what the effects of the student's clumsy and rough attempts at percussion were on the poor emaciated patient.

All surgical operations, and certainly the more difficult and delicate ones, necessitate, of course, a more or less high degree of manual dexterity, but even the most difficult and complicated operative measures in surgery do not require anything like the manual skill that is requisite for a musician who has to play a difficult piece of music—say a Bach fugue—correctly and intelligently. It is a fortunate thing that such is the case, otherwise it would be a bad look-out for a large number of patients who, sooner or later, have to come under the surgeon's knife.

In general surgery there is usually a certain amount of what one may term margin for error, very little margin indeed in ophthalmic surgery, and practically none in music.

Referring once more to the Consultative Committee's Report, I would say that in music, as far as my observations go, the girls are, perhaps, equal to the boys in technique, but are very far below them in creative power, such as in extemporization or in composition.—I am, etc.,

Gloucester, Feb. 17th. E. DYKES BOWER.

*** By the same post we received a note from Dr. Charles J. Hill Aitken (Kilnhurst, near Rotherham) entitled, "Wool rug making an aid to surgery." He writes: A well known surgeon lecturing on abdominal surgery told his students that if they wished to become experts at bowel operations they must start by learning to darn their socks—a statement that probably amused many of his hearers. For the last few months I have been making a wool rug, and having occasion to do a small operation the other day—the first for a long time—I was delighted to find how steady my hands and deft my fingers were. To the general practitioner who rather dreads his occasional operation because of possible clumsy fingers I can recommend wool rug making.

THE MEDICAL PROFESSION IN WAR.

SIR,—During the recent discussion at the Royal Society of Medicine on February 12th (SUPPLEMENT, February 17th, p. 52) regarding co-operation between the medical profession and the naval and military and air branches, we listened to many useful ideas, especially those in the fine paper of Surgeon Captain MacKeown, R.N., but no definite resolution was put forward. I should like to emphasize two suggestions I made.

The bar to complete concert in war is want of understanding, want of clear grasp of the different points of view of civilians and service members. Taken broadly the civilian idea is to carry out professional duties only, with little or no sympathy for the functions of the service officer, yet the duties of the latter are so complex that pure professional work forms only a part of the wide sphere of duty for which he is strictly responsible, initially to the D.G. of his service, then to the Admiralty or War Office or Air Ministry, eventually to Parliament. To obtain efficient co-ordinated work it is absolutely essential that there should be mutual understanding, and this is to be obtained only by widespread friendly conversations, not in London alone, but everywhere throughout the Empire. How is this to be brought about?

In my opinion, the best plan is to utilize the existent machinery of the British Medical Association and of the Territorial forces. The Directors-General of the Naval and Military Medical Services should issue distinct orders to all senior officers to call upon the local Branch of the British Medical Association and to attend their meetings when possible. This act of courtesy is in accordance with the custom of the medical profession when a member is about to take up a practice in a town. It at once establishes an *entente cordiale* and leads to those social amenities, conversations, and friendships which foster mutual understanding and to a true conception of ideas and of the difficulties that each has met with or anticipates.

The Branches of the British Medical Association should on their side impress upon their younger members the duty of joining one or other of the Territorial units, and while serving therein of studying, not their professional work in particular, but the complexities in recruiting and invaliding and pensions, in case recording, dieting and clothing, in sanitation in barracks and camps, in indenting for drugs and appliances, and in economizing expenditure, in office work and financial details, in the management of the N.C.O.s and men of the R.A.M.C., and in many other points.

But, says the purely professional man, I am concerned with none of these things. Quite so. He is then apt to become the fifth wheel of a coach, ornamental and only occasionally useful. His want of understanding may indeed transform him into an actual drag. Suppose, for instance, a naval or army medical officer was attached for duty to a great civilian hospital and declined to accept or to conform to the ideas of management therein, of a system which is the outcome of long experience?

One speaker said the Anglo-Saxons were a slow-thinking race. It is quite true. They could not realize the German menace, although Lord Roberts preached his warnings incessantly. They do not now realize that Germany, Russia, and Turkey may at any moment combine against us. They do not grasp the dangers of Bolshevism although the Duke of Northumberland, in his weekly paper *The Patriot*, sets these forth very clearly. Each citizen is concerned chiefly if not alone with his own petty interests.

War makes two demands upon each loyal and patriotic citizen: first, that he should carry out his own specialty so as to render the greatest service possible; secondly, that he should not impede the functions of others. Only by mutual understanding can these two demands be effectively combined. Schemes and systems, hard and cut and dry, are all very well, but they need the emollient influence of personal conversations, friendships, realization of each other's aims and of difficulties. Therefore in every city and every town, in every small station and in every far-away port, the method should be to bring the newcomer into touch with the older resident; and to make the resident part and parcel of the local naval or military organization.

