home to politicians who have the power to control the influx of undesirable aliens.

THE next session of the General Medical Council will open on Tuesday, May 23rd, when the President, Sir Donald MacAlister, K.C.B., will take the chair at 2 P.M.

Dr. Henry Head will deliver the Croonian lectures upon "Sensory Changes from Lesions of the Brain" before the Royal College of Physicians of London on June 13th, 15th, 20th, and 27th, at 5 P.M., at the College, Pall Mall East. Dr. Head wishes to announce that the whole of the work upon which the lectures will be based has been carried out in conjunction with Dr. Gordon Holmes.

THE Royal Commission on the Poor-laws and Relief of Distress have recommended that "a local authority should not be allowed to appoint an ex-member as a paid officer unless he or she has ceased to be a member of the local authority for a period of, say, 12 months before appointment." The Local Government Board are in agreement with this view, and most medical men will recognise the impropriety of appointing to paid offices persons who are or have recently been members of the authority.

THE annual general meeting of the Asylum Workers' Association will be held at 11, Chandos-street, Cavendish-square, W., on Wednesday, May 24th, at 2 P.M., Sir William J. Collins, M.D. Lond., F.R.C.S. Eng., president of the association, in the chair. The annual report will be submitted, officers elected, and presentations made of medals for long and meritorious nursing service. As matters of much importance to asylum workers will be discussed it is hoped that there will be a large and representative gathering of members and friends of the association.

THE NATIONAL INSURANCE SCHEME: THE PRUSSIAN OFFICIAL TARIFF FOR MEDICAL ATTENDANCE.

BY G. P. FORRESTER, F.C.S.

THE National Insurance Scheme laid before the country by the Chancellor of the Exchequer inaugurates a new era in the history of our social reforms, and will be called to take a leading position among the many legislative measures introduced during the past 100 years with the aim of safeguarding the worker from many of the unwelcome sequelæ of a highly developed industry and of ensuring that he shall work under regulated conditions and in surroundings designed to protect his health to the uttermost limit—measures which are recognised to be the best of their kind. Those who are from personal knowledge acquainted with the working in actual practice of the German scheme of insurance against sickness will note with pleasure that the British scheme skilfully avoids many of the defects which have come to light in the course of years in the German system, and which the Bill at present before the Reichstag is designed to remove; this is evidence that the Chancellor has profited by the experience collected on the other side of the North Sea, and contains an assurance that the mistakes made in the beginning by not defining sharply the relations of the medical practitioner to the sick club will not be an unwelcome feature of so beneficial a measure.

The promise given by Mr. Lloyd George that the medical profession was not to be "sweated," but on the contrary is to materially benefit in consequence of the introduction of national insurance against sickness is gratifying, and it remains to be seen on what basis the medical practitioner will be called upon to participate in the scheme. It is significant to note the statement that, as far as possible, the field of work of the physician was to be demarcated from that of the pharmacist, in that the latter would be entrusted with the supply of the medicines. Any step of this nature can only be welcome to the practitioner, and THE LANCET¹

has already expressed an opinion on this point. If in Great Britain the average patient is accustomed to associate the doctor with the bottle of medicine, both from the point of view of fee and of curative effect, as a result of the knowledge of the one and of the virtues of the other, he must not forget that this is another insular peculiarity. At the present moment, outside Great Britain, it is practically only in the United States and in some Swiss cantons that the doctors fulfil the double functions of physician and dispenser. In all other countries dispensing by doctors is strictly prohibited, and the physician has in every instance to write out a prescription which is then made up in a pharmacy. Indeed there are even laws in existence in some States which impose heavy penalties if it transpires that any arrangement exists between a medical man and a certain pharmacist. In Germany, Austria, Russia, Hungary, Denmark, Sweden, and Norway, and in the Balkan States, the number of pharmacies is limited by the population, an average of 10,000 souls being reckoned to one pharmacy. Only in out-of-the-way places at some distance from the nearest pharmacy is the physician granted permission to keep a small stock of drugs, but in dispensing these to his patients he has to observe all the rules and regulations otherwise applicable to the pharmacist. In Germany the doctor who has the right to keep a house pharmacy has to purchase his supplies from the nearest pharmacy. In those countries in which the exercise of the pharmaceutical profession is restricted and treated as a monopoly the Government imposes upon the pharmacists an official scale of charges according to which every prescription has to be charged at the same rate for poor and rich alike, and it is a punishable offence to charge more. In the case of prescriptions for members of sick clubs, some countries compel the pharmacist to grant a fixed rebate on the official charges.

