

NATIONAL HEALTH SERVICE ACT, 1946.

Central Health Services Council

Report of the Central Health Services  
Council for the Year Ending December  
31, 1950, preceded by a Statement  
made by the Minister of Health

NATIONAL HEALTH SERVICE ACT, 1946

**CENTRAL HEALTH SERVICES  
COUNCIL**

Report of the Central Health Services  
Council for the year ending December  
31, 1950, preceded by a Statement made  
by the Minister of Health

*Required by Section 2 (5) of the National Health  
Service Act, 1946, to be laid before Parliament*

*Ordered by The House of Commons to be Printed  
30th April 1951*

---

LONDON  
HIS MAJESTY'S STATIONERY OFFICE  
PRICE 1s. 6d. NET

## Statement by the Minister of Health

The Central Health Services Council is constituted by section 2 (1) of the National Health Service Act, 1946, and is required by section 2 (5) to make an annual report to the Minister of Health on its proceedings. That report is also to cover the proceedings of the Standing Advisory Committees constituted under section 2 (3) of the Act. The report is to be laid before Parliament with such comments as the Minister thinks fit.

This is the second report to be submitted. It covers the calendar year 1950. In this period the National Health Service was starting to settle down and the number of major problems was somewhat less than in the initial 18 months which were dealt with in the Council's previous report. Nevertheless, as will be seen from the report itself, there is still a wide range of matters on which I am glad to be able to seek the advice of the Council and the Standing Advisory Committees and on which the Council and the Committees have submitted advice to me. I welcome this opportunity of publicly thanking the members for all the work they have done.

The reports of the Standing Tuberculosis and Standing Nursing Advisory Committees, dealt with in Part I of this report, have played an essential part in preparing the way for the drive to get more hospital beds opened for tuberculosis patients, which was one of the major developments in the Health Service during 1950. Those recommendations of the Standing Tuberculosis Advisory Committee which could be put into effect at once within the limitations imposed by present resources were sent to Regional Hospital Boards and local health authorities. The most important of these was the need to set aside suitably segregated beds for tuberculous cases in general and isolation hospitals. A substantial increase of beds has been achieved already and a further considerable addition is in sight. A start has been made in London in working out schemes on the lines proposed by the Standing Nursing Advisory Committee for the secondment of student nurses to sanatoria.

The Council's other main contribution to the development of the hospital service during the year was its report on hospital administration in which it dealt with the constitution and power of the Regional Hospital Boards and their relations with each other and with the Ministry. My predecessor accepted many of the recommendations, which also appear in Part I of this report, and action has already been taken on them. An important one, relating to the standing orders of hospital authorities, is under consideration. I also accept the Council's view that control should be exercised over the administrative and clerical staffing of hospital authorities, but because of the urgency of the need to secure economies I have decided to go, in some respects, even further than the Council recommends. Individual establishments, including the number of officers required in each grade, are being worked out for each of the hospital authorities following visits by small teams of selected experts, associated, where the staff of a Management Committee is being reviewed, with representatives of the Regional Board. Once the establishment is fixed, authority will be required before appointments in excess of it are made. Similarly, other teams are visiting hospitals to review medical, nursing and domestic staffs in consultation with the hospital authorities themselves.

Towards the end of the year my predecessor felt that the time had come for the Council to follow up its wide-ranging study of the hospital service by undertaking a review of the structure of general practice. He therefore asked the Council to advise him whether the existing arrangements for

engaging in general practice under the National Health Service were such as to enable general practitioners to provide the best possible standard of service. The Council accepted the remit and has, as recounted in this report, set up a special Committee which is now at work.

This was not by any means the only activity of the Council during the year in connection with the general practitioner service, for it has continued its close watch on prescribing. The recommendations of the Joint Committee of the Council and the Scottish Council on Prescribing on Form E.C.10 (para. 19) have been accepted. The report was published and sent to all doctors with a letter asking for their assistance in avoiding unnecessary expense on drugs. One of the recommendations in the report was that it was undesirable that medicinal preparations advertised direct to the public should be prescribable. A list of such preparations was prepared and sent to doctors, who were asked not to prescribe the preparations unless it was clear that there was some special justification for doing so in an individual case. The advice in the Second Report of the Joint Sub-Committee on the Definition of Drugs (para. 18) has also been accepted. This report, and the first report—which dealt with the classification of borderline substances as foods or drugs (previous report, para. 19)—have been published and sent to doctors for their guidance. The English and Scottish Councils have continued to work together on these questions of prescribing and the advice given in the various reports has been accepted by the Secretary of State for Scotland.

