obviously the more scientific, and the latter has been generally condemned as of no value. Nevertheless, it is a method that I have employed as a routine in the out-patient department, and I can speak of it in the highest possible terms. It has the merit of extreme ease of administration.

I have three bottles made up with normal saline containing in each ounce $\frac{1}{1000}$, $\frac{1}{100}$, and $\frac{1}{10}$ mg. of T.R.; $\frac{1}{2}$ per cent. phenol helps to preserve the solution.

I commence by giving a child $\frac{1}{10}$ of the weak solution, or $\frac{1}{1000}$ mg., and the next week double the dose provided there has been no rise of temperature. In the out-patient department I rarely increase the dose beyond $\frac{1}{10}$ mg., as supervision is not easy.

I believe strongly in small doses to begin with, gradually increased and continued over a long time.

I have never seen any harm result. As a rule, after one or two doses the appetite and colour are better, and the lesion shows slight improvement.

I have here to-day a case of tuberculosis of the tarsus and metatarsus, which has had nothing in the way of treatment except tuberculin and cod-liver oil mixture. The child has run about on the diseased foot practically the whole time except for the first month of treatment, when, owing to the large swelling on the dorsum of the foot, it could not get its shoe on.

Before proceeding to demonstrate the cases of joint tuberculosis that I have collected here to-day, let me emphasize what I have already said, that surgical tuberculosis of joints in children can be cured and most efficiently cured, by the conservative measures which I have just now rapidly reviewed, and that the more radical methods are rarely required, and do not give such good results.

CASE I.—T.B. Hip. G. D., female, aged 8. First seen in April, 1912. Symptoms for three to four weeks. X ray shows changes in head and under surface of neck. *Treatment:* Rest in double Thomas six months. Tuberculin by mouth every fourteen days. November, 1912, movements in hip normal. April, 1913, splint off one month. No evidence of disease.

CASE II.—T.B. Knee. A. B., female, aged 13. Symptoms started January, 1910. Treated for some months with rest in plaster at convalescent home. November 23rd, 1910, readmitted. Knee very swollen. Synovial sac distended with pus. X ray showed erosion of cartilages and bone of tibial and femoral epiphysis. *Treatment:* Tuberculin by mouth every week until July, 1911. Iodoform injections on five occasions with aspiration of pus. Bier's elastic bandage, one hour on, three off. *Present condition:* Healthy-looking girl. Walking since July, 1912, with apparatus to guard against flexion. Shortening $\frac{1}{2}$ in. Knee ankylosed.

CASE III.—T.B. Ankle. F. A., female, aged 2 years 6 months. First seen March 5th, 1913. History five to six weeks. X ray, no bony changes. *Treatment:* Splint, Bier's bandage, tuberculin. *Present condition:* General health much improved; some reduction in size of swelling.

CASE IV.—T.B. Metatarsus (also subcutaneous nodule on buttock). First seen March, 1912. Large swelling over dorsum of foot. X ray shows large focus in first metatarsal and epiphysis of cuneiform metatarsal joint. *Treatment:* Splint one month; tuberculin by mouth every week. Child has run about since first month of treatment. *Present condition:* Swelling disappeared; no pain or symptoms of any kind; walks perfectly. X ray shows marked sclerosis around the foci.

CASE V.—T.B. Hip. H. P., male, aged 11. Abscess tapped left side, September, 1910; iodoform; double Thomas one year; tuberculin every week. Splint left off September, 1911. *Present condition:* Movements at hip perfect; slight limp; shortening 1 in. X ray shows focus in neck sclerosed; some coxa vara.

CASE VI.—T.B. Elbow. C. K., aged 8 years 9 months. January, 1912, swollen elbow; all signs disappeared after one month; was quite well through the summer. October, 1912, swelling recurred, gradually increased, pain marked, limitation of movement. January, 1913, x ray shows large focus in diaphysis of humerus. *Treatment:* Immobilized in plaster at right angle; tuberculin by mouth; general condition improved; swelling about the same.

