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GENERAL MEDICAL SERVICES COMMITTEE

REMUNERATION QUESTIONS

A meeting of the General Medical Services Committee was held on December 17, with Dr. A. TALBOT ROGERS in the chair. The business occupied the whole day, from 10.30 a.m. to 5.15 p.m.

A communication from the Ministry of Health was placed before the Committee relating to the precise calculation of the central pool 1952–3. One of the matters at issue was the ascertainment of receipts from private practice. The Ministry expressed disappointment that the Committee had not found it possible to agree to the forthcoming Inland Revenue inquiry being used to ascertain private-practice income, but was willing to discuss alternative methods; in the meantime it agreed to the provisional figure of £2m. (the figure taken by Mr. Justice Danckwerts) in the calculation of the central pool, subject to adjustment for under- or over-payment in the following year.

The CHAIRMAN said that it had been pointed out to the Ministry that income from private practice was a diminishing and not an increasing amount. They had been willing to accept the figure mentioned, which was agreed at the time of the Danckwerts award, and if it should be subsequently shown that the figure should have been higher or lower they would consent to adjustment.

The question of monthly payments of capitation-fee remuneration to general practitioners (which was provided for in certain circumstances in the distribution scheme) was another matter which had been discussed with the Ministry. It was stated that in Middlesex, if a monthly payment system were adopted, it would entail, with 1,600 doctors on the list, the permanent employment of two extra clerks by the executive council. On the other hand, Sheffield has been following the system for some time.

The DEPUTY SECRETARY said that the Ministry had carried out its undertaking and in a letter to executive councils had suggested that requests for monthly payment should be interpreted in a reasonable way without insistence on detailed proof of the nature of a practitioner's difficulty. He thought that the Ministry had gone a long way to meet the Committee's view.

Responsibility of Partners

A matter to which the Committee had drawn the Minister's attention was the anomalous position which arose under the terms of service whereby a general practitioner was responsible for all acts or omissions of his deputy or assistant. Whilst this provision was equitable in the cases of assistants and locumtenents, in the case of members of a firm each partner should be held responsible for his own acts. A suggestion from the Ministry was that partners should be held jointly responsible, and that where both agreed that the deputy should accept responsibility then the practitioner on whose list the patient's name appeared would take no further part in any proceedings.

It was pointed out that under the Ministry's scheme it would be possible for a medical services committee, having had one of the partners before it and finding no case against him, to call upon the other. Dr. GORSKY said that it was possible for the partnership agreement to contain certain clauses respecting indemnity which would be rendered null and void in these circumstances. There were certain dangerous implications in all this, and he suggested that it would be well to consult with the secretaries of the defence societies.

Dr. DAIN said that not only should a partner be covered, but any deputy should take his responsibility for what he did. It ought to be ensured that a doctor should not be proceeded against when either a partner or a deputy had acted for him.

It was agreed that the Chairman, with Dr. Dain, Dr. Gorsky, and Dr. J. T. Baldwin (representing Scotland), should discuss this matter with the defence societies.

General Practitioners on Regional Hospital Boards

The CHAIRMAN said that it had been pointed out by the Ministry that in composing the regional hospital boards it was necessary to have regard not only to the type of persons nominated and their experience but also to certain geographical conditions so as to ensure an appropriate distribution of representatives. Therefore it was suggested that when submitting nominations more than one name should be put forward, to avoid the possibility of the rejection of the single nominee purely on geographical grounds. This was agreed to as a general procedure, but it was felt that it would be inappropriate to put forward additional names when a representative who had served already and was eligible was prepared for re-nomination.

Clinical Research in Relation to the N.H.S.

The White Paper on clinical research in relation to the N.H.S., issued by the Medical Research Council, was the subject of some comment. Dr. B. CARDEW strongly impressed on the Committee that, in co-operation with the College of General Practitioners, it should urge at once that general-practitioner research should be undertaken. This should be done before the new Clinical Research Board had laid down its plans, which otherwise might not adequately cover general-practitioner aspects. Dr. F. M. ROSE thought that the Committee and the College would be in a stronger position if it had actual representation on the Board. It was also urged that some part of the fund of £250.000 should be allocated directly to general-practitioner research, otherwise it might be devoted entirely to hospital research projects. It was agreed that the College should be invited to make joint representations to the Research Board.

Student Entry and General Practice

A report was presented by a subcommittee which has been studying how medical manpower is related to the present intake of students into medical schools. The subcommittee had arrived at the conclusion that the Council should be asked to invite the Ministry to co-operate in the setting up of a working party to examine on a long-term basis and with the widest possible terms of reference the future number of general practitioners likely to be required in all branches of the profession and to relate these needs to the intake of students (see leading article at p. 83).

The CHAIRMAN said that many aspects had to be considered, including the diversion of medical manpower to the colonial services, the armed Forces, public health, and industrial medicine. Some figures had been worked out and were presented to the Committee in the form of tables and graphs, showing that as the years went on a certain number of qualified people would be looking for posts over and above those required to fill the vacancies which occurred through death or retirement in the different sections of the profession. With a more or less fixed establishment in the hospital and other services, the only big field open to absorb those who were otherwise redundant was general practice, into which more and more students would go.

Dr. P. J. GIBBONS suggested that a factor on the other side might be the growing disinclination of parents to encourage their children to enter medicine. The number of posts in the higher ranks was more or less fixed, and this alone prevented many able people from entering the profession. The DEPUTY SECRETARY pointed out that there had been a consistent rise (except for the immediate post-war years) in the numbers on the *Medical Register* over the last quarter of a century. The conclusion was inescapable that more and more doctors would be coming into the field of general practice every year.

The recommendation for the setting up of a Working Party was agreed to unanimously.

