The medical profession, the National Insurance Act, and the state of the Poor Law dispensaries in Ireland : being the first part of the Carmichael prize essay, 1913 / by H. Nelson Hardy.

THE CARMICHAEL PRIZE ESSAY

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The Medical Profession,

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The State of Poor Law Dispensaries in Ireland.

BEING THE FIRST PART OF THE CARMICHAEL PRIZE ESSAY, 1913.

BY

H. NELSON HARDY, F.R.C.S., Edin.,

Vice-President, United Kingdom Police Surgeons Association; late Divisional Surgeon, Metropolitan Police.

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The State of the Medical Profession in 1911-12.

THE state of the Medical Profession in Great Britain and Ireland, since Mr. Lloyd George last year (1911) introduced his National Insurance Bill, now become an Act of Parliament, may be best described as one of profound disquietude and unrest. Never, surely, since Mr. Carmichael instituted these Prize Essays has any legislation been proposed or carried through Parliament which has so deeply moved the whole medical profession, from the highest to the lowest, with forebodings of evil, as did some of the provisions of this Bill when introduced in the House of Commons by the Chancellor of the Exchequer.

The General Medical Council, the Royal Colleges of Physicians and Surgeons, and the British Medical Association, all made representations to the Government on the subject; meetings of Medical Practitioners were held in all parts of the United Kingdom, at which the provisions of the Bill affecting the profession were loudly denounced, and at which it was resolved that unless the objectionable features of the Bill were removed from it, the great bulk of the profession would refuse to co-operate in carrying out the system of National Insurance proposed to be established when it became an Act. Nor can this be wondered at, when it is remembered that the only apparent provision for remunerating the Medical Profession for the arduous duties of giving medical attendance, medicines, and surgical appliances to about one third of the population of the Three Kingdoms—say 15,000,000 in all—was an allowance of 6s. per head, as estimated by Mr. Lloyd George's expert advisers, by whom the wretched club or contract system, long ago condemned by the medical profession, had been taken as a model.

For many years past club practice has had a bad reputation in the medical profession, and the leading medical journals have

over and over again pointed out the evils attendant on it. *The Lancet*, for instance, some years ago printed a series of able articles on the subject, which have been reprinted and published as a pamphlet under the title "The Battle of the Clubs," which deals with the relations of the medical profession with friendly societies, clubs, and medical aid societies all over the Kingdom. In *The British Medical Journal* also, especially during the last eight or ten years, the evils of club practice have been repeatedly pointed out. While recognizing that there are certain districts in which it appears to be necessary, under present conditions, that certain classes of the community should be enabled to provide for the cost of medical attendance and medicines by some system of small periodic payments, and that in those districts the club system has long been established and is very prevalent, it has nevertheless been pointed out in the *Journal*, in the first place, that the rate of remuneration to the medical officer is in the majority of cases wholly inadequate. Another strong objection to the system has been that members who are well able to pay ordinary fees for medical attendance are admitted to club benefits, and are thus enabled to defraud the medical attendant; and a third objection is that as a rule the doctor has no representation whatever on the governing body of the club.

The inadequacy of medical remuneration under the club system, and also the general defectiveness of the mode of employment of doctors under the club system, and especially in connexion with the friendly societies, has been fully recognized by the Poor Law Commission in both the majority and minority reports.

Those reports have shown the failure, under existing conditions, not only of the system of public medical relief (poor law), but also of medical charities and of club or contract practice, to afford satisfactory medical attendance on the poorer classes. It has been made clear, in fact, that a large portion of the community does not at present obtain that prompt and efficient aid which it is the interest of the public that they should receive; that persons who, were the necessary organization in existence, could afford to provide by insurance for the cost of medical attendance, have not at present the facilities which would enable and encourage them to do so, and that not only are the medical practitioners engaged in these various services underpaid for their work—a circumstance in itself detrimental not less to the public interest than to that of the profession—but much of their work has to be performed under conditions which do not allow them to render the best service of which they are capable. It is, therefore, in full view of the public demand that there should be in the future some better provision of medical attendance for

the wage-earning classes, as shown both by the majority and minority reports of the Poor Law Commission, that medical men have had to consider what would be the effect of making the changes proposed in the Insurance Act upon medical practice. And, first of all, it is to be noted that if all those whose income is below the income-tax limit of £160 a year are to be compulsorily insured, a very considerable proportion of existing private practices will be affected thereby. There are many large districts both in England and Scotland where practically no medical attendance is given at present on club or contract lines. Probably a majority of families earning £2 a week or more pay the small fees needed without availing themselves of any insurance provision for the purpose. It is true they often run up bills with the doctor which they not infrequently find it difficult to meet; but, except in cases of illness requiring special medical or surgical skill, or exceptionally prolonged attendance, they and the doctors are satisfied to remain as private patient with private doctor. In cases requiring serious operations and skilled nursing, they apply to the medical charities, or avail themselves of the help given at Poor Law Infirmaries; and the main interest which the profession has in such places in the better organization of medical relief is, that better provision should be made for affording the assistance required in these exceptional cases, and for adequately remunerating the practitioners who give such assistance.

In Germany, where Mr. Lloyd George is understood to have obtained the leading ideas on which he has based his Insurance Act, the method of employment and the method of payment of the doctors in each district are left to local determination. In some districts selected practitioners are employed; in other districts the patients have choice of doctors. Where choice of doctors is permitted, practitioners are paid in some districts on a capitation basis, while in others the basis of payment per attendance is adopted. While it was well known that the medical profession in Germany was generally agreed as to the undesirability of the employment of selected medical officers for this public service, it was also found that there was no such general agreement as to the relative advantages of payment per attendance and capitation payments. Indeed, when the British Medical Association was in 1905 considering the desirability of itself establishing a Public Medical Service based on the Provident system, it was pointed out that the system of insuring certain sections of the community by means of weekly payments did not necessarily imply that medical practitioners should enter into contracts to give attendance on those terms; and that although the convenient system was for the doctor to be

remunerated on the same basis as the Insurance Fund was formed on (the capitation plan), yet there were cases under the provident system where the doctors were paid either by fixed salaries or by payment per attendance.

The chief example of the latter mode of payment under the provident system was found in 1905 to be the National Deposit Friendly Society the working of which Society in some districts had been found not altogether satisfactory.

The Friendly Societies, it was shown, were most unsuitable bodies to have control over the administration of any public medical service, most of them continuing to demand, in spite of repeated protests, that all their members, whatever their income, shall be free to obtain medical attendance upon the same terms, and maintaining that the payments they make (of 4s. a year, for example) are quite adequate. It was foreseen, of course, that if the administration of a Medical Service, such as the British Medical Association was in 1905-6 then designing to establish, were placed in the hands of the Friendly Societies, the better class of medical practitioners would decline to have anything to do with it.

Such, then, was broadly the general opinion in the profession on the subject, when the Chancellor of the Exchequer startled and amazed the profession and the public by introducing his National Insurance Bill in the House of Commons. From the Bill itself, and from Mr. Lloyd George's explanations of it in the House and elsewhere, it was found that the Public Medical Service proposed to be established by it was a system of club or contract practice of the lowest type, that it was to be administered by the very Friendly Societies against whose doings the profession had for years been protesting, and that it contained most of the evils of the old club practice, which were to be extended so as to include about a third of the population of these islands.

Mr. Lloyd George had not taken this step of adopting club practice as his model in ignorance of its many faults, for he had been reading, he tells us, the reports in *The British Medical Journal* on clubs and contract practice, and finding there that the ordinary Friendly Society capitation fee was at the rate of 4s. a year for selected lives, seems to have thought that he was acting quite generously to the profession in proposing that it should be 6s. a year for quite unselected, good, bad, and indifferent lives, with 1s. 6d. taken off for medicines, leaving it at 4s. 6d. a year. He quite expected, he tells us, to be hailed as a benefactor by the profession, instead of being denounced as a villain. He was soon undeceived. All the chief organs of medical opinion, *The Lancet*, *The British*

Medical Journal, *The Medical Press*, united in condemning the provisions of the Bill which applied to medical practice as most mischievous. All the representative bodies in the profession, the General Medical Council, the Royal Colleges of Physicians and Surgeons in London, Edinburgh, and Dublin, sent remonstrances against it, as did the British Medical Association : and the Chancellor was plainly told that if the Bill passed into law bearing the objectionable features it had when he introduced it, the profession as a whole would take no part in carrying out its provisions with regard to medical attendance.

This course, as was fully explained at the time, was taken, not because the profession did not fully sympathize with Mr. Lloyd George's desire to provide a National Insurance system against sickness for the lower classes of the population, but because it was already too well acquainted with the evils of club or contract practice to believe that its extension to 15,000,000 of the population could fail to prove injurious in the highest degree to the public health. The rank and file of the profession, of which the British Medical Association is largely composed, found themselves quite unable to accept Mr. Lloyd George's assurance that he meant to deal with them in a thoroughly generous manner, and they were not attracted but repelled by his offer of 6s. a head per annum.

As we have already said, the General Medical Council and the Colleges of Physicians and Surgeons, as well as the British Medical Association, made representations to the Chancellor of the Exchequer as to the changes required in the Bill if it was to be made acceptable to the medical profession. Let us now consider some of these in detail. The General Medical Council was principally concerned with the Bill from a well-grounded fear that if passed in the shape in which it was introduced, it would render the practice of the profession so much less attractive to intending students that the supply of candidates, which had been diminishing for a number of years, might be still more lowered, and result in a dangerous shortage of those seeking to enter the profession.

For the last twenty years it has been found that the number of medical men admitted to the medical register has been decreasing. It has fallen from an average of 1,462 during the period 1891-1895 to an average of 1,152 for 1906-10, and in the main the admissions to the register bear their proportion to the number of students who commence a professional career. The General Medical Council being aware of these facts, and fearing that the state of things might be made worse by the insurance proposals of Mr. Lloyd George, recommended that there should be medical representation among the Insurance Commissioners,

the Advisory Committee, and the Local Health Committees, that the medical benefits and maternity benefits should not be administered by the friendly societies, that there should be free choice of doctors by the insured, that proper provision should be made for the payments to hospitals in respect of insured persons, that a supply of surgical dressings should be included in the supply of drugs and medicines, and further that steps should be taken to ensure that the drugs and medicines are of the standard required by the British Pharmacopœia, and that the dispensing of them is carried out by qualified persons. Also that medical benefits should include provision for consultations and operations when these are necessary.

The Royal College of Physicians, Ireland, also took action in reference to the Bill in June, 1911, by issuing a circular letter to its members and licentiates, pointing out that it agreed with the policy which had been extensively adopted by the profession (the famous "six points" of the British Medical Association having been by this time widely circulated), and mentioned particularly the following points:—(1) That the profession should be adequately represented on all boards and committees controlling or administering medical benefits; (2) That the Friendly Societies should not make the arrangements with medical practitioners for attendance and treatment of insured persons, nor otherwise administer medical benefits; (3) That provision should be made for exclusion from medical and maternity benefits of persons whose average income from all sources exceeds £2 a week; (4) That adequate remuneration should be assured to medical men for their services; and (5) That the patient should be allowed to select his own doctor from those available, subject to the consent of the doctor selected.

During the same month of June, 1911, the Royal College of Surgeons of England, through its Council, represented to the Chancellor of the Exchequer that provision should be made for securing adequate remuneration to the profession for its services, restricting those insured to persons earning not more than £2 a week, and removing the administration of medical benefits from the Friendly Societies.

Also in the same month of June the British Medical Association issued its famous "six points" upon which, in its judgment, the profession should unitedly insist. They are as follows:—

(1) An income limit of £2 a week for those entitled to medical benefit.

(2) Free choice of doctor by patient, subject to consent of doctor to act.

(3) Medical and maternity benefits to be administered by Local Health Committees, and not by Friendly Societies.

(4) The method of remuneration of medical practitioners adopted by each Local Health Committee to be in accordance with the preference of the majority of the medical profession of the district of that committee.

(5) Medical remuneration to be what the profession considers adequate, having regard to the duties to be performed and other conditions of service.

(6) Adequate medical representation among the Insurance Commissioners, in the Central Advisory Committee, and in the Local Health Committees, and statutory recognition of a Local Medical Committee representative of the profession in the district of each Health Committee.

It was also stated in one of the printed circulars forwarded to the profession from the office of the Association in June, that in the opinion of the Association the Government should be urged to postpone dealing with the medical benefits under the Bill until a satisfactory arrangement should have been arrived at with the medical profession; and it was alleged that the replies received, and the reports of meetings held in every part of the country, proved that the policy of the Association in this was the policy of the medical profession in the United Kingdom as a whole.

Here we may pause a moment to narrate how it came to pass that ultimately Ireland was left out of the Bill so far as medical benefits were concerned. About the same time that the Irish College of Physicians had considered the subject, and passed the resolutions quoted above, the Roman Catholic hierarchy in Ireland held an important meeting at Maynooth, and passed a resolution asking the Chancellor of the Exchequer not to extend the Bill to Ireland, but to set aside the State contribution necessary for financing the scheme to the credit of Ireland, either for an insurance scheme to be specially devised for the needs of Ireland, or for some other purpose that may be deemed more beneficial to the general welfare of the population; and they called upon the Irish Nationalist Party to urge this policy in Parliament. They based their argument on the statement that while the Bill may do for England and Wales, of which 78 per cent. of the inhabitants are urban, and only 22 per cent. rural, it does not suit a country like Ireland, of whose population only 28 per cent. are urban and 72 per cent. rural, and of whom only a mere fraction—either urban or rural—are wage-earners, the immense majority being workers on their own account, such as farmers, shop-keepers, and others, who neither receive nor pay wages. They stated further that in their opinion the

measure would increase unemployment. There can be little doubt, however, adds the medical reporter to *The Lancet*, that among other things influencing the prelates was the well-known fact that the small farmers and their wives and children, who work on the land, can always at present obtain gratuitous medical attendance and medicines through the widespread dispensary system, which has no parallel in either England or Scotland. The result, as has been stated, was that, through the influence of Mr. Redmond and his party, Ireland was ultimately left out of the scheme so far as regards medical benefits.

From what has been said above, it is quite plain that so early as June, 1911, Mr. Lloyd George had been made fully aware of the objections of the medical profession to the provisions of his Bill which affected them. If he had been sincerely desirous to secure to those whom he was about forcing to insure against sickness proper treatment under the Act, he would have seen that it was necessary to change his plan. He had proceeded on the assumption that what was good enough for club patients in the olden days was good enough for the 15,000,000 of insured persons to whom he had promised to bring such refreshing fruit to their thirsty lips. He had forgotten, or perhaps had never known, that such changes had taken place in medical education and medical practice, as made the proper treatment of the insured under the conditions laid down in his Bill practically impossible. He had, it is true, never promised them proper treatment, except perhaps in his tabernacle speeches; and he had, no doubt unintentionally, done what was calculated to ensure the worst sort of treatment. The problem, on this side of it, seems never to have been considered, or at all events understood, by Mr. Lloyd George, and was never discussed in Parliament. His promised benefits of 9d. for 4d. were and are to be realized, if at all, at the expense of the medical profession and of the voluntary medical institutions. He took the assistance of both for granted in the same measure in which it has hitherto been forthcoming, and forgot the vast disturbance of existing relations caused by the increased scale of operations and by other demands. The treatment he contemplated in the Act is the treatment in vogue in the sixpenny dispensaries, where the ceremony of putting out the tongue is followed by the acquisition of "summut good in a bottle." This is the conception of doctoring cherished by the club and the Friendly Society, and handed on by them to Mr. Lloyd George. If he knows that the modern art of medicine works on different lines, he evidently thinks that the old style is good enough for his insurers. It is only by continuing it, he feels, that the promise of 9d. for 4d. can be even apparently realized.

If the medical profession in Great Britain and Ireland had quietly accepted the position offered to them by the Bill, of club doctors to a third part of the nation, they would have for ever disgraced themselves, while by their determined opposition to it they have at least shown themselves worthy of a nobler fate.

