Medical Benefit for Hospital Staffs

This question continues to engage the close attention of the Insurance Acts Committee, and in a recent interview with the Department the committee's representatives strongly urged that the resident medical officer who would actually attend the resident staff should be placed on the medical list, and not a principal medical officer. They pointed out

"that in practically every case the resident medical officer of the institution was debarred by the terms of his employment from giving treatment to the staff outside the institution, even if under obligation as part of his insurance contract to do so. If a resident member of the staff had to be sent or went home for illness no difficulty arose if the home was in another committee area, or was so far from the hospital as to be outside the usually recognized 'radius of practice' of the medical officer; but it frequently happened that the insured person's home was close to the hospital and in the same contract area. In that event the medical officer was debarred by the terms of his employment from giving treatment to the insured person in his home; the insured person could not get temporary resident treatment from another insurance practitioner as he was still within the radius of practice (in the insurance sense) of the medical officer, and the only course would seem for the insured person to call in another doctor and pay fees as a private patient. Difficulty also arose in the treatment of non-resident staff where admitted to the restricted list. As long as the non-resident staff could attend at the hospital the medical officer would give them whatever treatment was necessary, but if they required treatment in their homes the medical officer was debarred from giving them the necessary attention despite his possible obligation under his insurance contract."

It was further contended on behalf of the committee that when a member of the staff was sent home ill he usually required considerable medical attention, and it was accordingly considered that a higher ratio for temporary resident treatment should apply in these cases. The difficulty of discriminating between staff and other comparable cases—for example, a domestic servant sent home ill—was pointed out, but the committee's representatives urged that the illnesses in the case of the hospital staff were found in practice to be exceptionally severe or of long duration.

Among the suggestions put forward by the Department was that the matter might be conveniently dealt with through the machinery of the percentage deduction of credited units, for which provision was already made under the distribution scheme in the case of practitioners with limited lists, to offset the lighter service alleged to be given by the hospital as compared with the outside practitioner. It was also suggested that the committee might be content if the Department urged Insurance Committees to endeavour to induce hospitals and other institutions where "collective own arrangements" were in force (especially in the case of applications for approval to new arrangements) to accept liability for the cost of medical treatment (within the scope) incurred away from the hospital.

The outcome of the discussion was that the Ministry undertook to give sympathetic consideration to the committee's proposals.

DENTAL BENEFIT

As the result of inquiries made following representations by the Dental Benefit Council, the Department of Health for Scotland has declared that Mr. Thomas F. Tracey of Glasgow and Mr. Robert Moonie Smith of Glasgow are to be regarded until further notice as unsuitable for service in connexion with dental benefit under the National Health Insurance Acts.

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INSURANCE ACTS COMMITTEE

OF THE

BRITISH MEDICAL ASSOCIATION, 1935-6

SUPPLEMENTARY REPORT*

SIR HENRY BRACKENBURY

105. Insurance practitioners throughout Great Britain will learn with regret that Sir Henry Brackenbury has decided not to seek re-election to the Insurance Acts Committee.

106. Sir Henry first became a member of the Committee in 1915, but his interest in national health insurance affairs dates back to the time when the first Bill dealing with this great social service was introduced. He had not long been a member of the Committee before his outstanding ability as a leader was recognized by his appointment to the chair, a position he held with distinction from 1916 to 1924. During those eight years the Committee had many tasks of exceptional difficulty, chief among them being the remoulding of the terms of service of insurance practitioners at the close of the European war, the presentation of the profession's case for remuneration commensurate with those terms of service and the changed economic conditions, and the negotiations in 1923-4, including the Court of Inquiry, which followed an attempt to effect a drastic reduction in the insurance capitation fee. It was due in no small measure to Sir Henry's leadership during those years that the conditions of insurance medical practice were established and maintained at such a high level. Sir Henry's deep interest in the work he had so much at heart did not cease with his relinquishment of the chairmanship of the Committee, and those who have been privileged to work with him during the past twenty-one years will cherish the memory of an able colleague and a distinguished leader.

107. The Committee feels that the Conference, representative as it is of the whole of that section of the medical profession which is engaged in insurance medical practice, will wish to take this opportunity of paying one more tribute to Sir Henry Brackenbury for his outstanding services, self-sacrifice, and loyal devotion to the interests of national health insurance, and has great pleasure in recommending

> **Recommendation D :** That this Conference places on record its grateful appreciation of the invaluable services rendered by Sir Henry Brackenbury during the past twenty-one years in the cause of national health insurance.

INSURANCE CAPITATION FEE

(*Continuation of paragraph 10 of Report*)

108. The Committee has given further consideration to the question whether an approach should be made to the Minister of Health for an increase in the insurance capitation fee, and the conclusion reached is set out in the recommendation which appears below, and which has already been communicated to all Panel Committees.

109. This conclusion has not been reached hurriedly. It has been felt for some considerable time that the present capitation fee is insufficient for the services rendered, but there have been factors, mainly economic, which have made it desirable to postpone an application for an increase. Three years ago the Committee prepared a memorandum upon the subject, but before taking any further action sought an interview with the then Minister of Health, as the result of which it was decided that it would be unwise to put forward a claim until the economy deductions imposed in 1931 were fully restored. Those deductions were fully restored more than a year ago, and the Committee feels that, with a return to more normal conditions, insurance medical practitioners may now advance their claim in the expectation that it will be investigated on its merits alone.

110. The Committee has already set out, in a memorandum (M.30) to Panel Committees in May last, the present position of national health insurance funds in relation to the remuneration of insurance practitioners. The object of this memorandum was to show that the amount set aside for medical benefit is now fixed by statute at 13s. per head of the insured population ; that there appears to be no margin within that sum for an increased capitation fee, and that provision would have to be made by Parliament for any increase which an investigation of the facts proved to be justifiable. The Committee is fully alive to this aspect of the matter, but does not believe that it should outweigh the equity of the profession's claim for adequate remuneration for services rendered, and is confident that public opinion would recognize and endorse such a claim.

111. During the twelve years which have elapsed since the present capitation fee of 9s. was awarded by a Court of Inquiry there have been many developments influencing the services which a medical practitioner is called upon to give to his insured patients. The character of the service has changed considerably in recent years, concurrently with the rapid advance of medical knowledge involving new methods of diagnosis and treatment. This has not only widened the scope of the service required to be given, but has resulted in an increase in the time devoted to patients. Attendances and visits on insured persons have also increased considerably since 1924, when the statistics produced on behalf of the profession were accepted by the Court of Inquiry. This may be attributed to a variety of causes, not the least of which is the intensity of health propaganda and an increasing realization, particularly on the part of the younger generation, that the services of a general practitioner are available without personal financial obligation other than is represented in the weekly contributions to national health insurance funds.

