Dr. Mercier makes a bald statement which is not only contrary to fact, but insulting to the surgical profession, when he says, "The surgeon is a person employed by a physician to carry out his instructions, and it is anomalous that the servant should be remunerated on a higher scale than the master." When a surgeon is called in to meet a physician, or is called in by a physician, my experience is not that he is regarded in any sense as an inferior or that he goes in a menial capacity, but as an equal, who may be able not only to help in the diagnosis, but, what is of much greater importance in the eyes of the friends, effect a cure which the physician is incapable of performing; if any other proof of the surgeon's position is needed, it is that in ninety-nine cases out of a hundred his advice is followed, and if he thinks an operation is not needed or should be deferred, it is seldom indeed that his opinion is questioned or another surgeon summoned; in other words, if he disagrees with the physician, he assumes the whole responsibility, but in any case it becomes his, if an operation is performed.

If we admit, for argument's sake, "on how much higher a plane is the work of the physician than that of the surgeon" with his mechanical occupation, how comes it that the physician is so inadequately remunerated? There are, I think, two factors in the case—the practitioner and the public.

The practitioner, while recognizing the profound learning and the ability of the physician as a diagnostician, looks at the matter from a practical point of view, and says, "even if I get the valued opinion of the physician we shall be little for'arder; the opinion only will not satisfy the friends or effect a cure, while if I call in a surgeon, if an operation is needed, as it probably will be, not only is valuable time saved—a most important point—but the person who is to take the responsibility of the operation will also have the responsibility of deciding for or against it."

The public naturally do not object to paying an adequate fee to the person who, even if by mere mechanical skill and elaborate technique, can not only save a life, but possibly save many doctor's bills; while they naturally object to paying a long fee for an opinion, if the patient is to be no better.

The law certainly does not recognize what appears to be Dr. Mercier's attitude. The responsibility of an operation rests with the surgeon who performs it, and not with the physician who may recommend it.

By all means let the fees of the physician be raised if he can persuade the public to pay them, but no benefit to the profession in general or the physician in particular is likely to be gained by railing against the surgeon's fees, which, too, are often very inadequate.

No, Sir; Dr. Mercier's views are as antiquated as what I presume he intends as a description of the operation for adenoids.—I am, etc.,

London, W., Nov. 21st. DOUGLAS DREW.

SIR,—There are two points in connexion with this subject which would seem worthy of further emphasis.

The first is that the modern surgeon can in no way be considered the handmaid of the physician. Harvey Cushing expressed this view succinctly in his address at the International Congress of Medicine in 1913, when he stated that the physician had become his own surgeon. For example, a modern abdominal surgeon is one who, after a complete study of his patient—a study which is based on evidence derived from all sources—decides whether an operation is necessary or advisable. To do this he must know as much abdominal medicine as a general physician. He often knows more. Or, again, an orthopaedic surgeon, dealing, for instance, with a case of rheumatoid arthritis, must, in addition to the mere mechanical or operative treatment of the disabled joints, be able to direct the investigation of the metabolic disturbances and to carry out therapeutic measures which may be classed as medical.

The second point is that in most instances an operation fee includes the necessary after-care of the patient whilst in the nursing home. This may extend over a period of some weeks, and involve numerous visits. When the actual fee is compared with the number of visits, which are all equivalent to consultations, the surgeon's remuneration in many cases is as "inadequate" as that of the physician.—I am, etc.,

Manchester, Nov. 26th. HARRY PLATT.

SIR,—Dr. Thurstan Holland makes the common mistake of assuming that the present day physician claims to set up his opinion on the necessity for operation as more valuable than that of a surgeon of repute and experience. For his argument he quotes cases of appendicitis. The attitude I take is, that the experienced physician is more capable of deciding whether or not an attack of abdominal pain, etc., is due to appendicitis or some other condition. In such cases the surgeon is biassed in favour of the "look and see" policy; he wishes to be on the safe side. It is frequently the lot of the physician to find that the illness for which operation has been advised is non-existent, or at any rate there is no sufficient evidence thereof. On the other hand, his diagnosis may be erroneous, and the necessity for operation be apparent a few hours later. No doubt every one has had the experience of insisting on operation, although the surgeon has refused to agree with the diagnosis; and equally has seen the reverse side of the shield.