The curious mixture of so-called insurance and careless charity out of which the Bill seems to have been compounded was well shown during its passage through Committee in the House of Commons. On no account would Mr. Lloyd George consent, though repeatedly urged to do so by the Labour Members, to allow sick pay to commence from the first day of illness, as is usual in most Friendly Societies. No, it might only be a slight cold or a sneeze, he said, perhaps a slight attack of influenza, and were they to add millions to the expenditure for the sake of such slight cases! Let the insured person wait until the fourth day showed whether his or her illness was going to be serious or not, and then sick pay would commence, not from the first but from the fourth day. In the meantime medical benefits, of course, are not to be thus restricted: the doctor would naturally be called in, and medicines supplied from the first day; but if he chanced to order nourishing food or anything requiring immediate expenditure, by which the attack of illness might possibly be cut short, that would also have to wait till the fourth day, when the insured lived, as so many of the labouring classes do, from hand to mouth; to say nothing of the cases where, the sufferer being also the breadwinner of the family, their supplies for half a week might be seriously curtailed. On the other hand, when the Committee came to consider the provisions as to an insured person who, being a member of an approved society, was in arrear to an amount of 13 weekly contributions in the year (on the average since his entry into insurance), and in consequence his rights and benefits under this part of the Act were to be suspended, an amendment was moved and accepted by Mr. Lloyd George, to exclude from the reduced benefits the medical, sanatorium, and maternity benefits, on the ground that while the State was providing such huge sums for the treatment of disease, it was false economy to half cure people, or allow women to be untreated at the time of their maternity. While this arrangement, if looked at merely from a charitable point of view, is of course admirable, it must not be forgotten that it is one which no insurance company could possibly undertake, and one which no provident dispensary, so far as the writer is aware, has ever attempted. It may be charity, but it is not really insurance against sickness.

The two points which have been mentioned, taken together, seem to throw a useful sidelight on Mr. Lloyd George's

comparative estimate of the respective values of sick pay and medical attendance and medicines. Not even the lowest rate of sick pay, 5s. a week, can be continued to insurers in arrears for more than three months; but medical attendance and medicines, being much less valuable, may quite well be continued to those in arrear for fully six months. In a similar spirit of charity it is provided that while the right to sickness pay and disablement pay ceases at seventy years of age, the right to medical attendance and medicines shall continue throughout life.

THE PROVISION OF SANATORIUMS FOR CONSUMPTION.

As Shakespeare has reminded us:—

> "There is some soul of goodness in things evil,
> Would men observingly distil it out";

and it seems to be generally agreed that the proposal in the National Insurance Act to provide a large capital sum for the building and maintenance of sanatoriums for consumption is a wise and good one. The then leader of the Opposition in the House of Commons, Mr. Balfour, rightly sounded a warning note, indeed, as to the powers and limitations of sanatorium treatment. He pointed out that at the best it is but a half measure, and that any real advance towards the suppression of consumption can only be looked for as a result of further scientific research; and he urged that it is only by giving expert medical authorities the power of carrying on investigations that an advance towards extinction can be hoped for. While this is doubtless true, and quite in accordance with the present views held by those in the profession best qualified to judge, it should not be forgotten that a recently published report of the Charity Organization Society shows that 53 per cent. of patients who had been treated in sanatoriums were found to be fit for work for a long time afterwards.

The Chancellor of the Exchequer, in his reply to Mr. Balfour, made it clear that he and his advisers were alive to the force of arguments in favour of research, and pointed out that provision was made for its endowment, though only as a secondary object. Of this we shall have more to say by-and-by.

In the Chancellor's opinion the erection of sanatoriums for the treatment of many thousands of consumptives by skilled

observers may lead to the discovery of the long-sought cure. Against this it might be urged that skilled observations of this kind have been persistently made in all civilized countries during the last half century, and that it is not at the bedside that the chief advance has been made. The work of Koch and his followers, which has added so greatly to our knowledge of the disease and of its treatment, was done in the laboratory, and not in the wards; and it is to laboratory research, properly endowed and directed, that we must look for further enlightenment. Sanatoriums and chest hospitals apply the knowledge provided by the schools of research, but they can do little more. Scientific research and experimentation on animals susceptible to the infection have taught us that the natural forces in the human body can overcome the growth of certain microscopic organisms, such as the tubercle bacillus, if those natural forces are maintained in their fullest working order; but in order to maintain this high standard of health, the patient who has become the host of the tubercle bacillus must live an ideally hygienic life, and this, in most cases, he can only do if he gives up his whole time to it. By entering a sanatorium he places himself under scientific direction, and leads the kind of life that may be prescribed for him. Sanatorium treatment implies compulsory hygiene. The patient is forced to do the things that he ought to do, and to leave undone the things that he ought not to do. If his natural powers of recovery are then unequal to the contest with his microscopic enemy, the sanatorium treatment can do no more for him. The disease progresses, more slowly, perhaps, but still progresses. Hence the necessity, so often urged and so seldom acted upon, of adopting the treatment at the earliest possible moment.

THE ESTABLISHMENT OF TUBERCULOSIS DISPENSARIES.

From papers read at the British Medical Association meeting in Birmingham last year, it is evident that those who have studied the question practically regard the establishment of dispensaries for the treatment of tuberculosis as quite as necessary as, or even more necessary than, that of sanatoriums. Dr. Philip, of Edinburgh, who has had very great experience in the matter, maintains that the great purpose of these dispensaries is that there should be no case of the disease, even in its earliest stages, undetected or uncared for. He thinks it is best, in the interests

of the anti-tuberculous campaign, that the dispensary should be constituted a separate institution. To link it with existing general hospitals is likely, in his opinion, to lead to failure and disappointment. He desires the disease to be taken as a special study, worthy of the closest thought and highest effort. Sanatoriums, it was urged in other papers read at the meeting, could only deal with about ten per cent. of the sufferers, and there was no real antagonism between sanatorium treatment and that at tuberculosis dispensaries. Sir William Thompson, Registrar-General for Ireland, mentioned that since 1907 the death-rate from tuberculosis in Ireland had fallen from 2·7 to 2·3 per 1,000 in 1910. This meant 1,683 fewer deaths from consumption, or an average of 32 deaths less per week. The tuberculosis death-rate in Dublin had fallen from 4·6 to 3·7 in the same time. This had been brought about mainly by the work of the Women's National Health Association. A most important work of this Association was the aftercare of patients who had been in sanatoriums. The Association had found that patients soon lost what health they had gained at a sanatorium if allowed to go back to their wretched surroundings, and they were, therefore, encouraged and helped to carry out at home the treatment they had learned at the sanatorium.

This Association had been founded and was presided over by Her Excellency the Countess of Aberdeen, and the simple health principles propaganda issued by it included proper ventilation of dwellings, the necessity for personal and home cleanliness, the selection and cooking of nourishing food, and the instruction of mothers and children in the principles of good health.

Through its country branches the Association also provided and maintained a number of trained nurses working under medical supervision, provided meals for school children, and saw to the home care of consumptive patients—all of which undertakings the Registrar-General states in his annual report have had their share in bringing about the above-mentioned reduction in the mortality.

THE PROPOSED EXPENDITURE ON SANATORIUMS.

When objections were raised in the House of Commons to spending so much public money on building and maintaining sanatoriums (£1,500,000 and £1,000,000), it had to be explained that one-fourth of the sick pay granted by some of the Friendly

Societies was in respect of those members disabled by tuberculosis, and that in order to protect the National Insurance Fund it was necessary to undertake the prevention and treatment of a disease which had in the past been a greater charge upon the funds than any other. It had cost the Friendly Societies more than a million a year. Could there be any better arguments, it was asked, to justify the treatment of phthisis, both in regard to careful research, and in making the fullest use of the knowledge which had been already acquired? Another reason why it was very necessary to include this disease in the insurance scheme was the cost it at present brought upon the poor law. One and a half millions of the annual expenditure under the poor law is found to be due to tuberculosis.

Of course care must be taken to confine the expenditure upon bricks and mortar within reasonable limits; but it should be remembered that at the present time there are only 2,000 beds available in Sanatoriums for the whole community, and only 1,500 of these are available for people with small means. When it is realized that there are from 250,000 to 300,000 persons in this country suffering from tuberculosis, it becomes at once evident that 1,500 beds would not go far towards treating them in sanatoriums.

There are, as is well known in the profession, two classes of consumptive cases which might be usefully treated in a sanatorium. One class is that of early cases, of whom a large percentage may expect to have the progress of the disease arrested, and the duration of their lives distinctly prolonged. (At present the average duration of life of tubercular patients may be taken at about five years.) The other class is that of advanced cases who cannot be cured, but for whom much may be done in the way of relief, and much more by educating them how to avoid spreading the disease, after their return home, among their relatives and acquaintances. In regard to those who have left the sanatorium, it is very necessary that they should be followed up afterwards, and it will probably be found desirable for this purpose to establish public dispensaries where such returned patients can be seen and examined from time to time, as has been done to some extent in Ireland and also in Edinburgh. It has been estimated that 128 such dispensaries could be provided in England and Wales for £100,000—a very moderate sum for such a necessary provision for following up cases that have been treated in sanatoriums; but, needless to say, there is no such provision made in the National Insurance Act. It has also been estimated that 60,000 deaths from tuberculosis in one form or another occur every year; and if one-half this number, or 30,000, beds were to be provided to treat patients

for four or five months, of course a much larger sum would be required than that proposed in the National Insurance Act. In short, if we are going to wage war against tuberculosis in earnest, we are only, as the Chancellor of the Exchequer will find, just at the beginning of the battle.

THE POSITION OF VOLUNTARY HOSPITALS UNDER THE ACT.

One of the clauses of the Act provides that no payment shall be made in respect of sickness, disablement, or maternity benefit to any insured person during any period when he is an inmate of any workhouse, hospital, asylum, or infirmary, supported by any public authority or funds, or in a sanatorium. On this clause it was asked in Committee of the House of Commons what the position of the voluntary hospitals would be when the Act came into force. It was pointed out that our voluntary hospital system was an old-established one of slow growth, and largely founded by private effort. It seemed clear that institutions which had been largely dependent on the voluntary subscriptions of workers and employers could not expect to receive equal sums in future, when the State taxed both the worker and employer in order to provide that which hitherto the worker had to provide for himself, or receive from voluntary hospitals. Hospitals would, therefore, be very largely affected by the Act. The Hospital Saturday collections would fall off, for it was not reasonable to suppose that when compelled to contribute 4d. a week out of his wages, the workman would voluntarily add another 1d. a week for the Hospital Saturday Fund, as he had been in the habit of doing.

In view of such expected falling off of workingmen's collections, and of dwindling subscriptions from employers, it was asked that when an insured person became an inmate of one of these voluntary hospitals, if he had no dependents the whole of the money due to him as sick pay should go towards his maintenance in the hospital, and that if he had dependents the sick pay should be divided between the dependents and the hospital. Objection, however, was raised to diverting sick pay from the dependents of the insured to the hospital funds, and as Mr. Lloyd George expressed the opinion that the hospital authorities had taken needless alarm, and that these institutions would be better off under the Act than they were hitherto, nothing was done to make provision for repaying the hospitals

the costs to which they will certainly be put in the treatment as in-patients of insurers under the Act when it comes into force. Mr. Lloyd George seeks to soothe the hospital managers by telling them they will have to spend less on the treatment of tuberculosis in all its forms, and also that there will be a considerable diminution in the number of their out-patients; but as the relative average cost of out-patients and in-patients is stated to be 2s. 2d. as compared with £5 10s., the promised relief seems somewhat illusory; while, as to tuberculosis, hospital authorities, at all events, seem quite sceptical as to the proposed sanatoriums relieving the pressure on their wards to any appreciable extent.

As a matter of fact, with regard to the falling off of subscriptions, in the beginning of 1912 shoals of letters were received from former subscribers by some of the London hospitals, stating that in consequence of the Insurance Act they would be unable to continue to subscribe.

Had Mr. Lloyd George pursued his researches as to the Insurance system in Germany, upon which he has based his own scheme, he would have found that though at the first it was neglected to provide for hospital treatment, in 1892 an Act was passed enabling the authorized insurance societies to contribute liberally towards the treatment of insured persons in German hospitals. In 1893, when the principle of such payments for patients was generally adopted, the societies paid in contributions to hospitals a sum of 11,568,966 marks. In 1904 the sum had risen to 27,494,358 marks: in the same year they contributed to the funds of general hospitals 13 marks out of every 100 paid out as "expenses of treatment." An interesting summary of results is published in *La Revue Philanthropique*, which shows that the average payment per insured person (taken from the German and Austrian statistics) treated in hospital amounts to nearly £10—a figure which works out at approximately 4s. 6d. a day. In 1893 the Prussian societies alone contributed six million marks to hospitals; ten years later they were paying a yearly average of nearly triple that sum. This result has only been attained by enforcing the rule that no insured person can be treated free of cost in any hospital. The contributions made by the Insurance Societies are not voluntary gifts to the revenues of the institutions, but debts which can be recovered by law. When an insured person applies for hospital treatment, he can only be admitted on the order of his society doctor, and this certificate is a sufficient guarantee that the institution will be indemnified for the legitimate cost of his treatment. What constitutes legitimate treatment is a matter that must, if necessary, be

settled by the Law Courts; but the Insurance Societies have usually been very liberal in their interpretation of the term, and it has been held that dental treatment, for example, must be paid for by the societies.

It might perhaps have been feared that the payment of such large contributions to hospitals would have warranted the German Insurance Societies to claim a controlling voice in the administration and management of those hospitals, but it does not appear that any such claim has ever been made: and here we have at once a reply to Mr. Lloyd George's objection to accede to the General Medical Council's request, quoted above, that proper provision should be made for payments to hospitals in respect of insured persons treated in them, on the ground that he would have hesitated to propose that public inspection and control should be extended to the voluntary hospitals receiving moneys from the Insurance Fund. On the other hand, the contention of the hospital authorities that their subscription lists must necessarily suffer by the action of the Insurance Act has already been proved to be well founded, as we have seen, by the receipt of numerous letters at the beginning of 1912 declining for the future to continue to subscribe in consequence of being obliged to contribute under the Act.

The only effective safeguard, therefore, against a permanent loss to hospitals would be found in such a modification of Clause 16 of the Act (relating to sanatorium treatment) as would assure to hospitals a *pro rata* payment in return for work done by them for insured persons, as is now provided in the case of sanatoriums to be provided under the Act. A necessary corollary to this arrangement would be a reform of the out-patient department, and the adequate payment of the hospital medical staff, which practically means a reversal of the methods hitherto pursued by hospital authorities in this country.

Indirectly the German hospitals have benefited by the Insurance legislation, inasmuch as the Insurance Acts have popularized hospital treatment—a fact which has had the greatest influence on the improved national health in that country. In order to realize the progress that has been made in this direction since the introduction of National Insurance, we have only to glance at the position of hospitals in Italy, Dalmatia, Lower Austria, and Roumania at the present time. In those places, as in Germany formerly, the hospital is still shunned by the sick patient; it is regarded as a *dernier ressort*, when the choice is a Hobson's one, between death and degradation. With us too, in this country, there still exists, in many parts of London and the provinces, a disinclination

among the poor to seek admission as in-patients: we have not yet totally thrown overboard the notion that a hospital is a pauper asylum, or an undertaker's ante-chamber. In Germany, however, the notion has been effectually killed by the Insurance Acts, which have made it possible for an insurance patient to enter a paying ward with the feeling that he is trenching on no one's charity, but that he is drawing upon the sick-pay which his thrift and foresight have guaranteed him. It is thus scarcely possible to over-estimate the salutary effect of the Acts upon the German hospital system, as a factor in the improvement in the national health. Hospital treatment, to be effective, must be early treatment in the majority of cases, and such early treatment can only be obtained if the patients come at the beginning of their illness. No one can deny that the progress in medical and surgical science which has marked the last half-century in Germany has been largely due to the Insurance Acts, which have enabled the hospitals to obtain the best men, the best means, and the best methods of investigating and treating disease. The immense development of hospital work in Germany during the same period has no doubt been due to the progress of medical and surgical science, but it is at least doubtful whether such development and progress would have been possible without the sinews of war which have been provided through the working of the Insurance Acts. This is one of the many points upon which Mr. Lloyd George's Act will require to be improved by an Amending Act.

THE EXPECTED EFFECT OF THE ACT ON THE DUBLIN HOSPITALS.

The Board of Superintendence of the Dublin Hospitals issued in 1911 their Annual Report dealing with those hospitals which are in receipt of Government Grants. There are nine of these in Dublin: three general hospitals, Dr. Steevens's, the Meath, and the House of Industry; two lying-in hospitals, the Rotunda and the Coombe; and four other special hospitals, the Westmoreland Lock, the Cork Street Fever, the Royal Victoria Eye and Ear, and the Royal Hospital for Incurables. Two of these, the Westmoreland Lock and the House of Industry, are practically maintained by Government. They receive grants, respectively, of £2,600 and £7,600 a year. The grants to the other institutions have been made at various times, and apparently without much system. Dr. Steevens's

Hospital, which keeps wards for soldiers' wives and for the constabulary, gets £1,300 a year. The Royal Victoria Eye and Ear receives £100. The Board of Superintendence expresses the opinion that the hospitals named fulfil their objects in an economical and thorough way. In discussing the probable effect of the Insurance Act on the voluntary hospitals, the Board points out that hitherto the public looked on the labouring man disabled for work as a fit object for charity. They have subscribed and left legacies to hospitals because it was known that through the wards of hospitals, and the special dispensaries attached to them, lay the smoothest, shortest, and most economical road to recovery. It is unlikely, they think, should the State arrange for the care of the working classes when incapacitated by sickness, that the charitably inclined will continue to subscribe to the same extent.

