

baby was born in the chamber vessel. The placenta was expressed with some difficulty fifteen minutes afterwards, but came away quite intact. I had a good deal of trouble in stopping the haemorrhage after the placenta came away, for I could easily get hold of the uterus and make it contract, but it seemed to have very little retracting power, and filled with blood as soon as it was left. A hot continuous intrauterine douche was administered, ergot and strychnine given hypodermically, and the uterus held firmly for nearly one and a half hours before it was safe to leave it. From then onwards, however, there was no further haemorrhage of any note. Two pints of saline solution were given intravenously and pills of ergotin, quinine, and strychnine prescribed. The case ran a nearly normal course except for a slight rise of temperature to 100° during the first two days, probably reactionary and due to the extremely anaemic condition of the patient. The pulse, which immediately after the confinement was hardly perceptible at the wrist, was at 10 o'clock that night 110 and fairly full and strong.

The stillborn fetus, a female of the eighth month in development, weighed 5½ lb., and appeared quite normal and healthy. It had probably died the day before delivery, after the convulsive movements the mother had mentioned. The placenta was quite normal in every respect, but from the dark blood clots still adherent to it it appeared to have been separated from its uterine attachment over half of its surface; otherwise it presented no unusual features.

The points of interest in this case appear to me to be: First, the spontaneous emptying of the uterus without any previous signs of labour—an event which probably saved the patient's life. The loss of blood had in all likelihood so far reduced the general blood pressure, that what was left of the contracting power of the uterus was able to prevent further dilatation and to stop the haemorrhage, which had probably become feeble *in utero*, this action no doubt being stimulated by the pituitary extract. Why the labour should end so precipitately I can offer no opinion, unless it was again due to the action of the pituitary extract. The second feature of interest was the fact that I was able to get the uterus to contract and finally to retract so as to stop the haemorrhage. It is usually considered that in cases of concealed accidental haemorrhage the uterine muscle is so diseased as to have lost the power of contracting and retracting. The practically uninterrupted recovery of a patient who was so near to death must be rare. As to the predisposing cause of the haemorrhage, was the uterine muscle attenuated as a result of the attack of diphtheria, or was the nervous mechanism poisoned and stimulus interrupted by that malady? And, if so, why was the uterus able to contract sufficiently to expel the fetus and to remain contracted later? I may add that the urine was quite normal in quantity, acid reaction, specific gravity 1020, and at no time contained any abnormal constituents.

TECHNIQUE OF ANALGESIA IN INTRANASAL SURGERY.

By WILLIAM WILSON, M.D., B.Sc.,

HONORARY ASSISTANT SURGEON, ST. JOHN'S HOSPITAL FOR THE EAR, MANCHESTER.

RECENT discoveries have so modified the indications for general anaesthesia in intranasal surgery that, granted ordinary self-control by the patient and delicate handling by the surgeon, the discomforts and dangers of efficient analgesia are considered less than those of general anaesthesia. The only intranasal operation really unsuitable for local analgesia is the frontal sinus obliteration.

I have found the technique about to be described highly satisfactory in operations upon the turbinal bones and nasal septum; indeed, a patient who has slept through the greater part of the operation may be able, with a little assistance, to walk back to bed. The employment of chloroform (without admixture with ether), injections of cocaine and adrenalin, alone or in combination, and post-operative packing with adrenalin are absolutely unjustifiable in operations on the nose, and will sooner or later lead to catastrophe. Moreover, with or without the use of a general anaesthetic, the injections of cocaine and adrenalin lead to marked excitability, difficulty of breathing in the recumbent posture, and excruciating headache (through adrenalin vasomotor stimulation), with the need of constant administration of hot coffee and aromatic spirits of ammonia. The confidence of the patient is lost and the operation is rendered more difficult.

One hour before the commencement of the operation a

hypodermic injection of ½ grain of morphine with 1½ grain of atropine sulphate should be given and the nasal passages packed with gauze soaked in equal parts of 10 per cent. cocaine and adrenalin. This should be done with reflected light, so that narrow strips can in most cases be passed behind a marked deviation. The patient should be allowed to remain as quiet as possible for thirty minutes, when he is transferred to the operating table and the gauze strips are removed, a small portion of cotton-wool being inserted far back in each nostril to soak up any overflow from the following infiltration of urea-hydrochloride-quinine solution. In the case of an operation upon the nasal septum three points for injection will suffice on each side; these points are at the angles of a triangle with the base corresponding to the junction of mucosa and skin just behind the anterior nares and the apex over the vomer, its exact position being dependent upon the area infiltrated by the two injections in front. If the inferior turbinates are to be removed two injections will suffice on each side, one just behind the anterior extremity and the other at the junction of the middle and posterior thirds. The syringe employed should be all metal and the needle of the finest aperture procurable with bevelled tip without point. Dental needles are most convenient. The solution employed should be 1 per cent. quinine-urea-hydrochloride, and the amount injected should not be stinted. The nose is again packed with gauze wrung out of the cocaine-adrenalin solution, and in about twenty-five minutes the operation is commenced.

The haemostasis is perfect, and the analgesia is so thorough as to be truly anaesthesia, even the tactile sensibility being in most cases destroyed. There is but little emotional distress, and I have known patients, on being told to close the eyes and sleep, who have done so, and snored away during the entire operation, the only disability being that the head has had to be steadied by an assistant. The analgesia persists as a rule for about eight to twelve hours. I have not met any instance in which it has lasted several days, as claimed by other observers. There is no after-sickness, and the patient is free to go about his business in about twenty-four hours. In consequence of the exudation caused by the quinine-urea solution, there is some after-swelling, but this seems to minimize the possibilities of post-operative oozing.

It is quite possible to drain and explore the antrum of Highmore by this method, as is the routine practice of many American surgeons, but time is required before the advantages of efficient analgesia are fully appreciated in this country. It is safe to predict that the future will see further rapid progress as new chemical discoveries of non-toxic anaesthetics are announced.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

A CASE OF CEREBRO-SPINAL MENINGITIS.

C. W., aged 23, a driver A.S.C., was removed on April 9th to the Red Cross Hospital, Trent Vale, and from there, on April 10th, to the Bucknall Isolation Hospital. At the onset there was nausea, with violent headache and retraction of the head, and the temperature rose to 103° F. When admitted into the isolation hospital he was quite unconscious, with the head greatly retracted and the back curved; there was slight squint, increased reflexes, Kernig's sign, on the left buttock a patch of spots, and on the lips a well-marked patch of herpes. The pupils were inactive and contracted, *tache cérébrale* very marked; the urine was passed freely, and contained no albumin. During the second day incontinence of urine and faeces set in, and continued during the illness. Lumbar puncture was performed on April 10th with Barker's needle. Lumbar fluid was sent to the Health Laboratory, Manchester, for examination, and was said to contain *Meningococcus intracellularis*. The jaws were so clenched that it was impossible to obtain a swab from the throat. Soamin was given intramuscularly in 6-gram doses daily, until 100 grams had been given. Lumbar puncture was made every four days (six times altogether); 30 to 60 c.cm. of fluid was removed each time, and 15 c.cm. of antimeningococcus given after the withdrawal of fluid on each occasion until 75 c.cm. had been given. The puncture was made each time that

there was a rise of temperature. On April 30th the temperature fell to normal, pulse 112, respiration 28, and the patient became more conscious, and took food well. On May 4th he was able to move his head about freely, and to raise himself from the pillow and to answer questions well; he gave a history of himself and his family; he began to take solid food on May 8th. The improvement was maintained also on May 9th and 10th, and he appeared to be going on fairly well.

On May 11th temperature fell to 96.8° F.; the pulse was 116 and very feeble. Violent sickness set in at 11.55 a.m.; he could not take any liquid food, and became restless and quite unconscious. There had been no action of the bowels for twenty-four hours, and the urine was scanty.

On May 12th the pupils were contracted, the head retracted, and he was breathing heavily; the pulse was 60 and feeble. Lumbar puncture was made, but without relief. Ether and digitalis were given hypodermically; the patient sank and died at 11 p.m. No *post-mortem* examination was allowed.

Stoke-on-Trent.

C. H. PHILLIPS, M.D.

TREATMENT OF WOUNDS.

I PUBLISH this note in order to give the medical profession at home and abroad an opportunity of employing the following treatment for septic wounds:

Mix equal quantities of pure ichthyol and glycerine, spread it on boric lint by means of a camel-hair brush, and apply it to the wound. The wound should be dressed daily. If there is also suppuration from a sinus, as in the case of a bullet wound, it should be syringed out with pure spiritus vini rectificatus; in this case dressing with gauze is preferable to boric lint.

This treatment produces a healthy granulating surface in a few days, and does not cause any irritation of the wound. The daily dressing has a great advantage over fomentations, which necessitate frequent changing and disturb the patient, besides prolonging suppuration. The less moisture about a wound the better. I have almost discarded that barbarity—the drainage tube. The results obtained by this treatment are most brilliant.

C. W. DUGGAN, Major R.A.M.C.

Military Hospital, The Barracks, Lincoln.

COMPLETE INVERSION OF THE UTERUS WITH PROLAPSE: RECOVERY.

The following case is similar in many respects to that recorded by Dr. Oag:

On the morning of August 22nd, 1914, I was called to see Mrs. W., aged 23, primipara. During the previous night she had felt some slight colicky pains, and in the morning thought she was only commencing labour; but when I examined her the head was on the perineum. As the pains were deficient I applied forceps, and the child was born easily at 11.30 a.m. The uterus contracted well, and about ten minutes after the birth of the child (a healthy female) the placenta was coming out of the vagina; in removing it with the usual care, I found it bringing along with it, right outside the vulva, the completely inverted uterus. There was practically no haemorrhage; as the placenta was not markedly adherent, I detached it, and tried to reduce the inversion under chloroform, but after about twenty minutes' manipulation the patient became pulseless and so profoundly collapsed that I deemed it advisable to desist. The cord was of the usual length, and in every way normal. My efforts—and those of the district nurse, who was also in attendance, and whose help and inestimable services cannot be over-estimated—were afterwards directed to combating shock, which was extreme, by means of pituitary extract, hypodermics of strychnine and digitalis, saline under the breasts, and other usual means. In the afternoon the patient rallied, and she was removed to the Maternity Hospital, Edinburgh; but owing to difficulty of securing suitable transport, it was nearing 7 p.m. when she reached the institution in a motor ambulance. Her condition remaining satisfactory, she was given an anaesthetic on admission, and the inversion carefully reduced by Dr. Eddington, not, however, without much difficulty; shock was extreme. After a tedious and perilous convalescence the patient recovered, and is now in perfect health.

The case, like that of Dr. Oag's, is of great interest owing to the following facts:

1. The extreme rarity of complete inversion—1 in 200,000 confinements.

2. The mortality, said to be as high as 66 per cent. This mortality, high though it be, is probably an under-estimate.

3. The absence of any apparent cause. Cord usual length; no abnormality; no torsion made on cord. Placenta not adherent.

Since writing these few notes I have read Dr. Carruthers's illuminating remarks on the same subject with very great interest and pleasure.

Kirkliston.

PETER STEWART, M.D.

CARCINOMA OF CERVIX: TWIN DELIVERY WITHOUT LACERATION.

MADAME T., aged 37, a multipara with three children, the youngest aged 7, was admitted into a temporary hospital for women at Châlons-sur-Marne on December 24th, 1914. A French army doctor had seen the case, and as the pains were very distressing he had given morphine hypodermically before sending the case into hospital. There was a history of loss of matter and discharge, often blood-stained, for at least four months. The patient was very sallow, and said she had not been at all well during pregnancy. The uterus corresponded in size to that of full-term pregnancy; there were intermittent contractions, and there was so much tenderness that the fetal parts were difficult to locate. There was a considerable quantity of very foul blood-stained discharge coming away from the vagina.

The os was about the size of a five-shilling piece, but the edges were very hard and irregular and bled easily, and examination with a speculum showed all the naked-eye appearances of an early carcinoma of the cervix. Next day, as very little progress was being made, Dr. Evrain kindly saw the case with me in consultation. He also had no doubt about the diagnosis, but thought that spontaneous delivery was possible, and that a Champetier de Ribes's bag might help, as the membranes had ruptured before the patient came into the hospital. The bag, unfortunately, soon began to leak, so was of little service. Labour was very tedious, and the patient was so exhausted that when the os was three-quarters dilated I decided to perforate the fetal head, as no one had been able to hear the fetal heart.

Delivery was effected slowly with ordinary long curved forceps and a female baby of rather small size was delivered, but it then became quite evident that it was really a case of twins; as the second child was presenting by the vertex delivery was effected with forceps of a very puny living female child weighing 5½ lb. The placenta with two cords attached came away without any trouble, and pituitary extract was given hypodermically. No lacerations could be felt in the cervix, the os contracting down well.

The puerperium was normal apart from the discharge caused by the growth and the uterus involuted well. The baby never cried strongly and died within three days.

On January 9th examination of the cervix showed that there was slight extension on to the posterior vaginal wall but no severe lacerations. The patient was seen at her home towards the end of January and also about the end of February; the growth was extending rapidly posteriorly, and there was so much pain that narcotics had to be given frequently.

The case is, I think, interesting from two points of view: First, the comparative rarity of carcinoma of the cervix complicating pregnancy, and, secondly, the fortunate fact of there being twin pregnancy, the heads being comparatively small made delivery without any laceration possible.

C. DYSON HOLDSWORTH, M.D., B.S.Lond.,

M.R.C.S., L.R.C.P.Lond.,
Assistant Surgeon to the Clayton Hospital and
Wakefield General Dispensary.

TUBERCULOSIS IN CHILDREN.

