NEWS AND NOTES

Views

It's an agreeable sign of the times when a paperback on health education makes the top ten, as has happened in the Irish Republic to *Heart Attack and Life Style*. I don't know Dr Noel Hickey (medical director of the Irish Heart Foundation, which publishes the book at 82½p); but the other author, Dr Risteard Mulcahy has enlivened several of my recent visits to Dublin. An exuberant speaker, never afraid to express his mind, he is instantly recognisable by his tall, trim figure and inevitable bow tie. The book takes the layman through the risk factors associated with a coronary, with some sensible advice on smoking, exercise, and diet (including a chapter on cholesterol-lowering recipes). How much the message is needed is apparent from the IHF's Mediscan programme, which has now screened over 15 000 middle-aged men. Only 15% came into the low-risk profile—"the individual who is active in mind as well as body, who eats and drinks to satisfy physiological needs only and who is not dependent on unnatural aids to living such as drugs and tobacco."

Human plague has been unusually common in the USA this summer, and there have been at least three deaths. The disease is endemic among many of the small mammals, especially rock and ground squirrels, and their infected fleas may pass the disease on to man. Dr Alan Barnes of Colorado says that the "Bambi syndrome" is to blame in many cases: well-meaning but futile attempts are made to nurse or comfort any wild animal found sick. Another possible hazard is the soft target. A predator such as a bobcat which is seen by a hunter during daylight in circumstances such that it presents an easy shot is, according to Dr Barnes, almost certainly ill. If the animal will let you come near, he warns, it should be avoided—like the plague.

Surrounded by spokespersons for the Canine Defence League, the Kennel Club, and the Tailwaggers, I felt a little out of my element at the meeting on "dogs in society" organised last week by the British Small Animals Veterinary Association. There is growing public concern about dogs—in particular their fouling of footpaths and parks, and the threatening behaviour of packs of strays. Already the tenants associations in some London housing estates have insisted on a total ban on dogs, while in Scotland the council at Cumbernauld has had two years' experience with a system of dog wardens. Yet health risks from dogs are, in fact, small: that was the message from Dr P McKenzie of Belvidere Hospital, Glasgow. While dog bites account for 2% of all casualty attendances and many adults have serological evidence of toxocariasis, any really serious disease from contact with dogs was, he said, extremely rare. Dog faeces were an unpleasant nuisance, not a public health hazard.

Most speakers agreed that closer controls were needed—more efficient licensing, dog wardens to round up strays and enforce laws about fouling, and disincentives to the impulse buyer. There was a weary disbelief that education campaigns would ever achieve much—the British citizen seems to behave as if it is his inalienable right to discard litter wherever he wants and to allow his pets (and his children) to be equally indiscriminate in the ways in which they harm the environment. Unfortunately early legislation seems unlikely with the huge load of Government bills already held up in the Parliamentary pipeline.

In the engineering industry "rusters" have been known for many years. These unfortunates have sweat which makes steel go rusty, and their presence in a precision toolroom is a disaster. No ruster can make a living as a skilled engineer, for the dexterity required rules out the use of gloves. Workers attribute the effect to acidic sweat, but research at Bristol (British Journal of Dermatology, 1976, **95,** *417) has shown that the rusting is caused by a high concentration of sodium chloride. There does not seem to be any link with fibrocystic disease of the pancreas—and in fact "rusters" have far higher sweat salt concentrations than do heterozygotes for fibrocystic disease.*

The bawdy Restoration comedies we enjoy so much may not, it seems, reflect their times very well. In fact, they may have served much the same purpose then as our liberated books today. In the current *British Journal of Sociology* Peter Laslett concludes that Restoration times were relatively chaste. Bastardy rates are, Laslett says, a good index of chastity, and his chronological study of these in 98 English parishes shows that these remained very low throughout the period of Restoration comedy—having been high in Elizabethan times and, surprise surprise, fallen with the Puritans. Bastardy rates didn't start rising again until after the 1750s and they reached a high plateau during the supposedly restricted reign of Queen Victoria. So "the sexual fantasies of Wycherley, Congreve, Etherege and the rest must have been some compensation for the sexual deprivation which . . . might have been characteristic of their whole generation." There is one alternative possibility that Laslett does not discuss: courtesans rarely had a large brood of bastards because their tubes seized solid with gonorrhoea. Might it not be the case that bastards decline in frequency once venereal disease has become widespread in a promiscuous society?