Now there is no doubt, they add, that for the maintenance of hospitals the system of voluntary aid, supplemented by help from the State, yields the best and most economical results. By it the services of men of the highest standing are put within easy reach of the poor, both in the hospital wards and in dispensaries. They think this system is in danger, and that if it be once allowed to collapse, it may not be possible to reconstitute it. This would be a serious thing, they hold, for the poor, a serious thing for the progress of medical science, a serious thing for the tax-payers, and for the training of those designed for the medical profession.

The practice of medicine, they point out, is advancing by specialization. Each class of disease has its department in a hospital. It is not too much to say that a club doctor (under the Insurance scheme) will have, when he is responsible for the health of a large number of work-people, in a great majority of cases to call on the hospitals and dispensaries for help. On what terms, they ask, will this be given? If the voluntary aid system is abolished, it must mean a suitable remuneration for all medical services rendered. The Board maintains that such a system would not work as well or as economically as the present one does.

PROVISIONS OF THE INSURANCE ACT AFFECTING PUBLIC HEALTH.

1. As to the sanatorium provision.

The money to be spent on building sanatoriums has in reality no direct connexion with the insurance scheme at all. The section dealing with it says that if such funds are provided by

Parliament they shall be distributed by the Local Government Board with the consent of the Treasury, and the Treasury before giving their consent shall consult with the Insurance Commissioners. If any such grant is made to a County Council, the Local Government Board may authorize the County Council to provide such an institution and to erect buildings and manage and maintain the institution, and for the purpose of facilitating co-operation amongst county councils, borough councils, and other local authorities (not poor law), the Local Government Board is authorized to form joint boards or Committees for the purpose.

The Local Insurance Committees will apparently have nothing to do with the management of these institutions, but they may, with the consent of the Insurance Commissioners, enter into agreements with any person or authority (not poor law) to contribute out of the funds available for sanatorium benefit, towards the maintenance of the institution or provision of treatment, such annual or other amount as may be agreed on between them. Not every building that is dignified with the name of sanatorium is fit for the treatment of consumptives; and even if the building is all right, the treatment of the patients by expert doctors is quite as important as the site and construction of the building. It is to be hoped that a more liberal estimate of the value of the doctor's services will prevail than that of 6s. a year per head.

The experience in Germany has shown the necessity of giving the insurance authorities power to compel insurers to submit to sanatorium treatment; but Mr. Lloyd George's Act gives no such power.

In a circular letter issued by the Imperial (German) Insurance Office on April 17th, 1909, it is stated that tuberculous patients are frequently disinclined to seek admission to a sanatorium, and that the patients who are admitted very frequently leave the institution after a very short sojourn, frightened either by the symptoms of their fellow-patients, or by the cases of death occurring amongst them. In Germany also, the institutions by which the insurance against invalidity is administered, though continuing to supply the sanatorium treatment, have begun to think of other methods to be used in the struggle against consumption. They have commenced to support the voluntary dispensaries which provide for the prevention of phthisis, or which assist the treatment in the early stages of the disease, and may supply the medical examination of the relatives of patients.

PROPOSALS AS TO CONVALESCENT HOMES.

The building or leasing of premises suitable for convalescent homes, and the maintenance of such houses, is mentioned in Schedule IV as one of the additional benefits to which members of approved societies who have come under a scheme providing for additional benefits may become entitled. A right to such additional benefits may arise in any case in which a Friendly Society applies its accumulated funds in a manner sanctioned by the Insurance Commissioners, or in the case of any actuarial surplus being found to exist on the triennial valuation of the assets and liabilities of any approved society. As there are numerous other "additional benefits" which may be provided by any such scheme, and most of them are of more direct and immediate benefit to the individual members, it seems highly improbable that the power to use funds for the object in question will ever be exercised; if it were to be exercised, there would be a little more scope for originality and variety than in the case of sanatoriums, were it not for the necessity to obtain the Commissioners' approval, which in all probability would be made dependent on the observation of a cut and dry set of rules. In this connexion it may be remarked that the Act does not confer any right to convalescent treatment, or any power to apply funds for such treatment, except in the case of an insured person who has no one dependent on him or her. The German Sickness Insurance Law, on the contrary, enables any of the autonomous sick fund societies to pass rules entitling any insured person to be received in a convalescent home for any period not exceeding a year after the termination of his illness.

PROPOSALS AS TO THE SUPPORT OF HOSPITALS AND DISTRICT NURSES.

An approved society may, under the provisions of the Act, become entitled to certain windfalls which include—(1) the contributions paid by the employers for persons remaining uninsured on the ground of irregularity of employment or of their becoming employed after attaining the age of 65; (2) the contributions forfeited on the ground of non-payment of arrears. Out of the funds so provided an approved society or Insurance Committee may grant subscriptions or donations to hospitals or other charitable institutions, or for the support of district nurses, and also appoint nurses for the purpose of visiting and nursing insured persons. Here, again, we have provisions which may

be usefully applied, but the prospect of this being done seems rather remote, as the accrual of funds in the manner described depends greatly on accidental circumstances, and as besides, it is very doubtful to what extent the approved societies and Insurance Committees would make use of the powers thus given them. When the Act comes into force, the public will naturally imagine that proper provision for the treatment of sickness among the working classes has been taken over by the State, and this will undoubtedly have a tendency to dry up the flow of charitable funds for that purpose from private sources.

One other very important point on which Mr. Lloyd George's insurance scheme differs from the German system is the following :—The German hospitals receive a great deal of support in consequence of the rules which enable the Insurance Societies there to compel a member in certain specified cases to substitute hospital treatment for medical benefits and sick pay, and which enable the invalidity societies to apply hospital treatment to cases which are likely to come under their charge ; the expenditure for these purposes during the year 1909 amounted as regards the insurance sick funds to over £2,000,000, and as regards the invalidity insurance to over £1,000,000. As there is no corresponding provision in the British Act, we are forced to the conclusion that either the provision of hospital treatment for the insured is not a matter of much concern to the author of the Act, or that the scheme as a whole has not been well thought out.

THE PROVISION FOR A RESEARCH FUND.

Under Section 16 of the Act, insurance committees are to receive out of moneys provided by Parliament the sum of one penny in respect of each insured person resident in the area in such Committee's charge, for the purposes of being applied towards the administration of sanatorium benefits, but the Insurance Commissioners may retain the whole or any part of this penny for the purposes of research. Here, as in other cases, a most undesirable uncertainty is created. The Commissioners will either have to curtail the amount applicable for sanatorium benefit, the sufficiency of which is in any case uncertain, or their power to use part or whole of the Treasury grant for purposes of research will be entirely nugatory. Assuming that they exercise this power, the vagueness of the expression " purposes of research " will probably cause them to be inundated with proposals for the testing of innumerable theories or inventions.

THE INSURANCE COMMITTEES' POWERS OF INVESTIGATION, &c.

The Insurance Committees, in addition to their duties as regards the administration of medical benefits in respect of insured persons, and of all benefits in respect of deposit contributors, have a number of general duties partly in competition with the existing local authorities. One of these duties consists in a general consideration of the needs of their respective areas with regard to all questions of public health. As in the case of the above-mentioned "purposes of research," the indefinite nature of this expression allows the imagination to wander over a wide field, but before speculating on the questions which may be suggested as fit subjects of investigation, we may consider the more practical problem as to the method of raising the funds which would be necessary if any such inquiry is to be efficient; for without the assistance of medical experts an aimless wandering over the field of public hygiene will be useless, and it is hardly likely that trained experts will be found who will supply their knowledge without proper remuneration. The only funds available for the general purposes of the Insurance Committees are those derived from the sick-pay of inmates of hospitals and sanatoriums who have no dependents, and on behalf of whom no payment is made to the institution of which they are inmates, but these will probably not go very far. The Medical Officer of Health for the particular area may, if he feels so disposed and if he is requested to do so, attend the meetings of the Insurance Committees and give his advice; but he will, as a general rule, not be able to spare much time for this purpose, and his unaided advice will, in many cases, be hardly sufficient.

The Insurance Committees are also authorized to make provision for the giving of lectures and the publication of information on questions relating to health, and for that purpose to make arrangements with Universities, educational authorities, and other institutions; but here again comes the question, how are the funds to be provided? and another question also arises—Will the Insurance Committees, composed largely of working-class insurers, be so constituted as to make them proper agencies for the collection and distribution of scientific knowledge? Three-fifths of each of these committees are to consist of representatives of the approved societies; one-fifth are to be appointed by the council of the county or county borough; three or four are to be medical practitioners; and the remaining members are to be appointed by the Insurance Commissioners.

The elected members, many of them persons of inferior education, will therefore form the majority, and, as authorities on the subject of hygiene, can hardly be expected to command the confidence of either the medical profession or of the public generally.

THE PROVISIONS RELATING TO INSURED INDIVIDUALS.

It may be said at once that if by any general scheme of compulsory insurance a state of things could be brought about under which efficient medical treatment could be assured to all cases where those belonging to the poorer classes are in want of such treatment, the medical profession would certainly be inclined to overlook many disadvantages attaching to other parts of such a scheme, for the sake of the important benefits which would be conferred upon the race. The question, indeed, whether or not the masses of the population are likely to receive efficient medical treatment under the Insurance Act, does not concern the profession alone, but concerns everyone who values the progress and well-being of his country. But efficient medical treatment cannot be secured unless a position be given to medical men making it reasonably certain that long years and large sums of money spent for the purpose of acquiring knowledge and experience, and obtaining the use of a skilled eye and a skilled hand, will not have been spent in vain, and that the *res angusta domi* will not unduly hamper the mental freedom, that the individual practitioner will not be so overtaxed by the number of cases coming under his care that he has to do scamped work, and retains neither time nor energy for following the progress of medical science. Efficient medical treatment is not secured if the man who trims his sails to the wind—the man who wins his post by sacrificing his intellectual independence—the man who regulates his conduct by the requirements of those who have a voice in his selection—if, in short, the man of inferior moral character—has a better chance of employment than one who follows his course without fear or favour.

The experience in Germany is stated to have shown that any scheme under which the selection of doctors depends on popularly elected bodies is likely to favour the inferior man, but we will hope better of our new Insurance Committees until the contrary is proved ; and the formation of a panel of doctors in each district, from which the insured person can make his choice, seems to provide against the danger alluded to above.

Lastly, in considering the probable effects of the Act upon the public health, it must not be forgotten that large classes of

the population will be left without any medical benefit under it, more particularly children, married women not in regular employment, all deposit contributors who have exhausted their deposits, all workers who work on their own account, or for occasional employers, and are unable or unwilling to become voluntary insurers, all insured persons who through unemployment or other causes have been unable to keep up their contributions during 26 weeks in each year of insurance, and all persons who have no regular employment and cannot be admitted to an approved society. Some of these excluded persons live under the worst conditions, and the fact that their medical treatment is not secured under the Act would alone seriously interfere with the effect that may be expected to be produced if efficient medical treatment be provided for the insured under the Act. It is, however, well known that the Act is not designed to supply the place of an efficient Poor Law Medical Service; and, indeed, one of the great mistakes in framing the Act appears to the writer to be the placing of the arrangements for building sanatoriums under the tutelary care of the Local Government Board. That Board has not been shown by the Report of the Royal Commission to have been so successful in its own work, or so free from red-tape blundering in the past, as to make it desirable to entrust a most important portion of the new Health Insurance to its charge, and the better class among the insurers will probably endeavour carefully to avoid any buildings that have the least taint of the Poor Law upon them.

On the whole, then, the impression left upon the mind after a study of the provisions of the Insurance Act, which was designed to bring about a general improvement in the health of the community, is that the funds provided are too inadequate, and the chances of even those inadequate funds being available in many districts too uncertain, to enable us to build any great hopes of improvement in the national health on the scheme proposed in the Insurance Act. Even as regards the treatment to be provided in sanatoriums, this uncertainty exists; for when the sums coming out of the Insurance Fund—1s. 3d. for each insured person in the particular area, and the Treasury grant of one penny for each such person, less such amount as may be retained for purposes of research—are exhausted in any year, no further sanatorium benefit can be provided. Moreover, the patients suffering from tuberculosis belong to different classes, both socially and as to the stage of the disease from which they are suffering. Supposing there is a limited supply of funds, as seems not unlikely, is it not highly probable that the advanced cases will be sent to sanatoriums, and the early cases, which might derive the most benefit from the treatment, be

obliged to wait until their cases have become more pronounced and less hopeful for treatment? It is no doubt true that provision is made for a few medical men to be on the Insurance Committee, and that they may also possibly be aided by the presence of the county or borough medical officer of health, but the voting power will be with the laity; and even with the best intentions in the world, it will be found quite impossible to carry out many of the objects aimed at in the Act without sufficient funds. The best that can be hoped for is that the Insurance Committees may serve a valuable educational purpose, leading their members and the educated public generally to see how much remains to be done before the health conditions of this country can be considered satisfactory, and so preparing the way for a large amendment of the present Insurance Act.

THE BRITISH MEDICAL ASSOCIATION AND THE INSURANCE BILL.

As we have already seen, the Association had early in June, 1911, formulated and published its six famous points as the minimum required by the profession in order to render the Insurance scheme acceptable. It had also stated that it was the opinion of the Association that Government should be urged to postpone dealing with the medical benefits under the Bill until a satisfactory arrangement should have been arrived at with the medical profession. Those medical practitioners who were not already members of the Association were urged to join, and also to contribute to the fund which was being raised to carry on the campaign. Hundreds of doctors did so, deeming themselves quite safe in the hands of a powerful society which was fortunate in having at the time a medical secretary who was well acquainted both with the points of the Insurance Bill and with the evils of club and contract practice, which were threatened to be perpetuated by it. Meetings were held all over the kingdom, at many of which the Medical Secretary spoke, and after showing how the Bill, in some of its provisions, would seriously affect the practice of many general practitioners, exhorted those whom he addressed to stand firm, and assured them that if they did so victory was assured to them. This went on until the end of November, 1911, when the Bill was nearly through Committee in the House of Commons, when early in December both the Association and the profession generally learned with amazement that the Medical Secretary had, with the approval of the Council of the

Association, accepted the post of Deputy Chairman of the Insurance Commissioners at a salary of £1,500 a year. A paper-war followed both in *The Times* and the medical journals, in which accusations of shameful and shameless betrayal were freely made. A mass meeting of the profession was held at Manchester, at which it was resolved to form a new National Medical Union, not in antagonism to the British Medical Association, but in order to stir up its Council, and to take action against the Insurance Act; and this was followed by large medical meetings in London, at which the action of the Council of the Association in approving the Medical Secretary's taking of office was denounced; and it was resolved that a Reform Committee be organized within the Association itself, with the twofold object of turning out the existing Council and organizing a resistance to the Insurance Act, as it had now become. The Council, in its defence, tried to throw the blame upon the representative body, from whom it alleged it had received its instructions, and also tried to show that some amendments had been made in the Bill while passing through Parliament, in the direction of the desired six points; but a summary of these changes, as given by the Solicitor to the Association in the *Journal* of January 12th, shows that on the most material points no real advantage has been gained. The Solicitor takes the six points in order as follows:—

(1) An income limit of £2 a week for those entitled to medical benefits.

No income limit, he says, is in terms fixed in the Bill (Act), except in so far as concerns Voluntary Contributors and non-manual workers, in which case a limit basis of £160 is fixed. Under Clause 15, however, it is provided that the Insurance Commissioners shall authorize the Insurance Committees to fix an income limit.

(2) Free choice of doctor by patient, subject to consent of doctor to act.

Clause 15 affords free choice of doctor to the fullest extent.

(3) Medical and maternity benefits to be administered by Insurance Committees, and not by Friendly Societies.

The provision in regard to this is contained in Clause 14 of the Act, which requires that medical benefits shall in all cases be administered by and through the Insurance Committees. It is, however, open to be contended, he adds, that the generality of this provision is controlled by Clause 15, with corresponding advantage in the direction of existing officers of approved societies. It is to be noted, however, Mr. Hempson adds, that it is not compulsory on any Insurance Committee to approve the system of medical attendance and treatment then in use;

and if it be not so approved, the Insurance Commissioners have no power to compel the Insurance Committees to make the regulations required by Clause 15.