THE following passage, which you quote from the annual report of the Chief Medical Officer of the Board of Education,¹ is full of meaning: "In early childhood lymphatic tissue, bones, and joints are more frequently invaded than the lungs, and although infection of the lungs appears to become increasingly common as the child grows older, it

¹BRITISH MEDICAL JOURNAL, D. 555.

comparatively seldom presents a similar picture to the well known pulmonary tuberculosis of adult life. Although I examine a large number of school children yearly, I have never yet met with a case presenting "a similar picture to the well known pulmonary tuberculosis of adult life." During routine examination I see very many cases presenting signs of infection of the bronchial glands, and one is tempted to put all these in the same category with infected glands in other parts of the body. The clinical signs presented by a child suffering from tuberculous glands of the neck are identical with the symptoms present in a case of infected bronchial glands, except that in the latter we get pressure within the thorax giving distinctive signs. I venture to make the proposition that primary pulmonary tuberculosis in the child of school age is very rare, and the cases we see simulating pulmonary tuberculosis are in reality infections of the bronchial glands, and that the lung lesions in these cases are secondary to and part of a general glandular infection, probably caused by the tubercle bacillus of bovine origin.

Heverley.

T. READMAN.

Reviews.

THE NEW ANATOMY.

ANY one who is watching the progress of anatomy in Britain must have noted a very definite change—almost a revolution—in the outlook of our younger anatomists. No better evidence as to the nature and degree of the change that is coming could be found than in the *Clinical Anatomy of the Gastro-intestinal Tract*¹ by Professor WINGATE TODD, just issued by the Manchester University Press.

It is true that Professor Todd occupies the chair of anatomy in one of the universities of the United States, but every page of his book proclaims him to be a British anatomist of the younger school. It is not difficult to define the nature of the changes which are taking place in our dissecting-rooms. The older school studied and described the *dead* human body; the aim of the newer school is to study and teach the anatomy of the *living* body. Many will remember the black, dried, inflated, hardened stomachs and the blown-out parchment caeca with membranous gaping ilco-caecal lips on which we were asked to base our knowledge for a career in the practical application of surgery and medicine. Then came a "formalin" period in anatomy, in which the conception of anatomical forms underwent a change, but in the opening years of the formalin period the anatomist's point of view remained centred on the various forms seen after death. The discovery of Roentgen rays was the factor which ultimately killed the dead, unimaginative study of the human body. In his description of the viscera of the abdomen Professor Todd has used his knowledge of the living viscera as revealed by the use of *x* rays. The student and practitioner will feel as they read the pages of Professor Todd's book that the anatomist has at last got a glimpse of the world of clinical endeavour that lies beyond the doors of the dissecting-room.

Another change that has come across the anatomical mind is to be noted. The teachers of a former day were inclined to regard the study of anatomy, not as the basis of medicine, but as an end in itself. There were so many tempting paths which led into the unlimited realms of comparative anatomy and embryology, and along these paths teachers often guided their willing students without any thought as to the ultimate aim a medical student had in view. It must not be thought that the younger anatomist does not make excursions into such collateral subjects; one finds that Professor Todd often does, but for the same reason as John Hunter—namely, to find living facts that help the medical student and the medical practitioner to understand the mechanism of the living human body. Comparative anatomy can throw a flood of light on obscure structures like the appendix vermiformis.

Perhaps the most remarkable change in the outlook of the anatomist is the change in his attitude towards his colleagues—the physiologist and pathologist. Professor

Todd has used the discoveries of the physiological and pathological laboratories to the full in explaining the anatomical problems of the alimentary tract; he also shows a wide and accurate acquaintance with medical and surgical literature—a knowledge which is absolutely essential for one who is to help in the education of new generations of medical students. We can recommend Professor Todd's book to medical students as the best clinical manual on the anatomy of the alimentary tract and as an exemplar of how anatomy should be studied and taught.

EXPERIMENTS ON ANIMALS.

DR. W. W. KEEN is well known to his profession in this country as one of the very foremost of the great American surgeons. He has enjoyed, over here, that sort of distinction, that welcome, which were given to Lowell. And his book, *Animal Experimentation and Medical Progress*,² has distinction and high authority. None of us could desire a better summary of the evidence, to put into the hands of anybody who still doubts that experiments on animals are of absolute necessity for the advancement of the work of our profession.

The book is a collection of many papers and addresses by Dr. Keen, dating from 1885 to 1913. Thus, it is not only a system of evidence—it is also an account of antivivisection in the United States. On this point we have only to say that antivivisection in the United States seems to be even worse than it is here—more false, more unscrupulous, more wild in its charges of cruelty. It could not have a more gentle, polite, and patient opponent than Dr. Keen; indeed, we may wonder that he takes to heart so anxiously the extravagant statements of a few American antivivisectionists. But that is not our affair; the opposition in our own country is well-nigh silent now, in these grave times; and let us hope that it will not for many years after the war regain any hold on public attention. We can now well leave it to itself.

The historical part of Dr. Keen's book—the tracing of the great discoveries, the explanation of the ways and purposes of research, and the study of the rise and influences of bacteriology—are admirable. He writes very quietly, with a most delightful style, and he writes with that insight which comes of life-long experience in great practice.

To complete the value of this very valuable book, there is an introduction by one of the most illustrious of living Americans—Dr. Eliot. None of us in this country who read what Dr. Eliot wrote of the ethical or spiritual purposes of the present war, will doubt his authority to teach ethics; and in this introduction he says of the ethics of experiments on animals all that needs to be said, and with an authority and dignity that must carry conviction to all unprejudiced minds.

We very heartily commend this book not only to all medical men who would like to have the evidence at hand for their own use, but to all non-medical readers. It would be hard to find a more useful book on the subject.

MEDICAL WOMEN AND THEIR WORK.

ONE result of the war will probably be a considerable extension of the field of practice now open to medical women. In his presidential address to the General Medical Council on June 1st, Sir Donald MacAlister said that the services of medical women had been freely offered and accepted for many of the places now vacant at home. In a book, to which Mr. Stephen Paget has contributed an introduction, Miss A. H. BENNETT³ gives a brief and readable account of the struggles by which a few determined women battered down the portals of the profession which were closed to them till less than half a century ago, and opened up a new career for their sex. Repulsed at Edinburgh, they were more successful in London, where the School of Medicine for Women was founded in 1874. But the battle was not yet won. The Medical Qualifications Act of 1876 threw open the medical profession to women, but the qualifying bodies only gradually abandoned their obstructive attitude. Although Mrs. Garrett

¹ *The Clinical Anatomy of the Gastro-intestinal Tract*. By T. Wingate Todd, M.B., Ch.B., F.R.C.S. Eng. Manchester: The University Press. London, New York, etc.: Longmans, Green, and Co. 1915. (Cr. 8vo, pp. 276; 32 figures. 6s. net.)

² *Animal Experimentation and Medical Progress*. By W. W. Keen, M.D., LL.D. With an introduction by C. W. Eliot, LL.D. Boston and New York: Houghton Mifflin Co. 1914. (Post 8vo, pp. 332.)

³ *English Medical Women: Glimpses of Their Work in Peace and War*. By A. H. Bennett. With a preface by Stephen Paget, F.R.C.S. London: Sir I. Pitman and Sons, Ltd. 1915. (Cr. 8vo, pp. 167; 3 illustrations. 3s. 6d.)

empties the glands and ducts of gonococci which constitute the plugs of muco-pus I described as filling the catheter perforations.

Having varied the circuiting and tried current reversals during the last three years of work at gonorrhoea, I believe the system I described to be the best. Still, I endeavour to keep an open mind until more is known of bacterial movements and vitality in relationship to the inflamed membranes or tissues which so many of us are trying to heal.—I am, etc.,

London, W., June 21st.

CHARLES RUSS.

THE DISCOVERY OF CHLOROFORM.

SIR,—Permit me to add a few facts in support of your views on the claims made on behalf of Waldie to be considered the discoverer of chloroform. In 1886 I put forward the claim of Samuel Guthrie of Sacketts Harbour, then an important naval base, where he resided, and as a surgeon in the Army of Independence acted as consulting chemist to the munitions department. Guthrie was a regular contributor to *Silliman's Magazine*, then the principal scientific monthly in the United States of America, and in volumes xxi and xxii he published his articles on a new method of preparing solution of chloric ether. This paper appeared ten years prior to C. W. Long's discovery of the anaesthetic properties of ether and long before J. Y. Simpson sought a substitute for the ill-smelling ethyl oxide. Guthrie's other papers consisted of "Chemical fulminating preparations," "Vapourization of mercury," "Sugar from potato starch," and "On oil of turpentine."

He is credited with not alone discovering chloroform, but also with being the first to use it medicinally.—I am, etc.,

Dublin, June 21st.

GEORGE FOY.

DESTRUCTION OF LICE AND OTHER BODY VERMIN.

SIR,—I have read Dr. J. Parlane Kinloch's admirable article in the *JOURNAL* of June 19th with very great interest. I am commandant of the 7th Northumberland Voluntary Aid Hospital, where patients are taken in from the local "billets," often in a verminous condition, and I write to beg that Dr. Kinloch would be so good as to make a suggestion as to how best to deal with the condition in the most economical way. It would be sufficient for my purposes if I could "disinfect" the kit of only one man at a time, and it would appear that the provision of a dry-cleaning bath and extractor would be unnecessarily expensive; yet I wish to use petrol rather than any other agent, as it is easily obtainable here, and its use would not require that the clothes (uniform particularly) should be dry-cleaned afterwards, as is the case, I understand, after using the phenol derivatives; indeed, to use the latter would necessitate some appliance to raise the temperature to 65° C., which we do not possess.—I am, etc.,

Monkseaton, Northumberland, June 22nd.

H. E. DAVISON.

Obituary.

SURGEON-GENERAL ARTHUR JAMES PAYNE, of the Bengal Medical Service (retired), died on May 21st, aged 88. He was born on October 21st, 1826, the son of Quartermaster Payne, of the Grenadier Guards; educated at King's College, London, took the diploma of M.R.C.S. in 1847, and the degree of M.D.Lond. in 1848. He was also B.A. of London University. He was nominated an assistant surgeon in the I.M.S. on December 20th, 1848, became surgeon on February 1st, 1863, surgeon-major on December 20th, 1868, and deputy surgeon-general on September 13th, 1879, retiring with a step of honorary rank on February 1st, 1885. After serving in the artillery for a short time after his arrival in India, in 1849, he entered civil employ in the North-West Provinces, and was civil surgeon of Fatehgarh and Gorakhpur in 1850–52. In 1852 he reverted to military duty, and on December 27th, 1855, was appointed garrison surgeon of Fort William, and spent the whole of the rest of his thirty years' service in Calcutta. On October 31st, 1856, he entered civil employ in Bengal, as second assistant surgeon of the Presidency European

General Hospital, and in 1863 was appointed superintendent of the Calcutta lunatic asylums, holding that post till his promotion to the administrative grade in 1879. In 1880 he became administrative medical officer of the province of Bengal, with the local rank of surgeon-general. Though he was serving in India during the Mutiny, the *Army List* assigns him no war service. At the time of his death he was third in seniority of the retired officers of the Bengal Medical Service, after Surgeon-Majors H. B. Hinton and W. F. Mactier.

LIEUTENANT-COLONEL MONTAGUE STOKES EYRE, Madras Medical Service (retired), died at Bath on May 29th. He was educated at Edinburgh University, where he took the M.B. and C.M. in 1876, and entered the I.M.S. as surgeon on September 30th, 1876, becoming surgeon-major on September 30th, 1888, and surgeon-lieutenant-colonel on September 30th, 1896. He retired on April 7th, 1907. Though most of his thirty years' service was spent in military employ, the *Army List* assigns him no war service. He was the second son of the late Edmund Walter Eyre, Inspector-General of Hospitals, Madras.

LIEUTENANT-COLONEL GEORGE TURNER TREWMAN, R.A.M.C. (retired), died suddenly on June 13th, aged 59. He was born on September 12th, 1855, the eldest son of the late Rev. Arthur Peile Trewman, vicar of Ilminster, Somersetshire, educated at Westminster Hospital, and took the diplomas of L.S.A. in 1876, and of M.R.C.S. in 1878, and the degree of M.B.Durh. in 1879. He entered the army as surgeon on July 30th, 1881, became surgeon-major on July 30th, 1893, lieutenant-colonel on July 30th, 1901, and went on half-pay on March 17th, 1904. He retired on August 3rd of the same year, but had been re-employed during the war. He served at Suakin in the Soudan campaign of 1885, and received the medal with a clasp, and the Khedive's bronze star.

MAJOR ARTHUR TREGELLES PRIDHAM, Indian Medical Service, died suddenly on June 6th. He was the second son of the late Arthur E. Pridham of Plymouth, and was born on August 4th, 1877. He was educated at St. Bartholomew's Hospital, and took the diplomas of M.R.C.S. and L.R.C.P.Lond. in 1899, and graduated M.B.Lond. in 1900, in which year he obtained the Brackenbury medical scholarship. After acting as house-physician at St. Bartholomew's and at the Queen's Hospital for Children, Hackney Road, he entered the I.M.S. as lieutenant on September 1st, 1902, becoming captain on September 1st, 1905, and major on September 1st, 1914. He was appointed medical officer of the 8th Gurkha Rifles in 1907, and in 1912 went into civil employ in Burma as Superintendent of the Rangoon Central Gaol, but had been on sick leave since October 6th, 1913. He served in the Abor campaign on the North-East frontier of India in 1911–12, and received the medal with a clasp.

The Services.

TERRITORIAL FORCE.

EXCHANGES OF MEDICAL OFFICERS.

CAPTAIN J. M. POSTLETHWAITE, 1st East Lancashire Field Ambulance (T.F.), whose request for an exchange was published in the *JOURNAL* of May 1st, asks us to state that, as he is now at the front on active service, an exchange is no longer desired, and in any case would be difficult.

Universities and Colleges.

VICTORIA UNIVERSITY OF MANCHESTER.

The following candidates have been approved at the examination indicated:

M.D.—J. S. B. Stopford (awarded gold medal), G. C. Mort.