Lack of Government finance is hitting universities and the NHS so hard that both are having to appeal to the public for support, said Professor John Walton last week when launching an appeal for funds for research into biomedical engineering at Newcastle University. The university's development trust has already raised £1·7m for a variety of projects, and local businessmen seem keen to help further. With so many individuals and organisations looking for ways in which they can help a national recovery, the sources of good will are there for the tapping.

Fifty years is a long time in medicine. In his obituary of Sir John Parkinson in the current *British Heart Journal* Dr William Evans recalls that when he first reported for duty as the great man's house physician he was warned not to prescribe any medicine to patients admitted to hospital until Parkinson himself had seen and examined them. "I interpreted this caution as an absence of confidence in his new house physician," says Dr Evans, "but I was soon to notice how well the patients reacted to rest only, and in the absence of any medicinal therapy. Indeed, as house physician to Parkinson, I learnt that nature was itself a physician capable of curing illness, and that a knowledge of the natural history of disease along with its dictum of *vis medicatrix naturae* was being annihilated by overzealous therapeusis."

MINERVA

EPIDEMIOLOGY

Insect infection in man

The following notes are compiled by the Epidemiological Research Laboratory of the Public Health Laboratory Service from reports submitted by public health and hospital laboratories in the United Kingdom and Republic of Ireland.

Three cases of insect infection in man were reported during the summer. Such infections may be more common than reports suggest.

Oestrus ovis

A 16-year-old girl presented in a casualty department in the West Country complaining that she had some worms in her eye which had been present for two days. About 20 minute wriggling worm-like creatures, 2 mm long and about 0·5 mm across, were removed from the conjunctival sac with a swab, and about the same number were removed in the eye clinic on the following day. When seen again after a few days the patient was symptom free and the eye appeared normal.

The worms were tentatively identified as the first-stage larvae of *Oestrus ovis*, the sheep nasal bot fly, and this was confirmed by the department of entomology of the British Museum (Natural History).

Oestrus ovis is one of a number of insects whose larvae may invade human tissues. The fly is widely distributed throughout the world, including the UK, but human infections, though common in the USSR, northern Africa, and the eastern Mediterranean areas, are rare in western Europe and the USA. It is primarily a parasite of sheep and goats. Man is infected only when conditions have favoured multiplication of the flies and there is a relative paucity of sheep.

The mature adult fly is about 1 cm in length, and to the layman may look similar to a house fly, though it is rather broader and more stockily built. The gravid females dart into the conjunctiva, the outer nares, lips, or buccal cavity, and deposit the first-stage larvae, which by means of large claw-like oral hooks and spines rapidly bore into the mucous membrane. In the eye the larvae may burrow into the eyelid, conjunctival sac, or lachrymal duct. From the nares the larvae may reach the nasopharynx or paranasal sinuses. In man the first-stage larvae do not develop further and usually die or are eliminated from the tissues after a few days.

Conjunctival myiasis caused by *Oestrus ovis* does not seem to have been reported previously in the UK, but three further cases have recently been seen by the department of entomology at the London School of Hygiene and Tropical Medicine. One of these patients came from Kent, another from London, and the third was a child who lived in London but had recently returned from Israel. A further unconfirmed case in a holidaymaker in the South Hams, Devon, has been noted by a general practitioner. It is probable that the long hot summer favoured the multiplication of the bot flies, with the occurrence of human infections. Close proximity with sheep or goats is not a necessary factor in the epidemiology of the infection, though both the patients from the West Country had been in an area where there is much sheep farming.

Patients are not always conscious of having been in any way assaulted by a fly before larval infestation occurred. Only two of the five patients described having had a fly in their eye. In man larvae will normally die within a few days, and simple removal with a swab seems to be sufficient.