CASE VII.—T.B. Wrist. P. B., aged 5 years 3 months. December, 1912, large swelling on dorsum; sinus discharging; x ray shows no bony change. *Treatment:* Splint from elbow to metacarpal joints; Bier's bandage; tuberculin; iodoform injections on three occasions. *Present condition:* Sinus healed; swelling almost disappeared except on radial side of wrist; movements of fingers good; no pain; general condition improved.

CASE VIII.—T.B. Shoulder. M.B., female, aged 3 years. September, 1912, swelling and pain right shoulder; abscess pointing anteriorly; x ray showed very extensive disease of head and shaft. *Treatment:* Tuberculin given for two weeks. *Operation:* Incision in front of deltoid; joint opened; sequestra and granulation tissue sharp-spooned; iodoform emulsion introduced; healed per primam; arm fixed to chest by bandage;

tuberculin continued. *Present condition:* Wound soundly healed; movements in joint slight; no pain; general condition good.

CASE IX.—T.B. Knee, and teno-synovitis middle finger of right hand. E. H., female, aged 3 years. November, 1910, typical tuberculous swelling knee; x ray negative. *Treatment:* Thomas's knee splint; crutches and patten; Bier's; tuberculin. *Present condition:* Knee shows no swelling, stiff but some movement which is increasing; walking well; finger practically normal.

Presidential Addresses

TO THE

BRANCHES OF THE BRITISH MEDICAL ASSOCIATION.

METROPOLITAN COUNTIES BRANCH.

THE PROFESSION, THE PUBLIC, AND THE INSURANCE ACT.

By R. L. LANGDON-DOWN, M.B., M.R.C.P.

In entering upon the duties to which you have called me, may I be allowed to give expression to the two feelings which are uppermost in my mind? The first is the sense of the honour you have conferred upon me in placing me in the chair of this Branch, for which I take this the earliest opportunity of thanking you; and the second is the sense of the responsibility that rests upon me. All I can say is that I will do my best to carry on the high traditions of the office, well assured that in this I shall have the help and support of able and willing workers on the Council, as my predecessors have had in the past.

Since the report of the Council was issued death has withdrawn from among us a distinguished member of our profession, who was also a member of this Branch, and for a brief period edited our JOURNAL. Sir Jonathan Hutchinson, by his enthusiasm for medical education and by showing how much could be done to advance science by the method of patient observation, record, and comparison, will always be remembered among the great men we honour as pioneers in medicine. His name and memory therefore claim a place in our thoughts to-day.

REORGANIZATION.

The report of the Council for the past year shows that the Branch has been ready to take the lead in important matters of Association policy, such as the rearrangement of the boundaries of Divisions, and the proposals it has made for strengthening and perfecting the constitution of the Association, on the initiative of Dr. Biggs, which are now the basis of the proposals before the Representative Meeting; it has also devoted much time and thought to the suggestions of the Central Council dealing with schemes for a public medical service under the auspices of the Association and in regard to improvements of the Insurance Act. The power of organization and the readiness to work enthusiastically shown by the Metropolitan Divisions during the latter part of last year was very remarkable, and reflected great credit on them and their leaders. Such a record cannot fail to give weight to the counsels of this Branch in the Association, and any changes in the constitution which may give greater powers and more duties to the Branches will naturally affect the work and responsibility of the Metropolitan Branch in an especial degree.

The rearrangement of the Division boundaries in which this Branch took a very early part, following the enthusiastic lead of Dr. Sykes and Dr. Barnes, may seem to some to have been a mere piece of mechanical adjustment. I venture to think it is of more significance than that: it implies a new meaning, a fresh principle of policy. Hitherto the criterion in mapping out Divisions had been the convenience of members in attending meetings; now we have taken as the guiding idea the necessity for making our organization march side by side with the organization for local government, and our boundaries tally as far as possible with those of civil administrative areas.