In the three weeks ending June 19th, 19 cases of plague with 17 deaths were reported at Hong Kong. In Mauritius there was one fatal case of the disease on June 14th.

Medical News.

WE regret to learn that Mr. Howard Marsh, Master of Downing College, Cambridge, and formerly surgeon to St. Bartholomew's Hospital, died on June 24th.

DR. WILLIAM MURRAY DOBIE of Chester left estate of the gross value of £6,006, with net personalty £3,851.

MR. A. H. TUBBY has been elected an Honorary Member with Medal of the First Class of the Società Fisico-Chimica Italiana.

THE Civil List pensions for 1914-15 include a pension of £150 to Dr. Charlton Bastian, F.R.S., in consideration of his services to science.

THE names of the following gentlemen have been added to the Commission of the Peace for Perthshire: David G. Donaldson, M.D., Dunning, and John Irvine, M.D., Muthill.

MAJOR LEONARD DARWIN, President of the Eugenics Education Society, will open a discussion on alcoholism and eugenics at the meeting of the Society for the Study of Inebriety, to be held in the rooms of the Medical Society of London, 11, Chandos Street, W., on Tuesday, July 13th, at 4 p.m.

BRITISH nurses who may be desirous of offering their services to Italy are recommended to communicate with Miss Snell, Matron of the Scuola Convitto Regina Elena, Policlinico, Rome, who would be glad to give advice as to the way in which such help can be put into the best channels.

THE annual general meeting of the Poor Law Medical Officers' Association of England and Wales will be held on Tuesday, July 6th, in the Council Chamber of the British Medical Association, 429, Strand, London, W.C., at 4 p.m. All Poor Law medical officers are cordially invited. Tea will be provided.

THE annual general meeting of the Research Defence Society will be held at the house of the Royal Society of Medicine, 1, Wimpole Street, Cavendish Square, W., on Wednesday, June 30th, at 5 o'clock. In the absence of the President, Lord Lamington, on military service, Major-General the Hon. Sir Reginald Talbot, K.C.B., will take the chair. The report will be presented by Lord Knutsford, Chairman of Committee. Other speakers will be Sir William Osler, and Surgeon-General Sir Alfred Keogh, K.C.B. After the meeting Dr. Andrew Balfour, C.M.G., will give a demonstration, with the cinematograph, on the protective treatment against typhoid fever and cholera.

In a paper read before the Royal Meteorological Society on June 16th by Mr. C. Harding, some support was given to the belief that artillery fire may have some effect on the rainfall. From the beginning of the war until the middle of October the weather conditions in the western area of operations were bright and dry with occasional short spells of rain, but from the middle of October to the end of February rainy and rough weather continued with little cessation. In the British Isles the rainfall for the nine months ending April, 1915, was below the average in the north and west, but greatly in excess of the normal in the south and south-east. The rainfall was also in excess at all western Continental stations. Mr. Harding, while not suggesting that the rainy conditions were generated by gun firing, thinks it quite possible that at times, when the conditions were favourable to rain, the rains may have been augmented or accelerated by the concussion initiated over the battle grounds.

THE Central Midwives Board met on June 17th. A letter from the Midwives Institute was read relative to the decision of the High Court in *Stock v. Central Midwives Board*. The Board's reply is: "That the decision of the High Court in the case of *Stock v. Central Midwives Board*, although reversing the decision of the Central Midwives Board to remove the name of the midwife from the Roll, confirms the Board in its position as the authority which determines what is and what is not misconduct in a midwife, and decides that misconduct is not to be limited to misconduct in a professional sense; the Board has held that conduct which, before enrolment would render it impossible to certify that a candidate was "of good moral character" renders her, after enrolment, liable to be removed from the Roll for 'misconduct,' and there is no likelihood that the Board will depart from this position." Recognition as lecturers was granted to Drs. Arthur Crook, G. F. Odhams and Herbert Edward Taylor, M.D., and approval to undertake the practical training of pupils to two certified midwives.

Letters, Notes, and Answers.

THE telegraphic addresses of the BRITISH MEDICAL ASSOCIATION and JOURNAL are: (1) EDITOR of the BRITISH MEDICAL JOURNAL, *Attitully, Westrand, London*; telephone, 2631, Gerrard. (2) FINANCIAL SECRETARY AND BUSINESS MANAGER (Advertisements, etc.), *Artitully, Westrand, London*; telephone, 2630, Gerrard. (3) MEDICAL SECRETARY, *Medisecra, Westrand, London*; telephone, 2634, Gerrard. The address of the Irish office of the British Medical Association is 16, South Frederick Street, Dublin.

QUERIES.

MEDICAL ATTENDANCE AT PRIVATE SCHOOLS.

A SCHOOL DOCTOR writes: May I ask the readers of your JOURNAL, especially those who have schools under their charge, if it is customary to give a 10 per cent. discount on their accounts against schools? Such an application has been made to me. To quote from the letter: "The head master is not anxious to press this, but as it appears to be the custom in other schools he thought you would be willing to grant the 10 per cent. which appears to be the usual amount allowed."

ANSWERS.

BREATHING EXERCISES.

DR. G. E. SHUTTLEWORTH (London) writes, in reply to "A. D.," that a serviceable sheet, entitled *Breathing Exercises*, by Duncan Matheson Mackay, M.D., is published by Messrs. Bale, Sons and Danielsson, Great Titchfield Street, W., price 1d.

PARTNERSHIP AGREEMENTS.

A.M.S.—(1) We have never known of an agreement in a medical partnership in which the share of one of the partners on his demise lapsed for the benefit of the surviving partners. If such a windfall were to take place, on general principles it would be divided among the survivors in proportion to their respective shares in the partnership. (2) If, in a partnership of three, B. and C. paid out A., and then sold A.'s share to another, the purchase money would be divisible among B. and C. in the same proportion as the amounts respectively found by B. and C. in paying out A. As the firm would pay out A., these amounts would be usually in proportion to the respective shares of B. and C. in the partnership.

LETTERS, NOTES, ETC.

BODY VERMIN.

DR. W. LYLE (Newtownstewart) writes: I have found that boiling the under garments for half an hour, then drying, and afterwards steeping in a 1 in 1,000 solution of corrosive sublimate, and allowing them to dry, will destroy body lice and free patients from a recurrence under ordinary conditions for several months. This has been my treatment in private practice for several years in cases of old patients suffering from these distressing pests, and I have found it invariably successful.

VITAMINES AND PASTEURIZED VERSUS CLEAN RAW MILK.

DR. JAMES OLIVER (London) writes: Your very excellent leaderette in the JOURNAL of May 29th, p. 938, on "Vitamines," raises the important question of the relative values to life of pasteurized and clean raw milk, when fed more especially during infant life, seeing that pasteurization lowers if it does not actually annul the value of milk vitamines. We are all so familiar with milk that we fancy we know a very great deal about its health-giving qualities and can pasteurize it with impunity, and yet it is only during the last few years that we have become aware that it contains a substance known as vitamines, and that there is in milk a considerable amount of volatile sulphur. Now, unfortunately, by the process of pasteurization these two very valuable substances are practically expunged from milk and other very essential mineral substances are so chemically altered that they no longer fulfil their due physiological functions in our bodies when pasteurized milk is fed. It is thus and in a host of other ways that the resisting powers of our bodies are being lowered, and we are being rendered more susceptible to various different diseases. Paradoxical though it may seem, the more we struggle to live the more we tend to die.

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NOTE.—It is against the rules of the Post Office to receive *post-restante* letters addressed either in initials or numbers.

INDEX TO SUPPLEMENT FOR VOLUME I, 1915.

A.

- Aberdeen, National Insurance, 260
Action re assignment of patients, 36
ADAMS, W. Coode: National Insurance, protest against the reduction of capitation payments, 239
ALEXANDER, George: National Insurance, approved societies and certificates from non-panel practitioners, 76
Army, British, medical service of, 5, 14, 22, 30, 38, 46, 61, 70, 77, 85, 94, 106, 117, 127, 131, 137, 147, 159, 261, 271, 279, 289, 306, 317, 339
Army, British: Army Medical Service, 5, 14, 22, 30, 38, 46, 61, 70, 77, 85, 94, 106, 117, 127, 131, 137, 147, 159, 261, 271, 279, 289, 306, 317, 339
Army, British: Colonial Medical Services, 138
Army, British: Royal Army Medical Corps, 5, 14, 22, 30, 38, 46, 61, 70, 77, 85, 94, 106, 117, 127, 131, 137, 147, 159, 261, 271, 279, 289, 306, 317, 339
Army, British: Special Reserve of Officers, 5, 22, 39, 61, 70, 94, 117, 127, 137, 262, 271, 279, 317, 340
ARMY, BRITISH: TERRITORIAL FORCE, 6, 14, 23, 30, 39, 47, 61, 70, 78, 94, 106, 117, 127, 131, 137, 147, 159, 238, 262, 271, 279, 290, 306, 317, 340
Army Medical Services, 6, 14, 23, 30, 78, 106, 117, 137, 147, 271, 279, 290, 306, 340
Royal Army Medical Corps, 6, 30, 39, 47, 61, 70, 78, 94, 106, 117, 127, 131, 137, 147, 159, 262, 271, 279, 290, 306, 317, 340
Army, British, Territorial Force Reserve, 6, 14, 30, 47, 106, 128, 138, 238, 290—Royal Army Medical Corps, 6, 14, 30, 47, 106, 128, 138, 238, 290
Army, Indian, Medical Service of, 6, 23, 30, 39, 47, 94, 106, 117, 238, 262, 279, 289, 340
Army, Indian, Subordinate Medical Department, 106
ASKIN, T. Cuming: National Insurance, treatment of juvenile members of friendly societies, 130
Assam Branch. *See* Branch
Assignment of patients (King's Bench case), 36
Association, British Medical, Annual General Meeting, 333—Alteration of Articles of Association, Extraordinary General Meeting, 338
Association, British Medical, Annual Representative Meeting, 161—Provisional agenda, 161
Association, British Medical, attendances of Representative Body, Council and Committees, 247
Association, British Medical, changes of boundaries of Branches and Divisions, 77, 94, 127, 238, 276
Association, British Medical, Council elections, 70, 77, 312—Nominations, 268, 275—Result of elections, 312
ASSOCIATION, BRITISH MEDICAL: COUNCIL PROCEEDINGS, 41, 166, 237
Annual Report of Council: Preliminary, 166
ASSOCIATION, BRITISH MEDICAL: COUNCIL PROCEEDINGS (*continued*)
Finance: Financial statement, 168—Apportionment of subscription, 178—Estimate for 1915, 178
The Association and the war: Organization of medical attendance upon dependants of men serving with the colours, 179—Organizing the profession to meet the needs of the Forces in addition to those of the civil population, 179—Assisting the Belgian medical profession, 179
Organization: Membership, 180—Alterations of Articles, 180—Eligibility for membership, 180—Question of Association becoming also a Federation for other medical bodies, 180—Grouping for election of Council, 1916–17, 180—Representation in Representative Body, 1915–16, 180—Bound volumes of Supplements, 180—Reports of Divisions and Branches for 1914, 181—Conferences of secretaries, 181—Conference of secretaries, 1915, 181—Status and authority of decisions of Association, 182—Representation of Oversea bodies in Central Association, 182
Journal, 182
Science: Research scholarships and Science grants, 183
Medical Ethics: Ethical appeals, 183—Revision of Model Ethical Rules, 184—Cases submitted to General Medical Council, 184
Medico-Political: Payment of practitioners called in on advice of midwives, 184—Contract fees for attendance on juvenile members of friendly societies, 185—Select Committee on patent medicines, 185—Insufficiently trained nurses, 185—Practice of dentistry by unqualified persons, 186—Municipal ambulance services, 186—Crime and Punishment Subcommittee, 186—Fees for medical examinations for life insurance, 186—Royal Commission on Venereal Diseases, 187—Adjudication on questions of professional charges, 187—Assistant asylum medical officers, 187—Medical inspection and treatment of school children, 187—Conference with National Union of School Teachers, 187—Medical aid institutions, 188—Maternity and child welfare, 188—Committees on Care of Mentally Defective, 188—Incipient insanity, 188
National Insurance: Proposed Standing Insurance Acts Committee, 188—Local Medical and Panel Subcommittee, 189—Conference of Representatives of Local Medical and Panel Committees, 189—Medical aid institutions, 189—Certification, 189—Drug tariff, 190—Proposed Federation of Local Medical and Panel Committees, 192—Departmental Committee on Excessive Sickness Claims, 192—Future developments of Insurance Acts, 192—Attendance on soldiers on furlough, 193
ASSOCIATION, BRITISH MEDICAL: COUNCIL PROCEEDINGS (*continued*)
Public Health and Poor Law: Security of tenure and superannuation of public health officers, 193—Tuberculosis cases receiving domiciliary treatment, 193—Model scheme for treatment of tuberculosis, 193—Action as to public health and Poor Law appointments, 193
Hospitals: Model scheme for treatment of tuberculosis, 193—Voluntary hospitals and maternity benefit, 193—Payment of hospital staffs for operations in cases of tuberculosis, 194—Position of hospitals under the Insurance Act, 194
Naval and Military: Shortage of medical officers in Royal Navy, 194—Pay of Territorial and Emergency R.A.M.C. surgeons, 194
Scotland: The war, Scottish Medical Service Emergency Committee, 194—Insurance Act, 194—Question of Scottish Medical Secretary, 195
Ireland: Medical Secretary for Ireland, 195—Insurance Act, 195—Question of amalgamation with Irish Medical Association, 195—Poor Law, 195—Dependants of men with the colours, 196
Oversea Branches: Medical reciprocity, 196
List of appendices, 196
Aberdeen meeting, 41
Apologies, 237
Bequest by the late Dr. Fotherby, 42
Cambridge meeting, 41
Candidates for election to the Association, 43, 237
Central Ethical Committee, 42
Central Nursing Council for London, 43
Deaths of former members of Council, 41, 237
Distribution of unallotted funds, 41
Election to Council (1914–15), 237
Finance, 237
Finance Committee, 42
Insurance Act Committee, 43
Journal Committee, 42
Medico-Political Committee, 42
National Relief Fund, 41
Naval and Military Committee, 43
New members of Council, 41
Non-Panel Committee, 43
Organization Committee, 42, 237
Public Health Committee, 43
Roll of honour, 41, 237
Science Committee, 42
Solicitor to the Association, 41
The President, 237
War Emergency Committee, 43
Association, British Medical, grants in aid of scientific research, 238, 276, 310
Association, British Medical, the library, books added, April–June (1914), 18, 29, 311
Association, British Medical, members elected (June, 1914–January, 1915), 125
Ayr county, National Insurance, 136
Ayrshire Division. *See* Division

B.