112. The responsibility for the final decision must rest with the Conference, and whatever that decision may be the Committee does not feel that it should be in the direction of further delay. The time is approaching when legislation may be introduced involving the question of medical benefit for the dependants of insured persons, and the Committee is of opinion that before such extension is contemplated the capitation fee which is paid in respect of the present insured persons should be subjected to review and determined anew after due consideration has been given to the case for an increase, which the Committee hopes the Conference will instruct it to prepare. The Committee earnestly hopes that Panel Committees will give full consideration to, and instruct their representatives how to vote upon, the following recommendation:

> **Recommendation E :** (1) That the case for an increase in the capitation fee for insurance practitioners is sound ;
>
> (2) that the time is now opportune ; and
>
> (3) that the Insurance Acts Committee be instructed to proceed with an application to the Minister of Health for an increase in the capitation fee.

* The Annual Report appeared in the *Supplement* of August 22nd, 1936, p. 125.

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NEW MEDICAL BENEFIT CONSOLIDATED REGULATIONS

(*Continuation of paragraph 11 of Report*)

113. A draft of the new Regulations (" Medical Benefit Regulations, 1936 ") has been issued, but they do not take effect until January 1st, 1937.

CENTRAL MILEAGE FUND

(*Continuation of paragraph 22 of Report*)

114. After careful consideration of the position, including the available data, the Committee has decided, on the recommendation of its Rural Practitioners' Subcommittee, not to press at present for a revision of the Central Mileage Fund.

DISPENSING BY INSURANCE PRACTITIONERS—SPECIALLY EXPENSIVE DRUGS

(*Continuation of paragraph 33 of Report*)

115. Representations were made to the Ministry of Health for the removal of the words " for the treatment of pernicious anaemia " from the entry relating to liver and allied substances in the list of drugs and appliances appended to Part II of the Distribution Scheme, which would give dispensing practitioners freedom to supply those substances, at the expense of the Drug Fund, to patients suffering from other conditions. The Ministry is unwilling, however, to accede to the request, mainly on the ground that the efficacy of liver and allied substances for conditions other than pernicious anaemia is not yet sufficiently established. There still exists, however, the right of a dispensing practitioner to apply, through the Insurance Committee, for special sanction to supply liver products at the cost of the Drug Fund for a condition other than pernicious anaemia.

MEDICAL BENEFIT FOR INSURED PERSONS EMPLOYED AND RESIDENT IN HOSPITALS WITH A RESTRICTED MEDICAL STAFF

(*Continuation of paragraphs 49–51 of Report*)

116. The proposals outlined in paragraph 51 of the Committee's report have been discussed with representatives of the Ministry of Health, who have promised to give them sympathetic consideration.

SCHEDULE OF APPLIANCES—HYPODERMIC NEEDLES

117. Attention has been drawn to the inferior quality of hypodermic needles supplied as part of medical benefit, and representations upon the matter are being made to the Ministry of Health.

IMPROPER ACTION OF INSURANCE CHEMIST

118. In a case which was recently the subject of an investigation by a Joint Services Subcommittee it was alleged that an insurance chemist had supplied, in the first instance, a bottle of mixture in accordance with a practitioner's prescription, but had subsequently accepted the return of the mixture and given in exchange a bottle of lotion. No action was taken against the chemist, on the ground that he had fulfilled his obligation under his terms of service by supplying the drug prescribed, any subsequent transaction being irrelevant to the question of a breach of contract. Although the matter is not one directly affecting insurance practitioners, it is considered that, in the interest of the insurance medical service, appropriate action should be taken to prevent the recurrence of such an incident, and representations to this effect are being made to the Ministry of Health.

NATIONAL INSURANCE DEFENCE TRUST

(*Continuation of paragraph 74 of Report*)

119. The trustees have had submitted to them the general outline of a scheme in amplification of the proposal of the Birmingham Panel Committee that a loan should be raised from insurance practitioners to supplement the present funds of the Trust. No definite decision has been reached, however, pending consideration of the question whether the present fund is of sufficient size.

SCOTLAND

Cancellation of Conference of Scottish Local Medical and Panel Committees

(*Continuation of paragraph 93 of Report*)

120. The Conference of Scottish Local Medical and Panel Committees, provisionally arranged for October 7th, 1936, has been cancelled, mainly on the ground that important issues arising out of the Departmental Committee's Report on Scottish Health Services may require consideration at a later date.

H. C. JONAS,
Chairman.

REPORT OF SEPTEMBER MEETING

The Insurance Acts Committee met at the British Medical Association House, London, on September 24th, with Dr. H. C. Jonas in the chair. Dr. F. Gray, a direct representative, and Dr. N. E. Waterfield and Dr. H. S. Howie Wood, who had been elected by the Annual Representative Meeting, were in attendance for the first time, and were welcomed by the chairman. The resignations of Sir Henry Brackenbury, Dr. J. W. Bone, and Dr. J. J. Day were announced, and, on a motion from the chair, it was unanimously resolved to record on the minutes an appreciation of the services rendered by these three old and valuable members. The chairman further proposed that the forthcoming Conference of Local Medical and Panel Committees should be asked to place on record its grateful appreciation of the invaluable services rendered by Sir Henry Brackenbury for so many years in the cause of national health insurance, the proposition to go forward as part of the Committee's report to the conference. Dr. Dain, in seconding, said that this was a sad meeting, because for the first time for very many years Sir Henry Brackenbury was not a member. Many of those present could recall the long years of his chairmanship, and they knew how greatly the position of the insurance practitioners and of the committee as their mouthpiece had been enhanced as a result of Sir Henry's logical outlook, command of argument, and experience of public affairs. The proposition was supported by Dr. C. F. T. Scott, who spoke from his knowledge of the valuable services which Sir Henry Brackenbury had rendered in his own county of Middlesex, and by Dr. E. A. Gregg, as an old member of the Committee. The Medical Secretary, Dr. G. C. Anderson, said that, though it was unusual for a member of the staff of the Association to take part in such proceedings, he felt he must add his word of grateful thanks for the enormous help which Sir Henry Brackenbury had given to the staff in connexion with national health insurance work for many years.