Nos. 4 and 5 of the six cardinal points, dealing with the method and amount of remuneration, Mr. Hempson finds it convenient to deal with under one head ; and this is what he says about them :—

Under Clause 61 the Insurance Committee is required to consult with the local Medical Committee on (amongst other things) "the arrangements made with medical practitioners giving attendance and treatment to insured persons," which would include method and amount of remuneration.

In his opinion, he adds, the strength of the position in so far as the medical profession is concerned lies in this—namely, that they cannot be compelled to accept any bargain as to method or amount of remuneration which is in their view unreasonable. In this respect the Act places them under no compulsion, and they would not by uniting themselves on this head be exposed to an action for conspiracy.

(6) Adequate medical representation among the Insurance Commissioners, in the Central Advisory Committee, and the local Insurance Committees, and statutory recognition of a local Medical Committee representative of the profession in the district of each Insurance Committee.

By Clause 56, the Solicitor says, it is provided that there shall be at least one medical practitioner among the English Insurance Commissioners, and similar provisions are made so far as concerns Scotland, Ireland, and Wales in other clauses.

It is also provided for the appointment of medical practitioners on the Advisory Committee.

Concerning the local Insurance Committees, if such Committee consists of forty persons, which is the minimum number, it would have four medical members ; if the Committee consists of sixty persons, there would be five medical members, and if the Committee consists of eighty persons, which is the maximum, there would be six.

It should be remembered that the above legal opinion was obtained from the Solicitor to the Association expressly with the view of showing how far the six cardinal points of the Association's (or rather the Council of the Association's) policy were obtainable under the Act. If anyone outside the Council was satisfied with the results shown above of the six months' negotiations which had been carried on between the Council through its Medical Secretary and the Chancellor of the Exchequer, he must have been as easily pleased as the Council itself, and that is saying a good deal. The profession as a whole,

however, being thoroughly dissatisfied with the action recently taken on their behalf by the authorities of the British Medical Association, determined to actively oppose and watch the development of the Act on its own account; not only were the two above-mentioned bodies formed, but the Colleges of Physicians and Surgeons in England and Scotland formed Committees with reference to the subject.

At the Royal College of Surgeons of England, a resolution had been passed at the annual meeting of Fellows and Members in November, expressing the hope that no Fellow or Member of that College would take part in carrying out the Act until the demands of the profession had been complied with; and in January the Council of the College, following up that resolution, appointed a Committee to watch the interests of the Fellows and Members of the College under the Insurance Act, with power to confer with other Committees formed with similar objects; and about the same time the Royal Colleges of Physicians and Surgeons of Edinburgh, and the Faculty of Physicians and Surgeons of Glasgow, formed a Joint Committee for dealing with the matter, and to make representations to the Scotch Board of Commissioners appointed under the Act, as to the regulations to be made by them, on which so much depended as to the future action of the profession in Scotland.

THE ATTITUDE OF THE FRIENDLY SOCIETIES TOWARDS THE INSURANCE ACT.

Very naturally the Friendly Societies were not at all pleased at the transfer of medical administration from their societies to the Insurance Committees. At the annual meeting of one of the largest of these bodies in August, 1911, a resolution was carried, protesting against the action of the House of Commons in taking away the right of 3,370 branches of the Ancient Order of Foresters to continue their own arrangements for medical service, and several of the speakers strongly criticized Mr. Lloyd George. One of them, the Parliamentary Agent to the Order, went so far as to say that they had been sold by the Chancellor of the Exchequer.

The President of the National Conference of Friendly Societies, also—a body which is said to represent a membership of 6,000,000, with funds of £40,000,000—is quoted in the Press as saying that there was considerable dissatisfaction throughout the Kingdom in consequence of Dr. Addison's amendment being carried, "whereby a plan which had resulted in an amicable understanding between Friendly Societies and their medical

officers was taken away." The President of the National Conference must surely have been living in a fool's paradise if he really believed that the relations between the medical profession as a whole and the Friendly Societies have hitherto been cordial. Of course there have been cases where the Friendly Societies have treated their doctors properly, but these have been the exceptions, not the rule.

Over and over again the medical journals have borne witness to the distressing circumstances which have marked contract work done under the so-called Medical Aid Associations; and the profession has been quite unanimous in its desire to be free from the control of Friendly Societies and clubs for the future.

In January, 1912, a manifesto was issued by the President and Secretary of the National Association of Friendly Societies, in which, referring to medical benefits under the Insurance Act, it is said that if the demand of the doctors succeeds, the whole insurance scheme becomes insolvent. If the medical profession, it adds, should not be unanimous, it will obviously be the youngest and least experienced practitioners (if practice they have) who will accept the 4*s.* 6*d.* per annum—assuming drugs to cost 1*s.* 6*d.*—allowed in the Government actuaries' financial estimate.

The alternatives for the societies to consider are therefore—

(*a*) Whether they will support the doctors in their demand for adequate remuneration, and thereby procure the best medical service; or

(*b*) Whether they will submit to have imposed upon them a medical service inferior to that which they have obtained in the past by voluntary arrangements with their medical officers, but which has perforce been brought to an untimely end by this Act.

To assist the doctors to attain their end would probably be, they think, to delay bringing the scheme into actual operation, for it is unthinkable that the Government and the Commissioners would incur the odium of putting clause 15, sect. 2, paragraph 2, into operation by excluding medical benefit from the Act and handing back to the insured persons 6*s.* a head as an equivalent wherewith to pay doctors' bills, which would then have to be incurred by all—the former voluntary agencies for the purpose having been meanwhile killed. A "Health Insurance Act" it would then cease to be, whilst delay, so secured, could be utilized both by societies and insured persons to force the State to provide the necessary additional grant to ensure that the minimum benefits of the Act should have at least a chance of being secured by those who are compelled to insure to obtain them.

Opportunity should be taken, the manifesto advised, to impress upon members of all approved societies the dangers which they run through either the initial insolvency of the scheme or an inferior medical service.

In January of the present year (1912) the Insurance Commissioners proceeded to invite a conference between the various medical bodies and themselves as to the working of the Act, but were met with refusals—the General Medical Council, the Royal Colleges of Physicians and Surgeons, the Society of Apothecaries, the British Medical Association, and the Reform Committee of the latter body, as well as the Medical Defence Society, each in turn refusing to take part in the conference, while some of these bodies offered to assist in drawing up an Amendment Bill designed to render the National Insurance Act acceptable to the medical profession. Under these circumstances the Commission had no option but to postpone the proposed conference. About the same time *The Practitioner*, having obtained legal opinions from Sir Edward Clarke, K.C., Mr. W. O. Dauckwerts, K.C., and Mr. Stuart Bevan, Barrister-at-Law, as to whether under the Act the Insurance Commissioners or the Insurance Committees have power to make arrangements with medical practitioners embodying all or any, and if so which, of the "six cardinal points," and having been advised that, none of these had been absolutely secured, and moreover that, however much the profession may bargain and haggle—and this is the method provided under the present arrangements—the position of affairs was absolutely intolerable, because, practically speaking, the profession was left entirely in the hands of the approved societies. That members of a profession should be compelled to bargain at all for their requirements is, as *The Practitioner* rightly says, not only distasteful, but degrading in the extreme: that they should have to haggle for what there is not the slightest probability of their obtaining is preposterous. In sending out copies of the legal opinions above referred to, to every member of the profession in England and Scotland, 21,000 of whom had already signed the "No-service-whatever" pledge of *The Practitioner*, it is suggested that by adopting this policy, instead of the policy of "Drift," which had hitherto guided it, the Council of the British Medical Association could consolidate all sections of the profession.

Should the Council not do so, however, after the meeting of the representative body in February, further steps must be taken to secure the ultimate triumph of the "No-service-whatever" policy.

The well-considered refusal of the Royal College of Physicians of London to meet the National Health Insurance

Commissioners at the proposed conference was in the following terms :—

"The Royal College of Physicians is of opinion that the Insurance Act as it stands, or even after any modifications in it which the Act empowers the Commissioners to make, is not adapted to secure the benefits of insurance against loss of health, and the prevention and cure of sickness, which are its stated objects ; and further, that under this Act, or such modifications of it, it is not possible to obtain the co-operation of the medical profession without grave injury to their interests.

"The College, therefore, though in complete sympathy with the objects of the Act with reference to the health of the community, is not prepared to accept the invitation to the Conference on February 2nd, 1912, for the purpose, as therein stated, of selection of medical members of the Advisory Committee, and upon other matters of procedure in bringing the Act into operation.

"But should a suitable amending Act be proposed whereby the primary purposes of this Act can be efficiently secured, the College would be prepared to render every possible assistance, bearing in mind those objects which it has always kept in view, namely, the promotion of the public health, the progress of medical science, and the proper interests of the medical profession."

Mr. Lloyd George's rejoinder to the Colleges of Physicians and Surgeons was in the style which ever since his famous Limehouse speech we have been accustomed to expect from this latest example of his special class of politicians in office. In his speech on February 12th, 1912, after stating that he did not complain of the Council of the British Medical Association waiting until they had heard the opinion of their Representative Meeting on February 21st and 22nd, he went on :—

"But I do not think that quite applies to the Royal College of Surgeons and the Royal College of Physicians [*sic*], who sent back a curt, undignified, discourteous refusal to meet a Government department to discuss matters which affect the profession which they officially represent. What are these Colleges? These Colleges are formed under a charter—under an Act of Parliament; and when they refuse an invitation of a Government department to discuss matters they have been officially called into existence to represent, I say it was an example of rude ineptitude which is utterly without parallel, fortunately, in the history of the country. There is not a strike committee in the land which would have demeaned itself in that way. They said the Act was unworkable, the finance was inadequate ; there was no use in discussing it." That was the

very reason, Mr. Lloyd George declared, why they ought to have discussed it; and having declared that, in his opinion, their refusal showed that these societies—the Royal Colleges, that is—were absolutely unfit for the position which they assume, he wound up with the awful threat that for the future negotiations would be conducted with societies that really are prepared to discuss these solemn and important matters like business men, who are prepared to treat these Government departments without regard and respect to their political complexion.

Further on in his speech, discussing the question, What will happen if the profession follow the advice given them, and refuse to have anything to do with the Act—refuse to recognize Committees set up by the law of the land—what will happen then? Mr. Lloyd George's answer is: Nothing will happen, except this, all the safeguards inserted in the Act for the protection of the profession will be wiped out at once. It is assumed, he says, by those critics of the Act who have been stirring up the doctors to do foolish things that the moment they refuse to work the Act the Act is as dead as Queen Anne. The Act, he says, would be as alive as ever, but the safeguards for the protection of the profession would be dead.

We are quite content to leave our readers to judge between the sound common sense of the Royal College of Physicians' refusal and the rhodomontade of Mr. Lloyd George's speech, without troubling to quote the dignified reply of the two Royal Colleges published in *The Times*. Later in the month the special meeting of the representatives of the British Medical Association passed a resolution expressing its high appreciation of the action of the Royal Colleges in the defence of the interests of the public and of their members, and its strong condemnation of the expressions used by Mr. Lloyd George with respect to those Colleges.

At the same meeting of the representative body a resolution was also passed directing the Council of the Association to inform, in plain and unmistakable language, the Commissioners appointed under the Insurance Act that unless the minimum demands of the Association be embodied in the regulations to be issued by the Commissioners, in such a manner as shall be effectual and permanent, with the view to having the same embodied in an amending Act, it was the intention of the Association to call upon all its members, and upon all other practitioners, to decline to form panels, or undertake other duties under the Act, in conformity with the undertaking which had already been signed by over 26,000 medical practitioners.

The position of affairs, then, towards the end of February, stood thus—the Commissioners were challenged to frame

regulations which would effectually secure the terms laid down by the British Medical Association. If they were not able or willing to comply, the medical profession refused to work the Act. It had constantly been asserted by defenders of the Act that the doctors could get all they wanted under the regulations to be framed by the Commissioners. It remained to be seen whether this was true or the reverse.

By the end of March it had become clear that the Insurance Commissioners were either unable or unwilling to grant the demands of the British Medical Association. No reply, beyond an acknowledgment of their letter, had been sent, and questions put in the House of Commons showed that none was intended to be sent.

About the same time, a fully attended meeting of the representatives of the Medical Faculties of the English Universities, the Royal College of Physicians of London, the Royal College of Surgeons of England, and of the Society of Apothecaries of London, was held at the Royal College of Physicians, and the following resolution was unanimously passed :—

"That this Conference, in which are represented the Medical Faculties of the Universities of England and Wales, the Royal College of Physicians, London; the Royal College of Surgeons, England, and the Society of Apothecaries, recognizes that there is a remarkable unanimity of opinion within the Medical Profession as to the attitude which its members should adopt towards the working of the National Insurance Act of 1911.

"This Conference desires to place on record its general approval of the principles which inspire that attitude ; and while conscious that there is some difference of opinion with regard to details, expresses its willingness to support the demand that these principles should be recognized by those who are responsible for the administration of the Act, before medical practitioners consent to work under it."

THE POSITION OF IRISH PRACTITIONERS UNDER THE ACT.

About the same time there was published in the *British Medical Journal* the Report of the Conjoint Committee of the British Medical Association and the Irish Medical Association to the medical practitioners of Ireland.

The Committee regret that all their efforts by interviews and correspondence with the Chancellor of the Exchequer and the Irish Members of Parliament failed to secure the restoration of medical benefits to Ireland within the Act. Under these

circumstances they were obliged to deal with the Bill as amended by the Irish Parliamentary Party; but not having received instructions on this point, were only able, in answer to queries, to give unofficial information, and so avoided any risk of the profession, as a whole,' being held responsible for views put forward in that way.

They state, however, that no practitioner in Ireland is now liable to compulsory service, mainly, they believe, owing to their representations.

They further state that during the last days of the Session changes were made in the Bill to the effect that "an insured person in Ireland shall not be entitled to medical benefits under this part of this Act, and the provisions with respect to medical banefit shall not apply. Provided that medical benefit for an insured person, being a member of an approved society, shall be deemed to be included amongst the 'additional benefits' specified in Part II, Schedule 4, to this Act."

As this permitted medical benefit to be given by the Friendly Societies without any safeguards, the following was added on the Joint Committee's recommendation:—"And that such medical benefit, when provided, shall be administered by the Insurance Committee in accordance with the provisions of this part of the Act, *unless the Irish Commissioners otherwise direct*," the words in italics having been added subsequently without an opportunity for protest.

Two methods of providing medical attendance in Ireland under the Act as it now stands, the Committee point out in their Report:—(1) As an additional benefit under the terms of the Act and the regulations of the Commissioners; (2) by societies outside and independently of the Act.

The first method can only be made use of when societies can show a surplus available for additional benefits, and is, therefore, not likely to be taken full advantage of immediately the Act comes into force; but as the Act is, in the opinion of the Committee, certain to be amended in the near future, the amendments and conditions of service desired by the Irish practitioners should be put on record.

THE APPLICATION OF ADDITIONAL BENEFITS TO IRELAND.

Thus, though medical benefits, as understood in England, are deleted from the Irish Clause of the Act—are not "within" the Act, so to speak—they may be available in Ireland, the Report points out, as an "additional benefit" to insured persons,

members of an approved society, and their dependents, as soon as they can show a surplus; and as under Clause 36 the valuation of assets may take place at any time at the discretion of the Insurance Commissioners, it is quite possible in the case of existing solvent societies now giving medical attendance and other benefits similar to those provided in the Act, that full medical benefits may be dispensed as an "additional benefit" within a year of the Act coming into force.

(It is to be noted that Maternity and Sanatorium benefits are not affected by the special regulations as to medical benefit for Ireland.)

THE ADMINISTRATION OF MEDICAL BENEFITS.

The intention of Parliament, the Report states, is that medical benefits shall in all cases be administered by and through the Insurance Committees,* and the new Irish Clause, 81 (9), provides that the additional medical benefits are to be administered by the Insurance Committee "unless the Irish Commissioners direct otherwise"! The Joint Committee view the extraordinary power thus conferred on the Irish Commissioners with alarm, and fear it may result in defeating the intention of Parliament that in all cases medical benefits should be administered by the Insurance Committees, and not by approved societies. The Joint Committee therefore suggested that notice should be given to the Irish Commissioners and the Insurance Committees that if the authority given by Clause 81 (9) were ever made use of, Irish medical practitioners would absolutely decline to take any service under the Act.

(2) Medical attendance through societies outside and independent of the Act. Owing to the deletion of medical benefits from the Act (as regards Ireland), this is the class of medical attendance that will, for the most part, be administered in Ireland, and therein, the Committee reports, lies a great danger both to the profession and to the public, as the administration of this medical service will be without the safeguards and protection, imperfect as they are, provided by the Act. Irish practitioners are, therefore, advised to be fully determined that this form of contract practice shall only be introduced to Ireland, where it has been practically unknown heretofore, on fair and equitable terms, and on a sound basis for its efficiency.