The next step that lies immediately ahead of us is to bring the Local and District Medical Committees into closer touch with the Association. There is the danger that the men on these bodies may become so preoccupied with details of insurance work that they may lose sight of other matters of equal importance to the profession. No such isolated statutory bodies can properly replace the independent and co-ordinated activities of our Association. On the other hand, the local interest and personal activity which has been stimulated by the formation of these bodies should be utilized as far as possible to draw new strength to the Association.

Among our twenty-seven Divisions we now welcome representatives of the whole of Hertfordshire, Middlesex, and London; but we have no desire to annex for the sake of annexing, and if we were asked to part with some of our Divisions in Surrey, as is possible, we should, I feel sure, be guided by what we conceive to be the ultimate interests of the Association as a whole.

NATIONAL HEALTH INSURANCE.

In spite of this, owing to cleavage produced in the profession by the coming into operation of medical benefit under the Insurance Act and the attitude of hostility to that measure adopted by the Representative Meeting in January, there has been throughout the Association a situation most unfavourable to any vigorous action. There is a sense of unreality and ineffectiveness about our proceedings; meetings are less well attended, and Divisions are less interested in the doings of the Association.

Until some solution of our present difficulties and this state of suspense and uncertainty can be found, we cannot go vigorously ahead with the work before us. Our members are looking to us to take an active hand in modelling the regulations under the Act and in administering the Act and the regulations in the best interests of the profession.

We have most important questions in front of us in regard to the perfecting of our own constitution and organization. This will make large demands on our time and energy. How can we concentrate effectively on such work in our present frame of mind?

One of the most pressing problems requiring solution is that of the dependants of insured persons, to which is closely allied the question of the treatment of elementary school children found on inspection to be defective. Much may be done here by prompt and united action to prevent the mischief of underselling and to avoid the mistakes and difficulties that arose in connexion with the National Insurance Act. We ought to be preparing to help our members and others engaged in work under the Act with schemes under which by co-operation and specialization the work can be systematized and carried out under better and more convenient conditions, such as treatment centres, etc.

We have also to consider such questions as the provision of institution treatment, co-ordination of the hospitals with the men for scientific work, the provision of clinical laboratories, special appliances needed in treatment, the whole question of nursing, and many other points.

All these matters the Association is better fitted to deal with than any other body in the profession. And yet, in the uncertainty which exists as to our position and future action, we find ourselves weak and distracted owing to the absence of the necessary driving power, unanimity, and enthusiasm.

That this is a misfortune for the public interest no less than for the profession can hardly be doubted. There is nothing in the relations of the authorities with large bodies of the industrial and commercial world which leads to more difficulties and disagreements than the want of a well-organized, broad-based, independent representative body to speak in the name of the employers on the one hand and the employed on the other. That the Association should again be in a position to speak in the name of a united profession with vigour and decision is, I am convinced, a thing to be desired no less in the interests of the public, so that they may have a well-considered and authoritative statement of our views on any subject, than for the maintenance of the honour and interests of the profession.

I have therefore felt impelled to review the position of the profession in regard to this great change that has

come over medical practice during the present year with a view to seeing if it is possible to find a course that shall bring us together again for the objects we all have in view, and in particular the unity and strength of our Association.

The Voluntary Club System.

That legislation of some kind in regard to provision of medical treatment had become necessary is a matter of general agreement. The existing arrangements had failed to bring medical assistance of an adequate kind to large sections of the people, and even where it had, the conditions were profoundly unsatisfactory to the medical profession. Whether the principle of club practice was originated by the doctors or the clubs I do not know, but the profession found it necessary in most industrial areas to adopt this plan if they were to be secure of even a moderate reward for the services they rendered to the people, and not press unduly on their patients' resources.

The essential vices of the voluntary club system were: (1) The fact that the club and not the patient was the employer of the doctor, and (2) that the appointments were practically put up to auction with all the consequent evils of underselling; in short, though admitted to be necessary, it was regarded by the profession as unsatisfactory. The attitude of the public in regard to provision for sickness may be briefly summed up in the following passage from a speech by one of the lay Insurance Commissioners.