There is much more to be said on various points, and much also upon the advantage of studying naval and military tactics and strategy in addition to medical organization, but your space is limited.—I am, etc.,

T. M. CORKER,

London, W., Feb. 15th. Major-General A.M.S. (ret.).

HOSPITAL POLICY.

SIR,—In your issue of February 17th (p. 303) appears a proposal by Dr. L. S. Luckham, President of the Salisbury Infirmary League, that instead of the staff of a voluntary hospital being paid, or even receiving a nominal fee for work done for those patients who are not indigent, they should be content to enter into a pension fund scheme. He adds that this would probably meet with the contributors' approval. Probably it would; owing to its remoteness.

From repeated talks, circulars received, and schemes issued it would seem that the greatest confusion is gradually arising, and in the resultant chaos the prestige of medicine as a science will deteriorate. I would venture therefore to urge that the true position must be defined clearly, and in order to assist in this would submit the following statement for general approval:

1. Voluntary hospitals were built for the indigent poor—that is, for those unable in any way to contribute for their medical treatment.
2. The charitable found the money and doctors the services.
3. These hospitals are now required for the indigent poor only to the extent of 15 per cent.
4. The surplus accommodation (85 per cent.) is put at the disposal of those who indirectly or directly are able to pay in full for medical treatment.*
5. For those under an agreed income limit who pay through a contributory scheme the premiums should be fixed at such a level as will allow of full payment being made from the fund to the hospital. These persons, whatever their individual financial position may be, are no longer objects of hospital charity. Any financial assistance given by the charitable public should be paid to the fund and not to the hospital direct. Those above the income limit could also pay into the scheme, but at such a premium as will make them eligible as private patients for beds either in the private wards of the hospital or at recognized nursing homes.
6. The Board of Management, therefore, should see that not one penny of the funds received from charitable sources is used for this 85 per cent. A separate account should be kept.
7. The tariff of payments fixed for this 85 per cent. should be such as to pay in full the whole cost to the hospital, including remuneration of the staff.
8. Owing to the economic conditions at present existing the staff should be willing temporarily, without prejudice and as a concession, to receive a nominal recognition of the services rendered, by means of a percentage payment.

* These include those paid for by Ministries of Pensions, War, Admiralty, Education, and Health, municipal authorities, employers of labour, approved societies, insurance companies, etc., or under a contributory scheme where there is a stated or implied return required from the hospital.

9. By this concession the Board of Management will be able to fix a lower tariff of fees than it otherwise could for the reception of this 85 per cent.

10. If the staff gives its services for nothing to this 85 per cent. they are thereby underselling their colleagues in their district, many of whom are equally competent to be on the staff as themselves.

11. The consequent loss of experience and income to these colleagues will result in (*a*) the deterioration of medical skill in the district through competent practitioners being unable to obtain a livel hood and having to leave; (*b*) loss of a chance of skilled attention for those of the public able to pay private fees; and eventually to (*c*) the provision of a second or third rate staff for the hospital itself. The whole status of medicine in England will go down.

If this general statement of the position is correct it becomes very difficult to see why the staff should be asked to be content with a suggested pension scheme instead of payment for work done. One has never heard this proposal made in relation to club or national insurance domiciliary practice as an alternative to the accepted mode of payment adopted so far. Why, then, should it prove acceptable for hospital practice?—I am, etc.,

Hove, Feb. 19th. E. ROWLAND FOTHERGILL.

P.S.—The present sentiment displayed for those who are mentally unsound or who are on the border-line, admirable as it is in the abstract, will, if allowed to develop its schemes for *free medical services for all*, tend to the deterioration of this branch of medicine, as suggested above. The situation requires watching very closely. It is very doubtful whether those who are giving their medical services free to these patients realize what it may lead to.

INDIAN MEDICAL SERVICE.

SIR,—The terms of the advertisement in your issue of December 16th, 1922, of thirty vacancies in the Indian Medical Service are likely to mislead possible applicants; and in the opinion of many I.M.S. officers it is time that the India Office altered its description of the attractions of the service to bring it more in line with the facts.

However hopeless it may be to look for improvement in one's own position, one has a right to object to the unvarying repetition of these statements, which are likely to mislead others.

(*a*) "*He may apply after two years' Indian service for transfer to the civil side,*" *etc.*—This is true literally; but if it is meant to imply that the European officer has any chance whatever of transfer to the civil side soon after two years' Indian service, it is simply untrue. Even before the war the average period was about six years; while since the war officers of ten years' service and more have been refused civil employment on the ground of military necessities. I think I am right in saying that no European officers have been given civil surgeoncies since the war, except those who had held these posts before 1914 and so had a claim to them. Not one of the thirty officers now called for will have any reasonable prospect of leaving military employment under the present system.

