Local News

ENGLAND AND WALES

The L.C.C. Domiciliary Midwifery Service

After negotiations with the London Maternity Services Joint Committee, which is the representative body of the voluntary organizations employing domiciliary midwives, the London County Council proposes to increase the payments made to voluntary hospitals and to district nursing associations for confinements. The payments at present are: to voluntary hospitals, £2 6s. 10d. for each confinement attended by a midwife acting alone or when a medical student is present, and £1 17s. 6d. for each confinement attended by a midwife accompanied by a pupil midwife; to district nursing associations, £2 14s. for each confinement attended by a midwife. The revised payments are to be £3 5s. for each confinement attended on behalf of a voluntary hospital by a midwife alone or with a medical student, and £3 12s. 6d. for each confinement attended by a midwife in the employ of a district nursing association. Since the payment of £1 17s. 6d. was fixed for confinements attended by a midwife with a pupil midwife revised rules have been approved by the Central Midwives Board for the training of pupil midwives, and these have resulted in a loss of income to the training hospitals. It is considered, therefore, that the payment authorized for confinements attended by a midwife only should be granted in respect of confinements attended by a midwife with a pupil. The fees fixed for the attendance of a midwife employed by the Council or a midwife employed by a voluntary organization are £2 for a first confinement, £1 10s. for each subsequent confinement, and £1 10s. for the attendance of a maternity nurse. Because of the increased cost of the domiciliary midwifery service it is proposed that these fees should be raised to £2 10s. for first confinements and to £2 for subsequent confinements and for maternity nursing cases. The assessment rules, which ensure that a patient who is unable to afford the full fee is not asked to pay more than she can afford, will continue to operate. The Council provides a free sterile outfit for domiciliary confinements undertaken by its own midwives, and many of the voluntary hospitals already provide free outfits. The district nursing associations usually arrange for the patient to obtain the outfit from the appropriate metropolitan borough council, which generally makes a charge for it conformable with the patient's financial circumstances. It is proposed that the voluntary hospitals shall be required to provide a satisfactory sterile maternity outfit free of charge to the patient, but in the case of district nursing associations the outfit will be provided by the Council free of charge. This arrangement will facilitate both freedom of choice of midwife by the patient and interchange of patients between midwives employed by the Council and the associations.

INDIA

Medical Women's Service in India

The annual report of the Countess of Dufferin's Fund for supplying medical aid by women to the women of India states that two new Dufferin hospitals have been opened during the year—at Calcutta and at Amraoti in the Central Provinces. The Lady Hardinge Medical College, New Delhi, reported 137 women students on the college rolls and the laboratories in full occupation. At the college hospital there were 5,000 in-patients and 67,500 out-patients during 1939. Reports are given concerning the work of medical relief to women in the Punjab, where, during three years, the number of women's sections of hospitals and women's dispensaries has grown from 52 to 68, and the number of women assistant and sub-assistant surgeons from 36 to 62. In ten medical colleges in India (exclusive of Burma) there were 570 Indian and 48 non-Indian women medical students taking the university course for the M.B., B.S., and in these colleges and in the schools of medicine there were 740 Indian women students training as licentiates. At the twenty-six hospitals in areas directly under the Government of India or in Governors' Provinces under the local Dufferin Fund, all of them under officers of the Women's Medical Service, there were 2,219 beds and cots, and the staff of the women's service attached to these hospitals numbered 37, with 86 assistants, and 237 sisters and staff nurses and 413 probationers. In the 158 hospitals in the Indian States under the charge of women doctors there were over 4,000 beds. It is mentioned that the public still seem slow to realize the fact that medical relief according to modern Western methods is expensive, and that if they wish to obtain the services of highly qualified and experienced doctors such as Women's Medical Service officers and to take the treatment required they must be willing to contribute towards the expenses in proportion to their resources. Many middle- and better-class patients insist on occupying beds in general wards, though paying rooms are available, and at most give a small donation to the poor box on leaving, even after confinements and operations. Modern India, like other countries, needs to assimilate the fact that it can only afford free medical treatment to the real poor.