The important question that so often came up nowadays was how far professional work, unless effectively organized, could meet modern needs. These were difficult, but they had to be faced and thought out. All social reform must follow certain stages of progress. In the first place there was the position when there were only a few in the whole population who realized and enjoyed certain benefits as a result of their wealth and position. The next stage came when the many had begun to see what excellent effects followed on the possession of these advantages and arrangements, and then arrangements were made for the advantages to be more widespread through the community and made available for any who desired them. The third stage was when the community, having seen first the good effect on the few, and then the good effect on the many, came to realize that this particular thing, which was the luxury of the few and then the possession of the many, had become so important to the welfare of the whole that no one should be allowed to do without it. The question of health had now reached the third stage, when the community had said it was impossible to allow any one to go without suitable means for the mitigation of sickness. These obligations were in the interest of the community as well as of the individual.

The Attitude of the Association to the Insurance Bill.

The British Medical Association has from the first admitted the necessity for legislation to extend medical assistance to the poorer classes of the community, and the National Insurance Act was accepted in principle by the Representative Meeting as a means of attaining this end.

The main objects of the scheme were:

1. To provide effective medical assistance to the wage earner in every family, together with certain sickness and invalidity benefits.
2. To do this on the compulsory insurance principle, of which the essential feature is a regular small payment during health.

In agreeing to the principle of the Act, it must be taken that we agreed with these objects. Incidentally it may be mentioned that one of the indirect consequences of the payments being collected compulsorily, was to give them technically the status of taxes and public funds.

It hardly concerns us as to the sources from which the money was to be raised, but it seems clear that without direct aid from the national exchequer any improvement in the remuneration of the doctor would be very difficult; on the other hand, if one thing was more certain than another, it was that the State would inevitably insist upon an important voice in controlling the expenditure of such funds, and that all medical men who drew payment from or administered these funds would have to be in some degree public servants.

Assuming, then, as I think I may, the general acceptance of these principles of the Insurance Act by the profession, the next question that had to be settled was as to the form of medical practice to be adopted under the bill.

There were broadly three possible choices :

I.

A continuation of the friendly society system, under which the doctor was a direct servant of the society and the members had to put up with the medical man chosen for them. This was, as I have said, one of the root evils of the old contract practice system; it failed to provide or to foster the relations of confidence and trust between doctor and patient that are so essential to success in treatment, and it led often to perfunctory, ill-paid work, which was all that the doctor could afford to give in the circumstances, and which was all that those who received his treatment came to expect. The other evil of this system was the mutual distrust and jealousy engendered in the profession by constant underselling, and the inadequate level of payment which resulted from such competition, and which as an Association we strove, often in vain, to remedy.

II.

The second possible choice was the organization under the State of a salaried medical service. A scheme founded in part on this basis was set forth in the admirable address delivered from this chair last year. In abstract logic there is much to recommend such a plan. It would solve many difficulties which still lie ahead of us. It has many keen advocates among advanced politicians, and even in our own ranks one is sensible of a movement in this direction.

Among the extreme supporters of this principle the ideal is the extinction of private practice. Others desire the persistence of private practice side by side with the State service.

The difficulty in this latter case is that the industrial classes could not afford to forego sickness benefit, and it is difficult to see how the State could administer sickness benefit except through its own salaried officers. The result of this would be that private practice would become restricted to the well-to-do classes, unless, indeed, the acceptance of sickness benefit came to be held to carry the stigma of pauperism, when we should be in practically the same position as under the old system.

But so far the idea of a State medical service has received the support of only a small minority both of the profession and the public. It is easy to see why the profession is hostile, for such a change would be far more revolutionary than the Act, and private practice would not merely be changed in character, but restricted to quite narrow limits or destroyed. The unreadiness of the public, as I believe, for such a change is based on a deep-seated, instinctive preference for an intimate and personal rather than for a purely official relationship between patient and doctor.

III.

We come, then, to the third alternative—that is, to maintain as far as possible under the Act the essential features of private practice.

The distinguishing character of private practice is the personal relation; this will on consideration be found to rest in the last resort on the right of the patient to change his doctor and on the right of a doctor to decline a patient. This principle was put in the forefront of our programme with the universal approval of the profession, and was adopted by the Government.