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*What about the Harmsworth Amendment, however? Sect. 15 (4) authorizes the continuance of such administration under any system or institution in existence when the Act passed.

Societies, it is stated, are already in keen competition, offering medical attendance at one penny, and even as low as one halfpenny, per member per week, in order to attract members, and so strengthen their positions for the other purposes of insurance under the Act; and there is reason to believe that this contemptible rate of remuneration is intended to cover, not only the insured, but also his family!

An inclusive family rate, the report proceeds, no matter how liberal it may appear, should be unconditionally refused, because, owing to the possibility of a heavy sickness rate among children, it throws all the risks of insurance upon the doctor.

Medical attendance is thus made use of as a bait in the interests of societies in a way that will result in the profession being sweated in a humiliating manner. The medical service offered at the ridiculous prices quoted could not be an honest and efficient one, and would, therefore, be detrimental to the public interest, and defeat the object of the Insurance Act as a measure "for the prevention and cure of sickness."

The well-known objections of the medical profession to being under the control of Friendly Societies are enumerated as follows in the Report:—

(1) Cheap medical practice under lay control is not to the advantage of the community, and is unsatisfactory to the profession.

(2) In the past the Friendly Societies have shown their unfitness to carry on such work, and a want of appreciation of high-class medical work.

(3) These societies have hitherto cut down remuneration to the lowest figure they could get accepted. The insurance scheme, under them, would mean a repetition and extension of a system disliked by the profession.

(4) Where the doctors are appointed by the societies there is frequently among the members a distrust of their own doctor, and they employ some other doctor; they have more confidence in the doctor they choose themselves.

(5) Want of free choice of doctor: society control interferes with that confidential relationship that should exist between doctor and patient, and which is so often an element in successful treatment.

(6) The Insurance Committee has been entrusted with the management of any institutional treatment provided by the Act; therefore it would save a division of responsibility to have all medical administration in the hands of the same committee.

For these reasons the Joint Committee considers it would not be to the public advantage, or tend to promote an efficient medical service for the public, if the societies are allowed to intervene between practitioners and their patients.

THE JOINT COMMITTEE'S FINAL CONCLUSIONS.

After a careful consideration of the whole question, the Committee come to the conclusion that a grave revolution in the system of medical practice would be brought about under the Insurance Act. Members of Parliament, they found, were urging their constituents to join existing societies or form new ones for the purpose, *inter alia*, of obtaining medical attendance for themselves and their families. Politicians saw that by attracting the masses of the people to societies and providing them with medical attendance, the load of the poor law service would be very much lightened, and its reform rendered comparatively simple and cheap. Immediately would follow, they supposed, a reduction in the number and salaries of poor law medical officers; there would be nobody requiring their services *quâ* poor law medical officers, unless those who prove destitution and are too poor even to become insured persons.

In one direction practitioners would see most of those who have hitherto paid moderate fees, and on the other hand many who were dispensary patients, swept into the Insurance net.

A vast system of State-contract club practice would be spread throughout the country. In order that the new system should not bring ruin and disaster on the profession, Irish practitioners must be thoroughly organized, locally and generally; they must be loyal and united, viewing the matter from a professional rather than a political point of view. While admitting that the public interests must be considered, and that the public are entitled to the best medical service they can procure, they must remember, and ask the public to remember, that there are two parties to every bargain, and that the labourer is worthy of his hire. As to organization, the Committee considers that the organization of the Irish practitioners should be by counties, and they send with their report a scheme of organization and a form of undertaking.

The Committee also decided to call a mass meeting of the profession in Ireland as soon as possible, but considered it best first to circulate full information on the matters to be discussed, and allow time for full examination of them by the local organization.

PAYMENT *PER CAPITA* AND PAYMENT *PRO RATA*.

Many prominent practitioners have urged that it would be a mistake for the medical profession to accept a *per capita* system of payment for medical services, and that quite

independently of the amount of any probable rate of payment, the system itself is radically and essentially bad. Why, it may be asked, is a plan which works well with other occupations bad in the practice of medicine? The answer is simple. Because the services demanded of the medical practitioner are entirely different in kind and in character of obligation from those of any other profession or occupation. They are imperative on the score of humanity, and there can be, in consequence, no arbitrarily fixed limitation set to the amount of service that may be demanded at a given time of each individual practitioner, or to the time at which, or the hours during which, he shall be required to labour. This may best be brought out by a consideration of what actually happens in the course of (1) private practice, (2) so-called club practice—*i.e.*, contract practice based on a *per capita* system, and (3) salaried contract practice, of which the naval and military medical services may be taken as examples.

Private practice has this much in common with club practice, that the medical attendant is the employee of each of his individual patients. The *prima facie* claims of all patients on the doctor's services are equal. Priority of service can be demanded only on the score of priority of summons, or of obvious urgency. If two or more patients happen urgently to want the doctor's services at the same time, he attends to the first comer first, and later to all subsequent comers in turn—there are no closing hours for the doctor—provided they have not already betaken themselves elsewhere for assistance, which in private practice is not unlikely to happen. In the latter event these patients do not have to pay the doctor for what they have not had. The fee that would have been his, had he attended them, goes to the doctor who actually did attend. Moreover, having a fee to pay for each separate act of service rendered, the patient is not so apt to summon his or her medical attendant unnecessarily, and even if he or she did, the doctor would have the right, when already overtaxed with work, to forego his fee and refer the patient to some other medical man.

In club practice, on the other hand, each patient has already paid the appointed doctor—or the one he may choose from an authorized panel—for every service that can be demanded of him during the currency of the subscription. If a number need him simultaneously, or in rapid succession, each has theoretically an equal right to his instant service, for all alike have paid him equally. Supposing that in some case of serious emergency the better-disposed patients are content to yield place until he has done with the serious case, they merely postpone their own

call on his services, and expect him, and rightly so, at once to direct his attention to them. Thus a string of claims upon his time and strength may, and sometimes does, accumulate in such a way that for long periods together the doctor is deprived of proper time for repose, for meals, or for leisure, recreation, or study, the first of which is essential for the continued performance of good work, and the latter necessary in the public interest. The medical man in private practice can, if he chooses, and he often does, decline to take more obligations than he can adequately fulfil without undue strain on his health and reasonable comfort. Those that he cannot attend to when need arises are free, without being mulcted twice for the same service, to seek aid elsewhere. But in contract practice it is not so. Having taken a number of *per capita* payments by contract, he is bound to fulfil his obligations with equal loyalty to everyone, regardless of the cost to his own health and well-being, and of the results to his own family life. And although the club or insurance authority is not his real paymaster, it will insist on his performing to the full the duty he has undertaken. When one or the other—the doctor or the patient—must suffer, its sympathy is practically always on the side of its own *protégé*, of whose interests it is the custodian.

Now let us look at the difference between *per capita* club practice and salaried practice in the army, for instance. Both, it is true, are forms of contract practice. But the army doctor enters the service as the employee, not of each individual patient, but of the Government which pays him. He arranges terms and conditions of service—or rather accepts those which the profession has secured for him—not with 1,000 masters, having different, often conflicting interests, but with one master. He is responsible, not to his patient, but to his employer, the Government. His employer, advised and represented by his superior officers in the service, knows what is humanly possible in the way of work, and what is not. It realizes—sometimes, it is true, not until it has had a rude lesson—that to get the right kind of men, competent and willing to do the work, it must make the terms of its service attractive. It arranges for him his hours off duty, during which under ordinary conditions no work can be demanded of him, thus securing to him time for repose, leisure, and relaxation. He is assured of social position and of a certain amount of social life. Provision is made for increase of rank and pay with years of service, and his future is provided for by either a pension or a retiring allowance, at his choice. Opportunity is periodically afforded him by leave on full pay for both recuperation and professional study. His work is thus collected into one con-

sistent whole under one master, to whom alone he is responsible. How different is the case in club practice! Here the practitioner's obligations are distributed among many individuals, with necessarily conflicting interests, to each of whom he is personally responsible as to a different master. To this fact are traceable all the intolerable results of the club contract system—the inconsiderate demands, the frivolous complaints, the exactions, the incessant grind, resulting in an overworked and often underfed, or at least improperly fed, doctor, who cannot himself carry out the very precepts it is his duty to instil into others.

What wonder that his *clientèle* in its turn should suffer from scamped work, inadequate care and attention, waning skill through lack of opportunity for study, and the absence of that magnetic sympathy between doctor and patient which is half the battle in the struggle with disease. The point of all this is that whatever other mode of payment may be found suitable, one feels convinced that a *per capita* payment, which renders the medical man a slave to the caprices of a number of distinct and independent masters, is in itself radically bad, both for the medical profession and for the public interests.

Allusion has already been made in these pages to the work of the National Deposit Society, but it may be as well here to go a little more fully into the principles on which it carries on a large business of sickness insurance in England. It receives *per capita* payments from its members, but it pays the doctors who accept appointments on its staff at certain fixed rates for work done, and it endeavours to secure good quality of work, as well as to guard against malingering, by the simple rule that a portion of each individual fee paid to the doctor is debited to the patient. The result of this is, that while the patient does not needlessly visit the doctor, he is not prevented from visiting him the moment that the occasion is genuine.

It has been calculated that about one-fourth of all contract work consists of needless attendance upon patients who are not really ill. No one can possibly say to what extent malingering will grow under the stimulus of State funds to draw upon; but what every doctor who has had any experience of club practice knows is that the reputation of the doctor rests largely in the hands of his patient. To believe that an illness is "put on" is one thing; to assert it, and assume legal responsibility for asserting it, is quite another.

The advocates of a system of payments for work done under the National Health Insurance Act, as against Mr. Lloyd George's *per capita* contract system, sum up the advantages of the former under the three following headings—(1) Its members,

they assert, actually have—what is impossible under any system of pool or capitation—freedom to call in, to reject, or to change the doctor they employ. (2) The work done for them being limited, *can* be efficiently done. (3) That because the members pay a fraction of the cost out of their own pockets, they place confidence in, and value upon, their doctors. In other words, the members under such a system become like private patients, and reap to the full the marked contrast between them and club patients.

On May 1st, no further progress having been made towards a settlement of the questions in dispute between the medical profession and the Government with reference to the Insurance Act, it was resolved *nem con.* in the House of Commons—"That this House is of opinion that immediate steps should be taken by the Government to ensure the co-operation of the medical profession in the administration of the National Insurance Act, and that, until such co-operation is ensured, the Act will fail efficiently to provide medical benefit."

In the course of the debate on this motion it was suggested that the Chancellor of the Exchequer should do penance in his shirt outside the College of Surgeons for his insults to the medical profession, and also that some £3,000,000 more than Mr. Lloyd George had calculated would be required to carry out the Act. Although the motion was described from the Treasury Bench as a first-class party "rag," the Government did not venture to divide the House upon it.

Since it is impossible for us in this Essay to follow the fortunes of this Insurance Act beyond the end of June, 1912, when the Essay had to be sent in to the College of Surgeons, we may here give a short *résumé* of its history so far as concerns the medical profession. From the first introduction of the Insurance Scheme, two things were quite clear about the position of medical men in regard to it. The first was that their co-operation was necessary to its success; the second was that they were so organized as a profession as to be able to act with practical unanimity where their legitimate interests were assailed. The question as to how much was actually done before the production of the Bill to ascertain the views of the medical profession has been involved in a cloud of characteristic inaccuracies and tall talk by the author of the scheme; but it was apparent from the first that whatever was done was totally ineffectual. The profession had no sooner examined the proposals contained in the Bill, than they began to see that it was impossible for them to work the sick-benefit part of the plan without robbing themselves or neglecting their patients. To work on the terms offered meant that if they attended properly

to the cases they could not make a living. But such was the reckless haste with which the measure was forced through Parliament that the Bill became an Act without their arguments receiving fair consideration. They at once entered upon an agitation of national scope. It was sneered at and denounced by the Ministerial party as a political move. All the medical corporations refused to meet the Insurance Commissioners to confer on the administration of the Act while the position of the medical men remained as it stood—and stands—under the terms of the Act. Thereupon Mr. Lloyd George repaired to the London Opera House, and told the doctors, in a violent speech, that if they refused to work the Act it would be worse for them ; that the medical benefit would be paid, not to them through the Commissioners, but to the insured through the Friendly Societies, thus leaving the doctors face to face with the old tyranny of the contract club system: and that there would be a great development of cheap dispensary practice.

By the beginning of May, however, the imbecility and futility of attempting to bully the medical profession had been recognized, and Mr. Lloyd George was fain to accept a resolution of the House of Commons demanding that immediate steps should be taken to ensure the co-operation of the doctors in the working of the Act. In the meantime the British Medical Association had taken steps to protect the profession still further against any future attempts at bullying on the part of Mr. Lloyd George.

We can only add here that up to the middle of June no arrangement had been come to between the representatives of our profession and the Government to ensure the co-operation of the doctors in the working of the Act, as required by the above resolution of the House of Commons.

THE IRISH POOR-LAW DISPENSARY SYSTEM.

From the reports which have appeared in *The British Medical Journal* during the last ten years, it would seem that the work which the country district dispensary officers have to do in Ireland is harder and worse paid than in almost any other field in which medical men are employed. The average size of an Irish dispensary district is, it appears, 42 square miles, and the average population is 6,000, scattered over that wide area. Many districts are much larger, and it is not uncommon for a medical officer to have charge of two or more branch dispensaries, with a sphere of work extending over 60 or 70 or even 100 square miles. Twice a week he must see and prescribe for patients who come to the dispensary ; he has to visit at their own homes those too ill to attend—a laborious

duty for which a horse and trap are required ; he has to send to Dublin for drugs, and to do not only the clerical work but also the menial work involved in the receipt of the packages, the checking of the contents, and the return of the empty bottles ; he has to dispense all the medicines with his own hands ; he has to send out samples of each consignment of drugs to be tested ; he has to keep a number of registers, and to draw up reports of various kinds ; he has to advise as to sanitary improvements, and to devise and superintend the execution of measures for the suppression of epidemics. He has an exacting and vexatious taskmaster in the Irish Local Government Board. He has to see his patients and dispense his medicines in squalid hovels destitute of the commonest conveniences for medical examination, and too often wanting in rudimentary hygienic decency. He has frequently to live in a miserable house or in a village inn. He has to drive many miles in different directions every day, climbing hills and going down into valleys where there are no roads, crossing bogs or arms of the sea perhaps, passing the night it may be by a dying patient or a woman who in her hour of need has no help but him, and returning worn, wet, famished, and heartsore, to begin the same weary round again next day.

And what is his reward ? A pittance for the most part of less than £100 a year, out of which he has to pay for his horse and trap, and for the boat which he often needs if his district is on the coast. There is here scarcely a question of a living wage. The medical officers do indeed contrive to live somehow, eking out their beggarly salaries by private practice, by acting as public vaccinators, and registrars of births, deaths, and marriages. In the large majority of cases, however, the little private practice there is does not come to the dispensary medical officer.

In the struggle for life under these conditions, even hope, which sustains men through difficulties and hardships, often abandons the Irish dispensary doctor. Too often, indeed, he has nothing to look forward to but a life of increasing toil to the bitter end. For him there is, as a rule, no prospect of an increase of salary or a change of district. He has no chance of getting out of the rut into which he sinks, for he cannot afford to buy books or journals to keep himself abreast of medical science, and if he had them he would hardly have time to read them. If he is fortunate, he may, when he is past work, get a superannuation allowance just sufficient to keep together for a little while the body and soul which he has spent in the service of people often not poorer than himself. But he has no right—and he is sometimes made to feel it—to a pension, and by a refinement of cruelty he must actually resign his appointment

before he can apply for a pension. The fear of a refusal makes men of fourscore years continue to do, as best they can, work that taxes the strength of the young and robust.

The case for the reform of the Irish Dispensary system rests, however, not alone on what may be called sentimental considerations, but on the solid ground of the interests of the Irish people. It is for the benefit of those people that the service exists, and it is in the interest of the people that it should be thoroughly efficient. It is simply impossible for men to perform efficiently the multifarious duties that fall to the lot of Irish dispensary doctors under the conditions of distance, want of necessary appliances, want of skilled assistance, and in many cases of the most elementary appliances of medical practice. The reports in the *Journal* show clearly how unworkably large and inconveniently arranged are the districts, how inadequate is the number of doctors, and how futile must be the fight, with such weapons as the Irish Local Government Board places in the hands of its medical officers, against sickness and death among people often destitute of the bare necessaries of existence, and living in insanitary surroundings. The existing state of things, to speak plainly, tends to the physical and moral degradation of the Irish race, and is thus a source of weakness to the Empire.

