the doctors' point of view. To quote one doctor : " I find it a stimulating experience to have someone to teach, and I am sure that the presence of a potential critic must have a salutary effect upon the standard of one's work. The mere fact of discussion will operate to eliminate acts of omission which tend to creep in when handling frequent attenders at the surgery." The scheme is purely voluntary so far as the students are concerned. In 1951 55% of the final-year students took part, and in 1952 77%. Most of the students who did not take part could not do so because of other commitments.

Introductory Lectures

Before the scheme begins the students have a lecture telling them of the purpose of the scheme and giving them details of their attachment ; at the same time any questions relating to the appointment can be answered. In addition, they receive three lectures on the ethics and conduct of general practice by a general practitioner. All the doctors participating in the scheme are invited to a meeting to discuss the details of its operation.

An opportunity is afforded to find out what the students think of the appointment at the luncheon given by the local branch of the British Medical Association to those who have recently qualified.

The course has been welcomed most enthusiastically by both students and doctors ; the only criticisms have been the following : the course is probably too near the final examinations, when most of the students are preoccupied with reading, and many of the doctors consider that a fortnight is too short. It would also be of benefit if each student could see something of the different types of practice—for example, in poor, well-to-do, and rural areas—although this would be difficult to arrange. I think that the inclusion of general-practitioner training in the preregistration curriculum should be seriously considered.

Important Differences

The following points made by doctors and students indicate some of the important features of general practice as distinct from hospital practice.

1. The facility with which the practitioner must switch from one " branch " of medical practice to another, after the increasing compartmentalism of hospital work.

2. The necessity to rely upon one's senses in arriving at a diagnosis instead of upon the wholesale routine investigations by ancillary departments which constitute the hospital diagnostic method.

3. The vast amount of minor yet real disease which must all be labelled and treated, and which is largely outside the ken of the consultant.

4. The minor infectious ailments, which may be the subject of examination questions and which are rarely seen in hospital. " Koplik's spots were a real winner in this respect."

5. The experience required in predicting the natural history of a malady, particularly with reference to the spacing of one's visits.

6. The necessity to treat trivialities with dispatch yet without hurting the patient's feelings.

7. The importance, to all parties, of honest certification, and its difficulty when one's living depends upon good will.

8. The value of attending to the organization of the practice, so that time may be available for the " long case " and leisure for the practitioner.

9. The fact that the G.P. does indeed treat organic disease, despite opinions to the contrary held and disseminated by inexperienced hospital workers. " I was not guiltless in this respect myself during my resident days!"

The undoubted success of this scheme has been due to the general practitioners who have taken on this extra work, and I should personally like to take this opportunity of thanking them on behalf of the university.

THE PUBLIC HEALTH SERVICE

BY

G. L. C. ELLISTON, M.A.

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Despite the prophets who have foretold the winding-up of the public health service or the transfer of its remnants to other branches of the National Health Service, the number of whole-time posts in the medical services of local authorities appears to stay constant at about 2,000. The Chief Medical Officers of both the Ministry of Health and the Department of Health for Scotland have expressed the need for adequate recruitment of high-quality medical graduates to this branch. There has undoubtedly been a lack of suitable candidates for public health posts during recent years, but this was largely due to the prolonged delay in bringing remuneration of medical officers of health and their colleagues into some relation with those of specialists and general practitioners. Since the Industrial Court made its awards, after the failure to agree of the Management and Staff sides of Whitley Medical Council Committee C, the scales awarded for public health medical officers have been almost universally implemented. They are identical for England and Scotland and Wales, and similar salaries are paid in Northern Ireland. Although these are a considerable improvement on previous rates, there is still some doubt whether they represent a reasonable comparison with the remuneration of other classes of doctors, particularly in respect of departmental or assistant medical officers, who form the largest section of the public health service, and that from which promotion to higher ranks is taken. However, the assistant's scale of £850, rising by £50 annually to £1,150, is often improved upon by local authorities who wish to obtain medical officers with some additional experience. Such posts are usually designated as " senior assistant M.O.H." The larger local health authorities usually appoint senior medical officers in charge of departments (maternity and child welfare, school medical service, mental health, port health) under the medical officer of health and school medical officer : the senior M.O. scale is laid down as £1,250, rising by £100 annually to £1,650, but higher scales are paid by some of the largest authorities.

One of the largest sections of the public health service is that of doctors holding mixed appointments as M.O.H. of one or more county districts and also as area or divisional medical officers for county councils with responsibilities for local day-to-day administration of personal health services, or as assistant county medical officers carrying out duties at maternity and child welfare centres or at school clinics. The Industrial Court laid down rules for arriving at appropriate scales for such posts. Broadly speaking, the commencing figures for these " mixed " posts range between £1,050 and £1,500 and the maxima between £1,300 and £1,900, according to circumstances and responsibilities.

There are a limited number of whole-time divisional medical officer posts (mainly in London and adjoining counties) for which the salaries have commencing figures between £1,300 and £1,500 and maxima between £1,700 and £1,900 (or higher where the population of the division is over 400,000).

Lastly, whole-time medical officers of health were awarded a series of scales and ranges, varying with the populations of their authorities and allowing for an additional £100 where the M.O.H. serves more than one authority. The minimum commencing figure for an M.O.H. can lie between £1,450 and £2,300 and the maximum between £1,650 and £2,700 or

higher where the population concerned exceeds 600,000. Deputy M.O.H.s and S.M.O.s are paid scales commencing at two-thirds of the figures appropriate for their chiefs, and receive the same annual increments.

So much for the financial prospects of the public health service, which also include contributory superannuation schemes under the National Health Service (Superannuation) Regulations or the Local Government Superannuation Act, 1937.

