SUPPLEMENT TO THE
BRITISH MEDICAL JOURNAL
LONDON SATURDAY MAY 12 1956

CONTENTS

DIVINE HEALING

B.M.A. EVIDENCE TO ARCHBISHOPS' COMMISSION

Just over two years ago the Commission on Divine Healing, set up by the Archbishops of Canterbury and York, asked the British Medical Association to prepare a statement of its views, particularly on evidence that the medical profession might be able to submit of spontaneous cures of apparently incurable disorders or of rapid or accelerated recovery from serious illness, following upon spiritual ministrations. The Commission asked also whether there was any evidence of the physical or psychological value of healing services, the laying on of hands, unction, and the influence of public and private prayer, and again in what circumstances these practices might be attended by possible harmful effects, such as the risk of delay in securing medical advice.

The Commission further asked for evidence of co-operation between doctors and clergy, the methods by which this had been achieved, and how it could be encouraged and extended, whether centrally, as between medical and Church organization, or locally, as between doctors and ministers.

The Council of the Association referred the request to an *ad hoc* committee consisting of the Association's six representatives on the Churches' Council of Healing, namely, Dr. MARY ESSLEMONT, who acted as chairman of the committee throughout, Dr. E. E. CLAXTON, Assistant Secretary of the Association, Dr. PETER EDWARDS, Dr. ROBERT FORBES, Dr. DORIS ODLUM, and Dr. H. H. D. SUTHERLAND. To this body were co-opted Mr. G. J. ALEXANDER, Dr. E. A. BENNET, Dr. CUTHBERT E. DUKES, and Dr. J. A. HADFIELD. Invitations were extended to three Roman Catholic doctors who are prominent members of the medical profession, but none of them was able to accept. Ten members of the profession who were known to have special knowledge of, or experience in, the subject submitted memoranda on request; nine others attended the Committee personally and assisted in its discussions with information from their own experience and practice, and three attended one meeting of the Committee to assist in the final drafting of the report. The memorandum of the evidence furnished to the Committee has been published in booklet form by the B.M.A.[1]

A questionary[2] was sent to a number of individuals, including members of the Christian Medical Fellowship. Honorary secretaries of Divisions and Branches of the Association were requested to make inquiries in their localities and to pass copies of the questionary to interested doctors. Some seventy doctors replied to the questionary, giving their personal experiences of recovery from apparently incurable disorder with or without spiritual ministration, also their opinions on methods of co-operation between doctors and clergy. Inquiries on the subject of healing were restricted solely to members of the medical profession, but on the question of co-operation between clergy and doctors information was obtained from a number of clergy and also from the Hospital Chaplains Fellowship.

In cases of alleged spontaneous healing full details of diagnosis were requested, with special emphasis on the nature of the case—i.e., organic, with corroborative evidence (*x*-ray, histological, etc.), or mental or psychosomatic. Many of the case histories, the Committee states, would require much substantiation before they could be regarded as evidence that anything more than what might be called normal healing had occurred. A large proportion of the examples came from mission hospitals, where presumably the habit of the lay and medical staff is to pray corporately or individually over the patients.

What Constitutes "Cure"?

The cure of disease is, the Committee realizes, a relative matter. The patient's criterion of healing is freedom from symptoms; the doctor's standard is restoration of normal anatomical structure and physiological function. Sometimes a case is spoken of as "cured" when pain is alleviated or when there is a remission, although the trouble remains latent. The types of illness said to be cured by spiritual healing fall into the following two categories: (1) psychogenic or psychosomatic disorders and (2) organic conditions.

Disorders of psychological origin, says the Committee, may be cured by many methods of treatment affecting the patient's mind and emotional state, and these may include spiritual healing, the laying on of hands, and unction, as well as forms of analytical treatment and suggestion or hypnosis. Some of these methods direct themselves simply to the abolition of the symptom, such as the removal of pain or a hysterical paralysis; others aim at discovering some of the causes and the meaning of the illness and by allaying the anxiety may cure the patient more radically and permanently. Relief of psychogenic disorders appears to depend partly on the individuality of the patient and his

[1] London. British Medical Association, Tavistock Square, W.C.1. 2s. 6d.
[2] *British Medical Journal Supplement*, 1954, **1**, 293.

capacity to respond, partly on the personality of the healer and his power of suggestion, and to some extent on the method employed.

"It is undesirable and even dangerous for anyone to apply these methods of treatment [suggestion, laying on of hands, etc.] without a knowledge of the nature of the disease from which the patient is suffering. To treat certain forms of depression by laying on of hands or resort to the help of spirit media, or by suggestion, when specific treatment is available, is to do the patient the greatest disservice."

Most of the "cures" of organic diseases claimed for spiritual healing are explained, in the view of the Committee, by mistaken diagnosis or prognosis, alleviation or remission, spontaneous cure and combined treatment. As for mistaken diagnosis, there are, for example, some cases which, without sufficient investigation, are diagnosed as epilepsy, but which appear to be cases of hysteria. An impressive religious service, equally with psychological treatment, may be enough to benefit such a patient, and there is no need to doubt the efficiency of the former or of the latter.

Here a reference is made to the "miracles" of Lourdes. It appears that an authority at Lourdes known as the Bureau des Constatations[3] investigates cases of so-called "miracles" in order to exclude psychogenic and hysterical conditions, and "in spite of the immense pressure of popular enthusiasm the number of miracles actually attested and registered over the years has been exceedingly small (not even one every year), and every attempt is made to emphasize the spiritual value of the pilgrimage rather than such healings as may be claimed."

Wrong prognosis is even more frequently the explanation of an apparent cure than wrong diagnosis. The Committee points out that sometimes the probable course of a disorder as suggested by past experience is not the course which the disease takes. Thus a condition which a doctor regards from his previous experience as incurable may resolve itself unexpectedly. In such a case, if there have been spiritual ministrations by clergymen or other healers the cure may popularly be ascribed to them.

Again, alleviation of symptoms, such as the abolition of pain in organic illness, may be mistaken for cure, and the mere removal of pain may facilitate recovery. But when the effect of the treatment, whether morphine or suggestion or anything else, which has been used to dull the pain wears away, the old condition returns.

Finally, some diseases are subject to remissions, during which the patient appears to have recovered, though a complete medical investigation would usually show that the aetiological factors of the illness still exist. In one case of leukaemia which was said to have been cured by spiritual healing, the spleen was found to have remained enlarged, indicating that the disease was still present in spite of the supposed cure. Such investigations cannot be made by the lay therapist, and consequently the friends of the patient might mistake remission for cure, and a "miracle" might be reported in the press, while the subsequent relapse received no publicity.

Spontaneous Cures

It is agreed by the Committee that medical men not infrequently meet with illness which, on the basis of previous experience, should prove fatal, but which appears to resolve unexpectedly. There are reports of cancers behaving in that way. Such cures take place apart from medical or surgical treatment and without special ministrations of other kinds such as "spiritual healing." Not enough is known about the processes at present to enable anyone to say exactly what is happening, and naturally any extraneous factor, such as spiritual healing, or equally a course of diet or the carrying of charms, might be regarded as the cause.

Another factor which has to be considered in this connexion is the effect of combined treatment. The "cures" claimed for spiritual healing often reveal that the patient was at the same time continuing the treatment prescribed by the doctor. The fact that the patient improves after spiritual healing is no proof that the cure was due to that rather than to the medical treatment; but in many of these cases the fact that medical treatment was also being given is not stated and emerges only on questioning and investigation.

"When all these possibilities are considered" (the report goes on) "it leaves little room for miraculous cures of organic disease by the methods of spiritual healing. In any event, spontaneous or unexpected cures in this country, like those of Lourdes, which cannot be explained are very few; and in the Committee's opinion it is probably better to acknowledge that they are at present inexplicable on scientific grounds."

"As far then as our observation and investigation have gone, *we have seen no evidence that there is any special type of illness cured solely by spiritual healing which cannot be cured by medical methods which do not involve such claims.* (The Committee's italics.) The cases claimed as cures of a miraculous nature present no features of a unique and unexpected character outside the knowledge of any experienced physician or psychiatrist."

Value of Religious Ministration

The Committee agrees that there is considerable evidence on the value of religious ministration in the treatment of disorders of various kinds. Take, first, the fact of religious conversion. The complete upheaval of the emotional life of the patient is capable of curing various forms of neurosis, alcoholism, and other functional disorders, apparently by removing the causative factors which contribute so largely to the neurotic temperament. The patient thus acquires a peace of mind and contentment which to a large extent removes the effects of strain and stress. Conversion basically operates through a change in motives and will, and, by giving the patient a personal faith that God can satisfy his deepest needs, furnishes him with an adequate purpose in life and supports him in adversity, so that in organic illness he becomes courageous and co-operative.

Many of the cures effected by unorthodox means, including spiritual healing, are mainly due to suggestion, but the Committee agrees that such suggestion is likely to be more effective when it has a religious background. If the suggestions of confidence and strength which the patient is given are reinforced by the suggestion that God will be present to help him they will be more likely to be potent, always provided, of course, that the therapist himself believes in the truth of what he is endeavouring to impart to the patient.

Religion is, of course, of the first importance in keeping up the patient's morale in a serious illness. Such methods of keeping up the patient's morale may be and often are efficiently carried out by clergymen and ministers, though the doctor, too, by his quiet confidence, helps to give the patient reassurance and peace of mind.

Summing up, the Committee finds no evidence "that there is any type of illness cured by spiritual healing alone which could not have been cured by medical treatment, which necessarily includes consideration of environmental factors." While persons suffering from psychogenic disorders may be "cured" by various methods of spiritual healing, just as they are by methods of suggestion and other forms of psychological treatment employed by doctors, the Committee can find no evidence that organic diseases are cured solely by such means. The evidence suggests that many such cases claiming to be cured are likely to be either instances of wrong diagnosis, wrong prognosis, remission, or possibly spontaneous cure. On the other hand, as there are multiple factors—whether of body or mind—which may contribute to the precipitation of an illness, so there are multiple factors which conduce to the restoration of health.

Any means which may lead to the restoration of health must receive attention, because all the functions of personality react upon one another.

[3] *The Facts of Lourdes and the Medical Bureau.* By Dr. A. Marchand.

Commission's Questions

The Committee then addresses itself to six specific questions on which the Archbishops' Commission had particularly sought the views of the Association. Some of these have been already set out and answered in the earlier observations, but for more detailed replies the Committee looked into and analysed the experiences narrated and the opinions given in the answers to its own questionary, as well as the evidence of witnesses who appeared before it. The bulk of the replies to the questionary—which were mainly from believers in divine healing—were diffuse and uncritical and presented little on which definite conclusions could be drawn. Many witnesses failed to distinguish between partial and complete healing, and the word "healing" was used in different senses. The Committee found itself unable to accept the evidence as proof of direct divine intervention or healing in the usual sense of those expressions.

The first of the Commission's questions relates to evidence of spontaneous cures of apparently incurable disorders. One member of the Committee, Dr. Cuthbert Dukes, was invited to write a memorandum on his subject. He stated, *inter alia*:

"In spite of the unreliability of the evidence of cures based on unexpected survival or absence of symptoms, spontaneous cures cannot be entirely ruled out, even in the most incurable diseases, but" (Dr. Dukes's italics) "*spontaneous cures cannot be expected to occur often and it is extremely difficult to find anyone who has met with a completely convincing case.* In the few cases that might be looked on as 'miracles' one would need to know whether to attribute them to the intervention of a supernatural Power or to the action of natural laws as yet undiscovered. It might well be ascribed to 'the chancy, unpredictable factor which is always bursting in and upsetting all our calculations about living creatures.'"

Cures Associated with Magic

The Committee sought some information on alleged cures associated with magic or witchcraft, and some examples are given from replies to the questionary.

One doctor wrote that the practice of magic, both white and black, was widely spread in his Devon practice. He had had one definite death from witchcraft—or he supposed he should say suggestion—while he was there. "The practice of charming away warts is extremely effective."

A doctor in India quotes a tea planter who told him of a "Christian" clerk on his estate who was suffering from an intractable skin complaint and sent to a busy mission hospital, which failed to cure it with penicillin, sulphonamides, *x* rays, vitamins, etc. The patient then persuaded the planter to let him get in a witch doctor, who did spells nightly before idols, and the skin condition cleared in a week.

The Committee comments that apparently in these and like cases the power of suggestion from the witch doctors proved stronger than that of the doctors and missionaries.

