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MEDICAL PRACTICE IN GERMANY

BY

Dr. KARL HAEDENKAMP, Berlin

The following is the fifth of a short series of articles on medical practice in Germany. It completes an account of German social insurance, the first part of which appeared in the issue of July 2. Earlier articles in the series were published on May 28 and June 4 and 25.

V. SOCIAL INSURANCE (cont.)

The employer and the insured person contribute to the fund in equal shares. The contributions are fixed by statute and are the same for all societies. Their amount varies with the insured person's wages, and determines the amount of the various cash benefits. It also determines, as will appear from a later article, the amount of the doctor's remuneration—a very interesting provision.

Benefits in kind are the same whatever the contribution. Insured persons with dependants who are entitled to benefit pay the same contributions as single persons, but both classes are entitled to the same services. The single person pays more in proportion, since he has no family, he does not get the services which he would if he had one. The State does not subsidize the health insurance fund, and apart from contributions and the interest on its capital, the fund's only source of income is fees for sickness forms. When an insured person wishes to consult a doctor he must first obtain from his society a form, which is valid for three months and which costs him R.M. 0.25. This charge prevents, or much reduces, unnecessary calls on doctors' services. Many insured persons are exempt from it, such as those with large families, unemployed, pensioners, and needy tuberculous and venereal patients. The insured person, subject to similar exemptions, has also to pay R.M. 0.25 for every medical prescription he obtains. In 1935 the revenue from contributions was R.M. 1,344,000,000 and from medical certificates, not counting prescription fees, about R.M. 11,000,000.

I propose to deal with the arrangements for medical attention, the relations of the doctors with the societies, and the rights and duties of insurance doctors in my last article. I will deal here as briefly as possible with the other branches of social insurance, as they are less closely connected with the doctor's professional life than is health insurance.

Compulsory Accident Insurance

Accident insurance is not a personal insurance but an insurance of a specified industry, the benefits being given to the employees of that industry. It is a system of compulsory State insurance and there is no private insurance against accident. Most industries are insured, as accidents may occur in nearly all of them. The amount of the wages of the employees is not material; there is a statutory duty to insure and a statutory right in the employees to be insured. The classes of persons covered are unskilled workers, labourers, artisans, apprentices, and higher-grade employees (Angestellten) who are engaged in industries or occupations which are subject to accident insurance. The benefits consist of medical treatment, the placing of injured workmen in other employment, pensions, cash benefits, sickness money, unemployment money, family money, death benefit, and dependents' allowances. Medical treatment can be provided in the form of free nursing and treatment in an institution. The contributions are paid by the proprietors of the industry and not by the employees. Their amount is not fixed but varies with the local rates payable by each undertaking. The insurers are the industrial federations (Berufsgenossenschaften), under a president appointed by the highest supervisory board and assisted by an adviser. The system is naturally subject to State supervision.

Accident insurance covers not only the victims of industrial accident but also those of twenty-six scheduled industrial diseases, and is therefore very important to the medical profession. Among the other duties of the insurers are the prevention of accidents and of industrial diseases, and the instruction of employees in preventive measures.

Medical treatment is provided, according to the severity of the injury, either by the industrial federations themselves or in co-operation with the insurance societies (Krankenkassen), on a basis which is fixed partly by statute and partly by arrangement between the two parties. The treatment itself is identical in its scope and completeness with that given under health insurance, except that it also caters for the special requirements of victims of industrial accident and disease. It provides all the necessary drugs and splints, and institutional treatment. Treatment is given free to the patient and without extra charge.
to the undertaking. Pensions are paid for total and partial incapacity. Death benefit is payable if death is due either directly or indirectly to the employment. Other benefits are pensions to widowers, widows, and children, and temporary assistance to widows.

In 1934 the revenue of the accident insurance funds was RM. 322,000,000 and the expenditure RM. 317,000,000. In the same year compensation was paid to 591,358 victims of injury and disease or to their dependants.

The medical "industries" themselves are also liable to compulsory State accident insurance. Hospitals, sanatoria, nursing homes, maternity homes, lying-in hospitals, and similar "industries" are all liable, and so is the "industry" of private medical practice. There is a special association of employees of public health and welfare services (Berufsgenossenschaft für Gesundheitsdienst und Wohlfahrtspflege).

The duties of the medical practitioner consist of the certification and ascertainment of accidents and their sequelae and of industrial diseases; in the determination of incapacity and of disablement last but not least in the treatment of victims of accident and disease. The system of medical attention and the relations between the doctors and the insurance organizations will be dealt with in my concluding article.

Disability and Old Age Pensions

Disability insurance (Invalidenversicherung) covers workpeople only, for the higher-grade employees (Angestellten) have a separate system. It includes old age insurance. The classes of workers who are compulsorily insurable, irrespective of the amount of their wages, are unskilled workers, labourers, artisans, apprentices, domestic employees, some workers, the crew of seagoing and inland vessels, and shipyard employees. The benefits are chiefly in cash. Disability pensions are payable at the onset of chronic illness or at the age of 65—that is, old age pensions; and there are pensions for widowers, widows, and orphans. The insurer may offer, as an optional and not a compulsory benefit, medical treatment for the prevention of threatened disability or for the cure or alleviation of an existing state of disability.

The disability insurance organization also undertakes certain public health duties. It combats tuberculosis—partly in its own sanatoria but chiefly by means of advice and welfare centres—cancer, and venereal disease. The insurers are the provincial insurance departments, which are statutory organizations directed by government officials. In 1934 their total revenue was RM. 961,000,000 and expenditure RM. 776,000,000. Of that sum, RM. 38,000,000 was spent on treatment. The employer and the employee each contribute one-half. The contribution depends on the amount of the salary and is paid by affixing stamps every week to a card. The number of persons covered by disability insurance during 1935 was about 17,300,000. In 1934 the number of persons was about 2,440,000, and of their dependants about 930,000, a total of about 3,370,000. The part played by the doctor in this branch of insurance is chiefly the important one of certifying disability, but he also takes part in the provision of treatment.

The higher-grade employees' insurance (Angestelltenversicherung) may be dealt with quite shortly, as it renders fundamentally the same services as the disability insurance. These classes of workers are compulsorily insurable up to an income limit of RM. 7,200, and may extend their cover voluntarily, but if they elect to do this they must pay the whole of the contribution themselves. The statutory benefits are payment on sick leave, pensions for dependants, and treatment. Female employees in these grades who leave their employment to get married may claim a return of their previous contributions. Pensions are payable to employees who become unfit for work or reach the age of 65.

Treatment may be continuous (ständig) or casual (nichtständig). Continuous treatment is directed towards the prevention or cure of disability, and temporary towards the cure of transitory illnesses. Temporary treatment includes dental treatment, appliances for physical defects, allowances towards the treatment of wives of insured persons for tuberculosis, and towards the treatment of tuberculous, threatened tuberculous, and rachitic children. The insured person has no legal right to treatment; it must be specially conceded in every case. The insurer is a single organization: the Central Insurance Office for Higher-grade Employees (Reichsversicherungsanstalt für Angestellte). Contributions are based on income. In respect of persons with an income not exceeding RM. 50 a month, the employer pays the whole contribution; persons with a larger income pay half the contribution. It is collected by means of monthly stamps on cards. Here again the doctor's part is chiefly the giving of certificates, and to a certain extent treatment.

In 1934 the number of persons covered was 3,700,000; the total sum distributed in pensions was RM. 247,000,000 to 225,000 employees and 137,000 dependants. This insurance fund also maintains a preventive service, principally for tuberculosis, cancer, venereal disease, rheumatism, and diseases of the gums; and transacts building society business.

Medical Treatment of Unemployed

Unemployment insurance only enters the scope of the present article in so far as the unemployed are entitled to medical treatment in case of sickness. Their numbers have been much reduced in Germany during the last few years. This insurance is compulsory for all persons who are compulsorily insurable against sickness or as higher-grade employees, but they may take up extra cover if they desire. The benefits chiefly consist of cash payments, with a supplementary of medical treatment. The contribution is paid in equal shares by the employer and the employee. The insurer is the Reichsanstalt für Arbeitslosenversicherung und Arbeitsvermittlung (Central Unemployment Insurance Department and Labour Exchange).

An unemployed person receives in the event of sickness the same benefits as a member of a sickness insurance society (Krankenkasse). The society which is responsible for payment must render these services, and receives a contribution from the unemployment insurance fund a contribution in respect of each unemployed person. The person pays, of course, no further contributions after he has become unemployed, either to the society or to the insurance fund. The doctor receives his fee for treatment from the society; it is 5 per cent. less than the fee he would be paid in respect of a member of the society. His duties are the certification of fitness for work and employability, and the treatment of the unemployed person and his family.