The resolution was unanimously carried.

THE CAPITATION FEE

The Committee resumed consideration of the question, postponed from the last meeting, of issuing a second communication to Panel Committees on the subject of the insurance capitation fee. Following the issue of the earlier memorandum, known as M.30, in May last, certain observations had been received from Panel Committees, notably a reasoned statement from the Birmingham Panel Committee in support of its resolution instructing the

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Insurance Acts Committee to demand a revision of the capitation fee in the light of the knowledge gained from statistics of work done under the Acts. Birmingham had summarized under various headings the reasons why an increased capitation fee should be sought, as, for example, the increased attendances and visits due to intensified health propaganda and other causes; the greater time and skill demanded by modern methods of diagnosis and treatment; the increased equipment required by the practitioner; the more lengthy consultations necessary on account of the growing influence of dietetics in treatment; and the greater responsibilities attendant upon precise certification. Several other committees had furnished arguments and data, and some of them had entered upon calculations to show what the figure should be, on the basis of the 1924 award, after taking into account the increased work and responsibility and the cost of practice. In particular, the Norfolk committee gave figures for a large practice with a list of over 2,000 showing that for approximately the same number of persons 1,000 more attendances were made in 1936 than in 1924. Norfolk put forward the proposition that if the 13s. arbitrarily laid down to provide for all medical benefit were not sufficient to meet the justifiable increase in the fee the Committee should ask for legislation to provide the fresh money.

The chairman said that some committees appeared to have regarded the document M.30 as the final word, but there was no justification for that. The Insurance Acts Committee could, of course, only go forward on complete figures based on statistics collected throughout the country. It was mentioned that the London Panel Committee had sent out a questionary to all insurance practitioners in its area and had a section still dealing with the matter, so that it had not yet been able to send in its contribution to the discussion. A representative of that committee thought the circumstances warranted a special meeting of the Insurance Acts Committee prior to the Conference.

To test the feeling of the Committee, a vote was taken on the proposition: "That the time is not opportune to approach the Government," and this was defeated, after which there was a long discussion on the next step. It was suggested that many Panel Committees were waiting for a lead, which they would expect to find in the Supplementary Report. Eventually it was agreed, on the motion of Dr. Dain, seconded by Dr. Thwaites, to put forward a motion to the Conference asking it to declare that the case for an increase in the capitation fee was sound, that the time was now opportune, and that the Insurance Acts Committee should be instructed to proceed with an application to the Minister. If the Conference gives its approval the Committee will at once get down to the preparation of the case.

MEDICAL BENEFIT FOR INSURED PERSONS ON INSTITUTION STAFFS

The Committee received a report of a discussion which had taken place between its representatives and representatives of the Ministry of Health on proposals agreed to at the last meeting of the Committee for dealing with the provision of medical benefit for resident insured persons on staffs of hospitals and other institutions of local government authorities. The Committee's representatives had urged that the officer to be placed on the medical list should in all cases be the resident officer actually responsible for the treatment of the staff, not a principal medical officer who did not actually attend the persons concerned. On behalf of the Ministry it was stated that neither the Department nor the Insurance Committee could prevent the medical officer of health putting his name on the medical list; the Insurance Committee could only watch the position and take action if, being on the list, he committed a breach of his Terms of Service. Certain alternative solutions were suggested to the Ministry—namely, that it could be made plain to the authorities controlling institutions that if they wished their medical officer to be placed on the panel with a list restricted to hospital employees he must be prepared to visit and treat such persons, when necessary, in their homes if their homes were within the applicable contract area; also, that the radius of practice of the medical officer might be defined in his contract as the hospital itself. The difficulties of the situation were explored in a lengthy discussion, and the Ministry undertook to give sympathetic consideration to the Committee's suggestions.

DRUGS AND APPLIANCES

It was reported to the Committee that the Ministry had approved the amendment of the distribution scheme by the addition to the list of drugs appended to Part II of "desiccated stomach, extracts of stomach, and the active principles of stomach supplied for the treatment of pernicious anaemia." It had been suggested to the Ministry that the words "for the treatment of pernicious anaemia" should be removed from the entry relating to liver and allied substances in order to give dispensing practitioners freedom to supply these substances, at the expense of the Drug Fund, to patients suffering from other conditions; but the Ministry said that the only other conditions for which these substances were efficacious was disseminated sclerosis, and their use in that condition was still in an experimental stage. The right of a dispensing practitioner to apply through the Insurance Committee for special sanction to supply liver products at the cost of the drug tariff for a condition other than pernicious anaemia still remained.

It was agreed to send forward to the Ministry of Health a proposal from the London Panel Committee to explore the question of the quality of hypodermic needles supplied to diabetic insured persons, and to suggest that, if possible, these should be standardized and be of British manufacture; also that some method of prescribing methyl-red should be found, discussion to take place with the Ministry as to the most effective means.

The cost of drugs and appliances also came before the Committee. The situation in this respect was stated to be becoming anomalous. There were areas in which the cost of prescribing was more than double that in other areas without any apparent reason for such diversity. The cost of prescriptions per insured person in Salford was 55d., in Manchester 52d., in Lancashire 41.21d., and in London 37.93d. A member pointed out that it was natural for costs to increase in all areas, because when national health insurance started those who came under the scheme had been accustomed to pay their doctor and not to go to him unless they were seriously ill; but as time went on, and the value of insurance was appreciated, there was a far more general consultation of the doctor for slight illnesses. The majority of those now insured had never at any time obtained their medical attendance by private arrangement, and therefore had never got into the habit, so far as doctoring was concerned, of the older generation. The cost of prescribing would continue to increase until every insured person was of such an age that he or she had never had private medical treatment. As against this the opinion was expressed that, although the cost of drugs might not be diminished, many drugs having increased in price, yet the volume of prescribing, and consequently its cost, could be reduced without disadvantage to the patient.