Sarcophaga

A woman of 33 years was admitted to hospital with a 24-hour history of diarrhoea and vomiting. Her mother and cousin were also suffering from similar complaints. The patient had suffered from Crohn's disease for 14 years and was on prednisone 8 mg daily. She was treated with oral fluids and an anti-diarrhoeal remedy, and the vomiting soon ceased. Routine culture and examination for intestinal pathogens were negative. Seven days after admission a stool specimen was found to be full of maggots. Three further specimens were similarly infested. These maggots were identified as third stage larvae of *Sarcophaga*, the flesh fly. The maggots were at least a week old and were probably swallowed in meat which had begun to decay. By the eleventh day no more maggots were found and the diarrhoea had stopped. No stool specimens were available from the other members of the household, neither of whom admitted to seeing maggots in their stools. Diarrhoea in these patients had ceased after three days. Despite intensive questioning no common source of food for the infestation could be identified.

Tunga penetrans

A 26-year-old man who had recently returned from Gabon in equatorial Africa presented in a casualty department with two painful swellings about 0·5 cm in diameter on his feet. One was on the tip of his second toe and the other was on the sole of the foot. Each swelling was surmounted by a small dark dot.

These were excised and later identified as pregnant adult females of the sand flea *Tunga penetrans*. During their removal and examination a number of 0·05 mm glistening white ova were released.

T penetrans was originally indigenous in tropical areas of America but was later carried to Africa, where it is found in most equatorial areas. The fleas live in dry sandy soil and suck the blood of warm-blooded animals—especially pigs. The pregnant female burrows into the skin where the abdomen distends enormously until it may become as big as a small pea. The eggs escape through the skin opening, through which the last two segments penetrate. The lesions, variously known as chiggers, jiggers, chigoe, or nigua, may occasionally be present in very large numbers on the soles of the feet and can cause considerable disablement.

Treatment consists in removing the flea with a fine scalpel blade or needle. The main complication seems to be secondary bacterial infection, which may become extensive if there is a heavy infestation. The wearing of adequate footwear in chigger-infested areas seems to be adequate prophylaxis for visitors to most tropical areas.

MEDICOLEGAL

Legal objection to a doctor

FROM OUR LEGAL CORRESPONDENT

It is now the practice[1] in personal injuries litigation for the court to stay a plaintiff's action if he refuses (unreasonably) to submit to a medical examination on behalf of the defendant. The defendant has the right to choose the doctor he wishes and earlier this month the Court of Appeal laid down[2] that there must be some substantial reason to do with the doctor's competence or impartiality before the plaintiff can refuse an examination and not run the risk of his action being stayed.

There is still no express power in the rules of the Supreme Court under which the court can order the examination of the plaintiff and commit him to prison if he refuses. In 1953 the Evershed Committee concluded[3] that such a power was unnecessary and thought that it might raise important questions of principle in relation to the liberty of the subject. A case in 1961 concerned a plaintiff with dermatitis allegedly contracted in the course of his employment, who refused to submit to an examination and patch test by a dermatologist instructed by the defendant. The Court of Appeal turned down an application to stay the action. Lord Justice Donovan thought it was wrong in this class of case to make an order shutting out the plaintiff from the seat of justice even if he refused all medical examination by the defendant, and still less if he merely refused the particular doctor chosen by the defendant. Lord Justice Willmer for his part disliked the sight of the defendant seeking to obtain by indirect means, —namely, the pressure of the stay—what he could not obtain by direct means. Like the Evershed Committee, he thought that to order a stay would be an improper and unnecessary interference with civil liberty, and he reminded himself that it was the plaintiff's case with which the court was concerned: prima facie he was entitled to present it in his own way, and if his objection to a particular doctor was shown at the trial to be ill-founded then that would be a powerful influence on the mind of the judge in assessing the bona fides of the plaintiff and the merits of his claim.

