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THE ASSOCIATION OVERSEAS

CONFERENCE OF DOMINION AND COLONIAL REPRESENTATIVES

The representatives of Overseas Branches who had attended the Annual Representative Meeting met in conference at B.M.A. Headquarters on June 16, Dr. E. A. GREGG, Chairman of Council, presiding. The President, Dr. A. W. S. Sichel, also attended.

The Conference was addressed by Dr. E. GREY TURNER, Secretary of the Colonies and Dependencies Committee of the Association, who referred first to the composition of that committee. In order to ensure that all large areas of the Colonial Empire were represented a proposal had been approved for the co-option of one or two additional members. The overseas members of the Association numbered something like 20,000, but well over half of these were in the great Dominion Branches and largely arranged their own affairs. It was with the interests of the 33 Branches in the Colonial Empire that the Committee was chiefly occupied.

Pay of Colonial Medical Officers

Perhaps the most important item of the Committee's work, said Dr. Grey Turner, had been the continuance of the negotiations started two and a half years ago with a view to bringing the remuneration of Colonial medical officers into line with the levels of remuneration obtaining in the United Kingdom under the National Health Service. The difficulty was that in the areas of the 33 Branches concerned there were great differences in conditions of service, ranging from Bermuda, where there was practically no Government service, to the Sudan, where there was almost a whole-time Government service, from Kenya, where the specialist service was highly developed, to some of the West Indian islands, where there was no true specialist service at all.

The kind of figure which it was decided to endeavour to make general was, for junior medical officers, a scale beginning at £850 and running up to £1,600, and for senior medical officers a salary in the region of £1,650. The A.D.M.S. should be at £1,700 or thereabouts, the D.D.M.S. at about £1,800, and the salary of the director should be the same as that of the Attorney-General or the Financial Secretary of the Colony. It had been agreed that junior specialists on appointment should receive the same salary as the senior medical officer, with, in addition, consulting practice, and the senior specialist the same as the deputy director, again with consulting practice.

The difficult problem arose with the smaller Colonies. It was not reasonable to expect a tiny island like St. Lucia to offer the same salaries to its medical officers as the great territory of Nigeria. Each Colony had to be looked at by itself and an endeavour made to group it with some contiguous area—Zanzibar and Aden, for example, with East Africa.

The Problem of Private Practice

A perennial problem was that of private practice by medical officers in the Colonial Service. In the case of doctors employed whole-time by local authorities or universities in the home country, of course, nobody had suggested that they should be allowed to earn private fees, and some years ago the Colonial Office decided that the practice should be abolished in the Colonies. But in many parts of the world where, for example, there were not the resources in medical man-power available to cover the mercantile community who were not Government officials, such abolition was impracticable. The Colonial Office had drafted a memorandum on the subject, and the Association had made comments; but for the present these must be regarded as confidential.

One point to be taken up in future negotiations was the difficulty which Colonial medical officers experienced in having their children educated. The suggestion had been made for a special school in this country for the purpose, but the segregation of the children would be unfortunate. More to be commended was the suggestion that special places be set aside in boarding schools for children of overseas officers. The matter of interchange with the National Health Service had been broached, but while there was agreement in principle it bristled with practical difficulties.

Then there was the problem of early retirement. Formerly the medical officer retiring with a substantial pension at 45 or 50 was able to come back to this country and supplement his pension by income from a bought practice. But practices were now no longer purchasable, and the man who had given the best years of his life to the Colonies was apt not to be regarded favourably as a candidate for a vacancy in the National Health Service. Early retirement from the Colonial Service, once an attraction, was now a disadvantage.

Turning to Branch affairs Dr. Grey Turner said that a model set of rules for overseas Branches had been formulated. It was desired to have in each Branch area a first-class local agency on which Headquarters could rely for information and action. Efforts were being made to improve the service to overseas members still further. Many overseas

members would be grateful to have the use of the lending library, but the appropriate committees had decided reluctantly, on the ground of the time which would be taken for the transport of books, that this was not possible. A scheme had been devised with a well-known medical circulating library by which group subscriptions could be taken out on behalf of overseas members, but the scheme cost money, and at the moment the Finance Committee was looking askance at new expenditure.

A World Tour

Finally the speaker took his hearers on a rapid world tour. In Fiji there was concern about the status of locally licensed practitioners. The Hong Kong Branch was thriving despite the troubles in China and Korea. The new Borneo Branch was settling down well. Malaya was the biggest colonial Branch, but did not supply much news. The new Middle East Branch would have a great part to play. The Sudan was passing through a difficult phase. Cyprus was an area of developing importance, with a medical service very badly paid. The East and Central African Branches were in good shape. He had high hopes that a Branch would be established in the Gold Coast this year. Sierra Leone, after a period of quiescence, was now starting its meetings again.

The conference of the Caribbean Branches held last January under the presidency of Dr. H. Guy Dain was a great success and a number of important proposals were brought forward; and these had been received sympathetically by the Colonial Office. A council of the Caribbean Branches was to be set up and would hold its first meeting in Jamaica in the autumn of this year. He also mentioned the "unattached" members of the Association—in the Seychelles, in Somaliland, and elsewhere. The fact that there was no Branch in their area did not mean that they were forgotten. Headquarters took the same active interest in their affairs.

Discussion

Dr. P. W. HUTTON (Uganda), after expressing the gratitude of his Branch for what had been done by the Committee in effecting improvement of salary scales, mentioned some of the difficulties of liaison between Branches in the Colonies and the parent body. It would be a good idea if Branches so far as possible let the parent body know when any of their members were on leave.

Dr. D. J. M. MACKENZIE (Nyasaland) said that his Branch had wished him to bring up the question of the unduly low salary scale of newly joined medical officers; some of these men had a difficult time in making ends meet. The vexed question of private practice was tied up with salary scales. In his area private practice depended on the discretion of the D.M.S. In the circumstances of the Colony there were not enough private practitioners to serve the general population. Therefore, apart from two areas, where there was a concentration of non-Government doctors, this work had to be done by medical officers in the service. Speaking of "unattached" members, he mentioned the medical officers in the High Commission territories.

Dr. D. R. MCPHERSON (Central Malaya) said that the increases in salary received bore only a small relation to the increase in cost of living, either at home or in Malaya, and many of the increases were not pensionable. The effect of political developments was making itself felt in Colonies such as Malaya. It had not brought their careers to a premature conclusion, but they felt that political developments were being given undue weight when their claims were being considered.

Dr. M. C. F. EASMON (Sierra Leone) referred to the expatriation allowance, and said that there was a feeling in West Africa that, owing to this allowance, men who were equally qualified did not get the same amount of pay for the same work. In his own early days no children of European officers were born in West Africa, but now it was very different. The young medical officer came out with his wife and children and was not maintaining two homes. Thus the argument for the expatriation allowance fell to the ground.

Dr. GREY TURNER said that there were three arguments which could be used to justify an expatriation allowance. The first was that an officer working away from his country of domicile was put to a greater expense than an officer working in his own country. The second was that an officer was entitled to some reward or compensation for undertaking to be mobile. The third arose out of the market value of doctors, which was not uniform throughout the world. The Committee, however, would never approve any discrimination in pay solely on the grounds of race or colour.

Dr. F. L. G. SELBY (Nigeria) spoke about private practice in his area; Dr. R. K. BROOKS (Mashonaland) mentioned that the Government in Southern Rhodesia was considering the preparation of a register of specialists, and Colonel W. J. MOODY (Middle East) and Dr. E. F. THOMSON (New South Wales) confined themselves to complimentary expressions.

The CHAIRMAN OF COUNCIL said that, particularly in recent times, the British Medical Association had taken a lively interest in the concerns of its members overseas. He hoped that opportunities for personal contact would increase. He spoke with pleasure of his own impressions of the Branches he had visited during his tour to Australia and New Zealand the previous year. He had hoped this year to visit several of the African Branches during the journey to and from the Johannesburg meeting, but the cancellation of that meeting had prevented him from having that opportunity. Finally he drew attention to the work of the Empire Medical Advisory Bureau, whose director, Dr. H. A. Sandiford, was ever ready to advise and help practitioners visiting the United Kingdom, particularly those from the Dominions and Colonies.

On the second day of the Annual Representative Meeting (June 14) a luncheon was given to overseas representatives at the Russell Hotel, when Dr. J. A. Brown, Chairman of the Representative Body, welcomed the visitors, and Dr. A. W. S. Sichel, President-elect, briefly replied.

MENTAL HEALTH

AIMS OF FUTURE LEGISLATION

A Conference of the Psychological Medicine Group of the British Medical Association was held at B.M.A. House on May 28, when, after some formal business, including the adoption of the annual report of the Group Committee, a discussion took place on the aims of future legislation for mental health. Dr. W. G. MASEFIELD presided.

Dr. J. B. S. LEWIS said that the title of the discussion was itself revolutionary; in this country legislation had been directed towards lunacy and mental deficiency, but there had been no legislation for mental health. All legislation touching on psychiatry should be one integrated whole so that there would be no danger of certain types of patients being left out. He understood that among those interested in mental deficiency there was objection to the term "mental defective," and there was something to be said for a change of name. Under Northern Ireland legislation these cases were described as those of arrested or incomplete development and the defective as a person in need of special care or as socially inefficient.

A large body of opinion held that there was no justification for maintaining four grades of mental defectives, but the point which struck the layman in this matter was the absence of provision for voluntary admission. Why should there not be temporary care for the mentally deficient as well as for those of unsound mind? Sir David Henderson had stated that he could see no adequate reason why the procedure governing certification should be different in the case of mental defectives from what it was in the case of the person suffering from mental disorder. The two conditions were part and parcel of the same problem—inability because of dysfunction of the mind to adapt to the ordinary conditions of social life. The Mental Treatment Act might be applied equally to the mental defective.