THE FUNDS OF THE TRUST

Sitting as Trustees of the National Insurance Defence Trust, the Committee considered a report on a proposal from one of its members, Dr. J. A. Brown, on a scheme for raising by levy a fund supplementary to the existing one, the subscriptions to be returnable in whole or in part to subscribers on retirement or to their executors in the event of death. The subcommittee which had inquired into the proposal, after canvassing the not insuperable administrative difficulties and the advantages, nevertheless came reluctantly to the conclusion that it could not recommend approval of the scheme. A real

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difficulty would arise when depreciation of capital value occurred, as was not unlikely under a fixed trust. Although the scheme was for the present laid aside, the view was expressed that if later there was a decision to raise another £250,000 this returnable levy would be a very attractive way of raising it, and one likely to appeal to many Panel Committees and practitioners. The trustees thanked Dr. Brown for his interesting and stimulating proposals, and filed the report for possible future reference.

OTHER BUSINESS

On the Rural Practitioners' Subcommittee report a question which had arisen in Denbighshire was mentioned. On certain applications by practitioners for special subsidies, after a joint subcommittee had recommended grants towards meeting the cost of telephones, places of call, and locumtenents for holidays, the Welsh Board of Health had granted subsidies in respect of places of call only, and stated that on a careful review of the circumstances and with due regard to approvals which had been given in the past, it had come to the conclusion that the continuance of subsidies in respect of telephones and the employment of locumtenents could not be justified in the cases of applications in question. The Insurance Acts Committee approved the action taken by its subcommittee in advising the Denbighshire Panel Committee to ask for a statement of reasons for the change, and, failing a satisfactory explanation, itself to reconsider the matter with a view to representations to the Welsh Board of Health.

The Insurance Acts Subcommittee for Scotland presented a very brief routine report explaining the circumstances in which the Scottish Panel Conference originally fixed for October 7th had been cancelled. The Scottish Committee of the Association is being recommended to hold a special meeting with the subcommittee for the purpose of appointing certain joint sections to take appropriate action with regard to the report of the Departmental Committee on Scottish Health Services.

An advertisement for a Divisional (Regional) Medical Officer for Scotland who, it was stipulated, should be not more than 35 years of age, evoked some comment. One Panel Committee had suggested that it was an insult to older practitioners, whose judicial faculties were at their height between the ages of 35 and 50. The view expressed in the Insurance Acts Committee was that the standard of such officers in Scotland should not be less than in England and Wales, and that the efficiency of the service would be improved if 35 was regarded as the minimum age and 50 as the maximum.

Dr. H. W. Pooler was appointed representative on the Ophthalmic Committee.

Among many matters of more than local interest referred to the Committee was the case of a chemist in the Sheffield area who had dispensed a prescription for a certain medicine, and subsequently, at the request of the messenger of the insured person, had accepted the return of the medicine and given in exchange a bottle containing lotion. It was agreed to send a letter to the Ministry pointing out the seriousness of such an action, and although the technical point might be made that the chemist had in fact, by supplying the drug in the first instance, fulfilled his obligation under the Terms of Service, the lack of propriety and the potential danger of such a practice were obvious.

The annual dinner of the London Local Medical and Panel Committee, which is open to all insurance practitioners in London and their wives and friends, will be held on Thursday, October 15th, at the Connaught Rooms, Great Queen Street, W.C.1. The guests of the evening will be Dr. Adolphe Abrahams, Mr. Norman Birkett, Mr. D. C. L. Fitzwilliams, and Mr. R. Scott Stevenson. Tickets, price 10s. 6d. each, may be obtained from the organizing secretary of the committee at 17, Russell Square, W.C.1.

British Medical Association

OFFICES, BRITISH MEDICAL ASSOCIATION HOUSE, TAVISTOCK SQUARE, W.C.1

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Irish Free State Medical Union (I.M.A. and B.M.A.): 18, Kildare Street, Dublin. (Telegrams: Bacillus, Dublin. Tel.: 62550 Dublin.)

Diary of Central Meetings

October

9	Fri.	Public Medical Services Subcommittee, 11.30 a.m.
		Science Committee, 2 p.m.
14	Wed.	Advisory Committee, 10 a.m.
		Works Medical Officers Subcommittee, 2 p.m.
		Committee on Organization of Profession in India, 2.15 p.m.
15	Thurs.	Dominions Committee, 2 p.m.
16	Fri.	Journal Committee, 2.30 p.m.
20	Tues.	Organization Committee, 2 p.m.
21	Wed.	Medico-Political Committee, 11 a.m.
23	Fri.	Public Health Committee, 2 p.m.
28	Wed.	Finance Committee, 2.30 p.m.

November

4	Wed.	Committee on Health Services, 2.15 p.m.
10	Tues.	Joint Subcommittee on Nursing Problems, 2.30 p.m.
11	Wed.	**Council**, 10 a.m.

Conference of Pathologists Group

Notice is hereby given that a Conference of the Pathologists Group of the Association will be held at B.M.A. House, Tavistock Square, London, W.C., on Friday, October 30th, 1936, at 4.30 p.m. Members of the Association who are working in an institutional or private pathological laboratory, engaged in examining and reporting on specimens for general clinical purposes, are *ipso facto* members of the Group, and are invited to attend the Conference.

Agenda

1. Appoint: Chairman of Conference.
2. Receive: Report of Group Committee, 1935–6.
3. Appoint: Group Committee for session 1936–7.
4. Any other relevant business.

G. C. Anderson,
Medical Secretary.

10th October, 1936.

Branch and Division Meetings to be Held

East Yorkshire Branch.—At Quern House, Park Street, Hull, Wednesday, October 14th, 8.15 p.m. B.M.A. Lecture by Dr. H. Crichton-Miller: "The Neurotic in General Practice."

Metropolitan Counties Branch: South-West Essex Division.—At Whipps Cross Hospital, Leytonstone, Tuesday, October 13th, 3.15 p.m. Clinical meeting.

Metropolitan Counties Branch: Stratford Division.—At Invalid and Crippled Children's Hospital, Balaam Street, Plaistow, E., Friday, October 23rd, 3 p.m. Clinical meeting arranged by Mr. Kenneth Heritage. Cases and demonstrations by honorary staff.

Southern Branch: Portsmouth Division.—At Portsmouth Cathedral, Sunday, October 18th, 3 p.m. St. Luke's Day Service. Preacher: The Lord Bishop of Portsmouth. At Kimbell's Café, Osborne Road, Southsea, Wednesday, October 21st, 8.30 p.m. Annual Members' Small Dinner and Dance.

Staffordshire Branch: Walsall and Lichfield Division.—At Walsall General Hospital, Friday, October 16th, 8.30 p.m. Report by Dr. A. B. Davies on Annual Representative Meeting at Oxford; Film illustrating production of antitoxins and vaccine lymph.