Whatever may have been said to the contrary (and undoubtedly extravagant things were said), free choice of doctor can never imply unlimited freedom of choice; even in ordinary private practice the choice is limited by such circumstances as the means of the patient, the place of his residence, the number of doctors available, etc. But even if there are only two doctors to choose from, the right to change from the one to the other serves to distinguish the relationship from that with a doctor appointed by an official, and in whose selection the patient has practically no voice; and, similarly, the correlative right of the doctor to refuse to treat a patient must be subject to certain slight practical limitations, but these do not destroy its effective value.

Similarly, seeing that the medical man working under the Act must be in some sense a public servant, there must be some conditions and regulations to which the doctor must submit; but with the right secured for both

patient and doctor to exercise selection, and with the doctor free to follow his own line of treatment, as is practically assured, we have the nearest possible approach to private practice in its essentials.

One of the consequences arising out of this was the plan, also originally suggested by the Association, that in order that the public might know which doctors were willing to serve under the Act, and to help them in making their choice, a list of the doctors willing to serve should be published. This list we called a panel. It seems to be a practical and simple arrangement. But putting the name on the panel involves the acceptance of certain conditions, and there is a number of men willing to do the work and accept payment from and share in the administration of what have been decided to be public funds, but who are unwilling to subscribe to the conditions, and desire to make their own arrangements entirely free from public control. This, I submit, would be in direct contravention of one of the most firmly established rules of public policy in this country; also, if extensively allowed it would greatly impair the value of the Act from the point of view of collecting information and statistics.

I think it will be clear to those who have followed my argument that any attack on the panel system as such comes up against inexorable and inevitable conditions, and that the only alternative is some form of State service which would be equally or more distasteful to the objectors.

Compulsory National Insurance.

Let us consider the position. Pure private practice failed to meet the wants of the people; the old form of club practice stands universally condemned; the reception accorded locally to our carefully considered schemes for a public medical service organized by the profession showed that they were felt to be impracticable, and could not live side by side with a scheme of compulsory national insurance.

What other alternative is there than some form of State service more or less complete and universal? Can it be doubted that at the present time any such scheme would be regarded as more injurious to the profession than the present Act? If this is the only alternative, then let us realize that those who demand changes in the Act which are inconsistent with its fundamental character are in effect leading the way to far more drastic and sweeping changes, however little that may be their intention.

In regard to reasonable requests to make private arrangements within the conditions of the Act and the regulations, no obstacles are now being raised, and permission has been granted for a doctor to limit himself as to the number of patients he will attend, and to indicate the fact on a list. This right, coupled with the right of the doctor to select his patients, will secure for the able and experienced man in better class practice, if he exercises his selection rigidly, the advantages to which his superior ability entitles him. It is probably the case that in the first start of the Act the selection of the doctor was rather a happy-go-lucky affair, and that we are not yet in a position to judge of its results. The elimination of undesirables will begin next year.

It was at first feared that the bad lives would generally be refused, or would be left over for distribution among the doctors, often against their will. Experience seems to be showing that the bad lives had no difficulty in being accepted, and that the great mass of those who have not chosen a doctor and have to be allotted are persons who do not know what it is to be ill. Presumably, too, those doctors who join the service for a limited number of patients only will not be required to take any of the unallotted surplus. It is probable that this surplus will be disposed of by mutual arrangements among the doctors without any great hardship.

Another illustration of unexpected results is the fact that in South Wales the provision by which the insured are allowed to make their own arrangements is being utilized to re-establish some of the worst evils of the discarded system, and this will have to be carefully guarded against.

The Working of the Scheme.

But it will be said, and rightly, that the most important thing of all is that the medical service should be adequate and efficient.

What are the facts of the situation to-day? There are in the United Kingdom some 32,600 practitioners, of whom probably 2,000 have retired from practice, and about 5,000 more are in the category of medical officers of health, specialists, school doctors, asylum and Poor Law officers, etc., and so stand outside the ranks of those engaged in general practice, who thus number about 25,600 for the United Kingdom; if 2,200 be deducted for those in Ireland, we find that 23,400 are available for Insurance Act work in Great Britain.