Proper safeguards

In 1968 the Winn Committee on Personal Injuries Litigation[5] came to the opposite conclusion. It had no doubt that every claimant of damages for personal injuries must be bound to submit himself to a medical examination of a reasonable character, subject to proper safeguards and to the claimant's right to object to any particular doctor. Early in the following year the Court of Appeal decided that what the Winn Committee had said should be the law was the law. The court had before it a case[1] in which the plaintiff, who had been injured at work, initially particularised only relatively minor injuries. It was only after he had been examined by the defendant's doctor that he first claimed (in his own doctor's report) that the accident had aggravated existing osteoarthritis. His

solicitors (who are renowned for the amount of personal injuries work they handle for trades unions) did not object to the defendant's original doctor re-examining the plaintiff but said that they would not allow him to see any one of six specialists nominated by the defendant to deal with the alleged osteoarthritis.

Lord Denning, in imposing a stay, said that the court had ample jurisdiction to do so where the defendant's request was necessary and reasonable. The defendant was faced with an allegation of osteoarthritis not made in the statement of claim and ought to have the opportunity to be advised upon it. He would also need the further advice in order to assess the payment into court so as to dispose of the whole matter without it coming to trial. But Lord Denning added: "It might be different if the defendant had suggested one particular name to which the plaintiff could reasonably object."

In 1970 the Court of Appeal held[6] that there must be good grounds before the plaintiff can reasonably object to the doctor chosen by the defendant. Lord Denning then rejected the argument by a plaintiff in a pneumoconiosis case that where the defendant nominated only one doctor and did not give a choice, the plaintiff could turn the examination down without giving a reason. It was not sufficient reason to found an objection, he said, that the doctor concerned would not accept instructions from the plaintiff's solicitors (the same ones as in the 1969 case), who had originally asserted quite wrongly that she worked only for insurance companies.

Lord Justice Edmund Davies stated that a party was entitled to nominate the doctor of his choice. "If there are any grounds for suspecting the integrity, the qualifications, or the standing of the doctor, then," he said, "however embarrassing it may be, let such objection be made clear." This month for the first time a plaintiff sought to sustain such an objection.

Objection

A miner employed by the National Coal Board claimed that he had sustained ulnar nerve compression while working an electric boring machine underground with inadequate support. The Board nominated Dr X, a consultant neurologist of high reputation and qualifications, to examine the plaintiff and insisted upon Dr X, even when the plaintiff's solicitors consented to an examination by any neurologist but Dr X.

The miner's solicitors did not suggest that Dr X would be partial or otherwise attack his personal competence or integrity. However, they did argue that a reasonable belief that the proposed examination and report might be unfair to the plaintiff or conducted without due regard to his feelings was an adequate reason for refusal. In the Court of Appeal the plaintiff referred to what, according to Lord Justice Geoffrey Lane, he had called "Dr X's peculiar technique for catching out malingerers," as well as to three of Dr X's past reports. (He does about 250 a year.)

The court concluded that there was nothing to substantiate the plaintiff's solicitors' lack of confidence that Dr X would not produce a report which was not misleading; and it commented that even if such a report were produced it could be discredited at the trial by cross-examination and comment. The senior member of the Court, Lord Justice Cairns, held that once the defendants showed that an examination of the plaintiff by a particular doctor was necessary in their interests and that the doctor they had chosen was well qualified, then if the plaintiff were to object validly he must show some substantial ground for any belief that the doctor in question lacked the right qualification or was likely to make his examination or report unkindly or unfavourably.

[1] Edmeades *v* Thames New Board Mills. (1969) 2 QB 67.
[2] Starr *v* National Coal Board. *The Times*, 14 October 1976.
[3] *Final Report of the Committee on Supreme Court Practice and Procedure*. London, HMSO, 1953, cmnd 8878.
[4] Pickett *v* Bristol Aeroplane Co. (1961) Bar Library Transcript No 114.
[5] *Report of the Committee on Personal Injuries Litigation*. London, HMSO, 1968, cmnd 3691.
[6] Murphy *v* Ford Motor Co. (1970) Bar Library Transcript No 379.

