THE WILLIAM BUDD HEALTH CENTRE

THE FIRST YEAR

BY

R. H. PARRY, M.D., F.R.C.P., D.P.H.

J. SLUGLETT, M.B.

AND

R. C. WOFINDEN, M.D., D.P.H.

The William Budd Health Centre in Bristol, one of the first to be provided under the National Health Service Act, 1946, was opened officially on September 16, 1952, by the Minister of Health, Mr. Iain Macleod.

A full description of the buildings has been given elsewhere (*Lancet*, 1952), but a brief résumé may not be out of place here. It is a prefabricated single-story building of "Orlit" construction containing six general-practitioner suites, each with its own waiting-room, surgery, and examination-room; a main waiting-hall; a large office; a staff room; a medical treatment room; and the usual offices. The practitioners were not in group partnership, and the centre was to cover their branch practices. All rooms were to be used either by general practitioners or by the local health authority, but in general the former used the centre mornings and evenings, the latter in the afternoons. The centre was provided to serve a housing estate covering some 1½ square miles, with a population of 30,000, on which there lived no medical practitioner, although the periphery of the estate was well served with general medical and dental practitioners, pharmacists, and two local authority clinics.

It is a matter of some importance that all those who are interested in the health services of this country should be kept informed of the progress made in the few experimental health centres which have been set up. This article contains the substance of the first annual report of the House Committee.

Throughout the past 12 months the centre has been visited by legislators, administrative, health, and social workers from all parts of the British Isles, Europe, the Americas, Scandinavia, and South-east Asia. Almost without exception the visitors' reports have been very favourable.

The period under review has been one of rapid evolution of the health services in the area served by the centre. It is now true to say that in no other district in Bristol, and possibly in the whole of the country, is there such close co-ordination of medical services or such excellent co-operation between the medical and ancillary staffs employed in the field by various health and welfare administrative bodies.

The original staffing arrangements to cover both practitioner and local authority work within the centre included a sister-in-charge, a deputy sister, and three nurses; two secretary-typists, one general clerk, two porters, and two part-time sisters. Experience has enabled us to effect some economy, and the staff has now been reduced by one nurse and one secretary-typist, although the doctors' evening surgeries necessitate the additional employment of part-time sessional clinic nurses. It should be noted that because of the special circumstances in the area full nursing cover for a day and night service had to be provided (*Lancet*, 1952). The nurses live in a near-by hostel.

Time-table

Although there was some apprehension at first that the accommodation at the centre might not be fully used for large parts of the day, Table I shows that, in fact, almost every room is in full use from 9 a.m. to 8 p.m., Monday to Friday, inclusive.

Adhering to the original plan, the practitioners use the suites in the mornings and evenings and the local authority in the afternoons. This arrangement has proved highly satisfactory, and the fact that the practitioners' surgery hours are staggered (this was purely chance and not planned) has helped to prevent congestion and overloading of staff, and has facilitated the cleaning of rooms. The rooms are prepared by the centre staff for the next user.