Correspondence

Large-scale X-ray Examinations

SIR,—Why should Dr. J. F. Brailsford (October 5, p. 471) be accused of seeking "subtly to undermine the position of those who advocate the extension of mass radiography for pulmonary tuberculosis" because he dares to show the dangers that go with such a system? I venture to say that instead of being "unfortunate," as Dr. P. D'Arcy Hart (October 19, p. 534) calls it, it is fortunate that radiological experts should candidly give their evidence in respect of any new system of radiological examination.

Lieut.-Colonel Eric L. Cooper, whose article (August 24, p. 245) was the origin of the present controversy, makes some extraordinary admissions as to the conditions under which the clinical examination of Australian recruits was conducted: "hurried examinations in a noisy drill hall"; acknowledged "disabilities under which the medical boards worked in the camps"; so that it is not surprising that men were passed as "Fit, Class I," in whom subsequently "*x*-ray examination showed extensive chronic tuberculosis with large cavities in both lungs" (!), or "*x*-ray examination revealed *extensive* areas of infiltration," and so on. Are we asked seriously to take this as an argument for the superiority of *x*-ray diagnosis of pulmonary tuberculosis over clinical diagnosis?

In many years of tuberculosis work I have been convinced that it is just as possible to be led astray by *x*-ray examination as by ordinary clinical examination in the diagnosis of early pulmonary tuberculosis. The wholesale diagnosis of "hilum tuberculosis" in children, so common some twenty years ago, on evidence now discredited by all intelligent radiologists, though still, alas! not completely scotched, constitutes perhaps the outstanding example. In doing temporary work in recent years I have been again and again struck by the number of cases in which the diagnosis rested only on *x*-ray reports, and in which, after perhaps some years, clinical evidence was still lacking, and a further *x*-ray examination showed no evidence of tubercles: and here I am not referring only to children. As Dr. Brailsford says: "Radiographs may show appearances indistinguishable from pulmonary tuberculosis at one period, and yet within a week or so radiographs may show that the suspicious shadows have disappeared."

Sir Henry Bashford has expressed what, to my mind, is the real crux of the matter in the concluding sentence of his letter (September 21, p. 395): "It is profoundly to be hoped . . . that the utmost care will first be taken to learn and assess what is in fact really prognostically significant in these *x*-ray findings; and to avoid unnecessary labelling . . . with possibly dire psychological consequences to themselves and their families, new hosts of young men and women as cases of

Obituary

WILLIAM ROBINSON, M.D., M.S., F.R.C.S.

Consulting Surgeon, Sunderland Royal Infirmary

We regret to report the death of Dr. William Robinson of Sunderland, which took place at his native village of Stanhope, Co. Durham, on October 9.

Dr. Robinson was born in 1859 and had practised in Sunderland for nearly half a century. As a young man he showed great promise, and when he entered the medical faculty of the University of Durham in 1876 he secured apparently all the prizes and scholarships that were offered. In 1881 he won the Gibb, the Charlton, and the Dickinson scholarships. In that year he qualified M.B., M.S., and three years later he took the M.D. of Durham; his thesis was awarded the gold medal.

After qualification Dr. Robinson returned to Stanhope, where he interested himself particularly in the health of the workers in the lead mines, whom he found to be unduly subject to tuberculosis. At a meeting of the Independent Order of Odd Fellows in 1888 he suggested the establishment of a convalescent home for such patients, to be supported by an annual levy of a few pence from each member. His suggestion was adopted and the eventual result was the establishment of the Friendly Societies' Convalescent Home at Grange-over-Sands, which has helped many thousands of patients to recovery.

A vacancy occurring in a partnership in Sunderland, Dr. Robinson started medical practice in that town. He was a highly skilled surgeon, taking the F.R.C.S.Eng. in 1892, but as there was no surgical vacancy at the Sunderland Royal Infirmary at that time, the surgeon having been appointed for life, Dr. Robinson was elected physician but did most of the operations. Some ten years afterwards he became surgeon to the hospital, and on his retirement after long service he was made consulting surgeon, which position he held until his death. He was also in turn surgeon and consulting surgeon to what is now known as the Sir John Priestman Durham County and Sunderland Eye Infirmary, a well-appointed institution with sixty beds, but at the time he joined its staff it was a very small affair. Here he did much good work on the cataract which is the peculiar affliction of bottle finishers, one of the Sunderland trades. He was deeply interested in both these institutions, and in 1934 he published the *Story of the Sunderland Eye Infirmary*, which he set against its social and historical background. Two years later a centenary history of the Eye Infirmary also came from his pen.