- Banff, Elgin, and Nairn Division. *See* Division
 Barnsley and the war emergency, 142
 Barrow Division. *See* Division
 BASKETT, B. G. M.: National Insurance, Defective bases of the Act, 4, 59, 84, 116
 BATEMAN, A. G.: National Insurance, petty complaints and vexatious regulations, 239
 Bath Division. *See* Division
 Bazett v. London Insurance Committee, 36
 Bedford: National Insurance, 313
 Belfast Division. *See* Division
 Berkshire, National Insurance, 2, 43, 256, 285
 Berwickshire, National Insurance, 38, 90
 Birmingham Branch. *See* Branch
 Birmingham, National Insurance, 19, 56, 91, 285, 314
 BIRK, National Insurance, 68
 Blackburn Division. *See* Division
 Blackpool Division. *See* Division
 BLAKE, Henry: National Insurance, surcharging of panel practitioners, 306
 Bolton Division. *See* Division
 Bolton, National Insurance, 45
 Bombay Branch. *See* Branch
 Bournemouth Division. *See* Division
 Branch, Assam, 267—Annual meeting, 267—Election of officers, 267
 Branch, Birmingham, 336—Annual meeting, 336—Annual reports, 336—Presidential address: The Present Attitude of the Profession towards the National Insurance Act (John Orton), 336—Election of officers, 336
 Branch, Bombay, 18—Special meeting, 18—Ordinary meeting, 18
 Branch, Dorset and West Hants, 282—War emergency, 283—Annual meeting, 282—Annual reports, 282—President's address, 282—Next meeting, 283—Election of officers, 283
 Branch, Dundee, 283—War emergency, 283—Annual meeting, 283—Model rules, 283—Election of officers, 283—Matters referred to Divisions, 283—Ethical rules, 283
 Branch, Fife, 243, 338—And the war emergency, 243, 338
 Branch, Glasgow and West of Scotland, 298—Annual meeting, 298—Election of officers, 298
 Branch, Kent, 298—Annual meeting, 298—Election of officers, 298—Annual report and financial statement, 298—Vote of thanks, 298—President's address, 298—Dinner, 298
 Branch, Metropolitan Counties, 142, 309—And the war emergency, 142—Election of Council, 309
 Branch, Munster, 60, 68—National Insurance, 60, 68—New members, 60—Medical certification under the Insurance Act, 60
 Branch, Perth, 143, 275—And the war emergency, 143—Doctor's holidays, 275
 Branch, Shropshire and Mid-Wales, 152—And the war emergency, 152
 Branch, South-Eastern of Ireland, 102, 275—And the war emergency, 275—National Insurance, 102—Report, 102—Amalgamation of the British Medical Association and Irish Medical Association, 102—Approved societies and existing arrangements for medical certification, 102—Medical certifiers, 102—Annual meeting, 275—Election of officers, 275—Vote of thanks, 275—Resolutions and congratulations, 275—Medical service of the army, 275—Ethical Committee, 275
 Branch, South-Western, 115, 242—And the war emergency, 151, 242
 Branch, Stirling, 244, 245, 299—And the war emergency, 244, 299—National Insurance, 299—Annual meeting, 245—The late Dr. Mitchell, 245—Election of officers, 245—Private practice and midwifery fees, 299—Works and Panel Committee, 299
 Branch, Wiltshire, 337—Annual meeting, 337—Election of officers, 337—Financial statement, 337—Annual Representative Meeting, 337
 Brighton and the war emergency, 300
 Bristol, National Insurance, 56, 121
 British army. *See* Army

- BROCK, Arthur J.: National Insurance, the defective bases of the Act, 21, 69
 Buckinghamshire, National Insurance, 276
 Burnley Division. *See* Division
 Bury and the war emergency, 143

C.

- Camberwell Division. *See* Division
 CAMPBELL, ARTHUR: National Insurance, the finances of the Act, 260
 Canterbury and Faversham Division. *See* Division
 Carlisle and the war emergency, 243
 Carnarvon and Merioneth Division. *See* Division
 Central Ethical Committee. *See* Committee
 Channel Islands Division. *See* Division
 Chesterfield Division. *See* Division
 City Division. *See* Division
 COHEN, Myer: National Insurance, alterations in Insurance Act regulations, 114
 Colchester and the war emergency, 300
 Committee, Finance, 42—Accounts, 42
 Committee, Insurance Act. *See* Insurance
 Committee, Irish, 35, 153—Quarterly meeting, 35, 153—Workhouse medical officers, 35—Amalgamation of the British and Irish Medical Associations, 35—Medical advisers (medical certificates), 35—Apologies for absence, 153—Medical officers for the Army Medical Service, 153—Admission of well-to-do patients to workhouse hospitals, 153—Illegal conditions in advertisements for Poor Law medical officers, 153
 Committee, Irish Medical. *See* Insurance Act, subheading Insurance Act Committee
 Committee, Journal, 42—The war and the JOURNAL, 42
 Committee, Medico-Political, 42—Crime and punishment, 42—Insufficiently trained nurses, 42—Royal Commission on Venereal Diseases, 43—Select Committee on Patent Medicines, 42—Treatment of incipient insanity, 43
 Committee, Non-Panel, 43
 Committee, Organization, 42—Bound volumes of SUPPLEMENT for secretaries, 42—Conference of secretaries, 42—Grants to Branches, 42—Question of Association becoming also a Federation for other medical bodies, 42—Representation in Representative Body (1915-16), 42
 Committee, Public Health, 43—Forms of report on tuberculosis cases receiving domiciliary treatment, 43—Superannuation of medical officers of health, 43
 Committee, Science, 42—Scientific grants and scholars, 42—Stewart prize, 42
 Committee, Scottish Medical Service Emergency, 17, 109, 267, 273, 338—Draft statement, 17—Exchanges, 18—Belgian doctors, 18—Appeal by, 109—A correction, 273—Letter to Secretaries of Divisions, 338. *See also* War emergency
 COOKE, C. J.: National Insurance, the exploitation of the medical profession in respect to medical certificates, 158
 Cork, National Insurance, 58
 Cornwall Division. *See* Division
 COTTER, J.: National Insurance, 58
 COUNCIL, GENERAL MEDICAL, 61, 105, 287, 293
 Apothecaries' Hall, Ireland, 105, 293
 Belgian diploma in dentistry, 105
 Committees, 289
 Constitution of committees, 293
 Dental degrees of the University of Melbourne, 105
 Dental disciplinary cases: Valleck Cartwright Mallan, 293—George William Hammond, 298
 Dental Education and Examination Committee, 295
 Disciplinary cases, 295
 Examination of secondary schools, 105
 Executive Committee, 61, 105
 Finance, 105
 Finance Committee's report, 289

- Indian Subordinate Medical Department, 293
 Medical disciplinary cases: Alexander Orford Schorn, 296—Alfred Bertie Kramer, 296—Arthur Samuel Stokes, 296
 New Zealand Act, 105
 Number of medical students, 61
 Pharmaceutical Society, 295
 Pharmacopoeia Committee's report, 295
 President's address, 287
 Reciprocity with Belgium, 61—With Ontario, 105
 Recognition of teaching institutions, 295
 School-leaving examinations, 295
 The Registrar, 298
 University of Allahabad, 105
 University of Madras, 105

- County Meath, National Insurance, 287
 Coventry, National Insurance, 91
 Croydon, National Insurance, 19, 37, 91, 254, 256

D.

- Derbyshire, National Insurance, 114
 Devon county, National Insurance, 112
 Division, Ayrshire, 143—And the war emergency, 143
 Division, Banff, Elgin, and Nairn, 274—Annual meeting, 274—Election of officers, 274—Matters referred to Divisions, 274
 Division, Bath, 241—And the war emergency, 241
 Division, Belfast, 244, 300—And the war emergency, 244—Annual meeting, 300—Election of officers, 300
 Division, Blackburn, 309—Annual meeting, 309—Election of officers, 309—Annual report of Council, 309
 Division, Blackpool, 299—Annual meeting, 299—Election of officers, 299—Vote of thanks, 299—Representative at Representative Meeting, 299
 Division, Bolton, 242, 245—And the war emergency, 242—Representative at Representative Meeting, 245—Matters referred to Division, 245—Attendance on dependants, 245—The late Dr. Charles Macfie, 245
 Division, Bournemouth, 336—Annual meeting, 336—Annual report and financial statement, 336—Election of officers, 336—Vote of thanks, 336—And the war emergency, 339
 Division, Burnley, 299—Annual meeting, 299—Election of officers, 299—Annual report, 299—Vote of thanks, 299
 Division, Camberwell, 142, 274—And the war emergency, 142—Annual meeting, 274—Election of officers, 274—Mental Deficiency Act certificates, 274—Matters referred to Divisions, 274
 Division, Canterbury and Faversham, 150, 153—National Insurance, 153—And the war emergency, 150, 154—Juvenile members of friendly societies, 153—Annual report and financial statement, 154—Annual meeting of the Branch, 154
 Division, Carnarvon, South, and Merioneth, 5—Election of officers, 5—Vote of thanks, 5
 Division, Channel Islands, 133—Belgian Doctors' and Pharmacists' Fund, 133—Election of officers, 133—First meeting, 133—Library, 133—Service with the colours, 133
 Division, Cheshire (Mid), 266—And the war emergency, 266
 Division, Chesterfield, 151—And the war emergency, 151
 Division, City, 274—National Insurance, 274—Annual meeting, 274—Election of officers, 274—Nomination for Central Council, 274—Annual report of Central Council, 274—Payments to military medical officers, 274—Insurance certificates, 274—Vote of thanks, 274
 Division, Cornwall, East, 336—Annual meeting, 336—Election of officers, 336
 Division, Dorset, West, 266—Annual meeting, 266—And the war emergency, 266

Division, Dudley, 266—And the war emergency, 266
Division, Dumfries and Galloway, 282—War emergency, 282—Annual meeting, 282—Election of officers, 282—Annual report of Central Council, 282—Good wishes to Colonel Kerr, 282
Division, Edinburgh and Leith, 284—War emergency, 284
Division, English, 243—And the war emergency, 243
Division, Essex, North-East, 245—Annual meeting, 245—Election of officers, 245—Model rules, 245—Matters referred to Divisions, 245
Division, Essex, South-West, 301—And the war emergency, 301
Division, Furness, 267—And the war emergency, 267
Division, Glasgow, Eastern, 152, 153—And the war emergency, 152—Annual meeting, 153—Election of officers, 153—Annual report, 153
Division, Glossop, 267—War emergency, 268—Annual meeting, 267—Election of officers, 267
Division, Harrow, 284—War emergency, 284
Division, Hertfordshire, East, 336—Annual meeting, 336—Election of officers, 336
Division, Holland, 146, 299—And the war emergency, 146, 299—Matters referred to Divisions, 146—Election of officers, 299—Annual Representative Meeting, 299
Division, Huddersfield, 151—And the war emergency, 151
Division, Inverness, 301—And the war emergency, 301
Division, Isle of Ely, 273—And the war emergency, 273
Division, Isle of Thanet, 241—And the war emergency, 241
Division, Kendal, 152—And the war emergency, 152
Division, Kesteven, 242, 299—And the war emergency, 242—Annual meeting, 299—Election of officers, 299
Division, Kingston-on-Thames, 300—Annual meeting, 300—Election of officers, 300
Division, Lambeth, 283—War emergency, 283—Annual meeting, 283—Election of officers, 283
Division, Lanarkshire, 244—And the war emergency, 244
Division, Leeds, 337—Annual meeting, 337—Election of officers, 337—Annual Representative Meeting, 337
Division, Leicester and Rutland, 266—And the war emergency, 266
Division, Liverpool, 60—Annual meeting, 60—Election of officers, 60—Medical attendance on dependants, 60—Service with the forces, 60
Division, Marylebone, 268—Annual meeting, 268—Election of officers, 268
Division, Middlesex, North, 149—And the war emergency, 149
Division, Newcastle-upon-Tyne, 107, 129, 142—Patients of practitioners serving with the colours, 129—Recommendations from the Central Council, 129—Restrictions on school medical officers, 129—The late Dr. Hindhaugh, 129—Treatment of dependants, 129—War emergency, an appeal, 109, 142
Division, Northamptonshire, 266, 310—And the war emergency, 266, 310—Annual meeting, 310—Election of officers, 310—Matters referred to Divisions, 310
Division, Nottingham, 242, 245—National Insurance, 245—And the war emergency, 242—Election of officers, 245—Matters referred to Divisions, 245—Medical referees, 245
Division, Oldham, 273—Annual meeting, 273—Election of officers, 273
Division, Plymouth, 266—And the war emergency, 266
Division, Portsmouth, 151—And the war emergency, 151
Division, Reigate, 151, 241, 246—And the war emergency, 151, 241
Division, Rochdale, 245—Annual meeting, 245—Annual report, 245—Election of officers, 245—Expenses of Representative, 245
Division, Rochester, Chatham, and Gillingham, 150—And the war emergency, 150

