draughts. With the disappearance of tachycardia the patient can be allowed out of doors, but must in the first instance be protected from direct sunlight, extremes of temperature, and boisterous winds.

The child should be given a warm as distinct from a hot bath morning and evening. In order to soothe and lessen skin irritation boric crystals (2 oz.—57 g.) should be added to each gallon (4.5 litres) of bath water. A preferable alternative is to bath the child in warm normal saline. Soap should not be used. Bathing must be followed by careful drying with a warm towel and by the application of pulverized fuller's earth or of a high-grade *baby* dusting powder. Calamine lotion is commonly used, but is less effective. Special attention should be paid to situations where there are opposed skin surfaces. The eyes should be bathed and the mouth rinsed with normal saline or boric lotion. Clothing must be light, and the garments next to the skin should be of cotton or silk. Frequent changes of clothing are necessary to avoid chilling while sweating persists. Cardboard splints may have to be applied to the limbs to prevent rubbing. Cotton mittens and socks are useful in protecting the hands and feet.

Feeding

Every effort must be made to ensure that the child obtains adequate nourishment despite his lack of appetite. If the mouth and gums are tender he should (depending upon his age) be fed by feeding-bottle or by a feeder to the spout of which a soft rubber tube has been attached. The use of metal spoons should be avoided as being likely to cause pain. Nourishment should be given frequently—hourly if necessary—in small amounts, and lukewarm or cold according to the child's preference. According to age, chicken jelly, coddled egg, barley jelly, fruit jelly, the cream of fresh milk, and ice-cream (from a reliable source) can be offered. With improvement of appetite in a child of over 9 months choice can be extended to include "smooth" items of semi-solid nourishment such as Benger's food, cornflour pudding, carefully prepared oat flour, egg custard, and fruit juices. At a later stage calves' liver, chicken, and rabbit (all of which should be pounded) and creamed vegetables can be gradually added. Hard or "crumbly" items of diet should not be given until the child shows a readiness to take them. At all times fluids should be allowed generously in the form of diluted milk, provided it does not prove nauseating, or of fresh fruit juices, suitably diluted and sweetened. The aim should be to establish the child on a full diet as soon as he is able to tolerate it.

Although there is no proof that pink disease is of itself a deficiency state the debilitated condition of the child with pink disease requires that an adequate vitamin intake should be assured. In a severe case it is a wise precaution daily to give cod-liver oil (in amounts corresponding to 1,500–2,000 i.u. of vitamin D), ascorbic acid (50 mg.), and one of the reliable preparations of the vitamin B complex.

Sedation

The restlessness and lack of sleep call for sedation. Chloral hydrate is the drug of choice (1–3 gr.—0.06–0.2 g.). On occasion potassium bromide (2–5 gr.—0.13–0.32 g.) is effective when chloral fails, but is apt to give rise to a bromide rash. Sometimes a combination of the two drugs gives the best results. Exceptionally, recourse to phenobarbitone for a limited period of time is necessary. Medicaments, no matter what their form, known to contain mercury should not be given; it should be remembered that teething powders are suspect in this connexion. The risk of secondary infections has been mentioned. Penicillin or

sulphonamide therapy is indicated when these threaten, but is not to be regarded as an essential part of routine treatment. Atropine has been employed as a means of controlling the sweating, but the advantages are more than offset by the aggravation of thirst which results. Artificial sunlight and massage therapy are of value after symptoms of irritation and photophobia have disappeared and when the stage of convalescence is being approached. A simple bitter tonic is useful at this stage.

Ideally, the city child should be sent to the country for convalescence—preferably inland rather than to the seaside. In her own interest the mother should if possible accompany the child. Follow-up care must have as one aim the prevention of delayed respiratory complications.

I am indebted for the illustrations to Mr. W. Blackledge, Department of Photography, the University of Leeds, and to Mr. J. Hainsworth, Department of Medical Photography, St. James's Hospital, Leeds.