Turning to the question of mental illness, he said the categories for admission were four: voluntary, temporary, certified, and "Broadmoor." Were these adequate? Were there not some who, just as "patients," might enter and leave a mental hospital in the same way as patients went into and out of a general hospital? As for voluntary patients, some advocated that notice to leave should be increased from three to seven days, and others that patients should agree to a minimum period of detention. He was against this because it would impair the voluntary principle. Concerning temporary patients a lead was given by Northern Ireland legislation, whereby temporary patients came in for a year, a period which could be extended. In Northern Ireland, too, only one medical certificate was required, but two certificates gave greater protection to the patient on the one hand and to the doctor on the other.

So far as discharge from mental hospitals was concerned, there was a great deal to be said for simplification of machinery. Something should be done to modify the ordeal for patients and their relatives of an interview with the discharge committee.

Although criminal psychopaths were a relatively small class, he thought that special provision should be made for them. He described an experiment in Denmark, but he was doubtful whether the British public would accept what was virtually an indeterminate sentence. But some definite statutory provision should be made for psychopaths and specifically for sexual offenders. He hoped that any new Act would recognize that sexual offenders were a psychiatric problem. Some differentiation should be made in homosexual cases between offences between adults and offences committed on children. He doubted whether they were yet in a position to lay down anything definite about the preventive aspects of mental health; they could express pious hopes and see that money was set apart for investigation.

The Voluntary Patient

Dr. C. KENTON said that he would perpetrate a drastic operation on the existing Lunacy and Mental Treatment Acts. He thought the only clauses, suitably amended, in the present Acts which were required to ensure that patients got treatment were those which would bring unwilling patients or patients without volition under treatment if they needed it. He would retain voluntary treatment under the Mental Treatment Act for those patients who wished for such treatment. For those who had no volition and needed indoor hospital treatment he would use the temporary treatment clause in the Mental Treatment Act, and he would have only one medical certificate, for it was a little hard in rural areas to find two practitioners one of whom must be approved by the Board of Control. For those patients who had volition and who were certainly in need of mental hospital treatment but declined to take it, he would use section 11 provisional urgency order—that is, the patient would be admitted only on one medical certificate, and that would last for a certain term and there would be authority for further consideration.

As for patients already in hospital under temporary certificate or urgency order and who required further treatment he would keep them under certificate by the medical officer in charge for periods to be determined. So far as psychopaths were concerned, he was very unhappy about treating the psychopath under any legislation at the present moment. Public opinion was not ripe for it, and not enough was known about the psychopath. It was not right to bring in legislation committing people in some cases to indeterminate sentences.

Mental defectives should surely only be admitted to colonies if the colony could provide the kind of training required and only to be given there, or at least could start them in training, which could be carried on in the community. He could not see why the institutional training of the defective should be under a different authority from the one responsible for the training of the defective who was not institutionalized.

Dr. B. H. KIRMAN held that the certification of mental defectives under the age of 5 should be abolished completely. There was no advantage in such classification, which must be merely on the ground of their antecedents. Occupational services with special schools should be the responsibility of the education authority, as should the educational provision for residential patients.

Mental Hospital Doctors and Out-patient Work

Dr. T. P. REES asked to what extent the present shortcomings were due to faulty legislation or to the fact that full use was not made of existing legislation. Before any treatment under the Mental Treatment Act could be worked successfully it was desirable that the same doctor should do out-patient work in the area and work in the hospital. Some people had suggested the abolition of the voluntary class of patients. He had made it a practice before giving a voluntary patient a prolonged insulin course of asking him to give an undertaking to stay in hospital until the treatment was completed. He would hesitate before doing away with the voluntary category altogether. With an adequate out-patient service, and the hospital staff attending the out-patient clinics, there was no difficulty in getting the patients to enter the mental hospital as voluntary patients, provided they were told what was going to happen to them in hospital. For the past six years over 90% of the admissions at his hospital had been on a voluntary basis. When all was said and done, certification was a very small problem. He would make certification a little more difficult. If there was one way in which they could lose public confidence it was by taking on their own shoulders the certification of patients.

Dr. SAWLE THOMAS said that one of the difficulties in getting patients into mental hospitals in the time required was the complication of the methods of admission. These should be reduced to a minimum. With regard to mental deficiency, could not children be admitted by the same procedure as for voluntary patients under 16, on the application of whoever was responsible for the child?

Dr. A. TORRIE said that certain differences of opinion which had manifested themselves in that discussion showed that they should take a leaf out of the book of the social scientist and have an adequate survey made to show where the gaps and the pressures were, and then, having made their plan, they should give it a trial run.

In the course of further discussion Dr. DORIS ODLUM drew attention to the memorandum on sexual offenders published last year by the Joint Committee on Psychiatry and the Law, in which many of the points raised by speakers that afternoon were discussed. Dr. WILLOUGHBY CLARK contested the suggestion that out-patient clinics should be run by the doctors in mental hospitals. He also thought that no doctor should be allowed to stay inside a mental hospital for more than five years at a stretch; he should then go out for two years into general practice. Dr. PETER CHARLTON thought that the building up of a good domiciliary service, with good out-patient clinics in association with the hospital, would result in a high voluntary admission rate. Dr. RUBENSTEIN, Dr. M. SIM, Dr. HARRIS, and others made brief contributions to the discussion.

The CHAIRMAN (Dr. Masefield), in summing up, said that he still advocated the increased use of temporary admissions without the hedging round of volition or non-volition. He wanted to see all patients who were non-voluntary admitted as temporary patients. He said this because the admission of a patient was a medical matter; he wanted to see the justices out of it. He remembered many of the comments made by responsible people when the 1930 Act was passing through Parliament. There were hospitals which, very soon after that Act had come into force, were admitting 40 or 50% of their patients as temporary patients.

While he agreed that not all out-patient work should be done by the doctors in mental hospitals, he did not think such doctors should be debarred from working extramurally. After all, they were the pioneers.

MERIT AWARDS

INFORMATION SENT TO COMMITTEE

Special forms are kept by every hospital board by means of which consultants may send information about their qualifications, appointments, publications, and any other activities in their career to the Merit Awards Committee. These forms were sent to every consultant when the Awards Committee started work, and they are sent to all new consultants on appointment. The information is of great importance to the Awards Committee, which wishes to be kept informed of up-to-date information about consultants' careers.

Every consultant has free access at any time to the Awards Committee, and all information, advice, or complaints will be received readily by the committee. Communications should be addressed to the secretary, Distinction Awards Committee, Ministry of Health, 23, Savile Row, London, W.1.

TEACHING HOSPITAL APPOINTMENTS

Appointments, mainly to fill vacancies caused by the retirement in rotation of one-third of the members, have been made to the boards of governors of the 26 London teaching hospitals by the Minister of Health. Out of a total of 240 appointments 209 are reappointments of retiring members. There are nine appointments outstanding. Members of these boards all serve in a voluntary capacity. Tenure of office will be for three years—until March 31, 1954. Another one-third of the members will retire on March 31, 1952. Total membership of the boards, excluding chairmen, is 643. Those reappointed or newly appointed for each board are as follows, the names of medical members being in small capitals:

Royal Hospital of St. Bartholomew.—Reappointed: Sir George Aylwen (chairman); Dr. GEORGE GRAHAM; Dr. C. F. HARRIS; Mr. J. B. HUME; Lord Huntingfield; Miss K. M. Halpin; Mr. R. C. Hammett; Mr. H. K. Eaton Ostle; Mrs. A. L. Reeve; Alderman C. H. Simmons. New Member: Professor A. Wormall (London).

London Hospital.—Reappointed: Sir John Mann (chairman); Mr. A. G. Allen; Professor J. D. BOYD; Mr. S. F. Johnson; Mr. H. R. Hobson; Mr. F. T. Baldock; Mr. T. O'Leary; Sir Albert Stern. New Members: Mr. V. J. F. LACK (London); Mr. T. Aitken (Goodmayes, Essex). One appointment outstanding.

Royal Free Hospital.—Reappointed: Mr. Geoffrey Bostock (chairman); Lady Lucan; Mr. John Bruce; Mr. B. M. L. Fynn; Miss GLADYS HILL; Dr. T. J. HOSKIN; Miss A. M. C. MACPHERSON; Alderman E. A. Minter; Sir Frank Newnes; Miss E. M. SCARBOROUGH; Mr. W. R. H. Steer.

University College Hospital.—Reappointed: Sir Alexander Maxwell (appointed chairman vice Sir Harold Wernher); Sir HAMILTON FAIRLEY; Sir ARCHIBALD GRAY; Miss S. GRIFFITHS; Mr. George Mitchell; Dr. ANDREW TOPPING; Miss D. E. Westmacott. New Members: Lady Iris Capell (London); Mr. W. Robinow (London); Mr. B. H. Russell (London).

Middlesex Hospital.—Reappointed: The Hon. J. J. Astor (chairman); Mr. Ronald Chamberlain; Mr. W. Holmes; Sir Desmond Morton; Alderman H. R. Neate; Mr. Ernest T. Thornton-Smith; Sir Hugh Turnbull. New Members: Professor R. W. SCARFF (London); Professor A. KEKWICK (London); Dr. D. E. BEDFORD (London); Mr. PHILIP WILES (London).

Charing Cross Hospital.—Reappointed: Lord Inman (chairman); Mr. John Adamson; Mr. W. H. Bateman; Mr. W. N. Chellingworth; Mr. E. A. CROOK; Mr. A. O. GRAY; Dr. BERNARD HOMA; Miss Kathleen Proud; Dr. E. C. WARNER; Miss E. S. Laing. New Member: Dr. E. GRUNDY (Wembley).

St. George's Hospital.—Reappointed: Sir Walter Monckton (chairman); Mr. Anthony Greenwood; Mr. E. K. H. Hilleary; Mr. P. J. JORY; Mr. R. MARNHAM; Mrs. A. I. M. Adams; Mr. IVOR BACK [since deceased]; Mr. A. H. Clarke; Mr. I. F. Salmon. One appointment outstanding.