Division, Ross and Cromarty, 283—War emergency, 283—National Insurance, 283—Annual meeting, 283—Matters referred to Divisions, 283—Belgian Doctors' and Pharmacists' Relief Fund, 283—Annual report, 283—Election of officers, 283—Votes of thanks, 283
Division, St. Helens, 127—Matters referred to Divisions, 127
Division, St. Pancras and Islington, 241, 310—And the war emergency, 241—Annual meeting, 310—Election of officers, 310
Division, Salisbury, 150—And the war emergency, 150
Division, Sheffield, 300—National Insurance, 300—Annual meeting, 300—Election of officers, 300—Medical referees, 300—Annual Representative Meeting, 300—Medical treatment of the dependants of men serving with the colours, 300
Division, Southampton, 299—Annual meeting, 299—Election of officers, 299
Division, South-Eastern Counties, 14, 61, 243, 244, 267—And the war emergency, 14, 243, 267—National Insurance, 14, 61, 244—Belgian Doctors' and Pharmacists' Relief Fund, 14, 244—Local Medical and Panel Subcommittee, British Medical Association, 14—School medical officers, 14, 244—Payments to panel practitioners, 14, 244—Annual dinner, 14—Medical referees, 61, 244—Financial statement, 244—Medical certificates for soldiers on leave, 244—Matters referred to Divisions, 244—Certificates for mentally defective children, 245—Sickness certificates for insured persons, 245
Division, Southport, 299—Annual meeting, 299—Election of officers, 299—Annual reports of Central Council, 299—Annual meeting of Branch, 299
Division, Staffordshire, South, 283—War emergency, 284—Annual meeting, 283—Election of officers, 283—School medical officer, 283—Medical attendance on dependants of soldiers and sailors, 284—Vote of thanks, 284
Division, Stratford, 265—And the war emergency, 265
Division, Suffolk, West, 150, 245—And the war emergency, 150—Vice-Chairman, 245—Matters referred to Divisions, 245
Division, Wakefield, Pontefract and Castleford, 152, 243, 246—And the war emergency, 152, 243—Matters referred to Divisions, 246
Division, Warrington, 273—Annual meeting, 273—Election of officers, 273—Vote of thanks, 273—Representative Meeting, 273
Division, Wigan, 152—And the war emergency, 152
Division, Willesden, 299—Annual meeting, 299—Election of officers, 299
Division, Worcester, 242—And the war emergency, 242
Doctors' holidays, 275
Dorset Division. *See* Division
Dorset and West Hants Branch. *See* Branch
DRAKE, J. A.: Temporary displacement of part-time medical men, 244
Drugs, cost of during war time, 35
Dublin and the war emergency, 273
Dudley Division. *See* Division
Dumfries and Galloway Division. *See* Division
Dundee Branch. *See* Branch
Durham, National Insurance, 19, 90, 315

E.

Edinburgh, National Insurance, 1, 20, 74, 90, 156, 305, 315
Edinburgh and Leith Division. *See* Division
Ely. *See* Isle of Ely
English Division. *See* Division
Essex Division. *See* Division
Essex, National Insurance, 27, 136
Essex and the war emergency, 142
Exeter, National Insurance, 257

F.

FARMAN, R. J.: National Insurance, 286
Fife Branch. *See* Branch
Finance Committee. *See* Committee
Forfar, National Insurance, 2, 38, 75, 259
FORBES, Charles: National Insurance, the relation of Panel Committees to the British Medical Association, 316
FOTHERGILL, E. Rowland: National Insurance, 287
FRASER, Charles: National Insurance, statistics for 1914, 21

G.

Galway, National Insurance, 113, 260
Garden Life Pocket Diary, rev., 32
GARRATT, Dr.: National Insurance, the defective bases of the Act, 69, 93, 130, 261
General Medical Council. *See* Council
Glamorgan, National Insurance, 45, 82, 315
Glasgow Division. *See* Division
Glasgow, National Insurance, 57, 84, 136, 259
Glasgow and West of Scotland Branch. *See* Branch
Glossop Division. *See* Division
Gloucestershire, National Insurance, 3, 303
GORDON, Alban: National Insurance, dental treatment for domestic servants, 278

H.

HAMILTON, James: National Insurance, over-prescribing, 13—Adjustment of lists of insured persons, 305
HAMMOND, George William, disciplinary case of, 298
Harrow Division. *See* Division
Herefordshire, National Insurance, 257
HERMON, J. M., National Insurance, adjustment of lists of insured persons, 305
Hertfordshire Division. *See* Division
Hertfordshire, National Insurance, 104, 257
Holland Division. *See* Division
Hospital, Lebanon, Asfuriyeh, Syria, annual report, 30
Hospitals and asylums, 30—Lebanon Hospital, Asfuriyeh, Syria, annual report, 30
Huddersfield Division. *See* Division
Huddersfield and the war emergency, 151

I.

Insurance. National:

Approved societies and part-time medical certifiers (Ireland), 135
Arrangements with unqualified persons, 46—Worcester Insurance Committee and a herbalist, 46
Bazett v. London Insurance Committee, 36
Capitation payments, protest against the reduction of, 157—Letter from Insurance Commissioners, 254
Central Bureau for checking prescriptions, 158
Committee on Drug Tariff. *See* Drug
Conference of Representatives of Local Medical and Panel Committees, 321—The system of payment of insurance practitioners, 321—Interest on postponed payments, 322—Suspension of medical benefit, 324—Delay in the issue of medical cards, 324—The correction of the registers, 325—Transfer of persons on military service, 325—Reduction of capitation payments, 325—(a) Under war conditions, 325—Persons discharged from the services, 327—Insured persons permanently incapacitated, 328—The new certification scheme, 328—Phraseology of certificates, 328—Certificates in chronic cases, 329—Framing new

Insurance, National (continued)

agreements, 329—Relationship with the British Medical Association, 329—Collective *v.* individual bargaining, 330—Grievance under the Act, 330—The revised Regulations, 330—Termination of agreements, 330—Alleged over-prescribing, 331—Prescriptions by consultants, 331—Elections of Panel Committee, 331—Medical representation on Advisory Committees, 331—Domiciliary treatment of tuberculosis, 332—Suspension of medical records, 332—Medical benefit in Ireland, 332—Dispensing by doctors, 332—Transfer of insurance practices, 332—Appeals to the Commissioners, 332—*Ex Gratia* payments to chemists, 332—Medical referees, 332—Sickness benefit in venereal cases, 332—Record of the Proceedings, 332—Vote of thanks to the British Medical Association, 333—Nomination of members for the Standing Insurance Acts Committee of the British Medical Association, 333—Nomination of Representative, 333—List of Representatives present, 333—*Appendix A*: Reduction in amount of the periodical advances to insurance practitioners under present war conditions, 334—*Appendix B*: Position of insurance practitioners with regard to insured persons who are discharged from the Services, 334—*Appendix C*: Memorandum as to composition of Advisory Committees, 335—*Appendix D*: Memorandum on method of payment for domiciliary treatment of tuberculous insured persons, 335

Co-operation between the Association and Local Medical and Panel Committees, 50, 269—Letter addressed to secretaries, 50—Conferences of representatives, 269—Provisional agenda, 269

Delay in payment of panel practitioners. *See* Panel

Drug fund, 122—Conference of Lancashire Insurance Committees, 122

Drug tariff, deputation of pharmacists to the Chairman of the Joint Committee, 134

Drug tariff, question of stock mixtures, 254

Drug Tariff Committee, constitution of, 81

Drugs, cost of during war time, 35

Exempt persons, consolidated regulations, 1915, 123

Glasgow Insurance Committee *v.* Scottish Insurance Commissioners, 59, 84

Local Medical and Panel Committees' Conference, 50, 269

Medical treatment of soldiers on furlough, correspondence with Insurance Commissioners, 89

National Insurance through approved societies, 92

Non-panel practitioners and the new certification forms, 53, 65, 103—Further correspondence with the Commissioners, 65

Overprescribing (H. Howard Murphy), 9

Panel Committee regulations (England and Wales), 133

Panel practitioners, payments of, 110, 121—Meeting at Bristol, 121

Panel Medico-Political Union, 26, 92—Proposed rules, 26—Discussion on grievances and difficulties, 92

Panel Medico-Political Union, 68, 270—Meeting at Caxton Hall, 68—Urgency meeting, 270

Panel practitioners, delay in payment of, 255—Strong protest from East Sussex, 255

Payment of panel doctors. *See* Panel Pharmaceutical Committee Regulations, 134

Present position of the profession towards the Act (John Orton), 336

Protest against capitation payments. *See* Capitation

Record cards, return of Circular Med. 2, 1, 21

Reduction of capitation payments. *See* Capitation

Insurance, National (continued)

Reductions in advances to insurance practitioners, 252—Solicitor's opinion, 252

Regulations, alterations in, 104—Letter from Sir Robert Morant, 104

Scottish Drug Accounts Committee, 59, 84—Glasgow Insurance Committee *v.* Scottish Insurance Commissioners, 59, 84

Temporary residents and travellers, 135

Temporary suspension of the keeping of records by panel practitioners, proposed, 153

War economies, suggestion to approved societies as to less frequent certificates in chronic cases, 73

CORRESPONDENCE, 4, 13, 21, 46, 59, 69, 76, 84, 93, 115, 124, 130, 158, 239, 260, 278, 286, 305, 316

Adjustment of lists of insured persons, 278, 305

Alterations in Insurance Act Regulations, 116, 124

Approved societies and certificates from non-panel practitioners, 76

Cards and records, 22

Defective bases of the Act, 4, 21, 59, 69, 84, 93, 116, 130, 261

Dental treatment for domestic servants, 278

Departmental Committee on Sickness Claims, 46

Exploitation of the medical profession in respect to medical certificates, 158

Finances of the Act, 116, 260

Irregular certificates, 5

Medical referees, 22

Muddle of the registers, 287

New insurance certificates, 15

Over-prescribing, 15

Panel Medico-Political Union, 287

Payments to panel practitioners, 286

Petty complaints and vexatious regulations, 239

Protest against the reduction of capitation payments, 239

Relation of Panel Committees to the British Medical Association, 316

Statistics for 1914, 21, 261

Surcharging of panel practitioners, 306, 316

Treatment of juvenile members of friendly societies, 130

Under-payment of panel doctors, 60, 115

INSURANCE ACT COMMITTEE :

Attendance on soldiers on furlough, 73, 110, 282

Central Insurance Defence Fund, 111

Certificates, 154

Certificates of non-panel doctors, 281

Chairman's report, 73

Checking prescriptions in Wales, 21

Circular letter to insurance practitioners, 73

Conference of Representatives of Local Medical and Panel Committees, 43, 154

Co-optation of members, 43

Departmental Committee on Drug Tariff, 43, 73

Domiciliary treatment of tuberculosis, 155

Drug tariff, 73, 154, 282

Drugs, cost of during war time, 35

Duplicate certificates, 110

Excessive sickness benefit claims, 21

Expenses of Pharmaceutical Committee, 73

Forms of certificates for use of doctors attending insured persons in a private capacity, 155

Insurance Act accountancy, Scotland, 155

Local Medical and Panel Subcommittee, 43

Medical benefits, 111

Medical referees, 282

Non-panel practitioners and certificate forms, 20, 73

Non-panel practitioners and new certification arrangements, 43

Nurses as sick visitors, 282

Partnerships, 111

Payments to panel practitioners, 33—Interview between deputation from a subcommittee of the Insurance

Insurance, National (continued)

Act Committee of the British Medical Association and the Insurance Commissioners on the question of payments to panel practitioners, 33

Position of deposit contributors, 20

Practitioners supplying drugs and appliances, 20

Preventive side of the Insurance Act, 111

Reduction in amounts paid to panel practitioners, 155

Reduction of clerical work of panel practitioners during the war, 155, 282

Resignation, 73

Rhymney Valley Medical Association, 282

Statistics of attendances, 21

Treatment of insurance patients discharged from the army, 281

Vacancy on committee, 110

War emergency, 281

IRISH MEDICAL COMMITTEE, 25, 246

Annual meeting of delegates, 246

Appointment of part-time medical certifiers, 25

Approved societies and the certificates of medical attendants, 25

Circulation of misleading reports, 25

Deputation to Mr. Montagu, 246

Election of Chairman and Vice-Chairman, 246

Fees for certificates for sickness benefits, 246

Finance, 25

Interviews with Members of Parliament, 25

Local Medical Committees and local representatives of approved societies, 25

Medical certifiers for dispensary districts, 246

Part-time tuberculosis officers, 246

Votes of condolence, 246

OFFICIAL DOCUMENTS: Quarterly list of those recently issued, 54, 302**PARLIAMENTARY QUESTIONS on, 69, 77, 85, 93, 115, 146, 158, 261, 270, 278**

Actuarial estimates, Manchester Unity, 115

Business of Insurance Committees, 69

Chemists' accounts, 77

Chemists' claims, 93

Consumption, extra nourishment, 85

Disabled sailors and soldiers, 77

Disablement benefit, 261

Drug fund deficits, 271

Extra nourishment, 115

Grants in aid of nursing, 115

Grants and loans for sanatoriums and institutions for mental deficients, 115

Insurance doctors' arrears, 278

Medical benefit (Ireland), 146

National Insurance Act (drug und deposits), 271

Panel doctors' salaries, 270

Patients of practitioners on military duty, 158

Payment to doctors and pharmacists, 85

Sickness benefit in Ireland, 93, 158

Sickness claims, diminution of, 69

REPORTS OF LOCAL ACTION: Local

Medical Committees, Panel Committees, Provisional Local and Medical Committees, and resolutions of Branches and Divisions:

Aberdeen, 260

Panel Committee, 260

Ayr county, 136—Certificates, 136—

Co-operation with the British Medical Association, 137—Domiciliary treatment of dependants, 137

—Panel Committee, 136—Payments to doctors, 137—Records, 136—

Supply of drugs and appliances, 137

Bedford county, 313—Attendance on soldiers, 313—Expenses of Pharmaceutical Committee, 313—Local

