new equipment and future rebuilding, and then on the basis of this annual budget it would be possible to announce the amount necessary from the local community for the support of their hospitals, and he did not doubt that the money would be afforded voluntarily.

Mr. H. S. SOUTTAR referred to the sweeping away of divisions between classes of hospitals. He had been a member of the staff of a voluntary hospital, but at present he was taking charge of an L.C.C. hospital under the control of the Ministry of Health. He referred to the work of the Medical Planning Commission as a kind of "Brains Trust" to determine the character of the after-war service, but, of course, the International Hospital Association, along its own lines, had a still wider purview.

Voluntaryism and State Aid

Lord GIFFORD, who has been associated with a hospital in Sydney, said that that hospital preserved its voluntary character although 60% of its income came from the State. More than half its board were State-appointed, but once they took their seats they were indistinguishable from other members. Voluntary hospitals would ask a great deal more aid from the State, and yet he believed that they could preserve their democratic character. Sir EARLE PAGE also said that in Australia they had endeavoured to incorporate the voluntary system with the maximum amount of State aid. Sir WILLIAM GOSCHEN (London Hospital) spoke of the need for a scheme which would bring the voluntary and municipal hospitals together. Mr. CARUS WILSON (St. Bartholomew's) said that the doubts which had been expressed as to the survival of voluntary hospitals after the war were also expressed during the last war, but voluntary hospitals continued then, and they would continue now. But they must look to such organizations as the Hospital Saving Association for augmentation of their income.

Among other speakers were representatives of the British Dental Association and the Royal College of Nursing, and the discussion was closed by Dr. ANDREW DAVIDSON (Chief Medical Officer for Scotland), who said that although the Committee on Scottish Health Services found a shortage of 3,600 beds, this had been more than made up by the Emergency Hospital Service. There was also now available for the first time in Scotland a comprehensive orthopaedic scheme.

E.M.S. Hospitals

Mr. ERNEST BROWN, Minister of Health, mentioned the close relation between Great Britain and the United States in connexion with the Emergency Medical Service. The U.S.A. not only had given material help but had lent medical and nursing personnel. The E.M.S. was not designed as a pattern for future development, but it had nevertheless proved a very useful experimental ground from which lessons of long-term value had been learned. It was organized to cope with the expected casualties of war, but in practice it had assumed a shape which made possible the adaptation to war needs of all kinds of existing hospitals and services. It had yielded experience with regard to the relation of hospitals one to another which would greatly influence the peacetime situation.

A HOMESTEAD SCHEME FOR MOTHERS AND CHILDREN

The family unit is the first casualty in war. If the nucleus of the State is the family—the living unity of father, mother, and children—then by some means the family should be enabled to maintain its status and fulfil its function, in spite of the disruptions caused by the war. The family unit was the basic idea of that great social venture, the Pioneer Health Centre at Peckham, whose work is now largely suspended because so much of the population it served has migrated. But the ideas which animated the Centre go on, and some of them are ably put forward in a memorandum addressed to the Ministry of Health and other Departments over the signature of Dr. Innes Pearse, the medical director.

Dr. Pearse proposes a homestead scheme, which will provide a reasonably healthy and useful life for the wives and children of mobilized men. She wants to see the evacuated women and children introduced into a society of people like themselves, of which they would become an integral and significant part. If the family is to function the mother and child must not be separated, as they would be if the former went into one of the auxiliary services or into "munitions." Perhaps one-third of the mother's working day must be given to the young child, but the remainder could be devoted to work of national importance, most obviously food production. The running of a mixed farm and garden—a homestead—on an estate of thirty or fifty acres, of which there are many in this country, should be within the capacity of a group of twenty-five to thirty women with two-thirds of a day's work to give on the spot where they are living. Under the guidance of advisers and with the help of a nursery-school worker, the mothers in such a colony would be able to undertake useful self-supporting work on the land, they would take their turn in household duty, they and their children would live in relative safety and under optimum health conditions, and, what is of equal importance, the fathers, to their own great benefit, could rejoin them on the farm during their periods of leave. Dr. Pearse begs the Government to set up a voluntary service of young mothers with children under 5, to begin with, to be called "The Mothers' Auxiliary Yeomen Service." The health overhaul, which was another idea of the Peckham Centre, could be undertaken by a visiting doctor and nurse-laboratory attendant travelling in a motor van to each of a batch of homesteads, and they would also supervise the diet and general hygiene and assure antenatal and post-natal care and child welfare. It is not pretended that such a scheme could do more than touch the fringe of the vast evacuation problem; but it would at least provide that a certain number of women, made familiar with the land and having had their resourcefulness and initiative developed and their health reinforced, would be ready to stand with their men on the return of the latter from the war, a reconstituted family unit in wholesome surroundings, better able to meet the demands of the new world.