DISORDERED SOCIETY

BY

R. N. TRONCHIN-JAMES, M.R.C.S., L.R.C.P.

Working in an international organization for the care of refugees, in Austria, over a period of some 18 months, my attention has been drawn to interesting behaviour patterns, which, as I shall try to show later, seem to lend themselves to a more general application—that of human behaviour in the insecure and disordered world that we live in at present. After all, the refugee is the physical example of the insecurity that may overtake any of us.

The subject being complicated and controversial, only brief mention can be made of those working for or with the refugees and their motives for doing this work, and of the attitudes of the members of the occupying Power, the Austrian authorities, the voluntary agencies (mostly of various religious denominations), and members of missions sent by Governments to select candidates to emigrate to their various countries.

In the area to which I refer the organization employed an international staff of 45, comprising 12 different nationalities, to supervise the care of the refugees. A temporary organization of this type and size had not existed before, and many of the posts had no parallel elsewhere, so that the holders often had had entirely different training for doing the same job. For instance, "eligibility officers" decided whether a refugee should be accepted as a responsibility of the organization (with enormous advantages to the small proportion of stateless people who were entitled to this privilege), and "resettlement officers" gave the opportunity for and facilitated emigration. Such professions have not existed before and probably have no future to them, yet their incumbents were of overwhelming importance to the refugees.

The members of the occupying Power mostly dreamt of returning home, and anticipated fate by living a life in these alien fields as akin to that at home as possible. They were nominally all-powerful in the life of the organization and of the refugee, but—with rare, though important, exceptions—avoided contact with the problem except at the highest levels, where it could not be avoided. At times the Austrians performed their obligations to the refugees, which were considerable, only under duress.

The mission members were treated with particular respect, because it was they alone who could achieve the most

important work of the organization, by selecting candidates to emigrate to their respective countries. That they also suffered from the frustrations and insecurity of modern life, even with their diplomatic passports and privileges, was nicely demonstrated when (in the middle of its work interviewing refugees) the members of the mission of a certain South American republic heard of a revolution in their country that made refugees of them also. The feelings of the candidates they had accepted for emigration, a work of course nullified by the upheaval, can be imagined.

Observations on Refugees in the Field

In dealing with a subject where so many factors come into play it is necessary to pass from the general to the particular. I shall limit myself to consideration of the non-Jewish refugees, and give a few rough statistics. Though a large number of statistics are available, I find that their value is vitiated by many factors, such as the transient nature of some of the population (a pogrom in Bucharest would produce two trainloads of Jews, who would depart just as rapidly to Israel as soon as arrangements were made) and the unevenness of the standard of data upon which the statistics were based: the figures I use are adjusted for such factors so as to have statistical value. My observations are mainly personal, though confirmed by discussions with others trained to observe and working in the same field.

Over the 18-months period some 30,000 non-Jewish refugees were in my medical charge; my work was largely administrative, with from 45 to 60 doctors and numerous ancillaries to assist me, and with a general hospital of 300 beds, a children's home, and other necessary installations. I had occasion to indulge in clinical medicine on few occasions only, such as when I discovered that the physicians at the hospital did not ask for, nor the pathologists know how to determine, the rhesus blood factor. My work went far beyond the fields of administrative medicine, because of the opportunity and co-operation of those in other branches of the organization.

The refugees referred to were ex-Allied nationals who had been deported by the Germans as slave labourers, or those who had fled for political reasons from Communist-occupied countries. About half of them lived, completely dependent on the organization, in huddled camps (or former barracks), where they received all the essentials of life free—lodging, food, fuel, medical care.

Refugee Population Under Consideration

	Oct. 1, 1948	March 31, 1950
Living in camp	12,450	6,000*
Living out of camp	11,482	4,294
Total eligible refugees ..	23,932	10,294

Resettled or repatriated during this period: 17,000 refugees.