Part II of the report contains in full the Council's report on the lines on which Health Centres should be developed. I cannot allow the opportunity to pass without expressing my indebtedness to the Council, and to its Health Centres Committee, for the extensive and detailed study which they made of this subject. I am considering the conclusions and recommendations and I propose to have this part of the Council's report sent to all local health authorities.

Most of the detailed recommendations made by the Standing Advisory Committees and listed in Part III of the report have been accepted and many of them have already been acted upon.

HILARY MARQUAND.

April, 1951.

PORTLAND PLACE,

LONDON, W.1.

March, 1951.

SIR,

**CENTRAL HEALTH SERVICES COUNCIL**

I have the honour to present our report for the year ending 31st December, 1950.

This report, as required by section 2 (5) of the National Health Service Act, 1946, covers not only our own proceedings but those of the Standing Advisory Committees. In Part I we deal with the principal subjects of general interest with which we have been concerned. In Part II we reproduce in full our report on Health Centres. In Part III we give an account of the work of the Standing Advisory Committees insofar as that is not covered in Part I.

The report does not include an account of the constitution of the Council nor of the Standing Advisory Committees. This will be found in our previous report for the period ending December, 1949.\*

I am, Sir,

Your obedient Servant,

FRED MESSER,  
Chairman of the Council.

To the Right Honourable HILARY MARQUAND, M.P.  
Minister of Health.

---

\* Report of the Central Health Services Council for the period ending December 31st, 1949, preceded by a statement made by the Minister of Health, London, H.M.S.O. One shilling.

**MEMBERS OF CENTRAL HEALTH SERVICES COUNCIL AS AT  
31st DECEMBER, 1950**

*Ex-officio (6 members)*

WALTER RUSSELL BRAIN, Esq., M.A., D.M., F.R.C.P.*	President of the Royal College of Physicians of London.
Sir CECIL WAKELEY, K.B.E., C.B., F.R.S.Ed., D.Sc., F.R.C.S., F.A.C.S., F.R.A.C.S.	President of the Royal College of Surgeons of England.
Professor HILDA NORA LLOYD, B.Sc., M.B., Ch.B., F.R.C.S., F.R.C.O.G.	President of the Royal College of Obstetricians and Gynaecologists.
EDWARD ANDREW GREGG, Esq., J.P., M.D., L.R.C.P.I., L.R.C.S.I.	Chairman of the Council of the British Medical Association.
Professor DAVID CAMPBELL, M.C., M.D.	President of the General Medical Council.
Sir ALLEN DALEY, M.D., F.R.C.P., D.P.H.	Chairman of the Council of the Society of Medical Officers of Health.

*Medical Practitioners (15 members)*

*Period of Office until*

Miss JANET AITKEN, C.B.E., M.D., F.R.C.P. ... ..	31.3.53
JAMES ALEXANDER BROWN, Esq., A.B. (R.U.I.), B.Ch., M.D., B.A.O. ... ..	31.3.52
Sir ERNEST ROCK CARLING, M.B., F.R.C.S., F.R.C.P., Hon.F.F.R. ... ..	31.3.52
Professor Sir HENRY COHEN, J.P., M.D., LL.D., F.R.C.P., F.F.R. ( <i>Vice-Chairman</i> ) ... ..	31.3.52
Professor ROBERT CRUICKSHANK, M.D., F.R.C.P., D.P.H.† ...	31.3.53
HARRY GUY DAIN, Esq., M.D., LL.D., F.R.C.S. ... ..	31.3.51
Sir STEWART DUKE-ELDER, K.C.V.O., M.A., D.Sc., Ph.D., LL.D., M.D., F.R.C.S., F.A.S.C.‡ ... ..	31.3.53
WILFRED VIVIAN HOWELLS, Esq., M.A., M.B., B.Ch., M.R.C.S., L.R.C.P. ... ..	31.3.53
HORACE JOULES, Esq., M.D., F.R.C.P. ... ..	31.3.51
Professor AUBREY JULIAN LEWIS, M.D., F.R.C.P. ... ..	31.3.52
WILLIAM GORDON MASEFIELD, Esq., C.B.E., M.R.C.S., L.R.C.P., D.P.M. ... ..	31.3.51
WILLIAM NORMAN PICKLES, Esq., M.D., M.R.C.P., D.P.H. ...	31.3.51
Professor Sir HARRY PLATT, M.S., M.D., F.R.C.S., Hon.F.A.C.S. ... ..	31.3.51
Professor Sir JAMES CALVERT SPENCE, M.C., M.D., F.R.C.P.	31.3.52
CLEMENT WILLOUGHBY WALKER, Esq., M.B., B.Ch., M.R.C.S., L.R.C.P. ... ..	31.3.53