Geriatric Units

The Liaison Committee (of consultants and specialists and general practitioners) recommended that a joint subcommittee should be appointed forthwith to give further study to the establishment of an integrated service for the treatment and rehabilitation of those chronically disabled by age or illness. Several members gave their experience of the work of geriatric units and of the conditions for the treatment and accommodation of the elderly. Dr. C. F. R. KILLICK referred to the tendency to look upon old age itself as a disease, and to deny the use of general hospitals to old persons suffering from some disease and to consign them to special hospitals for the aged. Other members also deplored the modern tendency on the part of many young people to waive their responsibilities to aged relatives. Dr. SORSBY considered that the teaching hospitals and their schools should take over some of the responsibility for looking after ageing people. It would be useful for students who intended entering general practice to learn something in hospital about the treatment of the aged, and this was one of the ends to which also nursing training should be directed.

After some further discussion it was agreed that the suggestion of a special subcommittee should be supported and that there should be four representatives of each of the committees concerned—General Medical Services, Consultants and Specialists, and Public Health.

Guillebaud Evidence

The Committee devoted considerable time to a draft memorandum on aspects of the National Health Service from the point of view of general practice to which it considered that reference should be made in the Association evidence to the Guillebaud Committee. The memorandum dealt with general administration, finance, pharmaceutical services, and other matters of important policy.

The views submitted by local medical committees were carefully considered and a number of them were incorporated in the memorandum of evidence.

Vacant Practice: Acceptance of Patients

Dr. ROBERT FORBES and Dr. ANNIS GILLIE attended as representatives of the Central Ethical Committee to discuss further the fixing of a time limit after which an acting practitioner in the case of death or retirement of a doctor would be freed from any obligation not to accept as his patient anyone to whom he had been introduced or with whom he had been in professional relationship while acting as locumtenent until the successor in the practice was appointed.

Dr. FORBES said that this arose out of a previous discussion between the two committees, which had appeared to be in agreement except for the time limit attaching to the bar they were seeking to impose. The Central Ethical Committee had suggested that a local practitioner who acted in the interval between the vacation of a practice through death or retirement and the appointment of a successor should refrain during that period and for 12 months thereafter from accepting as his patient any patient of the practice with whom he had been in professional relationship, except, of course, with the consent of the successor. Further, that a whole-time locumtenent specially engaged for the purpose of keeping the practice in being should similarly refrain for five years from setting up in the area. It was pointed out that the practitioner in possession during the interval was in a position of peculiar advantage in his access to patients.

The difficulties of the situation were discussed at length and various possibilities were envisaged. The feeling of the Committee was that it would be impossible to lay down any rule to satisfy all parties. One member said that the Ethical Committee was trying to maintain a ruling made for entirely different circumstances—that is to say, for the pre-N.H.S. period when goodwill in a practice still existed.

A form of words was suggested by the Secretary of the Association and approved for the consideration of the Ethical Committee at its next meeting.

Other Business

Dr. CATHERINE HARROWER presented a report from a joint subcommittee which, with representatives of the Public Health Committee, had been considering ways and means of effecting better co-operation between the general practitioner and the health visitor. A short statement on the subject was agreed to for submission to the Council, and subsequently with the Council's approval for issue to divisional secretaries, secretaries of local medical committees, and medical officers of health, and for publication in the *Supplement*.

Some criticism was expressed concerning a draft leaflet on whooping-cough prepared by the Central Council for Health Education. The criticism was on the ground that it was likely to cause unnecessary worry for the doctor. It was agreed to ask the representative of the Committee on the Central Council to draw attention to the points of objection.

A brief report was made on a meeting of representatives of the pharmaceutical industry and the National Pharmaceutical Union to discuss the differential rate of discount allowed by manufacturers to dispensing doctors and to retail pharmacists. The matter was referred to the Rural Practices Subcommittee.

An alleged increase of suicides due to the ingestion of barbiturates and other sedatives was brought forward in a letter from the East Sussex Local Medical Committee, which suggested the advisability of urging the Minister to make regulations restricting the quantity of drugs and preparations ordered by doctors on N.H.S. prescriptions. The proposal, however, was not considered acceptable.

Several matters on the agenda were deferred until the next meeting.

EXCHANGE VISITS WITH CANADA AND THE U.S.A.

The scheme for exchange visits between members of the American, British, and Canadian Medical Associations, which has the approval of the Bank of England, will be continued this year.

Procedure

Three doctors from Britain may visit Canada in exchange for three doctors from Canada. Each doctor from Britain will be required to make all his own travel arrangements, and will also be required to deposit up to £200 with the B.M.A. in London. On arrival in Canada he will receive the equivalent in Canadian dollars. Similarly, each Canadian doctor on arrival in Britain will receive the sum deposited in sterling.

Three doctors from Britain may visit the U.S.A. in exchange for three doctors from the U.S.A. Each doctor from Britain will be required to make all his own travel arrangements, and will also be required to deposit up to £200 with the B.M.A. in London. On arrival in the U.S.A. he will receive the equivalent in U.S. dollars. Similarly, each U.S. doctor on arrival in Britain will receive the sum deposited in sterling.

Duration of Visits

The duration of the visits is left to the discretion of the doctors concerned. The American, British, and Canadian Medical Associations cannot accept any responsibility for a doctor who allows his visit to outlast the money placed at his disposal.

Applications are invited from members of the B.M.A. to take part in such exchanges during the next financial year—i.e., April 1, 1954, to March 31, 1955. Each applicant must state the object of his visit. Medical practitioners in all branches of the profession, including general practice and public health, are eligible. Applicants should also give approximate dates of the visit desired. (Successful applicants will in due course be required to furnish exact dates and details of travel.) Applications must be received by the Secretary of the Association by March 1, 1954.

RECIPROCITY OF PRACTICE

AUSTRALIAN STATE'S LEGISLATION

The Victorian Legislative Assembly has passed a Bill which will allow graduates of medical schools from Britain and other countries of the British Commonwealth to practise in the State of Victoria. The New South Wales Parliament introduced similar legislation several months ago.