TABLE I.—Surgery Hours

Firm of Doctors	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<i>Morning</i>						
D	9-10	9-10	9-10	9-10 (I.W. by appt. 10-10.30)	9-10	9-10
B	9.30-10	9.30-10	9.30-10	9.30-10	9.30-10	9.30-10
A	10.30-11 Dr. a	10.30-11 Dr. b	10.30-11 Dr. a	10.30-11	10.30-11 (I.W. by appt. 11.30-12)	10.30-11 Dr. a
F	11-11.30 Dr. c	11-11.30 Dr. d	11-11.30 Dr. c	11-11.30 Dr. d	11-11.30 Dr. c	11-11.30 Dr. d
E	11.15-12	11.15-12	11.15-12	11.15-12	11.15-12	11.15-12
C	12-12.30	12-12.30	No surgery	12-12.30	12-12.30	12-12.30
<i>Afternoon</i>						
C	Inf. welfare 2.30-4.0					
A, D			Wednesday Afternoon A.N. clinic by appt.			
B, F						
D	5.0-5.45 Dr. e	5.0-5.45 Dr. e	5.0-5.45 Dr. e	5.0-5.45 Dr. e	5.0-5.45 Dr. f	No surgery
A	5.15-6.0 Dr. a	5.15-6.0 Dr. a	5.15-6.0 Dr. a	No surgery	5.15-6.0 Dr. g	No surgery
F	6.0-6.30 Dr. d	6.0-6.30 Dr. d	No surgery	6.0-6.30 Dr. c	6.0-6.30 Dr. d	No surgery
E	6.30-7.0	6.30-7.0	6.30-7.0	No surgery	6.30-7.0	6.30-7.0
B	7.0-7.30	7.0-7.30	No surgery	7.0-7.30	7.0-7.30	No surgery
Local authority clinics Session 1.30-4.30 p.m.	Mids., A.N.C., school med. sess.	Inf. welfare	Inf. welfare	Relaxation; mothercraft	A.N.C.C.	
			Nutritionist	Sch. med. sess.	A.N., P.N., B.C.C. clinic	

During the period under review 10 doctors attended the centre at some time or other, but the bulk of the work was done by one or other of the principal partners of the six firms mentioned. It should be noted that four of the doctors are now using the centre in the afternoons for the purpose of carrying out antenatal and infant welfare clinics for their own patients. School medical sessions in the charge of a medical officer engaged for the purpose by the local authority have been held on two afternoons a week since January, 1953. A consultant obstetrician session, a nutritionist's session, and relaxation and mothercraft sessions have also been in operation from an early stage.

General-practitioner Work

Statistics are appended of the volume of work undertaken in the centre from August, 1952, to July, 1953.

Patients Registered at the Centre.—Although there is a population of about 30,000 at risk, Table II shows that only just over 10,000 people on the lists of the general practitioners concerned attend there for examination or treatment.

TABLE II.—Total Patients Registered at the Centre

1952		1953						
Nov. 9,473	Dec. 9,565	Jan. 9,732	Feb. 9,850	Mar. 9,993	April 10,153	May 10,248	June 10,332	July 10,354

Between 20 and 30 practitioners other than the health centre doctors have patients on the estate, and these people, living mostly on the periphery, find it more convenient to attend these doctors or the main practice premises of the participating doctors, which are just outside the area. Two local authority clinics also serve the periphery of the health centre area. Moreover, before the centre came into operation a busy minor ailment school clinic was in operation within the grounds of one of the schools on the estate, and this has remained for continuation treatment. For these and other reasons it cannot be claimed that the health centre is, in fact, serving the main medical needs of 30,000 people.

Patients' Attendances at the Centre.—Table III shows the quarterly attendances of patients to each practitioner firm. On average, 8,261 patients attended each quarter; the busy winter quarters November to January and February to April are noteworthy.

TABLE III.—Quarterly Attendances for Each General-practitioner Firm

Firm of Doctors	1st (Aug.-Oct.)	2nd (Nov.-Jan.)	3rd (Feb.-Apr.)	4th (May-July)
A ..	2,735	3,419	3,734	2,699
B ..	135	412	472	365
C ..	340	591	488	402
D ..	1,477	2,054	2,348	1,717
E ..	1,092	1,271	1,450	1,109
F ..	989	1,222	1,419	1,105
Total ..	6,768	8,969	9,911	7,397

An average of 8,261 patients were seen by G.P.s at the centre each quarter.

Practitioner Special Clinics.—Table IV relates to the recently started maternity and infant welfare clinics operated by the practitioners. This development is very promising, as the doctors see their expectant mothers in association with the district municipal midwives and health visitors; the hospital specialist obstetrician is also available for consultation if required. Thus the patient, instead of having to visit midwife, general practitioner, local authority doctor, and hospital specialists on separate occasions in different places, has only one place and visit, at which all her antenatal care is given, including mothercraft teaching and relaxation. Only one, instead of four, sets of notes is in existence for each patient. Similarly, the doctors conducting their own infant welfare clinics have the advantage of the co-operation of the health visitor in general health education and special teaching in infant care. A fuller description of this service will be given elsewhere.