The number of names on the panels is 18,000, which after full allowance for duplication, probably represents at least 15,000 individuals actually doing the work, or nearly two-thirds of the available members of the profession. Again, the members of the Association in Great Britain number 18,200, as compared with 29,800 in the profession as a whole. If the men working the Act are drawn in similar proportions from members and non-members, then of the 15,000 panel doctors 9,160 are members of the Association; that is more than half our members in this country.

I think it may be taken from this that the work is at present in the hands of a fair average sample of the medical profession, and the choice of doctor, though not as large as it might be, must still be ample in most places. In some areas every member of the profession has joined the panel. But it is not only the right men that must be secured, it is necessary if they are to maintain their high standard of work and efficiency that the remuneration and conditions should be such that the work need not be unduly hurried.

As regards the adequacy of the remuneration, it is far too early to come to a conclusion. The incidence of sickness is variable, and it is only right to bear in mind that the sickness experience of the first quarter of the year happened to be exceptionally heavy, and very different results may be shown in other quarters. Allowance must also be made for the fact that the surgery attendances for slight ailments would probably be excessive owing to the novelty of the opportunities enjoyed by the insured. But it is stated that in some cases the number of visits at the patient's home is far below expectation.

In any case it would seem *prima facie* that the 15,000 practitioners who continue to do the work are not altogether discontented with the payment received. We shall know better how results turn out at the end of a year.

As to the conditions of the work, the authorities have shown that they are anxious to reduce the clerical work to the lowest level possible. The relief from dispensing should be a great boon to many men. As far as I can gather in other respects the conditions are not burdensome and work easily as a rule.

We are, unfortunately, reading of complaints as to the inefficiency of the medical service under the Act, and there has been a tendency to welcome these complaints as evidence of the unsatisfactory nature of the conditions, and to use them as proof that the prophecies of evil were coming true. That in the early days of medical benefit, when the sudden and concentrated burden of the clerical work coincided with a period of exceptional sickness, some of the complaints arose from the inability of the doctors to cope with the work I think there can be no doubt, but in recent complaints I have noticed some which point to inefficient work from quite other causes.

First of all it may be said to be common ground that under the old and bad system inefficient work was inevitable. The same men have come into this work and their old habits are likely to persist for a time in some cases. But the machinery provided by the Act and the principle of free choice of doctor will in due course tend to raise the quality of the work now required and to crush out neglect and abuses. In any case before condemning the new system let us remember how bad things were before, and be sure that there is not already a great improvement.

Such defects in the working of the Act are a matter of regret, in the first place because they tend to throw discredit on the profession, also because they are being used by some of the public to prove that the service under the Act is from the nature of the case inadequate and inefficient. The remedy which many who are hostile to the Act desire is by no means an extension of the liberties of the profession under the Act or an increase of the

remuneration of its services, but a universal State Medical Service, for which they have long been working.

On the other hand, the doctor, anxious to do his best for the invalid and finding himself often for the first time in a position to prescribe what is frequently most needed by the patient—namely, "money instead of medicine," and rest, which are available in the form of sickness benefit—may not at first have given sufficient thought to his responsibilities in the matter. When one case only is before one the needs of that case may seem trifling in comparison with the seemingly bottomless purse of the Insurance Fund.

But the doctor is placed in a position of trust. He has to administer public moneys for the benefit of his patient and at the same time to safeguard the insured as a whole against unnecessary or improper claims on their funds. It is clear that on the lowest grounds no more deadly injury could be inflicted on the principle of private practice among the insured than a failure to execute this trust without fear or favour; but, more than that, the reputation of the profession for honour and trustworthiness is at stake in this matter, and no words could be too strong to condemn the folly and disgrace of deliberate misconduct in regard to it. The appointment of medical referees is a valuable protection to doctors against unreasonable complaints on the part of the patient if the doctor is firm in resisting imposition.