Suffolk Branch: West Suffolk Division.—At Crown Court, Shire Hall, Bury St. Edmunds, Saturday, October 10th, 8.30 p.m. Major H. S. Blackmore, O.B.E. (Medical Adviser, Air Raids Precautions Department, Home Office): "Air Raid Precautions, including Anti-gas Measures, and the Medical Profession."

Surrey Branch: Richmond Division.—At Richmond Royal Hospital, Friday, October 9th, 3 p.m. Clinical meeting.

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SURREY BRANCH: CROYDON DIVISION.—At Croydon General Hospital, Tuesday, October 13th, 8.30 p.m. Dr. D. H. Brinton: "The Neurological Aspect of Head Injuries."

WORCESTERSHIRE AND HEREFORDSHIRE BRANCH.—At Herefordshire General Hospital, Thursday, October 15th, 3.15 p.m. Autumn meeting, followed by clinical meeting.

POST-GRADUATE NEWS

The Fellowship of Medicine announces the following courses: gynaecology at Chelsea Hospital for Women, October 19th to 31st; neurology, especially intended for general practitioners, at West End Hospital for Nervous Diseases, October 19th to 24th; urology at St. Peter's Hospital, November 2nd to 14th; medicine, surgery, and gynaecology at Royal Waterloo Hospital, November 2nd to 14th; general surgery at Royal Cancer Hospital, October 17th and 18th; obstetrics at City of London Maternity Hospital, October 24th and 25th; physical medicine at St. John Clinic and Institute of Physical Medicine, November 7th and 8th; clinical cases and pathological specimens (in preparation for the M.R.C.P. examination) at National Temperance Hospital, November 24th to December 10th, at 8 p.m. A series of lectures on endocrinology will be given at the National Temperance Hospital on Monday, November 23rd, and on Wednesdays and Fridays from November 25th to December 16th, at 8.30 p.m. Syllabuses of all courses can be obtained from the Fellowship of Medicine, 1, Wimpole Street, W.

WEEKLY POST-GRADUATE DIARY

BRITISH POST-GRADUATE MEDICAL SCHOOL, Ducane Road, W.—*Daily*, 10 a.m. to 4 p.m., Medical Clinics, Surgical Clinics or Operations, Obstetrical and Gynaecological Clinics. *Mon.*, 2.15 p.m., Dr. Duncan White, Radiological Demonstration. *Tues.*, 4.30 p.m., Dr. H. Yellowlees, Psychological Medicine in Practice. *Wed.*, 12 noon, Clinical and Pathological Conference (Medical); 2.30 p.m., Clinical and Pathological Conference (Surgical); 4.30 p.m., Mr. J. E. Barnard, Microscopy. *Thurs.*, 2.15 p.m., Operative Obstetrics; 2.30 p.m., Mr. G. Jefferson, Surgery of Nervous System; 3.30 p.m., Dr. R. E. Roberts, Radiology in Obstetrics. *Fri.*, 2.15 p.m., Department of Gynaecology, Pathological Demonstration.

FELLOWSHIP OF MEDICINE AND POST-GRADUATE MEDICAL ASSOCIATION, 1, Wimpole Street, W.—*Infants Hospital*, Vincent Square, S.W.: Mon., Tues., Wed., and Thurs., 8 p.m., Primary F.R.C.S. Anatomy and Physiology Course. *St. John's Hospital*, 5, Lisle Street, W.C.: Afternoon Course in Dermatology. *National Hospital for Diseases of the Heart*, Westmoreland Street, W.: All-day Course in Cardiology. *West End Hospital for Nervous Diseases*, Gloucester Gate, N.W.: Tues., 8.30 p.m., Demonstration on Fundus Oculi by Mr. R. Lindsay Rea. *Preston Hall*, near Maidstone: Sat., Demonstration on Pulmonary Tuberculosis. *Royal Cancer Hospital*, Fulham Road, S.W.: Sat. and Sun., Course in Surgery.

CENTRAL LONDON THROAT, NOSE AND EAR HOSPITAL, Gray's Inn Road, W.C.—*Mon.* to *Sat.*, Course in Anatomy and Physiology.

HOSPITAL FOR SICK CHILDREN, Great Ormond Street, W.C.—*Wed.*, 2 p.m., Clinical Lecture, Dr. W. G. Wyllie, Physiology and Nutritional Requirements of Infant Feeding; 3 p.m., Clinico-Pathological Lecture, Dr. A. Signy, Blood Cells, their Types, Origin, and Significance. Out-patient Clinics, mornings, 10 a.m. to 12 noon; Ward Visits, afternoons, 2 p.m. to 3.30 p.m.

INSTITUTE OF MEDICAL PSYCHOLOGY, Malet Place, W.C.: *Mon.*, 3 p.m.. Dr. H. Crichton-Miller, Toxic and Endocrine Factors in the Psychoneuroses; 4.30 p.m., Dr. E. A. Bennet, Methods of Investigation, Hypnosis, Word Association, Automatic Writing and Drawing; 5.45 p.m., Dr. W. Nunan, Hypnosis and Suggestion. *Wed.*, 6 p.m., Dr. J. A. Hadfield, Child Psychology in Relation to Adult Neuroses; 8.30 p.m., Professor C. G. Jung (Zurich), Psychology and National Problems. *Thurs.*, 3 p.m., Dr. Hadfield, Psychological Background; 4.30 p.m., Dr. Bennet, Free Association; 5.45 p.m., Dr. B. D. Hendy, A Case of Self-Consciousness.

LONDON HOSPITAL MEDICAL COLLEGE.—*Wed., Thurs., Fri., and Sat.*, 10 a.m., Post-Graduate Course for Former Students. *Thurs.*, 4.15 p.m., Schorstein Memorial Lecture by Prof. John A. Ryle, Anorexia Nervosa.

LONDON SCHOOL OF DERMATOLOGY, St. John's Hospital, 5, Lisle Street, W.C.—*Tues.*, 5 p.m., Dr. H. Corsi, Syphilis through Four Centuries. *Wed.*, 5 p.m., Dr. I. Muende, Histopathology of Common Skin Diseases.

NATIONAL HOSPITAL, Queen Square, W.C.—*Mon.* to *Fri.*, 2 p.m., Out-patient Clinics. *Mon.*, 3.30 p.m., Dr. S. A. Kinnier Wilson, The Motor System. *Tues.* and *Thurs.*, 3.30 p.m., Dr. E. A. Carmichael, The Sympathetic Nervous System. *Wed.*, 3.30 p.m., Dr. S. A. Kinnier Wilson, Clinical Demonstration. *Fri.*, 3.30 p.m., Dr. Bernard Hart, Psychopathology.