Westminster Hospital.—Reappointed: Lord Nathan of Churt (chairman); Mr. A. LAWRENCE ABEL; Mr. E. P. BROCKMAN; Mr. H. E. HARDING; Mr. A. G. Linfield; Professor R. J. PULVERTAFT; Mrs. Jane Lesser; Miss M. C. Robertson; Mr. R. B. C. Ryall; Sir Geoffrey Shakespeare; Alderman T. Wheeler.

St. Mary's Hospital.—Reappointed: Mr. Anthony G. de Rothschild (chairman); Mr. V. ZACHARY COPE; Alderman Mrs. E. Daniels; Mr. H. Floyd; Dr. G. B. MITCHELL-HEGGS; Dr. S. L. SIMPSON; Mr. H. E. Verey; Sir Adrian Carton de Wiart. New Members: Professor R. CRUICKSHANK (London); Professor C. G. ROB (London); Mr. J. F. SIMPSON (London).

Guy's Hospital.—Reappointed: Lord Cunliffe (chairman); Mrs. E. G. M. Barlas; Mrs. Iris Brook; Dr. J. M. H. CAMPBELL; Mr. C. J. Conway; Sir Patrick Ashley Cooper; Sir WILLIAM KELSEY FRY; Mr. O. GAYER MORGAN; Mr. F. J. O. Prescott; Mr. L. B. Wimble. New Member: Mr. R. J. Mellish (London).

King's College Hospital.—Reappointed: Marquess of Normanby (chairman); Mr. T. H. Barr; Mr. P. R. Colville; Mr. L. M. E. Dent; Mr. M. V. Ely; Viscountess Hambleden; The Hon. Mrs. S. L. Henley; Sir CECIL WAKELEY. New Member: Mr. W. I. DAGGETT (London). One appointment outstanding.

St. Thomas's Hospital.—Reappointed: The Hon. Arthur J. P. Howard (chairman); Mr. E. F. Crundwell; Mr. F. H. Elliott; Mr. W. G. R. Boys; Sir Jack Benn Brunel Cohen; Mr. J. R. DICKINSON; Professor T. POMFRET KILNER; Mr. A. H. Montgomery; Mr. R. H. O. B. ROBINSON; Mr. L. H. Simmons. New Member: Sir CHARLES MAX PAGE (Faversham, Kent).

Hammersmith, West London and St. Mark's Hospitals.—Reappointed: Dr. SOMERVILLE HASTINGS (chairman); Mr. G. F. GRANT BATCHELOR; Sir ALLEN DALEY; Judge J. Norman Daynes; Dr. CUTHBERT E. DUKES; Sir FRANCIS FRASER; Mr. Geoffrey Huddle; Mr. T. H. Jones; Mr. A. E. Tyler. One appointment outstanding.

The Hospital for Sick Children.—Reappointed: Mr. T. H. Bischoff (chairman); Sir ALLEN DALEY; Mr. T. TWISTINGTON HIGGINS; Mr. C. H. Hodge; Mr. Patrick Kirkman Hodgson; Mr. ERIC IVAN LLOYD; Mr. A. E. Middleton; Dr. GEORGE NEWNS; Dr. B. SCHLESINGER. New Member: Professor T. H. Marshall (London).

National Hospital for Nervous Diseases.—Reappointed: Sir Ernest Gowers (chairman); Dr. W. RUSSELL BRAIN; Dr. E. A. CARMICHAEL; Sir ARCHIBALD GRAY; Mr. A. C. Longland; Lady Milverton; Mr. P. D. Power. New Members: Mr. F. C. Wareham (London); Mrs. O. Deer (London).

Royal National Throat, Nose and Ear Hospital.—Reappointed: Mr. E. E. Taylor (chairman); Mr. F. R. Eiloart; Mrs. Mary Haydn Davies; Mr. G. H. HOWELLS; Mr. W. Humphrey; Mr. R. N. Wright. New Members: Mr. M. P. ELLIS (London); Mr. J. C. HOGG (London).

Moorfields, Westminster and Central Eye Hospital.—Reappointed: Lord Luke (chairman); Mr. E. P. Carter; Mr. A. Gorman; Mrs. A. L. Hollingsworth; Mr. George Parker-Jervis; Earl of Rothes; Mr. G. C. Stanley. New Members: Dr. FRANK ELLIOTT (London); Mr. Harry Hutchinson (London).

Bethlem and Maudsley Hospitals.—Reappointed: Dr. C. P. BLACKER; Mrs. Kathleen Wilson; Alderman T. E. Morris; Mrs. N. C. Runge; Dr. E. F. SCOWEN. New Members: Lady Norman (London); Lieutenant-Colonel G. J. C. Welch (London); Alderman J. C. Maclean (Welling, Kent).

St. John's Hospital for Diseases of the Skin.—Reappointed: Mr. I. A. M. Ellison-Macartney (chairman); Mr. A. Franklin; Dr. G. B. MITCHELL-HEGGS; Mr. A. D. Long; Miss Dorothy FOX; Dr. SEYMOUR COCHRANE SHANKS; Mr. S. I. Salmon.

Hospitals for Diseases of the Chest.—Mr. Widdrington Stafford has been appointed chairman for the rest of the period of his office—that is, to March 31, 1952. Reappointed: Mr. R. C. BROCK; Sir John Little Gilmour; Dr. J. L. LIVINGSTONE; Mr. H. K. Eaton Ostle; Mr. V. C. THOMPSON; Mrs. Sarah Candy; Mrs. Marguerite Watson. New Member: Dr. GEORGE SIMON (London). Three appointments outstanding.

Royal National Orthopaedic Hospital.—Reappointed: Mr. Louis Fleischmann (chairman); Sir Henry R. K. Floyd; Mr. W. Morgans; Mr. H. C. Willig; Miss M. Joan Wood. New Member: Dr. REGINALD NASSIM (London). One appointment outstanding.

National Heart Hospital.—Reappointed: Mr. J. M. Oakey (now appointed chairman); Mr. J. M. F. Cohen; Dr. T. F. COTTON; Sir FRANCIS FRASER; Dr. B. T. PARSONS-SMITH. New Member: Mr. E. G. Gooch (London).

St. Peter's and St. Paul's Hospitals.—Reappointed: Mr. L. E. D. Bevan (chairman); A. McN. Farquhar; Sir Bertram Galer; Mr. A. R. C. HIGHAM; Mr. J. Russell Kelly; Mr. L. G. Mitchell-Innes; Mr. H. Short; Mr. H. P. WINSBURY-WHITE. One appointment outstanding.

Royal Cancer Hospital.—Reappointed: Sir Edward Stewart Cripps (chairman); Professor IAN AIRD; Dr. P. E. THOMPSON HANCOCK; Mr. G. L. Jacob; Professor W. V. Mayneord; Mrs.

Noel Patrick; Mr. G. C. Stanley; Mr. Claude S. Harvey; Dr. E. A. CARMICHAEL.

Queen Charlotte's and Chelsea Hospitals.—Reappointed: Sir Frederick Minter (chairman); Mr. H. G. E. ARTHURE; Mr. A. GOODWIN; Viscountess Jowitt; Mr. E. Musgrove; Dr. CHARLES NEWMAN; Mr. A. M. Niven; Lady Ogilvie; Mr. Alan Sainsbury; Mr. G. Whiffen.

Eastman Dental Hospital.—Reappointed: Sir Frank Hillyard Newnes (chairman); Brigadier R. A. BRODERICK; Sir WILLIAM KELSEY FRY; Mr. B. M. Lindsay Fynn; Mr. G. Meekcoms; Mr. W. R. Young. New Member: Mr. G. J. PARFITT (Reading).

PUBLIC HEALTH AWARD

SUPPORT BY GENERAL PRACTITIONERS

An important extension of B.M.A. policy has been made in order to ensure that public health medical officers are supported by general practitioners in gaining implementation of the Industrial Court award. This was expressed in the following resolution passed at the Annual Representative Meeting on June 16:

That, if local health authorities do not implement the recent Industrial Court awards to medical officers of health, then general practitioners should give full support to the medical officers even to the extent of refusing to undertake any local health authority appointments until such awards are implemented.

In the past general practitioners have been asked to support their public health colleagues by not applying for or accepting work usually undertaken by a whole-time medical officer. General practitioners are now asked not to undertake any new work for local authorities not yet implementing the first award of the Industrial Court.

Advertisement Policy

Any advertisement of a whole-time or part-time appointment submitted for publication in the *British Medical Journal* by an authority failing to implement the first award will be refused. On and after September 1 similar action will be taken with reference to the second award.

Present Contracts

General practitioners already in contract with local authorities for part-time work under the sessional agreement of 1947 or the part-time agreement of 1951 are not affected by the resolution passed at the A.R.M. and should not withdraw their services.

A letter setting out the position has been sent by the Secretary of the B.M.A. to the honorary secretaries of all Branches and Divisions in the U.K.

COST OF PRESCRIBING

A SPECIAL INVESTIGATION UNIT

We learn that about a year ago a special unit was set up by the Ministry of Health to investigate prescribing in general practice. During the year ending March 31, 1951, the unit investigated the prescribing of 151 doctors (in 95 practices). The Ministry's regional medical officers visited 126 of the doctors, and warning letters were sent to 106. Second investigations were made into the prescribing of 31 doctors. The Ministry found that there was a remarkable improvement in nearly all the cases investigated.

In general the doctors are said to have been surprised at the cost of their prescribing and grateful for the manner in which it was drawn to their attention. The visits and advice of the regional medical officers seemed to be generally welcomed. The Ministry considers these results encouraging.

Of the 151 doctors whose prescribing was investigated only one was brought before the local medical committee. The Ministry emphasizes the ready co-operation of the doctors when their attention was drawn to the fact that the cost of their prescribing was relatively high.

