can be achieved. More emphasis should be laid on the health visitors' visiting duties than on those of acting as clinic receptionists.

Co-operation with the General Practitioner

Occasionally a doctor will find that a parent quotes the health visitor as advising contrary to his own. This apparent contradiction is usually due to a misapprehension on the part of the mother. Nevertheless, even the most minor difference in advice can be exaggerated to such an extent that the parent is hopelessly confused.

It is easy for general practitioners to be exasperated by having to go out in the early morning to see a child that has already been seen at the clinic earlier in the day, only to find that the mother always visits his surgery which could have waited until the morning. Health visitors should be prepared to accept the responsibility of telling the mother in obvious cases that there is no need to call the doctor until the next day, and that an aspirin, or part of one, is all that is required for a reasonable night's sleep. The more experienced health visitor does in fact do this.

Occasionally a health visitor will suggest that a patient should be seen by the doctor without giving adequate reasons. Sometimes this will result in the doctor being called to see an elderly patient rather against the patient's will. When he gets there the patient does not give all the details that the health visitor was given, and he will find his visit wasted. If on the other hand the health visitor had written a note to the doctor describing briefly the symptoms, if he saw it, and where she thought he might be able to render assistance, he would have been enabled to grasp the situation at once.

Suggestions for Improving Co-operation

The all-important establishment of liaison between health visitors and doctors should not depend on chance meetings. It seems reasonable to ask that when a health visitor is appointed to a district she should make an effort to visit the local general practitioners as a matter of courtesy. For example, it might be a good idea to drop in at the end of morning surgery, or write and suggest that they meet, or else wait until some opportunity arises which affects a patient and where the health visitor feels that useful work could be done by co-operation.

The average doctor at qualification knows very little about the health visitor's duties, and in what instances co-operation would be to their mutual advantage.

The general practitioner should not leave the entire onus of establishing contact to the health visitor. He should visit the school and infant welfare clinics, especially when he has a particular case to discuss. Tea-parties have been tried to achieve contact, but this can be accomplished far better by exchanges of view on specific cases.

The sort of controversial subjects on which mothers delight in playing the doctor versus the health visitor are: should a child be reduced in its feed if it is gaining over eight to ten ounces a week? Should a child be fed by the clock, by demand, or by convenience to mother and child? Should a hungry child be fed in the middle of the night? Should a baby wear wool next to its skin? Circumcision. And complimentary feeding—does it work?

Should there be any divergences of opinion most health visitors are prepared to fit in with the doctor.

Cases Where the Health Visitor is Most Useful

Many doctors are not aware of all the duties which health visitors will willingly undertake. For example, they are prepared to take scales round to a patient's house and do test feeds on the spot if a doctor requires it. Where a doctor encounters feeding difficulties, the health visitor will be only too glad to help by providing National dried milk, and advising the mother of all the finer details that her doctor cannot be expected to do—for example, sterilization of bottles and teats. The health visitor's eye is trained for a different type of detail from that of the doctor.

The health visitor will be only too glad to observe any behaviour problems in children and report back details which the doctor will find invaluable in his handling of the case—details which sometimes only come to light from neighbours by accident.

Any health visitor of experience must be able to recall many instances in which she has achieved great improvement in people's way of living in dirty homes by gentle tact and persuasion continued over long periods.

Cod-liver Oil

No doctor would question the importance of vitamins A and D in the first few years of life. As a result of this study, I was very intrigued by the high incidence of children who were not being given cod-liver oil, although the health visitors with whom I spent the day were very insistent on its importance when interviewing the mothers. In every instance children who were not taking it were given adexolin drops as a substitute.

In all there were twenty-five mothers questioned on whether their children took cod-liver oil, as distinct from other sources of vitamins A and D, and only ten of these were actually taking it: this means that over half the children refused it. It is interesting to note that none of the mothers visited could get their children to take cod-liver oil, whereas those seen at the clinic were the most successful. This was possibly due to the fact that the mothers who needed to be visited were of lower intellect than those who came to the clinic.

It is possible that many mothers smell the cod-liver oil for themselves, and are reluctant to press it on their infants when they show the slightest signs of rejecting it. They are glad to have an excuse to give it up without further trial. It is well known that the child is very reluctant to take the oil. It would be easy to eliminate. Some of the Ministry cod-liver oil was sampled by the health visitors and myself, and we all agreed that it was very unpleasant.

I investigated the possibility of giving children B.P.C. emulsion of cod-liver oil made by two different manufacturers. These emulsions have the added advantage that they contain calcium. One made sold under the B.P.C. title was sampled by myself and my own babies, both under 2 years, and we were unanimous that it was no better to take than the Ministry cod-liver oil. It is generally agreed that the emulsion manufactured by Messrs. Scott and Bowne is readily taken by most children. Unfortunately the comparative cost in terms of units of vitamins A and D was unfavourable in the case of "Scott's emulsion" as against adexolin drops in the proportion of 3:1. Scott's emulsion would not therefore be an economic substitute to issue in place of adexolin.

On the other hand many children who will not take the Ministry form will take "seven seas" cod-liver oil. It would appear, therefore, that if an effort was made to refine the Ministry cod-liver oil and make it more palatable there would be less recourse to substitutes on the part of the clinic. This might result in an overall economy.

I wish to thank Dr. Maddison, Medical Officer of Health for Area 10 of Middlesex, and his staff for their great kindness and help in making it possible for me to visit one of the clinics in his area.

Corrections—In the report of the Annual Representative Meeting under the heading "General Practitioners and Institutional Midwifery" (Supplement, June 11, p. 278) Dr. H. N. Rose moved the resolution on behalf of the Stratford Division, and not Dr. A. Elliott as stated. Mr. D. S. Pracy in the following paragraph said that "the encouragement of domiciliary midwifery would prove an economy to the country," and not "an encouragement to the country" as printed.

Dr. J. O. M. Rees presented the Guildford motion on diesel oil (p. 284), and not Dr. D. F. Whitaker as stated.