UNIVERSITY COLLEGE, Gower Street, W.C.—*Mon.*, 5 p.m., Dr. R. J. Lythgoe, Physiology of Vision. *Tues.*, 5 p.m., Dr. C. Reid, Endocrine Organs in Relation to Metabolism.

WEST LONDON HOSPITAL POST-GRADUATE COLLEGE, Hammersmith, W.—*Daily*, 2 p.m., Operations, Medical and Surgical Clinics. *Mon.*, 10 a.m. to 12 noon, Genito-Urinary Operations, Skin Clinic, Surgical Wards; 2 p.m., Gynaecological and Surgical Wards, Eye and Gynaecological Clinics. *Tues.*, 10 a.m. to 12 noon, Medical Wards, Surgical Demonstration; 2 p.m., Throat, Nose, and Ear Clinic; 4.15 p.m., Lecture, Dr. Owen, The Newborn Baby. *Wed.*, 10 a.m. to 12 noon, Medical Wards, Children's Clinic; 2 p.m., Gynaecological Operations, Eye Clinic; 4.15 p.m., Lecture, Mr. Harvey Jackson, Head Injuries. *Thurs.*, 10 a.m. to 12 noon. Neurological and Gynaecological Clinics, Fracture Demonstration; 2 p.m., Eye and Genito-Urinary Clinics; 4 p.m., Venereal Diseases. *Fri.*, 10 a.m., Medical Wards, Skin Clinic; 12 noon, Lecture on Treatment; 2 p.m., Throat, Nose, and Ear Clinic; 4.15 p.m., Lecture, Mr. Vlasto, Minor Operations in Otolaryngology. *Sat.*, 10 a.m., Medical Wards, Children's and Surgical Clinics. The lectures at 4.15 p.m. are open to all medical practitioners without fee.

EDINBURGH UNIVERSITY, New Buildings, Teviot Place, Edinburgh.—William Ramsay Henderson Trust Lectures: *Tues.*, 5 p.m., Prof. W. E. Le Gros Clark, Morphological Aspects of the Hypothalamus; *Thurs.*, 5 p.m., Dr. John Beattie, Functional Aspects of the Hypothalamus.

LEEDS POST-GRADUATE CLINICAL DEMONSTRATIONS.—At Leeds General Infirmary: *Tues.*, 3.30 p.m., Dr. G. W. Watson, Medical Cases.

LEEDS PUBLIC DISPENSARY AND HOSPITAL.—*Wed.*, 4 p.m., Dr. S. J. Hartfall, Acute Blood Disorders in General Practice.

MANCHESTER ROYAL INFIRMARY.—*Tues.*, 4.15 p.m., Mr. F. G. Wrigley, Some Causes of Nasal Obstruction. *Fri.*, 4.15 p.m., Dr. F. E. Tylecote, Demonstration of Medical Cases.

DIARY OF SOCIETIES AND LECTURES

ROYAL SOCIETY OF MEDICINE

United Services Section.—Mon., 4.30 p.m. Presidential Address by Surgeon Rear-Admiral J. Falconer Hall: Mental Treatment Act, 1930, with Application to Service Cases.

Section of Therapeutics and Pharmacology.—Tues., 5 p.m. Presidential Address by Dr. Dorothy C. Hare: A Therapeutic Trial of a Raw Vegetable Diet in Chronic Rheumatic Conditions.

Section of History of Medicine.—Wed., 5 p.m. Paper by Dr. J. D. Gilruth: Chiron and Minoan Medicine.

Section of Dermatology.—Thurs., 5 p.m. (Cases at 4 p.m.) Cases by Dr. H. MacCormac, and Dr. H. S. Burnell-Jones and Dr. R. Carswell.

Section of Neurology.—Thurs., 8.30 p.m. Presidential Address by Dr. C. M. Hinds Howell: Arachnoiditis.

Section of Radiology.—Fri., 6.45 p.m. Presidential Address by Dr. Douglas Webster: The Contribution of Radiology to the Cancer Problem.

Section of Obstetrics and Gynaecology.—Fri., 8 p.m. Short Papers by Dr. Elizabeth Hurdon, Mr. V. B. Green-Armytage, and Miss Alice Bloomfield. Cinematograph Film by Dr. A. H. Jacob, and description by Mr. James Wyatt: The Progress of Jubilee.

BIOCHEMICAL SOCIETY.—At Biochemical Laboratory, Cambridge, *Sat.*, 2.30 p.m. Communications and Demonstrations.

BRITISH INSTITUTE OF RADIOLOGY, 32, Welbeck Street, W.—*Thurs.*, 8 p.m., Presidential Address by Professor J. A. Crowther, Sc.D.: Physics and Radiology. *Fri.*, 3.30 p.m., Medical Committee; 5 p.m., Meeting of Medical Members.

BRITISH RED CROSS SOCIETY, 9, Chesham Street, S.W.—*Fri.*, 5 p.m., Lecture on Air Raid Precautions.

HUNTERIAN SOCIETY.—At Simpson's Restaurant, Cheapside, E.C., *Mon.*, 7.15 p.m. Presidential Address by Mr. H. L. Attwater: Reflections in the Cystoscope.

MEDICAL SOCIETY OF LONDON, 11, Chandos Street, W.—*Mon.*, 8 p.m., Annual General Meeting. 8.30 p.m., Presidential Address by Sir William Willcox: Clinical Immunity.

PADDINGTON MEDICAL SOCIETY.—At Great Western Royal Hotel, Paddington, W., *Tues.*, 9 p.m. Dr. R. D. Gillespie: Indications and Contraindications for Barbiturate Medication.

ROYAL SOCIETY OF TROPICAL MEDICINE AND HYGIENE, 26, Portland Place, W.—*Thurs.*, 8.15 p.m., Dr. H. Lyndhurst Duke: Recent Observations on the Biology of the Trypanosomes of Man in Africa. Preceded by Demonstration at 7.45 p.m.

SOCIETY FOR THE STUDY OF INEBRIETY.—At Friends House, Euston Road, N.W., *Tues.*, 4 p.m. Seventeenth Norman Kerr Memorial Lecture by Prof. D. K. Henderson: Alcoholism and Psychiatry.