PARLIAMENT

Health Services Bill: considered by the Lords

The Health Services Bill was given a second reading in the House of Lords on 21 October.

The Government's spokesman on health, Lord Wells-Pestell, told the House that the NHS was not in business to meet the special needs of private patients and the 1000 beds which the Bill sought to phase out immediately were little used anyway. He pointed out that between the spring of 1975, when the Government's policy was first announced, and the expected end of the initial period, May of next year, about 300 new beds for acute treatment in the private sector would have become available in London alone. This would bring the total number of private sector beds for acute treatment in London to about 2000, almost half the total number of such beds in the whole of Great Britain.

Medical apartheid

For the Opposition Lady Young thought that the separation of private practice from the NHS would create a kind of medical apartheid. The Bill was a step in the direction of a full-time salaried service which would mean that minimum and not maximum standards of care would be set. The importance of the Bill according to Lord Goodman was to reassure doctors that private medicine would remain indefinitely. This importance could not be exaggerated. It was to make the doctors realise that they had a choice if they wished to take it.

Lord Hunt said that if the Bill became law his profession would do their best to make it work provided it included the negotiated Goodman compromises. Government, trades unions, local authorities, and others must agree that there would be no interference in future, on political doctrinaire grounds, with the building, staffing, or running of any private hospitals mentioned in the Bill nor with private beds remaining in the NHS during phasing out. During the past 12 months the mood of his profession had hardened. It had learnt how to fight. In December 1975 it was the collective professional action of doctors which had played a large part in persuading the Government to introduce Lord Goodman's proposals into the Bill. "You will appreciate," said Lord Hunt, "that I and many of my colleagues are in a fighting mood. We are determined to protect our patients and our own legitimate and reasonable professional freedoms whatever happens to this particular Bill."

Lord Wells-Pestell thought that the militancy displayed by Lord Hunt was almost incitement to strike. "It was not going to help the consultants, the medical profession, or the Government, who were trying to deal with a difficult situation."

The Bill was read a second time.

MEDICAL NEWS

Royal Commission evidence

The Royal Commission on the NHS is now ready to receive evidence, and last week Sir Alec Merrison gave details of the topics on which it wants comments from individuals and institutions. These are the quality of the service; the adjustments that will be needed to adapt to the future; the service patients have been getting in general practice, hospitals, and the community—and in private practice; the structure of the NHS and the efficiency of its management; and the resources (both manpower and finance) that have been and should be available. Sir Alec stressed at his press conference on 19 October that the commission did not believe that its existence should slow or prevent change; indeed, the DHSS had agreed that the commission would be given the opportunity to make effective comments on major developments at a formative stage.

The commission expected to modify the list of topics both as a result of its own investigations and in the light of the public discussion it hoped to stimulate by announcement of the list. "We can successfully undertake the programme we have set ourselves only with the help and co-operation of those who submit evidence to us," the guide concludes. (*The Task of the Commission*, London, HMSO, price 32p.)

Nobel prize

The 1976 Nobel prize for medicine has been divided between Dr Baruch Blumberg and Dr Daniel Gajdusek for their contributions to the study of persistent virus infections. Dr Blumberg played a leading part in the recognition of the Australia antigen as the agent responsible for hepatitis B or serum jaundice. Dr Gajdusek was responsible for the research which showed that kuru, the chronic neurological disease that is prevalent in New Guinea, is a slow virus infection.

Barts concert

A concert in aid of the Gordon Hamilton Fairley Fund will be given by St Bartholomew's Hospital Choral Society in Central Hall, Westminster, on Thursday, 11 November, at 7.30 pm. The music to be performed includes *Misericordias Domini*, *Ave Verum Corpus*, and *Regina Coeli*. In this last work the choir will be joined by Jill Gomez, who will also be the

soloist in the motet *Exsultate, Jubilate*. Andrew Morris, organist and director of music at the Priory Church of St Bartholomew the Great, will play three organ sonatas by Mozart, and the concert will be conducted by Robert Anderson. Tickets for the concert (£1) are now available from Box 16, the Nurses' Home, St Bartholomew's Hospital, London EC1A 7BE. A record will be obtainable from the same address or from the Church of St Bartholomew the Great, West Smithfield, price £2·50. Further information is available from Robert Anderson (01-937 5146) or David Wells (01-681 3521).

