

any person desirous of becoming a member is or is not, for the purposes of the scheme, a consultant or specialist.

Membership of the scheme entitles a consultant or specialist who becomes engaged on whole-time Government service to receive from the funds compensation towards the financial loss suffered in respect of his practice during his absence.

Brief Outline of the Scheme

A participating member is required to pay an entrance fee of £1 1s., the stamp duty on the Agreement with the Trustees (10s.), and an annual subscription of 10s. 6d.

(A) *Members remaining in Private Practice.*—On the occurrence of a national emergency a participating member who continues in private practice will be required to subscribe to a fund administered by the Trustees an annual contribution, comprising one-half of the sum representing the increase between (a) the average annual amount of his "earned income" (as previously defined) during the preceding two years, and (b) the amount of his "earned income" in each year from the commencement of the emergency until the termination of the scheme. Counsel has advised that members making contributions will be entitled to deduct income tax therefrom and that the amount of such contribution will be allowed as a deduction in computing the member's liability to surtax.

(B) *Members engaged on Whole-time Government Service.*—On the occurrence of a national emergency a participating member who becomes engaged on whole-time Government service (an "absentee member") or his nominee(s) will receive from the funds of the scheme an annual payment on a dividend basis in proportion to the annual loss incurred. The annual loss will be computed in much the same manner as the annual gain of the consultants who remain in private practice—that is, the difference between the "earned income" during each year of the emergency and the average annual "earned income" for the two years preceding the emergency. Government pay received by absentee consultants will be taken into consideration in assessing the annual loss.

Confidential Nature of the Scheme

When the scheme comes into operation each participating member will be required at his own expense to arrange for a chartered or incorporated accountant to submit for the use of the Trustees' accountants (Messrs. Price, Waterhouse and Co., 3, Frederick's Place, E.C.2) certain certificates. These certificates will simply relate to the increase or decrease in annual "earned income" during the emergency as compared with pre-emergency figures, and will be regarded as *strictly confidential* by the Trustees' accountants. Although the Trustees are empowered to request information and accounts relating to any certificate furnished under the scheme, the only person to whom a consultant need normally divulge his income is the local chartered or incorporated accountant, whose services are utilized by him under the scheme. Members of the scheme will receive at the appropriate time an explanation of the method to be adopted in computing the increase or decrease in "earned income."

Applications for Membership of Scheme

Every practitioner desirous of becoming a participating member will be required to enter into an agreement with the Trustees. The Trust Deed, however, provides that the scheme shall not come into force until the Trustees so declare by written notice to the participating members and in any event not until there are at least 500 participating members.

Consultants and Specialists in England and Wales have recently been asked to signify their willingness or otherwise to participate in the scheme. The Association is anxious that every practitioner predominantly engaged in private consultant or specialist practice who is able to conform to the criteria set out in the first paragraph under the heading "Availability and Object of Scheme" should have details of the scheme. Practitioners in this category who have not received particulars are requested to apply for a copy of the scheme to the Secretary, British Medical Association, B.M.A. House, Tavistock Square, London, W.C.1.

Local News

FRANCE

[FROM OUR PARIS CORRESPONDENT]

Health and Old Age Insurance for Doctors

The powerful *Confédération des Syndicats Médicaux Français*, to which two out of every three French doctors belong, and whose enterprising secretary-general is Dr. P. Cibrie, has formally endorsed the so-called Pomaret scheme for the compulsory insurance of French doctors against sickness and old age. But certain other medical corporate bodies and several distinguished leaders of the medical profession have expressed profound disapproval of important features of this scheme. The most snarled over bone of contention concerns the proposal that when a doctor reaches the age of 65 and wishes to continue to practise he shall be disqualified for the pension to which he may have contributed throughout a long professional life. The intention of this clause is to make way for younger doctors embarrassed by competition with their seniors. Looked at from this angle, the problem is one of supply in excess of demand. While superfluous coffee and wheat can be burned, this solution for elderly but still competition-capable doctors has seemed too ruthless, the more so because if the Pomaret scheme becomes law they can be bought off. One of the most sensible suggestions recently made for the settling of this controversy is that a referendum should be taken in order that every doctor interested in the matter can throw his weight into the scales on whichever side pleases him.