TABLE IV.—Attendances During 1953

Firm of Doctors	At G.P.s' Antenatal and Post-natal Clinics	At G.P.s' Infant Welfare Clinics
A ..	205 (27 sessions)	310 (28 sessions)
B ..	79 (18 ")	—
C ..	—	296 (28 sessions)
D ..	239 (28 sessions)	112 (27 ")
E ..	106 (26 ")	—
Total ..	629	718

Work in the Medical Treatment Room.—Table V shows the number of "treatments" given by the nurses for each practitioner firm. The treatments include dressings, injections of penicillin, insulin, liver preparations, and so on. The number of "casuals" given treatment—that is, patients not on the health centre doctors' lists—is also given for each quarter. For the first few months the purpose of the centre was misunderstood; the population regarded it as a casualty out-patient department and used it, often for trivial complaints; a few outside practitioners thought they could refer their patients for treatment to the centre. By personal instruction and group talks to local organizations the purpose of the centre is now better understood. There has been a falling off in the number of casuals until the summer months, when the lighter evenings put local children at longer risk. However, no genuine emergency is turned away from the centre. Arrangements are made to call the appropriate doctor or to order an ambulance to send the patient to hospital, or initial treatment is given and the patient is referred with a note to his or her own doctor.

TABLE V.—Treatments Given for Each General Practitioner (Quarterly)

Firm of Doctors	1st (Aug.-Oct.)	2nd (Nov.-Jan.)	3rd (Feb.-Apr.)	4th (May-July)
A ..	980	1,334	1,236	948
B ..	21	80	54	59
C ..	180	201	153	79
D ..	666	767	542	380
E ..	211	126	57	49
F ..	465	469	344	308
Total ..	2,523	2,977	2,386	1,823
Casuals ..	120	48	63	98

The quarterly average of patients treated, apart from casuals, is 2,425.

Night Calls.—Table VI shows the night calls (8 p.m.—8 a.m.) dealt with at the health centre. Here we should explain that the estate residents asked in the planning stage that some form of night service should be made available. At one stage serious consideration was given to the provision of sleeping quarters for a practitioner within the centre. For various reasons this idea was rejected and night cover is now provided by having a porter on duty each night, during which he attends to night inquiries and also cleans the centre. The nursing staff, who live in the vicinity, work a night rota and are on call when needed by the porter. It should be noted that the doctors had estimated the need to cover between 10 and 12 calls a night. It will be seen from Table VI that, in fact, calls have averaged 1 to 2 a night, and in the light of this experience a doctor's flat would have been needless. How far the fewness of the night calls is the result of the psychological reassurance of an ever-open health centre it is difficult to say. Out of 543 "out of hours" calls a nurse had to be called on 150 occasions—that is, an average of 12.5 per month.

TABLE VI.—Night Calls (All Types)

Aug. 19	Sept. 36	Oct. 34	Nov. 30	Dec. 47	Jan. 52	Feb. 35	Mar. 47	Apr. 52	May 51	June 69	July 71
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Average per month, 45+.

Use of and Reference to Specialist Services.—(1) The centre consultant antenatal clinic:—From an early stage an obstetric specialist from the professorial unit has held a

regular consultant session at the centre. His services have been freely available to general practitioners and to the local authority doctor and midwives; personal contact with him has been most valuable. Twenty-four sessions have been held, at which 374 patients were seen, an average of 15 per session. (2) Reference of patients to hospital and specialist services:—Table VII shows the number of patients referred

TABLE VII.—*Patients Referred to Hospital Diagnostic Units (All Doctors and Local Authority)*

	Routine Chest X-ray Exams.	Haemoglobin	Complete Blood Count	Microscopical Exam. of Urine
Total (Jan.-Sept.)	328	356	79	63

to hospital diagnostic units by practitioners and local authority doctors for some of the more important special investigations. Table VIII shows the number of patients referred to hospital consultants by general practitioners. It should be noted that in accordance with the practice in

TABLE VIII.—*Patients Referred to Hospital Consultants (All Doctors)*

	Orthopaedic	Paediatric	Physicians	Surgeons	E.N.T.
Total (Jan.-Sept.)	55	41	253	224	45

all Bristol local health authority clinics every expectant mother is encouraged to have a routine chest x-ray examination, which is provided by the local authority at the central clinic; this practice is being followed at the William Budd Health Centre.