COMING EVENTS

Glasgow University Club, London—Annual dinner, 4 November, London. Details from Dr J F Heggie, 94 Wynchgate, Southgate, London N14 6RN.

Invalid Children's Aid Association—Conference "Integration?—the special education issue," 11 November, London. Details from Conference Secretary, 95 Visa Way, Kenton, Harrow, Middlesex. (Tel 01-907 4688 and 01-730 9891.)

London Hospital—Introductory course on mental disorder in the elderly, 17-18 November, London. Details and application forms from Miss Maureen Marshall, London Hospital (St Clement's), 2a Bow Road, London E3 4LL. (Tel 01-980 4899 ext 226.)

Postgraduate course on industrial skin diseases—22-26 November, Birmingham. Details from Dr M A Cooke, Albright and Wilson Ltd, PO Box 80, Oldbury, West Midlands B69 4LN. (Tel 021-552 3333 ext 201.)

British Institute of Radiology—Afternoon meeting on whole body counting and scanning, 24 November, London. Details from the general secretary, British Institute of Radiology, 32 Welbeck Street, London W1M 7PG. (Tel 01-935 5237/6867.)

St Christopher's Hospice—Therapeutics conference, 26 November, London. Details from co-ordinator of studies, Miss D H Summers, St Christopher's Hospice, 51-53 Lawrie Park Road, Sydenham, London SE26 6DZ. (Tel 01-778 9252.)

Manchester Medical Society—Details of the November programme are now available from the Society, the University, Manchester M13 9PL. (Tel 061-273 6048.)

Robert Jones and Agnes Hunt Orthopaedic Hospital—Career training programme on the total care of the injured, 1976-7, Oswestry. Details from Mr B T O'Connor, Director of Clinical Studies, Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry, Shropshire SY10 7AG. (Tel Oswestry 5311.)

Royal Society of Medicine—Copies and details of the programme 1976-7 are now available from the Society, 1 Wimpole Street, London W1M 8AE. (Tel 01-580 2070.)

BMA NOTICES

Diary of Central Meetings

NOVEMBER

2 Tues	Scottish Joint Consultants Committee (7 Drumsheugh Gardens, Edinburgh), 10.15 am.
3 Wed	Education Subcommittee (GMSC), 10.30 am.
3 Wed	Practice Premises and Organisation Subcommittee (GMSC), 10.30 am.
3 Wed	Consulting Pathologists Group Committee, 2 pm.
3 Wed	Rent and Rates Working Group (GMSC), 2 pm.
4 Thurs	Compensation and Superannuation Committee, 10.30 am.
4 Thurs	Executive Subcommittee (CCHMS), 10.30 am.
12 Fri and 13 Sat	Executive Subcommittee (CCHMS), 2 pm.
16 Tues	Scottish General Medical Services Committee (7 Drumsheugh Gardens, Edinburgh), 10.30 am.
17 Wed	Statutes and Regulations Subcommittee (GMSC), 2 pm.
19 Fri	Board of Science and Education, 10.30 am.

SOCIETIES AND LECTURES

*For attending lectures marked * a fee is charged or a ticket is required. Applications should be made first to the institution concerned.*

Monday, 1 November

ROYAL NORTHERN HOSPITAL—5 pm, Dr Yutaka Hosoda (Tokyo): Japanese diseases.

Tuesday, 2 November

INSTITUTE OF DERMATOLOGY—4.30 pm, Dr A Challoner: Measurement of skin blood flow (with particular consideration to practical aspects).
ROYAL ARMY MEDICAL COLLEGE—5 pm, Mr A G Parks: Recent developments in colorectal disease.
INSTITUTION OF MECHANICAL ENGINEERS—6 pm, discussion: Mechanical handling in the treatment of hospital and other patients.