The existence of an official scale of charges for prescriptions in a number of countries leads to the question as to the possibility and feasibility of a similar measure in the case of doctors, especially in regulating their relations towards sick clubs. The position of the sick-club doctor in Great Britain and of his German colleague is to a very great extent identical. The sick-club doctor is paid a sum of 3s. to 5s. per annum for every member of the club, and for this has to attend professionally to all who call upon their services; or the whole sum set out for medical attendance is divided among the club doctors, either through the local medical organisation or by a system of counting a certain number of points for different kinds of services, and then dividing the sum according to the total number of points recorded by each doctor; these are the usual methods of remuneration in force. It stands to reason that any system of fixed payment for an indefinite amount of work is bound to bring a number of injustices and hardships in its train, and thus it is that the *per capita* system of payment has led to those unworthy results that mar the whole—the remuneration of a man who has spent years engaged in expensive study is valued at a couple of pence each time that his services are required. It is therefore obvious that a just and equitable form of payment for medical attendance can only be based on a fixed scale of charges, varying according to the gravity of the case, the skill required, and the time employed.

As the Chancellor foreshadows that the introduction of his scheme will mark the advent of the Golden Age for the oppressed physician, it may be assumed that some kind of tariff will be established to form a basis of remuneration for professional attendance. In this he has a precedent, and some remarks concerning this aspect of governmental authority may prove of interest at the present moment.

An official scale of charges for professional services rendered by physicians and surgeons is in existence in Germany, and its provisions are legally applicable in all cases in which a dispute as to the fee arises in the absence of any special agreement between patient and doctor. These charges also apply in the case of services rendered on behalf of the authorities, &c., and many sick clubs pay their medical men on the basis of this tariff, the doctor agreeing to grant a rebate varying from 10 to 20 per cent. on the total amount of his bill for attendance to members of the club. This is, in fact, the aim of German sick club doctors, that the provisions of this tariff should alone regulate the payment of medical services on behalf of members, so that every case receives payment in accordance with the actual amount of ability and time required. The Bill now before the

¹ THE LANCET, April 1st, 1905, p. 879.

Reichstag requires that every sick club shall draw up a regular agreement with every medical practitioner who attends its members.

The Prussian scale of charges for qualified medical practitioners and dental surgeons, which forms the basis of the following remarks, was introduced in 1897 and amended in 1906. It contains a maximum and a minimum charge for each kind of service, the latter to be applicable in the case of the obviously poor, for patients of sick clubs, &c., unless other arrangements have been entered into by both parties. However, it is distinctly stated that the charge may vary within the prescribed limits according to the circumstances of the case, especially if a considerable degree of skill is required or if other considerations apply. It enumerates in all 185 different medical functions.

THE PRUSSIAN SCALE OF CHARGES FOR QUALIFIED MEDICAL PRACTITIONERS.

First visit in the patient's house	2s. to 20s.
Every following visit in the same case	1s. to 10s.
First visit of patient in the doctor's house	1s. to 10s.
Every following visit " "	1s. to 5s.

The charge includes an examination of the patient and writing out a prescription; if a special examination is required, necessitating the use of a microscope, laryngoscope, or ophthalmoscope, &c., 2s. to 5s. may be charged extra.

Consultation over the telephone... ..	1s. to 3s.
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If the doctor is required to stay with the patient for longer than half an hour, he is entitled to an extra charge of 1s. 6d. to 3s. for every half-hour or part thereof. Visits or consultations between 9 P.M. and 7 A.M. are charged double or three times the above rates, and a visit of the doctor at the patient's house at night time is not to be charged under 3s.

Consultation between several doctors, to each	5s. to 30s.
To every other doctor who assists at an operation, &c	5s. to 20s.
A short certificate of the patient's state of health or illness	2s. to 5s.
An exhaustive report of a case	3s. to 10s.
Vaccination, including the certificate and a visit to control the result	3s. to 6s.
Production of general anaesthesia	5s. to 15s.
Applying a hypodermic injection, a clyster, or an injection into the urethra	1s. to 3s.
Intravenous injection	3s. to 20s.

In case the doctor visits a patient residing outside his own place of abode, he is entitled to charge a certain amount to defray his loss of time and the cost of travelling. If the journey lasts more than ten hours, in addition to all other expenses and charges, he is entitled to a sum of 30s. to 150s. for the day.

SPECIAL SERVICES.

Surgical Procedures.

Opening a superficial abscess or enlarging a wound	2s. to 10s.
Curettage	2s. to 10s.
The first simple dressing of a small wound	1s. to 10s.
Suture and first dressing of a larger wound	10s. to 30s.

Each following dressing is charged half the above rates, but not under one shilling. The surgeon usually writes out a prescription for the necessary dressings, which are obtained by the patient in a pharmacy; where this is not done the surgeon may claim the value of the dressings used by him.