A Legal Difficulty

Introducing the Bill, the Minister for Health explained that the British Government had amended its own medical legislation to allow Commonwealth graduates to practise in England without doing a postgraduate course there. The Victorian Bill was a reciprocal arrangement with the British Act. It was not contemplated at present, he said, to make any change in the requirements for the registration of medical graduates from countries outside the British Commonwealth. They would still have to pass a medical course at an Australian university.

The difficulty, a purely legal one, about reciprocal recognition of registration first arose when Britain introduced the compulsory pre-registration year into the medical curriculum.

U.S. COMMITTEE'S STUDY OF MEDICAL SERVICES

Mr. Charles A. Wolberton, chairman of the U.S. Congress Committee on Interstate and Foreign Commerce, during his visit to Australia in the course of a world tour of inspection, said that he and other members of his committee had recently examined the British health services. He had been surprised to find that "the opposition to the British scheme, evident at its introduction four years ago, had now disappeared. There was splendid co-operation between the doctors and the public health authorities, and many early problems had been overcome."

Mr. Wolberton's committee deals with legislation on such matters as public health and medical and scientific research. It examined health schemes in France, Sweden, and Spain as well as Britain.

OCCUPATIONAL HEALTH

FITNESS OF TRANSPORT DRIVERS

The Occupational Health Committee of the Association held an all-day meeting on December 16, with Dr. J. A. L. Vaughan Jones in the chair. It was announced that Drs. G. E. Graves Peirce, J. M. Rogan, and J. S. Spickett had accepted co-option.

The Future of the Services

A report was made on the Council's reception of the Committee's memorandum on "The Future of Occupational Health Services"—a report to which more than one meeting of the Committee has been devoted. The Council had found itself unable to accept the wording of two paragraphs, and amendments of these had been agreed to by the Chairman of the Committee with the Chairmen of the Council and the Representative Body, and the amended memorandum submitted to the Ministry of Labour and National Service.

List of Industrial Medical Officers

The Committee again considered the practicability of compiling a list of all industrial medical officers. The Association maintains a list of whole-time officers, but no list of part-time officers at present exists. The difficulties of obtaining a complete list were explained. A suggestion was made that the help of local medical committees might be enlisted for this purpose, also that information might be available through divisional secretaries.

It was agreed to ask the General Medical Services Committee whether in its view the information would be available through local medical committees, perhaps in collaboration with executive councils.

Medical Standards for Road Transport

The Committee devoted more than two hours to a memorandum prepared by a subcommittee under the chairmanship of Dr. L. G. Norman on medical standards for road transport. The original terms of reference of the subcommittee included rail and air transport, but Dr. Norman said that as yet only brief consideration had been given to these two groups, and both railways and airlines had their own medical services. Moreover, so far as airlines were concerned the medical standards for aircrew were laid down by international agreement and were constantly under review. The subcommittee therefore felt it desirable without delaying to complete its reference to put forward at once the conclusions reached with regard to road transport.

The report, which will be published in due course, presents information concerning present visual and hearing standards, physique, general medical condition, including emotional stability, and frequency of examinations, and includes a long series of recommendations (which were accepted) for the examination of public service and heavy goods vehicle drivers and private car drivers, and also a revised draft form of medical report.

Remuneration of Industrial Medical Officers

A report from the Remuneration Subcommittee expressed the view on a preliminary consideration that the existing recommendations for the remuneration of industrial medical

officers were too rigid. Many large industries did not wish to be tied to an incremental scale of 6% per annum. In some instances they preferred to give an industrial medical officer with two to three years' experience an increase amounting perhaps to the total of his probable increments for the ensuing five years and then to keep him at that higher salary for several further years. But it was essential to ensure that there were reasonable increments leading to a maximum within the range laid down by the Association. A revised draft of the existing recommendations will be submitted to the Committee at its next meeting.

Occupational Dermatitis

A report was presented by Dr. H. Alexander on behalf of the Occupational Dermatitis Subcommittee. Two films on industrial dermatitis were seen, one by Imperial Chemical Industries for professional audiences and the other by the Ministry of Labour and National Service for lay audiences. The latter came in for some criticism in that it gave the impression that occupational dermatitis was normally cleared up in 10 days, that whilst the patient was on the sick list the treatment was given at the factory, and that insufficient emphasis was laid on the desirability of changing the man's job inside the factory to avoid absence from work altogether—in the words of one member of the Committee, "the film gave a general impression that industrial dermatitis was just the easiest thing in the world to deal with."

New Approach about Notification

It was also reported by the subcommittee that discussions on the possibility of making occupational dermatitis a notifiable disease and attempts to secure that employers were notified in all cases where an employee was receiving industrial injury benefit had so far proved unsuccessful. The subcommittee felt that a completely new approach should be made to the Ministry of Pensions and National Insurance on this subject and a memorandum was being prepared for the next meeting. It was realized that the problem was bristling with difficulties. Dr. A. Meiklejohn suggested that something should be done on the lines of the memorandum on medical standards for road transport which had just been considered—a memorandum which could go to the Ministry of Pensions and National Insurance.

A suggestion was made that the preparation of advisory notes on the treatment of acute skin inflammations in the initial stages might prove useful to a number of general practitioners in avoiding the use of substances likely to aggravate skin diseases. The Chairman suggested seeking the views of the Dermatologists Group Committee.

The draft proposals for legislation in connexion with the Gowers Committee report on health, welfare, and safety in non-industrial employment were deferred for consideration to a later meeting.

REMOVAL FROM THE MEDICAL REGISTER

ADDRESS NOT KNOWN

In the course of discussion of a matter put before the General Medical Services Committee at its meeting on December 17 by Dr. Bruce Cardew it was mentioned by him that 1,692 names were removed from the *Medical Register* in 1952. This large number represented the periodical purge of the *Register*, which the G.M.C. is bound by statute to carry out, of the accumulation of names of doctors who cannot be traced.