\* Dr. Brain succeeded Lord Moran, M.C., M.D., F.R.C.P., as President of the College and *ex-officio* member of the Council in 1950.

† Professor Cruickshank succeeded Professor William George Barnard, F.R.C.P., M.R.C.S., in April, 1950, as a member of the Council.

‡ Sir Stewart Duke-Elder succeeded Aleck William Bourne, Esq., M.A., F.R.C.S., F.R.C.O.G., as a member of the Council in March, 1950.

*Persons with experience in Hospital Management (5 members)*

	<i>Period of Office until</i>
FRANK JOHN CABLE, Esq., F.H.A. ... ..	31.3.52
FRANK STANCLIFFE STANCLIFFE, Esq.,* ... ..	31.3.53
HON. ARTHUR JARED PALMER HOWARD, C.V.O. ... ..	31.3.53
Sir OWEN FREDERICK MORSHEAD, K.C.V.O., D.S.O., M.C. ...	31.3.52
Major-General Sir HAROLD AUGUSTUS WERNHER, Bt., G.C.V.O., T.D. ... ..	31.3.51

*Persons with experience in Local Government (5 members)*

Alderman ALBERT FREDERICK BRADBEER ... ..	31.3.53
Sir WYNNE CEMLYN-JONES ... ..	31.3.51
FRED MESSER, Esq., C.B.E., J.P., M.P. ( <i>Chairman</i> ) ... ..	31.3.52
Mrs. DOROTHY THURTLÉ ... ..	31.3.53
Alderman WILLIAM ERNEST YORKE, C.B.E., J.P. ... ..	31.3.51

*Dental Practitioners (3 members)*

FREDERICK JOHN BALLARD, Esq. ... ..	31.3.52
Professor ROBERT VIVIAN BRADLAW, C.B.E., D.D.Sc., M.D.S., F.R.C.S., F.D.S.R.C.S.E.† ... ..	31.3.51
JOSEPH LAUER, Esq., L.D.S.R.C.S. ... ..	31.3.53

*Persons with experience in Mental Health Service (2 members)*

Sir CECIL OAKES, C.B.E. ... ..	31.3.51
CLIFFORD FRANK COMER, Esq. ... ..	31.3.52

*Registered Nurses (2 members)*

Miss ELEANOR JEANNETTE MERRY, S.R.N., S.C.M. ... ..	31.5.52
Miss CLARE HELEN ALEXANDER, O.B.E., S.R.N., S.C.M. ... ..	31.3.53

*Certified Midwife (1 member)*

Miss NORA BRYAN DEANE, M.B.E., S.R.N., S.C.M. ... ..	31.3.51
------------------------------------------------------	---------

‡*Registered Pharmacists (2 members)*

Alderman WILLIAM JOHN TRISTRAM, J.P., M.P.S. ... ..	31.3.52
-----------------------------------------------------	---------

\* Mr. Stancliffe succeeded Sidney Clayton Fryers, Esq., C.B.E., F.H.A., as a member of the Council in March, 1950.

† Professor Bradlaw succeeded Harry Thomas Roper-Hall, Esq., M.D.S., M.B., Ch.B., M.R.C.S., L.R.C.P., F.D.S.R.C.S., as a member of the Council in March, 1950.

‡ Richard Henry Henriksen, Esq., A.R.I.C., M.P.S., resigned in October, 1950. At 31st December, 1950, there was a vacancy on the Council.