* Including the following in special medical installations: 254, Refugee General Hospital; 105, Chronic Sick Home; 254, Old People's Homes.

The chief object of our work was, however, resettlement—that is, to encourage and facilitate emigration of the refugees to countries where they could become citizens; a few refugees also were repatriated to the countries of their origin in accordance with their wish. They consisted of nationals of all the countries of Eastern Europe, the first wave from the Baltic and Ukraine, and later from the Balkans, Czechoslovakia, and Hungary.†

†The Yugoslavs formed the biggest group, followed closely by the Hungarians. Next came the Ukrainians, then Czechs, Poles, and Russians. The Rumanians and Balts were the last considerable group.

In about the same proportion as a typical community in Europe they consisted of aristocrats and professional and working classes. I cite a few examples:

A Czechoslovak, a prosperous lawyer of middle age. His grandmother was a Jewess, and under the Nazis he was put in a concentration camp; with the Allied victory he regained possession of his practice and his house, but when Czechoslovakia acquired a Communist Government he was adjudged a "bourgeois" and dispossessed once more. He fled to Austria.

A Bulgarian peasant who owned a few acres and two cows; he was an ardent Catholic, and fled when the Communists took over his country.

An Estonian father and son, farm labourers, who were deported by the Germans in 1940 for slave labour. They got into Austria when the war came to an end, but have heard nothing from the rest of their family, who remained in Estonia. The father has an injured leg from an accident and, being 52, was not accepted by any country for emigration; the son refuses to leave without him.

A Yugoslavian coal-miner. He was a trade unionist, and, although a poor man who earned his living hewing coal, he had to flee when his brother was put into prison for his activities with the trade union.

A Hungarian count. His house was occupied as a school and his land taken away. The secret police were interested in him because he was receiving letters from abroad; he was warned that he was going to be arrested as a spy, so he fled the country.

About half the refugees fled their countries with their families, taking very little with them. The "hope that springs eternal in the human breast" did small service to refugees; hardly any of those with whom I had dealings made preparations against such an eventuality. A typical example was a friend of mine, a member of an old Czech family who had vast wealth and estates. When he fled he did not have any ready cash in the house, and the family jewels were inaccessible in a bank: he left literally in the clothes he stood up in.

These refugees lost nearly all those material things and psychic factors that give a sense of security. Not only were they no longer members of a "fatherland"; they had lost membership of their village or town community, of their social or professional group. Even if they found work they were badly paid and in a disadvantageous position in comparison with the native workers. They held most tenaciously to what they still possessed, and most important of all were any family members who had escaped with them.

A family of seven members—father and mother in their early forties, two sons, a daughter and son-in-law, with a baby—refused a most advantageous resettlement offer (where the father could work in his own profession as an engineer) because they could not take along their 82-years-old ailing grandmother. The father continues his job as luggage porter at the local station for a pittance.

There are many such examples. So much having been given up when they fled as refugees, it was tragic to see the future of a whole young family sacrificed for the sake of one senile member. The enormous importance of this factor was overlooked administratively when setting up installations such as for vocational and rehabilitation training; it proved impossible to get the candidates to leave their families for a few months to travel a few dozen miles to enjoy the advantage of such training, which might be vital in getting them accepted by a country for resettlement. The difficulty in persuading a family to move from one pitiful room in a hut to another in a camp 10 miles away was another example of this conservatism: the room contained the few possessions they had escaped with or since acquired; they feared to change the room, feared that unimaginative bureaucracy would put their possessions

in store and not allow them to be used in their new habitation, or that they would get lost en route.

They clung also to their identity of national origin. In spite of their all being reduced to kinship at the lowest common denominator of existence—demand for security, warmth, food, and a roof—they maintained this identity. I had to be constantly on guard that the chief doctor at the hospital, a Hungarian, did not introduce his fellow-countrymen into every vacant post.

