that British principles would be spread around the world as a sound basis for countries to deal with disease and to give their peoples good medical service compounded of official and non-official forms, central and local authorities, and governmental and voluntary services. This was long before his achievements of high office in the British Government enabled him to see his ideas moulding the then Colonial Office medical services after the second world war.

It is perhaps not widely known how much Jameson, allied in 1946 to 1948 with Dr. Melville Mackenzie, did to get the World Health Organization properly started. He was so honest and blunt with his clear administrative knowledge and awareness of the wholeness of life and society that he was a welcome corrective to international doctrinaires and "blue-print" enthusiasts. The sad thing is that he had so little time to help internationally before he retired. However, many of us took our problems to him personally thereafter, and I for one was more than rewarded to be told emphatically on one occasion that a critical decision of mine to abide by principle and not by expediency had his full support and blessing. No one can ever take his place in such a relationship with his ex-students and his colleagues. They still pursue in so many countries his ideas and idealism, but will feel lonely now that he is no longer there in London to cheer them on.

# Medical Notes in Parliament

## RECRUITMENT OF NURSES: EFFECT OF REGIONAL ALLOCATIONS

[FROM OUR PARLIAMENTARY CORRESPONDENT]

M.P.s were persistent in the questioning of the MINISTER OF HEALTH on December 10 about the financial allocations to hospital authorities and the effect of them on nursing staff and recruitment. There was a preliminary brush between Mr. A. FELL (Yarmouth, Con.) and the Parliamentary Secretary, Mr. B. BRAINE, about the Eastern Region. Mr. FELL asked if there was a shortage of nursing staff there, and which hospitals had stopped recruiting. Mr. BRAINE told him that there was no general shortage, numbers in post had increased further in the past year, and recruiting continued within the financial allocations.

Mr. FELL called this answer extraordinary, asserted that an instruction had gone out from the board that no additional nurses should be taken on for any hospital in the eastern area, and that hospitals had even stopped replacing nurses who left. The basic reason, he understood, was that the board had no money left to recruit nurses. Mr. BRAINE came back with some figures: in the 12 months ending last September 30 numbers in post increased 1.7% whole-time and 13.5% part-time. Mr. FELL: "The hospitals are not up to establishment." Mr. BRAINE said that recruitment continued, but was restricted at a number of hospitals. Increased real expenditure had been allowed for this year, but the responsibility for spending their money rests with the regional hospital boards.

### "It is for Hospital Authorities to Decide"

On this theme the argument was transferred to the principals, and developed with increasing intensity. Mr. K. ROBINSON (St. Pancras, North, Lab.) asked the Minister what advice he had given or proposed to give to hospital authorities who could fill vacancies in establishment but had not sufficient funds to meet the salaries of additional nurses. Mr. ENOCH POWELL answered briefly, "It is for hospital authorities to decide how best to use their allocations."

"Does not the Minister know," Mr. ROBINSON demanded, "that region after region has given instructions to management committees to stop recruiting nursing staff? We cannot possibly recruit nurses up to establishment when allocations are cut as finely as they have been cut this year, in some cases down to 1%, and even just over ½% increase on last year. How can one possibly run an expanding health service on this financial basis?"

"An expanding health service"—those words were right, Mr. POWELL retorted. "Allocations everywhere had provided for an increase in expenditure at constant prices and wages, as well as for the increase in service which was constantly taking place from a growth in efficiency, but hospital authorities must work within their allocations. These allocations had been adjusted and increased to allow for the increases in salaries and wage awards, and hospitals had now, as in the past, a duty to keep within them. Nevertheless, the hospital service had continued to recruit nurses throughout the past 12 months at a high rate, and for part-time nurses at the highest ever known."