Local News

ENGLAND AND WALES

London's Wartime Hospital Needs

Mr. Charles M. Power, house-governor and secretary, reports that the Ministry of Health has placed at the disposal of the Westminster Hospital 100 beds at an emergency hospital near London. To these beds civilian patients are now being transferred, after initial treatment in the London wards of the hospital. Here, also, out-patient children needing operations for the removal of tonsils and adenoids are being sent. The Westminster Hospital has been able to reopen some forty beds for the accommodation of contributory middle-class patients. The Ministry of Health, at the request of the National Radium Commission, is providing a centre to contain 120 beds for patients needing radium and *x*-ray treatment. Five of the London hospitals will share the beds. It is hoped that these beds may be the means of avoiding delay which has occurred during recent months, and that the treatment of these distressing cases will not again be interrupted should air raids on London be resumed.

Emergency X-ray Service for Hospitals

A fleet of fifteen *x*-ray vans now stands ready to answer calls for assistance from hospitals enrolled in the Ministry of Health's Emergency Hospital Service. These mobile vans, fitted with the latest type of equipment, have been presented by the War Organization of the British Red Cross and Order of St. John of Jerusalem. They will be stationed at selected hospitals in London and the Provinces so that calls from any part of the country can be answered. It is not intended to use them for routine work, but they will constitute reserve sets for an emergency caused either by raid damage or by unexpected demands on

a hospital's resources. Each van generates its own current for the *x*-ray apparatus, which can be operated by cable up to 100 yards away. There is also a dark-room with films and developer. Typical purposes for which these units will be used are: in temporary breakdown of a hospital's *x*-ray service because of raid damage or the interruption of power supply ; to examine cases in the wards of hospitals which have no mobile or portable apparatus ; and to supplement the *x*-ray service at hospitals where, because of the large number of casualties, the normal facilities cannot cope with the demand. The vans will have women drivers, and a radiographer will be attached to each unit. The radiographer, who will be appointed by the hospital at which the mobile unit is stationed, will work in the hospital while not engaged with the unit. The Ministry of Health is anxious that full use should be made of these mobile units. Application should be made to the Hospital Officer or, in the case of the London Sectors, the Group Officer.

Tuberculosis in Lancashire

To meet the need for economy in paper, Dr. Lissant Cox, the central tuberculosis officer to the Lancashire County Council, presents for 1940 a very truncated interim report. He notes that in 1940 the new cases reported of pulmonary tuberculosis numbered 1,394, an increase of 105 over the previous year. On the other hand, the number of new cases of non-pulmonary tuberculosis was 751, or 39 less than in 1939. The death rates from tuberculosis per 1,000 of the population recorded in 1940 were as follows (the average for the five years 1935-9 is added in parentheses): pulmonary tuberculosis, 0.46 (0.44) ; non-pulmonary tuberculosis, 0.09 (0.09). It is good to read that Lancashire has been fortunate in respect of institutional treatment, because the sanatoria and hospitals, being small, were not commandeered for other purposes, so that treatment and isolation have been carried out without much alteration in spite of the war. Dr. Lissant Cox adds some data on the examination of recruits in connexion with the National Service (Armed Forces) Act, 1939. Since the passing of the Act to the end of October, 1940, the number of suspicious cases referred by medical boards to the county tuberculosis officers was 614. Of this number 78 were already known to the tuberculosis officers. Of the remaining 536, 27, or 5%, were found to be suffering from active tuberculosis (the sputum contained tubercle bacilli in 11) ; 15, or 2.7%, had quiescent lesions ; and 3, or 0.5%, were patients with active disease who had received treatment for tuberculosis under another authority. The total number of recruits examined by the medical boards during this period has not been made known to Dr. Lissant Cox.