Local Authority Work

Antenatal Clinics.—The medical officers hold one session a week at the centre in order to give antenatal care to expectant mothers living in the area whose doctors do not work in the centre. At 24 sessions there have been 403 attendances—an average of 17 patients a session. The district midwives hold two sessions a week, and at 26 sessions have had 371 attendances—an average of 14 a session.

Infant Welfare Clinics.—At 44 sessions 1,992 children were examined or advice was given to the mother:

Under 1 year old	..	1,237, average 28 a session
1 year old	..	384 " 9 " "
2-5 years old	..	371 " 8 " "

Pre-school children on the lists of the health centre doctors are now not seen by the local authority doctor, although the latter's past knowledge and records of the child are useful to the health centre doctors.

School Medical Clinics.—There are two school medical officer's sessions a week. At 57 sessions there have been 1,215 attendances, an average of more than 21 a session. Schoolchildren on the lists of the health centre doctors do not attend these clinics.

Physiotherapy: Antenatal and Post-natal Exercises (Relaxation Classes).—At 21 sessions 105 patients attended—an average of 5 a session. This includes both local authority doctors' patients and those of the health centre doctors.

Nutritionist's Clinic.—The local authority nutritionist attends the centre for one session a week, in order to give dietetic advice to general-practitioner patients. The "gastric ulcer," "diabetic," "reducing," etc., diets prescribed by the doctors have been translated into practical daily diets worked out in accordance with the patient's financial means. There were 127 attendances.

Repercussions on General Practice in the Area

New Patients at the Health Centre.—By agreement, any new patient expressing preference is put on the list of the doctor of his choice. Unattached new patients attending the centre and with no special preference for any one doctor

have been allocated to each doctor in rotation. The number of such new patients on each doctor's list has been reviewed each quarter so as to keep a fair allocation.

Transfer of Patients in the Area ("Drift").—The additions to and deletions from the lists of all doctors working at the centre (including their partners, if any) for the first year were:

Total counts of the lists of the doctors concerned on July 1, 1952	..	..	..	29,206
Additions during the year	..	..	..	3,460
				32,666
Deletions during the year	..	..	..	2,840
Total counts on July 1, 1953	..	..	..	29,826
Net increase	..	..	..	620

It is probable from these figures that there has been no abnormal drift to or from the lists of the doctors connected with the centre during the year.

Co-operation of Health Workers.—One of the most important and significant developments in this area has been the tremendous improvement in co-operation between the general practitioner and the local authority health and welfare workers in the area. Mention has already been made of the greatly improved co-ordination of maternity services in the area and of the developing interest of the general medical practitioners in orthodox preventive medicine, as evidenced by their starting infant welfare clinics for their own patients as part of their general medical service. Further extension along these lines would lead to the exclusion of the local authority doctors without any loss in the efficiency of the preventive health services. In addition, there is now excellent co-operation between the three district health visitors based on the centre and the practitioners. The doctors appreciate that the health visitor can be as valuable to them as the midwife and district nurse, and many misunderstandings on both sides have been removed.

Standard of General Practice in the Area.—It is difficult to assess the standard of any general practice, and it would be invidious in this report to make extravagant claims about general practice at the William Budd Health Centre. However, the secretarial and nursing assistance has given the doctors more time to examine and advise their patients. The treatment room, in which an increasing volume of work has been undertaken, has enabled many patients to be treated who would otherwise have gone to hospital out-patient departments.