The first of the refugees were the youngest, healthiest, most active and alert. They had wasted little time in escaping from a dangerous or intolerable life, and emigrated as soon as possible to whatever country would accept them.

The age breakdown shows (non-Jewish refugees living in camps): April, 1949—out of 4,943 refugees 72.5% were under 42 years; March, 1950—out of 3,400 refugees 63% were under 42 years. The following graph gives the breakdown figures in greater detail.

The requirements of the resettlement missions varied, and often the most likely candidate was turned down without any reason being given. A healthy well-educated man of 47, whom I knew well, was rejected by 14 different missions before being accepted by the fifteenth. I discovered the reason for his rejection on one of these occasions over a glass of beer with the mission chief. The candidate was of Russian extraction, having left Russia in 1922, and the mission had secret orders not to accept any people of Russian extraction. The candidates were presented so that the country of the mission would not be accused of discrimination. This was an extreme example, but it was most disheartening for the candidates to be presented and then rejected, and contributed to the form of neurosis which was prevalent among refugees, and which is described below.*

Refugee Neurosis

On arrival in Austria the refugees were placed in camps, and all immediate responsibility was removed from them; they did not think about the future, and acquired a form of "institutional neurosis" with characteristic inertia. They had great difficulty in obtaining work and did not exert themselves to do so, mostly finding that they could not work in their own professions. This passivity and lack of initiative was encouraged by their dependent situation and loss of self-respect. The whole pattern of their social behaviour was broken down; those who had been Nazi slave labourers had not been permitted to marry,

*Just at the time that this unfortunate man went through this experience an official poster was issued: "The organization is closing; you must make up your mind now whether you want to resettle. After June 30 the chance will have gone."

and now saw no reason for doing so, having lived with one woman, and perhaps had several children by her, over a number of years; refugees of Russian birth were legally prevented from marrying foreigners, a rule supported by Austrian law, even though they were refugees.

It is to be expected that people reduced to so extreme a condition of misfortune would lose much self-respect and dignity. There was regression to infantile emotional behaviour, squabbling, and feuding, with complete preoccupation with the present. At the hospital, where refugees worked and lived in conditions most nearly approximating to the normal of all those in our care, competent middle-aged doctors would hold secret meetings behind closed doors over some insignificant personal quarrel, jeopardizing the whole valuable work of the hospital and their own respected status. When the Hippocratic oath was recalled to their attention they behaved like children caught at the jam cupboard. Many of the doctors had had important positions in their own countries, and some had managed to escape with their motor-cars as well as their families: the chief doctor led a string quartet at the hospital. In spite of all these opportunities for normal living, however, they showed the same refusal to face the future and the same dependence as the other refugees. There was never any question of disciplinary problems; they worked extremely well and loyally, but they had as much sense of dignity as a small child. It was the job of those caring for them to goad them into activity: notices that they would have to care for themselves after a certain date, when the organization would be closing, were treated with scepticism. I cite an example:

Four months before the organization was scheduled to close, a doctor of 35, with a wife and two children, was offered a post as a doctor in an American dependency on three years' contract at \$4,000 a year and his U.S. citizenship papers. It was a wonderful offer, but in spite of the persuasions of many people he delayed so long in accepting it that he nearly lost the opportunity by default. He had no reason for not accepting, nor any plan for the future. It was only by removing his present, as you might say—I dismissed him from his position in the hospital—that he was made to understand how very insecure that present was, with one small room in which his whole family lived and a pittance of a pay (less than one-tenth of what he was offered in the U.S.A.).

Once a refugee had been accepted to emigrate the conflict produced by the approaching date of departure produced a rash of physical complaints. Persons who had striven to get accepted by the mission fell and broke their legs, or their dentures were not ready by the date the transport was leaving, or they disappeared into hospital to have their varicose veins operated on. The reluctance of the older people to move was more understandable. Many of them had never travelled before: to go to a strange country, where an unknown language was spoken, far from Europe, perhaps leaving relatives behind, and (for the professional classes) to do a new and menial job, were powerful deterrents.