Medical and Panel Committee, 313—Local Pharmacopoeia, 313—

Medical referees, 313—Panel Committee, 313—Prescribing, 313

Insurance, National (continued)

- Berkshire, 2, 43, 256, 285—Drugs used for tuberculosis benefit, 285—Emergency set of dressings, 285—Local Medical and Panel Committees, 2, 43, 256, 285—Medical attendance and treatment, 43, 256, 285—Medical Committee, 256—New member, 2—Payments, 2—Pharmaceutical Committee's expenses, 2—Scrutiny of prescriptions, 256—Special mileage grant, 285—Supply of cod-liver oil, 256—Tuberculosis Subcommittee, 43—Vacancies, 256
- Berwickshire, 38, 90—Drugs account, 33—Election of officers, 90—Expenses of committee, 90—Local Medical and Panel Committees, 38, 90—Medical records, 38
- Birmingham, 19, 56, 91, 285, 314—Attendance on reservists, 91—Conference with approved societies, 285—Conference of Local Medical and Panel Committees, 314—Election of Committee, 314—Excessive prescribing, 19, 56, 91, 285—Expenses of committee, 19—New agreement, 91—Local Medical and Panel Committee, 314—Panel Committee, 19, 56, 91, 285, 314—Payments to practitioners, 56—Pharmaceutical Committee, 91—Prescribing, 19—Proposed central bureau for checking prescriptions, 91—Registers of Insurance Committees, 314
- Birr (King's Co.), 68—Board of guardians and the Act, 68
- Bolton, 45—Allocation of insured persons, 45—Free medical attendance on necessitous dependants of men serving with the forces, 45—Intermediate certificate, 45—Local Medical and Panel Committee, 45—Local pharmacopoeia, 45—Medical men in military service, 45—Scrutiny of prescriptions, 45
- Bristol, 56, 121—Certificates, 56—Medical adviser, 56—Panel Committee, 56—Panel service at Avonmouth, 56—Payments to panel practitioners, 121—Responsibility of panel doctors, 56—Scrutiny of prescriptions, 56
- Buckinghamshire, 276—Doctors' absent on military duty, 276—Local formulary, 276—Local Medical and Panel Committee, 276—Medical cards, 276—New certificates, 276—Payments to practitioners, 276—Serums and vaccines, 276
- City Division, 274—Insurance certificates, 274
- Cork, 58—Meeting of the medical profession, 58
- County Meath. *See* Meath
- Coventry, 91—Emergency drugs and dressings, 91—Panel Committee, 91—Scrutiny of prescriptions, 91
- Croydon, 19, 37, 91, 254, 256—British Medical Association circulars, 91—British Medical Association and panel practitioners, 37—Drug tariff, 254—Excessive prescribing, 256—Expenses of Pharmaceutical Committee, 91—Local Medical Committee, 19—Meeting of panel practitioners, 37—Panel Committee, 19, 91, 254, 256—Payments to practitioners, 256—Scrutiny of prescriptions, 256—Standard mixtures, 37—Stock mixtures, 91, 254
- Derbyshire, 114—The "Gag," 114
- Devon County, 114—Agreement with Insurance Committee, 114—Attendance on unallotted persons, 114—Doctors' lists, 114—Medical Committee, 114—Panel Committee, 114—Prescribing and the Drug Fund, 114—Scope of medical benefit, 114
- Durham, 19, 90, 315—Acting Secretary, 315—Advance payments to practitioners, 315—Alleged excessive prescribing, 19, 90, 315—Certificates, 20—Co-operation with the British Medical Association, 20—Expenses of Pharmaceutical Committee, 90—Final medical benefit credit, 315—Medical Benefit Fund, 20—Medical certification,

Insurance, National (continued)

- 315—Medical and Panel Committee, 315—Mileage grant, 315—Panel Committee, 19, 90—Secretaryship, 20—Supply of drugs and appliances, 20, 90—Suspense register, 315—Vote of thanks, 91
- Edinburgh, 1, 20, 74, 90, 156, 305, 315—Alleged excessive prescribing, 1, 156—Annual report and financial statement, 74—Assignment scheme, 1—Burgh Insurance Committee, 75—Central bureau for checking prescription forms, 1—Certificates of chronic cases, 90—Collective responsibility of panel practitioners towards insured persons, 315—Consultations on Sundays and off evenings, 156—Co-ordination of work of Local Medical and Panel Committees, 20—Correspondence with Insurance Committee, 305—Domiciliary benefit, 305—Excessive prescribing, 1, 2, 20, 156, 316—Financial statement, 156—Honorary secretary's honorarium, 90—Joint Services Subcommittee, 315—Levy on insurance practitioners, 316—Limitation of panel lists, 156—Local Medical Committee, 74—Medical records, 20—Meeting of practitioners, 1, 75—Panel Committee, 1, 20, 90, 156, 315—Prescriptions, 156—Proposed alteration of constitution, 74—Proposed limitation of doctors' lists, 20—Records, 90—Revised drug tariff list, 90—Rules for insured persons, 20—Scrutiny of prescriptions, 90—Subscriptions, 74—Transfer of patients, 1—War, 1
- Essex, 27, 136—Annual report, 136—Certifications, 27—Drug fund, 27, 136—Federation of Local Medical and Panel Committees, 27—Financial statement, 27—Local Medical and Panel Committees, 27, 136—Payment to panel practitioners, 27, 136—Pricing of drugs, 27—Rep. mist., 27—Unallotted persons, 136
- Exeter, 257—Certificates, 257—Panel Committee, 257—Sanatorium benefit, 257
- Forfar, 2, 38, 75—Annual report and balance-sheet, 75—Appointment of chairman, 75—Attendance on dependants of soldiers and sailors, 75—Capitation fee for uninsured persons, 75—Certification, 38—Dispensing fees, 38—Drug Accounts Committee, 2, 38—Election of Local Medical Committee, 75—Election of officers, 75—Grant for 1913, 38—Levy, 75—Local Medical Committee, 2, 75—Medical certificates, 75—Medical records, 38, 75—Medical referee, 38—Meeting of practitioners, 75—Panel Committee, 2, 38, 75—Pharmaceutical Committee expenses, 2—Representative on Forfarshire Insurance Committee, 75—Scrutiny of prescriptions, 75—Vote of thanks, 75
- Forfarshire, 259—Death certificates, 260—Local Medical Committee, 259—Medical certificates, 260—Panel Committees, 260—Proposed scheme for medical referees, 259—Repeat prescriptions, 259—Uninsured members of societies, 259—Vacancy on Committee, 259, 260
- Galway, 113, 260—Medical certifiers, 260—Medical Committee, 113, 260—War emergency, 260
- Glamorgan, 45, 82, 315—Conference of Local Medical and Panel Committees, 315—Doctors' lists, 315—Examination of prescriptions, 45—Overprescribing, 315—Panel Committee, 45, 82, 315—Payments to practitioners, 45—Report and balance-sheet, 45—Scrutiny of prescriptions, 82—Travelling expenses of members of committee, 315—Vacancies in Local Medical and Panel Committee, 45, 82—Vote of condolence, 82
- Glasgow, 57, 136, 259—Administration of medical benefit, 58—Allocation of credits, 136—B.P., 1914, 259—Certification, 57, 259—Complaints, 57—Election of officers, 259—Ex-

Insurance, National (continued)

- penses of Panel Committee, 259—Extravagant prescribing, 136—Free medical attendance on necessitous dependants, 58—Local Medical Committee, 57, 259—Annual report, 57—Medical Service Subcommittee, 58—Meeting of the executives, 259—Panel Committee, 136, 259—Range of services, 57, 259—Return of men on service, 259—Scheme of allocation, 259—Surplus for 1913, 259—Vacancy on committee, 259
- Gloucestershire, 3, 303—Annual election, 303—Conference of Local Medical and Panel Committees, 303—County panel practitioners' meeting, 3—Drug supply, 303—Fee to returning officer, 3—Levies, 3, 303—Local Medical and Panel Committees, 303—Panel Committee, 3
- Great Yarmouth, 3—Accounts Subcommittee, 3—Co-ordination of work of Local Medical and Panel Committees, 4—Distilled water, 3—Panel Committee, 3
- Herefordshire, 104, 257—Central bureau for checking prescriptions, 257—Certificates, 257—Elections, 104, 257—Finance, 104, 257—Local Medical and Panel Subcommittee of the British Medical Association, 104—Medical attendance on dependants of those serving with the colours, 104—Medical tickets, 257—Members of committee, 104—Panel Committee, 104, 257—Railway fares, 104—Secretaries, 257—"Stock mixtures," 104—Supply of drugs and appliances, 104—Terms of service for the year 1915, 104
- Hertfordshire, 257—Assignment of patients, 257—Attendance on soldiers, 257—Checking prescriptions, 257—Emergency Committee, 257—Expenses of Panel Committee, 257—Expenses of Pharmaceutical Committee, 257—Local Medical Committee, 257—Panel Committee, 257—Pharmaceutical Committee, 257—Vacancy on Insurance Committee, 257
- Ireland, 25, 45, 58, 68, 130, 135, 246—Approved societies and part-time medical certifiers, 135—Irish Medical Committee, 25, 246. *See also at end of Insurance Act Committee.* Medical certification under the Act, 58, 68
- Isle of Ely, 277—Drug tariff, 277—Mileage scheme, 277—Panel Committee, 277
- Isle of Wight, 256, 313—Certificates, 257, 313—Conference of Local Medical and Panel Committees, 313—Election of Committee, 313—Local Medical and Panel Committees, 256, 313—Payments to practitioners, 257—Scrutiny of prescriptions, 256
- Kingston-upon-Hull, 4, 28, 91, 304—British Pharmacopoeia, 91—Circulars of the British Medical Association, 304—Co-ordination of work of Local Medical and Panel Committee, 4—Credits, 28—Doctors' lists, 4, 28—Drug tariffs, 28—Duplicate prescriptions, 28—Local Medical and Panel Committees, 4—Local pharmacopoeia, 4—Panel Committee, 4, 28, 91, 304—Payments, 4, 91—Surcharge of practitioner, 4
- Kirkcaldy, 20, 82—Annual report, 82—Central bureau for checking prescriptions, 82—Checking accounts, 20—Drug Accounts Committee, 20—Election of Committee, 82—Election of officers, 20—Local Medical Committee, 20—Medical records, 20—Practitioners' meeting, 82—Secretary's report, 20
- Lanark County, 316—Conference of Representatives of Local Medical and Panel Committees, 316—Drugs account (central) bureau, 316—Local Medical and Panel Committee, 316—Suspension of election of Committees, 316
- Lancashire, 81, 122, 155, 303, 314—Agreement, 314—Appointment on

Insurance, National (continued)

Committee, 155—Certification, 303
—Checking of prescriptions and chemists' accounts, 155—Claim by panel practitioner, 303—Conference of Insurance Committees, 122—Doctors' agreements, 81—Deductions from payments to doctors, 303, 314—Excessive prescribing, 303, 314—Expenses of members of the committee, 81—Infant population of the country, 304—Issuing of medical cards, 314—Local Medical and Panel Committees, 81, 155, 303—Local pharmacopoeia, 314—Medical benefit, 314—Medical certification, 314—Mileage grant, 155—Panel Committee, 314—Payments for dispensing, 81, 155—Pharmacopoeia and metric system, 81—Scrutiny of prescriptions for 1914, 155—Small amounts due to doctors, 81—Special mileage, 81—Special reserve of £150, 155—Term of office of Panel Committee, 314—Treatment of discharged soldiers, 81—Treatment of insured persons in absence of panel doctor with H.M. Forces, 81
Leicestershire, 21—Reports of various subcommittees, 21
Limerick, 114—Election of Chairman, 114—Local Medical Committee, 114—Medical certification under the Insurance Act, 114—Votes of sympathy, 114
Lindsey (Lincolnshire), 156—Accounts to insured persons, 156—Balance sheet for 1914, 156—Extra mileage fund, 156—Panel Committee, 156—Scrutiny of prescriptions, 156
Liverpool, 11, 19, 27, 56, 58, 74, 105, 129, 258, 314—Alleged excessive ordering of drugs, 105—Allocation of surplus funds, 11, 27—Analysis of prescriptions, 11—Attendance on soldiers and sailors on furlough, 129, 258—Clerical work, 258—Conference of Local Medical and Panel Committees, 315—Co-operation with the British Medical Association, 105—Dockers' battalion, 258—Doctors' lists, 129—Drugs and appliances, 129—Duplicate prescriptions, 74—Examination of prescriptions, 19—Meeting of panel practitioners, 27—Panel Committee, 11, 19, 27, 56, 74, 105, 129, 258, 314—Payments on account, 58—Payments to practitioners, 27—Pharmacopoeia, 28—Practitioners' lists, 11—Proposed central bureau for checking prescriptions, 74—Quarterly payments, 19—Reinstatement of discharged soldiers, 258—Repeat mixture and duplicate prescriptions, 27, 28, 56—Resignations, 28—Seamen's National Insurance Society, 11—Scrutiny of prescriptions, 258—Service with the Forces, 27—Stock mixtures, 11, 57—Vacancy on Insurance Committee, 27
London, 37, 45, 74, 83, 111, 123, 145, 157, 270, 285, 339—Adequacy of the medical service, 74—Adjustment of lists of insured persons, 11, 145, 157, 270—Alleged excessive prescribing, 37, 285—Approved societies and certification, 11—Delay in considering complaints against practitioners, 46—Discrepancies in lists of insured persons, 37, 43—Drug Fund deficiency, 45, 83—Drug tariff, 111—Expenses of Panel and Pharmaceutical Committees, 123—General decisions, 37—Local Panel Association, 270, 339—Medical service investigations in 1914, 123—New form of certificate, 74—Number of practitioners on the panel, 74—Numbers on practitioners' lists, 111—Panel Committee, 37, 74, 111, 145, 270, 285, 339—Practitioners surcharged, 83—Procedure in surcharging of practitioners, 111—Resignation of Chairman, 157—Responsibility for correcting lists, 146—Use of the formula "Rep. mist.," 111—War Emergency, 270, 285, 339