VACANCIES

ALL SAINTS HOSPITAL FOR GENITO-URINARY DISEASES, Austral Street, S.E.—Hon. Anaesthetist.

AUSTRALIA: SYDNEY HOSPITAL.—Director of the Kanematsu Memorial Institute of Pathology. Salary £1,500 p.a. (Australian currency).

BARKING CORPORATION.—R.A.M.O. for Upney Maternity Hospital. Salary £350-£25-£450 p.a.

BIRMINGHAM AND MIDLAND EAR AND THROAT HOSPITAL.—Assistant S.

BIRMINGHAM AND MIDLAND HOSPITAL FOR WOMEN.—Acting Hon. S. and Registrar.

BIRMINGHAM CITY MENTAL HOSPITAL.—J.A.M.O. (female). Salary £350-£450 p.a.

BIRMINGHAM MATERNITY HOSPITAL.—H.S. Salary £75 p.a.

BRIDGWATER GENERAL HOSPITAL.—H.S. Salary £130-£150 p.a.

BRIGHTON: ROYAL ALEXANDRA HOSPITAL FOR SICK CHILDREN.—H.S. (male). Salary £120 p.a.

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Bristol City and County.—Police Surgeon. Salary £1,000 p.a.
Bristol: Cossham Memorial Hospital.—J.R.M.O. (male). Salary £100 p.a.
Bromley and District Hospital.—R.M.O. (male, unmarried). Salary £150.
Burnley: Victoria Hospital.—H.P. (male). Salary £150 p.a.
Chesterfield and North Derbyshire Royal Hospital.—C.O. and Fracture H.S. (male). Salary £200 p.a.
Coventry and Warwickshire Hospital.—H.S. (male) for the Aural and Ophthalmic Departments. Salary £125 p.a.
Cowbridge Rural District.—Part-time Medical Officer of Health. Salary £150 p.a.
Derbyshire Royal Infirmary.—Whole-time Pathologist. Salary £750 p.a.
Ealing: King Edward Memorial Hospital.—J.R.M.O. (male). Salary £150 p.a.
East and West Suffolk County Councils.—J.A.M.O. (male, unmarried) at St. Audry's Hospital for Mental Diseases, Melton. Salary £350-£25-£450 p.a.
Ebbw Vale General Hospital.—Surgeon. Salary £750-£100-£950 p.a.
Essex County Council.—Assistant County M.O.H. (male). Salary £750-£25-£937 10s. p.a.
Fort William: Belford Hospital.—Surgical Officer. Salary £600 p.a.
Glasgow Eye Hospital.—(1) R.H.S. Salary £100 p.a. (2) Clinical Assistant. Honorarium £30 p.a.
Golden Square Throat, Nose, and Ear Hospital, W.—H.S. Salary £100 p.a.
Great Barrow: Barrowmore Tuberculosis Sanatorium and Settlement.—H.P. (male). Salary £150 p.a.
Grimsby County Borough.—Venereal Diseases M.O. and Pathologist. Salary £750-£937 10s. p.a.
Halifax County Borough.—J.R.M.O. (male) at Halifax General Hospital. Salary £250 p.a.
Halifax: Royal Halifax Infirmary.—Third H.S. (male, unmarried). Salary £150 p.a.
Hampstead General and North-West London Hospital, Haverstock Hill, N.W.—H.S. (male, unmarried). Salary £100 p.a.
Harrogate: Royal Bath Hospital.—R.M.O. (male). Salary £156 p.a.
Hereford: Herefordshire General Hospital.—H.S. and C.O. (male). Salary £100 p.a.
Hertford County Hospital.—Senior H.S. (male). Salary £200 p.a.
Hospital for Epilepsy and Paralysis, Maida Vale, W.—(1) R.M.O. (2) H.P. Males. Salaries £150 p.a. and £100 p.a. respectively.
Hostel of St. Luke, Fitzroy Square, W.—R.M.O. (male). Salary £200 p.a.
Hull Royal Infirmary.—(1) R.S.O. (2) H.P. to the Sutton Branch Hospital. Males. Salaries £200 p.a. and £160 p.a. respectively.
Kettering and District General Hospital.—Second R.M.O. (male). Salary £125 p.a.
King's College Hospital, S.E.—(1) Radium Registrar. (2) Surgical Registrar.
Lancashire County Council.—Second R.M.O. (unmarried) at Park Hospital, Davyhulme. Salary £225 p.a.
Lancaster: Royal Lancaster Infirmary.—J.H.S. (male, unmarried). Salary £130 p.a.
Leeds Public Dispensary and Hospital.—(1) C.O. and H.S. (2) H.P. Males. Salaries £150 p.a. each.
Lincoln County Hospital.—(1) Senior H.S. (male, unmarried). Salary £250-£300 p.a. (2) J.H.S. (male, unmarried). Salary £150-£200 p.a.
Liverpool Eye, Ear and Throat Infirmary.—Ophthalmic H.S. Salary £120 p.a.
London County Council.—(1) A.M.O.s (Grade I) at (*a*) Queen Mary's Hospital, Sidcup (male, unmarried); (*b*) St. James's Hospital, S.W. (two appointments); (*c*) Fulham Hospital, W. (male); (*d*) St. Mary, Islington, Hospital, N. Salaries £350-£25-£425 p.a. each. (2) A.M.O.s (Grade II) at (*a*) Queen Mary's Hospital, Sidcup (male); (*b*) Paddington Hospital, W. (male); (*c*) Lewisham Hospital, S.E. (male); (*d*) St. Pancras Hospital, N.W. (male); (*e*) St. James's Hospital, S.W.; (*f*) St. Alfege's Hospital, S.E. Salaries £250 p.a. each. (3) Temporary District M.O.s. for (*a*) Area VIII, District H (Camberwell and Peckham); (*b*) Area III, District E (Kentish Town and Gospel Oak); (*c*) Area VII, District N (Wandsworth, Putney, etc.). Provisional salaries £300, £200, and £170 respectively.
London Hospital, E.—(1) Surgical First Assistant and Registrar. Salary £300 p.a. (2) Assistant in the *X*-Ray Department. Honorarium £100 p.a.
Macclesfield General Infirmary.—Second H.S. Salary £150 p.a.
Maidstone: Kent County Ophthalmic and Aural Hospital.—Ophthalmic H.S. (unmarried). Salary £200 p.a.
Maidstone: West Kent General Hospital.—H.S. (male). Salary £175 p.a.