CLOSED SHOP AT DURHAM

B.M.A. DEMANDS ACTION

The B.M.A. has asked the Minister of Education to take action with the Durham County Council in the closed-shop dispute. After its recent dispute with the teachers in the area, Durham County Council has given an assurance that the closed-shop policy will not be applied to the appointment of teachers. The B.M.A. has attempted, without success, to obtain a similar assurance regarding medical officers employed by the Council.

The Durham Council has not rescinded its closed-shop resolution, under which it is a condition of employment that a medical officer employed by the Council shall be a member of a trade union or professional organization.

The B.M.A. has accordingly placed the facts before the Minister of Education and has asked him to take the necessary action, since he is the Minister responsible for the school medical service. The Minister of Health has also been informed.

Since Durham's closed-shop policy contravenes the policy of the B.M.A., an "Important Notice" appears in our advertisement columns, asking doctors not to apply for four vacant posts for assistant school medical officers under the Durham County Council without first communicating with the Secretary of the B.M.A.

X-RAY EXAMINATIONS FOR GOVERNMENT DEPARTMENTS

REVISED FEES

The Radiologists Group Committee of the B.M.A. has been undertaking negotiations with Government departments in respect of fees for *x*-ray examinations. The Ministry of Pensions and the Ministry of National Insurance have agreed that the existing scale of fees, fixed some 10 years ago, should be revised, in view of the increase of the cost of *x*-ray apparatus and materials.

The new scale of fees, which operates from January 1, 1951, is as follows:

Group No. 1.—Extremities (one area); teeth, one area; foreign body, demonstration of; gall-bladder, plain; spine, one area; jaws; abdomen, plain; salivary glands; pelvis; chest, without screening: *£2 2s.*

Group No. 2.—Foreign body, localization of; all teeth; extremities, several areas; chest, with screening; urinary tract, plain; pregnancy; pelvimetry; cephalometry; mastoid and petrous temporal bones; sinuses; skull; cystography; urethrography; abdomen, screening; cholecystography; cholangiography; fistula, injection of contrast medium: *£3 3s.*

Group No. 3.—Localization of foreign body in eye; spine, more than one area; tomography; kymography; barium meal, oesophagus; barium meal, stomach and duodenum; barium enema; hystero-salpingography; arthography; sialography; intravenous urography: *£4 4s.*

Group No. 4.—Full barium meal; angio-cardiography; arteriography; venography; bronchography; ventriculography; encephalography; myelography: *£5 5s.*

This scale is to be regarded as the standard for all *x*-ray examinations undertaken at the request of Government departments other than as part of the hospital and specialist services of the National Health Service. It therefore applies to examinations undertaken for the Ministry of Labour and National Service, but in this case the new fees are payable from May 1, 1951.

This scale of fees does not apply to examinations included in Category 1 of the Schedule to paragraph 14 of the Terms and Conditions of Service of Hospital Medical Staff. The fees set out above are therefore not chargeable in respect of examinations and reports on persons referred from medical boards of the Government departments concerned where these are undertaken in hospital.

REVIEW OF GENERAL PRACTICE

EVIDENCE INVITED

A special committee of the B.M.A.—the General Practice Review Committee—is carrying out a large survey of general practice. It would like to hear evidence from general practitioners. The Secretary of the B.M.A. therefore invites general practitioners to submit to him a memorandum on matters about which they wish to give evidence.

Main Inquiries

The committee is also carrying out two large-scale inquiries in order to obtain information. The secretary of the committee is travelling round the country studying at first hand about 200 practices selected by a random method. Questionaries are also being sent to all general practitioners. The investigation is under expert statistical supervision.

NEW CERTIFICATE OF INCAPACITY

The B.M.A. has produced a certificate of incapacity based on the certificate E.D.652, which was previously supplied by the Ministry of Labour and National Service. The certificate is designed for use when a patient requests evidence of incapacity for presentation to his employer or for a similar purpose.

The new certificate is made up in books of 50, and supplies may be obtained on application to the Finance and Business Officer of the Association. In order to cover the cost of paper, printing, and postage, 1s. 6d. is being charged for each book of 50 certificates.

AUXILIARIES' HIGHER PAY

INDUSTRIAL COURT AWARD

The Industrial Court has awarded that the present salary scales of medical auxiliaries shall be increased by £50 at all points as from April 1.

The medical auxiliaries concerned are almoners, occupational therapists, orthoptists, physiotherapists, psychiatric social workers, remedial gymnasts, speech therapists, and therapeutic dietitians.

The Court noted that the present salaries had been in operation since 1948 or earlier—in some cases since 1946. The claim was negotiated through the Whitley Council, both sides of which agreed that the present salaries needed revision.

TRADE UNION MEMBERSHIP

The following is a list of local authorities which are understood to require employees to be members of a trade union or other organization:

County Council.—Durham.

Metropolitan Borough Councils.—Bethnal Green, Fulham, Hackney, Poplar, Southwark, Stoke Newington.

Non-County Borough Councils.—Crewe, Dartford.

Urban District Councils.—Droylsden, Houghton-le-Spring, Huyton-with-Roby.

Correction.—In our report of the Annual Representative Meeting (*Supplement*, June 23, p. 253) we erroneously stated at p. 281 that Dr. A. V. J. Russell moved the motion on "The Trade Union Issue." In fact it was moved by Dr. R. W. L. Pearson (Birkenhead and Wirral).

Heard at Headquarters

The Credulous Iconoclast

The spate of books about G.B.S. which have followed his death have shown what an enemy he was to pretensions and shams in medicine as in other spheres. But on reading the book by Miss Patch, who was his secretary for 30 years, one is startled to find how credulous was this iconoclastic philosopher when it came to a question of treatment of himself. Anything, however preposterous, was welcomed by him so long as it had not anything to do with the orthodox medical profession. He was treated five or six times by Abrams's box, a device which many years ago had a great vogue in the United States. He had heard from a Scandinavian who claimed to be able to treat all ailments by natural methods. Said Shaw, "There is no harm in finding out what this naturopath has to say at my expense." Miss Patch tells us that Shaw's most fantastic "cure" was one which he passed on, with perfect seriousness, to an actress of his acquaintance for loss of sight. His idea was that loss of sight which was due to shock cured itself by means of another shock, and he gave explicit directions how that shock was to be administered. It appears that Shaw, who left a third of a million, wrote to the National Health Service authorities inquiring how he stood for registration under the Act, as he wished to have a "national" doctor in case he was unable to afford a private one.

Health and Beauty

From a doctor's letter: "I have been asked for many things under the National Health scheme, but here is the latest request. A woman put down her medical card and demanded to have her ears pierced for ear-rings. I declined."

Sport Section

A doctor writes to say that when he answered his telephone the other day a voice said: "Oh, doctor, this is A. B. speaking. When my mother comes to surgery this morning will you ask her to wash my white flannels to-day?" The doctor did not commit his reply to paper, but apparently the man's mother did not turn up.

The Spa Handbook

Many messages of appreciation have been received of the B.M.A. handbook on *The Spa in Medical Practice*. In particular the British Spas Federation, believing that the handbook will be useful to all concerned with the treatment of patients at spas, has expressed the hope that all doctors will obtain a copy. In order to encourage them to do so the Federation has generously offered to defray the cost of a second printing for free distribution. The offer has been gladly accepted, and copies of the handbook are available to members of the profession free of charge. They are obtainable on application to the Publishing Manager at B.M.A. House.

Something Wrong

A doctor writes that the following conversation was overheard recently in his surgery waiting-room:

1st Old Gentleman: Hallo! What's wrong with you?
2nd Old Gentleman: Why, nothing.
1st Old Gentleman: Don't be silly. There must be something wrong or you wouldn't be here.
2nd Old Gentleman: Oh, I just like to come occasionally for a bottle of medicine. After all, it's all free.

He asks who is responsible for this attitude of mind—the Minister or the profession?

Questions Answered

Journeys from Home

Q.—*I hold an honorary contract as a consultant with both the regional hospital board and the board of governors; my headquarters is in the teaching hospital. Am I entitled to travelling expenses from the regional hospital board for journeys between my home and the teaching hospital while I am on call for emergencies which may occur in the regional board hospital?*

A.—Whole-time officers of hospital boards are not normally entitled to mileage in respect of journeys between home (or consulting-room) and hospital. In the case of a part-time officer such journeys are regarded as being in the board's service and therefore rank for the payment of mileage allowance, provided that no expenses are allowed for any journeys which would have been undertaken by the officer irrespective of his employment with the board.

It is difficult to understand how a regional hospital board could be assumed to be responsible for the payment of travelling expenses in respect of journeys undertaken on the business of a board of governors, and the answer to the questioner would appear to be "No." But if the questioner is under contract with the board of governors for part-time services there would appear to be no reason why he should not claim mileage for the journeys between his home (or consulting-room) and the teaching hospital. The holders of honorary contracts are entitled to expenses on the same basis as other officers.

Superannuation Deductions

Q.—*Questions arise from time to time owing to the fact that the superannuation deductions of 6% from the fees received under the National Health Service are credited to a practitioner on the basis of the number of patients on his list and not on the basis of the sharing arrangements between the partners. Are there any statutory arrangements for adjusting this anomaly, and can a practitioner require a local executive council to divide up the superannuation contributions between the partners on the basis upon which they share profits?*

A.—It is possible for practitioners in partnership to notify the executive council that they wish superannuation to be related to their respective shares. The position is covered by a proviso to Regulation 46 (2) (*b*) of the N.H.S. Superannuation Regulations, 1950, which is as follows:

"If the practitioner is a party with any other practitioner or practitioners to a partnership agreement, his remuneration shall, if such practitioners assent by notice in writing given to the executive council, be deemed to be such proportion of the total remuneration of such practitioners as the proportion of his share in the partnership profits bears to the total proportion of the shares of such practitioners in those profits."