Doctors who change their permanent address should always notify the G.M.C. Those who have changed their address and have not notified the G.M.C. should find out if they are still registered practitioners, because their legal status depends upon the fact that their name is included in the *Register*.

THE PRIVATE PATIENT

SECTIONS OF HEALTH SERVICE AVAILABLE

Some patients believe that they are bound to obtain their family doctor service through the National Health Service to qualify for National Insurance benefit, or to have the use of other sections of the National Health Service.

There is no foundation in this belief, and, in view of inquiries received, the Private Practice Committee has considered it wise to set out the present position.

Open to Choice

The National Health Service is available voluntarily in full or in part to all the population of this country excluding the armed Forces. It is thus possible to obtain separately the benefits of any of the following sections of the Service:

(1) Family Doctor Service; (2) Specialist and Hospital Service; (3) Dental Service; (4) Supplementary Ophthalmic Service; and (5) certain services provided by the local authority, as, for example, ambulances, school clinics, and home helps.

At present selection within a section of the Service is not permitted. For example, despite repeated representations to the Ministry, a patient receiving attention from his family doctor under private arrangements cannot obtain his medicines under the National Health Service. He can, however, take advantage of any other part of the Service.

National Insurance Separate

National Insurance is obligatory for very many of the population, and the benefits are not contingent in any way on participation in the arrangements of the National Health Service. These benefits of National Insurance, where applicable, include unemployment benefit, sickness benefit, retirement pension, widow's benefit, guardian's allowance, maternity benefit, death grant, and industrial injury benefit.

JOINT COMMITTEE ON PRESCRIBING

MINISTRY'S REASSURANCE ABOUT COSTS INVESTIGATIONS

The publication of lists of preparations classified in categories 5 and 6 by the Joint Committee on Prescribing has raised doubts in the minds of some practitioners about their liability to surcharge in the event of preparations in these categories being ordered for National Health Service patients. The letter from the Chief Medical Officer to the Ministry of Health, which was enclosed with the copy of the Joint Committee's classifications sent to every medical practitioner, stated that, while doctors were asked not to prescribe articles in categories 5 and 6, this request was without prejudice to the individual practitioner's right to prescribe whatever drugs he considered necessary for any particular patient, though he might subsequently be called upon to justify his action before his colleagues on the local medical committee.

The General Medical Services Committee has now taken this point up with the Ministry of Health. As a result of the Committee's intervention, and to remove any possible misunderstanding, the Ministry has given a categorical assurance that those drugs listed in categories 5 and 6 will *not* be referred by the Pricing Bureaux for investigation merely because they come within these categories. Indeed, the Regulations themselves do not permit of investigations on this count. Only where the individual practitioner's prescribing costs are substantially above the average for his area and are the subject of an inquiry on those grounds will the prescribing of drugs in categories 5 and 6 be one of the factors which may be taken into account. In such circumstances the frequency of prescriptions for substances in the two categories will also be considered.

B.M.A. LIAISON MACHINERY

PUBLIC HEALTH REPRESENTATION

The Consultants and General Practitioners Liaison Committee was originally appointed, as its name suggests, to discuss matters of common interest to consultants and general practitioners. At its last meeting on November 11 the chairman suggested, and the Committee agreed, that it would be advantageous to include in its membership representatives of the Public Health Committee. The Committee therefore recommended the proposal to its parent committees, the Central Consultants and Specialists Committee and the General Medical Services Committee, both of which approved the recommendation.

The Public Health Committee has accepted the invitation and has appointed the following to the Liaison Committee: Dr. K. Cowan (chairman of the Public Health Committee), Drs. H. D. Chalke, S. C. Gawne, J. Kelman, Llywelyn Roberts, and J. B. Tilley.

OPHTHALMIC GROUP COMMITTEE

The meeting of the Ophthalmic Group Committee, held at the Association Headquarters on December 11, was mostly occupied with two matters still largely in the confidential stage. One of these was the statutory registration of opticians following the recommendations of the Crook Committee, and the other the preparation of evidence for the Guillebaud Committee. Mr. O. Gayer Morgan occupied the chair.

Statutory Registration of Opticians

It was reported to the Committee that a joint deputation appointed by the Faculty of Ophthalmologists and the Group Committee had attended at the Ministry to discuss the action to be taken following the report of the Crook Committee. It is hoped to have further discussions with the Ministry at a later stage, after which the Group Committee's representatives will report again.

The Guillebaud Committee

The Group Committee then considered the draft memorandum of evidence prepared for presentation to the Guillebaud Committee by the joint subcommittee with the Faculty of Ophthalmologists. The problem was considered under two main headings: (1) "Would the replacement of the present per capita Supplementary Eye Service by a sessional clinic service under hospital authorities lead to a more economical use of public funds, as well as allow for the integration of the work of ophthalmologists, opticians, and orthoptists?" and, if such should be the case, (2) "What steps can be taken to provide more eye clinics with suitable staff?"

The DEPUTY SECRETARY pointed out that some members wished to see an extension of the hospital service whereas others desired an extension of the supplementary ophthalmic service. Was there not scope for a middle course? He thought the draft memorandum of evidence took the middle line. It hinged on one recommendation, that the financial control and administration of all ophthalmic services should be brought under the hospital and specialist service. Perhaps it had not been sufficiently stressed that if the ophthalmic medical practitioner was working in the clinic he would enjoy an enhanced status, would be permitted to undertake treatment, and have opportunities for promotion and advancement in the hospital service. The supplementary ophthalmic service would, however, continue side by side with the hospital service.