### Deputation from Royal College of Nursing

Dame IRENE WARD (Tynemouth, Con.) told the Minister that the Royal College of Nursing wanted to take a deputation to him about all this, and the matron of the Royal Victoria Hospital at Newcastle had sent him a report about the North-east coast. She added that he must not dismiss this matter so vehemently: there was a problem. Mr. POWELL did not recollect having personally seen a communication from either source. He pointed out that the rate of expansion was limited but the yearly rate could now be foreseen over a period of years, and this was enabling hospital authorities to plan and recruit much more effectively than in the past. Mr. K. ROBINSON interposed that it was now easier to recruit student nurses than it had been for many years, and if the opportunity were lost it would be the Minister's fault. Mr. POWELL answered that he had no reason to doubt that recruitment would continue to increase. The rate at which the hospital service could be developed was limited not by the rate which the resources offered but by the rate at which resources could be made available along with the other commitments.

### Waiting-lists

Dame IRENE WARD turned attention to the effect on waiting-lists, and argued that the decisions of regional boards to stop recruiting in order to match up with financial commitments would be a deterrent in reducing them. She exhorted the Minister, "Let us face the facts fairly and squarely." Mr. POWELL stated that the hospital authorities had given no general indication that recruiting should be stopped. Their financial allocations had enabled them to expand nursing staffs in the past year, and to go on doing so. Shortage of nurses was not the limiting factor in disposing of waiting-lists, many of which were much too long. "I intend to make 1963," Mr. Powell declared, "a year in which the reduction of waiting-lists drastically is one of the prime objects of the hospital service."

## OTHER QUESTIONS

### Approval of Drugs before Marketing

Sir THOMAS MOORE (Ayr, Con.) asked the Minister of Health if he could state the number of deformed babies so far born whose deformity could be directly attributed to the use of thalidomide. Mr. POWELL said this could not be known exactly, but was less than the 390—302 surviving—whose mothers had taken or might have taken thalidomide at some stage of pregnancy.

Sir THOMAS MOORE asked him to take powers to prohibit any manufacturer putting any drug on the market until it had been submitted to the Minister and approved. If he had not this power Parliament would willingly give it to him. Mr. POWELL pointed out that he was receiving advice on this from the Standing Medical Advisory Committee. He had already made an interim statement, and would make another as soon as he received the further advice he was expecting. He added, in reply to Mr. K. ROBINSON, who

wanted to know when this would be, that he would be reluctant to press them, but he knew they realized the time as well as the other aspects.

### Register of Congenital Deformities

Lieut.-Colonel J. K. CORDEAUX (Nottingham, Central, Con.) asked the Minister whether he would consider making it a statutory obligation that all congenital deformities should be officially registered at birth. Mr. POWELL: "I am arranging for returns of children born with recognizable abnormalities. Statutory powers should not be necessary."

### Cancer Registration

Mr. J. BOYDEN (Bishop Auckland, Lab.) asked if arrangements for the registration of all hospital cancer cases had now been completed. Mr. BRAINE, Parliamentary Secretary, said, "Not everywhere." Mr. BOYDEN asked what was holding things up—lack of money, or bad administration? Mr. BRAINE explained that cancer registration was complex and information was sought on a variety of points. The Minister was asking that this should be given the highest priority where coverage was still not satisfactory. In three hospital boards and 11 London teaching hospitals there was already 90% coverage or better, and the figures showed considerable improvement.

### Emigration by Doctors

Dr. DONALD JOHNSON (Carlisle, Con.) asked the Minister if he was aware of the continued high rate of emigration of British doctors and the problems of staffing in the National Health Service thereby created; and what steps he was taking within the full context of a free society to keep doctors in Great Britain. Mr. POWELL replied: "No," and, "This does not arise."

Dr. JOHNSON asked the Minister to look at this question in greater depth than he had done hitherto in view of its serious nature. The fundamental factor was a world-wide shortage of doctors. At the moment we were losing doctors to the other English-speaking countries and importing them from India and Pakistan and elsewhere, but this alternative source of supply might dry up by the force of other events taking place in India. Mr. POWELL said the evidence he had been able to obtain from the medical schools shows that the percentage of students who took up residence abroad—for example, the percentage of those qualified in the 1950s who were abroad to-day—was quite small, about 6%. This, in turn, was only part of the more active flow of doctors and other professional men from one part of the world to another which had characterized the post-war world. The fact was that the number of British-born doctors in the hospital service had been increasing and continued to increase.