It has been impossible to give a comprehensive account of the German system of social insurance, but I have said enough, I hope, to show its great importance for German doctors. That importance will perhaps be made plainer in another article dealing in rather more detail with the relationship between the doctor and the separate branches of the social insurance system.

The Ministry of Labour has published a report on juvenile employment and unemployment for the year 1937. The report consists of an extract from the Ministry's annual report for 1937 and contains a survey of juvenile employment and unemployment throughout the year, of the work of local committees for juvenile employment, of the operation of courses of instruction for unemployed boys and girls, and of the scheme for the transference of juveniles from the special transfer areas. The report is published by H.M. Stationery Office, price 3d., and is obtainable from Adastral House, Kingsway, or any bookseller.
AN INQUIRY INTO THE WORKING OF THE MENTAL TREATMENT ACT (SECTION I)

BROKAN ON AN ANALYSIS OF 500 PATIENTS

BY

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This investigation was undertaken at St. Ebba's Hospital, which has been set aside by the London County Council for the treatment of recoverable cases of all types, but especially for voluntary patients. The 500 cases analysed were the first direct voluntary admissions, and include no patients who were made voluntary by alteration of status. As this hospital has now been dealing with the voluntary type of case in considerable numbers for seven years (actually 1,051 voluntary patients have been treated to date) we decided that our experience was wide enough to draw some conclusions about the working of this section of the Mental Treatment Act, and it was from this point of view that the analysis was undertaken.

Source of Patients

As will be seen from Table I, the main sources of our patients were the observation wards, Maudsley out-patient department, and other London County Council psychiatric clinics. As we both acted in consultant capacities to two observation wards we were able to persuade grossly psychotic patients who would otherwise have been certified to come into hospital on a voluntary basis, and in practically all these cases a rapport was established in the observation ward, which was continued after admission to the mental hospital.

Duration of Illness before Admission

In view of the fact that one of the objects of the Mental Treatment Act was to allow rate-rated patients to receive early treatment, the duration of the illness before admission was analysed, and is shown in Table II.

<table>
<thead>
<tr>
<th>Duration</th>
<th>M.</th>
<th>F.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 1 month</td>
<td>35</td>
<td>21</td>
<td>56</td>
</tr>
<tr>
<td>&quot; 2 months</td>
<td>14</td>
<td>13</td>
<td>27</td>
</tr>
<tr>
<td>&quot; 3</td>
<td>18</td>
<td>26</td>
<td>44</td>
</tr>
<tr>
<td>&quot; 6</td>
<td>14</td>
<td>42</td>
<td>56</td>
</tr>
<tr>
<td>&quot; 1 year</td>
<td>27</td>
<td>52</td>
<td>79</td>
</tr>
<tr>
<td>&quot; 2 years</td>
<td>36</td>
<td>52</td>
<td>88</td>
</tr>
<tr>
<td>Over 2 years</td>
<td>51</td>
<td>59</td>
<td>110</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>305</td>
<td>500</td>
</tr>
</tbody>
</table>

It is obvious from the figures that the majority of patients have still delayed their admission to hospital much too long. Most of the early cases were those collected from observation wards, and it would appear that many patients are treated too long as out-patients, and are only recommended for in-patient treatment when their illness is of very considerable duration. Under ideal conditions the figures should run in exactly the opposite direction. This will only happen when psychiatrists attached to out-patient departments prove themselves anxious to obtain in-patient treatment much earlier in the course of the disease: extended facilities at other observation wards would no doubt increase the number of early cases treated on a voluntary basis.

In some cases general practitioners appear to be at fault in not recognizing the need for early in-patient treatment and in waiting until the illness is well established before referring the patient for expert advice. In other cases the patients themselves delay their admission to a specialized hospital as long as they can, and only by increasing the knowledge of the possibilities under the Mental Treatment Act will this state of affairs be remedied.

Diagnoses

Table III shows the diagnoses of the cases treated. The main groups are the schizophrenic and manic-depressive ones, most of the patients in the second group being in the depressive phase. The involutional and organic states

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>M.</th>
<th>F.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>74</td>
<td>86</td>
<td>160</td>
</tr>
<tr>
<td>Manic-depressive</td>
<td>42</td>
<td>57</td>
<td>99</td>
</tr>
<tr>
<td>Depression</td>
<td>22</td>
<td>50</td>
<td>72</td>
</tr>
<tr>
<td>Organic states</td>
<td>7</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>(a) Arteriosclerosis</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b) Epilepsy</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) Post-encephalitis</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) Huntington's chorea</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e) Disseminated sclerosis</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f) G.P.I.</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcoholic states</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Confusional states</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety states</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hysteria</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurasthenia</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychopathy</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obsessional states</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviour disorders</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

and psychoneuroses provided a large number of patients, but it can be seen that almost any psychiatric condition can be treated under this section. Only two cases of G.P.I. are found on the list, owing to the fact that these cases are now invariably referred to Horton Hospital, where special facilities for malarial treatment exist. In our experience the only patients who cannot be treated on a voluntary basis are the non-volitional ones, who should be treated under Section 5 of the Mental Treatment Act.

Certifiability

Table IV shows the number of patients who were certifiable or not on admission. It is rather striking that 341 patients out of 500 were certifiable and, prior to the passing of the Mental Treatment Act, could only have been dealt with under certificate. Of the non-certifiable cases, before the passing of the Act many of them would of necessity have lacked skilled treatment until such
time as they became so ill mentally that they would have had to eventually avoid certification their ultimate fate is discussed later.

**Age Groups**

The age distribution is shown in Table V, and it will be seen that patients of all ages were admitted, but the highest figures occur about the menopausal or involutional periods, which is to be expected. The comparatively high number round about the age of 30 corresponds to the admission of a large proportion of patients suffering from schizophrenia and depression.

**Length of Stay**

Table VI shows the length of stay in hospital. In our opinion these figures are not ideal by any means, in that about two-fifths of the patients left hospital in the first three months. In view of the severity of the illness in the vast majority of cases admitted, at least twice that length of stay would have been advisable in order to re-establish definite stability. It so happens that these patients are taken from a difficult and often unpleasant environment, and after being in pleasant surroundings for a short time begin to improve rapidly, and tend to take their departure earlier than would be advisable from a medical point of view. This, however, is one of the disadvantages of voluntary treatment which it is impossible to overcome. A considerable number of the 105 still in hospital are of the psychopathic or schizophrenic types who, although no longer showing acute symptoms, are unable to adapt themselves to the outside world but are able to lead useful and co-operative lives inside the hospital.

**Departure**

Table VII shows the state of the patients at the time of departure. It will be seen that 171 out of 372 who have left had completely recovered, while the sixty-two who were improved consisted largely of those patients already mentioned who left hospital before it was thought advisable, and who, with a further short period of treatment, could have been included among those recovered. A total of 139 left the hospital unimproved, many of these consisting of the unreasonable psychotic type of patient, but even in these cases certification was not always necessary, and an analysis of the after-condition of all 500 cases discharged is given later.

Table VIII shows that 250 patients left the hospital with full medical approval, while 122 left against advice. Many of the sixty-two patients included in the improved group came into this latter category, and only a small proportion, as will be seen later, were sent to observation wards for certification.