Dr. J. N. TENNENT was asked briefly to present certain points he had suggested on the ground of economy. These suggestions were mainly concerned with improvements in the supplementary ophthalmic service, and a number of them were agreed for inclusion in the memorandum of evidence.

Eventually it was agreed that the report be revised by the Deputy Secretary in the light of the views expressed in the discussion, that any figures of cost, etc., given as examples, should be the result of expert scrutiny, and that the revised memorandum should be submitted to the chairman of the Group Committee (Mr. Gayer Morgan) and the chairman of the Faculty of Ophthalmologists (Mr. J. H. Doggart), after which it could go forward to the Council of the Association as an agreed document.

Spectacle Frames for Schoolchildren

Dr. I. LLOYD JOHNSTONE brought forward the matter of the free range of spectacles for schoolchildren. He said that Worcester Ophthalmic Services Committee had resolved to urge upon the Minister that a serviceable frame strong enough and suitable for children could not be manufactured from the white metal material at present in use for frames C.221 and C.223, and that rolled gold frames should preferably be made available in the free range for children, or, alternatively, that frames of basic material similar to the hospital steel frame in use before the war, but suitably covered, should be substituted. The Ministry, however, felt that there was no evidence that nickel frames were not strong enough for children, nor that gold-filled frames were more serviceable than nickel.

Dr. Lloyd Johnstone demonstrated to the Committee a pair of child spectacles with cylinders in the region of +4.00 D, in which the frames were very easily bent and the child was wearing the glasses with the axes of each cylinder roughly 20° out of position. Even when straightened they could not be expected to stay in the position for long.

The Committee agreed to look into the problem.

"Reminders" by Opticians

A letter from the Guild of Dispensing Opticians concerning the sending out of "reminders" was read. The Group Committee's view was that "reminders" were unethical and unprofessional. Some ophthalmic opticians had alleged that "reminders" were sent out by dispensing opticians which indirectly resulted in sight-testing appointments being made for ophthalmic medical practitioners, and the Guild of Dispensing Opticians had been asked to recommend their members not to solicit their clients in any way for sight-testing appointments. The Guild had replied that it was emphatically against the issue of any communications by dispensing opticians which related to sight-testing. This was the exclusive province of the ophthalmologist; but there was nothing unethical, improper, or provocative in the issue of communications offering adjustments to the spectacles of former patients. By this means dispensers provided a useful after-service, and would much resent being asked to discontinue such a long-standing practice.

Mr. G. W. BLACK said that he was gravely perturbed about this question, and thought the Group Committee should reaffirm its opinion that the sending out of circulars of any kind should be discouraged.

This was the general feeling of the Committee, and the matter is to be reopened with the Guild.

Service Opticians

It was reported that after a meeting with representatives of the Service departments and the Ministry of Health which was attended by the chairman of the Group Committee and other members the proposals made by the Committee concerning sight-testing of dependants of Service personnel appeared to be favourably received—namely, that Service ophthalmologists should have complete responsibility for the work of the Service eye centres, including responsibility for scrutinizing and signing prescription forms for glasses. In reply to a recommendation on these lines the War Office now stated that the recommendations of the Group Committee were already in operation in the Army, opticians carrying out refraction work only under supervision, and the

completion of prescriptions was carried out by ophthalmologists. It was also intimated that the same thing applied in the Royal Air Force.

In the circumstances it was agreed that no objection could be taken to the proposal that ophthalmic opticians in the Services should be entitled to apply to have their names included in the central list in order that they might treat Service dependants under the supplementary ophthalmic service.

ABERDEEN APPRENTICESHIP SCHEME

A GOOD START

Early last year the City of Aberdeen Division of the B.M.A. with the co-operation of the Executive Council and University put forward its scheme for the voluntary apprenticeship of fifth- and final-year medical students during their vacations to general practitioners (*Supplement*, March 28, 1953, p. 94).

Keen Students

The scheme got off to a good start in the summer vacation and it is reported that two-thirds of the students of the year took part. Several more are booked for this Christmas and for the Easter vacation. Each student stays a month with a G.P. The students are said to have been more than satisfied with the instruction and encouragement they got; and in turn the practitioners found the students diligent pupils, and both sides were stimulated by their association.

The Patient

The patients seem to have received the apprentices well. A little screening was necessary here and there, and with this, and some tact, there were no difficult situations. Clinical teaching is not the main object of the scheme. Greater emphasis is placed on what is called the "general practitioner bedside manner." The student also obtains an insight into the technique of general practice.

A university spokesman has said that the experiment has been very successful and he hopes that it will be continued in the years to come.

Questions Answered

Trainee Assistant's Expenses

Q.—*As trainee assistant during the financial year 1951–2 I was paid £850 plus £150 car allowance. (1) A condition of employment was that my wife and I were responsible for answering the telephone every other week out of office hours, and I wished to pay my wife £60 per annum for this. The Inland Revenue did not allow this. (2) Is subscription to a medical protection society allowed as an expense? (3) When I was previously doing a house job and did not need a car for business, my father gave me his car, which he had used for general practice and had claimed tax relief. This was worth about £700 in the second-hand car market. The income-tax authorities worked out its value from January, 1949, when it was bought and was worth £600. For 1951–2 they allow me only £83 wear-and-tear allowance, which with other car expenses comes to only £176 8s. Are they correct?*

A.—(1) Seeing that it was a condition of the employment that the questioner and/or his wife should be responsible for answering the telephone every other week, and that the questioner himself could not have been expected to be always available for that duty, it follows that he should be entitled to treat as an expense "wholly, exclusively, and necessarily incurred in the performance of the duties" a reasonable amount payable for the service which he himself was unable to render. Whether £60 was a reasonable amount to be paid must depend on the circumstances; it seems reasonable enough. (2) The subscription to a medical protection society is not allowable unless continued membership was an expressed condition of the employment. (3) With regard to the car given by the questioner's father, the allowance is not strictly due in law if it was given before July 9, 1952—gifts on and after that date are governed by the provisions of the Finance Act, 1952. The allowance would in any case not become due until the car was actually used in such a way as to make the running costs legitimate expenses for income-tax purposes. It is understood that in such circumstances the commencing value is in general calculated by reducing the original cost of the car by the appropriate yearly income-tax allowances for wear and tear—which would similarly form the basis for any adjustment of the donor's liability. That point would apparently apply in this case, as the father had used the car for business purposes, and the revenue authorities would be justified in adopting for the questioner's commencing value the value at which the car dropped out of the calculation of the father's liability.