Still, if a surgeon gets a large fee for operation, and a physician a mere three guineas for saving the patient from operation and a considerable tax on his pocket, there is no justification for asserting that surgical fees are too high. Up to a certain fairly well-recognized standard the surgeon is justified in charging a fee appropriate to his position and the means of the patient. Physicians and surgeons, in their capacity as such, may be compared with high-class brands of champagne. If the public want the best, and are prepared to pay the price, they choose a well-known brand. In doing so they are most likely to get a first-rate article, whereas an unbranded specimen may or may not be of extremely good quality. Let me repeat Dr. Holland's closing sentence slightly altered—God help us all, and our patients too, if the ultimate court of appeal as to question of diagnosis ("operation" in his letter) is to be the opinion of the surgeon ("physician").—I am, etc.,

London, W., Nov. 27th. EDMUND CAUTLEY.

THE SCOPE OF AN INFANTS' WELFARE CENTRE.

SIR,—The letter which appeared recently in the *Times*, asking for a sum of £10,000 to provide the babies of the poor with a particular recipe, for which it was claimed that it invariably conferred health on all babies, and the wise rejoinder which it provoked from Sir Thomas Barlow, should open our eyes to the dangers which surround infant welfare work. From the folly of searching for a curative diet other than mother's milk, which shall be universally applicable to all the ailments of all babies, even medical men are not free. We may define the normal child as the child which possesses the capacity of thriving upon any diet which is rationally constructed, and the limits of rational construction are fortunately fairly wide. The abnormal child—that is, the child whose tolerance for certain constituents of the diet has been lowered by chronic infection or persistent catarrhs, or who suffers from an inborn weakness of digestion—may exhibit symptoms of disturbance even when fed upon a rational diet. Not only the lay public but medical men are apt to be misled by the spectacle of a large number of normal children thriving upon some particular rational diet, and to make for it the claim that it possesses universal curative properties, and should be used for all children suffering from dyspepsia. Citrated whole milk, for example, is no doubt a rational diet, but it is curative only when the previous feeding has been irrational. Often when dyspepsia has occurred the high percentage of fat in whole cow's milk aggravates the symptoms, and we are forced to adopt a therapeutic modification of the diet—to give less fat and more carbohydrate. The manufacturers of patent foods know well that in many cases of malassimilation and dyspepsia the digestion of carbohydrates remains less impaired than the digestion of fat, and provide, for the most part, foods which offer a variety of the most easily-assimilated carbohydrates. Such diets are therapeutic prescriptions, to be replaced in turn by the rational diet when recovery takes place. To claim that any one diet, whether it is a rational diet or a therapeutic diet, invariably confers health is equally ridiculous.

The distinction between these two sorts of diet, the diet of health and the numerous modifications which may be forced upon us in illness, is important because it corresponds

to the distinction, too apt to be obscured, between the preventive work of an infants' clinic and the curative work of hospital or dispensary. I have no hesitation in saying that it seems to me essential for the proper working of an infants' welfare centre that all the babies should be fed upon some one rational diet, and that if an infant persistently fails to thrive upon this standard diet, it should be transferred to an ther place for treatment by modification of the diet or otherwise. The advantage of using one and the same standard diet in all infant centres would lie not in the superiority of any one rational diet over another, but in the simplification of the work which would result. Statistics in any one centre would then be comparable from year to year, and a comparison between the results in different centres could be instituted. If in an infants' centre many forms of diet are used, and attempts are made to treat symptoms by changes of diet, the work of the centre is curative and not preventive, and becomes indistinguishable from that of a dispensary or hospital. Attention is concentrated on the ailing child and diverted from those for whom the centre exists—the healthy—while the mothers are quick to conclude that they need no longer bring their babies unless ailing.

The task of the infants' centre is threefold—to instruct the mothers, to divert the sick babies to a place where they may be treated, and to provide the rest with a certificate of health in the shape of a steadily rising weight curve achieved upon the breast, or, failing that, upon some standard rational diet. Those who placed their signatures to the letter in the *Times* would appear to confuse preventive with curative work, and to imagine that infant welfare work is concerned with ailing babies. We can hardly blame them when we hear that at least one endowed infant centre is considering the appointment of a salaried dispenser of drugs.—I am, etc.,

London, Nov. 26th. H. CHARLES CAMERON.

SIR,—The Association of Infant Welfare and Maternity Centres, as parent society of some 500 affiliated infant welfare centres, has received many inquiries with reference to the so-called "Steade system" of infant feeding, and the appeal for £10,000 made in the public press to demonstrate its universal applicability. The association has been unable to glean further particulars of the system than those which have appeared in the press. It would, however, advise inquirers to satisfy themselves as to the following points before lending adherence to the proposed scheme:

1. Is any part of the £10,000, for which appeal is made, to be expended in purchasing the rights of the "Steade system"?
2. Is there anything new about this system not already known to the medical profession as a whole, or to those specially engaged in infant welfare work at one or other of the 800 centres which already exist?