Removal of small tumours on the surface of the body	5s. to 15s.
Removal of complicated larger tumours	20s. to 200s.
Plugging the nose	2s. to 5s.
Removal of a tonsil... ..	3s. to 15s.
Removal of a nasal or pharyngeal polypus	10s. to 30s.
Resection of a rib	10s. to 150s.
Operation for hare-lip	10s. to 100s.
Operations on the internal organs of the abdomen	50s. to 500s.

Ophthalmic Operations.

Sight testing	3s. to 15s.
Removal of foreign bodies from the cornea	3s. to 20s.
Iridectomy	20s. to 150s.
Operation for glaucoma	50s. to 300s.
Choice and application of an artificial eye	2s. to 5s.

Gynaecological Operations.

Examination for pregnancy, or affections of the genitals	2s. to 10s.
Assistance at a natural birth... ..	10s. to 40s.
In the case of twins one half more is charged.	
Cæsarean section on a living woman	50s. to 500s.
" " " " dead woman	20s. to 50s.
Curettage of the uterine cavity	10s. to 100s.
Examination of a wet-nurse	3s. to 10s.

Dental Operations.

Extraction of a tooth	1s. to 5s.
For local anaesthesia during a dental operation	2s. to 5s.
For filling a cavity with plastic material	3s. to 10s.
" " " " gold	10s. to 30s.
For devitalising pulp	2s. to 4s.

The above excerpt from the charges enumerated in the Prussian tariff will illustrate the "official" view of the value

of medical skill and knowledge, and should prove a useful standard of comparison with the existing rates of remuneration in Great Britain, not only in club but in private practice.

Darmstadt.

REPORT OF THE SANITARY COMMISSIONER WITH THE GOVERNMENT OF INDIA FOR 1909.

ALMOST simultaneously with the appearance of the report of the Sanitary Commissioner with the Government of India for 1909 arrives the intelligence of the death of its author, Lieutenant-Colonel J. T. W. Leslie, C.I.E., I.M.S., which occurred at Marseilles, while on his way home on furlough. He was an Aberdeen man, and studied also at Edinburgh, in London, and on the continent. In 1884 he joined the Indian Medical Service, obtaining the first place at Netley, and for five years was in military employ, seeing active service in Burma. After officiating as chemical examiner and professor in the Calcutta Medical College he became secretary to the late Surgeon-General Robert Harvey, then Director-General of the Indian Medical Service. In this post he made his mark by his great industry and wide knowledge of affairs. Somewhat reserved in disposition, he devoted himself entirely to his work; he was a great student, and made himself thoroughly acquainted with all the details of medical head-quarter administration in India. On appointment as Sanitary Commissioner with the Government of India he threw himself with great energy into the duties of this important office, and the reports that have proceeded from his pen during the last five years have been exceedingly valuable to all students of epidemiology and public health. His work in connexion with the standing committees on malaria and on enteric fever has been of the greatest benefit both to the European and native inhabitants, and has had much to do with the improvement that has been so noteworthy during the last three years.

Meteorology.

The four periods into which the year is divided in regard to weather conditions in India are the cold weather season, the hot weather from March to May, the period of the south-west monsoon from June to September, and that of the retreating monsoon from October to December. During 1909 the cold weather season was unusually free from rain over Northern and Central India, but rainfall was excessive over the southern half of the peninsula. The hot weather period resembled that of 1907, but was very different from that of 1908, March being exceptionally dry, April exceptionally wet, while in May the precipitation was near the average. On the whole, the north-western part of the country and Eastern Bengal and Assam received less, and the rest of India more, than the usual rainfall during this period. In the regular rainy season the precipitation was on the whole more abundant than usual, and in the final period, that of the retreating monsoon, there was, speaking generally, less than the average rainfall. Akyab had the highest rainfall, 234 inches, being 44 inches above the average. Of this enormous quantity, 110 inches fell during June and July. The highest shade temperature registered was 117·8° F. at Multan in June, which station also had the highest mean temperature for the month—viz., 98·1°, the thermometer never falling below 79°.

Health of the European Army in India.

The average strength of European troops in India during 1909, excluding officers, was 71,556; of this force 716·9 per 1000 were admitted to hospital, 40·3 per 1000 were on an average constantly sick in hospital, 6·25 per 1000 died, and 9·07 per 1000 were invalided home. All of these ratios were the lowest ever recorded for the European army in India, every disease of importance, except influenza, sharing in the decrease. The chief cause of death was, as usual, enteric fever, but it is noteworthy that more than a third of the decrease in the total death-rate was due to lessened mortality from this disease. The diminution in sickness has been due largely to the lessened prevalence of enteric fever, and as well to diminution in malarial fever and venereal disease; these are, and always have been (since the practical disappearance of cholera), the three diseases of most importance in the European army. It is pointed out