(*b*) "*Private Practice.*"—As this is practically non-existent, the advertisement should not hold it out as a bait to these military officers.

(*c*) "*Increased Cadre.*"—It should be widely known that since 1918 no study leave, as such, has been granted to military officers of the I.M.S. That is to say, an officer desirous of doing study has to convert his ordinary leave and furlough into study leave, and so, of course, by that amount forfeit the real leave which he requires after years in the tropics. In fact, as regards study leave, their position is exactly as it was before the loudly advertised new regulations were drawn up.—I am, etc.,

January 18th. PROTEST.

SIR,—In your issue of December 30th, 1922, an advertisement *re* recruitment for the Indian Medical Service is published. I would be glad if you could spare space for a few remarks on the passage headed "careers." In the third line occur the words "military side, which has medical charge of the Indian army." This is not so. The R.A.M.C. hold at least as many administrative appointments as the I.M.S.; the relative strength of the troops is about one Britisher to four Indians. I know of at least two Indian general hospitals commanded by R.A.M.C. officers. In line 7: "or a specialist post." The possession of specialist qualifications is of practically no assistance in obtaining such posts. Later: "He may apply after two years' Indian service for transfer to the civil side." Quite, and possibly get on the civil side after twelve to fourteen years' service. Further on a reference is made to "professorships in the medical schools." Practically all such appointments are now in the hands of the Indian Ministers of Education for the various provinces; they are no longer reserved for the I.M.S.

Pay is absolutely comfortable for a bachelor and hopeless for a married man. The effect of the "increased cadre" appears to be the abolition of the usual two months' leave in the hot weather, for Europeans at any rate, and a great curtailment of home leave.

The best advertisement for any service is a contented body of officers in that service, a fact which the authorities do not appear to realize.—I am, etc.,

January 19th. I. M. S.

"T.B."

SIR,—May I once again call attention to the misuse of the abbreviation "T.B." or "t.b.," and the serious errors to which it may give rise? The abbreviation is now commonly used to signify not only "tubercle bacilli"—which is its proper use—but also "tuberculosis" or "tuberculous," which is entirely improper and often misleading. The following instances of the abuse of this abbreviation are culled from various documents:

"The patient should be under the supervision of the Dispensary Tb."

"No *Tb bacilli* in sputum."

"T.B. of lungs. . . . T.B. not found in sputum."

"T.B. not found."

The last instance, owing to the confusion occasioned by the varying significance of the abbreviation, leaves one in doubt as to whether the meaning is "No tuberculosis was found," or only "No tubercle bacilli found." Properly it should signify the latter, but from a study of the context it seems probable that the former was meant, and that in fact an examination of the sputum had not been made. The same uncertainty has arisen in several other cases, in like manner.

The Ministry of Pensions seems to set the fashion by appointing special medical officers with the title "D.C.M.S. (T.b.)," and by officially addressing tuberculosis officers as "T.B. Officer." As might be expected, therefore, many instances of the abuse of the abbreviation "t.b." are to be found in Ministry of Pensions reports; but unhappily the Public Health Tuberculosis Service appears to have followed suit. The matter is surely one that calls for authoritative action.—I am, etc.,

E. WEATHERHEAD, M.B.Camb.

Alderley Edge, Cheshire, Feb. 8th.

STANDARDS OF VISION IN COUNCIL SCHOOLS.

SIR,—Mr. Bishop Harman has added to the very great debt which school medical officers already owe him by his recent article on "Standards of vision for scholars and teachers in council schools," published in the JOURNAL of January 13th.

Both from a theoretical and practical standpoint I agree with the scale he lays down for teachers. This is substantially the scale which I have carried out for some years in Bristol. It is perhaps open to question whether six d opters of myopia should be the maximum instead of five, but five is undoubtedly to be preferred. In applying such a scale one of course decides upon each case on its individual merits, after a careful examination of the eyes and also of the general health of the student, allowing a wider latitude in the case of a thoroughly healthy person who lives as far as possible an out-of-door life.

In regard to scholarships, while I agree that the standards laid down by Mr. Harman are theoretically ideal, I do not think that in practice it is possible to enforce so rigid a scale. Many children who obtain scholarships at age 11 have not yet decided upon their future careers, and may or may not take up close work occupations. To refuse to allow such children to hold secondary school scholarships because of a myopia of three diopters, which corrects to 6/6, is, I think, scarcely possible, and I would like to suggest to Mr. Harman that he should reconsider his standards for junior and senior scholarships.

I hope Mr. Harman's valuable article will be widely read. If it is, much trouble which is caused at present by the widely divergent views held by the medical profession on this subject will be saved.—I am, etc.,

Guildhall, Bristol, Feb. 5th. R. A. ASKINS, M.D.