Insurance, National (continued)

London Insurance Committee, 36, 277—Adjustment of lists of insured persons, 277—Assignment of patients, 36—Bazett v., 36—Chairmanship, 277—Excessive prescribing, 277—Full-time tuberculosis adviser, 278—Practitioners with the Forces, 277
Lothian, West, 38—Drug Accounts Committee, 38—Drugs and appliances, 38—Financial statement, 38—Panel Committee, 38
Manchester, 56—Appointment to Insurance Committee, 56—Drug tariff, 56—Excessive prescribing, 56—Local Medical and Panel Committee, 56—Quality of drugs, 56
Meath, County, 285—Medical certifiers under the Insurance Act, 286—Medical Committee, 286—Part-time tuberculosis medical officers, 286
Middlesex, 58—Sickness certificates by private practitioners, 58
Monmouth, 81, 257, 304—Chairmanship, 304—Chemists' accounts, 82—Conference of Local Medical and Panel Committees, 305—Cost of prescriptions, 305—Doctors' lists, 81, 257, 305—Expenses of Pharmaceutical Committee, 305—Finance, 82—Grant to Pharmaceutical Committee, 256—Medical certificates, 82—Mileage, 82—Panel Committee, 81, 257, 304—Panel Committee's expenses, 257—Secretaryship, 305—Unallocated funds for 1913, 257, 305—Ynysddu and Risca scheme, 257
Munster Branch, 60, 68—Medical certification, 60, 68
Newcastle-on-Tyne, 57, 258—Central bureau for checking prescriptions, 259—Certificates, 258—Final allocation for 1913, 252—Legal defence for panel doctors, 259—Medical benefit credit for 1914, 57, 259—Medical certificates, 57—Panel Committee, 57, 258—Record cards and quarterly reports, 258—Reinstatement of discharged sailors and soldiers, 57—Scrutiny of prescriptions, 57, 259
Northamptonshire, 4, 44, 314—Allocation, 4—Checking of prescriptions, 4—Complaints, 44—Co-ordination of work of Local Medical and Panel Committees, 4—Election of Committees, 314—Medical referees, 44—Panel Committee, 4, 44, 314—Payments, 4—Scrutiny of prescriptions, 44—Selection of doctor, 44—Voluntary levy, 314
Nottingham Division, 245—Medical referees, 245
Oldham, 74, 146, 339—Carbon copy prescriptions, 74—Complaints, 74—Doctors' lists, 339—Domiciliary treatment of tuberculosis, 339—Election of committees, 339—Excessive prescribing, 146—Local Medical and Panel Committees, 74, 146, 339—Sanatorium benefit, 339—Scrutiny of prescriptions, 74—Treatment of tuberculous dependants, 146
Oxfordshire, 3, 55, 129, 256—Analysis of prescriptions, 256—British Medical Association, 56—Certificates, 130—Checking of prescriptions, 130—Chemists' report, 130, 256—Circular to employers of domestic labour, 55—Co-option, 55—Diphtheria antitoxin, 256—Donations, 255—Drug tariff, 55—Election of Panel Committee, 130—Enlisted men, 3—Etiquette, 256—Honorary secretary, 256—Incapacity for work, 3—Index register, 3—Local Medical and Panel Committees, 3, 55, 256—Medicine for sanatorium patients, 55—Medicine supplied to temporary residents, 55—Mileage, 130—New certificate form, 3—Nurse visitors, 56—Panel Committee, 55, 130—Payments to panel practitioners, 55—Practitioners' meeting, 129—Prescribing, 3—Quarterly count, 55—Quarterly forms of account, 55—Record cards, 3—Recruits and others serving, 256—Scope of medical benefit, 130—Scrutiny of prescriptions, 55—Temporary resi-

Insurance, National (continued)

dents, 55, 256—Total credits for 1913, 256—Transfer, 3—Tuberculosis, 3
Perth, 2, 28, 82, 112—Absent colleagues, 113—Allocations for the county, 83—Annual report, 28—Arrangement to accept responsibility for unallocated persons, 113—Assignment of unallocated persons, 113—Central bureau for checking chemists' accounts, 28—Combined meeting, 112—Local Medical and Panel Committees, 28, 82—Medical certificates, 82—Meeting of practitioners, 82—Over-prescribing, 2—Panel Committee, 2, 28—Personnel of Local Medical and Panel Committees, 113—Pharmaceutical Committee's expenses, 28, 82—Scrutiny of prescriptions, 82—Surcharging doctors, 83—Treatment of soldiers and sailors and their dependants, 112—Unallocated insured persons, 2—Weekly certificates, 112
Portsmouth, 313—Alleged excessive prescribing, 313—Finance, 313—Local Medical and Panel Committee, 313—Proposed Portsmouth Insurance Pharmacopoeia, 318
Renfrew, 2, 75, 113, 260—Administrative expenses, 75—Allocation of insured persons, 260—Assignment of insured persons, 113—Drug Accounts Committee, 75—Extravagant prescribing, 260—Free choice of chemist, 260—Insurance cards, 2—Insured persons in the forces, 2—Insured persons suspended from benefit, 113—Local Medical Committee, 113—Medical benefit of ex-soldiers, 269—Minutes to British Medical Association, 260—New certificates, 113—Overpayments, 2—Panel Committee, 2, 75, 113, 260—Repeat prescriptions, 113
Rochester, Chatham and Gillingham Division, 153—Juvenile members of friendly societies, 153
Ross and Cromarty Division, 283
Roxburghshire, 12, 28—Administration expenses, 12—Auditor, 28—Election of Drug Accounts Committee, 28—Fees of medical referees, 12, 28—Incapacity for work, 12—Medical records, 28—Model tariff, 12—Panel Committee, 12, 28—Remuneration due to practitioners, 12
Salford Insurance Committee, 36, 76, 114, 157—Alleged excessive prescribing, 36—Drug fund, 76—Drug tariff, 36—Effect of the war, 35—Medical certificates and non-panel practitioners, 35—Reduction in advances to panel doctors, 157
Sheffield Division, 330—Medical referees, 330
Southampton, 135—Attendance on soldiers on furlough, 136—Panel Committee, 136—Payments to doctors, 136—Prescriptions, 136—Supply of drugs and appliances, 136
South-Eastern Counties Division, 14, 61, 244—Local Medical and Panel Subcommittee, British Medical Association, 14—Medical referees, 61, 244—Payments to panel practitioners, 14, 244—Sickness certificates to insured persons, 245
South-East of Ireland Branch, 102—Approved societies and existing arrangements for medical certificates, 102—Medical certifiers, 102
Southport, 44, 112, 258, 304—Alleged excessive ordering of drugs, 112, 304—Allocation of unallotted insured persons, 44—Attendance at military camps, 304—Central bureau for checking prescriptions, 112—Certificates, 304—Conference of Local Medical and Panel Committees, 304—Co-operation with Local Medical and Panel Committees, 112—Drug Fund, 304—Excessive prescribing, 304—Local Medical and Panel Committee, 112, 258, 304—Panel Committee, 44—Payments to practitioners, 258—Regulation, 45, 304—Rep. mist., 304—Scrutiny of prescriptions, 44

Insurance, National (continued)

- Staffordshire, 38, 91, 114—Excessive prescribing, 38—Executive Committee, 38—Honorarium to returning officer, 38—Local Medical Committee, 91—Medical referee, 38—Model rules, 91—Panel Committee, 38, 91—Payments, 91—Personnel of Local Medical Committee, 38—Recognition, 91
- Stirlingshire, 75, 113, 299, 305—Administration expenses, 75—Annual report, 75—Card system for keeping medical records, 113—Drug Accounts Committee, 75—Election of Chairman and Secretary, 75—Election to County Local Medical Committee, 75—Expenses of committee, 305—Medical records, 75—Meeting of practitioners, 75—Panel Committee, 75, 113—Panel fund, 305—Transfer of insured patients of practitioners on military duty, 305—Treatment of soldiers, 113—Works and panel practice, 299
- Suffolk, East, 3, 37, 111, 156, 277, 313—Attendance of members of committee, 156—Deputy Secretary, 3—Drugs, 37—Elections of new committee, 277—Expenses of committee, 111, 314—Medical referees, 37—Medical treatment of persons called up for service with the forces, 37—Mileage, 314—Panel Committee, 3, 37, 111, 156, 277, 313—Payments to doctors, 277, 314—Recognition, 3—Reinstatement of discharged soldiers, 277—Scope of medical benefit, 156—Scrutiny of prescriptions, 112, 156—Special mileage grant, 37, 112—Treatment of soldiers, 112
- Suffolk, West, 3, 28, 91, 314—Annual report and balance sheet, 314—British Medical Association circulars, 91—Election of committee, 314—Financial statement, 91—Further payment for the year 1913, 314—Panel Committee, 3, 28, 91, 314—Payment of sick benefit, 91—Payments, 91—Rules for administration of medical benefits, 91—Suspense slips, 3, 28—Treatment of men serving with the Forces, 28—Voluntary deduction towards expenses, 3, 28
- Sunderland, 82—Panel Committee, 82—Prescribing, 82—Proceedings, 82
- Surrey, 12, 44, 111, 255, 313—Assignment of insured persons, 44—Certificates during disablement, 111—Conference of Local Medical and Panel Committees, 313—Distribution of unallotted funds, 313—District Committees, 12—Doctors' lists, 255—Drugs and appliances, 44, 255—Drugs and dressings for insured inmates of hospitals, 111—Honorary Treasurer's statement, 313—Medical cards of persons who have joined the army, 111—Medical referees, 12, 44—Medical Service Subcommittee, 12—Medical tickets, 255—New pharmacopoeia, 44—Panel Committee, 12, 44, 111, 255, 313—Panel Medico-Political Union, 255—Practitioners' lists, 111—Prescribing, 12—Proceedings of Committee, 12—Range of services, 313—Special Mileage Fund, 44—Sunday consultation hours, 313—Supply of drugs and appliances, 44, 255, 313—Temporary residents, 255, 313—Trained nurse visitor, 12—Vacancy on Medical Service Subcommittee, 313
- Sussex, East, 255, 313—Delay in payment of panel practitioners, 255—Local Medical and Panel Committees, 313—Official medical referees, 313
- Swansea, 67—Local Medical Committee, 67—Medical referees, 67—Scrutiny of prescriptions, 67—Unallotted funds, 67
- Tipperary, North, 114—Certification for sickness benefits by medical certifiers, 114—Local Medical Committee, 114

Insurance, National (continued)

- Tyrone Co., 68—Medical certifiers and the Insurance Act, 68
- Warwickshire, 286—Conference of Local Medical and Panel Committees, 286—Election of new committee, 286—Expenses of committee, 286—Expenses of Pharmaceutical Committee, 286—Local Medical and Panel Committees, 286—Panel Committee, 286—Range of medical service, 286—Supply of drugs, 286—Voluntary contributors, 286
- West Ham, 92—Attempted abolition of the local pharmacopoeia, 92—Deductions from monthly payments, 92—Documents received from the British Medical Association, 92—Local Medical Committee, 92—Panel Committee, 92
- Wexford, 45, 130—Local Medical Committee, 45—Medical advisers, 130—Medical certification under the Insurance Act, 45
- Wiltshire, 303—Certificates, 303—Conference of representatives of Local Medical and Panel Committees, 303—Definition of "dangerous incompatibility," 303—Panel Committee, 303—Pharmaceutical Committee's expenses, 303
- Wolverhampton, 11, 304—Certification of incapacity for work, 11—Checking prescriptions, 11—Conference of Local Medical and Panel Committees, 304—Local Medical Committee, 11—Model rules, 11—Panel Committee, 11, 304—Surplus capitation fees, 304
- Worcester, 46—Arrangements with unqualified persons (herbalist), 46
- Yarmouth, Great. *See* Great
- York, 114, 277, 304, 315—Complaint against a practitioner, 277, 315—Conference of Local Medical and Panel Committees, 304, 315—Co-operation with British Medical Association, 114—Finance, 114—Election of Committee, 315—Local Medical and Panel Committees, 304—Panel Committee, 114, 277—Payments to practitioners, 277, 315—Representative on Insurance Committee, 304—Treatment of soldiers, 114—Unallocated insured persons, 114
- Yorkshire, East Riding, 258—Attendance on soldiers on furlough, 258—Co-operation of Local Medical and Panel Committees, 258—Drug tariff, 258—Expenses of Panel Committee, 258—Medical referees, 258—Panel Committee, 258—Scrutiny of prescriptions, 258—Transfer of patients of doctors on military service, 258—Travelling expenses of members of Committee, 258
- Yorkshire, North Riding, 11, 155—Agreements, 11—Allocation of insured persons, 11—Attendance on employees preparing war camps, 155—Certificates, 156—Emergency Committee, 12—Excessive prescribing, 12, 155—Financial statement, 12—Local Medical Committee, 12, 155—Medical referees, 155—Meeting of practitioners, 11—Mileage, 11—Model rules, 12—Panel Committee, 11, 155—Payment of expenses, 11—Pharmaceutical Committee's expenses, 156—Railway fares of members attending Local Medical and Panel Committee meetings, 155—Solicitor's agreement with Emergency Committee, 155—Unallotted funds, 11—Vacancy in committee, 155—Vote of thanks, 11
- Yorkshire, West Riding, 57, 67, 156, 286, 315—Administration of medical benefit, 57, 67—Administrative expenses, 57—Belgian Doctors' and Pharmacists' Fund, 315—Co-ordination of work of Local Medical and Panel Committees, 57—Doctors absent on military service, 57, 67, 156—Drugs and appliances, 57, 67—Election of officers, 57—Local Medical and Panel Committee, 57, 156, 286, 315—Medical certificates, 156—Medical referees, 286—Motor ambulance fund, 57, 156—New British Pharmacopoeia,

Insurance, National (continued)

- 68, 156—New edition of West Riding formulary, 286—Payments to practitioners, 68, 156, 315—Range of medical service, 57, 156, 315—Record cards of doctors absent on military service, 315—Rules for administration of medical benefit, 286—Secretary's salary, 57—Travelling expenses, 57, 67, 285—Vacancies in the committee, 156, 315—War emergency, 286

- Inverness Division. *See* Division
- Insurance Act Committee. *See* Insurance
- Ireland, National Insurance, 58, 68, 130, 135
- Irish Committee. *See* Committee
- Irish Medical Committee (Insurance Act). *See* Insurance
- Isle of Ely Division. *See* Division
- Isle of Ely, National Insurance, 277
- Isle of Thanet Division. *See* Division
- Isle of Wight, National Insurance, 256, 313

J.