Agreements.—The official machinery set up to deal with the health centre is as follows: (1) The Joint Advisory Committee with no executive functions. On it sit members of the local health authority, the executive council, the local medical committee, and the house committee. It gives advice on policy matters to the two parent bodies—the local health authority and the executive council—and was set up to ensure fair representation of the views of each authority and of the health centre workers as well as the doctors who work in the area but not in the centre itself. (2) The House Committee, consisting of the health centre doctors, the representative of the medical officer of health, the sister-in-charge, and the secretary of the executive council. It deals with domestic matters. The Joint Advisory Committee has met on five occasions—three of them before the centre was opened—and the House Committee on five occasions. No formal agreements have been in force either between the executive council and the local health authority, or between the council and the doctors, or between the doctors themselves. At an early stage the question of rent was informally agreed by all concerned, and as the centre has evolved the various parties have honoured the decisions of the two committees.

Finance

The gross cost of operating the centre for both local authority and practitioner services is within £65 of the estimate made two years ago—namely, £10,000 per annum, or £200 a week. This covers loan charges, salaries, uniforms and laundry, local authority drugs and dressings, equipment, upkeep of nurses' hostel, maintenance and repairs, rent,

rates, heating, lighting, water, printing and stationery, telephone, but does not include capitation fees, the proportion of the salary of the local authority doctor, the regional board specialist, and the cost of the drugs prescribed.

Discussion

No doubt it would be interesting to discuss the first year's experience at the William Budd Health Centre in the light of the Hadfield Report (1953), the Review of General Practice by the General Practice Review Committee of the B.M.A. (*British Medical Journal*, 1953) and the articles by Joseph Collings (1953) on group practice. Space does not permit this, but we would point out that all these reports, in their references to health centres, are discussing a theoretical conception, as none of those authorities have had the opportunity of first-hand experience of the functioning of a health centre under the National Health Service Act. We must limit our discussion to our own experience and try to give answers, albeit provisional, to some of the questions that have been asked.

Let us say at the outset that, so far, the health centre has provided many advantages to the patients, doctors, and other health workers in the area, and few if any disadvantages that we have been able to discover.

The two most promising developments are the relief of the doctors from "unproductive" work by the provision of clerical and nursing assistance, thereby enabling them to devote more care and attention to their patients, and the greatly improved co-ordination of health services and co-operation of health workers in this area.

The theoretical conception that co-operation and co-ordination would be improved by allowing health workers of all types—general practitioners, local authority doctors, district midwives, and health visitors—to work under one roof has been borne out in practice. Reference has already been made to the closely knit maternity services in this centre with the attendant advantages to all concerned, and not least to the expectant mother. The staff room has proved to be the most important room in the building, for it is there that all medical, nursing, and social workers in the district (including probation officers, children's officers, voluntary case workers, and the like) forgather and meet the doctors to discuss particular patients or their families over a cup of tea or coffee. With greater rapidity than had been expected, the health and social workers in this area are welding themselves into a team which has the interest of the patient and family at heart, and each member of the team is now in the favourable position of being fully informed on all known factors operating in each case.

Nevertheless we would not say that such a happy development would necessarily follow in every health centre. Two main factors have helped at the William Budd Health Centre. The relatively small size of the centre, together with the joint use of rooms by general practitioners and local authority staff, instead of resulting in disagreements as might theoretically be expected, has resulted in closer co-operation. Secondly, we feel that our early decision that a nursing sister should be in overall charge of the centre rather than a lay manager was the right one. Much has depended on her in achieving co-operation; her qualifications and experience enable her to smooth out day-to-day difficulties in a manner which could never have been achieved by even the most charming of lay administrative officers.

The original objective in this health centre was to provide suitable premises for general practitioners, and in the planning stage the local authority services were of secondary importance. As time has gone on we have found the need for, and proved the advantage of, other services. For example, the specialist obstetrician has been brought in, relaxation classes for expectant mothers have been started, and the advice of the local authority nutritionist has been made available to the doctors. This nutritionist's clinic is proving a unique and valuable undertaking and will be reported on more fully at a later date. The general practitioners are

unanimous in their belief that the provision of x-ray and minor pathological investigational facilities would be a great advantage to the patients and to themselves, and this is the direction in which they would like to see future developments.