**Destination**

Table IX shows the destination of the 500 cases. It will be seen that, of 372 patients who left the hospital, 298, or 80 per cent., went home. This percentage is extremely high, and all patients who left against advice, and whom it was possible to trust, were allowed to go home rather than be sent to an observation ward for the purpose of being certified at once, as we believe avoidance of certification to be one of the main purposes for which the Act was introduced. In the follow-up of patients, to be discussed later, it will be seen that only three patients committed suicide at home, and in view of the fact that 298 patients went home the procedure adopted seemed to be justified. Out of the remainder of the patients who discharged themselves against advice, it was found necessary to send fifty-five to observation wards for certifica-

<table>
<thead>
<tr>
<th>Table IV</th>
<th>M.</th>
<th>F.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certifiable</td>
<td>137</td>
<td>204</td>
<td>341</td>
</tr>
<tr>
<td>Non-certifiable</td>
<td>58</td>
<td>101</td>
<td>159</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>305</td>
<td>500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table V</th>
<th>M.</th>
<th>F.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>14-15 years</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>16-20</td>
<td>15</td>
<td>20</td>
<td>35</td>
</tr>
<tr>
<td>21-30</td>
<td>45</td>
<td>57</td>
<td>102</td>
</tr>
<tr>
<td>31-40</td>
<td>50</td>
<td>63</td>
<td>113</td>
</tr>
<tr>
<td>41-50</td>
<td>32</td>
<td>67</td>
<td>99</td>
</tr>
<tr>
<td>51-60</td>
<td>30</td>
<td>69</td>
<td>99</td>
</tr>
<tr>
<td>61-70</td>
<td>17</td>
<td>23</td>
<td>40</td>
</tr>
<tr>
<td>71-80</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>305</td>
<td>500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table VI.—Excluding 105 still in hospital and 23 who died</th>
<th>M.</th>
<th>F.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 1 month</td>
<td>49</td>
<td>79</td>
<td>128</td>
</tr>
<tr>
<td>3 months</td>
<td>31</td>
<td>55</td>
<td>86</td>
</tr>
<tr>
<td>6 months</td>
<td>28</td>
<td>50</td>
<td>78</td>
</tr>
<tr>
<td>1 year</td>
<td>13</td>
<td>33</td>
<td>46</td>
</tr>
<tr>
<td>Over</td>
<td>8</td>
<td>15</td>
<td>23</td>
</tr>
<tr>
<td>2 years</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>134</td>
<td>238</td>
<td>372</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table VII.—Excluding 105 still in hospital and 23 dead</th>
<th>M.</th>
<th>F.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovered</td>
<td>61</td>
<td>110</td>
<td>171</td>
</tr>
<tr>
<td>Improved</td>
<td>20</td>
<td>42</td>
<td>62</td>
</tr>
<tr>
<td>Not improved</td>
<td>53</td>
<td>86</td>
<td>139</td>
</tr>
<tr>
<td>Total</td>
<td>134</td>
<td>238</td>
<td>372</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table VIII.—Excluding 105 still in hospital and 23 dead</th>
<th>M.</th>
<th>F.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>With approval</td>
<td>92</td>
<td>158</td>
<td>250</td>
</tr>
<tr>
<td>Without approval</td>
<td>42</td>
<td>80</td>
<td>122</td>
</tr>
<tr>
<td>Total</td>
<td>134</td>
<td>238</td>
<td>372</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table IX</th>
<th>M.</th>
<th>F.</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>103</td>
<td>195</td>
<td>298</td>
</tr>
<tr>
<td>Still in hospital</td>
<td>52</td>
<td>53</td>
<td>105</td>
</tr>
<tr>
<td>Observation wards</td>
<td>26</td>
<td>29</td>
<td>55</td>
</tr>
<tr>
<td>Died</td>
<td>9</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>Mental after-care</td>
<td>2</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Other hospitals</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Certified and still in hospital</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Certified and died</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Probation officer</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>305</td>
<td>500</td>
</tr>
</tbody>
</table>
tion, and the unusual practice of certifying cases in the hospital was taken in five other cases, owing to special reasons. These five patients, one of whom died, have been included in the tables among those who had left the hospital, as they had ceased to be still in residence as voluntary patients. Of the total discharged, one of the great difficulties encountered in the discharge of patients is the rehabilitation and placing of the patient in suitable employment, and a scheme has been evolved in connexion with the education authorities of the London County Council for the re-education, and the placing in suitable posts, of patients who had previously relapsed through lack of employment. As this scheme is not limited to voluntary patients, it is proposed to describe it in more detail at a later date.

Follow-up

With the assistance of Miss Simpson, the social worker, a follow-up of all the cases discharged was undertaken, and Table X shows the results. Altogether 112 patients

| TABLE X |
|------------------|---|---|---|
| Remain well     | M. | F. | Total |
| Static or relapsing | 32 | 80 | 112 |
| Certified in mental hospital | 13 | 24 | 37 |
| Readmitted St. Ebba's | 37 | 52 | 89 |
| Unraced         | 5 | 22 | 27 |
| Died outside hospital | 43 | 50 | 93 |
| Still in hospital | 5 | 10 | 14 |
| Died in St. Ebba's | 9 | 14 | 23 |
| Total           | 195 | 305 | 500 |

had remained quite well and were fully able to undertake their various duties, having re-established themselves in their home environment, while the static or relapsing cases numbered thirty-seven.

Eighty-nine had been admitted to mental hospitals as certified cases, and this figure includes the fifty-five patients sent direct to observation wards for certification from this hospital. Therefore, out of the 372 patients who left the hospital it was necessary to certify only an additional thirty-four patients. Of the fifty-two female patients who ultimately were certified thirty-two went against medical advice, and fifteen of these were sent home from this hospital in the hope that certification might be avoided. The remaining twenty left here with approval, and of these eight went home but relapsed, and eventually were certified.

Of the thirty-seven male patients who were certified, sixteen left here against medical advice, and of these five went home. The remaining twenty-one left with approval; one of them had recovered but later relapsed at home. The remaining figures do not appear to require any comment.

Conclusions

To summarize the figures previously given, of 500 consecutive voluntary cases, 60 per cent. went home (that is, 80 per cent. of the total discharges); 20 per cent. are still in hospital; 12 per cent. required certification in this hospital or observation wards (another 6 per cent. requiring certification later); and 8 per cent. went to other destinations or died. It is obvious from these figures that if Section I of the Mental Treatment Act is worked to its fullest advantage only a small proportion of certifiable patients ever need certification, although considerable time is necessary to persuade patients in the first place to accept treatment, and, secondly, in many cases to dissuade them from leaving hospital prematurely.

One of the disappointing points brought out by these figures is the fact that the patient in many cases has been ill for too long a period before having in-patient treatment, and in this way one's original hope of early treatment for those suffering from nervous or mental disorder is still being frustrated to a considerable extent. As R. H. Curtis (1938) states, "It is of the utmost importance, if voluntary treatment is to mean anything vital and progressive, that the mental hospital should get its tentacles into the outside world." The only means at present by which a medical officer in a London County Council Mental Hospital can come in contact with his future patients outside the mental hospital is the observation ward to which he is attached as consultant, and it is to be hoped that the whole question will be reconsidered in the light of these figures in order to make this part of the Act more advantageous to the patient. At the same time the general practitioner and lay public require to be educated more fully regarding the possibilities and advantages of the Act.

REFERENCE


UNEMPLOYMENT INSURANCE FOR DOCTORS' EMPLOYEES

Except as stated below contributions under the Unemployment Insurance Acts are required to be paid in respect of any person whose employment falls within the scope of compulsory health and pensions insurance. As regards persons employed by doctors or dentists, there are two main classes in which liability to unemployment insurance does not coincide with liability to insurance under the Health Insurance and Pensions Acts—namely, employment as a female professional nurse for the sick, and employment in domestic service.

Nurses, Dispensers, Secretaries, etc.

Female nurses have been excepted from unemployment insurance since July, 1922, and contributions ceased at that date to be payable in respect of them. The exception does not extend to dispensers, secretaries, or persons employed by doctors or dentists on such duties as receiving patients, making appointments, answering telephone messages, cleansing and sterilizing instruments, cleaning and dressing surgery fittings, mixing cement, handling instruments, etc., to the dentist, or attendance on anaesthetic cases unless the attendant is a duly qualified nurse and employed as such.

Chauffeurs and Servants in the Business of the Employer

Domestic workers employed in a business carried on for the purposes of gain have been insurable against unemployment since 1920, contributions in respect of them being payable under the General Scheme. It has been held by the House of Lords in the case of H. J. Property Co. Ltd. v. Board of Trade that a chauffeur or servant is carrying on a business for the purposes of gain within the meaning of the Act, and domestic servants employed in that business are therefore required to be insured. Similarly, the judge decided that a chauffeur employed primarily to drive a doctor on his rounds and a domestic servant employed by a doctor in a nursing home carried on by him in addition to his practice were employed in the business of their respective employers. These decisions are held to cover in principle servants employed to attend upon the patients or staff in a nursing home and servants employed at the surgeries of doctors or dentists to admit patients, to make appointments, or otherwise in connexion with the employers' professional requirements.

In addition to chauffeurs employed in the business of the employers, those employed on the 4th of April, 1938, all chauffeurs, including persons employed in cleaning or attending to motor cars, became insurable under the General Scheme after April 4, 1938—that is, whether they are employed in a business or not.
Private Domestic Servants

As from February 1, 1937, private gardeners became insurable at the special rates fixed under the Agricultural Scheme. In the case of chauffeur-gardeners the rate payable in any week is that appropriate to the work which occupies the greater part of the employee's time in that week. If the rate varies from week to week special arrangements may be made to pay one rate of contribution throughout the employment.