Acute neurosis of the kind that takes a patient to a doctor with symptoms was almost non-existent. The refugee had plenty of opportunity to go to the doctor and little else to do (there was never less than one doctor living and working in each camp per 400 population). I looked very carefully into the diagnostic criteria of the doctors but without producing evidence of these forms of neurosis.†

†I instructed the doctors to record all cases of persons going sick without a clear physical cause—e.g., back, stomach, and headache, sciatica, indigestion—and persons with a physical complaint that did not recover as quickly as could be anticipated under treatment, but still failed to get evidence of neurosis.

The incidence of psychosis in the population described was less than 0.1%. Hebephrenic schizophrenia was the predominant form.

The neurosis I describe is of an all-pervading chronic anxiety type, with suppression of volition, similar to what is seen when somebody suffers a severe shock—such as death of an important member of his family. These subjects brood on the past, barely live in the present, and give no thought to the future. The circumstances in which the refugees were placed were not conducive to the recovery, after due passage of time, that normally takes place following such a catastrophe in a mentally healthy person. These symptoms continued for years. The symptoms of neurosis met with in a normal community seem to be a luxury of civilization and an ordered society: typical hysteria—conversion symptoms without insight or hypochondriacal plaintiveness—is not seen among refugees; nor is the typical anxiety state. Nervous restlessness, dejection, apathetic lack of concentration, loss of appetite, unsatisfactory rest (“I need more sleep than usual, but awake tired, Doctor”), bad temper, etc., do not manifest themselves as symptoms. For instance, the apathy that I have described is not associated with excessive anxiety over or irritability in relation to their children or with lack of interest in them; the fathers share the mothers’ work in caring for them, and this in spite of the fact that a whole family live in one small room and spend most of the day in it on top of each other—the typical father having no occupation. It is as if the father adopted what is usually considered in Europe as a passive female attitude and not a male active aggressive form of behaviour.

The refugee population was largely Slav in ethnic origin, and the Slavs are notoriously fatalistic: this I have taken into consideration, and what I describe goes far beyond this characteristic temperamental trait. It occurred as widely among refugees living outside camps as among those within, since neither group had security of status. When people are reduced to a simple struggle to survive, conversion or anxiety symptoms can achieve no object: in a totalitarian society illness is not tolerated among captives or slave labourers, so that survival often depends on not being ill—a fact of which the unconscious seems to take cognizance. That neurosis in such a community emerges when it is rewarded was borne out by findings among Jewish refugees, who occupied separate camps and whom otherwise I do not refer to. Here there was a noticeable amount of neurosis of the typical forms, which can be explained by the fact that the Jewish relief organizations were wealthy and thrust attentions on this smaller group of refugees. Symptoms produced tangible results (special food or living accommodation, a month in a mountain or spa hotel for “convalescence”). The Jewish population were also under great pressure to emigrate: the Israel Government would literally accept any Jew, without the tests which other countries demanded regarding age, health, profession, or morality, and which gave the other refugees time for adjustment or acquisition of the passive neurosis I have described. The world-wide wave of sympathy for Jews that followed their persecution, and the power, politically and over public opinion, of American Jewry, also placed them in a special category as refugees.

Conclusions

With his loss of national, civic, class, and professional identity the refugee has suffered permanent personal loss. The emotional impact of this loss is similar to that on someone in normal circumstances suffering the death of a most important member of his family. The symbolic importance of these factors on the emotional equilibrium

must be stressed: in them is inherent the source of confidence, independence, self-respect, and the aggressiveness essential for making an adjustment to new circumstances in a different environment. People dealing with refugees must appreciate this, so that they can strive to replace these factors temporarily and, by understanding the refugee's loss, make him feel confident that he himself will be able to regain his status personally and permanently. This therapy cannot be carried out by people who are emotionally incapable of understanding it and either (a) identify themselves with the refugees in their plight, thus perpetuating their mental state by justifying it and condoning their hopelessness; or (b) by projection make a scapegoat of the refugee so as to give themselves a feeling of superiority, thus turning into an apparent reality what happens to be temporarily true as a result of a material situation.