Correspondence

The Registrar Problem

SIR,—The long-term policy for the ultimate settlement of registrars appears to be little nearer solution. Would it not be possible for a B.M.A. subcommittee to look into the possibilities of the better utilization of our Colonies?

As a career, the Colonial Medical Service does not appeal to many registrars and consultants, but if the Colonies could be used in the training of registrars it would be of great benefit to both. Those who have not been to the Colonies do not appreciate how excellent are some of the hospitals and ancillary departments, and, as has already been pointed out, there is a shortage of medical manpower.

For example, if registrars were not permitted to do their full 5 years' training in a teaching hospital, but had to do (as a routine) 2 or 3 years in either a non-teaching hospital or the Colonies, they would undoubtedly get much more practical work and responsibility. They could do 1–2 years in a teaching hospital first (say until they had obtained higher qualifications), then 2–3 years as suggested, and return for their final year to a teaching hospital for the necessary polish and gloss.

The teaching centres might object—particularly on two points: (1) that they would not get such good continuity as regards the teaching of students, and (2) that in "super-specialties" a registrar requires the full 5 years in that branch of medicine. I do not think either theory is valid. It is doubtful whether a registrar is of real value for teaching until about his fifth year. As regards the super-specialty, it is surely better in all branches of medicine to get a liberal education first. The argument that this would make the training of a super-specialist impossibly long could be overcome if he (or she) started in the fifth year, and thereafter—if considered suitable for further training—he could be upgraded in salary to the equivalent of a consultant, and either given this status or an equivalent, which would soon receive full recognition in the medical world. As regards ultimate settlement of registrars as consultants, some might find places in the Colonies from personal contacts, and surely soon there must be more consultant posts available in this country for others.—I am, etc.,

Harrogate. C. RUTHERFORD MORISON.

The Obstetric List

SIR,—I have long felt that the principle behind the Obstetric List is an objectionable one, and that it should be abolished. The criteria adopted for admission to the List have been such that every young man entering general

practice feels that he can and must quickly satisfy them—he feels that he is an incomplete doctor if he is not on the List. The examiners who have qualified him have found him to be a complete doctor, but the local obstetric committee disagrees with this and insists on another 20, or 50, or some number, of confinements to be done first. A list based on such a system is clearly objectionable, and one fails to see how its exponents can counter the argument: if the standard of midwifery which allows qualification is too low, let the G.M.C. raise it.

It has recently occurred to me, however, that in the Obstetric List we have the possibility of putting into practice a vital principle which so far is completely missing from Part IV of the National Health Service. The man of long experience receives no practical recognition or reward. An Obstetric List could well make good this omission, even if only in one corner of the field of medical practice. A List which could be entered only after, say, 20 years of general practice would be something which we could well accept. It might be difficult to resist a claim that a man with much shorter experience but with a higher obstetric qualification should also be given a place on the List, but care should be taken that no one would get there merely by a process of "cramming." The completely qualified doctor with less experience would be free to practise midwifery as of old and competent to be called in by any midwife, and should command a proper fee (not the present miserable 5 guineas). The Obstetric List would be a list only of older, really experienced, practitioners, and the increase in their fee would be purely a bonus for their long years of experience. The Obstetric List to-day appears to be the thin end of a wedge. But whether the developments which it foreshadows are desirable or undesirable depends on the spirit in which it is worked, and the present spirit is the wrong one.—I am, etc.,

West Bromwich. D. SAKLATVALA.

The Private Physiotherapist

SIR,—The letter over the name Miss Patricia Lynch (*Supplement*, December 5, 1953, p. 220) is one deserving of notice by general practitioners, perhaps especially so by those in semi-rural practices. I have often been impressed by the results of good physiotherapy, but I am well aware how many doctors regard the methods of physical medicine only as a last resort. This form of treatment is consequently used mainly when the doctor is tired of seeing the patient himself, has run through his favourite prescriptions, or done his own line of manipulation, bandaging, strapping, or even suggestion.

I believe general practitioners have got into this habit because the hospital physiotherapy departments are so crowded and the results to the patient as a whole not as good as one would wish for. In the days of private practice one was frequently greatly helped by the services of a private physiotherapist—massage and exercises for strains and sprains, ultra-violet light for some "skins," breathing exercises for the asthmatics and so on. I wonder if other doctors are finding that they are reluctant to send these cases to hospital. The set-up is too elaborate and one is in danger of losing sight of the patient for months.

It seems that the answer is in Miss Lynch's letter. It should be possible to use the services of the private physiotherapist under the general practitioner's direction—much as we call in the aid of the district nurse—without expense to the patient.—I am, etc.,

Great Missenden, Bucks. H. DESMOND ROBINSON.

Remuneration of Hospital Medical Staff

SIR,—May I crave space to support in the strongest possible manner Dr. E. Snell's letter (*Supplement*, December 19, 1953, p. 237) on this iniquitous injustice and to call on those who are unable to augment their incomes with distinction awards, large numbers of domiciliary visits, or appreciable private practice to write to the *Journal* supporting Dr. Snell and to demand action.