Servants employed in doctors' or dentists' private residences solely in connexion with their employers' personal needs, and servants whose duties in connexion with their employers' business are confined to cleaning the surgery and admitting occasional patients, are not regarded as employed in the business and are not therefore required to be insured against unemployment.

Servants employed by doctors partly in connexion with their employers' professional requirements or in other insurable employment and partly in connexion with their employers' personal needs should be regarded, as insurable if their substantial employment is of an insurable nature. It has been held by Mr. Justice Roche in the High Court that one-third is a substantial part of an employee's working hours.

Part-time cleaners who are employed wholly outside the business hours of their employers or for a comparatively short time inside those hours are not insurable under the unemployment insurance schemes.

Doctors wishing guidance in special circumstances should communicate with the manager of the nearest employment exchange or with the District Health Insurance inspector, whose address can be obtained from the post office or the local insurance committee.

PUBLIC HEALTH NOTES

Annual Report of the Medical Officer of Health

Under the Sanitary Officers' Order, 1926, it is the duty of every medical officer of health, as soon as practicable after December 31 in each year, to make an annual report to the local authority on the sanitary circumstances, the sanitary administration, and the vital statistics of the district. Towards the end of each calendar year the Ministry of Health circularizes local authorities concerning the contents and arrangement of these reports. The circular states that it is anticipated that the vital statistics issued by the Registrar General will be available for the use of authorities during the latter part of March or early April, and expresses the hope that the early receipt of these statistics will enable reports to be completed and to be sent to the appropriate authorities not later than the middle of May. In point of fact many authorities do not receive their figures until some time in May; nevertheless, before the end of the month communications are sent to them pointing out that the report of the medical officer of health has not been received by the Ministry.

Dr. G. L. Bowes, Medical Officer of Health, Bedford, refers to this in his report for 1936, as follows:

"Some comment may be made on what may be considered the late appearance of this report. The Ministry of Health in their circular urge an early appearance of this report which is clearly desirable; and mention a date about the middle of May, a date which is, however, dependent on the early receipt of the Registrar General's statistics, when again a date about the end of March and beginning of April is suggested. So far as the writer's memory carries him this latter date has always erred on the side of optimism. In the present year the Registrar General's statistics were not received till May 25. Not only is it impossible to calculate rates for infectious diseases and other matters till the receipt of the Registrar General's statistics and estimates, but it is impossible to comment on these till they are known and can be compared with those of the corresponding month of last year. As much of the report as possible is prepared before the receipt of these statistics, some parts cannot be written before they are received and a large part must be revised after they are received and some parts even rewritten. These facts, therefore, provide an adequate explanation of the late appearance of the report."

The Minister of Health in reply to a question from Captain Elliston in the House of Commons recently, as to whether the Ministry of Health had drawn up a statistical report dealing with the arrangements to be made whereby practitioners would respond to the midwives' medical aid notices: "the local supervising authority, in consultation with the local medical profession, should, in future, be empowered to take steps to ensure that the best local obstetric skill is made available in all cases to which midwives are required under the rules of the Central Midwives Board to call in a doctor." The rules referred to are Rules 12 and 13 of Section E; that "in all cases of illness of the patient or child of any abnormality occurring during pregnancy, labour, or lying-in, a midwife must forthwith call in to her assistance a registered medical practitioner. . . . In calling in medical aid the midwife must always be in consultation with the doctor desired by the patient or, if the patient cannot be consulted, by the responsible representative of the family."

The recommendation of the Minister as to the local supervising authority arranging that the best local obstetric skill should be available is in variance with Rule 13 of the Board. On the Board's recently rescinding the rule, however, the way was cleared for the recommendation of the Minister in Circular 1705, that the most satisfactory procedure for authorities would be that they would "in consultation with such local organizations of registered medical practitioners as appears to them effectively to represent the opinions of practitioners in their area, draw up a list of practitioners who notify themselves as willing to be called in by midwives in an emergency. It would be convenient to distinguish on the list between those practitioners available for any emergency and those available only for attendance in an emergency arising with regard to their own patients. The list would indicate those practitioners who wish to be available for a limited district only. Practitioners could also be requested to nominate from among those included on the list the name of a local deputy to act for them if necessary, and a list should be made for revision of the list at frequent intervals to enable it to be kept up to date."

A copy of the list, the circular also suggested, should be supplied to every midwife employed in arrangements made in accordance with Section 1 of the Midwives Act, 1936, and, save in exceptional circumstances, the midwife, in summoning a practitioner, should select from that list. The Circular also mentions that the list represented the best local obstetric skill, a local advisory committee should be set up under the chairmanship of the medical officer of health, whose duty it would be to scrutinize the list and to make such recommendations to the authority as are desirable for securing and maintaining a high standard of obstetric practice on the part of the practitioners included on the list.
THE INSURANCE MEDICAL SERVICE WEEK BY WEEK

Medical Service Subcommittee Procedure

The paper read by Mr. J. C. Gilbert at the recent conference at Scarborough of clerks to insurance committees entitled "A Medical Service Subcommittee Case: from the Cradle to the Grave" contained a complete and interesting account of the whole procedure in medical service subcommittee cases. There is need to reproduce what he said generally, because it was very largely a paraphrase of what is set out in the Regulations, but the following two paragraphs dealing with special aspects are sufficiently interesting to be quoted:

"Perhaps I might say a word here as to what determines us in deciding whether a case should be orally investigated or disposed of on the written statements. If it can be called 'clear-cut'—that is, there is no conflict between the parties or it is clear that the practitioner was not at fault—it is usually decided with the consent of the parties to dispense with a hearing. Occasionally an insurer insists on his right to be heard. It is seldom that a practitioner does so. We generally hear a case in which it is clear that there will have to be a recommendation for the withholding of money, even though the facts are admitted and the case falls into the category of being 'clear-cut,' but we sometimes tell a practitioner that he is in a case of this kind that the subcommittee can dispose of the matter without him, but that on the information before them—a certificate case is typical—the subcommittee feel that they must ask the committee to represent to the Minister of Health that an amount should be withheld from his remuneration. Generally speaking, the practitioner asks us to proceed without him, not even wishing to come before the subcommittee, as it were, ad misericordiam. Another class of case which is invariably set down for hearing is the case in which the insured person has died. If the relatives have complained they must feel a grievance of some kind, and we always find that it gives more satisfaction to both sides if the matter is properly thrashed out.

"If a case is to be heard letters are dispatched to the parties in the terms set out in Appendix A. As you know, notice has also to be given to the Panel Committee and to the approved society concerned. Invariably the secretary or his deputy of the London Panel Committee attends inquiries held by the subcommittee. The proceedings are opened by the complainant and the respondent being called before the subcommittee, together with the officers of the Panel Committee and the approved society. No witnesses are admitted at this stage. The complainant is examined by the chairman and afterwards by a member of the subcommittee who so wishes. The respondent is then permitted to cross-examine the complainant on his statement. Any witnesses for the complainant are then called and examined in the same way. When the subcommittee have given their statements to the subcommittee they are excluded. The respondent's case is then taken in the same way, and at the conclusion the subcommittee consider the case in camera. If any issue which is not mentioned in the correspondence is brought up at the hearing it is our practice to ask the practitioner whether he wishes an adjournment to enable him to consider the new point. It may be of interest if I mention what happens if the practitioner fails to attend. If the complainant so fails to substantiate the case the subcommittee take the view that there is no case for the respondent to answer and no further action is taken. If the respondent defaults in this way and there is no application from him for a postponement the case is taken in his absence. An opportunity arises in this connection with the presentation of the medical record. As will be seen from the letter of invitation to the practitioner, he is asked to bring the document with him, but before it is used in any way the insured person is always warned he has any objection to the medical record put in and the information which it contains being used by the subcommittee. A shorthand note is taken of the proceedings before the subcommittee, but this is transcibed only if the practitioner appeals. A representation is made of the removal of the name of the practitioner from the Medical List. If the subcommittee decide that there has been a failure to comply with the terms of service it is the practice in London, before the subcommittee decide on the terms of their recommendation to the insurance committee, for the practitioner's record of previous cases against him to be produced."

Correspondence

MEDICAL SERVICE SUBCOMMITTEE CASES

Sir,—I was interested in the report in the Supplement of July 2 (p. 12) headed "Reduction of List as a Disciplinary Measure." Things have come to a pretty pass indeed now that the medical service subcommittee seeks out new and ingenious methods of inflicting punishment on a practitioner (as though the measures already recognized were apparently inadequate), and the Minister of Health must needs come to the rescue. It is not surprising that the Minister and his advisers have come to some serious thinking about the advisability of this procedure. I think most of us will agree that those words were not intended as a compliment to the subcommittee, and the latter's "courtesy" in offering an explanation (which, incidentally, does not appear to explain very much) is mildly amusing.