SCOTLAND

Post-war Reorganization of Hospitals

Mr. Thomas Johnston, M.P., Secretary of State for Scotland, in a recent address to members of the Scottish Advisory Committee of the Nuffield Provincial Hospitals Trust, urged the need for speed in defining Scotland's post-war hospital reorganization policy. He hoped the Trust would continue to help in propaganda for co-ordinating the voluntary and local authority hospitals and the new State-run emergency hospitals which had been created by the war. Mr. Johnston announced that the whole position was to be examined by a committee of inquiry which his Advisory Council on Post-war Problems had decided to set up as soon as possible. He said it was essential to have a vision now of how they were going to co-ordinate all the hospital services which would provide Scotland for the first time in its history with a surplus of hospital beds. One of the main tasks of the committee of inquiry would be to determine how co-ordination was to be secured and financial aid given to voluntary hospitals "without imperilling their jealously guarded autonomy." Members of the Scottish Advisory Committee of the Nuffield Trust agreed to give evidence before the committee of inquiry if required. It was also agreed to place at the disposal of the Secretary of State information which the Nuffield committee collected when examining the possibilities of regional reorganization of Scottish hospitals.

Correspondence

Radiology and Pelvic Disproportion

SIR,—Prof. Munro Kerr utters a warning against the easy assumption that *x*-ray examination now provides a lazy short cut to deciding the correct management of obstetric disproportion. I agree with his protest, and should be very sorry if recent publications have given any such impression. The radiologist who lacks obstetric experience, who has had no opportunity of studying the patient, and who cannot calculate with the components of difficult labour, is put in an impossible position when asked to pronounce, in a doubtful case, on obstetric prognosis and treatment ; his position is even more difficult than it is when he is faced with a similar problem concerning a patient with a doubtful lesion in the lung. Further, there are many subtle pitfalls in the radiological diagnosis of disproportion, and I, for one, would regard with the greatest alarm any suggestion that the radiologist should reign supreme as dispenser of authority for the performance of Caesarean section.

Nevertheless, are we holding an even balance? Speaking as an obstetrician, I believe that we have been unreasonably tardy in accepting the aid of a valuable tool. It is for us to learn the real uses, and for us to read the meaning—as we can do with increasing accuracy—of the "writing on the wall."

Prof. Munro Kerr refers to a passing criticism I recently made of trial labour. This was taken from a paper dealing with the methods, clinical and radiological, by which pelvic contraction can be detected and its meaning assessed ; and was intended to give point to my disapproval of the modern tendency to ignore pelvic measurements and to rely blindly on the method of trial labour for all sorts and types of foetal-pelvic disproportion. This tendency is, in my opinion, as reprehensible as is the extravagant and uncritical enthusiasm for radiological diagnosis which Munro Kerr so rightly deplores. But the careful obstetrician will make intelligent use of both methods. Trial labour achieves its greatest success in dealing with the antero-posterior brim contraction of the rickety flat pelvis. It is indeed amazing to find how extreme is the contraction that can sometimes be safely overcome by the forces of Nature. This I referred to in the paper quoted. But the benefits of trial labour are far less certain when the contraction not only affects the brim but is continued downwards through the birth canal (the simple flat and the generally contracted pelvis), or when there is a true funnel contraction of the pelvis. In such cases a very great responsibility rests on the observer, and too often in hospital practice unfair reliance is put on a relatively inexperienced house officer. Labour progress indeed takes place, but it is painfully, and sometimes dangerously, slow. Nor is the state of the cervix a safe indicator for deciding the duration of the trial, for in these cases the cervix may never reach full dilatation, and the patient, in fact, may never truly enter the second stage of labour. When, then, shall word be given that conservatism has failed and surgery must come to the rescue? When does watchful expectancy become ignorant idleness? Too often, while hesitation prevails the foetal heart stops. Too often the labour becomes so prolonged that Caesarean section is deemed unwise, and a supremely difficult foetal extraction is attempted from below ; too often a damaged woman is left to reflect in sadness on the loss of her firstborn, whose sacrifice she can ill understand. This, no doubt, paints the picture at its worst and is the reflection of poor obstetric judgment. But mature experience is not a universal asset, and in the very real difficulties that arise every aid is eagerly seized.