Locum Registrar

Q.—*I am shortly to be offered a locumtenent appointment as a senior registrar for about a month. I have not been a locum before, and would be pleased if you would give me some information. (1) Can I claim travelling expenses at the appropriate rate for my journey to the town in which the hospital is situated? (2) Should I, as a locum, be remunerated at the highest grade of the scale—i.e., £1,300 per annum—or not? (3) Should the hospital find accommodation for me or should I do it, and do I pay for this out of my earnings?*

A.—(1) Although a locum is entitled to travelling expenses for journeys incurred in carrying out his duties, in accordance with the Terms of Service, there is no provision for the payment of the expenses incurred in taking up the appointment. (2) A locum in the senior registrar grade should be remunerated at the rate of salary of the officer whom he is replacing. (3) The question whether the hospital authority provides accommodation is a matter for mutual arrangement. In any event the salary is gross, and if the locum is resident a charge for board and lodging is deducted from his remuneration.

Whole-time or Part-time

Q.—*Is a whole-time consultant anaesthetist under any obligation to give anaesthetics to a surgeon's private (fee-paying) patients if there is no part-time anaesthetist in the immediate area?*

A.—The model form of contract for consultants rendering whole-time service contains a clause requiring the consultant to provide treatment to patients occupying private beds in so far as they have not made private arrangements for such treatment under Section 5 (2) of the Act. Individual consultants are free to accept this condition or to delete it from their contract; but, where there are no part-time consultants available in the specialty concerned (as in this case), it would not be unreasonable for the hospital authority to insist on the retention of the clause in order to secure the provision of an adequate service. In brief, therefore, the answer to the questioner depends upon the terms of his contract.

Board and Accommodation

Q.—*I have a contract with a regional hospital board as whole-time consultant. The terms of my contract require that I shall reside in accommodation provided by the hospital management committee at a charge fixed by the committee and approved by the board. Is there an income-tax allowance on the charges for board and accommodation?*

A.—Payments for board and accommodation made in accordance with the contract of service are payments for personal benefits and cannot be regarded as "wholly, exclusively, and necessarily" incurred in the performance of the duties. They cannot be deducted for income-tax purposes from the amount of the emoluments.

B.M.A. FILM LIBRARY

The following films have been added to the film library:

"Varicose Ulcers and Eczema." By T. J. Smith and Nephew, Ltd. Colour, silent, 35 minutes. 1950. (Film presented by T. J. Smith and Nephew, Ltd.)

"Thrombosis and Embolism." By Hoffmann-La Roche Co., Ltd. Monochrome, sound, 37 minutes. 1948. (Film presented by Hoffmann-La Roche Co., Ltd.)

"Haemorrhagic Diathesis." By Hoffmann-La Roche Co., Ltd. Monochrome, sound, 25 minutes. 1949. (Film presented by Hoffmann-La Roche Co., Ltd.)

"Chiropodial Technique." By F. R. Wilde, F.R.C.S., and Miss D. Grant Nisbet, M.Ch.S. 1950. (Copy of film purchased by Association.)

"Streptomycin Drugs in the Treatment of Tuberculosis." By E. A. Squibb and Sons, New York. Colour, sound, 30 minutes. 1950. (Film lodged with the Association on indefinite loan.)

"The Lymphatic System." By Imperial Chemical Industries, Ltd. Colour, sound, 45 minutes. 1950. (Film presented to the Association by Imperial Chemical Industries, Ltd.)

"Functions of Carotid Sinus and Aortic Nerve." By Imperial Chemical Industries, Ltd. Colour, sound, 38 minutes. 1950. (Film presented to the Association by Imperial Chemical Industries, Ltd.)

"Electroencephalographic Control of Anaesthesia." By Dr. Courtin, Mayo Clinic, U.S.A. Colour, silent, 275 ft. 1950. (A copy of the film purchased by the Association.)

"Treatment of Tuberculous Epididymitis." By J. Cosbie Ross, F.R.C.S. Colour, silent, 275 ft., 1 reel. 1950. (A copy of the film purchased by the Association.)

Correspondence

Remuneration of General Practitioners

SIR,—The G.M.S. Committee was of course abundantly right to refuse to accept any basis of G.P. remuneration other than that recommended in the Spens Report and already accepted by both the Government and the profession. The account of the protracted negotiations and your excellent leading article (*Journal*, June 16, p. 1372) make it clear that we must fight for the full implementation of the Spens findings whatever the cost. If any member of the profession still has any doubt about that, nothing I can say is likely to be of any avail. My purpose is to emphasize an aspect of the matter to which I have previously drawn attention and which has not, in my view, received due consideration.

It seems to me that whatever the outcome of remuneration negotiations the advantage under present conditions is invariably with the Government. One way or another they can postpone a decision for so long that, apart from any possibility of a retrospective award, the doctors are deprived of any income increase for several years. If at some future date a reduction in our remuneration was indicated we have little reason to expect that the Government of the day would display a compensatory dilatoriness over a decision to withdraw money from the pool. Moreover, examination of the various factors affecting our income reveals no prospect of such a juncture. On the contrary, everything points towards our being involved in a long series of struggles to rectify a steady decline in our finances relative to those of other groups. At present this decline is so steep and the machinery for dealing with it so tardy that fresh claims for increase in our remuneration have to be lodged before any decision is reached on those outstanding. Ministers of Health come and go; Governments will rise and fall. If we stand firmly on Spens there will indeed be a moment of time when the profession may consider itself justly paid. But with existing negotiating machinery, even if the Spens Report is not lost sight of altogether, the further we look back on it over the years the greater will be the observed discrepancy between what we have actually received and the level of remuneration laid down therein.

Absolute insistence on accurate interpretation and application of the Spens findings as the only possible outcome of the present negotiations is a *sine qua non*. But I have endeavoured to show that prevailing currents and the present rectifying machinery will nevertheless permit Governments to maintain an adverse discrepancy in our standard of life. In practice Spens alone is not enough. Some machinery must be devised that will ensure constant application of the Spens yardstick.

At first sight it would appear that remedy lies in insistence upon all awards being made retrospective. But for many reasons that is not practical politics. Moreover, even if it were possible by this means to ensure ultimate equity, we should still be faced with the appalling prospect of a chronic state of discontent and conflict only momentarily relieved every three or four years. It is intolerable that with a standard of remuneration already virtually settled we should have nothing better to look forward to than a running fight to maintain it against relatively highly organized and powerful opponents. Our reluctance to resort to extreme measures would always turn the odds against us; and, whereas Governments live to fight another day, one defeat for us in a fight to uphold the Spens standard will probably spell our doom. Like nations we must realize that without winning a peace you cannot ultimately win a fight.

The best chance of permanent stability would now more than ever appear to lie in reducing the Spens generalizations to a formula correlating all the factors—e.g., monetary values, number of G.P.s and patients. Once such a formula had been devised and agreed, the question of whether at any given time Spens was being applied would be directly answered by anyone and with little fear of disagreement. The actual application of Spens would be practically automatic except on rare occasions when revision of the formula itself might be indicated.—I am, etc.,

Eye, Suffolk. J. SHACKLETON BAILEY.

The Mileage Fund

SIR,—I should like to point out that the allocation of mileage fund which came into operation with the National Health Service is both inadequate and unfair: inadequate inasmuch as it covers but a very small portion of expenses incurred in travelling within a distance of more than two miles, and unfair because a doctor residing in a rural area may claim mileage for attendance on patients living in an urban area more than two miles from his house. But a doctor practising in an urban area who may have to see patients living more than two miles away in the same area, many of them even as much as four miles from his house, may not claim any mileage grant at all, the distance covered being exactly the same whether he visits patients living in the surrounding rural area or within the same urban area as he does.

What with the increased cost of petrol, minor repairs to car, maintenance, cleaning and polishing, etc., and the so far unrealized expectation of an increased capitation fee, I submit that the present allocation of the mileage fund should be revised, so that a medical man may be encouraged to accede to the requests of patients who once lived within two miles of his house and who are anxious to continue being his patients when they have removed to some other locality as much as four or five miles from his house, without harbouring any sense of grievance on grounds of financial loss. The distance travelled in the course of a doctor's work should be the only thing that matters in deciding the proper allocation of any fund intended to cover—even if inadequately—the cost of travelling, and not whether a medical man lives in an urban area or not.

I trust that the B.M.A. may consider this question and take some sort of action to obtain redress for those who need it. —I am, etc.,

Greenhithe, Kent. D. W. STANDLEY.

*** The Secretary of the B.M.A. states: The whole question of the distribution of the mileage fund is now being considered by a Government committee on which the profession is well represented by rural practitioners.

Dispensing Capitation Fee

SIR,—I am sure that the majority of medical practitioners are unaware that a number of their colleagues are still being paid a capitation fee of 6s. 6d. per annum for the supply of drugs and dressings to patients who live more than a mile from a chemist. This figure was fixed—provisionally be it noted—at the start of the N.H.S. It was specifically stated that the figure would be amended when experience of the Service gave the actual cost per head per annum. Since then the cost of drugs and of dressings has soared, and the costs are still rising. The cost per head has proved to be over five times the 6s. 6d. still being paid to dispensing doctors "provisionally."

In defending itself against a charge of failing to remedy an obvious injustice there are two arguments that the Ministry of Health could use. The first is that the practitioner can, if he wishes, elect to be paid for each script in the same way as the chemist. If so, he must do this for all his patients for whom he dispenses. In actual practice the extra work, particularly the clerical work of costing each script and returning them sorted each month, makes this method impossible without employing a dispenser or clerk. The second argument is that there is an additional payment for "expensive" drugs on a special list. This list is very short and although it includes penicillin and all sulphonamides it does not include any dressings or vitamin preparations or any of the commonly used drugs.