One of the frequently expressed fears about health centres was that there would be local authority interference and dictation in their management. Such fears have proved groundless. Apart from the good will displayed by all concerned, we think the machinery set up, which includes a house committee and a joint advisory committee, has done much to facilitate the smooth running of the centre.

Fears were also expressed that health centre practice would be too remote and impersonal and would interfere with the doctor-patient relationship. This has not happened at the William Budd Centre. We believe that the provision of a separate waiting-room for each doctor's suite has helped to preserve the doctor-patient relationship. But the attitude of the secretarial and nursing staff is just as important. In this we have been fortunate. Most of the patients attending are now well known to the staff not merely as human beings but as human beings who are being attended by Dr. A, B, or C as the case may be.

It is difficult to canvass the opinion of patients attending the centre, but none have complained of an impersonal service or have deliberately transferred to a non-health-centre doctor. The patients have an undoubted sense of security in that they know the health centre is always open and they can always get service if they need it.

It should be noted that so far there has been no move towards a group practice in the sense of financial partnership. In other ways, however, the relationships of the doctors have become a good deal closer; for example, seeing and treating emergency patients on behalf of each other is now customary and relief in other ways is developing. Collings (1953, p. 611), the great advocate of group practice, has written: "The aims of basic group practice are identical with those of ordinary general practice. The primary aim is to provide patients with the highest level of diagnostic and therapeutic service attainable outside hospital, to inconvenience the patients as little as possible, and to preserve the best elements of personal service—all at a cost the patient (or better, the community or nation) can afford."

We think this is being achieved at the William Budd Health Centre without formal financial partnership but with the advantage that each practitioner firm maintains its individuality and that the patient can indeed be sure that he will see the doctor of his choice and not any one of half a dozen or more different members of a group practice.

Collings was careful to qualify these aims by reference to what the nation or community can afford, and here we should like to comment on the financial aspects of this health centre. It is true that it is costing £10,000 a year, but this is for fairly extensive local health and education authority services for 30,000, together with general medical services for some 10,000 people. This is a lot of money, but let us keep a sense of proportion. Even if the general medical practitioners had not participated in this project there would have been a need for, and statutory duty to provide, local authority services. The capital cost for the building would have been about the same and the maintenance may have been halved, but the centre would have been lying idle for many sessions a week. Indeed, there must be many hundreds of good local authority clinics which could be used with advantage by general medical practitioners without necessarily curtailing the local authority services. The sooner arrangements of this kind can be made the sooner many local authority doctors will relinquish their "clinical duties" in maternity and child welfare and minor ailment clinics. Moreover, the practitioners, relieved of non-productive work, can then turn their attention to the preventive and promotive aspects of health work. One other word on finance—and we say

this in no carping spirit—the cost of all the principal activities in the centre is no greater than buying part of the services of two consultants in receipt of a special merit award.

It is already apparent that many patients have been treated who, but for the health centre, would have gone to hospital out-patient departments. With further aids, such as a small laboratory and the help of a laboratory technician and facilities for simple radiography, there can be little doubt that not only will the patients benefit but the practitioners' interest and standard in general practice will be further stimulated and, not least important, the overworked hospital out-patient department must be still further relieved.

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Nova et Vetera

RICHARD MEAD: PIONEER AND PATRON

Before Barry built the vast brick and terracotta Hospital for Sick Children at Great Ormond Street, there existed at the corner of Powis Place a fine old Queen Anne mansion where for the last twenty-four years of his life Dr. Richard Mead lived, as Dr. Johnson said, "more in the sunshine of life than any other man." He was pre-eminently great in an age of great practitioners—the epitome of accomplishment in the fullest meaning of that word. For Mead enjoyed the best of both worlds, basking, like Sloane, in the approval accorded to generous patrons, and esteemed, like Cheselden, as a reliable physician. Pope has caught both qualities with his lines:

And Books for Mead, and Butterflies for Sloane
and

I'll do what Mead and Cheselden advise,
To help those limbs and to preserve those eyes.