Healing Services

The Commission next asked for any available evidence of the value—physical and psychological—of healing services, the laying on of hands, unction, and the influence of public or private prayer.

The Committee replies at once that there is no simple answer to this question. If such services raise the hopes of invalids—or of healthy people for that matter—they are of value. But what is the criterion of value? The results of treatment are often unexpected and unpredictable. Faith in the doctor or his remedies—or in something else—may be curative. The doctor-patient relationship is a mysterious, little-understood element in medical work, and cures can often be related to it. Many of the claims of healers appear to rest only upon suggestion, but the power of suggestion is still one of the mysteries of psychiatry. Anything—a religious practice or the reception of personal influence from others—which promotes an attitude of mind free from fear and morbid apprehension, and in which faith and expectancy play a part, comes within the ambit of spiritual ministrations.

An intimate and private healing service is known to be of value when the patient is fully informed and co-operative. Little direct evidence seems to be available of the value of the public type of healing service, and in the Committee's view the desirability of such services has not been established.

As for laying on of hands and unction, these practices may be instrumental in promoting the well-being of some patients, though when misunderstood—e.g., regarded as acting in a magical way to produce a cure—they may have undesirable features. Of the value to patients of public or private prayer, whether recovery takes place or not, many doctors are convinced.

Possible Harmful Effects

The Archbishop's Commission further asked in what circumstances healing services and the like might be attended by harmful effects, such as the risk of delay in seeking medical advice.

The Committee was informed of a few patients who had suffered through this delay in consulting a doctor. Several of the cases cited relate to Christian Science teaching and practice.

A patient with early disseminated sclerosis was persuaded not to seek medical advice and the diagnosis was not established. She finally had to go to a Christian Science nursing-home, and when she was near death was sent out to her relatives as they refused to keep her any longer in the home.

A very depressed patient who was "treated" by Christian Science practitioners was told she must not see a doctor and she finally committed suicide.

A child sickening for measles was told by her mother, who was a Christian Scientist, that she was not ill and she would not let the child see a doctor until the rash appeared and the child was so ill that the mother got frightened and called in a doctor.

These are selected examples extracted from statements made by doctors orally or in reply to the Committee's questionary. The Committee, however, has sought no information on the subject of Christian Science and makes no comment on the principles of that belief.

The Committee was informed of patients suffering from cancer and other organic conditions who had been led to believe that by prayer or the laying on of hands or by pilgrimage they would be "cured." When these methods failed they felt that God had failed them or that there was no God, and it was very difficult to restore their faith or give them a more balanced point of view.

"The people who suffer most damage from any unwise handling of the religious approach are unfortunately those to whom religion has always meant a great deal. Any suggestion of scolding or blame may do damage to the religious minded and in others it simply confirms their hostile or indifferent attitude towards religion. If unreasonable and irresponsible claims are made, through ignorance, misplaced belief, self-display by the 'healer,' mass suggestion and so on, the sufferer may at first respond emotionally, appearing to improve physically, only later to find that his complaint is still progressing. In these circumstances the task of both doctor and priest is made more difficult and the faith of both the patient and his family may be shattered."

CO-OPERATION BETWEEN DOCTORS AND CLERGY

The second part of the Committee's terms of reference relates to co-operation between doctors and clergy. In 1947 the Council of the Association issued a statement about co-operation with the clergy, and this was agreed to by the Representative Body. Part of the statement read:

"It is considered that more useful work may be done by close personal contact between doctor and clergyman, with an interchange of views and active co-operation where possible. With regard to the co-operation which can be secured at a divisional or parochial level, it is considered that arrangements can best be left to the B.M.A. Divisions acting in concert with any branch organization of the Churches' Council of Healing or similar body. Joint activities might include the appointment of and co-operation with hospital chaplains and their deputies, education of the public, and informal discussions between doctors and the clergy."

The statement went on :

"Medicine and the Church working together should encourage a dynamic philosophy of health which would enable every citizen to find a way of life based on moral principle and a sound knowledge of the factors which promote health and well-being. Health is more than a physical problem, and the patient's attitude both to illness and to other problems is an important factor in his recovery and adjustment to life. . . . For these reasons we welcome opportunities for discussion and co-operation in the future between qualified medical practitioners and all who have a concern for the religious needs of their patients."

The present Committee agrees that to some extent the work of the doctor and the clergyman or minister overlap. Teamwork between them can help to meet the total needs of the patient. Neither clergyman nor doctor, however, should trespass into the field of the other, but where their work, which is essentially for individual people, overlaps they can easily co-operate.

Evidence of active co-operation was difficult to obtain, but, apart from the activities of the Churches' Council of Healing, the Committee learnt of a few centres (e.g., Bermondsey, Bournemouth, Colchester, Reigate) where co-operation is taking place between groups of doctors and clergy. It also heard with interest that there is a group at St. Martin-in-the-Fields which includes eminent members of the medical profession. Co-operation between individuals appears to be fairly common, but direct evidence of its nature is scanty. B.M.A. Divisions from time to time hold joint meetings with clergy and ministers in their localities, and a number of bishops have invited the Branches and Divisions in their dioceses to hold joint conferences of doctors and clergy with a view to promoting active co-operation. Chelmsford, Coventry, Lichfield, and Liverpool are mentioned. The Committee considers that the purpose of co-operation should also be brought before medical and theological students by means of lectures and discussions.

The Committee endorses, in general terms, the principles outlined in a document from the Churches' Council of Healing.[4] The Committee is opposed to any central organization for official meetings between doctors and clergy on a formal basis.

The importance of the spiritual factor in rehabilitation is acknowledged. Doctors whose patients are attending rehabilitation centres and units might well co-operate with the clergy during the critical stage of return to active life. Clergy and doctors may also usefully co-operate in the resettlement of individuals who are convalescing from accidents and crippling conditions.

Ethical Considerations

The ethical aspect of co-operation in the treatment of patients has also been considered by the Committee. A difficulty for the attending medical practitioner may arise if the patient proposes to enlist the services of a healer who is not on the *Medical Register* and who engages in diagnosis and treatment. Doctors are forbidden by the General Medical Council to associate with such unregistered practitioners. There are spiritual healers who unduly publicize themselves and profess to make a diagnosis and to provide certain forms of physical and mental therapy in accordance with their views and convictions. Such persons must be regarded as occupying the position of unregistered medical practitioners, and their association with a registered medical practitioner may be the subject of condemnation by the General Medical Council or by an ethical authority.

If the clergy or other healers restrict their activities to the forms of ministration that have long been associated with the Church, and if they regard their sphere of helpfulness as that pertaining solely to the spiritual life of the patient, no objection need be taken by registered medical practitioners. The "spiritual healer" would be regarded as ministering to the religious life of the patient, while the registered practitioner would be regarded as ministering to his physical needs. "That these two ministrations have contact is well recognized, and indeed that they may overlap is often conceded." But it would be a denial of the real facts of the situation if the spiritual healer were regarded as a medical auxiliary. Most medical practitioners would say that they were wholly unable to direct or supervise the professional work of a spiritual healer, but they can and often do reach the conclusion that the patient needs spiritual help and advice and recommend accordingly.

"It is clear that a registered medical practitioner would not be guilty of committing any ethical offence if the activities of the clergyman, or healer, are restricted as described above and provided he does not deal with matters calling for the exercise of professional discretion, or skill, in the accepted sphere of medical practice."

The Committee's general conclusions on the whole subject of co-operation are that doctors and clergy or ministers can meet and co-operate in their work, and that the best meetings between them are meetings of two, where the doctor and clergyman discuss how they can best help the individual patient. Informal gatherings between small groups of the doctors and clergy in a locality are of value and often bring to light people in need, and in this way help can be provided. Occasional general meetings between doctors and clergy may be of value for the reading of papers and discussions.

Examples of Evidence

In an appendix to its report the Committee gives some forty selected examples of cases described by doctors mostly in reply to its questionary. It points out that many of the case histories would be quite unacceptable as medical evidence, and it has not been possible to draw valid conclusions from them, though they are useful in that they give an impression of the cumulative experience of a number of doctors. Here is an example of so-called spontaneous cure:

"I knew of a case, at Cambridge, before I was qualified, where a lady patient, a devout Christian, had her abdomen opened and the peritoneum was found studded with malignancies (I do not know what type). She was sewn up to die, but to my personal knowledge was alive and well some 20 years later. I do not think she attended any healing service."

One or two examples of rapid or accelerated recovery associated with spiritual ministrations are given:

"A baby girl born with atresia of the duodenum. An operation took place, but immediately afterwards it appeared that the baby would not survive. A healing service was held and the baby made uninterrupted recovery. Another child was born to the same parents 18 months later with a similar condition, the same surgeon operated—this time no service was held, and the child died within a few days."

A doctor gave to the Committee the following instances where recovery had occurred, usually in a very short time, after a healing service had been held for patients with grave or hopeless prognosis:

"A case of disseminated sclerosis with widespread lesions."

"A lady in her forties with frontal sinus for whom inhalation and antiseptics had provided no relief."

"A lady of 71 who had been in bed for nine weeks following a stroke and who had been told by her general practitioner that she would not walk again."

"A baby of 2½ years with tuberculous intestinal peritonitis who had been given two weeks to live."

"A child of 9 with a diagnosis, confirmed by biopsy, of cirrhosis of the liver."

"A woman in her forties who had ulcerative colitis with frequent haemorrhage from the rectum—a condition from which she had suffered for a number of years."

"A child of 11 years with macular degeneration of the retina."

[4] The Churches' Council of Healing is a central body on which there are official B.M.A. representatives. The document it has published suggests joint conferences, central and regional, and also certain practical local measures, including personal friendship between parson and doctor, which is fundamental; specific activity over individual cases; groups of helpers, such as a youth, men's, or church fellowship which can take on helpful tasks for the sick and incapacitated; the joining with other doctors and clergy to work together, and consideration of the needs and problems of the nation as occurring in the locality.

"A patient running a hectic temperature which had not responded to any drugs, sent home to die, after three years in a sanatorium."

Several cases related to the Committee referred to sacramental observances.

"A lady with cancer of the breast had the laying on of hands before a radical mastectomy almost five years ago. She attributes her freedom from recurrence so far in a large measure to the sacrament."

"Three cases in which a saintly Roman Catholic priest called me after he had given unction. (1) Heart failure with auricular fibrillation; (2) pneumonia with heart failure, the patient *in extremis*; (3) a boy with blackwater fever. In each case recovery."

Many examples are given of recovery following prayer.

"A boy who had acute osteomyelitis of humerus which was healed in a dramatically quick time in answer to the prayers of the —— Church. In this case I felt certain enough to tell the mother he would be healed without surgery while the wound was still discharging freely. Next time I did the dressing the sinus was completely healed and never broke down again. The child was a few weeks old, the abscess appearing before the tenth day."

"Man over 50 with septicaemia following rat-bite. When first seen he was very ill, with high temperature and rapid pulse. In those days streptomycin and even sulphonamides had not been discovered. Nearest hospital nearly 30 miles away. In a small Methodist chapel a service was being held almost next door. I looked in and asked for special prayer. The patient made a rapid recovery, commencing almost at once. No relapse."

Examples are quoted of the effect of conversion upon the course of illness, and of the patient's religious faith playing a part in recovery, but several cases are also described in which reliance on spiritual ministrations had harmful effects. In one case a service of exorcism was performed upon a woman in her thirties who was suffering from an endogenous depression. It had been explained to her that her depression was due to evil spirits and that the service would be beneficial. No benefit followed this procedure and the patient was consequently further disturbed as she was a woman with strong religious feelings.

In drawing up its report the Committee has not relied solely on the views expressed by those who appeared before it or submitted written statements, but has drawn to a considerable extent on the cumulative experience of its own members.

SPIRITUAL HEALING

INVESTIGATION OF Mr. H. EDWARDS'S CASES

While the B.M.A.'s Special Committee was preparing its evidence for submission to the Archbishops' Commission on Divine Healing, it was asked to investigate nine cases submitted to the Commission by Mr. Harry Edwards in which he claimed spiritual healing had occurred. The Committee investigated Mr. Edwards's reports on these cases and also those of the patients' medical attendants, and forwarded its findings to the Commission.