Let us quote but a few examples of how the system works in various parts of the country; and first let us get a general idea of the distribution of the poor law medical officers.

PROVINCE OF ULSTER, NINE GROUPS.

County.	Dispensary Medical Officers.	Workhouse Medical Officers.	Total.
1. Antrim	53	7	60
2. Armagh	14	2	16
3. Cavan	20	4	24
4. Donegal	36	8	44
5. Down	33	5	38
6. Fermanagh ...	14	3	17
7. Londonderry ...	24	4	28
8. Monaghan ...	15	4	19
9. Tyrone	29	6	35

Province of Munster, Seven Groups.

County.	Dispensary Medical Officers.	Workhouse Medical Officers.	Total.
1. Clare	23	7	30
2. Cork	84	17	101
3. Kerry	34	6	40
4. Limerick ...	29	5	34
5. Tipperary, North Riding ...	20	4	24
6. Tipperary, South Riding ...	27	5	32
7. Waterford ...	17	4	21

Province of Leinster, Twelve Groups.

County.	Dispensary Medical Officers.	Workhouse Medical Officers.	Total.
1. Carlow	8	1	9
2. Dublin	47	4	51
3. Kildare	20	3	23
4. Kilkenny ...	20	5	25
5. King's County ...	18	3	21
6. Longford ...	12	3	15
7. Louth	18	3	21
8. Meath	18	5	23
9. Queen's County ...	13	2	15
10. Westmeath ...	17	3	20
11. Wexford ...	24	4	28
12. Wicklow ...	14	3	17

PROVINCE OF CONNAUGHT, FIVE GROUPS.

County.	Dispensary Medical Officers.	Workhouse Medical Officers.	Total.
1. Galway	43	10	53
2. Leitrim	11	3	14
3. Mayo	29	8	37
4. Roscommon ...	16	4	20
5. Sligo	13	3	16

Total—Thirty-two Counties ; one with two Ridings.

DISPENSARY MEDICAL OFFICER, WORKHOUSE MEDICAL OFFICER, WORKHOUSE INFIRMARY MEDICAL OFFICER.

It must be borne in mind that there are often two or more dispensaries in charge of a single dispensary medical officer. These out-stations are often colloquially called depôts, but officially they are dispensary stations.

Thus Ulster, with its 234 medical officers, has 344 dispensary stations ; the province of Munster has 361 stations to 231 medical officers ; Leinster has 336 stations to 228 medical officers ; and Connaught 156 such depôts for 112 medical officers.

As depôts were probably only formed because the distance from the central dispensary was too great for the sick folk to travel, the question arises why the medical officer has to travel such a long distance to see sick patients who cannot attend. If a medical officer were posted for each out-depôt, the corps of dispensary officers would be increased by 387 medical men, or nearly 100 more for each province than at present. Such an increase would raise the dispensary staff, now quite insufficient, from 810 to 1,197 medical men.

THE DISPENSARY ORGANIZATION IN A TYPICAL COUNTY.

Let us now take a typical county, and see how its dispensary system is organized. Antrim, as it stands first in the reports of the service, may be chosen as the type county. It covers

787,866 acres, and has a population of 418,190 people. For poor law purposes it is divided into seven unions or county sections, namely—

County.	Inhabitants.
1. Antrim	29,470
2. Ballycastle	12,686
3. Ballymena	53,082
4. Ballymoney	28,267
5. Belfast	368,266
6. Larne	33,029
7. Lisburn	46,463

Each union is an administrative centre of the poor law service generally of the surrounding districts, and at each centre an elected board of guardians meets weekly as a rule. The average number of guardians is 42, elected by the divisions of the union, 18, 20, or more in number.

TYPICAL UNIONS AND DISPENSARY DISTRICTS—COUNTY ANTRIM.

Let us now take the first union (Antrim) of this first county (Antrim) and analyse its elements. This union contains six dispensary districts, very arbitrary divisions of the union. The districts are often ridiculous in shape, and without logical geographical boundaries. They grew up haphazard after the famine of 1848, and have never been fully and systematically considered.

The dispensary districts in the Antrim Union are as follows :—

1. Antrim Dispensary District.
2. Connor Dispensary District.
3. Crumlin Dispensary District.
4. Doagh Dispensary District.
5. Randalstown Dispensary District.
6. Templepatrick Dispensary District.

For each of these dispensary districts a medical officer has been appointed, and must live within his dispensary district. We will examine the six districts separately. The Antrim dispensary district contains 21 square miles of territory, and has a population of 5,356 persons. The area is quite below the

average size, which is, for all Ireland, 42 square miles. The population (5,356) is slightly below the average, which is just 6,000 persons. There is but one dispensary, and no out-stations or depôts. There is a single medical officer, and no midwife, compounder, or district nurse. The medical officer in the year 1902 saw at the dispensary 648 new cases, and these he treated over and over again, until they got better—that is to say, he passed through his hands the strength of an average battalion of infantry as fresh cases at his dispensary. He also attended at their own far-scattered homes over this 21 square miles of territory 321 fresh and separate cases of illness so serious as to be unable to attend at the dispensary for outdoor treatment. If we estimate the average number of visits paid to each of these cases at six—a very moderate estimate—the doctor paid 1,926 visits at the patients' homes, and also made up for them the medicines at the dispensary, where the State supplies the drugs. He vaccinated at various centres of his district 66 cases, and drew from the State some £6 12s. as pay for his duty. The medical officer also acted as registrar of births, deaths, and marriages, receiving 1s. an entry for births and deaths, and 6d. for marriages. The rent of the dispensary, paid by the State, was £10 per annum. The drugs and appliances cost £53 10s. annually. The doctor was paid £100 a year by the guardians, one half of this being repaid to them from a central fund. The medical officer employed a *locum tenens* for a time at a cost of £9, and of this the State paid half. Roughly, then, the total cost to the district, 21 square miles in extent, and with 5,356 inhabitants, from the rates was £50 for the year's medical work. In order to do this work, however, the doctor had to keep a horse and trap, and servant. The Royal Irish Constabulary officers have a fixed allowance for a horse of £50 a year, and for a man £45. If we allow only £5 for the up-keep of trap and harness, we shall find that this medical philanthropist did all his onerous and exhausting labour practically for nothing his pay only equalling the cost of his horse and car.

In the next district in the same union, Connor, which is 32 square miles in extent, the medical officer received £92 10s. for the care of a population of 3,636, so that the salary he received did not even suffice to maintain the horse-trap and servant used in the practice.

The third district in the union is Crumlin Dispensary. It is 35 square miles in extent, with a population of 3,862 scattered over it. The medical officer saw 359 new cases at the dispensary, and visited at their homes 263 more severe cases. At six visits to each case he paid 1,578 visits throughout the year. His pay amounted to £84 19s. 9d.

The fourth dispensary district is Doagh. It is quite small, only 23 square miles in extent. The medical officer saw 404 cases at the dispensary, and visited at their homes 230 new cases of illness. He received as pay £92 10s.

Randalstown is the fifth district. It contains 31 square miles of territory, and 7,157 people. The doctor saw at the dispensary 524 cases, and visited at their homes 256 cases, receiving as pay £100 for the year.

The last district of this union is Templepatrick. It is 32 square miles in extent, and contains 4,132 people. Pay of the doctor, £92 10s.

If now we turn from a well-settled county like Antrim to the western highlands of Ireland, and take as a sample of the unions of Donegal County, Glenties union, containing six dispensary districts, we find that in this union the care of a territory covering nearly 400 square miles, and actually proclaimed as a poverty-stricken district with 33,191 inhabitants, is confided to seven medical officers, who between them have to work fourteen dispensaries, many of them lying far apart from one another, and that these seven doctors get just £100 a year each.

If next we come to Leinster, we find in the Baltinglass union of the County Wicklow four medical men responsible for twelve separate dispensaries, scattered over a territory of 234 square miles, and inhabited by 16,000 people. How difficult it must be to afford suitable medical aid to the sick in so wide an area, and with so short a staff; and where can private practice possibly come in? In the Arklow dispensary district of the Rathdrum union, in the same county, which is 26 square miles in extent, with a population of 6,379, the medical officer saw 662 cases at the dispensary, and attended 389 at their own homes, his pay being £120 per annum.

In the neighbouring county of Wexford, we find at New Ross union and New Ross dispensary district, a population of 6,289, with 992 cases of illness at the dispensary, and 372 visited at home—pay, £100 a year.

The question which will naturally occur to most medical men who read these examples of Poor Law life and practice in Ireland is, How is a country doctor with only £100 a year to maintain himself by private practice, and at the same time do his duty fully by the far-scattered population living in every possible condition of difficult approach, over high hill-ranges, down long valleys, by rocky shores of the sea, round long lakes, or impassable bays?

THE ELECTION AND APPOINTMENT OF THE IRISH DISPENSARY MEDICAL OFFICERS.

In the early Victorian period the local power of the Irish landlord dominated nearly everything in his district, and largely dominated the election of the dispensary medical officer. As a rule the candidate who was backed by the local territorial magnate got the appointment. Nominally chosen as the doctor for the poor, the medical officer was really the State-aided medical man whose main business was to practise amongst the local paying classes, while to afford medical aid to the sick peasant was, in those days, merely a sort of side-duty. The appointment was never a brilliant one; but agriculture was not then in so low a position as at present: the landlord class had money, and often paid a yearly sum to the doctor for the medical care of their households and retainers. Nor was there the same proportion of ailing people in Ireland—the *débris*, as it were, left after the unceasing emigration of the fit and strong. Life assuredly was pleasanter for the "classes," though not perhaps for the "masses," in Ireland. More of the smaller landlords existed, and the amenities of life were greater. Moreover, medical men were more easily made—technique was simpler, and methods more primitive, than to-day. Science had not yet seized on medicine so fully. The lot of the dispensary medical officer at the time, though not a rosy one, had not reached the acute condition now existing, and men were readily found to take the appointments.

Year by year during the last forty years things have altered. The three years' medical curriculum was extended to four years; the four years became five; the standard of knowledge was varied; examinations became harder; fewer men graduated or took diplomas to practise. Side by side with these changes began the growth of the Irish democracy, and the ultimate peasant, hitherto looked upon as almost below notice politically, became a definite entity in Irish life. Enfranchised in 1886, he took his seat on the throne of Irish local life and administration in 1898. The medical profession in Ireland, badly organized, unready for the fight, and without political influence, was, to the extent of 50 per cent. of its members, handed over by the Act of 1898 almost completely to the control of the local body of Poor Law Guardians, that is to say, largely to the peasantry, whose long years of suffering had, it is said, undermined their native good qualities, and who, in many cases, looked on the doctors generally as a portion of the ascendancy army, now wholly out of power and authority. The members

of the new Boards of Guardians which under the Act of 1898 came into power, are, as all classes in Ireland seem to complain, too numerous, being, in fact, double the number of those who used to do the work before the Act passed. The election of a dispensary medical officer now rests with all the guardians of the union, and not with the local representatives of the district for which he is appointed, as was formerly the case; and the result is said to be, by those who have observed matters on the spot, that the election thus widened out has lost all scientific, medical, or professional element.

The question asked when a candidate applies for a vacant dispensary appointment, is not—Is he a clever surgeon, a sympathetic physician, or an active sanatorian, anxious to remove the scandalous sanitary conditions of too many Irish towns and villages? Such qualifications are never even mentioned. The real questions are—Is the candidate a sound Orangeman? Is he a good Presbyterian? Is he a good Tory Catholic, or does he belong to the United Irish League? It is the same, we are assured, north and south, east and west, from wild Inishowen to the Head of Kinsale, and from Dingle to Dundalk, and no one attempts to deny it. A man may have become quite obsolete and inefficient so far as his profession is concerned, but if he is a good Orangeman in the north, or a keen Nationalist in the south of Ireland, that covers all other deficiencies. For us the proper question is, Where do the poor sick and dying patients come in, lying without proper medical attendance in their lonely cots, while their so-called guardians give themselves up to politics instead of attending to the wants of their sick poor?

With reference to the large number of guardians in each union, it must here be explained that the Local Government Act of 1898 greatly increased the number, causing two such local representatives to be sent from each electoral division of the country. The country unions are large and scattered, the roads in many places few and bad, the communications are not easy, the farmers are poor, and it costs time and money to attend the frequent meetings of the guardians. Many do not attend the ordinary meetings; but when a dispensary doctor is to be elected, there is a regular gathering of the clans, and the fiery cross penetrates down the deep valley and up the mountain side. On the day of election the market-town is filled, and the scene is one of excitement in a land where other excitements are few. The young candidates for the post have, we are told, for the previous weeks or months been regularly attending all the local fairs and markets, and have, it is said, been treating and drinking with the guardians while trying to secure their

votes. They have had also to expend money on travelling round the widespread countryside to catch the guardians in their homes, for all the guardians in the union, as has been said, vote in this election; so that, for example, while the Ballybot dispensary district of the Newry Union contains only seven square miles, the voting guardians come from a territory covering 218 square miles of broken country. Or again, when the people of Westport, Co. Mayo, containing sixty-two square miles of country, need a new medical officer, he is voted for by guardians gathered in from 526 square miles of very difficult country. The population of the Powerscourt district of Rathdown Union, Co. Wicklow, numbers 1,826, but is voted for by guardians representing 57,000 people.

Let us now follow the successful candidate in one of these elections to the daily round and common task presented when he takes up his new duties.

He has been appointed, let us suppose, Dispensary Medical Officer of Drumbocht, the lonely village well called in the Gaelic tongue "the hill of poverty." Having won his election, he has taken a room at the local inn, in the absence of any suitable house in the village. He attends at the dispensary up a side street for two hours on Mondays and Thursdays, and drives over on Wednesdays to the dispensary station at Carrigmore by 11 a.m., and remains for two hours there. Fresh from the Dublin hospitals, he feels a rude shock when he sees the draughty waiting-room and the untidy dispensary, the smoky stove, and the room looking like an old bottle store, where he is for the term of his natural life, without hope of promotion or reward, to attempt to afford medical aid to the poor of the Drumbocht countryside.

The deaf old woman who looks after the dispensary has failed to light the fires in time, and all the out-patients are sitting in the chilly waiting-room as he arrives.

For two hours he deals with all these ailing people, the poor human *débris*, male and female, of the poverty-stricken village, where throughout the whole winter there is no work to be found, and where for want of work the place is sinking to decay. He endeavours to be sympathetic, to take an interest in the poor people, to listen to their tales of distress, and to do his best for them; and before he knows how the time has passed, it is noon-tide. Then he has before him many "red tickets," waiting for him to visit all over his thirty square miles of district. He soon sees that if he is to get through his work at all he must hasten on with his patients and stop their long stories. He must also hurry over his physical examinations, and his diagnosis must be cursory and rapid. Here in a melancholy troop come the

poverty-worn aged, who will not go into the workhouse: the delicate, anæmic girls who work for the "sprig-work" cottage industry, and never stir out of the house the whole day, until their health breaks down, and they fade away in consumption; the old men, the delicate children, the whole of the people hungry for bread, and needing not so much physic as food. Amongst them he spends his morning, giving each a written prescription as in his Dublin hospital. The outside car hired from his local inn comes for him to go out to see his scattered home-patients by half-past twelve, but before he can leave the dispensary he must make up the patients' medicines, and he has to stop to do this weary work. The deaf old woman who cannot bring hot water worries his soul, but at length by one o'clock or after he gets away. He would fain have lunched at the inn, but there is no time, and the innkeeper suggests a glass of whiskey instead, and in the rain and mist he begins his drive through the countryside. He drives five or six miles, perhaps eight or ten, often in blinding rain, and then, after ascertaining the neighbourhood where his patient is supposed to live, leaves his car and finds that he has to walk a mile over a broken hill-side, down the rough boreen or narrow road that leads to the cabin where his patient may be. At length he reaches the place to find the husband ill with pneumonia in a wretched cottage. Fowls are perched over the bed, under the bed is the pig, the calves are in the house, even the cows may be. Here in this poverty-stricken home, with no one to help, no one to understand his orders, no medicines to be obtained, save by the wife herself returning on foot to the district dispensary from which she cannot return until the night has fallen, and then only if the doctor has returned from his round of visits over a scattered and difficult countryside; here he deals with the life of the bread-winner, the ultimate peasant, head of the family crowded into the single room with the animals and poultry.