It is precisely for the reason that prognosis varies with the type of pelvis that accurate appreciation of pelvic shape and size, and of foetal size, is of supreme importance in the management of the slighter degrees of disproportion. In doubtful cases the information given by the lateral *x*-ray picture *made during the course of trial labour* is specially useful. In my experience this has sometimes helped to decide the issue in favour of Caesarean section before the trial of labour has degenerated into a test of the endurance of foetal life. Much

simple question: Was the father's refusal reasonable in all the circumstances? and the jury had little hesitation in finding that it was.

A correspondent has asked whether in such a case a court has power to order a given operation to be performed. The answer seems to be clearly laid down in the 1933 Act, Section 63. If the jury acquits, the court of course takes no notice of the order, but if the parent is convicted the court may make an order committing the child to the care of a "fit person." Often the fit person is the local authority, and under the order it has the powers of a guardian to give consent to the indicated operation. Alternatively, the court may bind the parent over to exercise proper care and guardianship, and this would presumably include his consent to the operation.

The Services

NAVAL AWARDS

The D.S.C. has been awarded to Temporary Surgeon Lieuts. Emlyn Roderick Llewellyn Davies (H.M.S. *Manchester*), Cyril Joseph Vaughan (H.M.S. *Forester*), and Eric John Yates (H.M.S. *Fearless*) for courage and resolution in operations in Mediterranean waters.

CASUALTIES IN THE MEDICAL SERVICES

ROYAL ARMY MEDICAL CORPS

War Substantive Captain ERNEST JOHN FRANK HINDE, who was announced as "Missing at Sea" in the *Journal* of November 1 (p. 638) and who is now reported to have died at sea in August as the result of enemy action, was the eldest son of Dr. and Mrs. E. B. Hinde of Norwich and qualified M.R.C.S., L.R.C.P. in 1938. In October, 1939, he was granted a temporary commission as lieutenant in the R.A.M.C., and was promoted captain a year later. He was a member of the British Medical Association. He leaves a widow.

Missing

Lieut. Niall Eugene O'Neill (*not* prisoner of war, as announced in the *Journal* of November 16, p. 689).

Prisoner of War

Lieut. John Edward Readman.

Universities and Colleges

UNIVERSITY OF EDINBURGH

At a meeting of the University Court, held on November 17, with Sir J. Donald Pollock, Rector, in the chair, it was reported that Dr. H. M. Traquair had been appointed a member of the Court as a General Council Assessor in succession to Sir Norman Walker.

On the recommendation of the Senatus and the Faculty of Medicine, the Court approved the appointment of Prof. Bruno Nowakowski, professor of hygiene, as a member of the Faculty of the Polish School of Medicine in Edinburgh.

It was announced that a bequest had been received from the late Mrs. M'Laren of Stirling of £2,000 in memory of her husband, Lawrence M'Laren, the interest to be used for research in the cause and cure of brain and nerve trouble and to be called the Lawrence M'Laren Bequest.