The unfairness of the present drug capitation fee is so obvious that one had hoped the Ministry of Health would increase it spontaneously. There is no indication that it intends to do so. Unfortunately there is no sign that the B.M.A. is moving in the matter either. Could not the representatives at present negotiating with the Minister bring this forward? If they do, they should press for the increase, the case for which is unanswerable, to be made retrospective. The drug bills for this last winter have been, without exaggeration, crippling.—I am, etc.,

Blackwood, Mon. EDWARD J. JONES.

*** The Secretary of the B.M.A. states: The Rural Practices Committee has in its possession sufficient evidence to justify an increase in the dispensing capitation fee. Representations to the Ministry had previously been postponed pending a settlement of the general remuneration question. In view of recent developments, however, the General Medical Services Committee at its last meeting authorized the Rural Practices Committee to negotiate with the Ministry for a higher dispensing capitation fee.

Junior Hospital Staff

SIR,—May I make another plea for junior hospital staff, many of whom now find themselves in a desperate position? These practitioners have never had a square deal under the N.H.S., for their betterment factor was never adequate. In 1948 this was put at 20% (which included superannuation) at a time when wages were at 120% above pre-war figures. The position is far worse now that wages are rising rapidly and that the cost of living is increasing steeply every month. For many of us the position is getting desperate. The only thing left for many young doctors to-day, if they wish to follow their true vocation, is to run themselves heavily into debt, and this is happening on a large scale.

The B.M.A. rightly takes an interest in the troubles of the G.P. It does not, however, appear able to do anything to alleviate the hardships of young doctors in hospital jobs. Many of these are living very near subsistence level, especially ex-Servicemen with families, some of whom are having to live almost on standards rejected by manual workers.

The argument is often advanced that this sort of thing continues only for a year or two, and therefore should be tolerated without complaint. This is totally untrue in the case of a man who wishes to specialize. He cannot get over £890 per annum unless he has been qualified four years at least, and unless he has passed the very high standard required for entry to the Royal Colleges. Up to this stage he has had to stand intense competition to obtain and to hold a training post, and after he has obtained his higher qualification this competition is still further intensified. If he is again lucky he may earn £1,000 a year, subject always to annual review.

Even now, however, there is no guarantee whatsoever that he will ever become a specialist, and thus be able to recoup himself for years of scraping and penury. He has after his three years as senior registrar the option of going into general practice as an assistant and starting at the bottom of the ladder again, or changing to an allied specialty, in which case he must drop his grading to that of junior registrar at a salary which he was earning one year after he qualified, a drop which the Spens Report, as accepted by the profession, never envisaged. We are playing a game of snakes and ladders, only there are very many snakes and very few ladders.

In no other walk of life is a man expected to move his entire home every year or two, entirely at his own expense. The acute housing shortage makes an inconvenience into a great hardship, for he cannot sign a lease or buy a house, and in the London area it is far worse, as there is no salary weighting as in many other professions.

Nothing is done, however, and our sufferings continue. The profession has the power and the moral right to enforce its just demands, without detriment to the patient or the national finances, where thousands are frittered away on needless administration. That nothing is done is due largely to the intransigence and the cheese-paring attitude of the Government (only towards professional employees). The B.M.A. is discussing the registrar cut, and rightly so, but let us also make a stand for a full and honest implementation of the Spens Report, along with our G.P. colleagues. Polite requests to the Government are useless, for the latter only understands trade union methods, where force is always available to gain desired objectives. We must be prepared to fight for ourselves, and we must stick together as a profession, for if we do not hang together we will hang separately. —I am, etc.,

Slough, Bucks. A. ARNAUD REID.

The Position of Registrars

SIR,—In the *Supplement* of June 16 (p. 249) you were good enough to quote some remarks of mine on the registrar situation. I should be grateful if, to avoid any misunderstanding, you would print this brief amplification of the views of the Registrars Group Council.

It is the senior registrar whom we regard as the "trainee." It is for him that we have suggested flexibility of tenure, and we believe that the senior registrar establishment should be governed by prospects of eventual specialist employment (allowing for a reasonable measure of competition).

As far as the registrar is concerned, we are agreed that the future establishment must be governed by the needs of the hospital service. We are agreed that the idea of a "training ladder" based on a definite ratio of registrars to senior registrars is no longer tenable. It is also clear that in future the majority of registrars must find their way into general practice. Despite this, we are concerned that all posts bearing the title "registrar" should carry adequate work and responsibility and should give their holders sufficient experience to enable them to sit for their higher examinations if they so wish. We are anxious that inflation of registrar establishments shall not occur, and we have drawn attention to the following dangers:

(*a*) The appointment of registrars to bolster up an inadequate consultant service.

(*b*) The creation of registrar posts where consultants and senior house officers could between them do the work.

(*c*) The labelling of junior posts as "registrar" in order to attract applicants.

These views have been expressed in much more detail in two memoranda submitted to the Joint Committee, and it is the intention of the Registrars Council that they shall be pressed when our representatives meet members of the Joint Committee next month.—I am, etc.,

Vice-chairman, Executive Committee, Registrars Group Council. R. M. FORRESTER.

Shameful Injustice

SIR,—I recently put forward a series of claims to the medical officer of health, L.C.C., in respect of fees owing both to my anaesthetist and myself for emergency attendances at different maternity cases. The M.O.H., in rejecting same, replied to the effect that, while sympathizing with me in every way, he regretted that he had no power to meet my claims, as I had unfortunately omitted to submit them within the statutory limited period of three months from the date on which I was called in by the midwives concerned. He further stated that any such payment under the circumstances would be illegal, and that the council's officers might be surcharged when the accounts were audited.

As this ruling meant that we should be very much out of pocket I sought advice on the matter from the secretary of my local medical committee and also from the Medical Defence Union. Both authorities confirmed the legal correctness of the M.O.H.'s decision and were able to offer me nothing more than their sympathy.

It seems to me a shameful injustice that a doctor who, owing to pressure of overwork, has inadvertently delayed

the submission of his claim for fees earned, should be so meanly treated. That my anaesthetist should suffer is an added embarrassment. I should be grateful if you would kindly give this subject the publicity it deserves.—I am, etc.,

London, N.4. H. R. CLINE.

Remuneration of House-men

SIR,—I have read with great interest of the recent activities of the General Medical Services Committee in their fight for reasonable conditions of remuneration for general practitioners. Perhaps it would be timely for me to draw attention to the state of affairs appertaining to certain rather more junior members of the profession.

You will agree that it is of considerable value to the young doctor to obtain a post in his own hospital, possibly the more so as the compulsory year's resident appointment comes into force. Among the applicants for these posts is an increasing number of men who saw fit to serve their country in a combatant role during the recent war, many of whom are married and with families to support. Such was my case when I was appointed to a resident post in my own hospital. I have had to resign from this post, my reasons being solely financial.

May I, Sir, remind you of the financial position of the ex-Service student who qualifies with no private means at his disposal? Prior to qualification he has managed on a grant from the Ministry of Education, made up of a maintenance grant, marriage allowance, and graded children's allowance, which, if he has two children, amounts to approximately £420 per annum, tax free, with no liability for superannuation or insurance contributions. On obtaining a house job he gets £350 per annum from the Ministry of Health, which the Ministry of Education is generously prepared to make up to a gross figure of approximately £420 per annum. Even this means that, with the standard deductions of £100 per annum for residential emoluments, superannuation, and insurance, he is roughly £130 per annum *worse* off than when a student. Running expenses for the family remain virtually unchanged, and a cheque for £18 or so for the month does little to keep a home going. Is this what the late Minister of Health meant when he proudly told the House of the young doctor embarking on his professional career free from financial worry?

Considering the situation from the point of view of hours of work, the house-man is in fact earning about 1s. 5d. an hour. I wonder what the Minister of Health pays his charlady? And as for excusing this on the pretext that this post is a part of a doctor's education, this is sheer nonsense! Once a man's name is on the *Register* he should be paid as a professional man and not as an overgrown schoolboy.

Finally, it is surely utterly iniquitous that the newly qualified practitioner should have the choice between a house job at £250 per annum (allowing for residential emoluments) and an assistantship in general practice at £1,000 per annum. Believe me, Sir, I am not ungrateful for the help I have had meted out to me since I returned from the war, but I feel most strongly that to be forced out of a coveted post by the gross inadequacy of what masquerades as a salary is a state of affairs that should be recognized by the profession as a whole.—I am, etc.,

London, S.W.5. JOHN K. PATERSON.

Prescribing in General Practice

SIR,—Some of my colleagues may be interested and intrigued by the workings of the Ministry of Health.

I refer to the letter by the Ministry dated May 23, published in the *Supplement* of June 16 (p. 242). This letter points out the fact, among other conditions, that unless steps are taken to eliminate "unnecessary" prescribing further money will not be forthcoming.

Some months ago we had a letter from Mr. Bevan asking for our co-operation in reducing the drug bill. In reply to this letter I wrote to the Ministry of Health pointing out that, unless the Ministry took the trouble to educate the public to stop asking for unnecessary or pointless drugs and appliances, excessive and unnecessary prescribing *must continue*, or else part of our patients will take their "goodwill" to a more "willing" colleague. To my delighted surprise a doctor from the Ministry telephoned me to say he was keen to come and "sit in" one of my surgeries (a facility which I had offered in my letter). The day arrived, with it the doctor—and the surgery commenced.

When I pointed out at the end of the surgery that at least half the prescriptions issued during its course were unnecessary, I received the reply, "But all the same, these people all feel better for getting attention and their medicine from you."

Can then the Ministry not give us a lead instead of threatening us with the big stick? As things are at present I would be able to save at least £250 per annum on my patients' drug bill (my list is under 3,000 patients) without detriment to any of my patients, but in doing so I am convinced I shall lose at least 40% of my patients within three months and another 20% within a year. My surgeries would last three hours each instead of 1½ hours, I would have to explain why it really is unnecessary to give Mrs. X sodium amytal capsules which have done her neighbour so much good, why phenobarbitone tablets would do her just as much good although they are much cheaper, and why it would be better still if she did not rely on tablets at all but ate a proper meal instead of living on tea and cigarettes.—I am, etc.,

Ewell, Surrey. P. A. BACHMAN.