His life illustrates the rich leaven which Nonconformity brought to English scientific and medical thought in the seventeenth and eighteenth centuries. Born at Stepney in 1673, he was first educated at home by his father, an eminent Nonconformist divine, then by two successive tutors until, at the age of 16, since Oxford and Cambridge were barred to him by the Test Acts, he proceeded to Utrecht, where he studied classics and philosophy for three years. He spent a further three years at Leyden, where he worked alongside Boerhaave, and then, with his brother and two others, he toured Italy, taking his doctor's degree in philosophy and physic at Padua at the age of 22.

At Stepney, too, began his professional career, where his father assisted, even to the extent of recommending him from the pulpit. His first published work showed that he had assimilated the teaching of Archibald Pitcairne at Leyden. Entitled *A Mechanical Account of Poisons* (1702), it accounted for the effects of several poisons by their admixture with the blood. An abstract of this, published in the *Philosophical Transactions* of the Royal Society for 1703, not only secured his election to that body but appointment as physician to St. Thomas's Hospital in the same year.

Moving as he did in wider circles, he took up residence in Crutched, and later in Austin Friars, adding further appointments *en route*—the readership in anatomy to the Company of Barber Surgeons, the vice-presidency of the Royal Society, and the doctorate of medicine of the University of Oxford. This last honour enabled him to be admitted to fellowship of the Royal College of Physicians, of which he subsequently became a Censor, Harveian Orator, and lived to refuse the presidency.

"Mead, I love you," said the irascible but generous John Radcliffe, "and I'll tell you a secret to make you a fortune—use all mankind ill." Though Mead took over Radcliffe's house and practice in Bloomsbury Square in 1714, he did not take his advice. On the contrary. When Watteau, the distinguished painter, came especially from the Continent

to secure his help in arresting his consumption, Mead commissioned him to paint two pictures, and this generous patronage was extended to a variety of others. He secured the liberation of Dr. Freind from the Tower of London, where he was imprisoned, and pardon for the Reverend G. Kelly. He was without a rival as a practitioner, making an average of from £6,000 to £7,000 a year. He attended the King, the Prime Minister, Sir Isaac Newton, and Bishop Burnet among others. A pioneer in public health, his *Short discourse concerning Pestilential Contagion and Methods to be used to prevent it* was first published in 1720 and ran to seven editions in twelve months and more afterwards. In it he recommends, as a first step, the establishment of a Central Council of Health, armed "with such powers as might enable them to see all their orders executed with impartial justice." He urged that the sick should be isolated in "clean and airy habitations" sustained at public expense.

After 1720, when Mead removed to Great Ormond Street, he built a large gallery at the bottom of his garden to house his treasures. Here he would entertain Richard Bentley, the formidable Master of Trinity College, Cambridge (over whom he possessed great influence), and Martin Foulkes, the antiquary. It was here, too, on February 16, 1754, that Richard Mead died, surrounded by over 10,000 books and numerous *objets d'art*. Unlike his great contemporary and friend, Sir Hans Sloane, no steps were taken to acquire his collection, and it was dispersed by auction. Sir Hans Sloane's name lives on both at Chelsea and at the British Museum, John Radcliffe's by the museum and observatory which bear his name at Oxford, but Mead's links with the present are more tenuous if equally binding. For it was he who persuaded the bookseller Thomas Guy to erect a new hospital at a cost of £18,793, increased by an endowment of £200,000 on Guy's death in 1724.

W. H. G. ARMYTAGE.

Preparations and Appliances

A REST CHAIR FOR ARTHRITICS

Dr. H. F. WEST, physician-in-charge, Sheffield Centre for Investigation and Treatment of Rheumatic Diseases, writes: Patients with painful and stiff hips or knees usually find great difficulty in getting in and out of ordinary rest chairs.

Being dependent on others in this matter they often spend too long at rest, stiffening up, or on their feet, developing oedema of the legs. The chair illustrated has been designed for such patients and is made in varying heights. A patient should have the highest chair he can manage to swing himself on and off. These chairs were made by Messrs. Shortall Ltd., Maltravers Street, Sheffield.