Wednesday, 3 November

ASSURANCE MEDICAL SOCIETY—At Medical Society of London, 5 pm, Dr H E Webb: Multiple sclerosis.
ROYAL COLLEGE OF PHYSICIANS OF LONDON—5 pm, Goulstonian lecture by Dr D K Peters: Observations on nephritis.
UNIVERSITY OF OXFORD—At Radcliffe Infirmary, 5 pm, medical consilia, Professor R E O Williams: Caries, cancer, congenital defect: are they microbial in origin?
INSTITUTE OF PSYCHIATRY—5.30 pm, Dr E S Paykel: Maintenance treatment of depressed women with drugs and psychotherapy.
INSTITUTE OF NEUROLOGY—Sandoz Foundation lectures, 6 pm, Dr T Bennett: Autonomic nervous control of the cardiovascular system in normal and diabetic man. 7 pm, Dr P Sever: Peripheral noradrenergic transmission and drugs which influence it.
PHARMACEUTICAL SOCIETY OF GREAT BRITAIN—7 pm, Hanbury memorial lecture by Dr F Sanger, FRS: From insulin to DNA.

Thursday, 4 November

ROYAL COLLEGE OF SURGEONS OF ENGLAND—4.30 pm, Arnott demonstration by Professor H Ellis: Some factors affecting wound healing.
ROYAL COLLEGE OF PHYSICIANS OF LONDON—5 pm, Lumleian lecture by Professor M D Milne: Transport defects in disease.
UNIVERSITY OF LONDON—At Royal Society of Medicine, 5 pm, Mr I A McGregor: Problems of reconstructive surgery of the oral cavity.
NATIONAL HEART HOSPITAL—At Imperial College Conference Centre, 5.15 pm, St Cyres lecture by Dr Jane Somerville: Congenital heart disease—changes in form and function.
ST MARY'S HOSPITAL MEDICAL SCHOOL—5.15 pm, Aleck Bourne lecture by Professor J S Scott: Immunology and pre-eclampsia.

Friday, 5 November

NUTRITION SOCIETY—At Western General Hospital, Edinburgh, 10.30 am, 298th meeting.
INSTITUTE OF LARYNGOLOGY AND OTOLOGY—5.30 pm, Dr I Sarkany: Skin and ENT.

Division Meetings to be Held

*Members proposing to attend meetings marked * are asked to notify in advance the honorary secretary concerned.*

Barnsley—At Keresforth Hall Hotel, Thursday, 4 November, 8 pm, agm.

East Norfolk and Norwich—At Norfolk and Norwich Hospital, Saturday, 6 November, 9.15 am, joint BMA, Norwich Medico-Chirurgical Society, and Norfolk and Norwich Institute for Medical Education symposium.*

Guildford—At Bramley Grange, Thursday, 4 November, 8 pm, dinner meeting. Speaker Dr Charles Clarke: "Everest south-east face."*

Manchester—At Boyd House, Tuesday, 2 November, 8 for 8.30 pm, scientific meeting, speaker Dr G Hambleton: "Exercise induced asthma in children."* Supper will be provided.

Mid-Northumberland—At Ashington General Hospital, Thursday, 4 November, 7.30 for 8 pm, dinner and lecture, speaker Mr D Chapman: "The demographic challenge of disease."* (Wives are invited.)

Newcastle upon Tyne—At Royal Victoria Infirmary, Thursday, 4 November, 8 pm, joint meeting with North of England Veterinary Association, supper followed by Dr D Reid: "Communicable diseases from small domestic animals."

Salop—At Raven's Meadows Country Bus Station, Thursday, 4 November, 12.30 pm, conducted tour of Rolls Royce car factory at Crewe.

South Bedfordshire—At Strathmore Hotel, Luton, Wednesday, 3 November, 8 for 8.30 pm, annual dinner held jointly with Luton Medical Centre.* (Guests are welcome.)

West Cumbria—At West Cumberland Hospital, Thursday, 4 November, 7.30 pm, agm.