As long ago as 1887 Dr. Robinson became a member of the British Medical Association. In 1898–9 he was president of the North of England Branch, and when the Association held its Annual Meeting in Newcastle-upon-Tyne in 1921 he was vice-president of the Section of Obstetrics and Gynaecology. He was also at one time president of the Northumberland and Durham Medical Society. During the war of 1914–18 he held the rank of major, R.A.M.C., and was visiting surgeon to the Sunderland War Hospital.

Last year Dr. Robinson, who was a well-read and much-travelled man, published a small autobiographical volume entitled *Sidelights on the Life of a Wearside Surgeon* (reviewed in these columns on January 6, 1940). His modest, lively narrative of the experiences of a North Country surgeon revealed a kindly personality with the gifts of shrewdness and humour well developed. He was greatly esteemed among his own northern folk. In 1934 his University conferred upon him the honorary D.Ch. He was a J.P. of the county.

N. M. J. JITTA, M.D.

The Permanent Committee of the International Public Health Office announces with great regret the death of Dr. N. M. Josephus Jitta, its distinguished honorary president, which took place last June.

Dr. Jitta had been the delegate for Holland on the committee from 1920 until early in the present year. His health had been failing for some time, and when his term of office as president of the Permanent Committee came to an end in October, 1938, he did not wish to stand again for that position, on grounds of ill-health. Dr. M. T. Morgan (British Colonies) was therefore elected in his place. Dr. Jitta had had a long and fruitful career as clinician and hygienist and as the administrative head of the health services of his country. He had held the post of president of the Council of Hygiene of the Netherlands since 1920 and had directed important researches on such questions as vaccination and post-vaccinal encephalitis. Dr. Jitta was the representative of the International Office of Public Health on the Health Organization of the League of Nations for many years, and he did much to co-ordinate the activities of the two bodies. He took a considerable part in the work preparatory to the revision of the International Sanitary Convention of 1926, especially in connexion with problems concerning the Suez Canal and the Mecca pilgrimage. In 1935 he replaced Sir George Buchanan as president of the Permanent Committee.

All those who knew Dr. Jitta personally were particularly struck by his kindly manner and by the sureness and subtlety of his judgment. His long experience of international hygiene made his advice particularly welcome to his colleagues.

The Services

MENTIONS AND AWARDS

The names of Major Douglas Cran, R.A.M.C., Captain George Fairfoul Valentine, R.A.M.C., and Captain Herbert Arthur Ledgard, I.M.S., have been brought to notice in recognition of distinguished services in the field.

Lieut.-Colonel Robert Ancel Logan, I.M.S., has been appointed an O.B.E. (Military Division) for distinguished service.

CASUALTIES IN THE MEDICAL SERVICES

ROYAL NAVY

Prisoner of War

Temporary Surgeon Lieut. Arthur Philip Booth Waind, D.S.C., R.N.V.R.

ROYAL ARMY MEDICAL CORPS

Major LEONARD BUCKLEY, R.A.M.C., lost his life by enemy action in October, aged 54. He was born on August 12, 1886, and was educated at the University of Liverpool, where he graduated M.B., Ch.B. in 1910, also taking the M.R.C.S., L.R.C.P. After filling the posts of house-surgeon and house-physician at Liverpool Royal Infirmary he entered the R.A.M.C. as lieutenant in 1911, and became captain in 1915. He served through the war of 1914–18, and retired with a gratuity in 1921. He then settled at Wincanton in Somerset. He rejoined the R.A.M.C. as major at the beginning of the present war. He leaves a widow. He had been a member of the British Medical Association since 1921.

Prisoners of War

Lieut.-Colonel Thomas Henry Wilson, R.A.M.C.
Major John Humphrey Thornton Challis, R.A.M.C.
Major Leslie Wallace Lauste, R.A.M.C.
Acting Major Arthur Keith Gibson, R.A.M.C.
Captain Anthony Crook, R.A.M.C.
Captain (War Substantive) James David Recordon, R.A.M.C.
Lieut. John Henderson Bolton, R.A.M.C.
Lieut. Arthur Raymond Dearlove, R.A.M.C.
Lieut. Philip Athelstan Forsyth, R.A.M.C.
Lieut. Trevor Charles Noel Gibbens, R.A.M.C.
Lieut. Isaac Jacobson, R.A.M.C.
Lieut. John James Kennedy, R.A.M.C.
Lieut. Anthony Wright Camac Mellor, R.A.M.C.
Lieut. Isidore Schrire, R.A.M.C.
Lieut. Hugh Temple Tate, R.A.M.C.