EXAMINATION FOR CZECH MEDICAL DEGREES

At the request of the Czechoslovak Minister of the Interior and Education in London, the Examining Board in England of the Royal Colleges of Physicians and Surgeons has undertaken to conduct a special Final Examination (Second and Third Rigorosa) for the Czechoslovak MUDr. degrees. Part I (Pathology and Bacteriology) was conducted in London last week, when twelve candidates were examined, of whom the following satisfied the examiners: Artur Flach, Jan Glaser, Zdenek Pfeifer, Karel Skopek, Karel Josef Susat, Walter Tausig, Josef Voracek, and Josefina Liebsteinova.

Medical Notes in Parliament

Health and Disease in the Colonies

Mr. NOEL BAKER opened, on November 20, a debate on colonial affairs. He said Parliament was now building up the social services of the Colonies, but there was still too much poverty and preventable disease. Mr. DE ROTHSCHILD said that under the Colonial Development Act the production of subsistence crops should be encouraged. There was much chronic ill-health among the natives due to a diet of low nutritive value. Unless a deficiency of sound home-grown food was remedied the work of doctors, nurses, and hospitals stood little chance of success.

Dr. MORGAN said the people of the West Indies suffered from malnutrition because the ground was used for exportable crops. There were in the West Indies instances of a chief medical officer acting on a basis of favouritism and of crowds of doctors moved without cause to the poorest parishes. He found the people of the West Indies living in a cesspool of disease—yaws, hookworm disease, syphilis, malaria, tuberculosis, infectious diseases, leprosy. Tuberculosis in the West Indies was of a galloping type, and in certain places syphilis affected 60% of the population. Hookworm disease spread because the Government would not insist on preventive measures. The doctors were blamed for a medical policy with which they had nothing to do. He had never seen a more disgraceful hospital than at San Fernando in Trinidad.

Mr. GEORGE HALL replied to the debate, but did not deal in detail with Dr. Morgan's charges.

High-frequency Apparatus

On November 27 Mr. HERBERT MORRISON told Dr. Howitt that for security considerations he could not instruct the chief officers of police to report on the possibility of licensing the use of more short-wave high-frequency apparatus, such apparatus being completely screened and issued only to practitioners for whose integrity the police could vouch. This proposal, he added, had been considered before the Control of High-frequency Apparatus Order was made. Dr. HOWITT asked whether a test had been made of how far these rays travelled. Mr. MORRISON replied that he could not say. It was undesirable to discuss such details in public.

Diphtheria Immunization.—On November 18 Mr. VIANT asked the Minister of Health whether he would obtain information of the amount of immunization against diphtheria practised in the areas covered by his circular dated June 12, 1941, in view of the fact that unless this information was given the mere number of cases of diphtheria notified and the proportion of cases immunized would not have any significance. Mr. ERNEST BROWN replied that the main purpose of the returns referred to in the circular was to furnish information about the extent to which immunization of children against diphtheria was carried out between January 1, 1940, and September 30, 1941. The return had been asked for from all local authorities.

Disease in Wiltshire Labour Camps.—Sir PERCY HURD inquired on November 20 what action Mr. Brown had taken upon the report last month by the Wiltshire Public Health Committee that the committee had been called upon to provide facilities for cases of vermin, scabies, venereal disease, and advanced pulmonary tuberculosis among imported labourers, especially from Ireland, for employment on Government contracts. Mr. BROWN reported local consultations with all concerned regarding medical arrangements at the labour camps referred to. The county council's medical officer was giving valuable assistance, and the necessary measures were in train.

Sir PERCY asked whether steps would be taken to ensure a strict medical examination before importation of labour. Mr. BROWN said that point was being considered in conjunction with the Ministry of Labour and National Service.

Compensation for Shock.—Sir WALTER WOMERSLEY said on November 20 that his attention had not been drawn to a decision given in the Bristol County Court that injury under the Personal Injuries Scheme did not include shock unless accompanied by physical injury. He added that compensation was payable where, as a result of enemy action, a person sustained concussion of the brain, whether there was visible injury or not, or where a person sustained nervous shock of a commotional character associated with blast, burial among debris, or some similar severe incident. In either case the patient must be medically certified as incapable of work.