It would be interesting to hear what the medical members of this subcommittee had to say when this punishment was mooted. Did they protest as a body and threaten to issue a minority report? Or was it perhaps their own suggestion? We shall probably never find out. It would, however, be a consolation to the panel practitioner to feel that those who are elected to safeguard his interests on such a committee were indeed interested in his welfare.

This matter assumes even greater importance when we read on the same page the account of the meeting "Report on a letter from Dr. G. de Swiet suggesting that there is evidence that the attitude of our representatives is "not of the kind that is always very helpful to the insurance practitioner, but is, in fact, sometimes positively hostile to him." I regard such a statement as very serious, particularly when it follows a report such as the one upon which I have just commented. If Dr. de Swiet has any evidence in support of this statement, he must produce it publicly so that future elections may remedy this state of affairs.

In my own small way I have had cause to be suspicious of the attitude of some of those whom have been established as our representatives, and I can uphold him in his statement that they tend to support a bureaucratic point of view of the narrowest order, one that abhors the slightest independent breath of emancipation, and that they are only too ready to suppress individual attempts to establish principles of liberty and fairness. Dr. de Swiet has made a serious charge, and I call upon him to substantiate it if he can and those concerned to answer him to our satisfaction if they can.—I am, etc., London, W.9, July 3.

A. LEWIS.

GENERAL MEDICAL SERVICE FOR THE NATION

Sir,—It is gratifying to find so much endorsement of Dr. Alfred Cox's criticism of the general medical service scheme, particularly in regard to the question of infant welfare. During the long process of revision of the scheme by the Health Services Committee, I constantly endeavoured to point out the inconsistency of advocating a system which would provide for every individual and family a family doctor whose primary function would be to act as health adviser to these families and individuals, and at the same time of advising the permanent establishment of a different source of the same advice. Is it not at least likely that such duality will tend to perpetuate that overlapping and friction which the whole scheme is designed to overcome? No one with a sense of the realities of the problem suggests for a moment the immediate abolition of infant welfare centres, or that the provision under existing conditions of a family doctor, available without financial embarrassment on either side, will immediately provide the amount and kind of advice that we should aim to provide for every mother. But surely a policy, which, I take it, is what the scheme purports to outline, is a direction or plan for the future. The resolute implementing of the policy of providing for everyone a doctor trained in the functions of the general practitioner over the next twenty or twenty-five years, in the establishment of a service which would render infant welfare centres, as at present conducted, a superfluous anachronism. The same considerations hold good with regard to school medical inspection.
I am well aware of the Englishman’s distrust of the logical conclusion, and events have sometimes seemed to justify the attitude. I suspect that what he really distrusts is the premises from which the conclusion is drawn, and he is usually right in doing so. In any case, it is carrying things rather too far to argue (illogically) that because the logical conclusion is usually wrong the illogical one is likely to be right.

There is a general aspect of the scheme, which, I hope, will be properly debated and considered at the Representative Meeting. The whole tenor of the scheme is to encourage the trend towards municipal medicine. What it advocates is, in essence, a basic contributory scheme augmented by rate-aided services and administered by municipal authorities either singly or in groups. This may be the correct solution, but it is by no means unanimously accepted as such by the profession as a whole. There is a very considerable body of opinion similar to that expressed by Dr. Nathan in his letter (Supplement. July 2, p. 14) in favour of “some form of State medical service.” In my view the feeling in favour of such a solution is principally based on the desire for the relative security and freedom from financial anxiety afforded by a salaried service. To pour scorn on such an attitude, as is sometimes done by “old-timers” who have more or less successfully “been through the mill,” is not really very helpful. The great majority of unbiased people would agree that such security and freedom are essential to efficient service.

My personal belief is that we have not yet evolved the proper solution of the problem, and that we should continue to work on it. We have plenty of time. The international situation being as it is, it seems improbable that any major social legislation can occur within the next five years. I have great sympathy with those who are impatient to see something done, but to press forward, urged by impatience, in what may well be a wrong direction strikes me as most unwise. At any rate, the British Medical Association should be very chary of giving its blessing to a scheme important provisions of which are not only not supported but actually opposed by many of its members.—I am, etc.,

Aberdeen, July 5.

E. R. C. WALKER.

WHAT IS CHIROPODY?

Sir,—I understand that the British Medical Association will presently be discussing among other things the question of the official recognition of chiropodists. I have nothing against chiropodists. Indeed, I admire their efforts to improve their status, and their earnest desire to work in friendly cooperation with the medical profession. But inevitably the first question arising out of this discussion will be: What is Chiropody? Many of your readers will have noticed that at the Annual Convention of the Incorporated Society of Chiropodists held in London in March this year the programme included films showing: (1) an open operation for congenital dislocation of the hip; (2) a hinged graft for depressed nasal bridge; and (3) the treatment of fractures of both bones of the leg; while in the current number of The Chiropodist there is an admirable lecture by Mr. Norman Lake on “Recent Views on the Nature of Malignant Disease.” I have been trying rather unsuccessfully to find the connecting link between these matters and the cutting of corns, the padding of hammer-toes and bunions, and other activities commonly associated with chiropody. Are these lectures and demonstrations to chiropodists on serious major surgical problems to be regarded merely as light entertainment for the laity, or have they perhaps a significance?—I am, etc.,

London, W.1, July 12.

A. S. BLUNDELL BANKART.

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Places of interest. 1, Free Library and Museum. 2, Roman Catholic Cathedral. 3, Guildhall and Municipal Buildings. 4, St. Andrew’s Church. 5, Athenæum; Art Gallery and Antiquities. 6, Barbican and Mayflower Stone. 7, Sir Francis Drake’s Statue.
British Medical Association
OFFICES, BRITISH MEDICAL ASSOCIATION HOUSE, TAVISTOCK SQUARE, LONDON, W.C.1.

Addresses, etc.
SECRETARY (Telegrams: Mediseca Westcend, London.)
EDITOR, BRITISH MEDICAL JOURNAL (Telegrams: Atiology Westcend, London.)

SUBSCRIPTIONS, ADVERTISEMENTS, etc. (Telegrams: Mediseca Westcend, London.)

Telephone numbers of British Medical Association and British Medical Journal, Euston 2111 (internal exchange, five lines).

Scottish Secretary: 7, Drumsheugh Gardens, Edinburgh. (Telegrams: Associate, Edinburgh Tel.: 24361 Edinburgh.)

Irish Free State Medical Union (I.M.A. and B.M.A.); 19, Kildare Street, Dublin. (Telegrams: Bucillus, Dublin. Tel.: 62550 Dublin.)

Diary of Central Meetings

JULY
17 Sun. Regulations and Standing Orders, Subcommittee, 8.30 p.m. (at Grand Hotel, Plymouth).
18 Mon. Council, 9 a.m. (at City Council Chamber, Plymouth).
20 Wed. Council, 9 a.m. (at City Council Chamber, Plymouth).

AUGUST
5 Fri. Journal Board, 2 p.m.

Table of Official Dates
July 15, Fri. Annual Representative Meeting, Plymouth.
July 16, Sat. Annual Representative Meeting, Plymouth.
July 18, Mon. Annual Representative Meeting, Plymouth.
July 19, Tues. Annual Representative Meeting, Plymouth.
July 20, Wed. Council, Plymouth.
Meetings of Sections, etc., Plymouth.
Conference of Honorary Secretaries and Overseas Conference, Plymouth.
July 21, Thurs. Meetings of Sections, etc., Plymouth.
Annual Dinner of the Association, Plymouth.
July 22, Fri. Meetings of Sections, etc., Plymouth and Torquay.
July 23, Sat. Meeting of Sections, Torquay.

Middlemore Prize

The Middlemore Prize consists of a cheque for £50 and an illuminated certificate, and was founded in 1880 by the late Richard Middlemore, F.R.C.S., of Birmingham, to be awarded for the best essay or work on any subject which the Council of the British Medical Association may from time to time select in any department of ophthalmic medicine or surgery. The Council is prepared to consider an award of the prize in the year 1939 to the author of the best essay on: "The underlying causes of glaucoma, including notes on the lines of inquiry which have been pursued, with suggestions as to future research in clinical and laboratory." Essays submitted in competition must reach the Secretary, British Medical Association, B.M.A. House, Tavistock Square, London, W.C.1, on or before December 31, 1938. Each essay must be signed with a motto and accompanied by a sealed envelope marked on the outside with the motto and containing the name and address of the author. In the event of no essay being of sufficient merit the prize will not be awarded in 1939.