DEATHS IN THE SERVICES

Lieut.-Colonel DUNCAN FLETCHER, late R.A.M.C., T.A., lost his life at sea through enemy action in September. He was educated at the University of Glasgow and in the schools of the Royal College of Surgeons of Edinburgh, and took the Scottish Triple Qualification in 1895 and the D.P.H. in 1902.

He served for many years in the R.A.M.C., T.A., and rose to the rank of lieutenant-colonel. He had been chief district medical officer of health of the Islands and Western Inverness-shire, and medical inspector of schools, etc., for Inverness-shire. During and after the war of 1914–18 he served as officer commanding Crookston War Hospital, in charge of the neurological department of the Edinburgh War Hospital, and as medical officer of Grove Neurological Hospital. After retirement he settled at Dollar, Clackmannanshire. He had been a member of the British Medical Association for thirty-four years.

EPIDEMIOLOGICAL NOTES

Infectious Diseases for the Week

Owing to the continued and unavoidable delay of returns for the acute infectious diseases in England and Wales publication of the full table has had to be deferred one more week.

The figures missing from the table published last week for England and Wales (deaths in brackets, including those for London where available) are: cerebrospinal fever 129, London (0); diphtheria 1,153 (37), London (2); dysentery 68; encephalitis lethargica 5, London (1); enteric fever 60 (2), London (1); erysipelas, London 34 (1); infective enteritis or diarrhoea under 2 years (35), London (5); measles 7,910 (10), London (0); ophthalmia neonatorum 116; pneumonia, influenzal, 603 (17), London 42 (2); polio-encephalitis 4, London (0); poliomyelitis 47, London (0); puerperal fever 4, London 4 (0); puerperal pyrexia 140; scarlet fever 1,755 (3), London (0); whooping-cough 1,253 (7), London (0); deaths (0–1 year) 307, London 25; deaths (excluding stillbirths) 5,742, London 1,700; live births 6,318, London 878; stillbirths 218, London 17.

With the single exception of enteric fever the incidence of the principal notifiable diseases increased during the week, especially in the case of measles, scarlet fever, diphtheria, and pneumonia; the figures for whooping-cough, cerebrospinal fever, and acute poliomyelitis were only slightly higher.

Enteric fever is the most easily controlled of the diseases mentioned, and in recent months the little-practised measure in civilians of prophylactic inoculation of T.A.B. has been used on an increasing scale in anticipation of possible pollution of water supplies by damage to mains and service pipes during air raids. Combined injections of antityphoid vaccine and tetanus toxoid are now available; reactions appear to be no greater or more frequent than when the prophylactics are given separately. Protection, so far as experience goes, is adequate, while the merits of fewer injections over shorter periods are likely to commend themselves as much to the busy practitioner as to harassed populations.

Infectious diseases characteristically spread by the upper respiratory tract are likely to be more difficult than ever to control. The dispersal of an increasing proportion of non-immunes to areas hitherto relatively free from infectious diseases in epidemic form, the close aggregation in shelters of those who remain in densely populated centres, with correspondingly greater risk of exposure to infection, and the difficulty of providing adequate isolation accommodation for cases, even for selected contacts, at a time when the majority of infections are rife, are all factors calculated to facilitate spread and defeat measures aimed at prevention and control. Therefore prophylactic inoculation against those diseases for which the method holds out some measure of success should be encouraged and made freely available either at centres already established by local authorities or by general practitioners, to whom facilities should be provided by local authorities whenever necessary. Diphtheria and measles are readily controlled by recognized prophylactics of proved efficacy, while whooping-cough and scarlet fever may be controlled actively or passively, although with less certainty of success for the individual. The use of aerosols—antiseptics, such as sodium hypochlorite, in a suitable solvent and sprayed out in minute particulate form—may well prove the answer to air-borne and droplet infection in shelters and other places where people congregate and infect each other's respiratory passages.