The nine cases consisted of three of leukaemia, one of carcinoma of the bladder, one of kyphosis, one of ringworm of the finger-nails, two of doubtful diagnosis, and one of spinal disk lesion. During the inquiry two of the patients suffering from leukaemia died, so did the patient suffering from carcinoma of the bladder. These three patients all died of the diseases from which they were alleged to have recovered. The patient with carcinoma of the bladder had extensive secondary growths. The third case of leukaemia is still under medical treatment and continues to show signs of active disease, such as enlargement of the spleen and a characteristic blood picture. The patient with kyphosis improved while receiving physiotherapy in addition to Mr. Edwards's ministrations. The patient with ringworm of the finger-nails improved but also had medical treatment. Of the cases of doubtful diagnosis one had recovered and the other had not been seen medically, and therefore no opinion could be expressed. The patient who was suffering from prolapsed disk had recovered.

Scottish News

APPOINTMENTS TO REGIONAL HOSPITAL BOARDS

The following new medical members have been appointed by the Secretary of State for Scotland to fill vacancies on the Scottish regional hospital boards arising from the statutory requirement that one-third of the members retire annually:

South-eastern Region.—Dr. D. Ross, physician superintendent, Stratheden Hospital, Cupar, Fife.

Western Region.—Mr. A. H. Sangster, Kilmarnock.

The following members have been reappointed:

Eastern Region.—Professor D. M. Douglas, Medical School, Dundee.

South-eastern Region.—Dr. G. J. Summers, Midlothian.

Western Region.—Dr. T. Anderson, Glasgow; Dr. P. K. McCowan, Crichton Royal Mental Hospital, Dumfries (to March 31, 1958).

MEDICAL ETHICS

At a recent meeting under the Chairmanship of Dr. ROBERT FORBES, the Central Ethical Committee considered in the course of a long agenda a number of matters relating to broadcasting.

Anonymity in Broadcasting

At the meeting of Council in February (*Supplement*, February 18, p. 47), the Chairman had agreed that the Ethical Committee should consider, in the light of the Association policy, the position of medical practitioners broadcasting officially in the interests of the profession. Following a long debate, the Committee decided to recommend that there might be exceptional circumstances when a departure from the rule of anonymity would be justified, as for example when a medical practitioner broadcast in an official capacity on medico-political matters of national interest. In considering a submission that there was a particular need for a rigid policy of anonymity in broadcasting of matters on forensic medicine, the Committee was of the opinion that the policy should apply equally to all branches of medicine.

There was a type of broadcast programme in which members of the public discussed clinical details of cases, sometimes still under treatment, and received immediate comment from a panel which included medical practitioners. The Committee thought that these programmes could have serious consequences and be detrimental to the patient and to the public, and it decided to make representations to the broadcasting authorities.

Therapeutic Trials

An inquiry had been received on the ethics of controlled therapeutic trials. In the case under review it was proposed to test the effect of progesterone implants in patients who had had repeated miscarriages, by treating alternate patients with implants of the test substance and an inert compound: it would not be possible under the conditions of the trial to explain the nature of the investigation to the patient. In law and in ethics a doctor is not entitled to treat a patient without that patient's consent, and the risks and the nature of the procedure must be fully explained before obtaining consent. It would therefore be both unethical and illegal to conduct a controlled therapeutic trial in which it was not possible to explain to the patient the nature of the investigation.

Disclosure of Diagnosis by Ambulance Service

The Committee advised that protest should be made by the medical practitioners in a locality where the ambulance authority had on occasion disclosed to the police the diagnosis of some cases sent to hospital by doctors.

CONSULTING PATHOLOGISTS GROUP

A meeting of the Consulting Pathologists Group was held at Headquarters on April 27. Dr. S. C. DYKE was appointed to the chair. The Chairman mentioned that the present membership of the Group was 245.

Group Committee's Report

The report of the Group Committee for the period 1954–6 was presented by Dr. J. O. OLIVER, who stated that the possibility of having an observer on the Central Pathological Committee had been discussed with the Ministry. The Ministry's advisers, however, had decided against that course, considering that there was already sufficient liaison. Nevertheless, they had agreed to allow him (Dr. Oliver) to see the minutes of their meetings.

The CHAIRMAN said that the subject of accidental coal-gas poisoning had been considered by the Committee, as requested by the previous general meeting. The Association had been urged to draw the attention of the appropriate authorities to the numerous fatalities caused by coal gas and the possibility that many deaths commonly ascribed to natural causes, as well as much illness, might be due to unsuspected coal-gas poisoning. The Science Committee of the Association had thereupon appointed a special subcommittee to inquire into the problem and make recommendations. The work was now nearly completed, and he believed that the result would be very much in the public interest.

On the question of a suggested Group of Forensic Pathologists, the Council of the Association had requested that consideration be given to some other method of representation, and after joint discussions it had been agreed that the establishment of a Forensic Medicine Subcommittee of the Private Practice Committee was the most appropriate solution.

The CHAIRMAN also referred to various matters relating to blood transfusion which were discussed at the last Group meeting, and said that they had been informed that the Ministry was revising its pamphlet on the subject, but so far no new edition had appeared.

The Group Committee had been asked for its views on the model plans for mortuary accommodation which had been prepared by an unofficial working party of the Ministry of Housing and Local Government. It had seemed to the Committee that as these plans related to local authority mortuaries which would not be located at hospitals there was little point in criticizing them in detail. It was the policy of the Group that facilities for post-mortem examinations should be linked with the hospital.

Most of the members, said the CHAIRMAN, would have seen the document issued by the Ministry on the availability of hospital pathological services in emergencies. In this connexion a letter had been received from the Medical Superintendents' Society suggesting that a full, salaried 24-hour service was really the only satisfactory way of meeting the emergency requirement. In the Group Committee they had felt that the question of emergency services might be a little over-stressed, and that emergencies, generally speaking, were few and far between.

Discussion on the Report

In some general discussion on the report Professor D. F. CAPPELL asked about difficulties in recruitment experienced in the Central Medical Recruitment Committee. Dr. OLIVER pointed out that the pathologist was in a somewhat exceptional position; having once started his career as such, he could not switch to some other type of practice. He thought there was likely to be in the future an easing of the recruitment position. He went on to mention the fact that in rural districts many forensic pathologists, incurring travelling expenses in carrying out coroners' post-mortem examinations, found themselves considerably out of pocket. The Committee had introduced a schedule of special fees.

The CHAIRMAN referred to the resolution which was before the last Group meeting declaring that all reports from pathology departments should, where possible, in their final form bear the sign manual of a pathologist on the staff of the department. Only a small majority had been in favour of this, and it was felt that it should have more consideration. In the course of some discussion Professor CAPPELL said that the objection raised was one which could really be met by the head pathologist being master in his own house. The question was raised whether it was really necessary to come to any decision at all about this matter, and after a brief discussion it was decided to proceed to the next business.

The meeting concurred with a resolution passed by the Council of the International Society of Clinical Pathologists placing on record its conviction, and adopting as a matter of policy, that in the interests of public welfare a medically qualified person must be at the head of all laboratories devoted to the diagnosis, treatment, and prophylaxis of human diseases.

On the question of fees for post-mortem examinations, Dr. OLIVER said that several points had to be ironed out. One point which was emphasized was that cadavers should be brought to the pathologist. The proper place for post-mortem examinations was in the post-mortem department of the hospital to which the pathologist was attached. Professor CAPPELL said that they were all familiar with the case in which the patient had gone home and had, perhaps unexpectedly, died there, and difficulty had been experienced in bringing the body back to the hospital merely for the purpose of post-mortem examination.

The meeting supported a resolution that arrangements should be made for general practitioners to have a necropsy performed on their patients by a consulting pathologist in his own department when, on account of clinical interest, reports were necessary.

After a discussion on some other items, the Annual Report was adopted on the motion of Dr. J. F. HEGGIE, seconded by Dr. E. M. WARD.

Major-General SACHS brought forward an important point in connexion with the report of the Waverley Committee, whereby, according to one recommendation, the pathologist was relegated to a lower status—a reversal of the decision made in 1919. The CHAIRMAN suggested that the Committee should be asked to look into the matter with a view to making a protest in the proper quarter, and this was agreed to.

HOSPITALITY

A young German girl, aged 19, at present attending school in England, wishes to arrange a holiday exchange with an English girl of the same age. She would like to stay with a medical family in the London area from August 1–30, to perfect her English, and to take the English girl back to her home at Freiburg for a month afterwards.

A French doctor offers to exchange a flat in Paris for accommodation at the sea or in the country anywhere in Britain for three weeks in July,

Anyone interested should get in touch with Brigadier H. A. Sandiford, International Medical Visitors Bureau, B.M.A. House, Tavistock Square, London, W.C.1.

The conditions of qualification for industrial disablement benefit for sufferers from byssinosis have been relaxed as from February 8, 1956. The period of qualifying employment in the cotton industry is reduced from 20 years to 10 years, and the condition that benefit cannot be paid unless the disablement is assessed at 50% or more is removed. People in occupations involving exposure to cadmium fumes are now insured under the Industrial Injuries Scheme against chronic, as well as acute, cadmium poisoning. In view of the precautions taken cases of cadmium poisoning are likely to be infrequent. The Minister of Pensions and National Insurance made these decisions following a recommendation by the Industrial Injuries Advisory Council.

British Medical Association

PROCEEDINGS OF COUNCIL

The Council of the British Medical Association met on May 2 and 3 at B.M.A. House, with Dr. E. A. GREGG in the chair. The business dealt with on the first day was concerned mainly with routine matters, and on the second day with the report of the Committee (the Constitution Committee) set up on the instructions of the Representative Body in 1953 to examine and report on the present structure and constitution of the Association, with special reference to the reorganization of the Representative Body. A report on this part of the Council's proceedings will appear in next week's *Supplement*. The Council sat from 10 a.m. to 7.15 p.m. on the first day and completed its deliberations by four o'clock on the second. On May 3 a deputation of three doctors from the U.S.S.R. was received. They conveyed an invitation from the President of the Academy of Medical Sciences (U.S.S.R.) and the Minister of Health of the U.S.S.R. for six doctors to visit the U.S.S.R. in August this year.

Also on May 3 the new House Banner of the British Medical Association was unfurled above the Great Hall.

Appointments and Representations

The CHAIRMAN, before the business commenced, congratulated Mr. Tudor Thomas, Past President and Vice-President of the Association, on his appointment as High Sheriff for the County of Breconshire.

It was reported that Mr. T. Holmes Sellors was unable to accept the invitation to represent the Association at the International Congress of Diseases of the Chest and that Dr. T. W. Davies had accepted the Chairman's invitation to do so. Dr. R. E. Smith, of Rugby, had accepted the invitation to represent the Association on the proposed National Committee on Poliomyelitis. Professor R. A. McCance was appointed official delegate to the annual meeting of the Canadian Medical Association at Quebec in June. Dr. J. A. Moody was re-elected representative of the Council on the governing body of the British Postgraduate Medical Federation.

The result of the election of 40 members of Council for 1956–7 was reported, all except two being returned unopposed.

Arrangements Committee (Newcastle-upon-Tyne, 1957)

Mr. WELDON P. T. WATTS, chairman, presented the report of the Arrangements Committee for the 1957 annual meeting. The Committee recommended that three plenary sessions should be held to discuss (1) the management of hypertension, (2) the present status of prophylactic immunization, and (3) the care of the dying, together with recommendations on the speakers who should be invited to deal with the different aspects of each subject. It was also recommended that there should be 18 Scientific Sections. A recommendation arising out of the procedure adopted in Toronto last year, that the President should be installed at the adjourned Annual General Meeting in the evening instead of at the Annual General Meeting at midday, was accepted. It was also agreed that this should be the procedure to be adopted this year at Brighton.

The Dispute in Malta

Major-General J. C. A. DOWSE, reporting on the present position in Malta, said that agreement was reached between the Malta Doctors' Union and the Government on April 25 that there should be a resumption of service and a suspension of the ban. The Medical Officers' Union agreed to withdraw all resignations and to restore the full normal medical service. The Union was pledged not to take any action under the bond which existed between its members until the Commission to be appointed to go into the medical service had submitted its report. The Government agreed to reinstate all doctors as soon as the agreement was signed under the same conditions as before, including continuity of service and pensions; the *status quo* would be restored in each case. The reinstated officers would be considered as having been on unpaid leave.

