any improvement in their standard of work. What I do think is that they are doing a very necessary work, and should, when transferred to city councils, continue that work—for it must be done—and leave the voluntary hospitals to carry on the work for which they are better suited than the Poor Law hospitals. Mr. Holroyd Slater (July 20th, p. 126) calls attention to the hospital at Bradford as an example of what the transferred Poor Law hospitals should become. But the circumstances connected with the origin of this Bradford Municipal Hospital were altogether exceptional. The Poor Law Infirmary was municipalized ten years ago, for at that time the majority of the members of the city council were socialists, and they thought Bradford ought to have a municipal hospital. The large voluntary hospital of the city was too small, but a new site for it had been acquired, and attempts were made to raise the £200,000 required for its rebuilding. This was during the war, and, as might have been expected at that time, was unsuccessful. At this juncture the corporation started its scheme of the municipal hospital as a rival to the voluntary one. (See *Journal*, 1920, vol. ii, pp. 527, 552, and 753.)

If the voluntary hospitals do not receive adequate support from the charitable public, then we must have municipal hospitals to replace them, or the municipality must finance and control the hospitals now supported by voluntary effort; but once rate-supported hospitals, of equal efficiency to the voluntary ones, replace some of them, the charitable public will naturally feel inclined to leave the support of all hospitals to the municipality. The poorer classes will be the sufferers, for they will have to pay their share of the increased rates. It may be pointed out that at Bradford, although it has a municipal hospital run on the same lines as the voluntary one, still the latter continues to receive support from the public; but nevertheless I am inclined to think that the existence of such municipal hospitals will inevitably tend to put an end to voluntary support.

I see Mr. Slater agrees with me that in order to bring the transferred Poor Law hospitals up to the standard of the voluntary hospitals it is necessary to appoint visiting specialists on their staffs. But that is not enough to effect the change. There are already visiting specialists on the staffs of some of the large Poor Law hospitals, acting only as consultants. To raise the status of the Poor Law hospitals to that of the voluntary hospitals the whole system of treatment must be altered, so that all patients are admitted under the care of a specialist, and not under the care of a medical officer who is in charge of the whole institution. Dr. MacWilliam says in his letter in the *Journal* of July 20th (p. 125) that in the Walton Poor Law Infirmary at Liverpool specialists have wards allotted to them. This is not so in the large Poor Law hospital in Bristol, and must, I think, be quite exceptional. But even in these wards at Liverpool the specialists do not seem to have complete control over the treatment of their patients, for Dr. MacWilliam says they are "subject to the general responsibility of the medical officer." This seems to me a very undesirable position for any specialist, and one which would not be tolerated in a large city voluntary hospital. In the *Medical Directory* the medical officer is given the first place on the list of the staff, and then follows a list of eight "visiting medical officers," who are not described as in charge of any special departments. This is very far from being comparable to the working of a large city voluntary hospital.

I agree with Dr. MacWilliam when he says that the medical work and nursing in a Poor Law hospital are not as interesting as in a large voluntary city hospital, but when cases are transferred to the city council which would be better dealt with in the large voluntary hospitals, we cannot allot them to a Poor Law hospital simply to interest the staff. Dr. MacWilliam suggests that we should classify patients as "individuals," not by diseases. Does he suggest doing so by their temperaments or the colour of their hair? As for Mr. Slater's representation of my "fantastic" idea of the municipal hospital dump and the voluntary hospital treasure seekers therein, this is really too absurd to need reply.—I am, etc.,

Bristol, July 21st.

CHARLES A. MORTON.

SIR,—The problem of the relation of the voluntary hospitals to the municipal hospitals is the same as that which confronts us with regard to trade in the Empire. The voluntary hospitals naturally regard themselves as senior partners, while the municipal hospitals, quite rightly, wish to preserve and foster their growing industries. Given good will, a realization that both exist for the good of the community, and an efficient clearing-house, the problem should not be insoluble.—I am, etc.,

Dulwich, S.E.21, July 23rd.

H. M. STEWART.

FEES FOR ATTENDANCE ON DIFFICULT LABOUR.

SIR,—A primigravida was referred to me, by a form for medical help, on account of small pelvic measurements. After several examinations without anaesthetic I was still undecided as to the chances of normal delivery. An anaesthetic for possible induction of labour revealed that Caesarean section was inevitable, my colleague confirming this finding. The operation was performed later with the help of two practitioners. The baby was also circumcized. Apart from this the mother received much treatment before operation for gastric ulcer and burns.

A bill for fourteen guineas, together with a description of the treatment, was tendered to the medical officer to the county. The reply was that there are no provisions for fees outside those covered by the scale of fees, and I am allowed three guineas, including the fee for the anaesthetist.

I am dissatisfied, not only on my own account, but also that the colleagues who so willingly helped me are not to be sufficiently paid. I am anxious to know whether this unfortunate state of affairs exists only in my area; and as I propose to refer the matter to the local Branch of the British Medical Association, I should be grateful for any suggestions, and particularly the experiences of practitioners in this direction.—I am, etc.,

Llanelly, July 24th.

RHYS PATON.

Obituary.

THOMAS EAGLESON GORDON, M.Ch., F.R.C.S.I.,

President of the Royal College of Surgeons in Ireland.

WE regret to record the death of Mr. T. E. Gordon, President of the Royal College of Surgeons in Ireland, which took place on July 25th in Dublin. He was a native of the North of Ireland, and had been associated with the Adelaide Hospital in Dublin from his student days until a few months ago, when he resigned on account of trouble with his eyesight and general ill health.

Thomas Eagleson Gordon received his medical education in Dublin, and shortly after he had graduated M.B., B.Ch., in 1850, he was appointed house-surgeon at the Adelaide Hospital, where he had obtained a Hudson Scholarship; he later became assistant surgeon. In 1855 he obtained the diploma F.R.C.S.I., and on the death of Professor Edward Taylor in the same year he went to the Royal City of Dublin Hospital, where he was surgeon for about twelve months. When Dr. Henry FitzGibbon resigned his position as surgeon at the Adelaide Hospital he was succeeded by Dr. Gordon. For many years he was a demonstrator of anatomy in the Medical School of Dublin University, and in 1922 he was appointed professor of surgery; four years later he proceeded M.Ch. He was a member of the Dublin Biological Club, and of the Anatomical Society of Great Britain; he was a Fellow of the Association of Surgeons of Great Britain and Ireland, and of the Royal Academy of Medicine in Ireland, in which also he was president of the Surgical Section. For a number of years he was consulting surgeon to the Rotunda Hospital, Dublin. He was a vice-president of the Section of Surgery at the Annual Meeting of the British Medical Association at Aberdeen in 1914. In addition to conducting a large private practice, he was the London Midland