It is quite possible that inadequate provision has been made to meet the really urgent demands of sickness benefit; if so, it is the duty of the profession to say so, and to make it clear on trustworthy evidence. I have no doubt that the profession, now that it realizes the position, will prove equal to the trust.

Income Limit.

Of all the points for which we contended last year that of the income limit is the only one which we completely failed to secure and in regard to which the Government did not go a long way to meet our wishes. Many men consider that they have suffered heavily by the transition owing to this, and we all regret that this is so. It seems, however, to be the one point on which there still appears to be no hope of relief from any quarter. And yet even in regard to this hardship I hear it said that, provided the remuneration is adequate, the income limit does not much matter in the long run. Whether the remuneration will prove adequate to this remains to be seen. In estimating this it is important always to bear in mind the possibility of error in comparing receipts based on a regular annual payment from a large sleeping *clientèle* with the spasmodic receipts based on actual attendance. It is only necessary to remind you that under a State scheme income limits might be abolished altogether. It seems to me that this is a case where something might still be done by approaching the Government in a cordial spirit to find a plan which should alleviate this hardship. In one minor respect the claims of the profession in regard to income limit have been met in the amending bill now before Parliament.

Method of Remuneration.

It will be in the memory of those who followed the meetings of the profession in 1911 and 1912 how prominently this matter figured in the forefront of our debates, how equally divided the Association was, and how hot the feeling. Since the Act came into force the attitude of the profession seems to have undergone a steady progressive change. In this Branch, I believe, the capitation method of payment has been generally adopted. In the discussion on the proposed public medical service scheme this method was that which secured the adhesion of the Branch Council. I believe it may be said that it has been very generally adopted by the country as a whole. This may be due to force of circumstances rather than to deliberate choice, and to the realization that in any case the fund to be drawn upon would be definitely limited in either case.

It is sometimes argued in favour of the system of payment by attendance that the doctor should not be asked to take the risk, but it is clear that if the amount of the remuneration fund is fixed the doctor must bear a risk in either case. On the one hand he has the risk of exceptional work for the same pay, and on the other the risk of exceptional unemployment with diminished income.

That the fund should be fixed is an essential part of an insurance system. Salaried officials have to bear a similar risk of exceptional work. It is often assumed in discussions of this matter that contract payment is incompatible with private practice; so far is this from being the case that in many of our smaller colonial settlements all the private practice among the white population, even of the best class, is run on the contract system with complete success and general satisfaction. That it inevitably involves scamping and shirking is a proposition which is contradicted by the experience of other walks of life, and I decline to believe it is true in the case of the medical profession.

But from the point of view of mere logic, if the Insurance Act is accepted in principle, as it has been, then, seeing that the fund for the payment of the doctors is limited, the service is essentially a contract, whether the distribution of the fund is to be on the basis of persons on the doctors' lists or attendances given. Any other system restores the very evils from which the old individual system suffered—the risk of bad debts and the unlimited risk to patient coming just when he is least able to bear it, and introduces the element of the money anxiety into the relation between the doctor and his patient, which may hamper the doctor in his work and the patient in his recovery. So bound up is the flat-rate system of fee with the unity of interest of patient and doctor from the preventive side of medical practice that I cannot help thinking that one day it will be extended to better class private practice in proportion to the means of the patient and on the foundation that every family would be compelled to choose a regular medical attendant. It may be looking a long way ahead and sound impossible to-day, but it would carry with it immense advantages to all concerned.

CONCLUDING SURVEY.

I have ventured to carry your minds back over the familiar ground of this question from the very beginning, because it is only by viewing things as a whole that we see them in their right proportions and are able to subordinate that which is subsidiary to that which is fundamental and essential, and because it is here that our difficulties still lie.

It is only by standing back, so that one may get, as it were, a bird's-eye view of the situation in its broad outlines, that we can trace the direction in which the different roads are leading, and that we are reminded of the tracts of country we have left behind.