The Government of Malta was taking immediate steps to appoint a commission which would undertake a comprehensive review of the medical service and submit recommendations for the future organization and terms and conditions of employment. The commission would be composed of members from the United Kingdom to be approved by both parties and consisting of a chairman of legal status and two members to be nominated by the Royal College of Physicians and Royal College of Surgeons, and it was hoped it would undertake its task as soon as possible. The report would be made available to the Union as soon as it was made known to the Government. The Minister of Health had authorized the Union to state that he did not accuse the medical profession of dishonesty in a speech to the Legislative Assembly on March 21.

The Government undertook from the signing of the agreement until the Commission's report was submitted not to transfer any doctors in Government employ with private practices, or to take any other action against any doctor except in accordance with disciplinary proceedings taken in conformity with the Colonial Regulations as applicable generally to public services. No transfers would be made or disciplinary action taken for trade union activities or for political views expressed by doctors when not performing their official duties. The Minister of Health also undertook to re-employ the five doctors who had been dismissed; their allocation would be determined by the Minister and their conditions of employment would be as before. New posts already proposed by the Government would be re-advertised and be filled on a temporary basis pending the report of the Commission. The salary would be £600 plus cost-of-living bonus. No other posts would be created except by agreement. The Government had agreed that no action would be taken to fill the advertised posts on the island of Gozo or similar posts in Malta until the report of the Commission had been considered.

Mr. J. L. Gilks, Chairman of the Overseas Committee of the B.M.A., was now in Malta in consultation with the profession. An expression of grateful thanks for the support rendered to them had been received from the Maltese doctors.

The CHAIRMAN felt that the Council could express its satisfaction with the negotiations so far. Future developments would be awaited with great interest.

Mr. H. H. LANGSTON asked if the Overseas Committee was keeping a close watch on the conditions of service of the various branches of the Colonial Medical Service. Registrars unable to find posts in this country had looked to the Colonial Service for employment, and he had been disturbed by the contents of letters received from them. As he understood it there was a considerable amount of dissatisfaction arising from too much control and lack of modern drugs and modern appliances

Major-General DOWSE said that a large portion of the efforts of the Overseas Committee were spent in that direction; there was a constant review of the suggestions made by the Colonial Governments, and inquiries would be made

into specific points. There had been considerable success in persuading the authorities to improve conditions in the Colonies.

Dr. J. A. PRIDHAM said that the work done in Malta was somewhat unique in the history of the British Medical Association and he hoped it would receive adequate publicity. It showed the flexibility of the constitution that it was possible to assist colleagues overseas.

The Council passed a warm vote of thanks to Dr. E. Grey-Turner for the amount of work he had put in. The Council requested also that its thanks should be conveyed to Mr. J. L. Gilks for his willingness to go to Malta at short notice in straightening matters out.

The Waverley Committee

Presenting the Report of the Armed Forces Committee, Major-General J. C. A. DOWSE said that the Waverley Report had now been received and a subcommittee had been appointed to examine it in detail. In a preliminary consideration the Committee had noted with concern that the Waverley pay recommendations fell below the proposals made by the Association, which were based on a comparison with civilian remuneration. The principle that the pay of medical officers in the Armed Forces must be related to the remuneration of other branches of the profession was regarded as fundamental. The Committee was seriously dissatisfied with the present position because remuneration in the Armed Forces did not compare favourably with that of civilian doctors. The proposal to split the medical service by having a separate scale of promotion for specialists was viewed with disfavour. There were, however, many useful features in the Report, and the evidence given by the Association had had a marked influence on the Waverley Committee.

A further report to Council would be made when the Committee had had a further opportunity of studying the document.

Private Practice Committee

Dr. A. BROWN moved the reception of the Report of the Private Practice Committee. It was agreed that the revised scale of fees for payment to practitioners in England and Wales called in by the police should be presented to the Representative Body for approval.

Dr. Brown next moved a recommendation that representations should be made to the Committee on Car Parking in Inner London that a medical practitioner using a car in the course of his practice should be allowed to park in a prohibited area. He said that the present arrangements with regard to the parking of doctors' cars were not working satisfactorily and patients had had to be refused because of this. The Committee felt that representatives of the Metropolitan Counties Branch should give evidence to the Commission on these points. It was emphasized that the important point was "parking in the course of his practice."

Dr. F. GRAY was sure that the Metropolitan Counties Branch would accept the suggestion.

A model schedule of fees, allowances, and disbursements payable by a coroner under Sect. 25 of the Coroners Act, 1887, was approved for submission to the Home Office, that department to be requested to recommend its adoption to the local authorities concerned. The Committee had noted that the Central Consultants and Specialists Committee had decided to press for payment for fractions of a mile in the mileage allowances for part-time medical services for Government departments, but it was felt that the advantage gained by the removal of the upper limit more than outweighed any disadvantage from the payment for completed miles only.

The report of the deputation to the Minister of Health regarding the provision of drugs for private patients under the National Health Service was discussed and referred to the Committees concerned for consideration and report at a later date.

Dispute with the Treasury

Mr. T. HOLMES SELLORS said that when negotiations with the Treasury on the fees to be paid to consultants for sessional work for Government departments were in hand the Treasury was informed that this was work which should be undertaken by consultants only, and it was persuaded to withdraw the proposed separate schedule of fees for S.H.M.O.s. It was not foreseen that the new arrangements would prove detrimental to certain S.H.M.O.s who had been engaged in this work, in some cases for many years. When he interviewed a Treasury official he explained that it had been assumed that there would be a "no detriment" provision safeguarding the position of the S.H.M.O.s concerned. The Treasury official stated that had a "no detriment" clause been asked for the Treasury would not have agreed to abandon the separate schedule of fees for S.H.M.O.s, that the S.H.M.O.s had been given three months' notice and had ample time to find other work. A subsequent letter stated that except where a consultant was not available no exception could be made to the rule of employing consultants only in accordance with the agreement.

This state of affairs was reported to the Council at its meeting in February last and it was decided to approach the Treasury at a higher level. Eventually an interview was obtained with Miss Edith Pitt, M.P., Parliamentary Secretary to the Minister of Pensions and National Insurance, which Mr. Holmes Sellors, as chairman of the Consultants and Specialists Committee, attended with the Secretary and Assistant Secretary (Dr. S. J. Hadfield). The Chairman of Council was unable to attend because very short notice of the appointment was given. Every endeavour was made to put forward the Association's point of view without success.

The Council had before it a long explanatory statement from the Minister of Pensions and National Insurance. This was considered to be unsatisfactory, and it was left to Mr. Holmes Sellors to pursue the matter.

Central Consultants and Specialists Committee

Mr. HOLMES SELLORS moved the reception of the Report of the Central Consultants and Specialists Committee. The Committee had considered the motion referred to it by Council at the February meeting by Dr. S. F. Logan Dahne that no new S.H.M.O. appointments be advertised in the *British Medical Journal*. The Committee was in sympathy with the spirit of the motion, but suggested that the correct course would be to continue to keep a careful watch on S.H.M.O. advertisements in an endeavour to prevent unsuitable appointments. The Joint Consultants Committee had been informed of the Committee's anxiety about the way in which the S.H.M.O. Circular (RHB 50/96) was being applied, and had been asked to urge the Ministry to instruct hospital boards to consult the regional consultants and specialists committees before advertisements of vacancies were sent to the medical press. The revision of the circular was now being considered in consultation with the S.H.M.O. Group.

The Committee, having considered a number of resolutions passed by the Representative Body relating to the remuneration of S.H.M.O.s and house-officers, would keep them in mind in connexion with the reorganization of the structure of hospital medical staffing now under active consideration.

With regard to hospital medical staffing, the Committee has given further consideration to certain resolutions of the Representative Body, 1955, and the view has been expressed that a survey of consultant establishments was an essential prerequisite to any alterations in the structure of hospital medical staffing. There should be an expansion in the specialties where there was shown to be need for it, and existing S.H.M.O.s should be subjected to review and, where appropriate, absorbed into the consultant establishment before they were assimilated into any new structure of hospital medical staffing. The view of the Representative Body was

accepted that the grade immediately below the consultant should be regarded as part of the senior medical staff.

It was not considered practicable that all grades of medical staff should necessarily be represented on committees dealing with the review of hospital staffing.

Resolutions of the Representative Body on negotiating machinery had also been considered, and the Committee agreed that professional financial advice should be sought whenever necessary. Although the Committee was by no means satisfied with the operation of the Whitley machinery, withdrawal would have disadvantages greater than the advantages. The Staff Side of Committee B endorsed this view.

On this point, Mr. A. LAWRENCE ABEL drew the attention of Council to the necessity for employing legal assistance in negotiations.

Watch was being kept on the position with regard to pre-registration posts, and Dr. D. S. PRACY said that many of the posts advertised at present were not suitable for pre-registration posts. Was there no senate responsible for supervising pre-registration practitioners?

Mr. LANGSTON said that one of the difficulties with regard to S.H.M.O. posts was that one did not hear about them until a board decided that a post should be made: boards must be persuaded to consult the regional consultants and specialists committees at a much earlier stage. The Ministry could be asked to urge this course upon the regional hospital boards.

Dr. F. M. ROSE thought there was too much complacency about the arrangements for the pre-registration posts. There were difficulties which did not appear on the surface. There were plenty of house-surgeon posts, a limited number of medical posts, and an even more limited number of midwifery posts. Women could get these posts without difficulty, but once a male graduate had been in the Forces he could not take them because he was no longer in the pre-registration category.

Dr. BEAUCHAMP asked if it was a fact that a general practitioner attending a woman in a general-practitioner obstetric bed was debarred from calling in a consultant anaesthetist, whereas one could be called in a domiciliary confinement.

Mr. ABEL asked if legal advice had been obtained on the junior staffing proposals.

Mr. HOLMES SELLORS replied that the actual wording of the A.R.M. resolution was that legal advice should be obtained "where necessary," and he was quite certain the Joint Committee would take legal advice. With regard to the question of suitable pre-registration posts, control was exercised by the General Medical Council, the licensing body.

The Report was accepted.

General Medical Services Committee

Dr. A. TALBOT ROGERS, chairman, moved the reception of the Report, most of the items in which have been dealt with in the reports of the Committee meetings published in the *British Medical Journal Supplement* on March 31 (p. 109) and May 5 (p. 260). Special attention was drawn to the item relating to the agreement of the Committee with the Ophthalmic Group Committee that a child's doctor should be notified when the school medical officer referred a child for ophthalmic examination, and that the words excepting this examination should be deleted from the joint policy of the Association with the Society of Medical Officers of Health. This was not in accordance with the view of the Public Health Committee, which suggested that the phrase "other than an ophthalmic examination" should be amended to read "other than an examination for refraction."

Dr. J. B. TILLEY, chairman of the Public Health Committee, said that the major point was the size of the problem. It would be agreed that the policy adopted with regard to the reference of schoolchildren had worked well. In his authority he was responsible for 76,000 children. Dr. Scott in London must be responsible for more than half a million. In Northumberland some thousands were referred to consultants for conditions other than ocular conditions, less than a dozen for conditions which needed an ophthalmologist's opinion; thousands were referred for refraction. In his area there was a policy of screening children for refraction by a consultant in active practice who was employed on a sessional basis. If they were referred to their family doctor by far the majority were referred to opticians, something which one did not want for schoolchildren.

If this alteration in policy was insisted upon it would place a considerable burden on local health authorities. Without a reply the children could not be referred to a consultant, and an unnecessary bar would be placed in the way of a completely simple operation. How many doctors would reply? He knew the Ophthalmic Group Committee felt strongly about this, and he suggested that there should be consultation between that Committee, the Public Health Committee, and the General Medical Services Committee before any recommendation was made to the Representative Body.

Dr. ROSE, who opposed the suggestion in the G.M.S. Committee, said that if it were adopted other arrangements would be endangered.

Dr. I. G. INNES thanked Dr. Tilley for his explanation. He was quite unaware that such a large number of refractions were referred to consultants.

Dr. DAHNE asked if Dr. Tilley informed general practitioners that one of their patients had been so referred, and Dr. TILLEY said that he did not.

Dr. W. WOOLLEY said that all that the G.M.S. Committee was saying was that before a child was referred to a consultant for refraction the general practitioner should be informed and asked whether he would like the school medical officer to do it. In reply to Dr. Tilley's remark about the lack of response, there were quite a number of medical practitioners who answered postcards about other things and would answer postcards about refraction.