UNIVERSITIES AND COLLEGES

ROYAL COLLEGE OF SURGEONS OF ENGLAND

At a meeting of the council held on 14 October with the president, Sir Rodney Smith, in the chair, Diplomas of Fellowship were granted to M C Desai, J P Fletcher, and H R Robertson.

ROYAL COLLEGE OF SURGEONS OF EDINBURGH

At a meeting of the council of the college held on 18 October the following were admitted to fellowship of the college—

M F Abu-Eideh, A M Abutrab, B F Akasheh, T A Alexander, M S Ali, A W A K Al-Mukhtar, M A Ansari, Surajudeen O Arigbabu, S M Arolker, J MacG Auchincloss, G S Bachir, A Y Bashir, R N Basu, H Becker, Surya Bhan, G C Bhattacharyya, G Blake, R G Buick, R Campbell, W C Chan, D F Chapman, P G K Chin, N G Choudhary, A C Cinman, D B Cowan, B F Craig, B Cranley, R J Creel, K J Davidge-Pitts, P J Doyle, D R Le M DuQuesnay, P I Egberipou, F S El-Alfy, A R K El-Garoushe, M S El-Khodary, A I El-Lamie, T M Eloush, A T Ethell, R D S Fawdry, H H Fawzi, L J Ferguson, B K Ghosh, T N Ghosh, I C M Gray, P J Haddad, Z M Hammad, M S Hamza, Emu Z Hazarika, R R Henein, M J H Hillier, S J K Holmes, J D Huggan, P V B Hyde, S A M Ibrahim, A V John, B P Kakrania, D K Kapur, A K Kar, J G Karanjgaokar, K A W Khalifeh, A M I Kholoussy, V M Kolade, P S Kolhe, L R Kolli, M W P Kwa, A P Landra, C M Lewer Allen, R E Lewis, P B Lodenquai, C H Low, B St C Lucas, K Lukose, C A Lyn, C J McClelland, C N McCollum, A McGeorge, P G Magee, B Majumdar, M A El S Marzouk, A K Mathur, D G Mehigan, K Min, H D Mitcheson, C G Morrison, A I Naffouje, R N Nambisan, J R Niland, F G G Orr, S K Panja, D G Pennington, M F Ramadan, P B Ravi, G Ravichandran, V K Ravindran, M D Read, M U Rehman, E R Smith Ross, R J Sergeant, R M Sharif, J W Shepherd, A H M Sherif, M M Siddiqui, R K Sinha, J J F Somerville, H A I Sonbol, C D P Stone, N Subba Rao, S Subramaniam, M Tabone, P L Tan, T K Tan, M K Tandon, A S Tatari, W N Taylor, E Thomas, R G Tucker, M F Vere, N A Weston, M H Wilkins, F Wilson, P D Wilson.

ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

At a meeting of the council held on 23 September with the president, Professor C J Dewhurst, in the chair, the following were admitted to Membership—D H Jobson, A Parai, B C Parai, D G Cave, Lindsay E Cupidore, K S Koh, May L Sung, P A B Wranz.

APPOINTMENTS

HAMPSHIRE AREA HEALTH AUTHORITY (TEACHING)—Dr A R Jackson (consultant in radiology).

NORTHERN RHA—The following consultants have been appointed: Dr Marion E Richardson, Dr P K Pal (anaesthetics); Mr B B Porter, Mr D V Heath (orthopaedic surgery); Dr Moira Johnston, Dr Hester C Weaving, Dr N S Wallace (mental illness); Mr R R Roy (urology); Dr A K Shinnawi, Dr A R Bird (geriatric medicine); Dr W D Paterson (dermatology); Dr K B Robinson (pathology); Mr J R Bell (general surgery); Dr T I Wagstaff (obstetrics and gynaecology); Dr Muriel Blackburn, Dr L W Robinson (child psychiatry); Dr M J Akhtar (psychogeriatrics); Dr Elizabeth Dillon (radiology); Dr Anne K Collins (blood transfusion).

NORTH-EAST THAMES RHA—The following consultants have been appointed: Dr H A S Reid (histopathology); Dr R M L Warren (radiology).

Notice to authors

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