Sir Charles Hastings Clinical Prize

The Sir Charles Hastings Clinical Prize, which consists of a certificate and a money award of fifty guineas, is again open for competition in respect of 1939. The following are the regulations governing the award:

1. The prize is established by the Council of the British Medical Association for the promotion of systematic observation, research, and record in general practice; it includes a money award of the value of fifty guineas.

2. Any member of the Association who is engaged in general practice is eligible to compete for the prize.

3. The work submitted must include personal observations and experiences collected by the candidate in general practice, and a high order of excellence will be required. If no essay entered is of sufficient merit no award will be made. It is to be noted that candidates in their entries should direct their attention mainly to their own observations in practice rather than to comments on previously published work on the subject, though reference to current literature should not be omitted when it bears directly on their results, their interpretations, and their conclusions.

4. Essays, or whatever form the candidate desires his work to take, must be sent to the British Medical Association House, Tavistock Square, London, W.C.1, not later than December 31, 1938. The prize will be awarded at the Annual General Meeting of the Association to be held in July, 1939.

5. No study or essay that has been published in the medical press or elsewhere will be considered eligible for the prize, and a contribution offered in one year cannot be accepted in any subsequent year unless it includes evidence of further work. A prize-winner in any year is not eligible for a second award of the prize.

6. If any question arises in reference to the eligibility of the candidate, or the admissibility of his or her essay, the decision of the Council on any such point shall be final.

7. Each essay must be typewritten or printed, must be distinguished by a motto, and must be accompanied by a sealed envelope marked with the same motto, and enclosing the candidate's name and address.

8. The writer of the essay to whom the prize is awarded may, on the initiative of the Science Committee, be requested to prepare a paper on the subject for publication in the British Medical Journal, or for presentation to the appropriate Section of the Annual Meeting of the Association.

9. Inquiries relative to the prize should be addressed to the Secretary.

Important Notice concerning Appointments

The attention of medical practitioners is drawn to the important notice concerning appointments which is published each week in the advertisement columns of the Journal. This notice asks practitioners to communicate with the Secretary of the British Medical Association before applying for any of the appointments listed therein. It appears this week at page 53.

Branch and Division Meetings to be Held

Lincsionshire Branch: Kesteven Division.—At Church House, Castlegate, Grantham, Monday, July 18, 8.30 p.m. Air raid precautions lecture by Dr. A. G. Hudson, Home Office Lecturer for the Nottingham Centre.

Metropolitan Counties Branch: City Division.—At Hackney Hospital, Friday, July 22. Clinical Afternoon.

Worcestershire and Herefordshire Branch.—At Droitwich, Thursday, July 21. Annual general meeting.

Meetings of Branches and Divisions

Birmingham Branch: West Bromwich and Smethwick Division

At a meeting of the West Bromwich and Smethwick Division, held on June 16, Dr. W. S. Walton, medical officer of health for West Bromwich, announced that the Air Raids Precautions Subcommittee of the West Bromwich Council would pay a fee of 5s. for an examination and fitness report on air raid precautions volunteers, and if a special report was required the fee might be raised accordingly. This was agreed to. The meeting cordially accepted an offer from the honorary secretary of the Medical Advisory Committee for the Promotion of the Study of Medical Climatology and Hydrology in Great Britain to send a lecturer, who would deal with spa treatment and the diseases particularly suitable for such treatment, to address the Division, the date being provisionally fixed for January, 1939. It was also decided to accept Messrs. T. J. Smith and Nephew's offer to show a new film on "The Functional Treatment of Fractures" in October. The British Medical Association's proposals for "A General Medical Service for the Nation" were considered and a long discussion took place, chiefly on a national maternity service.
Lincolnshire Branch

At the annual general meeting of the Lincolnshire Branch, held at Lincoln on June 23, with Dr. F. Birtwhistle in the chair, the following officers were elected for the ensuing year:

- President, Dr. J. Lyons. Vice-President, Dr. C. H. D. Robbs. President-Elect, Dr. F. H. Rotherham. Honorary Secretary and Treasurer, Dr. H. W. Vaughan.

After the election of officers a cordial vote of thanks was accorded the retiring president. A visit was paid to Messrs. Chas. I. Iron and sons at Lincoln Cathedral. The party was then entertained to tea by Dr. and Mrs. Lyons.

Norfolk Branch: West Norfolk Division

The following officers were elected at the annual meeting of the West Norfolk Division, held on June 23:

- Chairman, Dr. W. E. H. Bull. Vice-Chairman, Dr. J. Sexton. Honorary Secretary and Treasurer, Dr. J. Lowin.

It was decided to accede to the request of the East Norfolk Division for a joint advisory committee to consult with the county medical officer of health on matters affecting the county council and the Division. The chairman and secretary for the time being and Drs. Barker and Sexton were elected to represent the Division. After the meeting the members were entertained to luncheon by the retiring chairman, Dr. J. W. McIntosh, who was warmly thanked for his hospitality and services during the past year. After luncheon the meeting comprising the Treasurer’s Cup golf competition was played, and D. M. Dean was the winner with a net score of seventy for eighteen holes.

The Library of the B.M.A.

The library contains files of the most important medical periodicals. The current number of each is kept for reference only in the library, but previous issues and bound volumes may be borrowed. Full particulars of the lending service may be obtained from the Librarian, B.M.A. House, Tavistock Square, London, W.C.1.

The following books were added to the library during June:

- Buchanan, S.: Doctrine of Signatures. 1938.
- Donnison, C. M.: Civilization and Disease. 1937.
- Frolow, Y.: Pavlov and His School. 1937.
- Poulton, E. P.: Diet and Recipes and the Treatment of Diabetes and Obesity. 1937.
- Rowe, A. H.: Clinical Allergy. 1937.
- Simpson, S. L.: Major Endocrine Disorders. 1938.
- Smith, H. W.: Physiology of the Kidney. 1937.


Postgraduate News

The Fellowship of Medicine announces that a course in physiology, in preparation for the Primary F.R.C.S. examination, will be given on Mondays, Wednesdays, and Fridays at 5.15 p.m., from August 15 to November 4. Courses in preparation for the M.R.C.P. examination will include clinical and pathological at the National Temperance Hospital, on Tuesdays and Thursdays at 8 p.m., from September 6 to 22; chest diseases at Brompton Hospital, weekly, at 5.15 p.m., from September 6 to October 1; chest and heart diseases at Royal Chest Hospital, on Mondays, Wednesdays, and Fridays at 8 p.m., from September 12 to 30; neurology at West End Hospital for Nervous Diseases, from September 19 to October 3; ophthalmological surgery, September 14 and 15; children’s diseases (suitable for D.C.H.) at Infants Hospital, September 19 to 24; proctology at Gordon Hospital, September 26 to October 1; and dermatology at Royal Bath Hospital, Harrogate, September 16, 17, and 18; ophthalmology at Royal Westminster Hospital, September 24 and 25. Courses are open only to members and associates of the Fellowship of Medicine, 1, Wimpole Street, W.1.

Weekly Postgraduate Diary

Fellowship of Medicine and Postgraduate Medical Association, 1, Wimpole Street, W.—All Saints’ Hospital, Austur Street, S.E.—Afternoon Course in Dental Anaesthetics at Eastman Dental College.

British Postgraduate Medical School, Duncan Road, W.—Daily, 10 a.m. to 4 p.m. Medical Clinics, Surgical Clinics and Operations, Obstetrical and Gynaecological Clinics and Operations. Tuesdays, 4.30 p.m., North-Western Hospital; Wednesdays, 4.30 p.m., Clinical Examination of Fever Cases and Demonstration of Modern Methods and Apparatus. Wednesdays, 12 noon, Clinical and Pathological Conference in Urology, Hospital for Diseases of the Skin. Thursdays, 2.15 p.m., Dr. Duncan White, Radiological Demonstration. Fri., 2 p.m., Clinical and Pathological Conference (Obstetrics and Gynaecology).

Hospital for Sick Children, Great Ormond Street, W.C.—Thursdays, 2 p.m., Dr. A. Simpson-Smith, Osteomyelitis. 3 p.m., Dr. Reginald Lightwood, Gastro-enteritis. Out-patient Clinics, mornings, 10 a.m. to 12 noon. Ward Visits, afternoons, 2 p.m. to 3.30 p.m.

St. George’s Hospital Medical School, S.W.—Thursdays, 5 p.m., Dr. Anthony Felling, Neurological Demonstration.