Dr. A. BARKER said that his experience had been that when children were not referred to the school clinic they went to an optician. The position would be hopelessly clogged up with all these letters.

Mr. J. W. TUDOR THOMAS said that the Ophthalmic Group Committee felt very strongly on this question. When a child was referred for refraction it really meant it was referred for an ophthalmic examination, which ought to be carried out by an ophthalmic surgeon.

The suggestion that there should be consultation between the three committees was accepted, and the Council agreed that the recommendation to the Representative Body passed at the last meeting of Council should be deferred for the time being.

Gold-headed Cane

After a prolonged discussion the Council resolved:

That the Council wishes to dissociate itself from the publication of the leading article "The Gold-headed Cane" in the *British Medical Journal* of April 7, 1956, of which article the Council had no prior knowledge, the article being entirely the responsibility of the Editor, according to the usual practice.

The remainder of the proceedings of Council will be reported in next week's *Supplement*.

The Duke of Beaufort has become patron of the Western Provident Association for Hospital and Nursing Home Services. It was announced at the meeting of the board of governors on February 2 that he is succeeded in the presidency by Mr. Egbert Cadbury. Since its formation as the Bristol Hospitals Provident Fund in 1945, the Association has steadily increased its income, which, at over £87,000 in 1955, exceeded that for 1954 by over £31,000, or 56%. A new group scheme, whereby subscriptions may be deducted from salaries and remitted to the association quarterly, is reported to be gaining strength rapidly.

WAS IT A DRUG?

Regulations 16 and 17 of the National Health Service (Service Committees and Tribunal) Regulations, 1948, provide that where a practitioner prescribes under the National Health Service preparations which are not drugs or medicines, and therefore outside the scope of the Act, the executive council may recover their cost from him. If he challenges their action the matter may be referred to the local medical committee, with the possibility of appeal to referees.

The findings of the referees in a recent appeal under the Regulations are reported below. The decision in this, as in all cases, is related to the circumstances of this particular case only and is not binding on the referees who may hear other cases.

"Covicone"

Dr. X prescribed, in all, 8 oz. of covicone for three patients; Dr. Y prescribed 4 oz. for one patient; and Dr. Z prescribed one tube for one patient. All five patients suffered from long-standing or acute dermatitis. The executive council decided that none of the covicone so prescribed was a drug which it was bound to provide. All three doctors appealed to the local medical committee, which upheld the decision of the executive council. The three doctors then appealed to the referees.

Mr. A, appearing for the three doctors, said that the local medical committee felt itself bound by recent decisions of referees on the use of covicone, and asked for the referees' opinion. The referees had had no collective statement from the committee that this consideration entered into the reasons for its decisions. It was, however, a fact that in several cases other referees had held that covicone could not be classed as a drug for preventing skin disease because its action was purely mechanical. The referees understood that every case referred to them should be judged on its merits.

Mr. A then admitted that covicone was completely inert, with no direct or chemical effect on any disease, but contended that in these five cases it could be considered as a drug, the medicinal purpose being to provide for the affected area a protective and soothing cover under which the body would repair itself—one object of medicine generally being to help the body to repair itself. Covicone was a more effective covering than oiled silk or "elastoplast" because it adhered closely to the skin, and the silicone which it contained had the property of repelling water. All the patients were cured, except one, in whose case the treatment was discontinued when the doctor learned the views of the executive council about covicone. Mr. A then argued that the *National Formulary* included a number of barrier creams and other substances whose only purpose was to give a protective covering—for example, quinine and tannin ointments, zinc oxide, and collodion. If executive councils always accepted these substances as drugs, because they were included in the *National Formulary*, other substances which operated in exactly the same way and were prescribed for exactly the same purpose ought also to be accepted as drugs, though not included in the *National Formulary*. In four out of the five cases a large number of traditional remedies had been used without success. The decision to use covicone was reached by a process of trial and error.

Mr. B, appearing for the Minister, contended that covicone had no medicinal character. It was used in the treatment of disease, but by a mechanical and not a medicinal method. It did not become a drug because it repelled water any more than did oiled silk because it was impervious to water. Executive councils were limited by the Act to supply proper and sufficient drugs and medicines and prescribed medical appliances. Covicone might perhaps be regarded as an appliance, but the Minister had not prescribed it. Until this was done medical practitioners had no authority to order it at the expense of executive councils. If zinc oxide, collodion, or any other substance was intended to be used for a mechanical and not a medicinal purpose it ought not to be ordered on form E.C.10.

In their findings the referees stated their opinion that covicone was not the kind of thing that would, in a general way, be regarded as a medicine; it was more in the nature of a medical appliance. The purpose of providing an affected part of the body with a protective covering, though clearly a medical purpose, could hardly be described as medicinal. If executive councils passed some barrier creams without question, this was not a good reason for saying that all barrier creams should be classed as medicines. They could not investigate every prescription; they must start from some sort of arbitrary classification to determine which were the prescriptions that they would investigate. And many traditional remedies, which, if investigated, might in some cases be found not to be medicines, were in the class which was not investigated. The medical members of the board of referees did, however, discern a medicinal purpose in all these five cases. In four of them many other remedies, including traditional barrier creams, had been tried without success. The covicone effected a cure. It looked as if it had some property which the other barrier creams lacked. It had often been held, especially in cases of skin disease, that where many other remedies had been tried without success the prescription of something which would not as a rule be regarded as medicine might be justified. In the fifth case the affected area was on the legs, and the disease was traced to a detergent used for washing the patient's clothes. It might well have been impracticable to devise a system of bandages to afford an adequate protective covering. They decided that this covicone was, in all five cases, a drug which the executive council was bound to provide.

FIFTY YEARS BETWEEN*

PRACTICE FINANCE THEN AND NOW

Recently I came across my father's accounts of fifty years ago and found the comparison with my own of great interest, as an indication of the serious loss of earning power of general practitioners. My father's and mother's parents were both public-school masters, and my wife's family were public-school masters and clergy in precisely the same social group, so my father's home and my own must have been planned on a very closely related set of values and mode of life.

Then

My father was born in 1866, and after going to Cambridge and a London teaching hospital he settled in practice by putting up his plate in 1892 or 1893. He chose a small town 20 miles from London where his family had lived for many years, and this no doubt helped him to build up his practice. This town and a neighbouring village had a combined population of 5,500 in 1900, and they lay in an area separated by natural barriers from the neighbouring centre of population.

There was one other doctor in this area, and no doubt there was some infiltration by the doctors from the neighbouring town, from where my father also acquired some patients as his practice progressed. But it is fair to say that my father and the other doctor served a population of between 5,500 and 6,000, as the natural barriers prevented much infiltration either way.

My father rented professional accommodation in the village for £20 16s. a year, and in 1897 he moved into a better house in the High Street of the town, where he also

*The author of this article wishes to remain anonymous.

had consulting accommodation. It cost him £27 16s. to have electric light installed, and furnishing the new house cost £206.

All his dispensing was done by the chemist; he travelled about his practice on a bicycle, and in bad weather hired a "brougham" or a "hansom." I have no record of the number of patients he visited, but I have often talked about his work to my mother, and I have learnt from her that he was at home most evenings, but sometimes paid a late visit to cases of serious illness. On Sundays, after attending the early church service, he usually visited in the mornings, the remainder of Sunday being free. During the week he took one afternoon off in addition to most of Saturday afternoon, and in the summer he usually finished work about half-past five. I have estimated that he probably worked about 65 hours a week in the winter, and 50 hours or less in the summer. He went away for four or five weeks each year, and this included two weeks each spring, when he returned to his old hospital to keep himself up to date. He engaged a locumtenent to look after his practice while he was away, to whom he paid about £5 a week.

I have tabulated his principal expenses for the three years 1900 to 1902. During this period his household consisted of himself and my mother, two young children, a "nanny," a cook, a house-parlourmaid, and for much of the time a nursemaid (living out) to push the "mail-cart." The housekeeping for this household averaged £228 a year. This figure includes all food, groceries, and cleaning materials, but excludes drinks and laundry, the latter costing £38 a year. Counting the two children as one adult, this works out at just over 12s. per head per week.

After about eleven years in practice, and a few months before I was born, my father died, aged 39, from an infection caught from one of his patients.

Now

Like my father, I went into practice after going to Cambridge and a London teaching hospital. I started in partnership in London in 1933, but my partner retired at the beginning of the second world war, and when I joined the Forces my practice, which had been wholly private, was left to look after itself. When I returned in 1946 the goodwill that remained enabled me to rebuild my practice fairly quickly. My father and I, therefore, were both fortunate in being in a position to gather a practice fast enough to compensate for our lack of capital assets.

I rented a flat and surgery accommodation about half a mile away. I started National Health Insurance practice at once in 1946, and in 1948 undertook National Health Service work, in addition to what private work I could find. I have taken the three years 1950 to 1952 to compare with my father's practice just fifty years before, and to include my own experience under the N.H.S.

During these three years my household consisted of myself, my wife, and two school-age children. We had no resident domestic assistance, but my wife had daily help for about 10 hours a week. At my flat telephone and door-answering arrangements cost me only 10s. a week, and the cost of a telephone extension, through the kind co-operation of the porter of the flats. Similar services were provided by the caretakers at the surgery, the cost being included in the rent I paid there.

In those years I had to work as hard as possible, as it was naturally my hope to give my children the same kind of education as I had had. I travelled round my practice in a car, and during the winter months I did not finish visiting till 10 or 11 p.m. on five nights a week. I took one afternoon off in the week, but Saturday was a full working day, and I took alternate Sunday duty with a colleague. The summer was better, but I doubt if I ever finished before 7 p.m. on five nights a week. Generally in the winter, therefore, I worked between 70 and 80 hours a week, and in the summer about 60 hours a week. I always took four weeks' holiday and had a reciprocal arrangement with a colleague to look after my practice, though I had to provide a part-time locum for one surgery a day (£1 11s. 6d. per session).

My father never had a secretary, and paid the chemist to do his dispensing. Under the N.H.S. the chemists did my dispensing with no cost to myself, but the modern requirements of record-keeping and the need for detailed accounts for income-tax purposes made it very necessary for me to have a secretary after 1947. Since 1952 expenses have increased considerably all round, and I have suffered a very heavy increase in rent and expect a further increase shortly.

The Difference

The table of accounts shows my expenses as compared with my father's. The table and the short account of our practices show that my father was able to have a reasonable income for the period at the same time as having a reasonable life. By good fortune I have been luckier than many of my colleagues in that I acquired an income above average for my time, but I achieved that only by persistent overwork and by sacrificing much of my family life. And then, after paying all the fundamental expenses demanded by my position, I only had on average twice as much cash as my father to spend on such things as food, education, holidays, amusements, savings, etc., and this when prices

	1950	1951	1952	1900	1901	1902
	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.
Earnings	*4,688 0 0*	*4,699 0 0*	*4,920 0 0*	*1,483 0 0*	*1,575 0 0*	*1,916 0 0*
Chemist, pathology, etc. (dispensing)	150 9 8	145 7 10	152 18 0	149 10 4	153 17 9	201 12 6
Car expenses (bicycle and cabs)	239 5 4	323 4 9	264 0 2	52 13 7	36 6 0	46 17 0
Postage and stationery	74 14 8	70 15 8	66 12 9	13 19 0	12 19 6	13 2 7
Locums	42 10 6	37 16 0	44 12 6	27 14 0	27 6 6	23 19 6
Secretary's salary	253 18 0	263 18 4	292 8 0	Nil	Nil	Nil
National insurance	24 19 1	25 15 6	36 1 8			
Personal ,,	195 10 8	198 10 7	199 16 11	103 ,,6 9	103 ,,6 9	103 ,,6 9
Pension contribution	130 14 3	135 2 7	144 3 6	Nil	Nil	Nil
Accountancy	10 10 0	15 15 0	15 15 0	,,	,,	,,
Telephone	47 1 11	44 8 1	46 1 5	,,	,,	,,
Subscriptions	19 18 0	21 16 0	27 18 0	23 0 6	19 12 0	31 6 0
Surgery rent (and cleaning)	176 0 0	201 10 0	210 0 0	20 16 0	20 16 0	20 16 0
Cleaner	23 8 0	23 8 0	53 15 0	—	—	—
Residence:						
Flat rent, rates, heat, and light	320 4 6	332 7 5	326 10 8	111 9 1	116 16 10	126 6 2
Daily help	39 0 0	39 0 0	39 0 0	—	—	—
Porter (part-time door and telephone)	26 0 0	26 0 0	26 0 0	—	—	—
(3 servants' wages)	—	—	—	73 4 6	77 13 6	78 16 3
Repairs, redecoration, etc.	24 12 6	138 16 6	254 5 1	31 0 3	25 9 7	57 18 3
Income tax	1,168 11 0	1,343 7 6	835 3 6	31 14 4	53 15 5	75 3 2
	2,967 8 1	3,386 19 9	3,035 2 2	638 8 4	647 19 10	779 4 2
Balance	*1,721 0 0*	*1,312 0 0*	*1,885 0 0*	*845 0 0*	*927 0 0*	*1,137 0 0*
(Invested or saved)				231 2 10	235 3 11	430 0 6
No. on N.H.S. List	3,328	3,498	3,519			

were four or five times higher. The equation works out at about half as much money for twice as much work.