Using the comparison of a refugee with a bereaved person, the psychological principles can be considered whereby refugees should be handled so as to achieve a complete recovery from the state of shock and the subsequent anxiety state that their situation has created. These principles can be divided into four stages: (1) The actively sympathetic and supportive. The friend encourages the bereaved to abreact and gives sympathy in an active manner. He insists on the bereaved staying with him and taking meals in his house. (2) The passively sympathetic. The friend allows the bereaved to abreact, but does not encourage him; he tries to divert him by unobtrusively placing opportunities of social or other activity in his way. (3) The actively encouraging. The friend will suggest to the bereaved that it is time he “cracked out of it,” that it is what “she” would have wanted him to do, that he is still young or still has valuable work to do. (4) The coercive. If the therapy has not worked after going through the above stages the friend will now tell the bereaved that he is indulging himself, that he is being a bother to his friends, and that he had better do something about it or they will all be fed up with him.

Translated into terms of the refugee, the corresponding stages would be: (1) Take him into a camp; give him clothes, food, warmth, and appreciation of one's active concern for his welfare, including mental welfare (understanding and sympathy for what he has lost). (2) Divert him from his painful thoughts of the past by bringing to his attention the opportunities to resettle, to rehabilitate (medically, or to learn a trade that will be of value in a new life). Bring jobs to his attention and encourage him to work while awaiting resettlement. (3) He should be taken in hand briskly, the organization purposively replacing the lost “father figures.” That this is an active need on the refugee's part was proved by his response if treated in this way: it is no good stopping at stage 2, leaving the onus of taking action on the refugee, and going straight on to stage 4 if he does not. The father figure may be stern, but he must be understanding and sympathetic; if he chastens it must be to produce results. (4) The threat of withdrawal, or actual withdrawal, of assistance from the refugee. In practice this stage was arrived at without putting stage 3 into effect, and therefore failed as a therapeutic measure, merely enabling the organization to free itself of responsibility.

Many refugees found jobs on their own initiative in the local economy, but for this reason the organization ceased to be interested in their welfare; they were merely exploited as cheap labour because of their disadvantageous position in relation to the native population. Rehabilitation and vocational training centres should be set up as a first

consideration. Life in camps and special installations should be arranged to give refugees the nearest approximation to a normal family life: every effort should be made to avoid institutional conditions, with the abnormal and dependent attitude that they imply, which perpetuate the pathological emotional state of the refugee.

Refugees have existed as long as the human race, but only recently has the human conscience evolved to the state of considering refugees a responsibility of mankind as a whole. This international organization was founded on grounds of expediency, and nothing of its scope had existed before. The work of the organization was (and is) a great physical success in caring for and resettling so many people under so many difficulties. However, that this work can be nullified if the psychological aspect does not receive full consideration is exemplified by the following press cutting from an American newspaper: "A 42-years-old refugee from Lithuania who had been over six months in New Orleans was found, having hung himself yesterday, after hearing a radio programme in which he believed he heard his name mentioned as going to be deported as a spy. Mrs. Y, his kindly sponsor, commented that she was never able to make him believe that he was in a free country."

Summary

Observations made over 18 months on a refugee population of 30,000 in Austria are recorded.

Although the population under consideration consisted of people of every age group and many nationalities, various creeds, and different professional, social, and economic status, their situation reduced them to a common plight with similar mental reactions.

The symptoms of more typical reactive or conversion neurosis were not found in this large population.