Edinburgh Postgraduate Lectures.—At Edinburgh Royal Infirmary, Thursdays, 5 p.m., Dr. C. G. Lampard, W. Thyreotrophic Hormone and its Relation to Clinical Syndromes.

Luncheon to Minister of Health

Dr. Walter Elliot, Minister of Health, was the guest of honour at an informal luncheon party held at British Medical Association House on July 8. The following were present: Sir Kay Le Fleming (Chairman of Council); Dr. H. Guy Dain (Chairman of Representative Body); Mr. N. Bishop Harman (Treasurer); Dr. Colin D. Lindsay (President-Elect); Sir Farquhar Burstall (Immediate Past-President); Dr. R. G. Gordon (Deputy Chairman of Representative Body); Dr. J. W. Bone; Sir Henry Brackenbury; Dr. J. T. D’Ewart; Dr. A. E. Gregg; Sir Ewen Maclean; Dr. J. C. Matthews; Dr. W. Paterson; Col. A. H. Proctor; Dr. Henry Robinson; Dr. W. E. Thomas; Dr. W. R. Waterhouse (Secretary); Dr. N. G. Horner (Editor of British Medical Journal); Dr. Charles Hill (Deputy Secretary); Dr. H. A. Clegg (Deputy Editor); Dr. R. W. Craig (Scottish Secretary); Dr. Mervyn Archdall (Editor, Medical Journal of Australia); Dr. Lindsay A. Dey (Australia); Dr. R. E. Victor (New Zealand); Dr. H. F. Bell Walker (South Africa).
Naval, Military, and Air Force Appointments

ROYAL NAVAL MEDICAL SERVICE

Surgeon Rear-Admiral B. P. Pick, C.B.E., K.H.S., has been placed on the retired list at his own request. Surgeon Captain E. F. Simms to be Surgeon Rear-Admiral, and appointed to the St. Angelo, for Royal Naval Hospital, Malta. Surgeon Commanders E. C. Bevis to the Warspite; E. J. K. Westham (July 15) to the Pembroke; Surgeon Lieutenant-Commanders T. McCarthy to the Dryad; M. J. Brosnan to the Pembroke, for Royal Naval Barracks, Chatham; J. F. Goodall and to the Pembroke (on commissioning); W. J. M. Salder to the Pembroke, for Royal Naval Barracks, Chatham; H. S. Marks to the President, for course; J. W. Caswell to the Norfolk II, for H. R. Buckyard, for course; Surgeon Lieutenant E. Cook to the Cornwall; T. F. Davies to the Centurion; J. Patterson to the Furious; M. J. M. Enright to the President, for course at R.A.F. Central Medical Establishment (August 13); and to the Furious (September 3); E. J. Littledale to the Pembroke, for Royal Naval Barracks, Chatham; F. S. Edgecombe and D. C. Dobson to the Excellent; J. W. Rhys to the Grenville; M. Cay to the Victory, for Royal Marine Infirmary, Portsmouth.

ROYAL NAVAL VOLUNTEER RESERVE


ROYAL AIR FORCE MEDICAL SERVICE

Squadron Leader F. C. B. L. Crawford to Headquarters, Flight Commander, Stanmore, for duty as a medical officer; A. L. St. A. McClosky to R.A.F. Station, Abingdon, for duty as medical officer.

Flight Lieutenant C. C. Parker to R.A.F. Station, Habbaniali, Iraq; C. Crowley to Princess Mary's R.A.F. Hospital, Halton; V. H. Tompkins to Central Medical Establishment, London.

TERRITORIAL ARMY

ROYAL ARMY MEDICAL CORPS


J. W. Macmillan, late Officer Cadet, Cambridge University Contingent, Medical Unit, Senior Division, O.T.C., J. Clay, late Officer Cadet, Larnham University Contingent, Senior Division, O.T.C.; J. D. Fraser, late Officer Cadet, Glasgow University Contingent, Medical Unit, Senior Division, O.T.C.; R. S. F. Schilling, late Officer Cadet, University of London Contingent, Medical Unit, Senior Division, O.T.C.; R. S. Ling, E. M. Stone, S. M. Laird, and E. T. Baker-Bates to be Lieutenants.

INDIAN MEDICAL SERVICE

The Services of Lieutenant-Colonel A. D. Loganadan have been placed temporarily at the disposal of the Government of the Punjab.

Captain B. Temple-Raston to be Major.


H. B. Beece-Smith and A. C. Glendinning have been restored to the establishment and had their seniorities antedated to August 14, 1937.

COLONIAL MEDICAL SERVICE

The following appointments have been made: I. D. Cameron, M.B., Ch.B., D.T.M. and H., P.D.M., Medical Superintendent, Lunatic Asylum, Jamaica; J. W. M. Dow, M.B., Ch.B., Medical Officer, Northern Rhodesia; G. A. Peltier, M.B., B.Ch., Medical Officer, Bahamas; J. F. B. Sanguinetti, M.B., Ch.B., Medical Officer, Jamaica; H. S. De Boer, M.R.C.S., L.R.C.P., D.P.H., D.T.M. and H. Director of Medical Services, Nyasaland; V. W. T. McGusty, M.B., B.Ch., D.T.M. and H., Director of Medical Services, Fiji.

A recent Home Office circular issued to all local authorities states that the Home Secretary is anxious that the arrangements for the local storage of civilian respirators should be expedited, and that he hopes the authorities responsible for air raid precaution schemes will be able to accept delivery by the end of August at the latest. The Respirators are to be held in Home Office regional stores, and the Minister considers it is preferable they should be stored locally even under some temporary arrangements than that they should remain concentrated in regional stores. An addendum to the circular suggests suitable methods of storage and distribution.

VACANCIES

All advertisements should be addressed to the Advertisement Manager and NOT to the Editor.

RESIDENT POSTS


BATH: ROYAL UNITED HOSPITAL.—H.S. Salary £150 p.a.

BIRKENHEAD COUNTY BOROUGH.—(1) Surgical Officer. (2) M.O. Male, unmarried. Salaries £300 p.a. each.

BIRMINGHAM CITY:—Birmingham (male, unmarried) for Romsey Hill Sanatorium. Salary £240-£275 p.a. Salary £75. Two J.M.O.s (one male and one female, unmarried) for Little Bromwich Hospital for Infectious Diseases. Salaries £300 p.a. each.

BIRTHWELL:—Midland HOSPITAL.—H.S. Salary £200 p.a.

BLACKBURN AND EAST LANCASHIRE ROYAL INFIRMARY.—Surgical Officer (male). Salary £250 p.a.

BOLTON ROYAL INFIRMARY.—H.S. Salary £150 p.a.


BROMLEY:—ROYAL INFIRMARY.—H.P. (male) for Radium and Skin Departments. Salary £175 p.a.


Bristol:—Coombe INFIRMARY.—(1) Medical Officer. Salary £120 p.a.

BURNEY COUNTY BOROUGH.—J.M.O. (male) for Municipal General Hospital. Salary £150-£200 p.a.


BURY INFIRMARY.—Two H.S.s. Salaries £150 p.a. each.

Bury St. EDMUNDS:—WEST SUFFOLK GENERAL HOSPITAL.—Salary £150 p.a.

CHESHIRE COUNTY COUNCIL.—J.A.M.O. for Clatterbridge (County) General Hospital, near Birkenhead. Salary £200 p.a.

CHESTERFIELD AND NORTH DERBYSHIRE ROYAL INFIRMARY.—H.S. (male) to the Ophthalmic and Ear, Nose, and Throat Departments. Salary £150 p.a.

DUDLEY:—GUEST HOSPITAL.—(1) Surgical Officer. (2) Two H.S.s. Males. Salaries £250-£300 p.a. and £100-£130 p.a. respectively, according to experience.


EVELINA HOSPITAL FOR SICK CHILDREN, Southwark, S.E.—(male). Salary £120 p.a.


HOTEL HOSPITALS, LONDON.—H.S. Salary £150 p.a.


INVERNESS:—ROYAL NORFOLK INFIRMARY.—H.P. Salary £150 p.a.

KEIGHLEY AND DISTRICT VICTORIA HOSPITAL, Yorkshire (West Riding).—(1) First H.O. (2) Second M.O. Females. Salaries £160 p.a. and £120 p.a. respectively.


KING'S LYNN:—WEST NORFOLK AND KING'S LYNN GENERAL HOSPITAL.—(1) H.P. (2) H.S. Salaries £130 p.a. and £120 p.a. respectively.

LANCASTER:—ROYAL LANCASTER INFIRMARY.—H.S. Salary £130 p.a.