How other general practitioners, less fortunate than myself, can manage to have a tolerable life and educate their children up to the same standard as themselves I fail to understand. Surely no occupation in trade or profession can hope to attract a good quality of new entrants unless the financial opportunities offered give a fair chance of maintaining the standards of life and education necessary for the calling.

S.H.M.O. AWARD

FINDINGS OF INDUSTRIAL COURT

The Industrial Court met on April 13 to determine a difference between the Management and Staff Sides of Committee B of the Medical Council on the Whitley Councils for the Health Services (Great Britain) arising out of the Staff Side's proposals for an increase in the present salary scale of the existing senior hospital medical officer grade for medical staff employed in the National Health Service.

The Court has now announced that it has awarded, as from the date of the hearing, an increase of £75 in the salary scales of senior hospital medical officers at all points. The award is "without prejudice to any negotiations current or pending between the parties hereto as to the general salary structure for the medical section of hospital staffs and the point in the salary scales at which senior hospital medical officers should be placed."

The present salary scale of senior hospital medical officers is £1,500 to £1,950. The Staff Side claimed:

(1) Main scale: £1,700×£50—£2,150 per annum. Scale for those appointed at age 30 or less: £1,600×£50—£2,150 per annum. Scale for those appointed at age 31: £1,650×£50—£2,150 per annum.

(2) The main scale to apply to senior hospital medical officers appointed at the age of 32 or over, subject to the provisions of paragraph 2(a)(2) of the Terms and Conditions of Service.

(3) The proposed scales to be implemented with effect from May 1, 1955.

(4) Assimilation to the new scales to be on the basis of "corresponding points."

(5) The operation of the proposed salary scales not in any circumstances to result in reducing the salary of any senior hospital medical officer now in post.

The award concerns approximately 2,630 senior hospital medical officers, of whom 1,441 are employed whole-time in the hospital service and 1,190 part-time. These figures are for June 30, 1955.

WELSH COMMITTEE

The Association's Welsh Committee met in Shrewsbury recently under the chairmanship of Dr. T. W. DAVIES of Swansea.

The main item for consideration was the function of the Committee. Some members felt that the interests of practitioners in Wales were adequately covered by the Welsh Association of Local Medical Committees (and the local medical committees it represents) and the Welsh Regional Consultants and Specialists Committee. Several members, however, pointed out the value of having a B.M.A. Welsh Committee which could co-ordinate the activities and safeguard the interests of all practitioners in Wales, including also public health medical officers and industrial medical officers. It was agreed to pursue the possibilities of liaison with other bodies in the principality in order that there should be an exchange of reports on matters of mutual interest between the various committees.

Arrangements for the Welsh Dinner of the Association, to be held at Brighton on July 6, were reported (see *Supplement*, April 21, p. 203).

A complaint was received from the North Wales Branch that a number of practitioners in the coastal resorts of North Wales were suffering financial hardship, and had been for some years, as a result of the impact upon their practices of the National Health Service. The Committee decided to institute an inquiry among these practitioners in order to ascertain details on which an assessment could be made of the size and the gravity of the problem.

A further meeting was arranged for June 27 in order that representatives of Divisions, who constitute the major part of the Committee, should have an opportunity of discussing the Agenda of the Annual Representative Meeting.

Questions Answered

Remuneration of Assistant's Wife

Q.—*I am an assistant in general practice. I engage my wife 74 hours a week in answering the telephone, door, etc. Can I claim income-tax relief on what I pay her? At the onset of my employment I was offered the services of a maid, but had to refuse through lack of accommodation. Am I entitled to any allowance in lieu of the maid?*

A.—Employment as an assistant involves tax assessment under Schedule E with allowance only for expenses "necessarily" incurred in the performance of the employee's duties, and unless there is a clause in the contract of employment requiring the wife's services it is unlikely that any allowance would be granted. If those services are in fact essential it would seem advisable that it should be so stated as a condition of the husband's employment, in which case allowance could be claimed for a salary fairly remunerating the services actually rendered, provided that salary is actually paid. Alternatively, the wife could be separately employed by the principal, and if the services of a maid are carried out by her this can properly be taken into account in deciding the salary, but no allowance can be claimed for a notional salary if no such expense is actually incurred.

Changing from Schedule D to E

Q.—*I am a part-time consultant on Schedule D assessment for income-tax purposes, and have been informed that I shall be assessed on Schedule E for the coming year. In addition to the usual monthly payments from my salary for 1956–7, Schedule D tax will be due for 1955–6, normally payable on January 1 and July 1, 1956. It would mean considerable hardship to have to pay two years' income tax in the year January, 1956, to January, 1957, but I am informed that the whole of my Schedule D tax for 1955–6 must be paid as due on July 1, or at the latest September 1, this year, virtually no concession being made. Can any further concession be obtained, and, if so, to whom should I apply?*

A.—If the Revenue has good grounds on which to change from Schedule D to Schedule E—i.e., if the major part of the income is derived from appointments properly assessable under Schedule E—there appears to be no general concession to give relief from the element of hardship involved in paying more than 12 months' tax in one calendar year. Any extension of time for payment is a matter for the collector, but if the amount is such that serious financial difficulty arises a personal interview may result in a more helpful attitude.

In reply to questions put to the chairman of the Health Committee at the meeting of the London County Council on March 20, it was stated that the annual cost to the council of Woodbury Down Health Centre is about £30,000. Excluding the day nursery, there were 2,038 attendances weekly in November, 1954, compared with 2,057 in November, 1955, but there was a small reduction in attendances at general practitioners' surgeries. The centre was meeting with the success anticipated, having regard to the experimental nature of health centres generally.

Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Non-disciplinary Erasure from the Register

SIR,—It is not generally realized that under the Medical Acts 1858–1950 the name of a registered medical practitioner may be lawfully erased from the *Medical Register* if he fails to reply to an inquiry from the Registrar of the General Medical Council concerning his address and/or possible retirement from active practice. Restoration of a name so erased is a costly and tiresome business. Application must be supported by an affidavit and at least two certificates of identity and good character, together with a fee.

Medical defence societies are seriously disturbed at the number of their members whose names are so erased. Not only are they unwittingly and illegally engaging in practice in the mistaken belief that they are registered medical practitioners but they may find themselves removed from membership of their defence society, which would prove a serious matter if they became involved in threatened or actual litigation.

It therefore behoves every medical practitioner from time to time to satisfy himself that his name appears in the *Medical Register* and to furnish an address at which he can be reached by communications from the General Medical Council or from the defence societies. In their own interests, both present and future, practitioners are strongly urged to give attention to this matter immediately and thereby ensure that they are not acting illegally or deprived of the necessary legal advice and protection should medico-legal trouble arise in the conduct of their professional duties.—We are, etc.,

ROBERT FORBES,
Secretary, Medical Defence Union.

ALISTAIR FRENCH,
Secretary, Medical Protection Society.

C. C. MILLAR,
Secretary, Medical and Dental Defence Union of Scotland.

Defence of the Middle Classes

SIR,—Dr. J. Leahy Taylor's letter (*Supplement*, May 5, p. 265) contains many succinct facts that I feel demand a full and authoritative examination which is much overdue, but when he refers to the inarticulateness of the middle classes I am sure they will remain inarticulate or at least impotent if they forgo their professional status to join an organization that stands for nothing and represents nobody but Mr. Henry Price and a heterogeneous mass of discontented Smiths and Browns.

No, we do not need Mr. Price. The way to gain an effective hearing lies in our own hands through the medium of the various professional associations and organizations already in existence which can and do speak on behalf of their members. It is surely possible and practicable for delegates from all these bodies to unite to form one national council which would speak, as does the T.U.C., for all its member organizations, and which would carry the full weight of professional opinion (accountants, architects, civil servants, dentists, doctors, engineers, lawyers, pharmacists, school-teachers, etc.) behind it. At the next budget we might then see the Government consulting not only the Employers Federation and the T.U.C. but our own national council as well.

I urge the B.M.A. to consider seriously the possibility of inaugurating such a council.—I am, etc.,

London, S.W.11. GORDON SUTCLIFFE.

Salaried Service

SIR,—It is evident that Dr. W. E. R. Branch (*Supplement*, April 28, p. 250) has never worked in a State-salaried service or he would not have glibly asserted that "the loss of our hypothetical freedom . . . would be a small price to pay . . ."

Sir, we have already lost some of our real freedom of movement and entry into practice through the loss of goodwill, but we have much left, and as true Englishmen it is our duty to fight for this to the last gasp. We can furnish and equip our surgeries as we wish, we can employ a dispenser of our own choosing (if we can afford one), we can arrange our off-duty and holidays when we like (if we have but one partner), and we are free from daily interference from a centralized medical bureaucracy. Surely no one could call this freedom "hypothetical," and, believe me, if we lost it by accepting a salaried service the price paid would be incalculable.

Let no one think that the public would be one whit better served by salaried doctors. I do not believe that there is any demand from patients for such a change, nor do I believe that they would like it if, by our own folly or the ignorance of some doctrinaire government, such a scheme were to be established.

It is true, of course, that many doctors are overworked and underpaid, but the remedy is not centralized planning with Government-provided accommodation, ancillary help, and facilities for practice. All this means loss of freedom, standardization, control, inspections, reports, and the other irritations which take the joy out of life for self-respecting individualists. On the contrary, I believe that an improvement in our present semi-nationalized system could be much more easily realized by the introduction of financial incentives for work done and more generous allowances for expenses. If our general level of income was raised by this means principals would be able to afford an extra partner if they were overworked, and if doctors were paid to some extent per item of service they would do more effective work than most of us do at present.—I am, etc.,

Bungay, Suffolk. HUGH CANE.

SIR,—I am most grateful to you for publishing the letter from Dr. B. Hirsh under this heading (*Supplement*, April 21, p. 208). For some time now I have been going about my daily duties in complete ignorance of the appalling conditions that must be threatening the livelihood of the great majority of my fellow general practitioners. My complacency has now been quite rightly destroyed, and, indeed, I begin to worry lest I am perhaps the sole survivor whose cup floweth over. For in my splendid professional isolation (dare I say it ?) it has been my good fortune never to have issued a false certificate, and not once has a patient requested a bribe to remain upon my list. Only now, thanks to Dr. Hirsh, has the truth been revealed to me. So much for the "surveys" of general practice which pretended to be critical while maintaining absolute silence about the complete degradation of the practitioner (to say nothing of British industry).

If indeed there remain any colleagues blessed with equal good fortune I beg you, Sir, to permit me to use your pages to summarize "the intolerable conditions which prevail at present," of which even now a selfish few may remain in ignorance. I hope by these means to rally a nucleus of relatively free men who will press forward with me to the aid of our standard-bearers, and in particular Dr. Hirsh (whose banner appears to have fallen in the mud).

Are you aware, gentlemen, that our gallant colleagues are "more or less forced to issue certificates to people who do not feel like a week's work" ? Moreover, they have, up till now, been "forced" to pander to the principle that anybody can take a week off work when he feels like it. It is little wonder that the introduction of a salaried service would reduce the sick-pay bill by half and "introduce a new spirit into industry," for the implications cannot be

escaped. The fact is, Dr. Hirsh quotes real figures to prove it—50% of all those certificates are necessarily false.