- JEFFERSON, George: National Insurance, irregular certificates, 5
- JOHNSTON, George: National Insurance, new insurance certificates, 13
- JOSEPH, Max: *A Short Handbook of Cosmetics*, rev., 72
- Journal Committee. *See* Committee

K.

- Kendal Division. *See* Division
- Kent Branch. *See* Branch
- Kesteven Division. *See* Division
- Kingston-upon-Hull, National Insurance, 4, 28, 91, 304
- Kingston-on-Thames Division. *See* Division
- Kirkcaldy, National Insurance, 20, 82
- KRAMER, Alfred Bertie: Disciplinary case of, 296

L.

- Lambeth Division. *See* Division
- Lanarkshire Division. *See* Division
- Lanarkshire: National Insurance, 316
- Lancashire, National Insurance, 81, 122, 155, 303, 314
- Leeds Division. *See* Division
- Leicester and Rutland Division. *See* Division
- Leicestershire, National Insurance, 21
- Limerick, National Insurance, 114
- Lindsey (Lincolnshire), National Insurance, 156
- Liverpool Division. *See* Division
- Liverpool, National Insurance, 11, 19, 27, 56, 58, 74, 105, 129, 253, 314
- LIVINGSTON, J.: National Insurance, approved societies and certificates from non-panel practitioners, 76
- London Insurance Committee, Bazett *versus*, 36
- London, National Insurance, 37, 45, 74, 83, 111, 123, 145, 157, 270, 277, 285, 339
- Lothian, West, National Insurance, 38

M.

- MALLAN, Valleck Cartwright, disciplinary case of, 298
- Manchester, National Insurance, 56
- Marlybone Division. *See* Division
- Matters referred to Branches and Divisions, 49, 97, 127, 146, 161, 245, 245, 255.

274, 275, 283, 310—War emergencies, 49—
Report on the question of fees for treat-
ment of juvenile members of friendly
societies, 97—Report to Divisions and
Representative Body on questions of
fees for medical examinations for life
insurance, 99—Report on eligibility for
election as a member of the Associa-
tion, 101—Provisional agenda for
Annual Representative Meeting, 161—
Notices of motion, 265
Medical attendance on dependants, reso-
lutions of: Liverpool Division, 60—
Sheffield Division, 300
Medical attendance on patients of practi-
tioners on military duty. *See* Patients
Medical certificates, the exploitation of
the medical profession in respect to
(Sir John Moore), 143
Medical needs of the army. *See* War
emergency
Medical treatment of soldiers on fur-
lough, correspondence with the Insur-
ance Commissioners, 89
Medico-Political Committee. *See* Com-
mittee
Mental Deficiency Act certificates, 274
Metropolitan Counties Branch. *See*
Branch
Mid-Cheshire Division. *See* Division,
Cheshire (Mid)
Middlesex Division. *See* Division
Middlesex, National Insurance, 58
Monmouth, National Insurance, 81, 257,
304
MOORE, Sir John: The exploitation of
the medical profession in respect to
medical certificates, 143
Munster Branch. *See* Branch
Munster, National Insurance, 60, 68
MURPHY, H. Howard: Over-prescrib-
ing, 9
MUSPRATT, C. D., address as President
of Dorset and West Hants Branch, 282

N.

Naval and Military Committee. *See*
Committee
Navy, Royal, medical service of, 5, 14, 22,
30, 38, 46, 61, 70, 77, 85, 94, 105, 117,
127, 131, 137, 147, 158, 261, 271, 278, 289, 306,
317, 339
Navy, British, Royal Naval Volunteer
Reserve, 5, 14, 22, 30, 38, 46, 61, 70, 77,
85, 94, 105, 117, 127, 131, 137, 147, 159,
261, 271, 279, 289, 306, 317
Newcastle-on-Tyne Division. *See* Divi-
sion
Newcastle-on-Tyne, National Insurance, 57, 238
Newcastle-on-Tyne, war emergency: an appeal, 109
Non-Panel Committee. *See* Committee
Non-panel practitioners. *See* Insurance
Northamptonshire Division. *See* Division
Northamptonshire, National Insurance, 4, 44, 314
North-East London, and the war emer-
gency, 241
Nottingham Division. *See* Division

O.

O'FERRALL, E. F.: National Insurance, medical referees, 22
Oldham Division. *See* Division
Oldham, National Insurance, 74, 146, 339—And the war emergency, 242
Organization Committee. *See* Com-
mittee
ORTON, John: The present attitude towards the National Insurance Act, 336
Over-prescribing (H. Howard Murphy), 9
Oxfordshire, National Insurance, 3, 55, 129, 256

P.

Panel Medico-Political Union. *See* In-
surance Act
Patients of practitioners serving with the
colours, resolution from Birmingham
district practitioners, 90
Payments to military medical officers, 274
Perth Branch. *See* Branch
Perth, National Insurance, 2, 28, 82, 112
Plymouth Division. *See* Division
POCHIN, F. L.: National Insurance, the
finances of the Act, 114
Portsmouth Division. *See* Division
Portsmouth, National Insurance, 313

PUBLICATIONS, RECENT, 32, 72

Cosmetics, Short Handbook of (Max Joseph), 72
Guardian Life Pocket Diary, 32
Skin Diseases, Notes on (David Walsh), 32

Public Health Committee. *See* Com-
mittee

Public health officers and the war emer-
gency, 147
Publishers' announcements, 24, 32, 64, 72,
120

R.

Reduction in advances to insurance prac-
titioners, 252—Solicitor's opinion, 252.
See also Insurance
Reigate Division. *See* Division
Renfrew, National Insurance, 2, 75, 113,
260
Rochdale Division. *See* Division
Rochdale and the war emergency, 242
Rochester, Chatham, and Gillingham
Division. *See* Division
ROSE, Percy: National Insurance, statistics for 1914, 21
ROSS, S. J.: National Insurance, 287, 316
—The surcharging of panel practi-
tioners, 316
Ross and Cromarty Division. *See*
Division
Roxburghshire, National Insurance, 12, 28
Royal Navy. *See* Navy

S.

St. Boswells and the war emergency, 243
St. Helens Division. *See* Division
St. Pancras and Islington Division. *See*
Division
Salford Insurance Committee. *See* In-
surance
Salford, National Insurance, 36, 76, 114,
157
Salisbury Division. *See* Division
SALTER, Alfred: National Insurance, alterations in Insurance Act Regula-
tions, 124
SCHORN, Alexander Orford, disciplinary
case of, 296
Science Committee. *See* Committee
Scottish Drug Accounts Committee, 59, 84. *See also* Insurance
Scottish Emergency Committee. *See*
Committee
Sheffield Division. *See* Division
Shropshire and Mid-Wales Branch. *See*
Branch
Southampton Division. *See* Division
Southampton, National Insurance, 136
South-Eastern Counties Division. *See*
Division
South-Eastern of Ireland Branch. *See*
Branch
Southport, National Insurance, 44, 112,
258, 304
Southport Division. *See* Division
South-Western Branch. *See* Branch
Staffordshire, National Insurance, 38, 91,
114, 304
Staffordshire Division. *See* Division

Stirling Branch. *See* Branch
Stirlingshire, National Insurance, 75, 113,
305
STOKES, Arthur Samuel, disciplinary
case of, 296
Suffolk Division. *See* Division
Suffolk, East, National Insurance, 3, 37,
111, 156, 277, 313
Suffolk, West, National Insurance, 3, 28,
91, 314
Sunderland, National Insurance, 82
Surrey, National Insurance, 12, 44, 111,
255, 313
Sussex, East, National Insurance, 255,
313
Swansea, National Insurance, 67

T.

Temporary residents. *See* Insurance Act
Tipperary, North, National Insurance, 114
TORRENS, Dudley F.: National Insur-
ance: cards and records, 22
Tyrone, National Insurance, 68

V.

VITAL STATISTICS, 6, 15, 22, 29, 39, 47, 62,
70, 78, 85, 95, 106, 117, 131, 138, 147,
158, 263, 278, 290, 307, 317
English urban mortality in the fourth
quarter of 1914, 85—In the year 1914,
117—In the first quarter of 1915, 317
Epidemic mortality in London, 6, 78
Health of English, Scottish, and Irish
towns, 7, 15, 22, 29, 39, 47, 62, 70, 79,
87, 95, 107, 117, 131, 138, 147, 158, 263,
278, 291, 307, 319
Registrar-General's quarterly return,
106, 319
Vital statistics of London during the
fourth quarter of 1914, 62—During
1914, 138—During the first quarter of
1915, 290

W.

Wakefield and the war emergency, 243
Wakefield, Pontefract and Castleford
Division. *See* Division
WALSH, David: Notes on Skin Diseases, rev., 32
War economy, 73. *See also* Insurance Act
WAR EMERGENCIES, 14, 17, 49, 109, 141, 149,
241, 260, 265, 273, 282, 299, 310, 338—
Matters referred to Branches and Divi-
sions, 49—Appeal by Scottish Emer-
gency Committee, 109—Appeal by
Newcastle-on-Tyne Division, 109—
Offers of part-time service, 141—Offers
of whole-time service, 141—Public
health officers, 149—Proposed tem-
porary suspension of the keeping of
records by panel practitioners, 153—
Temporary displacement of part-
time medical men, 244—The call in
rural districts, 267—Letter to secre-
taries of Divisions from Scottish
Emergency Committee, 338
Resolutions of Branches and Divisions,
etc.:
Ayrshire Division, 142
Barnsley, 142—Barrow, 267—Bath
Division, 241—Belfast Division, 244—
Bolton Division, 242—Bournemouth
Division, 339—Brighton, 301—Bury,
Lancashire, 143
Camberwell Division, 142—Canter-
bury and Faversham Division, 150—
Carlisle, 243—Chesterfield Division,
151—Colchester, 301

WAR EMERGENCIES (*continued*)

Dorset and West Hants Branch,
283—Dorset, West, Division, 266—
Dublin, 273—Dudley Division, 266—
Dumfries and Galloway Division, 282
—Dundee Branch, 283
—Edinburgh, 267, 284—Edinburgh
and Leith Division, 284—Ely Division,
273—English Division, 243—Essex,
South-West Division, 142, 301
—Fife Branch, 243, 333—Furness Divi-
sion, 267
—Glasgow Division, 152—Glossop
Division, 268
—Harrow Division, 284—Holland
Division, 146, 299—Huddersfield, 151
—Inverness Division, 301—Isle of Ely
Division, 273—Isle of Thanet Division,
241
—Kendal Division, 152—Kesteven
Division, 242
—Lambeth Division, 283—Lanark-
shire Division, 244—Leicester and
Rutland Division, 266—London In-
surance Committee, 270—London
(North-East), 241—London Panel
Committee, 285, 339
—Metropolitan Counties Branch, 142
—Mid-Cheshire Division, 266—Mid-
dlesex, North Division, 149
—Newcastle-on-Tyne Division, 142—
Northamptonshire Division, 266, 310—
Nottingham Division, 242
—Oldham, 242

WAR EMERGENCIES (*continued*)

Perth Branch, 143—Plymouth
Division, 266—Portsmouth Division,
151
—Reigate Division, 151, 241—Roch-
dale, 242—Rochester, Chatham, and
Gillingham Division, 150—Ross and
Cromarty Division, 283
—St. Boswells, 243—St. Pancras and
Islington Division, 241—Salisbury
Division, 150—Scottish Emergency
Committee, 17, 49, 267, 273, 338; A
correction, 273—Shropshire and Mid-
Wales Branch, 152—South-Eastern
Counties Division, 14, 243, 267—
South-Eastern of Ireland Branch,
275—South-Western Branch, 151,
242—Staffordshire (South) Division,
284—Stirling Branch, 244, 300—
Stratford Division, 265—Suffolk,
West, 150
—Wakefield, Pontefract, and Castle-
ford Division, 152, 243—Westmorland,
152—Wigan Division, 152—Worcester,
242
—Warrington Division. *See* Division.
—Warwickshire, National Insurance, 286
—West African Medical Service. *See* Army,
British, Colonial Medical Service
—West Ham, National Insurance, 92
—Westmorland and the war emergency,
152
—West Lothian. *See* Lothian

Wexford, National Insurance, 45, 130

Wigan Division. *See* WiganWillesden Division. *See* DivisionWILLIS, W. Addington: *National Insur-
ance Through Approved Societies: Being
a Practical Legal Treatise Incorporating
the Operative Orders and Regulations*,
rev., 92WILSON, Lorton: *National Insurance*,
approved societies and certificates
from non-panel practitioners, 76Wiltshire Branch. *See* Branch

Wiltshire, National Insurance, 303

Wolverhampton, National Insurance, 11,
304

Y.

Yarmouth, National Insurance, 3

York, National Insurance, 112, 277, 304,
315Yorkshire, East Riding, National In-
surance, 258Yorkshire, North Riding, National In-
surance, 11, 155Yorkshire, West Riding, National In-
surance, 57, 67, 156, 286, 315