Reporting to Hospital

SIR,—It is the custom of some consultants to ask a patient to come to see them again or to report to them direct. This is generally undesirable, and when it is an attempt to by-pass the general practitioner it not only harms the consultant but it may cause strained relations between the patient and his doctor.

But what results when hospitals adopt this practice? Let me give you a small series of examples:

(1) A gentleman who had injured his foot was taken to a hospital where a plaster-of-Paris boot was applied. He was sent home by ambulance with a letter to the casualty officer of the local hospital, to whom he was to report the next morning. How was he to get there? He could not walk down his three flights of stairs and he could not summon an ambulance. Who was to advise him, and if necessary treat him, during the four weeks before he was to report to have the plaster boot removed? Why should he have to go back merely to have this done?

(2) A lady whom I had looked after for thirty years was suffering from endarteritis obliterans complicating diabetes which was under control. On the advice of a consultant she was admitted to hospital. On her discharge, still completely crippled and still subject to times of great pain, she was ordered to report to the out-patient department in a month. Behind my back the district nurse was instructed to visit her, although strictly the nurse could work only under my direction. Meanwhile I had arranged for the patient to have a private nurse. I was unlucky not to be present when they met. When I protested against the order to report to hospital after four weeks, if only because of the suffering which the journey would cause, the young registrar gave the not exactly flattering reply that it was necessary for them to see whether there should be any change in the treatment.

(3) A lady had multiple metastases which appeared to be quiescent. Consequent on my report the Currency Control Board had given her a generous allowance so that she could go to the south of France for a change of air. There she was putting on a little weight, feeling better in every way, and having a very happy break, when she suddenly remembered that she was due to report at hospital. Immediately she gave up everything and took the first available plane home. (She did not ask for her fare to be repaid.) Although she had a credit remaining of £80 the poor woman was never fit to complete her holiday.

(4) A woman threatened with complete blindness was sent home without any note for me. She told me that she was to have no more injections and that she was not to report for four weeks. As the case had not been referred back to me it seemed unnecessary for me to continue to attend. But when I looked in in a

friendly way I found the eyes so much worse that I gave her a note and arranged for her to go to the next session in two days' time. She was promptly recommended for early readmission. But she would not have "troubled" me. She would have tried to wait until the four weeks were up.

Cases like these must be happening all the time. On the other hand hundreds of patients, often at the greatest inconvenience to themselves and their friends, not to mention the expense and loss of earnings, are visiting hospitals to show that clean wounds still heal by first intention, that anticipated recoveries continue to take place, and to report the ordinary variation of chronic disease—visits of no value to themselves or anyone else. Their cases are seldom used for teaching and their records are never read or referred to. This is true probably of not less than 90% of the old patients who are thronging the out-patient departments.

I suggest that the results of the present system are:

(1) The hospitals are assuming an impossible responsibility.

(2) The family doctor is being excused from a responsibility which he alone can carry.

(3) The prestige and work of the general practitioner are inevitably degraded and belittled, with eventual deterioration of the whole standard of medicine.

Surely it should be the rule for every patient to be returned to the care of his doctor, and the latter should decide whether it was desirable that the patient should attend at hospital again. (Incidentally this would diminish the pressure on the hospital beds; the O.P. surgeon or physician can send a patient to bed only by admitting him; the family doctor can send him to bed at home.) Cases of special importance can be inquired about by the "follow-up" department.

Although I am drawing attention to excessive—I might almost say morally illegitimate—control from the centre, I would like to add that I have nothing but gratitude for most generous and willing help from members of the staffs of every hospital with which I have had contact; and it is the same skill and kindness which the patients receive which make them so loyal and so willing, at whatever sacrifice, to report on the appointed day. It is the rarest event, too, for the registrar or his chief to fail to send me a detailed report, even if sometimes belated, on the case of every patient who has been seen in O.P.s or has been admitted to the wards.—I am, etc.,

Beckenham, Kent. W. M. PENNY.

B.M.A. LIBRARY

The following books have been added to the Library:

Association of British Chemical Manufacturers Inc.: British Chemicals and their Manufacture. 1951.
Bacon, J. S. D.: Science of Heredity. 1951.
Banks, H. S. (Editor): Modern Practice in Infectious Fevers 2 volumes. 1951.
Barclay, A. E.: Microarteriography. 1951.
Berens, C., and Siegel, E.: Encyclopedia of the Eye: Diagnosis and Treatment. 1951.
Bonnin, J. G.: Complete Outline of Fractures. Third edition 1951.
Bosselman, B. C.: Neurosis and Psychosis 1950.
Büchner, F.: Allgemeine Pathologie. 1950.
Curtis, A. H., and Huffman, J. W.: Textbook of Gynecology Sixth edition. 1950.
Dilling, W. J.: Pharmacology and Therapeutics of the Materia Medica. Nineteenth edition. 1951.
Dry, T. J.: Manual of Cardiology. Second edition. 1950.
Freeman, R. B.: Public Health Nursing Practice. 1950.
Frey, E. K., Kraut, H., and Werle, E.: Kallikrein, Padutin. 1950
Glauner, R.: Die Entzündungsbestrahlung. Zweite Auflage 1951.
Guiraud, P.: Psychiatrie Générale. 1950.
Haberda, M.: Schulhygiene (Schulgesundheitslehre). 1951.
Haler, D.: Aids to Clinical Pathology. Second edition. 1951
Hallows, R. W.: Atoms and Atomic Energy: A Simple Explanation. 1950.
Heisler, A.: Der Arzt als Diener der Natur. 1950.
Heyer, G. R.: Menschen in Not. Band II. 1951.
Hryntschak, T.: Die Suprapubische Prostatektomie. 1951.
Jötten, K. W., and Gärtner, H. (Editors): Die Staublungenerkrankungen. 1950.
Juillard, E.: L'Invagination Intestinale. 1950.
Klein, H. R., Potter, H. W., and Dyke, R. B.: Anxiety in Pregnancy and Childbirth. 1950.
Kogerer, H.: Psychotherapie: ein Lehrbuch für Studierende und Ärzte. Zweite Auflage. 1951.
Lassablière, P.: Sélections Thérapeutiques. 1951.
Madigan, M. E.: Psychology: Principles and Applications. 1950.
Odé, E.: De Ductus Arteriosus 1951.
Pratt, C. A.: Your Children's Feet. 1951.
Raymond, V., and Vallaud, A.: L'Oxyde de Carbone et l'Oxycarbonisme. 1950.
Reich, W.: Character Analysis. 1950.
Sigerist, H. E.: History of Medicine. Volume 1. 1951.
Sleeman, C., and Silkin, S. C. (Editors): Trial of Sumida Haruzo and Twenty Others. 1951.
Stolzenberg, J.: Psychosomatics and Suggestion Therapy in Dentistry. 1950.
Tietze, A., and Kühne, P. (Editors): Aktuelle Fragen der inneren Medizin. Band I, Teil 2. Veränderung der Reaktionslage im Krankheitsverlauf. 1951.
Tournay, R., and Viéville, R.: Allergie et Traitement Sclérosant. 1951.
U.S. Air Force: German Aviation Medicine in World War II. 2 volumes. 1950.
Wolff, E.: Pathology of the Eye. Third edition. 1951.
Woodside, M.: Sterilization in North Carolina. 1950.

H.M. Forces Appointments

ROYAL NAVY

Surgeon Captain C. N. Ratcliffe, K.H.P., has retired.

Acting Interim Surgeon Lieutenant-Commanders R. S. McDonald and G. H. Gunson to be Surgeon Lieutenant-Commanders.

Acting Interim Surgeon Lieutenant-Commander A. P. M. Nicol has been transferred to the Permanent List of R.N., in the rank of Acting Interim Surgeon Lieutenant-Commander.

ROYAL NAVAL VOLUNTEER RESERVE

Surgeon Lieutenant-Commander C. P. Hay has been removed from the Active List.

Surgeon Lieutenant-Commander C. P. Nicholas, V.R.D., has retired.

Surgeon Lieutenants E. V. B. Morton, P. Pattison, and W. P. Small to be Surgeon Lieutenant-Commanders.

ARMY

Brigadier H. T. Findlay, K.H.P., late R.A.M.C., has retired on retired pay.

Colonel R. H. C. Pryn, late R.A.M.C., on completion of four years in the rank, is retained on the Active List supernumerary to establishment.

Colonel G. O. F. Alley, M.C., late R.A.M.C., has retired on retired pay.

Lieutenant-Colonels L. R. H. Keatinge, O.B.E., and W. D. Hughes, from R.A.M.C., to be Colonels.

ROYAL ARMY MEDICAL CORPS

Lieutenant-Colonel C. B. R. Pollock has retired on account of disability.

Majors R. S. Hunt, P. Coleman, and K. F. Stephens to be Lieutenant-Colonels.

Major N. H. Stewart, from Short Service (Specialist Commission), to be Major.

Captains J. J. Voller, D. Gill, and A. A. Gregory-Dean to be Majors.

REGULAR ARMY RESERVE OF OFFICERS

Major-General A. D. Fraser, D.S.O., M.C., late R.A.M.C., having attained the age limit of liability to recall, has ceased to belong to the Reserve of Officers.

Brigadier D. Fettes, C.B.E., late R.A.M.C., having attained the age limit of liability to recall, has ceased to belong to the Reserve of Officers.

Colonel (Honorary Major-General) J. R. N. Warburton, M.C., late R.A.M.C., having attained the age limit of liability to recall, has ceased to belong to the Reserve of Officers.

Colonels (Honorary Brigadiers) R. G. Shaw, O.B.E., M.C., and R. R. G. Atkins, O.B.E., M.C., late R.A.M.C., having attained the age limit of liability to recall, have ceased to belong to the Reserve of Officers.