One moment, gentlemen ! This were indeed enough to anger you, but it is not all. Apparently only 50% (thank heaven for a scientific approach in nice round figures) or approximately half those prescriptions they are "forced" to issue are destined for the treatment of disease. Because of the iniquitous system of capitation payment the remainder constitute bribes to prevent patients moving from one practice to another. Of course the new salaried service would halve the national drug bill immediately (if not before), and Dr. Hirsh would no longer be "at a standstill." Forthwith he would proceed to "move about from practice to practice," together with the "hundreds of new doctors" absorbed "into the service as colleagues." Can you not picture the delighted doctors' wives, greeting with happy cries this return to some sort of normal conditions ?

Now, steady, boys, we must keep this on "an exalted plane"—none of your working-man's dirty blackmail ("not so justified"). By the merest chance all this "halving" of bills has left us in the new Utopian State with some £70,000,000 kicking around in the kitty. Here is no problem on this exalted plane : forthwith we march on Whitehall and place it in the hands of the Chancellor, first deducting an adequate sum for an increase in pay all round, and, of course, expenses. Good-bye to "business medicine"; henceforth we march shoulder to shoulder, "honestly facing tragic facts." No more will "ghastly conditions" be "forced upon us"; we go forward into the "obvious."

I suggest that the best signal for united action would be the publication in these columns of the evidence which Dr. Hirsh undoubtedly possesses, for no responsible person lacking this could reasonably accuse his colleagues of bribery and corruption to the tune of £70m. per annum—they might be tempted into thinking he was a trifle prejudiced.—I am, etc.,

Sheffield. F. WILLE.

Doctors' Remuneration

SIR,—We the undersigned group of assistants, general practitioners, and consultants, while regretting the state of inflation at present existing, would like to record our full support of the B.M.A. claim for the implementation of Spens.—We are, etc.,

C. A. BIRKS.
T. K. BRANDRETH.
H. CHAMBERS.
F. CLOUTING.
H. COLE.
R. CUBITT.
K. FOSTER.
D. GLENDINNING.
A. A. HALL.
D. HANDFORD.
D. HORTON.
D. LONSDALE.
A. R. MATHER.
R. NETHERY.
D. W. ORTON.
G. PIMBLETT.
J. D. RICHARDSON.
J. SCHOLEY.
T. SMALLHORN.
C. E. A. THOMAS.
H. WILSON.
E. WRIGHT.

Sleaford, Lincs.

Maternity Fees

SIR,—I have as yet seen no proposal that maternity fees should attract the betterment factor.

It is widely believed that, as any increase in these fees would correspondingly reduce the central pool, there is no point in pressing for an adjustment. Such argument disregards at least two major objections. First, not all doctors who share in the pool undertake midwifery work ; secondly, that among those who do there are big differences in the amount performed, due, among other things, to wide variations in the birth rate from place to place. To press for a general increase on account of the betterment factor while at the same time not pressing for a corresponding adjustment in maternity fees is tantamount to an admission that these fees were fixed at too high a level in 1948. There is even a belief that, as the role of the general practitioner in domiciliary midwifery is under attack, the profession should "soft pedal" any claim in this field at present.

I am sure I am not alone in believing that the family doctor is still the kingpin in the domiciliary scheme and that midwifery, though most rewarding in itself, is the most urgent, upsetting, and time-consuming part of his work. Surely the best way to answer critics is boldly to affirm the family doctor's vital role and ultimate responsibility in the domiciliary field. I believe that the level of fees was about right in 1948 and is too low in 1956. Nevertheless, a powerful case can be made out for the sliding scale of fees to be extended, so that doctors who do considerably more than the present minimum demanded are proportionately rewarded.—I am, etc.,

Sheffield. JOHN R. BATTY.

Drugs for Private Patients

SIR,—Correspondence in the *Supplement* of April 21 (pp. 206–7) refers to a committee as considering that the time is not ripe for approaching the Minister of Health with a view to sorting out the present anomalies in the supply of drugs under the National Health Service as these affect the patients of private doctors. As a compulsory subscriber to the N.H.S. I should enjoy the unqualified right to benefits. Discrimination against the patient of a private practitioner is, in my view, a piece of selective injustice. If I were in need of drug therapy over long periods I might, as a private patient, be unable to afford the treatment prescribed by my doctor.

It may be politically expedient to cheat a sick person out of a moral right, but surely professional bodies stand on slippery ground when they place expediency above ethics. The present anomaly has now disgraced the working of the N.H.S. for eight years, and the time is more than ripe for the issue to be faced. I hope you will press (to quote from Dr. William Russell's letter in the same issue) "for a reform which the Representative Body desires, and to which the political party at present in power has declared itself 'as being not opposed.'"—I am, etc.,

London, N.W.4. E. J. PRYOR.

Emergency Call Service

SIR,—The General Medical Services Committee on April 19 came to the conclusion that the Emergency Call Service was an undesirable scheme, and that ethical and legal complications might create two difficult problems (*Supplement*, May 5, p. 260). I have been a subscriber of the Emergency Call Service for the last three months, during which time the Emergency Call Service has effected some hundred calls for me. All of them have been carried out in a high spirit of professional efficiency, to the entire satisfaction of the patients, their families, and myself.

Never once has the E.C.S. questioned the justifiability of a call. I suggested once or twice that a particular call of an over-anxious patient should not have been done. The supervising doctor of the E.C.S. pointed out that it is their duty to go, and it was up to the doctor, after examination, to form his opinion.

I am happy and pleased with the E.C.S. I am free in the evening, which now at last belongs to my family. My wife is no longer a slave of the telephone after 6.30 p.m. until 8 a.m. All calls go direct to the E.C.S. I do not need to approach, reluctantly, the help of a colleague in the area whenever it might be necessary, nor do I need to search for a locum. Not only in my opinion is the E.C.S. desirable, but its short existence has fully proved its irreplaceable value and its most efficient and professional high standard. I am flabbergasted at reading the General Medical Services Committee's conclusion, and wonder on what evidence its finding is based.

In using the E.C.S. legal and ethical complications are no different than using a locum, or any other professional substitute on behalf of a doctor. We all have had the troublesome experience of a bad locum or assistant. I can assure the reader that the E.C.S. has hitherto satisfied me, and that is why I feel the General Medical Services Committee should review its finding. I wonder if the General Medical Services Committee has sought legal advice *ante sessionem*, which might have saved it criticism from a cautious reader.

I wish to see in London plenty more radio cars of these enterprising, active, and high-spirited young colleagues, not only for our professional satisfaction but also as an efficient means of quick service to the public. If the British Medical Association would have organized this long overdue service, equally useful to the profession and the public, or the London Executive Council had done so, there would not have been any need for this controversy. All those colleagues using the E.C.S. to whom I have spoken about it are of similar opinion. Could not the General Medical Services Committee invite a representative of the E.C.S. and some of the doctors using the scheme—I am willing to come—to a discussion, in order to get a clear and full picture ?—I am, etc.,

London, W.11. W. WEINBERG.

B.M.A. LIBRARY

The Library service is available to all members of the Association resident in Great Britain and Northern Ireland (and by special arrangement to members of the Irish Medical Association). A copy of the Library Rules will be forwarded on application to the Librarian at B.M.A. House.

The following books have been added to the Library :

Abel-Smith, B., and Titmuss, R. M.: Cost of the National Health Service in England and Wales. 1956.
Beaudette, F. R. (Editor): Psittacosis. 1955.
Beaumont, G. E.: Clinical Approach in Medical Practice. 1956.
Buxton, St. J. D.: Arthroplasty. 1955.
Chalmers, C. H.: Bacteria in Relation to the Milk Supply. Fourth edition. 1955.
Chapman, A. W.: Story of a Modern University: A History of the University of Sheffield. 1955.
Cole, S. W.: Practical Physiological Chemistry. Tenth edition, revised and rewritten by E. Baldwin and D. J Bell. 1955.
Comroe, J. H., jun., *et al.*: The Lung: Clinical Physiology and Pulmonary Function Tests. 1955.
Copeman, W. S. C., and Mason, R. M.: Rheumatism. (Modern Health Series.) 1954.
Ellis, R. W. B. (Editor): Child Health and Development. Second edition. 1956.
Frieboes, W. and Schönfeld, W.: Atlas der Haut- und Geschlechtskrankheiten. 2. Auflage. 1955.
Hanlon, J. J.: Principles of Public Health Administration. Second edition. 1955.
Harris, H.: Introduction to Human Biochemical Genetics (Eugenics Laboratory Memoirs XXXVII). 1955.
Hieger, I.: One in Six: An Outline of the Cancer Problem. 1955.
Hill, J. B., and Hill, H. D.: Genetics and Human Heredity. 1955.
Houser, H. H.: Hentz: Of Things Not Seen. 1955.
Jones, D. C.: Spiritual Healing. 1955.
J.A.M.A.: Clinical Abstracts of Diagnosis and Treatment. 1955.
McKay, Nurse: Babies Growing Up. 1956.
Macy (Josiah, Jr., Foundation, 1930-55: A Review of Activities. 1955.
"Medica": Change of Life: Facts and Fallacies of Middle Age. Revised edition. 1955.
Menninger, K. A.: A Guide to Psychiatric Books. Second edition. 1956.
Morris-Jones, Sir H.: Doctor in the Whips' Room. 1955.
Morrison, W. W.: Diseases of the Ear, Nose, and Throat. Second edition. 1955.
Murphy, H. B. M.: Flight and Resettlement. 1955.
Neame, H., and Williamson-Noble, F. A.: Handbook of Ophthalmology. Eighth edition. 1956.
Osborne, J.: Dental Mechanics for Students. Fourth edition. 1955.
Ottosen, P.: Pulmonary Resection for Tuberculosis. 1955.
Parfitt, J. B., and Herbert, W. E.: Operative Dental Surgery. Seventh edition. 1955.
Paterson, D., and Newns, G. H.: Modern Methods of Feeding in Infancy and Childhood. Tenth edition. 1955.
Prick, J. J. G., *et al.*: Thallium Poisoning. 1955.
Raven, R. W.: Cancer and Allied Diseases. (Modern Health Series.) 1955.
Rea, F. B.: Alcoholism: Its Psychology and Cure. 1956.
Riddell, P.: I Was an Alcoholic: the Story of a Cure. 1955.
Rubin, I. C.: Collected Papers, 1910-54. 1955.
Sava, G.: The Lure of Surgery. 1955
Sedative and Hypnotic Drugs: A Symposium Held Under the Auspices of the Miles-Ames Research Laboratory Elkhart, Indiana. 1954.
Shimmin, A. N.: University of Leeds: The First Half-century. 1954.
Smith, E. P.: Handbook of Marriage. 1955.
Sullivan, H. S.: The Psychiatric Interview. 1954.
Van Wersch, H. J.: Scurvy as a Skeletal Disease. 1955.
Walker, G. F.: Diabetes. (Modern Health Series.) 1955.
Weinmann, J. P., and Sicher, H.: Bone and Bones. Second edition. 1955.

In a report to the Minister of Pensions and National Insurance (Cmd. 9752) published on May 2, the National Insurance Advisory Committee, under the chairmanship of Sir Will Spens, recommends changes in the earnings rules applying to certain retirement pensioners, widows, and others getting National Insurance benefits. The Committee proposes among other things that the net amount which retirement and widow pensioners can earn without reductions in pension should be raised from 40s. to 50s. a week, and that pensioners earning over 50s. should have 6d. deducted for 1s. earned between 50s. and 70s. and 1s. for each 1s. earned over 70s. a week.

H.M. Forces Appointments

ROYAL NAVY

Surgeon Commanders C. G. Hunter, R. Russell, H. G. Wells, and T. F. Barlow have retired.

Surgeon Lieutenant C. W. J. Ussher to be Surgeon Lieutenant-Commander.

ROYAL NAVAL VOLUNTEER RESERVE

Surgeon Captain J. B. Oldham, V.R.D., has retired.

Surgeon Lieutenant-Commander L. B. Cohen has reverted to the Temporary R.N.V.R. in the rank of Temporary Surgeon Lieutenant-Commander.

Surgeon Lieutenant F. S. Preston to be Surgeon Lieutenant-Commander.

ARMY

Major-General A. Sachs, C.B., C.B.E., Q.H.P., late R.A.M.C., has retired on retired pay (Reserve liability).

Brigadier (Temporary Major-General) A. E. Campbell, Q.H.P., late R.A.M.C., to be Major-General.

Brigadier J. C. Coutts, late R.A.M.C., having attained the age limit for retirement, has retired on retired pay (Reserve liability).