As the system up to date has been kept secret, presumably it has not received any medical endorsement, nor, indeed, can it do so, without an infringement of medical ethics, until it is made public.

Signed on behalf of the A.I.W.M.C.,
ERIC PRITCHARD, Chairman.
FLORA SHEPHERD, Honorary Secretary.

London, W.C., Nov. 22nd.

SAFEGUARDING THE PRACTICES OF MEN ON ACTIVE SERVICE.

The Central Medical War Committee's Appeal.

SIR,—Having deserted my practice since the early months of the war in favour of army work I think I may claim to be disinterested in criticizing the scheme of the Central Medical War Committee embodied in the circular recently issued and reprinted in the SUPPLEMENT on November 18th for safeguarding the practices of men on active service, issued, presumably after grave consideration, in this, the third year of the war.

I fear that the friendliest verdict will be that the Committee means well. The scheme is brimful of lofty sentiment and kindly feeling, but it betrays a painful lack of the sense of actuality on the part of its framers as well as marked loss of memory for recent events.

The altruistic policy it formulates presumes a standard of ethics which would only be appropriate in the case of a chivalrous member of a noble profession dealing with members of a lay community possessing the morals of high class biblical characters. How little warranty there is for assuming such a utopian standard the fiasco of the National Insurance Act should have taught them. What could be more fanciful and impracticable than No. 7?—

"New patients introduced by the patient of an absentee should be regarded as belonging to the absentee's practice."

I fear the Committee would not believe me if I told them that one of my female relatives, whilst staying at a boarding house, found that by casually referring to me in general conversation she had aroused the curiosity of a medical honeymoon couple as to the locality of my deserted practice. Apparently they looked upon it as derelict and possibly a good find.

The proposed safeguards are intended, I take it, for private practices in general throughout the kingdom. As a fact, there are three kinds of practice in which it may work well—for example, a purely panel practice, a country practice of the "little opposition" type, and the practice in which appointments yield the greater part of the income. Unfortunately these are just the kind which least require protection.

I fear, from personal experience, that the man with the practice in which panel and appointments do not form an important part will find the safeguards in action only a snare and a delusion. Such a suburban or town practice is always in a fluid condition, as in peace time patients are constantly being lost through removals, whilst their place is taken by fresh arrivals. Besides this, there are patients who, while not actually leaving the neighbourhood, wander from one doctor to another. This, of course, complicates the problem, and is not allowed for in the Committee's scheme, which goes on the simple but fallacious principle of considering patients as chattel.

What actually happens in an absentee's practice run on the half fee principle is that even friendly colleagues often forget to ask a newcomer if he has been previously attended by the absentee, whilst naturally they never dream of putting the question to one of their old patients who returns to the fold after an unaccountable absence of several years. Another factor not allowed for by the Committee is that the majority of patients think that they get better attention at first than at second hand, and therefore not only seldom volunteer the information, but often deliberately conceal it.

Another class of patient is the ultra-loyalist who adopts expectant treatment rather than go to a strange doctor. The estimated loss under this heading will of course vary directly with one's egoism, so I will not attempt a guess, but I do know that in my practice during the first year the takings showed an actual decrease of 90 per cent.

I do not repine. I went into war work for the sport of the thing, knowing what I might expect to happen to my practice, as I had previous experience of the unostentatious and quiet way in which my brethren of the panel temporarily relieved me of any worry concerning the health of my working-class patients.

The world, although it smiles on them, is not yet as perfect as the Committee would seem to imagine, and war is a miserable business in which it is the lot of the good and heroic to achieve glory and death, whilst the undeserving quietly rake in the dollars.

This letter is devoted solely to destructive criticism because the constructive variety should not be offered unless the need for it is appreciated.—I am, etc.,

FRANCIS HEATHERLEY,
M.B., B.S.Lond., F.R.C.S.Eng.,
November 19th. No. 3, Medical Board, Manchester.

MASSAGE OF THE HEART.

SIR,—A successful application of the method of cardiac massage to a case of heart failure under an anaesthetic is reported in your issue of November 11th, p. 652. A mixture of chloroform and ether was administered to a child, aged 6, for the purpose of removing tonsils and adenoids. The child struggled during the removal of the second tonsil, and, what is termed in the report, "shock" supervened. Now, the only cause to which can be attributed, under the above-mentioned conditions, such a total cessation of the circulation as occurred in this case is