Colonels D. W. Beamish, M.C., G. D. Harding, A. C. Jebb, and C. O. Shackleton, O.B.E., late R.A.M.C., having attained the age limit of liability to recall, have ceased to belong to the Reserve of Officers.

ROYAL ARMY MEDICAL CORPS

The following Majors (Honorary Lieutenant-Colonels) have ceased to belong to the Reserve of Officers: A. C. Stevenson, E. H. Travers, A. W. D. Leishman, D. Perk, D. A. Lowe, K. E. A. Hughes, M.B.E., W. R. M. Morton, W. A. Oliver,

M.B.E., G. F. Wright, T. G. Faulkner-Hudson, A. L. D'Abreu, O.B.E., C. H. Stuart-Harris, J. M. Black, A. E. Francis, R. S. Handley, O.B.E., N. M. L. Lund, and R. G. M. Longridge.

The following Majors have ceased to belong to the Reserve of Officers: W. H. D. Priest, J. A. Brocklebank, J. N. Heales, M.B.E., R. F. Lawrence, S. D. Loxton, A. N. Fergus, P. W. G. Baxter, J. B. McCallum, S. T. Irwin, R. A. Binning, D. W. Ashcroft, E. Carew-Shaw, E. R. Dansie, G. A. Fowler, P. B. Barker, W. G. France, I. P. J Macnaughtan, R. A. Tennent, M.B.E., R. R. Gordon, M.C., L. C. de R. Epps, D. H. Sandell, J. R. Blackburne, A. St. C. Robertson, B. L. Williams, S. H. C. Clarke, J. H. Chambers, W. M. Macleod, E. H. C. Harper, P. H. Newman, D.S.O., M.C., C. M. Fraser, G. Lorriman, M.B.E., T. J. Fairbank, A. L. Williams, W. MacLeod, H. I. C. Maclean, and A. W. F. Catto.

Captain A. H. W. Fleming, having exceeded the age limit of liability to recall, has ceased to belong to the Reserve of Officers, and has been granted the honorary rank of Major.

SUPPLEMENTARY RESERVE OF OFFICERS: ROYAL ARMY MEDICAL CORPS

Major (Honorary Colonel) G. M. Frizelle, T.D., from T.A.R.O., to be Major, and has been granted the acting rank of Colonel.

Major (Honorary Lieutenant-Colonel) A. D. Briscoe, T.D., from T.A.R.O., to be Major.

Honorary Major W. F. Jepson, O.B.E., formerly Emergency Commission, to be Lieutenant.

TERRITORIAL ARMY

ROYAL ARMY MEDICAL CORPS

Major (acting Lieutenant-Colonel) J. S. H. Wade, M.C., has relinquished the acting rank of Lieutenant-Colonel.

Major F. J. G. Slater, M.C., T.D., to be acting Lieutenant-Colonel.

Captain (acting Major) T. F. Redman to be acting Lieutenant-Colonel.

Captain J. A. Düdgeon, M.C., T.D., to be acting Lieutenant-Colonel.

Captains (acting Majors) C. Giles, K. C. MacKelvie, J. V. Todd, and C. Cameron to be Majors.

Captains A. S. Davie, T. I. Palmer, P. S. Barclay, M.C., R. West, R. H. Baird, C. R. Tilly, M.C., and A. A. G. Flemming, O.B.E., to be Majors.

Captains J. C. Campbell and A. A. Guild to be acting Majors.

Captain A. J. M. Reese has been granted the acting rank of Major.

Lieutenants D. E. Sharvill and J. McL. Ross, M.B.E., to be Captains, and have been granted the acting rank of Major.

TERRITORIAL ARMY RESERVE OF OFFICERS

Colonel J. Kinnear, O.B.E., T.D., R.A.M.C., has ceased to belong to the T.A.R.O.

INDIAN MEDICAL SERVICE

Lieutenant-Colonel J. C. Drummond has retired.

COLONIAL MEDICAL SERVICE

The following appointments have been announced: R. B. Baird, M.B., M.R.C.P., Junior Specialist, Pathology, Medical Department, Nyasaland; R. H. Bland, M.D., M.R.C.P., Assistant Director (Leprosy Contact), Nigeria; D. A. Cannon, M.B., D.T.M.&H., Assistant Director of Laboratory Services, Nigeria; I. J. Christodoulides, M.D., District Medical Officer, Cyprus; T. Evans, M.R.C.S., D.P.H., Assistant Director of Medical Services, Northern Rhodesia; A. F. Fowler, M.R.C.S., D.T.M.&H., Senior Medical Officer, Tanganyika; H. P. Graham, M.B., B.S., Medical Officer, Sarawak; A. Kertesz, M.B., B.S., Pathologist, Nigeria; S. L. A. Manuwa, M.D., F.R.C.S., D.T.M.&H., Director of Medical Services, Nigeria; A. S. Moodie, M.B., Ch.B., D.P.H., Tuberculosis Specialist, Hong Kong; W. J. L. Neal, M.B., B.Ch., Director of Medical Services, North Borneo; J. I. Rerrie, M.R.C.S., D.P.H., Senior Medical Officer (Health), Jamaica; C. M. Ross, M.B., B.Ch., D.T.M., Senior Leprosy Officer, Nigeria; G. H. Wattley, M.D., M.R.C.P., D.T.M.&H., Medical Officer, Grade A, Trinidad; W. J. S. Wilson, M.D., M.R.C.P., Medical Specialist, Jamaica; W. E. Anwyl, M.R.C.S., Medical Officer (Surgical Duties), Somaliland Protectorate; J. V. Fitzpatrick, M.B., Medical Officer, North Borneo; H. N. Mansfield, M.B., M.R.C.O.G., Special Grade Medical Officer, Kenya; L. J. Topham, M.B., Medical Officer (Special Grade), Nigeria; Z. W. Skomoroch, M.D., Medical Officer (temporary), General Hospital, Barbados; M. R. Whitney, M.B., B.S., Medical Officer (temporary), Gambia; H. Trapl, D.T.M.&H., District Medical Officer (temporary), Leeward Islands; R. A. Ingles, L.R.C.P.&S.Ed., F. O. J. Shaw, M.R.C.S., and L. R. Whittaker, M.R.C.S., Medical Officers, Kenya; A. Gerada, M.D., I. Rizzo, M.D., and K. D. B. Thomson, M.B., Medical Officers (temporary), Nigeria; J. H. Comty, M.B., B.S., and D. S. Liu, M.B., Medical Officers, Mauritius.

Association Notices

SCOTTISH COMMITTEE

Session 1951–2

Election of three representatives by the Group of Eight Divisions comprising Orkney, Shetland, Caithness, Sutherland, Inverness, Outer Islands, Ross and Cromarty, and Argyllshire.

More than three nominations having been received for the above election, voting papers have been sent out to all members of the Group of Eight Divisions. As a result of this vote the following practitioners have been elected to fill the three vacancies on the Scottish Committee for the session 1951–2: J. R. Anderson (Fortrose), W. Nicol Gray (Helmsdale), and D. C. Wilson (Inverness).

ARMED FORCES COMMITTEE

Election of Direct Representatives

The following have been elected to the Armed Forces Committee for 1951–2:

Brigadier D. C. Bowie, O.B.E., F.R.C.S.Ed., to represent the R.A.M.C.

Surgeon Captain G. F. Abercrombie, V.R.D., K.H.P., to represent the Medical Branch, R.N.V.R.

No candidates were nominated for election as the representatives of the following:

Medical Branch, Royal Navy.
R.A.M.C. (T.A.).
Medical Branch, Royal Air Force.
Medical Branch, R.A.F.V.R.

A. MACRAE,
Secretary.

Diary of Central Meetings

JULY

3	Tues.	Pay-bed Subcommittee, Joint Committee for Consultants, 11 a.m.
3	Tues.	Merit Awards Subcommittee, Joint Committee for Consultants, 2 p.m.
4	Wed.	Whitley Committee B, Staff Side, 11 a.m. (B.M.A. House).
4	Wed.	Whitley Committee B, 2.30 p.m. (at Richmond Terrace, Whitehall, S.W.).
5	Thurs.	Empire Medical Advisory Bureau, Committee of Management, 11.15 a.m.
5	Thurs.	Special Subcommittee of Rural Practitioners Subcommittee, General Medical Services Committee, 2.30 p.m.
6	Fri.	Services Committee, 10 a.m.
9	Mon.	Committee on Psychiatry and the Law, 2 p.m.
10	Tues.	Registrars Subcommittee, Joint Committee for Consultants, 10.45 a.m. (B.M.A. House).
10	Tues.	Joint Formulary Committee, 2 p.m.
11	Wed.	Registrars Subcommittee, Joint Committee for Consultants, 10.30 a.m. (at Ministry of Health, Savile Row).
11	Wed.	Planning Subcommittee, Occupational Health Committee, 11 a.m.
12	Thurs.	Publishing Subcommittee, 10.30 a.m.
13	Fri.	Ophthalmic Group Committee, 2 p.m.
13	Fri.	Ophthalmic Qualifications Committee, to follow Ophthalmic Group Committee.
18	Wed.	Assistants and Young Practitioners Subcommittee, General Medical Services Committee, 2 p.m.
18	Wed.	International Relations Committee, 2 p.m.

Branch and Division Meetings to be Held

EAST KENT DIVISION.—At Chez Laurie Restaurant, Thanet Way, Herne Bay, Thursday, July 5, 7.30 p.m., dinner; 8.45 p.m., annual general meeting.

METROPOLITAN COUNTIES BRANCH.—At B.M.A. House, Tavistock Square, London, W.C., Tuesday, July 10, 2.30 p.m., annual general meeting. President's Address by Mr. A. Lawrence Abel.

WEST MIDDLESEX DIVISION.—At Ealing Town Hall, Uxbridge Road, Ealing, Thursday, July 5, 8.30 p.m. Subject: "Remuneration." All medical practitioners in the area of the Division are invited.

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