Dismay strikes him as he sees the surroundings and reflects that it is in such a life as this he is to spend all his future years. He may give instructions, but who is to carry them out? The day is passing and he has still many "red-ticket" patients to see, and he must hasten away. He drives miles away in another direction; he skirts the tall mountain; he drives round the head of the misty lake; he visits the lonely cottage deep down below the road; and night falls before his work is done, and he returns hungry; and everywhere whiskey, always whiskey, is offered him by the kindly-intentioned peasantry to whom he has given his medical aid.

So the day has passed, and it is 7 or 8 o'clock before he returns to his inn. He returns, perhaps, to find a censuring

letter from the Local Government Board dealing with the packing up of medical bottles; another may be directing him for the next month to visit daily a lonely hamlet up the mountain-side, where typhus has broken out, and to make sanitary recommendations to the local guardians to prevent the further spread of the disease. While he is reading these, a police-sergeant calls for him to come to certify a dangerous lunatic. Dinner is waiting for him—the lonely dinner at a third-rate country inn. The sanitary inspector arrives to make sanitary reports of the district; and after all comes on night—the dark and anxious night of the Irish dispensary doctor—during which he may expect some call to a far-away case, perhaps a tedious midwifery case, with no midwife to help him, perhaps no help at all but that of the husband, who, while the doctor binds up his wife, presses upon him a glass of whiskey. Then the long drive back in the cold over the rugged road, and sometimes through blinding rain; and this not as a single experience for days or weeks, but quite a fair sample of his future work for the rest of his days. No hope of better things, no equals to speak to or gain encouragement from, no one even to exchange thoughts with, except, perchance, a commercial traveller who comes to sell whiskey to the landlord, or to show samples of drapery to the village haberdasher.

The country folk, hearing that a kind and sympathetic doctor has reached the Drumbocht Dispensary, swarm in on him, and the red tickets flutter round him. He soon finds that he has not one moment to spare. The private practice which would pay him is practically non-existent, and he finds that because he is "merely a dispensary doctor," the few families that do employ and pay a doctor bring out the medical officer of the workhouse infirmary or the county infirmary to attend them, or else go to town themselves for their medical treatment. Under these circumstances it seems to the present writer almost incredible, though he finds it recorded in the reports published in *The British Medical Journal*, and written by an English medical man of high repute in his profession, that the following incident should have occurred:—It is stated that on a recent occasion, when after more than ordinary effort the dispensary doctor had carried through a typhoid epidemic, which wore out his spirits and almost his life, even the guardians, stony-hearted though they were, gave way, and in a moment of extraordinary sympathy voted him an increase of salary of £20 a year for his specially good work in the district. He and his wife rejoiced, for £20 to a dispensary doctor may at times make all the difference between actual want and decent existence. The local guardians' proposal passed up through the usual official

channels to the Local Government Board in Dublin, and this Board refused its sanction of the increase unless a similar rise in salary was given to all the other medical officers of the Union!

If the above is even a fair sample of the usual procedure of the Irish Local Government Board, it renders it quite easy to understand the statement made in these reports to the effect that the practically universal opinion held by the doctors engaged in the medical service of the Board is that the aim and practice of that Board is to find fault with, and to refuse concessions to, its medical officers, to work in unison with the guardians in every matter which weakens their prestige or destroys their influence, and to do nothing whatever to help them.

Some dispensary doctors, it is said, find other ways of making enough money to maintain themselves and educate their children. The horse is a noble animal, but the surroundings of those who deal in him are not always noble. A certain number of the dispensary doctors become horse-breeders and dealers. They attend race-meetings; they hunt; they first take up the horse gently and gingerly; later on the horse becomes master, and the scientific and painstaking side of medical life drops out of view. These men live for the horses they breed; for this means money and food and education for the children, and a home for the wife, while science and sympathy with the Irish peasant mean poverty, and a hopeless old age and despair for the doctor who simply does his duty.

To become a successful horse-dealing doctor in Ireland, whose moderate climate, limestone soil, and good pasturage are so favourable to these splendid animals, one must first develop in a marked degree the "hard dispensary manner," well known in Ireland. This chills off the peasantry, and checks both the black ticket and the red. It also reduces the night-calls. It gives time to go to the near and distant races, and the local hunt. This also gives prospect of a better superannuation than the paltry pension which the guardians offer, and the Dublin Board sometimes, it is said, refuses. This pays for the children's education, and makes the eldest son a doctor, who may, in his turn, breed horses in spite of Boards of Guardians who do not sympathize, or the Local Government Board, which does not understand. All seems well, it may be; and there are no sanitary recommendations to worry the guardians with, and no Local Government Board queries about anything of importance. Only one thing is ill, and that "thing," so valueless, so unimportant, so carelessly thrown aside, is but *Ireland*, in the shape of the peasant in his home, and his wife and children dying on the hillside. The well-to-do folk, who are few, do

not suffer, for the workhouse infirmary doctor drives out to see them from the distant town, and he may carry off the few fees of that country-side; but for the Irish peasantry, and the Irish sick poor, who cares? No one, apparently, for the horse-rearing doctor is a "good fellow," and stands well with his Nationalist or his Orange friends on the Boards of Guardians, and who shall then attack him? And as he ruffles no one's ideas about health or sanitation, he lives out his life, hurting no one, wounding no one, but only stabbing Ireland to the heart in the shape of her sickly sons and daughters. Who is to blame in all this? Not the medical officer only. He has been forced into this line of conduct, because the system he serves is bad, and no one really seems to care. The sole prospect for the future is to teach the Irish democracy how to care, and what to care for, in the interests of Ireland. The horse-dealing dispensary doctor has accurately gauged the powers that be; he has seen that neither guardians nor central authority really know the value of the Irish peasant's life; and that they, and not any outer forces, were tyrants more bitter than Saxon conquerors or landlord oppressors, or even far-away England, which had never understood the facts. Those facts they, the local people, knew, but knowing, still they cared not.

Quite as dangerous to the State, in his way, is the surgeon farmer, who ignores his work and lives entirely to farm. He too, needs the dispensary manner; he needs to kill off sympathy and check kindness. He has other interests more important in turnips and oats. To him the most important of the sciences is agricultural science. He cares more, perhaps, for turnips than for tourniquets, for parsnips than for pasteurism. He, too, sees how the wind blows, and behind his bluff manner and agricultural dress, and with much apparent *bonhomie* of manner, he, too, stabs Ireland to the heart, and leaves a countryside without proper medical or sanitary attention.

If it is asked, what is the remedy for this state of things? the answer is: just election, just pay, just duties, just control, with just pension to follow—these things would kill out horse-dealing doctors and farmer doctors, and they are the urgent needs for all Ireland. Club practice and the combination of the people for associated medical help by private union are practically unknown in Ireland, at all events in country districts. They are, in fact, impossible on account of the distance factor, and the many conflicting elements of creed and politics which for some years to come seem likely to interfere with any such voluntary combination. Only by State agency and State control could anything of the kind be attempted, and, therefore, it seems specially unfortunate that the Irish Nationalist M.P.'s should

have persuaded the Chancellor of the Exchequer to shut Ireland out of the medical benefits of the Insurance Act. The result of this, as it is evident the Irish dispensary doctors fear, will, no doubt, be to throw more work upon them in the way of certifying for insured persons, with no prospect of any increased pay being granted them for such extra work. This, at least, appears to have been the general opinion of a meeting of Irish poor law medical officers held in Dublin to consider the Insurance Bill in August, 1911, when resolutions were passed, and it was stated that the proposal of the Irish Nationalist Party to omit medical benefits from the scheme for Ireland, was held to be particularly dangerous to the Irish poor law medical men. At a meeting of dispensary doctors held in Thurles also, in the same month of August, it was resolved that if medical benefits were deleted, while sickness benefits were retained in the Bill as regards Ireland, the dispensary doctors' work would be enormously increased without any provision for proportionate remuneration. So far as Ireland was concerned, there were three courses, it was pointed out, which Parliament might adopt—(1) It might decide that the Bill should not apply to Ireland; (2) it might delete the medical benefits; or (3) it might arrange that as regards Ireland the Bill should be altered so as to make one part apply to the industrial centres, and the other to the agricultural districts. Unquestionably, it was declared, the worst and most unworkable scheme was the second (which, however, was the one finally adopted).

THE WORKHOUSE INFIRMARIES IN IRELAND.

Let us now glance at the condition of a few of the poor law infirmaries in Ireland, as given in the reports of *The British Medical Journal*, to which reference has already been made, and, taking one in each province, let us commence with that belonging to the Cootehill Union, County Cavan, which is said to be a typical Irish workhouse, containing three sections, the lodge, the body of the house, and the infirmary, the latter of which only concerns us. The infirmary, in its exterior, we are told, resembles more a prison than anything else. It is a long stone structure having two small windows at each extremity of the wall, the larger windows for light and prospect being turned on to the mortuary. The interior matches the exterior; on the ground-floor there is the medical officer's room, which is also his dispensary, two paved rooms intended for male and female day rooms, and a disused ward now used as an operating room; the day room on the female side has been fitted up as an infirmary kitchen.

The wards are above—long, narrow rooms having beds on each side, having a little passage-way down the middle, a large ward of six beds, a smaller one of four beds; this is the arrangement on both male and female sides. The walls of rough undressed stone, colour-washed; the roof opens to the slates, small windows facing north, in heavy iron frames, badly fitted, draughty and leaky, the slit apertures on the other wall representing the through ventilation. A rusty grate, all chimney, a bench, a bucket-chair, a few arm-chairs, and a small table, complete the picture of a country workhouse infirmary ward.

The patients included cases of arthritis (rheumatic), pneumonia, intestinal obstruction, ulceration of leg, and some good surgical cases recovering from operation. All operations are dealt with in the wards, as this is practically the district hospital. There is no lying-in ward; the women are confined in the general ward. The nurse has been trained in midwifery, and has acquired her training in general nursing under the medical officer. She is assisted by inmates, and on the male side there is a paid wardsman, who works under the nurse's supervision. The doctor selects the female helps from among the older women, rejecting those who are in the house with their illegitimate children. The wards showed evidence that it was possible to make even such unpromising surroundings clean and business-like. There is no night nurse. The lunatics are lodged on the ground-floor of the infirmary, underneath the wards, with no ceiling between; their quarters consist of the old cells disused by the medical officer, but not removed by the guardians, and the corridor and day-room attached. There were six women lunatics at the time of the visit, under the care of a feeble-minded inmate, and about the same number of men.

Sanitary appliances are of the most elementary kind; there are none inside, not even in the wards, and such as there are outside, being at a distance, can only be used in the day time and in decent weather. Under these circumstances there is recourse to open pails and buckets; those in the wards being placed under a wooden chair, and remaining unemptied during the night, and of course the same remark applies all over the house. The outside conveniences are on the waggon system; a movable trough receives the soil, and when full it is wheeled through a door at the back and placed on the land, the trough being returned to the privy with as much or as little soil clinging to it as a lazy pauper may choose to leave.

LONDONDERRY UNION, COUNTY DERRY.

At the Workhouse Infirmary for this Union it is reported that there was not enough accommodation for the sick ; it was crowded even in summer, and the needs of the city had long since outgrown its capacity to accommodate patients. There were 67 patients when it was visited, and for these there were one nurse, untrained, a night-nurse, also untrained, and pauper nurses.

The acute cases are taken to the County Infirmary in the city; but the residuum of chronic heart cases, bronchitis, paralysis, spinal, senile decay, and helpless cases, provides more than sufficient scope for trained and skilled nursing, which is conspicuous by its absence. Derry, the Maiden City, can apparently do no better by its sick poor than to give them hasson beds, with the improvement of a wooden dado for the bed-heads. All the structural defects of lighting, ventilation, and warming have been repeated in this infirmary, though it is of comparatively recent date. The pauper wardswomen, mothers of illegitimate children, have one ward appropriated to the use of those infants, so that they may have them under their care and be with them at night. It may, perhaps, be asked where the nursing of the sick comes in. Probably the old people at one end of the scale, or the infants at the other, are neglected.

One point in which Derry has improved upon her neighbours is the provision she makes for her lunatic class. It was quite a pleasure, the report says, to enter dormitories and day-rooms in which there were light and air, with a humane attempt at comfort by mats and chairs, and at recreation by plants and pictures. Paid attendants are on each side, and the patients looked clean and happy.

The infirmary night-nurse visits these wards, but unhappily the sanitary methods are still antiquated and unwholesome. This remark applies to the whole system throughout. The outside conveniences were attended to and kept clean. Cold water is laid on to the landings, but there were no baths, and the materials provided for washing were limited to one jug and basin in each ward, with a roller-towel "changed as often as necessary."

CORK UNION, COUNTY CORK.

This infirmary, as might be expected, is a large hospital, including in its area an important section for lunatics. There are two resident medical officers and two visiting doctors, who

go round the wards every day. The number of patients, including lunatics and fever cases, averages 900, but at the time of the visit there were nearly 1,000 on the doctors' books. The medical officers are frequently drawing attention to the congested state of the wards, "some of the patients having from time to time to sleep double"; and this, too, in wards which are low-pitched and below the ground-level. The blocks are square erections of two or three stories; they are classified as male and female general hospitals, lunatic wards, children's hospital, female hospital, and fever hospital. Some of them are the worst type of building, and a few are of modern construction.

In St. Joseph's Hospital for male patients chronics are on the ground-floor, the surgical patients on the first floor, and the medical cases, chiefly phthisical, on the top floor. In the winter the ground-floor is liable to be flooded in heavy rains; it has been repeatedly condemned by the medical staff as quite unsuitable; the sick and the paralysed and helpless who are relegated to these dark, low-pitched, damp wards appear to be lying in cellars. Above, the wards are divided by partitions, against which the beds are placed head to head, as well as at the side walls. These wards are lofty, with good-sized windows, but unfortunately placed so high that the patients cannot see out of them. The female hospital (St. Catherine's) is perhaps the oldest block. It repeats all the objectionable features of structure so often commented on in these reports.

The ground-floor is allocated to helpless and offensive cases, with the result that the ward was unwholesome. The surgical and the acute medical cases were on the next floor, and here also was an isolation ward for syphilis cases in married women. There were 116 cases in this block, which was seriously overcrowded. The maternity hospital is a separate block of two wards, one above the other, for ten beds in each. There is no labour-room, nor indeed any classification. As a bed is emptied it is re-occupied. This block has been repeatedly condemned by the medical staff, and it continues to be insanitary.

The lunatics have quite outgrown their section. There were 160 females in wards intended for 130: on the male side 70 in wards for 50. The class comprises epileptics, imbeciles, and harmless lunatics. The females were employed on needlework, and some were sent to the laundry; but the room in which needlework was done was too small for proper management. This room led into a dormitory, and though it was a long corridor, simply a lean-to shed, crowded with listless, restless, or talkative lunatics, no occupation was attempted, and it was impossible to keep them under proper supervision. The corridor was badly lighted and could not be made sufficiently warm.

The male lunatics were in even worse quarters, two dormitories and a day-room, dark, crowded, and ill-ventilated. There is a paid official on this side, assisted by "deputies," and a trained nurse on the women's side, also assisted by "deputies." Consequent on the overcrowding, about 30 of the women slept two in a bed, and some of the male patients slept in the dining-hall. This section has been repeatedly condemned, both by the Local Government Board Inspector and by the medical staff. The nursing of this large number of sick is undertaken by the nuns, except in the Protestant section, where there are trained nurses. It is understood that the nuns are not trained: they have acquired their experience in the Poor-Law hospitals. But whether trained or not, the number engaged in these hospitals is quite below the mark, so that a great deal of the actual nursing must be done by pauper inmates—"deputies" as they are called. Altogether the responsible nursing staff numbered 20, or about one nurse to 60 patients by day, one nurse to 200 patients at night. Needless to say that any good results that have been attained have made very great demands on the energy and watchfulness of the medical staff.

ATHLONE UNION, COUNTY GALWAY.

The patients in this Infirmary are nursed by the nuns, and, as was the case at Ballyshannon, these had introduced order, method, cleanliness, with the civilizing influence of humanity. They were not trained nurses, such experience as they have acquired having been gained in similar institutions. There are 80 beds in the infirmary, of which 71 were occupied at the time of the visit. Athlone is a busy centre, so that the workhouse is a large one. Many patients there were under treatment for serious ailments, and operations are performed by the medical officers in the wards. The epileptics are nursed in the general wards. The nuns have the supervision of the male wards, but the actual nursing is done by the wardsmen, who are inmates.

The question of night nursing was in dispute between the guardians and the Local Government Board at the time of the visit, and a nun had been temporarily placed on night duty.

The maternity ward had been taken off the lunatic quarters, and was reported to be dark, ill-ventilated, and quite unsuitable for the purpose. A bad case of puerperal fever was being "nursed" by an inmate: there appeared to be an absence of all sanitary precautions, and no attention to cleanliness of either patient or bedding. This department does not come under the charge of the nuns: the confinements, which average ten in the year, are attended by a midwife, and "nursed" by a pauper.