Grancher System for the Prevention of Tuberculosis

The system, started in 1903 by Professor Joseph Grancher, of boarding out healthy children from tuberculous homes in foster homes in the country was the subject of a comprehensive survey by Professor Marfan at a recent meeting of the French Academy of Medicine. With its central office in Paris, this system has been decentralized in such a way that the provincial centres now enjoy more or less complete autonomy. The provinces alone are dealing with more than 5,000 foster children this year. As for the results, so far as the threat of tuberculosis is concerned, it has been found that among 4,000 children dealt with by the central Paris office there were only twelve who developed tuberculosis after being removed from tuberculous to healthy homes, and among these twelve there were as many as nine who recovered under sanatorium treatment. With regard to costs, Professor Marfan made this instructive comparison. A tuberculous patient requires three years' treatment in a sanatorium at the cost of 15,000 francs every year, and even so only one out of every three tuberculous patients recovers. To achieve a single recovery it is therefore necessary to spend 135,000 francs, whereas it costs the Grancher system only 25,000 francs to prevent a child from becoming tuberculous.

Congestion in the Medical Profession

In an editorial note in a recent number of *Concours Médical* Dr. J. Noir deplores the unwillingness or inability of many doctors in Paris to join medical societies whose object is to defend the rights of the medical profession. There are now about 6,970 doctors in Paris and the Department of the Seine, but hardly 2,500 have joined the "syndicats" which combine to form the *Fédération Médicale Parisienne*. This negligence on the part of many doctors may to some extent reflect their straitened circumstances, membership fees having become too onerous in this period of cut-throat competition. In 1905 there were only 2,900 doctors in Paris and only 18,000 in the whole of France, whereas now, thirty-four years later,

there are as many as 30,115. Yet the population of the country has hardly grown at all in the interval. At the same time there has been an enormous expansion of the gratuitous services provided by hospitals, dispensaries, and similar institutions.

Correspondence

Treatment of Gastric and Duodenal Haemorrhage

SIR,—The communication by Professor E. Meulengracht published in your issue of August 12 (p. 321) demands comment, for the lessons implicit in it are so dangerous that neither gratitude for his visit nor admiration for his mastery of our language should deter criticism. After close examination of his words I believe that I am expressing his views fairly when I say that in cases of haematemesis and melaena he advocates that all patients should be allowed to move about, and particularly that they should be encouraged to eat and drink large quantities of a varied and liberal diet, including not only purées but slices of meat, cheese, and a "variety of dishes." His address, and previous accounts of his work, state that the primary object of the treatment is to diminish the risk to life presented by haemorrhage in cases of peptic ulcer. I am convinced that if his system is widely adopted in this country it will increase and not diminish the mortality, and it is a matter of regret that certain authorities, including my friend Professor L. J. Witts, have already given support to it.

Since the summer of 1936, in collaboration with Professor Samson Wright, I have been responsible for nearly all the cases of serious haemorrhage from the stomach and duodenum admitted to the Middlesex Hospital. In a preliminary communication we have shown how it is possible to distinguish between those cases in which the haemorrhage has been mild and those in which it is severe, and how it can be decided with accuracy whether haemorrhage has ceased or is continuing; we seek to learn what the actual risk to life is, what causes death when it occurs, and how mortality can be diminished. For mortality does occur, and even if we adopt the expedient of omitting from our series cases of cirrhosis of the liver and malignant disease we are left with a certain number of cases of true peptic ulcer which succumb to haemorrhage. None of our cases has been treated on the lines advocated by Professor Meulengracht, but I am not only convinced that critical survey of our failures could not suggest that such treatment would have saved a single life, but I am sure that had we persuaded the more serious cases to eat immediately and freely of a generous diet, including slices of meat and cheese, the mortality would have been increased.

The explanation of Professor Meulengracht's enthusiasm is probably given in his description of the disagreeable and dangerous state of exhaustion at one time produced in Danish patients by prolonged starvation, thirst, and immobility; such a state of affairs is outside my personal experience, but I can well believe that it would cause a serious and unnecessary mortality from dehydration and chloride depletion. It will nevertheless be a calamity if Professor Meulengracht's success in reforming this deplorable practice in his country is followed by the general adoption in Great Britain of a system which is, if applied to cases of proven gravity, not only dangerous but devoid of either logical or empirical justification.—I am, etc.,

London, W.1, Aug. 16.

T. IZOD BENNETT.

Absorption of Fat

SIR,—The interesting account of the work of Morton and his co-workers on the distribution of vitamin A and A₂ which you report in the *Journal* of August 12 (p. 345) calls for a note from an anatomist. You say "there is no lymphatic system in fish, and it is suggested that vitamin A esters, in combination with protein, may help in the dispersion of these droplets and in the removal of fat from the tunica propria" of the intestine.