Without additional remuneration the specialist to-day has a sorry time on his salary, and it would appear as if those in control of our affairs are either in ignorance of these difficulties or treat them with indifference. We have been kept so much in the dark as regards this problem that we can only assume various facts: (1) that in some way the Consultants and Specialists Committee were persuaded to keep out of any review of Spens salaries and the appropriate betterment factor and to allow the G.P.s' case to go forward as a "test case"; the wisdom of such a decision is now self-evident; (2) that the income of 95% of G.P.s was radically slashed as a result of the Service, hence a united action in which their leaders were personally interested and affected; (3) that those who guide the affairs of specialists are self-satisfied financially and are therefore prepared to listen to the blandishments of those in power who murmur, "National economic crisis."

The time has surely come to publicly demand justice and to inform those who benefit from the hospital service that the doctors who are in charge of their ills are, after a minimum of 14 years' training, expected to live on what has been agreed as an equitable salary in 1938–9 plus a 20% betterment factor in lieu of an 80–100% factor as agreed in a court of arbitration in the case of our more fortunate colleagues, whose salary has been adjusted retrospectively to 1948.—I am, etc.,

Southampton. BERNARD SUGDEN.

Service Recruitment

SIR,—The recent correspondence with regard to the remuneration of practitioners in the Forces has not, I think, done justice to our colleagues. The situation is that the Armed Forces Committee, when their opinion was sought just after the war, advised that medical students should complete their National Service before they started on their medical career. This advice was rejected, presumably because it was felt that the Government should have a call on the services of an adequate number of young doctors for the armed Forces. One of the consequences of this decision, and, of course, one of the reasons why there is the present discontent, is that medical men doing their national service are much older and therefore have more social and civil responsibilities than any other group of National Service men.

The next point to which I should like to draw attention is that the Government, not unreasonably in view of the fact that they intended to start a national health service, appointed an appropriate committee to assess what the proper emoluments of a doctor should be, and, having accepted the committee's findings, set about nationalizing medicine. In these circumstances, it was not unreasonable that the profession would expect that all medical men, employed by the Government, and of approximately the same age and seniority, would get the same pay with appropriate adjustments for extra responsibility, ability, matrimonial civil status, and so on, and it is because these expectations have not been fulfilled that there has been considerable discontent over the last few years.

That the present situation would arise was indicated to the Minister of Defence some years ago by the Armed Forces Committee who, both before that time and since, have constantly advised the Minister (and have supplied him with appropriate facts and figures) that unless something was done, not only would he have discontented doctors in the Forces, but these discontented doctors would leave as soon as they conveniently could. The Committee pointed out that this would inevitably lead to the present situation where there is a considerable shortage in the middle ranks of medical officers; indeed, if the present trend continues, there will soon not be any senior ranking officers either.

To sum up, Sir, the present situation has arisen really as a result of political-social development since the war, and neither the profession as a whole nor the B.M.A. in particular can accept any responsibility for the position in which the armed Forces now find themselves in respect of their medical commitments.—I am, etc.,

Newton Abbot. A. ROBINSON THOMAS.

B.M.A. LIBRARY

The following books have been added to the Library:

Anderson, D. J.: Physiology for Dental Students. 1952.
Bantug, J. P.: Short History of Medicine in the Philippines during the Spanish Regime, 1565–1898. 1953.
Bowley, A. H., and Townroe, M.: Spiritual Development of the Child. 1953.
Boyd, W.: Textbook of Pathology. Sixth edition. 1953.
Bundesen, H. N.: Towards Manhood. 1952.
Charnley, J.: Compression Arthrodesis. 1953.
Chesser, E.: Marriage and Freedom. Revised edition. 1952.
Clare, N. T.: Photosensitization in Diseases of Domestic Animals: A Review. 1952.
Compere, E. L., and Banks, S. W.: Pictorial Handbook of Fracture Treatment. Third edition. 1952.
Coruzzi, C.: Il Tabagismo e le Altre Intossicazioni Voluttuarie. 1953.
Craddock, D.: Introduction to General Practice. 1953.
Dickson, F. D., and Diveley, R. L.: Functional Disorders of the Foot. Third edition. 1953.
Eyles, L.: Sex for the Engaged. 1952.
Fairbrother, R. W.: Textbook of Bacteriology. Seventh edition. 1953.
Field, M.: Patients Are People: A Medico-social Approach to Prolonged Illness. 1953.
Hayek, F. A.: The Sensory Order: An Inquiry Into the Foundations of Theoretical Psychology. 1952.
Houston, W. V., *et al.*: The Scientists Look at Our World. 1952.
Jackson, Q. M.: Handbook of Paediatrics for Nurses in General Training. 1952.
Krause, M. V.: Nutrition and Diet Therapy in Relation to Nursing. 1952.
Kris, E.: Psychoanalytic Explorations in Art. 1953.
Lindner, R.: Prescription for Rebellion. 1953.
Litzenberg, J C.: Synopsis of Obstetrics. Fourth edition, revised by C. E. McLennan. 1952.
Lowman, C. L., and Roen, S. G.: Therapeutic Use of Pools and Tanks. 1952.
McCord, J. B., and Douglas, J. S.: My Patients Were Zulus. 1952.
McKellar, P.: Textbook of Human Psychology. 1952.
McKenzie, W.: Ear, Nose, and Throat Diseases for Medical Students. 1953.
Moench, L. G.: Office Psychiatry. 1952.
Osborn, L. A.: Psychiatry and Medicine: An Introduction to Personalized Medicine. 1952.
Piaget, J.: The Child's Conception of Number. 1952.
Pinsent, R. J. F. H.: Approach to General Practice. 1953.
Portmann, A.: Animal Forms and Patterns: A Study of the Appearance of Animals. 1952.
Poynting, Thomson and Awbery's University Textbook of Physics. Volume III. Heat. Eleventh edition. 1952.
Rennie, T. A. C., and Bozeman, M. F.: Vocational Services for Psychiatric Clinic Patients. 1952.
Reynolds, S. R. M.: Physiological Bases of Gynecology and Obstetrics. 1952.
Rypins' Medical Licensure Examinations: Topical Summaries and Questions. Seventh edition by Walter L. Bierring. 1952.
Sava, G.: Patients' Progress. 1952.
Scott, J. H., and Symons, N. B. B.: Introduction to Dental Anatomy. 1952.
South African Institute for Medical Research, Biochemical Department: Scope and Interpretation of the Commoner Biochemical Tests. 1952.
Symposium on Radiobiology: Basic Aspects of Radiation Effects on Living Systems, Oberlin College, June 14–18, 1950. 1952.
Ver Brugghen, A.: Neurosurgery in General Practice. 1952.
Wallace, J. S.: Newer Knowledge of Hygiene in Diet. 1952.
Warren, S., and LeCompte, P. M.: Pathology of Diabetes Mellitus. Third edition. 1952.
Wartenberg, R.: Hemifacial Spasm. 1952.
White, F. D., and Delory, G. E.: Course in Practical Biochemistry for Students of Medicine. 1952.
Widdowson, T. W.: Special or Dental Anatomy and Physiology and Dental Histology: Human and Comparative. Volume I. Eighth edition. 1952
Wittkower, E., and Russell, B.: Emotional Factors in Skin Disease. 1953.