As a consequence of the loss of this maternity ward, the quarters for the female lunatics are much curtailed. They are confined to one room, which was dirty, dark, with the door opening directly on the yard. One very noisy patient was in bed; the rest were up.

The men were no better off, for, though the cells were done away with, the corridor, which is supposed to be their day-room, was taken by the tailor. The nuns are held responsible for this class, but they are practically left to the care of the paupers, hence they were untidy in their persons, and their surroundings were squalid and unsavoury.

From the above short extracts, taken from the comprehensive reports published in *The British Medical Journal*, it will readily be seen that there are five points which call urgently for reform:—

(1.) The first is the improvement of the nursing by the employment of trained nurses in every workhouse infirmary, one or more according to the requirements of the medical officer: with the employment of the trained nurses the entire disappearance of pauper nursing.

(2.) The employment of one or more night-nurses, and, consequent on this, the removal of "deputies," or wardsmen and wardswomen, out of the wards at night.

(3.) The introduction of an efficient sanitary system into the infirmaries, by the provision of an adequate water supply both hot and cold, and the addition of baths, according to the requirements in each case, and the provision of a decent, wholesome, and efficient method for the receiving and disposal of excreta in the building: either by the earth system or the water system, according to local circumstances.

(4.) The entire remodelling of the lunatic quarters, bearing in mind the need for space, light, fresh air, classification, recreation, employment, and intelligent custody: the end to be aimed at being the amelioration of the condition of the lunatics, by placing them where the treatment prescribed by the medical officer shall have a chance of success, by the employment of specially trained attendants to ensure that his orders are complied with, and that the lunatics are treated with humanity and kindness.

(5.) The improvement of the sick quarters by the provision of day-rooms, and along with this the conversion of the exercise yards into gardens, or where that is not possible, the provision of seats and sheds, so that the prison-like system under which the pauper is confined should at least be made as merciful as possible. With this reform should be combined the placing of comfortable arm-chairs in the wards, the removal of the hard

bench, and the general brightening up of the wards, which could be done at very little expense. Also proper bedsteads, and other necessary appliances for nursing.

It is only right to repeat here that for years the medical officers over the whole country have been protesting against the state of things described in *The British Medical Journal.* By written reports, by word of mouth, by controversy in season and out of season, they have endeavoured to arouse the conscience of the nation to the sad and helpless condition of the Irish sick pauper. A prisoner, because he is destitute and past work—an object of neglect and ignorant apathy, because he is a useless hulk on the shores of time—almost his only friend has been the infirmary doctor, who for long years has been a voice crying in the wilderness of officialism, and feels he must go on crying until the present state of things is radically altered.

THE PROGRESS OF PHARMACY.

The production of medicaments has been one of evolution. In the early stages of pharmacy, the crude drugs themselves were employed, and the herbalist of that time used only the powdered and dried drugs; then came the use of extractives of these drugs, as tinctures, extractives, &c., the object being to exhibit the drug in a more convenient and active form. Although this showed an advance, in that the active substance was separated from some of the objectionable and inert matter, there still remained the problem of variation in the drug. This problem was solved by standardization. The earliest attempts at standardization consisted in working to standards of extractive, crude alkaloid, &c., but recent improvements have enabled most preparations to be standardized according to the amount of active principle contained therein. In cases where chemical standardization is not possible, physiological standardization has been adopted. The final stage in regard to naturally occurring drugs was the isolation of the active principles themselves in a state of purity. With these the physician can order a precise dose of a pure chemical, the action of which can be determined with accuracy.

The science of chemistry, however, has enabled us to go further than this. Chemical investigation led to the elucidation of the constitution of many of these active principles. The determination of the constitution leads to attempts to prepare the active principles synthetically. The production of synthetic substances in this way is a practical advantage, as it tends to

reduce the cost of medicinal preparations, and enables their purity to be controlled more readily than in the case of natural products.

Science, however, is not content with the synthesis of naturally occurring products, but aims at improving upon nature.

Many of these active principles, whilst having valuable and desirable properties, have a secondary action which is objected to by the prescriber. By a study of the relationship between chemical constitution and physiological action, the chemist endeavours to prepare, by synthesis, new drugs in which the desired effects are conserved or enhanced, and the objectionable ones eliminated.

He strives also to produce drugs with entirely novel physiological action, with the object of adding to the resources at the disposal of medical men.

Among the new drugs added in recent years to the medical armamentarium, two of the most important are *Salvarsan* and *Radium*.

Salvarsan, otherwise known by its diary number "606," has attracted a great deal of attention lately, both in this country and on the Continent of Europe. Years of labour and strenuous laboratory research, conducted not in a haphazard manner, but as a systematic scheme and with a definite goal in view, have led to its preparation. The object sought was to find a chemical product which would destroy bacteria, while in no way injuring the organs of the human body. Amongst hundreds of other arsenical preparations tested, Ehrlick believes that he has found in Salvarsan a substance which, like quinine in malaria, or mercury in syphilis, will bring about the destruction of bacteria in the human body. Salvarsan, having been biologically tested on animals, proved far more powerfully destructive to spirillar life, and considerably less injurious than all similar arsenical derivations previously tested.

After having been tried on patients in hospital and private practice on the Continent, where more than 1,000 reports and articles have been written about it, Salvarsan has been introduced to British medical and surgical practice as specially suitable for the treatment of syphilis in all its stages, particularly in such cases as proved refractory to mercury and iodide of potassium : also in incipient tabes, early paralysis, epilepsy and apoplexy of syphilitic origin, if used immediately when the earliest symptoms appear.

The reports from the Lock Hospital in London, published in *The Lancet*, show that astonishingly favourable results have been met with, especially in the more severe cases of syphilis.

It has also been tried in the Liverpool Royal Infirmary (Department for Specific Diseases) with a like result, and the conclusion reached after the treatment of forty cases of syphilis by this agent in the course of five months at that institution is, that Salvarsan is now recognized as an important factor in the treatment of syphilis, and that though it may not altogether supersede the older methods of treatment, it must be admitted that a welcome advance has been made. It is no uncommon thing, we are told, for mucous patches of tonsils, lips, and tongue to disappear within a week under its action. The cases treated included all three stages of the disease, ranging from infections of two months to twelve years. One case to which special attention is directed suffered from neuritis with ataxic symptoms. The patient had improved somewhat under mercurial inunctions, but consented, on his doctor's advice, to have an intravenous injection of Salvarsan. In ten days his condition had markedly improved: the gait was much steadier. He expressed himself as feeling a "different man." Further experiences of the action of the drug have shown, however, that it is neither so innocuous nor always so effective as was at first supposed. Several deaths have been reported after its use, in apparently tolerably healthy individuals; and whereas at the first it seemed to prove almost a miraculous cure for syphilis—so rapidly did many of the lesions disappear after a single dose, that it was at one time thought that no repetition of the remedy might be required—it has been found, however, that the symptoms recur after weeks or months unless further doses of Salversan are given, and it is beginning to be recognized that Wassermann's serum test is indispensable for controlling the effect of treatment, if the patient is to avoid the danger of being regarded as cured of his complaint when really he retains the syphilitic virus in his system. It is not sufficient, it seems, for the patient's serum to give a negative Wasserman reaction on a single occasion: the reaction must remain negative to repeated examinations made at intervals of a few weeks or months. The serum may give a negative Wasserman test temporarily, even though the treatment of the syphilis by Salvarsan has been inefficient, or at any rate only partially efficient: re-examination of the serum should therefore be carried out at periods of from three to six months at least, both during the treatment and after all the symptoms have disappeared.

RADIUM forms another very important addition to our resources for the treatment of disease, and special attention was drawn to it last year by the opening in August, 1911, of the Radium Institute in London, which had been founded two years previously, at the suggestion of King Edward VII, by Sir

Ernest Cassel and Viscount Iveagh. This Institute is devoted to the work of scientific research, and the skilled application of radium in the treatment of disease. In March, 1911, the Institute was inspected by His Majesty King George, who was accompanied by the Queen, and in July it was again honoured by a visit from Their Majesties Queen Alexandra and the Empress Marie Feódorovna of Russia.

Quite recently Madame Curie has isolated radium, and has described it as a white metal oxidising in water, burning paper, turning black on exposure to air, and having the property of adhering firmly to iron. It is, however, with the compounds of radium that treatment is carried on, and it appears that the Radium Institute has stored in its building a larger supply of radium than is possessed by any other institution in the world; and so priceless is the commodity that one hesitates to estimate in pounds, shillings, and pence, the value of the precious element now in the Institute. Great care has been taken in starting this Institute, to avoid the abuses to which special hospitals are known to be so liable, and with this view regulations have been drawn up which provide that patients will only be treated at the Institute in association with, and through the introduction of, their medical adviser. At their first visit they must either be accompanied by their medical adviser, or else bring with them his written statement of their case, giving details of the treatment already employed. New patients will be seen on Tuesdays and Thursdays, but the exact day and hour must be arranged previously by letter with the medical superintendent. The charges for treatment are necessarily high, and include for the first consultation at the Institute with the patient's medical adviser a fee of two guineas, and for treatment subsequently according as the lesion is situate on the external surface of the body or in a cavity—*e.g.*, the larynx, uterus, urethra, &c.—and also according to the strength of radium employed, from two guineas to five guineas per sitting.

With regard to necessitous patients applying for treatment, a letter is sent informing them that necessitous patients are only admitted to free treatment at the Institute if certified by their medical adviser to be suitable subjects for charity, and asking to have an enclosed certificate filled up by their doctor and returned to the Medical Superintendent at the Institute.

Thus the latest addition to the special hospitals of London has set an excellent example which might well be followed in many older institutions, both general and special.

Although the attention of pharmacists was in 1911 largely absorbed by legislative proposals and matters affecting their organization, scientific pharmacy has not been neglected, and

some useful work has been accomplished. The progress of pharmacy depends chiefly upon a comparatively small body of men, the results of whose work are usually communicated at the annual meetings of the British Pharmaceutical Conference or at the evening meetings of the Pharmaceutical Society held during the autumn and winter months in London and Edinburgh.

The papers which were communicated at last year's Conference meeting at Portsmouth were, we learn from *The Lancet*, of a useful character and of practical interest to the rank and file of pharmacists. A communication which attracted special attention was that in which Mr. F. W. F. Arnaud, public analyst for Portsmouth, showed the urgent need for some control over the sale of so-called diabetic foods. He demonstrated the worthlessness of many of the foods which are claimed to meet the special requirements of diabetic subjects, showing that of twelve different samples examined, the products of one manufacturer alone could be called satisfactory. The facts disclosed seemed to be of such importance that the executive of the Conference decided to draw the attention of the medical profession to what is undoubtedly a very unsatisfactory state of affairs. In another communication Mr. R. R. Bennett showed that the widespread belief among clinicians that the commercial thyroid preparations vary considerably in their 'degree of physiological activity was due to the absence of an officially recognized standardization process; and he suggested that an iodine standard should be fixed.

Much of the research work done by the Pharmaceutical Society has been conducted with the object of assisting in the revision of the British Pharmacopœia; and the final report of the Committee of Reference in Pharmacy of the Pharmacopœia Committee of the General Medical Council was issued in the late summer (of 1911). This report has formed the subject of further discussions; and the editors—Dr. Nestor Tirard and Professor H. G. Greenish—will have before them a mass of valuable suggestions on which to base the monographs of the coming edition.

IMPERIAL PHARMACEUTICAL RECIPROCITY.

Until the Poisons and Pharmacy Act of 1908 came into operation, the Pharmaceutical Society had no power to make certain proposed alterations in the educational system for its students; the same Act also gave the Society power to make by-laws providing for the admission of colonial pharmacists to the British Register without examination. By-laws for the

latter purpose have been drafted by the Council, and will shortly be ready to receive the approval of the Privy Council. In most parts of the British Empire the British Pharmaceutical diploma is accepted for registration in lieu of examination; but the Canadian Boards of Pharmacy have, during the last few years, declined to recognize the British diploma on the ground that their diplomas are not recognized in this country. When the new by-laws come into force, the Canadian grievance will be removed, and the door will be open for Imperial Pharmaceutical reciprocity. The new by-laws, however, will not permit of a similar interchange of courtesies between Great Britain and Ireland, for the English Pharmaceutical Society has no power to accept the Irish certificate, and, similarly, the Irish Society is not empowered to accept the British diploma.

PHARMACISTS AND THE NATIONAL INSURANCE SCHEME.

The Government scheme of National Insurance formed one of the chief subjects of discussion among pharmacists during the latter half of the year 1911. The Bill, as it was introduced into the House of Commons, was singularly deficient in regard to the provisions for the pharmaceutical service. It merely provided that Friendly Societies and Local Health Committees (as they were then called) should make provision "for the supply of proper and sufficient drugs and medicines"; and that, except in certain circumstances, they should not make arrangements for such supply with a medical practitioner at an inclusive fee. There was nothing in the Bill to prevent Friendly Societies from making arrangements which would have rendered them independent of pharmacists already established in business; and it was soon made clear that Friendly Societies intended to take advantage of the deficiencies of the Bill, and to open central drug-stores and branch dispensaries, from which insurance patients could be supplied with medicines. Had this intention been carried into effect, pharmacy would have suffered a heavy loss, and a large number of pharmacists would probably have been ruined. Such dispensaries would not necessarily have been under the supervision of a qualified medical or pharmaceutical practitioner, nor would they have been subject to the control of the Sale of Food and Drugs Act, the Weights and Measures Act, or the Pharmacy Acts, so that the scheme, so far as it related to the supply of drugs, would have been open to many abuses.

On the initiative of the Pharmaceutical Society, a campaign was begun with the object of obtaining such amendments as

would secure that the dispensing under the scheme should be done by qualified persons; meetings of local pharmaceutical associations were summoned in all parts of the country, and a mass meeting—the largest gathering of pharmacists, it is said, that has ever assembled—was held in London to protest against the inadequacy of the provisions made for the pharmaceutical service under the proposed scheme.

A deputation, arranged by the Council of the Pharmaceutical Society, and representing all branches of pharmacy, waited on the Chancellor of the Exchequer, and explained to him the alterations desired by pharmacists. Briefly, the more important of these were: that Local Health Committees, and not Friendly Societies, should control the medical and pharmaceutical services; that insured persons should have free choice of chemists; that the drugs should be supplied and the dispensing done under qualified supervision; that payment should be made according to a scale of charges to be agreed on between the Local Health Committee and those carrying on business as chemists within the area of the local committee; and that pharmacy should be represented on the Advisory Committee and the local committees.

During the committee stage some of these principles were incorporated in amendments introduced by the Chancellor himself, and others in amendments brought forward by Mr. Glyn-Jones, M.P., the Pharmaceutical Society's Parliamentary Secretary, who rendered valuable services. Some of the demands, notably that for representation on the administrative bodies, have not been conceded; but, on the whole, it is considered that the position of pharmacists under the Act is not altogether unsatisfactory.

The pharmaceutical sections of the "medical benefits" clause ensure that no arrangement for the dispensing of medicines shall be made—save in special circumstances—except with persons, firms, or bodies corporate entitled to carry on the business of a chemist and druggist, under the provisions of the Pharmacy Act, 1868, as amended by the Poisons and Pharmacy Act, 1908. Such persons will be required to undertake that all medicines supplied by them to an insured person shall be dispensed either by or under the direct supervision of a registered pharmacist, or by a person who for three years has acted as a dispenser to a medical practitioner or public institution. Drugs, other than poisons and medical appliances, may be supplied by unqualified traders; but medical practitioners will have the satisfaction of knowing that all medicines prescribed for insured persons will be dispensed under qualified supervision.

A considerable number of pharmacists are dissatisfied, we learn, because more has not been conceded to them ; but there can be no doubt that the action of the General Medical Council in desiring the Government to place the dispensing of medicines in qualified hands, greatly strengthened the case of the pharmacists. The threatening influence of the Insurance Bill in the form in which it was introduced had the effect of showing pharmacists the need and the value of organization. As a result, the forces of pharmacy were better organized at the end of the year 1911 than they had been at its beginning.

Moribund associations had become active, new ones had been formed, and in most localities the membership of associations had been increased. The Council of the Pharmaceutical Society, with the object of keeping pharmacists throughout the country informed as to its policy, and of assisting local effort generally, had appointed an officer whose special duty it is to control the movement, and direct it, through the Council's aid, into the proper channels.

If the Insurance Act has done nothing else for pharmacy, it has certainly given an impetus to pharmaceutical organization.

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