Also we are now able to reconsider the question at a time when we are beginning to test our anticipations and our fears in the light of actual experience, and this is much to be desired at a moment when some further decision must shortly be come to as to the attitude to be adopted by the Association.

May I say how such a survey strikes me? In the first place we are apt to underestimate the great influence we had in moulding the Act to our views in its broad aspect in the early stages, and also the successes we achieved as a result of our representations to the Government last autumn.

The next broad fact which we cannot ignore is that the Act is now in work and that a majority of our own members in this country are working under it and are apparently resolved to continue to work under it. How can we as an Association, in the face of this situation, maintain, as we did before medical benefit began to be administered, that the Act is to be condemned as derogatory and unworkable? Remember it is one thing for individual members or groups of members to continue to hold this view and to act upon it in their individual capacity, should they consider it their duty, by refusing to take service under its conditions, and another and very different thing to persist in condemning by resolution of the Association the action of those who, after experience of the work and in enormous numbers, apparently take a contrary view.

It is for those who continue working the Act to tell us their difficulties and in what respects we can help them to obtain improvements, when we ought to give them every assistance in our power.

It is a matter for those who are still dissatisfied and are standing outside and resisting to consider, on the one hand, whether they can bring the medical service of the

Act to a standstill, and if so, whether that would lead to a satisfactory solution, or whether the outcome might not be infinitely more disastrous to private practice than the present position; and on the other hand, if that is not their intention or desire, whether they are likely by their present policy to induce the Government to concede their demands, or whether they would not do better to drop their hostility to the measure and by friendly negotiation and co-operation with the men on the panel seek to make the Act as fair and efficient as possible.

But whatever view they may take on these matters, I suggest that the time has come when the Association should officially dissociate itself from any such hostile action.

The present position is that the Act is on its trial; it is still being improved, and it is too early to pronounce judgement upon it; it is not yet time to curse it nor to bless it altogether.

Let us, then, withdraw our condemnations, which were based mainly on anticipations; pronounce no blessings, but wait and see. If we call a truce now we shall save ourselves from the risk of humiliation and the loss of prestige in the public eye, which would be the result of ineffectual action.

And as regards our own members and the profession generally, we shall gradually heal our dissensions, we shall close our ranks, renew our vitality, and clear the ground for the Association to exert in an effective and whole-hearted manner that influence on public opinion and future developments to which it is entitled by its representative character and its splendid work and achievements in the past.

SOUTHERN BRANCH.

MEDICINE AND EUGENICS.

By JOHN COWPER, M.B., C.M.EDIN.,

Shanklin, Isle of Wight.

For some time past we have constantly had before us a subject closely affecting the relation of our profession to that of the general public. It came from without, having a political origin, and we had to face it, though not a few of us got rather weary of its changing aspects.

This year another subject, of a very different kind and origin, and of vastly greater ultimate significance, has been prominently brought before the notice of the people of this country, though it affects other countries as well as our own. I allude to the first Eugenic Congress, very appropriately held in London, the city in which Sir Francis Galton established his laboratory for the study of heredity as affecting the members of civilized communities.

Just as sanitary and hygienic reform was developed and pushed forward by the medical men so will this newer science rely to a large extent upon the same profession for the establishment in the minds of the community generally the grasping of the fundamental principles underlying it.

I do not assert that medical men alone have been the pioneers in the study of sanitation, hygiene, and heredity, but if you deduct the men who have had a medical education, whether they practised their profession or not, very little indeed would be left. Moreover, before any new studies bearing upon, and affecting, the lives of men and women can become effective the practical bearing has to be brought home to the minds of the people themselves, and in this respect I do not think that the profession to which we belong has had its due share of credit for the sanitary and hygienic reforms which it has been instrumental in bringing about, often not only without thanks or acknowledgement, but in the face of opposition and difficulty.

I am well aware that even amongst experts and medical men many of the questions in heredity are still theoretical, and some highly speculative, in spite of all the work that has been done in recent years. But besides these theoretical and speculative questions, certain well ascertained facts have emerged, as can easily be gathered from the treatises of such writers as Professor Thomson and Dr. Archdall Reid.