As regards acute poliomyelitis, the measures hitherto available, whether for prophylaxis or for treatment, have not proved themselves safe or reliable enough for general application, although for such a serious disease any method offering promise of success merits a trial under control conditions. Fortunately the disease has rarely acquired epidemic character in this country, although during each summer and autumn isolated outbreaks, occasionally of some magnitude relative to the population at risk, are recorded. This year notifications have slightly exceeded those of last year, but were much below those of 1938 and are unlikely to approximate to them. During the week notifications rose from 38 to 47. Although nineteen administrative areas were affected only six recorded more than one case, and two accounted for nearly one-half of the total. Details from areas recording more than 1 case are: Warwick 11 (Birmingham 6, Sutton Coldfield M.B. 2, Warwick M.B., Solihull U.D., Stratford-on-Avon R.D. 1 each); Lancaster 10 (Blackburn, Bolton, Salford, municipal boroughs of Chadderton, Colne, Morecambe and Heysham, Nelson, Prestwich, and urban districts of Turton and Whitworth, 1 each); Southampton 4 (in R.D. of Kingsclere and Whitchurch, New Forest, Petersfield, and Winchester); Glamorgan 4 (Cardiff, Swansea, Aberdare U.D., Penarth U.D.); Derby 2 (Matlock U.D.); Stafford 2 (Wolverhampton).

Universities and Colleges

UNIVERSITY OF OXFORD

An examination for the Theodore Williams Scholarship in Pathology, consisting of a written paper and a viva voce examination, will be held in the Sir William Dunn School of Pathology on November 10 at 2 p.m. The scholarship is open to any member of the University, whether man or woman, who on June 30 in the year of the award shall not have exceeded 26 years of age and shall have attended the course in general pathology and bacteriology in the Sir William Dunn School of Pathology either in the year of award or in the previous year. Entries must reach the Professor of Pathology before Wednesday, November 6, 1940.

UNIVERSITY OF CAMBRIDGE

Dr. James Dixon Boyd, professor of anatomy at the London Hospital Medical College, has been elected to a supernumerary Fellowship at Clare College, of which he is an ex-Fellow.

At a Congregation on October 22 the following medical degrees were conferred by proxy:

M.D.—R. W. D. Turner.
M.B., B.CHIR.—J. D. Kidd, B. L. F. Heydon.

ROYAL COLLEGE OF SURGEONS OF ENGLAND

The annual meeting of Fellows and Members has been called for Thursday, November 21, at 3 p.m., when a report from the Council will be laid before the meeting. Copies of this report can be obtained beforehand on application to the secretary. Motions to be brought forward at the meeting must be signed by the mover, or by the mover and other Fellows and Members, and must reach the secretary not later than November 11. A copy of the agenda will be issued on or after November 16 to any Fellow or Member who might apply for one.

CONJOINT BOARD IN SCOTLAND

The following candidates, having passed the requisite examinations, have been admitted L.R.C.P.Ed., L.R.C.S.Ed., L.R.F.P. & S.Glas.:

H. Baddeley, M. C. Bell, H. Bernstein, T. B. Binns, D. S. Bomson, T. Brittain, A. G. Buick, D. E. T. Donaldson, M. D. Evelyn, L. Feld, A. J. Friedman, A. P. Govender, A. Greenberg, J. J. Greenwald, E. Grossman, N. S. Handman, M. E. Haut, I. F. K. Hughton, B. Hurewitz, J. Israel, P. G. McE. G. Jones, S. Katz, M. J. Kelly, H. H. Kirk, A. M. Kumaraswamy, J. Kupchan, D. J. Livingstone, B. Levy, L. London, A. McAllister, E. W. Magill, Elizabeth D. Mercer, R. C. Nirsimloo, G. Novis, Agnes W. B. F. O'Gorman, S. Osroff, F. Pomerantz, M. I. I. Rajah, C. E. K. Ratnam, J. A. Reid, I. Robins, B. Ross, W. L. Schiffman, J. Siegel, M. N. Sholtzow, P. Snell, A. I. Swiller, Helen E. Swiller, M. P. Taff, M. E. Vawda, W. A. White, P. Wiesenfeld, D. L. Ziselman.

The following graduates of recognized foreign universities were also admitted licentiates:

W. B. Ehrmann, E. Forrai, E. Goldsmith, A. Horowitz, R. Posner, I. E. Reichenfeld, Marianne H. Weigert.