Manchester City.—(1) Medical Superintendent at Booth Hall Children's Hospital. (2) J.R.A.M.O. (unmarried, Grade III) at Crumpsall Hospital and Institution. (3) J.R.A.M.O. (male, unmarried, Grade III) at Booth Hall Children's Hospital. Salaries £1,000 p.a., £200 p.a., and £200 p.a. respectively.
Manchester Ear Hospital.—R.H.S. Salary £120 p.a.
Manchester: Royal Eye Hospital.—J.H.S. Salary £120 p.a.
Manchester Royal Infirmary.—(1) J.R.M.O. at Barnes Convalescent Hospital. Salary £150 p.a. (2) Four H.S. Salaries £50 p.a. each. (3) H.S. for Aural, Gynaecological, and Ophthalmic Departments. Salary £50 p.a.
Manchester: St. Mary's Hospitals.—Hon. S. to the Children's Department.
Margate and District General Hospital.—R.M.O. (male). Salary £150 p.a.
Metropolitan Ear, Nose, and Throat Hospital, Fitzroy Square, W.—Surgeon.
Metropolitan Hospital, Kingsland Road, E.—(1) Senior H.P. (2) Senior H.S. (3) J.H.P. (4) J.H.S. (5) C.O. and Resident Anaesthetist. Males. Salaries £100 p.a. each.
Minehead and West Somerset Hospital.—R.H.S. Salary £150 p.a.
National Temperance Hospital, Hampstead Road, N.W.—H.P. (male). Salary £100 p.a.
Nottingham City.—(1) Tuberculosis Officer and Assistant M.O.H. (male). Salary £750-£940 p.a. (2) A.M.O. at the City Hospital. Salary £350-£25-£450 p.a.
Nottingham: General Hospital.—H.P. (male). Salary £150 p.a.
Oxford: Radcliffe Infirmary.—R.M.O. (female). Salary £120 p.a.
Pontypool and District Hospital.—R.M.O. Salary £150 p.a.
Princess Louise Kensington Hospital for Children, St. Quintin Avenue, W.—H.S. (male). Salary £120-£150 p.a.
Queen's Hospital for Children, Hackney Road, E.—Assistant P.
Radium Beam Therapy Research, Radium Institute, Riding House Street, W.—Non-resident A.M.O. Salary £250 p.a.
Radium Institute, Riding House Street, W.—R.M.O. (male, unmarried). Salary £250 p.a.
Reading: Royal Berkshire Hospital.—H.S. (male) to the Special Departments. Salary £125 p.a.
Richmond, Surrey: Royal Hospital.—J.H.S. (male, unmarried). Salary £100 p.a.
Rotherham and Kiveton Park Rural District Councils.—Joint M.O.H. Salary £800-£50-£1,000 p.a.
Royal Free Hospital, Gray's Inn Road, W.C.—Part-time A.M.O. (female) for the Venereal Diseases Department. Salary £300 p.a.
Royal National Orthopaedic Hospital, Great Portland Street, W. Two Surgical Registrars (males). Honorariums £105 p.a. each.
Royal Waterloo Hospital for Children and Women, Waterloo Road, S.E.—(1) R.C.O. (2) H.P. (male). Salaries £150 and £100 p.a. respectively.
St. Mary's Hospital, W.—Casualty H.S. Salary £100 p.a.
Salford City.—A.R.M.O. (male) at the Hope Hospital. Salary £200 p.a.
Sheffield: Children's Hospital.—H.S. (male, unmarried). Salary £100 p.a.
Sheffield Royal Hospital.—Hon. P.
Staffordshire County Council.—(1) Whole-time A.M.O. for Maternity and Child Welfare. Salary £600-£50-£800 p.a. (2) H.S. (female) at Standon Hall Orthopaedic Hospital. Salary £200 p.a.
Stockton-on-Tees: Stockton and Thornaby Hospital.—J.R.M.O. (male, unmarried). Salary £150 p.a.
Stoke-on-Trent: Longton Hospital.—H.S. Salary £160 p.a.
Sutton and Cheam Hospital.—Two Hon. Anaesthetists.
Swanley: Hospital Convalescent Home.—R.M.O. (female). Salary £200 p.a.
Taunton and Somerset Hospital.—(1) H.P. (2) H.S. Salaries £100 p.a. each.
Tiverton and District Hospital.—H.S. Salary £120 p.a.
Truro: Royal Cornwall Infirmary.—H.S. (male). Salary £170 p.a.
Victoria Hospital for Children, Tite Street, S.W.—(1) Senior R.M.O. (male). Salary £200 p.a. (2) Dental S.
Wakefield: Clayton Hospital.—H.S. and H.P. Salary £150 p.a.
Warrington County Borough.—Medical Officer of Health (male). Salary £1,100-£1,250 p.a.
West London Hospital, Hammersmith Road, W.—R.C.O. (male). Salary £100 p.a.
West Riding of Yorkshire County Council.—R.A.M.O. (male, unmarried) at Middleton-in-Wharfedale Sanatorium. Salary £350-£25-£450 p.a.
Weston-super-Mare Hospital.—R.H.P. Salary £150 p.a.
Westminster Hospital, S.W.—Radiologist for Westminster Hospital Annexe, Fitzjohn's Avenue, N.W.
Wigan County Borough Education Committee.—Assistant School M.O. (female). Salary £10 10s. per week.
Windsor: King Edward VII Hospital.—Hon. Assistant P.
York Dispensary.—R.M.O. (female). Salary £175 p.a.

Certifying Factory Surgeon.—The appointment at Scalloway (Shetland) is vacant. Applications to the Chief Inspector of Factories, Home Office, Whitehall, S.W.1, by October 20th.

BIRTHS, MARRIAGES, AND DEATHS

The charge for inserting announcements 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.

DEATHS

Lyndon.—On October 1st, 1936 at a nursing home in Shrewsbury, after a very short illness, Charlotte, dearly loved wife of Dr. Arnold Lyndon of Grayshott, daughter of the late William Ransom of Hitchin, and widow of Robert A. Charleton of Clifton. Funeral took place at Grayshott Parish Church on Monday, October 5th, at 3 p.m.

Pulipaka.—On October 3rd, at 1, Elliot Place, Edinburgh, Richard Hay Pulipaka, M.D.

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