## PROVING BYSSINOSIS

[FROM OUR PARLIAMENTARY CORRESPONDENT]

Mr. LESLIE HALE, the Labour member for Oldham, West, was given leave on December 11 to introduce a Bill to make further provision for the definition of byssinosis and for the hearing and determination of cases relating to industrial disease. One clause, he said, was in his view simply declaratory of the law, and stated that when an application for benefit was turned down a later application could be made when fresh or more recent evidence was obtained. The principal clause provided that if a man who had complied with all the other conditions—proof of long employment in the appropriate industry or sections of it; proof of disablement by a severe respiratory pulmonary disease; proof of exposure to dust, and so on—if such a man could prove that he was suffering from a pulmonary disease medically indistinguishable from byssinosis, then the disease should be regarded as byssinosis. In a large number of cases it was labelled bronchitis. Informed medical opinion agreed that there was no physical test to distinguish bronchitis from byssinosis.

# Medico-Legal

## SWAB NOT REMOVED

[FROM OUR LEGAL CORRESPONDENT]

A patient died from paralytic ileus three days after a swab had been left inside his abdomen during an appendicectomy (*Yorkshire Post*, November 9). The operation was performed by a doctor who qualified in December, 1961, assisted by a male staff nurse and a student nurse. The student nurse (who had been training for five years, and who had taken her final examinations) was assisting because the theatre sister was required at an emergency operation in the other theatre. Although the two assistants counted the swabs the absence of one swab was overlooked. On the third day after the operation the swab was detected by *x*-ray examination, but its removal by a second operation failed to save the patient's life.

### View Taken by Courts

At the subsequent inquest evidence was given of the system at the hospital that swabs were carefully counted before an operation and again before the wound was closed. The coroner's jury recommended that it should be the duty of a surgeon to count the swabs when he had finished an operation. In fact, for a surgeon to break off and check the count before closing the wound would not be expected of him by the civil courts, which have generally taken the view that a surgeon has sufficient to do without having to do a swab count. However, it is the duty of the surgeon personally to take such precautions as are reasonable under the circumstances to ensure that all swabs are removed. In most circumstances this will include a duty to search by touch, though this duty may in other cases be overridden by the duty to bring the operation to a speedy close. The surgeon's duty will not be discharged simply by using swabs which have tapes and forceps attached and removing all swabs marked by forceps or tape: for this system is not infallible. Further, although a surgeon before terminating an operation ought to ask expressly for the result of the count from the nurse appointed to make it he is not entitled generally (unless speed is paramount) to rely wholly and exclusively on a satisfactory reply: for, again, this system is not infallible. However, it should not be beyond the wit of man to make a system for a swab count which would be very nearly infallible.

# Universities and Colleges

## UNIVERSITY OF OXFORD

In Congregation on December 1 the degree of D.M. was conferred on M. W. B. Bradbury.

The Martin Wronker Prize in Medicine for 1962 has been awarded to D. F. Horrobin, of Balliol College.

## UNIVERSITY OF CAMBRIDGE

In Congregation on November 17 the following degrees were conferred:

M.D.—A. W. Johnston.
M.B., B.CHIR.—*A. V. Gillespie.

*By proxy.

## UNIVERSITY OF ABERDEEN

At a Graduation Ceremony on October 31 the degree of M.D., with commendation, was awarded to D. T. Gordon.

## UNIVERSITY OF EDINBURGH

At a meeting of the University Court held on November 26, the status of Honorary Research Fellow in the Department of Orthopaedic Surgery was conferred on Dr. J. K. Weaver.

Mr. I. B. Macleod and Mr. R. M. Preshaw were appointed Assistant Lecturers in the Department of Clinical Surgery.