LIVERPOOL HOSPITAL FOR CONSUMPTION AND DISEASES OF THE CHEST, Mount Pleasant.—Full-time M.O. Salary £150 p.a.

LOUGHBOURGH AND DISTRICT GENERAL HOSPITAL.—(1) H.S. (2) H.P. Males, unmarried. Salaries £150 p.a. and £125 p.a. respectively.


MAIDSTON:—WEST KENT GENERAL HOSPITAL.—(H.S. Salary £175 p.a.

MANCHESTER CITY.—A.M.O. (male) for Booth Hall Hospital for Children. Salary £200 p.a.

MANCHESTER VICTORIA MEMORIAL JEWISH HOSPITAL, Cheetah.—Surgical Officer (male). Salary £250 p.a.

METROPOLITAN HOSPITAL, Kingsland Road, E.—C.O. and Anaesthetist (male). Salary £100 p.a.

MIDDLESBROUGH:—NORTH ORMESBY HOSPITAL.—(1) H.P. (unmarried). (2) H.S. Males. Salaries £120 p.a. and £6 6s. per week respectively.
NEWCASTLE-UPON-Tyne: Hospital for Sick Children.—(1) H.P. (2) H.S. Salaries £100 p.a. each.
NOTTINGHAM: General Hospital.—C.O (male). Salary £150 p.a.
OLDHAM: Royal Infirmary.—(1) Senior H.S. (2) Two H.S. Salaries £150 p.a., according to qualifications and experience, and £175 p.a. respectively.
Plymouth: Prince of Wales’s Hospital, Greenbank Road.—(1) H.P. (2) H.S. Salaries £120 p.a. each.
PORTSMOUTH: Royal Portsmouth Hospital.—(1) H.P. (2) C.O. Males. Salaries £130 p.a. each.
PRESTON: County Borough.—J.A.M.O. (female) for Sharpe Green Hospital. Salary £100 p.a.
RADIAN Beam Therapy Research, The Radium Institute, 1, Riding House Street, W.—A.M.O. Salary £150 p.a.
REDHILL: East Surrey Hospital.—J.H.S. Salary £100 p.a.
ROtherham Hospital.—Casualty H.S. (male) with charge of Out-patients. Salary £150 p.a.
Salford City.—Obstetric Officer for Hope Hospital. Salary £400–£520 p.a.
SOUTHAMPTON CHILDREN’S Hospital and Dispensary for Women.—(1) M.O. (female). Salary £150 p.a.
ST. ALBANS: General Hospital.—M.O. Salary £160 p.a.
ULSTER: County Antrim Mental Hospital.—Senior A.M.O. (male, unmarried). Salary £400–£525–£600 p.a.
VICTORIA HOSPITAL FOR CHILDREN, Tite Street, Chelsea, S.W.—(1) H.P. (2) H.S. Salaries £100 p.a. each.
WALKLEY: Victoria Central Hospital.—(1) Senior H.S. (2) J.H.S. Salaries £120 p.a. and £100 p.a. respectively.
WIMBLEDON Hospitat, Thurstan Road, S.W.—M.O. (male, unmarried). Salary £150 p.a.
WORTHING Hospital.—H.S. (male). Salary £150 p.a.
YORK: Two M.O.s (females). Salaries £200 each.

NON-RESIDENT POSTS

BRIGHTON: New Sussex Hospital for Women and Children.—Hon. Ophthalmic S. (female).
CHILDREN’S CENTRE, 6, Pembridge Villas, W.—Hon. Assistant P.s for Psychotherapeutic Department of Institute of Child Psychology.
COSSHAM MEMORIAL HOSPITAL, Kingswood, Bristol.—Hon. S.
EASTBOURNE: Royal Eye Hospital, Pevensey Road.—H.S. Salary £100 p.a.
MANCHESTER CITY.—Locum Pathologist for Crumpsall Hospital, Withington Hospital, and Booth Hospital. Salary £10 10s. per week.
MILLER GENERAL HOSPITAL, Greenwich Road, S.E.—Anaesthetist. Hourly Remuneration £5 12s. 6d.
PRINCESS LOUISE KENSINGTON HOSPITAL FOR CHILDREN, St. Quintin Avenue, North Kensington, W.—(1) Hon. Assistant P. with beds, and (2) Assistant P. in Charge of Child Guidance Clinic. (2) Hon. Assistant P. with beds.
QUEEN MARY’S HOSPITAL FOR THE EAST END, Stratford, E.—Clinical Assistant.

SALFORD ROYAL HOSPITAL.—Radiologist. Salary £300 p.a.
SOUTH LONDON HOSPITAL FOR WOMEN, Clapham Common, S.W.—Clinical Assistants (females) for Gynaecological Out-patients.
TRURO: Royal Cornwall Infirmary.—Hon. P.
WEST END HOSPITAL FOR NERVOUS DISEASES, 73, Welbeck Street, W.—Two Hon. Clinical Assistants for Child Guidance Department.
WEST LONDON Hospital, Hammersmith, W.—Hon. P.
WESTMINSTER Hospital, Broad Sanctuary, S.W.—House-Anaesthetist. Salary £100 p.a.

UNCLASSIFIED

BEXLEY BOROUGH.—Whole-time Assistant M.O.H. Salary £550–£750 p.a.
BRISTOL UNIVERSITY.—Senior Bacteriologist for Department of Preventive Medicine. Salary £700–£800 p.a., according to qualifications and experience.
COVENTRY CITY.—Assistant School M.O. and Assistant M.O.H. (male). Salary £600–£700–£800 p.a.
DURHAM COUNTY COUNCIL and CHESTER-LE-STREET URBAN DISTRICT COUNCIL.—District Tuberculosis M.O. and M.O.H. (male). Salary £800 p.a.
GORDON HOSPITAL FOR DISEASES OF THE RECTUM AND COLON, Vincent Square, S.W.—Surgical Registrar.
HAMPSHIRE COUNTY COUNCIL.—Assistant County M.O. Salary £750–£800 p.a.
KING’S COLLEGE HOSPITAL, S.E.—Biochemist (male). Salary £500 p.a.
LANCASTER COUNTY COUNCIL.—Full-time Dental S. Salary £550–£850–£1,200 p.a.
LIVERPOOL UNIVERSITY.—Whole-time Lecturer (ungraded) in Department of Pathology. Salary £350–£450 p.a.
MANCHESTER CITY.—Whole-time Assistant Tuberculosis Officer (male). Salary £600–£750–£1,000 p.a.
MIDDLESEX COUNTY COUNCIL.—Public Vaccinator for Laleham and Staines District.
NEWCASTLE-UPON-TYNE COUNTY and CITY.—Assistant Radiologist in charge of Deep Therapy Department of Newcastle General Hospital. Salary £500–£600–£800 p.a.
SHIELS: Royal Hospital.—Senior Clinical Assistant to Ophthalmic Department. Salary £350 p.a.
SOUTHAMPTON COUNTY BOROUGH.—Public Vaccinator.
SOUTHERN RHODESIA MEDICAL SERVICE.—Government M.O. (male). Salary £600–£750–£1,000 p.a.
WHITTINGHAM: County Mental Hospital, near Preston.—Whole-time Senior A.M.O. (male). Salary £700 p.a.

To ensure notice in this column advertisements must be received not later than the first post on Tuesday mornings.

Notifications of offices vacant in universities, medical colleges, and of vacant resident and other appointments at hospitals, will be found at pages 46, 47, 48, 49, 50, 51, 52, 53, and 57 of our advertisement columns, and advertisements as to partnerships, assistantships, and locumtenancies at pages 54 and 55.

APPOINTMENTS

SEARLE, W. N., F.R.C.S., M.C.O.G., Surgeon to Out-patients, Chelsea Hospital for Women, Arthur Street, S.W.

BIRTHS, MARRIAGES, AND DEATHS

The charge for inserting announcements of Births, Marriages, and Deaths is 9s., which sum should be forwarded with the notice not later than the first post on Tuesday morning, in order to ensure insertion in the current issue.

BIRTHS

PLATT.—On July 5, 1938, to Muriel (nee Shuter), wife of Dr. B. S. Platt, 93, Ashburnham Road, Luton, a daughter.
R. I.—On June 15, 1938, at Batu Gajah Hospital, to Eileen M. Rix, M.B., B.S., wife of H. Rodway Rix of Ipoh, Federated Malay States, a son.

DEATHS

KERRIGAN.—On July 11, 1938, (suddenly), at 18, Ornston Drive, Belfast, Herbert Wallace Kerrigan, M.B., B.Ch.Edin., late of Manchester.