Those who aim at ultimate appointments as M.O.H. must take the Diploma in Public Health or a degree in public health or hygiene statutorily recognized. For the clinical posts in public health, local authorities often require the holding of such special qualifications as the D.C.H., D.R.C.O.G., M.M.S.A., etc.

The views about the future of public health work vary between the ultra-pessimistic—which considers that the day is fast approaching when the well-established personal services will be handed over to general practitioners or hospitals, or both, the epidemiological work to the Public Health Laboratory Service, and the environmental to the engineers and sanitary inspectors—and the ultra-optimistic, which foresees the M.O.H. as a local C. in C. or administrative chief executive for all health and medical services, with expert chief assistants in all branches and a corps of salaried consultants and general practitioners.

The balanced view is perhaps that, as medicine and the National Health Service become more genuinely interested in prevention, the M.O.H. will find his rightful place as the epidemiologist, co-ordinator, and social physician in an integrated health service. There should also be room for the experienced medical officers with special knowledge of maternal and child health, school health, and the other spheres in which the progressive local authorities have done all the pioneering. No doubt general practitioners will take an increasing part in the preventive and educational clinic services, as they already do in considerable numbers; but this last depends upon changes in the outlook of medical training and in the structure of general practice. The reduction in the size of N.H.S. lists recommended as a result of the Danckwerts award is the first step in this direction.

Nova et Vetera

AIRY SYLLABUB

A Doctor's London. By Harvey Graham. (Pp. 107; 30 illustrations. 13s. 6d.) London: Allan Wingate. 1952.

This volume in the series of the Londoner's Library has a nostalgic charm for one who still remembers the delight of living in the Doctor's London. It is good to be reminded of the marriage in 1713 between Lady Henrietta Cavendish Holles and Edward Harley, Earl of Oxford and Mortimer, Baron Harley of Wigmore Cottage, and owner of the Wimpole Estate, a marriage which has provided so many consultants with professional addresses. The history of medicine and the history of London are eternally interesting and the author has combined the two in a delightful book. He has mahaged to compress an enormous amount of information into its 107 pages and flavoured it subtly with his own humour, so that what might have been a stodgy pudding of indigestible facts becomes an airy syllabub. Harvey Graham has included innumerable anecdotes of the famous and the not-so-famous, so that one can hardly open the book anywhere without coming on some fascinating or fantastic tale, and he ranges widely over the centuries, making the story of medical practice lively and continuous. The illustrations are well chosen and apt, there is an efficient index, and the production is pleasant. I cannot agree with the publishers' suggestion on the jacket that a copy should be in every waiting-room. Recalling a friend who thoughtfully furnished his waiting-room with a well-planned library of Everyman books, and shortly afterwards found his bookshelves bare, I do not think the copy would be there very long.

L. J. WITTS.

SELECTION OF STUDENTS

Nearly all the medical schools which have afforded the information appearing elsewhere in this Educational Number report that the applications for admission, though in some instances showing a tendency to diminish as compared with recent years, are still largely in excess of the available vacancies. At one London school, for example, not even one in seven can be accepted. This does not, of course, mean so widespread a disappointment as the mere figures would suggest, because many would-be students apply to more than one school. But it draws attention to the basis on which students are selected. In some cases local priorities to a certain extent govern the selection. But when it is left to an assessment of the applicant's own suitability several methods suggest themselves.

A little while ago the World Medical Association issued an interesting report on the subject, the result of a questionary sent to the various national medical associations comprising its membership. These associations in Belgium, the Netherlands, France, and the Irish Republic reported that no specific selection is employed, except in certain schools in Belgium and in one Irish school where written examinations are used. Interviews are a method employed in Great Britain, the United States, Canada, Czechoslovakia, India, and China. The United States, Canada, and India also use intelligence or aptitude tests, and such tests have been used experimentally in Great Britain. The most frequent methods of selection, reported by 15 national medical associations, are the use of written, oral, or both written and oral examinations for the screening of applicants, and a review of class records of previous school work. Only in Canada, apparently, are all four methods—interviews, aptitude tests, examinations, and class records—employed, though in Great Britain and the United States and in some other countries it is customary to employ three of these four methods.

The age of entry into medical schools varies the world over, from 16 in India and Spain to 22 in the United States. The average for all countries is about 19. In Norway and Sweden and in one or two other countries it is reported that the medical profession does not regard as satisfactory the present standards and arrangements for the selection and admission of students. On the other hand, the larger number of national medical associations questioned on this point reported that they were satisfied, although some of them suggested general lines of improvement and criticism. Some of them feel that the methods of selection could be improved by a wider use of selective and comprehensive examinations. A hint of the difficulties of deans is given in a communication from one London school which states that the raising of the standard of requirements for London University matriculation on the general certificate of education has the result that it is gained only at the end of the applicant's school career, and thus selection is made more difficult.

THE ENROLMENT IN MEDICINE

The total number of names in the current *Medical Register* is 82,256, which is 7,656 higher than the average for the last 10 years. Of these registrations, 39,911 were in England and Wales; 21,470 in Scotland; and 11,319 in Ireland. The registrations on the Commonwealth List numbered 7,513, and on the Foreign List 2,043. The following Table gives the position of the *Register* at the end of each of the last 10 years:

Year	Registration	Added by Restoration	Death or Removal	Total
1942	3,556	7	1,127	69,428
1943	3,532	13	1,091	71,882
1944	2,971	11	1,218	73,646
1945	2,666	11	1,190	75,133
1946	2,237	14	1,092	76,292
1947	2,787	10	1,160	77,929
1948	3,968	16	4,467	76,292
1949	3,109	19	1,280	78,140
1950	3,160	45	1,123	80,222
1951	3,075	29	1,070	82,256