A form of neurosis widespread among the refugees is described. The symptoms are those of emotional shock persisting for years, with suppression of active and aggressive psychic qualities, lack of volition, and emotional incapacity to consider the future. There is positive resistance to change even though the present may be most insecure, uncomfortable, and completely different from the previous pattern of life.

The physical care of these refugees was good, and the physical necessity of emigrating them to new countries was dealt with energetically and with considerable success.

A primary object, when such situations have to be dealt with in the future, should be to aim at restoring the refugees to mental health as a first consideration, so that each regains the fullest vigour of his ethnic and individual capacities for dealing with the new situation and environment that he has to face. The capacity for adjustment to a new situation in which the individual is placed is a criterion of his mental health for community living. To restore to the refugee the fullest enjoyment of that capacity should therefore be a prominent aspect of the work of an organization caring for refugees, and, if successful, would enormously decrease the amount of purely supportive work that has to be done.

The Board of the Institute of Physics announces that the Institute's Certificate in Laboratory Arts will not be awarded after 1951 in view of the establishment of the Intermediate Certificate for Laboratory Technicians by the City and Guilds of London Institute. This institute has agreed that holders of the Institute of Physics Certificate shall be eligible to enter, should they so wish, the course for the Advanced Laboratory Technicians Certificate, which is to be established shortly, on the same terms as those who have passed examinations for the new Intermediate Certificate. Students who have already begun courses for the Institute of Physics Certificate will be able to complete these by 1951, after which the Institute of Physics will no longer examine in Laboratory Arts.

A MEDICAL STUDENT IN PRAGUE

BY

P. L. C. DIGGORY

President of the British Medical Students Association

Since few people can nowadays penetrate the Iron Curtain it is possible that even the personal and general impressions gained by a medical student observer to the World Student Congress, held in Prague in the second half of August, will be of interest to readers of the *Journal*. In Communist countries it appears impossible to divorce medicine from political life, and it will therefore be necessary to outline something of the Congress and of the political atmosphere prevailing before dealing with specifically medical questions.

Importance of Youth Movement

In Eastern European countries the youth movements and the student body as a whole have very much more importance than is granted to them in Great Britain. Mass youth rallies have come to form a normal part of the political life of "The Peoples' Democracies," and during the last 12 months Budapest, Sofia, East Berlin, and Prague have each been the scene of such a gathering. The recent Student Congress in Prague was the result of very extensive preparations, and must have been heavily subsidized by the Czechoslovakian State.

On arrival at Prague airport we were met by a small committee of welcome, and every student was presented with a bouquet of flowers; we were then whisked through the customs and taken by special bus direct to the Congress headquarters. *En route* we could not fail to notice the immense scale of the preparations; the streets were decorated and every shop displayed posters of welcome. Even the buses and trams carried slogans in honour of the Congress.

Giant portraits of Stalin smiled down at us from many public buildings, but it is difficult to know whether these were specially erected for the Congress or whether they now form a part of the normal street decorations.

The facilities provided for delegates in Prague were excellent. We were accommodated in large student hostels, and extremely efficient arrangements were made for the provision of food, easy travel, and free entertainment. It is typical that a whole fleet of buses had been diverted from their normal duties in the city and placed at our disposal.

During our stay we were to come to realize the privileged position of students in Czechoslovakia, all of them receiving a generous Government grant. In addition they are provided with accommodation in student hostels at extremely cheap rates. They are allowed to use workers' canteens and are able to travel on all forms of transport at greatly reduced fares. The president of the Czechoslovakian National Union of Students is *ex officio* a member of the Czech Parliament.

It will be realized that these privileges are not attained without sacrifice. To gain admission to a university in Czechoslovakia a student requires recommendations regarding his "reliability." The very fact that all students receive a grant from the State makes it possible for the Government, by withdrawing this grant at any time, to dismiss individual students. All faculties of the universities include in their curricula the compulsory study of political science: for 12 months every medical student must study this subject, and in his final examinations he sits a compulsory paper.