In 1769 William Hewson, co-partner of John Hunter, published an account of the lymphatic system in fish. He demonstrated the lymphatic vessels, thoracic duct, and intestinal lacteals in cod, skate, haddock, and whiting. He indicated the absence of lymphatic glands in fish and reptiles and their presence in birds and mammals. He also noted the relative absence of valves in the lymphatic vessels of fish and their frequency in mammals. In particular, he stated "the lacteals in the cod (and I presume in most other fish) are remarkable for having a beautiful network of vessels between the muscular and villous coats of the intestines."

In 1926 R. H. Burne, physiological curator of the Royal College of Surgeons, described a system of "fine" vessels, probably of a lymphatic nature, which existed side by side with ordinary lymphatic vessels in the head and forepart of the body of the angler fish (*Lophius piscatorius*). He suggested that these "fine" vessels were probably the afferent component of a double lymph circulation, corresponding to the efferent component which constitutes the lymph vessels of mammalian anatomy. Burne discussed in detail the early evolution of the lymphatic system in the lowly vertebrates and its gradual segregation from the blood vascular system.

The view expressed by Lovern and Morton that "absorption of fat by fish differs from that obtaining in mammals, proceeding directly through the mucosal epithelium and not by a lymphatic system" is not tenable, nor is the claim that "the existence of a dense, continuous layer of connective tissue (stratum compactum) forms a barrier to fat transport as droplets, which accumulate in the adjacent tunica propria," inasmuch as the stratum compactum of the intestine of fish is no more compact than the submucous coat of many mammals.

The usual classification of fish into "fat" and "lean" is not adequate. Salmon, herring, and mackerel are "fat" fish, characterized by a high percentage of intramuscular fat. Cod, hake, haddock, and whiting are "lean" fish. The eel is characterized by large deposits of intra-abdominal fat, comparable to the kidney fat of well-fed mammals. The mesenteries also display varying amounts of fat, and the liver, ovary, and testis vary considerably from species to species in size and fat content.

Hewson suggested that the lymph of fish has a slower circulation than that of mammals, and stated that the lymph must be lodged for some time in the large lymphatic network of vessels before it is passed into the mass of the blood. He actually applied the term "varicose" to the lymphatic vessels of the fish.

In 1931 I called attention to the astounding fertility of both animals and plants which serve as a source of vitamin A; in the animal world the halibut and cod; in the vegetable world the cabbage family, lettuce, spinach, and the cultivated grasses such as oats, barley, and wheat. The eggs of the former are numbered by the million, the seeds of the latter by the hundred thousand. At the same time I called attention to the role of the phosphatic content of sea water in increasing the permeability to ultra-violet rays. The *Discovery* reports stated that the

dramatic improvement, often in half an hour to two hours, if the case is one of *mal de mer*. Should rigidity persist and there be no headache with the onset (this last has invariably been present in the less serious medical states) then one must concentrate on the treatment for appendicitis. Even if the abdomen is soft, temperature and pulse normal, and tenderness and pain are present this diagnosis is probable—especially in children, where delay is fatal.—I am, etc.,

Hove, Aug. 20.

J. HARTSILVER.

Bee-sting Anaphylaxis

SIR,—The following account of a personal experience of bee-sting anaphylaxis may be of interest:

In May, 1937, I was given a series of pneumococcal immunogen injections for post-operative pneumonia. Six weeks afterwards, when going through a hive, I received about six stings simultaneously. Almost at once I experienced violent tingling all over; marked constriction across the chest; dyspnoea, swelling of lips and tongue, and a tightening of neck muscles; intense palpitations and a profuse generalized erythematous and urticarial rash. I felt decidedly ill.

Previously when stung I have had a moderate local reaction, and since that unpleasant attack have had one or two isolated stings without marked effect.

Might it not be possible that owing to the recent injections I had become sensitive to foreign proteins, even if not specific. This possibility might account for the peculiar fact that hardened apiarists sometimes become suddenly sensitized to bee-stings.—I am, etc.,

Exeter, Aug. 16.

R. K. FOULKES.

Sodium Sulphate for Infected Wounds

SIR,—After reading a communication about sodium sulphate in the *British Medical Journal* some years ago, I began using it here, where we often see septic wounds already several days old and where the "first-aid dressing" has frequently had a basis of cow-dung. I should like to endorse what Dr. J. C. Lyth has said in its praise in your issue of July 8 (p. 89); with growing experience I use other dressings less and less in the presence of severe sepsis.—I am, etc.,

Kamdara, Bihar, Aug. 8.