Colonels (Temporary Brigadiers) T. F. M. Woods, O.B.E., G. T. L. Archer, Q.H.S., P. J. L. Capon, and E. M. Hennessy, O.B.E., late R.A.M.C., to be Brigadiers.

Lieutenant-Colonels J. P. Douglas, O.B.E., R. St. J. Lyburn, R. T. Shipman, and J. W. A. McIver, from R.A.M.C., to be Colonels.

ROYAL ARMY MEDICAL CORPS

Lieutenant-Colonel F. Holmes, O.B.E., has retired on retired pay, and has been granted the honorary rank of Colonel.

Majors N. G. G. Talbot, O.B.E., T.D., E. G. Wright, O.B.E., R. L. Marks, O.B.E., and W. N. S. Donaldson, T.D., to be Lieutenant-Colonels.

Major H. M. Upshon has retired on retired pay, and has been granted the honorary rank of Lieutenant-Colonel.

Major D. E. S Steele, M.B.E., has retired (Reserve liability).

Captains B. D. McKee and K. P. Milne to be Majors.

Short Service Commission.—Captain M. B. O'Doherty to be Major.

REGULAR ARMY RESERVE OF OFFICERS

ROYAL ARMY MEDICAL CORPS

Class III.—Captains (War Substantive Majors) (Honorary Lieutenant-Colonels) G. J. Harrisson and P. L. O'Neill, from R.A.R.O., to be Captains (War Substantive Majors) (Honorary Lieutenant-Colonels). Captain (Honorary Major) K. B. Lazarus, from R.A.R.O., to be Captain, retaining the honorary rank of Major. Captain (Honorary Major) A. T. Rogers, from R.A.R.O., to be Captain (Honorary Major). Captain (Acting Major) A. W. Weller, from A.E.R.O., to be Captain, relinquishing the acting rank of Major.

TERRITORIAL ARMY

ROYAL ARMY MEDICAL CORPS

Lieutenant-Colonel (Brevet Colonel) M. J. Lindsey, O.B.E., M.C., T.D., from T.A.R.O., to be Lieutenant-Colonel (Brevet Colonel).

Major J. R. G. Damrel has been granted the acting rank of Lieutenant-Colonel.

Major D. C. Taylor has resigned his commission, retaining the rank of Major.

Captains (Acting Lieutenant-Colonels) G. R. Venning and J. W. A. Crabtree to be Majors.

Captain (Acting Major) W. Brodie to be Major.

Captain J. D. A. Shedden, R.A.R.O., to be Captain, and has been granted the acting rank of Major.

Captain L. R. Davis has been granted the acting rank of Major.

ROYAL AIR FORCE

Air Vice-Marshal R. H. Stanbridge, O.B.E., Q.H.P., has retired.

Group Captain H. Penman has retired.

Flight Lieutenants F. G. Cumming, M. A. Stokes, D. R. H. Urquhart, M. Shearer, A. M. Kingon, M.B.E., D. J. White, and T. G. Dobie to be Squadron Leaders.

E. O. Barnes to be Squadron Leader.

ROYAL AIR FORCE RESERVE OF OFFICERS

Squadron Leaders K. B Redmond, C.B.E., T. J. M. Gregg, O.B.E., and R. H. Winfield, D.F.C., A.F.C., have relinquished their commissions, retaining the rank of Wing Commander.

Squadron Leader H. M. Carson has relinquished his commission, retaining his rank.

Flight Lieutenant A. R. P. Calder to be Squadron Leader.

ROYAL AUXILIARY AIR FORCE

Squadron Leaders T. McM. Boyle and S. E. Osborne have relinquished their commissions, retaining their rank.

ROYAL AIR FORCE VOLUNTEER RESERVE

Squadron Leaders C. Hardwick and J. S. F. Sutton have relinquished their commissions, retaining the rank of Wing Commander.

Squadron Leaders T. C. Henry, D. A. P. Anderson, and S. I. Ballard have relinquished their commissions, retaining their rank.

Flight Lieutenants H. H. F. Barns, S. W. Liggett, H. J. Richardson, A. H. M. Siddons, G. A. Van-Someren, J. Heginbotham, G. C. Smith, and J. E. G. Vincenzi have relinquished their commissions, retaining the rank of Squadron Leader.

Association Notices

Diary of Central Meetings

MAY

14	Mon.	Subcommittee re Waverley Report, Armed Forces Committee, 2 p.m.
17	Thurs.	G.M.S. Committee, 10.30 a.m.
17	Thurs.	Organization Subcommittee, Central Consultants and Specialists Committee, 2.30 p.m.
23	Wed.	Forensic Medicine Subcommittee, Private Practice Committee, 2 p.m.
24	Thurs.	Central Consultants and Specialists Executive, 3 p.m.
25	Fri.	Assistants and Young Practitioners Subcommittee, General Medical Services Committee, 2 p.m.
29	Tues.	Consultants Conference Agenda Committee, 2 p.m.

JUNE

1	Fri.	Ophthalmic Group Committee, 10.30 a.m.
1	Fri.	Ophthalmic Qualifications Committee, following Ophthalmic Group Committee.
1	Fri.	Subcommittee on Future of Ophthalmic Services, Ophthalmic Group Committee and Faculty of Ophthalmologists, 2 p.m.
6	Wed.	Private Practice Committee, 2 p.m.
15	Fri.	Overseas Committee, 2 p.m.
20	Wed.	Maritime Subcommittee, Private Practice Committee, 2 p.m.
21	Thurs.	G.M.S. Committee, 10.30 a.m.

JULY

5	Thurs.	**Annual Representative Meeting** (at Brighton), 10 a.m.
6	Fri.	**Annual Representative Meeting** (at Brighton), 9.30 a.m.
7	Sat.	**Council** (at Brighton), 9 a.m.
7	Sat.	**Annual Representative Meeting** (at Brighton), 10 a.m.
9	Mon.	**Annual Representative Meeting** (at Brighton), 10 a.m.
9	Mon.	**Council** (at Brighton), at conclusion of A.R.M.
9	Mon.	**Annual General Meeting** (at Brighton), 12.30 p.m.
9	Mon.	**Adjourned Annual General Meeting and President's Address** (at Brighton), at 8.15 p.m.

Branch and Division Meetings to be Held

BRISTOL DIVISION.—At Small Physics Lecture Theatre, Royal Fort, University of Bristol, Clifton, Bristol, Wednesday, May 16, 8.30 p.m., annual general meeting.

CARDIFF DIVISION.—At B.M.A. House, 195, Newport Road, Cardiff, Monday, May 14, 8 p.m., annual general meeting.

COVENTRY DIVISION.—At Masonic Hall, Little Park Street, Coventry, Tuesday, May 15, 7.30 for 8 p.m., supper and annual general meeting.

FURNESS DIVISION.—At Duke of Edinburgh Hotel, Barrow-in-Furness, Tuesday, May 15, 7.30 p.m., annual general meeting.

GREENWICH AND DEPTFORD DIVISION.—At St. Alfege's Hospital, Vanbrugh Hill, Greenwich, S.E., Wednesday, May 16, 8.30 p.m., clinical meeting. Members of the Woolwich Division are invited.

GRIMSBY DIVISION.—At Grimsby General Hospital, Tuesday, May 15, 8.30 p.m., meeting. Lecture by Dr. C. A. Birch: "A Month Behind the Iron Curtain." All medical practitioners in the area of the Division are invited.

HOLLAND DIVISION.—At White Hart Hotel, Boston, Sunday, May 13, 3 p.m., annual meeting.

MANCHESTER DIVISION.—At Fallowfield Hotel, Wilbraham Road, Manchester, Tuesday, May 15. 8.30 p.m., annual general meeting.

METROPOLITAN COUNTIES BRANCH.—At B.M.A. House, Tavistock Square, London, W.C., Tuesday, May 29, 3 p.m., annual general meeting. President's address by Dr. Alistair R. French: "Negligence is an Ugly Word."

NORTH MIDDLESEX DIVISION.—At Committee Room, North Middlesex Hospital, Silver Street, Edmonton, N., Tuesday, May 15, 8.30 for 8.45 p.m., meeting. B.M.A. Lecture by Dr. E. A. Blake Pritchard: "Migraine." Members of Enfield and Potters Bar Division and medical guests are invited.

NORTHERN IRELAND BRANCH.—Thursday, May 17, (1) at Jubilee Hospital, Belfast, 2.30 p.m., clinical meeting; (2) at Board Room, Belfast City Hospital, 4 p.m., annual meeting.

REIGATE DIVISION.—At Redhill County Hospital, Monday, May 14, 8.30 p.m., annual general meeting. Film: "Tissue Bank."

ST. PANCRAS DIVISION.—At Committee Room B, B.M.A. House, Tavistock Square, London, W.C., Tuesday, May 15, 3.30 p.m., annual general meeting. Members of the City Division are invited.

SHROPSHIRE AND MID-WALES BRANCH.—At Board Room, Royal Salop Infirmary, Shrewsbury, Thursday, May 17, 8.30 p.m., general meeting.

SOUTH ESSEX DIVISION.—At Hutton Masonic Hall, Saturday, May 12, 7 for 7.30 p.m., dinner.

SOUTH-WEST ESSEX DIVISION.—At Langthorne Hospital, Leytonstone, E., Wednesday, May 16, 8.30 p.m., meeting. Mr. C. Gill-Carey: "Ear, Nose, and Throat Diseases in General Practice."

WEST BROMWICH AND SMETHWICK DIVISION.—At Eye Hall, Out-patients' Department, West Bromwich and District General Hospital, Tuesday, May 15, 8.15 p.m., clinical meeting.

WEST DERBYSHIRE DIVISION.—At Physiotherapy Department, Whitworth Hospital, Darley Dale, Matlock, Wednesday, May 16, 8.30 p.m., joint meeting with West Derbyshire Medical Society. Lecture by Professor C. S. Russell: "Use of Hormones in Obstetrics."

WEST NORFOLK DIVISION.—At West Norfolk and King's Lynn General Hospital, Thursday, May 17, 3 p.m., meeting. B.M.A. Lecture by Dr. R. Bodley Scott: "The Chemotherapy of Malignant Disease."

WEST SUFFOLK DIVISION.—At Drummond Hall, West Suffolk General Hospital, Tuesday, May 15, 8.30 p.m., meeting. Talk by Dr. S. J. Hadfield (Assistant Secretary, B.M.A.) on relationship between general practitioners and consultants, followed by Dr. J. B. Ewen.

WIGAN DIVISION.—At Haigh Hall, Thursday, May 17, 8 p.m., annual general meeting. 9.30 p.m., Dr. E. E. Claxton (Assistant Secretary, B.M.A.) will speak on the new claim for increased remuneration.

A general meeting of the Liverpool Region S.H.M.O. Group will be held on Wednesday, May 16, at 8 p.m., in the theatre of the Liverpool Medical Institution.

Meetings of Branches and Divisions

BLYTH DIVISION

The annual general meeting was held on April 13, 1956. A resolution was passed pledging the Division's support for the G.M.S. and Joint Consultants Committees in their efforts to obtain an increase in the betterment factor. The following officers were elected:

Chairman.—Dr. R. Carr.
Vice-chairman.—Dr. John Brown.
Honorary Secretary.—Dr. E. B. Ross.

CAMBERWELL DIVISION

The annual general meeting was held in Dulwich Hospital on April 19, 1956. Dr. Michael Ward told the story of the conquest of Everest, illustrated by lantern slides. The following officers were elected:

Chairman.—Dr. P. A. Byrne.
Vice-chairmen.—Drs. R. J. Rosborough and H. J. Andersen.
Honorary Secretary.—Dr. W. B. J. Pemberton.

CO. ARMAGH DIVISION

At a meeting on March 27, 1956, Dr. R. Fawcett Stronge read a paper on "Cancer of the Lung," discussing the aetiology, histology, and symptomatology, illustrated by *x*-ray films.

Smoking is responsible for over 18% of fires in hospitals and homes—other important causes being fires in grates and electric and gas apparatus. A circular from the Minister of Health to hospital authorities (H.M.(56)36) contains information and advice on fire prevention, and on organization and management of hospital fire services. Wards where a nurse is not continuously on duty should, the circular states, be visited at hourly intervals. Special precautions are suggested for mental hospitals where doors need to be locked. Special attention is advised in dispensaries, laboratories, bedding stores, *x*-ray film storerooms, and other high-fire-risk departments. Hospitals should ensure that patient accommodation is sufficiently protected.