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:

Metropolitan Borough Councils.—Fulham, Southwark.
Non-County Borough Councils.—Crewe.
Urban District Councils.—Houghton-le-Spring.

Association Notices

Diary of Central Meetings

JANUARY

4	Mon.	Hospital Junior Staffing Subcommittee, Central Consultants and Specialists Committee, 11.30 a.m.
5	Tues.	Staff Side, Committee "B," 11 a.m.
5	Tues.	War Memorial Committee, 12 noon.
5	Tues.	Building Committee, 2 p.m.
5	Tues.	Full Committee "B" (at 14, Russell Square, London, W.C.), 2.30 p.m.
7	Thurs.	Rural Practices Committee, G.M.S. Committee, 2 p.m.
7	Thurs.	Central Consultants and Specialists Committee Executive, 2.30 p.m.
8	Fri.	Industrial Injuries Evidence Subcommittee, Occupational Health Committee, 2 p.m.
12	Tues.	Central Ethical Committee, 12 noon.
12	Tues.	Amending Acts Committee, 2 p.m.
13	Wed.	**Council**, 10 a.m.
14	Thurs.	Central Consultants and Specialists Organization Subcommittee, 10 a.m.
14	Thurs.	Staff Side, Committee "C," Medical Whitley Council (at 14, Russell Square, London, W.C.), 2 p.m.
14	Thurs.	Full Committee "C," Medical Whitley Council (at 14, Russell Square, London, W.C.), 3 p.m.
15	Fri.	Joint Committee of B.M.A. and the Magistrates' Association, 10.30 a.m.
15	Fri.	Scientific Exhibition Subcommittee, Arrangements Committee (at Glasgow Regional Office, 234, St. Vincent Street, Glasgow), 7.45 p.m.
18	Mon.	Armed Forces Committee, 2 p.m.
19	Tues.	Executive Subcommittee, Joint Formulary Committee (at Pharmaceutical Society, 17, Bloomsbury Square, London, W.C.), 2 p.m.
20	Wed.	Committee on the Rehabilitation of Disabled Persons, 10.15 a.m.
20	Wed.	Joint Health Visitors Subcommittee, G.M.S. and Public Health Committees, 2.30 p.m.
20	Wed.	Transport Medical Standards Subcommittee, Occupational Health Committee, 2.30 p.m.
22	Fri.	Complaints Procedure Subcommittee, Central Consultants and Specialists Committee, 2.30 p.m. (*Date changed from January 14.*)
25	Mon.	Staff Side, General Whitley Council (at 14, Russell Square, London, W.C.), 10.30 a.m.
25	Mon.	Full General Whitley Council (at 14, Russell Square, London, W.C.), 2.30 p.m.

FEBRUARY

3	Wed.	Committee on the Rehabilitation of Disabled Persons, 10.15 a.m.

Branch and Division Meetings to be Held

CHESTERFIELD DIVISION.—At Walton Sanatorium, Chesterfield, Friday, January 8, 8.45 p.m., meeting. Mr. Jonathan Hanaghan will speak on some psychological subject.

EAST KENT DIVISION.—At Winter Gardens, Margate, Friday, January 8, 8.30 p.m. to 2 a.m., annual supper and ball.

GUILDFORD DIVISION.—At Royal Surrey County Hospital, Guildford, Thursday, January 7, 8.30 p.m., Divisional meeting. Lecture by Mr. A. Lawrence Abel: "Common Diseases of the Rectum and Anal Canal"; colour film: "Resection of Rectum."

SWANSEA DIVISION.—At Osborne Hotel, Swansea, Thursday, January 7, symposium by general practitioners.

WEST HERTS DIVISION.—At Large Town Hall, Watford, Wednesday, January 6, 8.30 p.m. to 1.30 a.m., annual ball.

Meetings of Branches and Divisions

CHELSEA AND FULHAM DIVISION

A general meeting was held at St. Stephen's Hospital, London, S.W.10, on December 4, 1953. The Mayors of Chelsea and Fulham were present, together with an audience of 90, to hear Colonel W. L. Harnett, I.M.S. (retd.), give a lecture, illustrated by lantern slides, entitled "Journey into Tibet."

SOUTH MIDDLESEX DIVISION

At the annual general meeting on December 7, 1953, the following officers were elected for 1954:

Chairman.—Dr. H. Bergh.
Vice-chairman.—Dr. Mortimer O'Sullivan.
Honorary Secretary.—Dr. G. C. L. Woodroffe.
Representatives on the Representative Body.—Mr. C. D. Meadowcroft and Dr. G. C. L. Woodroffe.