N. P. BRUCE.

Universities and Colleges

UNIVERSITY OF LONDON

The Senate has appointed Viscount Dawson of Penn a member of the Court in the place of Professor F. Horton, F.R.S., for the period of Professor Horton's term as Vice-Chancellor. Lord Dawson has resigned his membership of the Senate as a representative of the Faculty of Medicine in view of his appointment by the Senate as a co-opted member.

Dr. A. E. Clark-Kennedy has been appointed a Governor of Queen Mary College.

Recognition of Teachers

The following have been recognized as teachers of the University in the subjects indicated in parentheses: *St. George's Hospital Medical School*: Dr. Desmond Curran (Mental Diseases); Dr. C. M. Gwillim (Obstetrics); Dr. C. K. Pinckney (Diseases of Children); Dr. K. Robson (Medicine). *St. Mary's Hospital Medical School*: Dr. I. H. Maclean (Bacteriology); Dr. D. M. Pryce (Pathology). *Westminster Hospital Medical School*: Dr. H. J. Ewen (Psychological Medicine). *King's College Hospital Medical School*: Dr. T. K. Lyle (Ophthalmology). *London School of Hygiene and Tropical Medicine*: Dr. J. C. Cruickshank (Bacteriology).

Diplomas in Clinical Pathology

The regulations for the Academic Postgraduate Diploma in Clinical Pathology have been amended for examinations in and after 1940.

Biology at First M.B. Examination

The syllabus in general biology at the first examination for medical degrees for external students (*Blue Book*, September, 1938, p. 816) has been amended by the deletion of the first paragraph under the heading "General Biology" and by the substitution thereof of the following:

The whole subject is to be treated in an elementary manner, with particular regard to the inculcation of general biological principles and to the subsequent work of the student. It should be noted that an equal amount of time is given to the written and practical examinations, and that equal importance is attached to the candidate's performance in each.

King's College

The following appointments have been made at King's College:

Lecturers in Physiology: E. F. McCarthy, M.B., B.Ch., and D. B. Taylor, M.B., B.Ch. *Demonstrator in Anatomy*: J. P. Bentley, M.B., B.S. *Demonstrator in Physiology*: D. J. N. Smith, M.B., B.S. *Medical Officer to King's College Theological Hall*: G. Hale, M.B., B.Chir.

The honorary secretary of the Lausanne Medical Graduates' Association informs us that the following medical practitioners have recently been approved for the M.D. degree at the University of Lausanne: G. R. M. Apsey, A. J. C. Eland, R. Robins-Brame, and D. K. Sundaresan.

The Services

DIRECTOR-GENERAL R.A.F.M.S.

The Air Ministry announces that the status of the Director of Royal Air Force Medical Services has been advanced to that of Director-General with the rank of Air Marshal. Air Vice-Marshal Sir Victor Richardson, K.B.E., C.B., D.P.H., K.H.S., Director of R.A.F. Medical Services, has become Director-General and has been promoted to the rank of Air Marshal, with effect from August 1.

DIRECTOR AND PROFESSOR OF PATHOLOGY, R.A.M. COLLEGE

Lieutenant-Colonel and Brevet Colonel L. T. Poole, D.S.O., M.C., K.H.P., late R.A.M.C., has been selected for promotion to colonel and to succeed Major-General H. M. J. Perry, C.B., O.B.E., K.H.S., as Director and Professor of Pathology at the Royal Army Medical College, Millbank, S.W., on the retirement of the latter from September 26.

HONORARY PHYSICIAN TO THE KING

Surgeon Rear-Admiral Thomas Creaser, R.N., has been appointed Honorary Physician to the King.

DEATHS IN THE SERVICES

Lieutenant-Colonel CHRISTOPHER BIRDWOOD MCCONAGHY, I.M.S. (ret.), died at Camberley on August 9, aged 62. He was born on March 25, 1877, the son of the late Surgeon-General W. McConaghy, Bombay Medical Service, and was educated at Edinburgh University, where he took the degrees of M.B., Ch.B., in 1900. Entering the Indian Medical Service as lieutenant on June 27, 1901, he became lieutenant-colonel on December 27, 1920, and retired on May 24, 1930. After three years' military service he entered the medical branch of the political department and served successively as residency surgeon at Baghdad, June, 1904, Bushire and the Persian Gulf, November, 1909, and Bhopal, September, 1914. From May, 1916, to May, 1918, he was on military duty serving in Iraq, and received the medals for the war of 1914-18. In June, 1918, he returned to the political department, and served as residency surgeon in the Eastern Rajputana States, June, 1918, Bhopal, January, 1919, and legation surgeon in Nepal from March, 1926, until his retirement. He had been a member of the British Medical Association for seventeen years.