# CONTENTS

	Page
<b>PART I</b>	
Tuberculosis ... ..	1
Hospital Administration ... ..	4
Prescribing ... ..	6
Co-operation between Hospital, Local Authority and General Practitioner Services	8
The General Practitioner Service ... ..	8
<b>PART II—HEALTH CENTRES</b>	
1. Introduction ... ..	9
2. Limits of the Enquiry ... ..	10
3. Long Term Plan for the Development of Health Centres ... ..	11
General ... ..	11
General Medical Services ... ..	14
Dental Services ... ..	18
Pharmaceutical Services ... ..	19
Local Health Authority Services ... ..	20
Hospital and Specialist Services ... ..	21
Information ... ..	23
Management ... ..	23
School Health Services ... ..	24
4. Immediate Practical Programme	
(a) Simple Health Centres for Group Practice ... ..	25
(b) Comprehensive Health Centres ... ..	26
(c) New Communities ... ..	26
(d) Planning ... ..	27
5. Summary ... ..	27
<b>PART III</b>	
Standing Medical Advisory Committee ... ..	32
Standing Dental Advisory Committee ... ..	32
Standing Pharmaceutical Advisory Committee ... ..	33
Standing Ophthalmic Advisory Committee ... ..	34
Standing Nursing Advisory Committee ... ..	34
Standing Maternity and Midwifery Advisory Committee ... ..	35
Standing Mental Health Advisory Committee ... ..	35
Standing Tuberculosis Advisory Committee ... ..	38
Standing Cancer and Radiotherapy Advisory Committee ... ..	38
<b>APPENDICES</b>	
I. Members of Standing Advisory Committees and of Committees of the Council	39
II. Schedule of Advice to the Minister given by the Council and Standing Advisory Committees... ..	47



# PART I

## Tuberculosis

1. Our first business in the New Year was consideration of the report of the Standing Tuberculosis Advisory Committee on the organisation of the tuberculosis service. We had, in the previous September, invited this Committee to forward a report to the Minister at an early date on methods of dealing with the tuberculosis waiting lists, but the Committee had decided that it was desirable to review the tuberculosis service as a whole.

2. Tuberculosis as a constitutional disease is a serious menace to public health in that it is infectious, insidious in onset, usually runs a chronic course and exerts its maximum effect on those age groups that are of the greatest value to the productive capacity of a nation. Special attention must, therefore, be given to it within a comprehensive health service. In the past in all anti-tuberculosis schemes the family has always been regarded as a unit and although a tuberculous person requires individual consideration with regard to treatment a much wider view has to be taken when plans for the prevention of the infection and the suppression of the disease are being formed. Prevention involves (a) discovery of the infectious individual ; (b) reducing to the greatest extent possible his spreading infection ; (c) general and special measures to increase the resistance of the community, especially that of the close contacts. It is essential to link prevention and after-care closely with treatment and there must be the closest co-operation between the bodies responsible for administration of the separate branches of the service. The problem is extremely complicated but should be capable of solution within the present framework of the National Health Service.

3. The statistics presented to the Committee left no room for complacency :

*Rates per 100,000 total population*

	Primary notifications		Deaths	
	Respiratory	Non-Respiratory	Respiratory	Non-Respiratory
1939 ... ..	84.2	27.2	52.0	9.8
1940 ... ..	86.4	24.9	56.5	10.7
1941 ... ..	94.6	27.5	56.7	12.1
1942 ... ..	97.0	28.6	50.1	10.9
1943 ... ..	100.6	28.3	50.6	10.2
1944 ... ..	103.2	24.8	47.4	9.6
1945 ... ..	98.9	23.3	46.9	9.2
1946 ... ..	98.3	21.3	45.2	8.1
1947 ... ..	100.2	19.9	46.8	7.9
1948 ... ..	101.2	19.8	43.9	6.6
1949 ... ..	101.6	17.3	39.9	5.4*
1950 ... ..	98.8*	15.7*	36.1	4.6*

\* These figures for 1949 and those for 1950 (provisional only) have become available since the Committee submitted its report. The 1950 figures for notifications are based on actual figures for England and estimated figures for Wales. The 1950 figures of deaths are based on deaths during the first two quarters only. Both death and notification rates are based on a mid-year estimated total population for England and Wales of 44,020,000.

More efficient methods of case finding may be responsible for a considerable part of the rise in notifications. It will be noted that the mortality is falling steadily but the toll of the disease is extremely heavy and it is clear that increasing effort must be made to control the scourge.

4. A cause for anxiety is the ever lengthening list of those awaiting admission for treatment, which means that a large number of infectious cases are living uncontrolled among the healthy population. Although shortage of nurses is one of the major causes of this waiting list, other factors contribute to the failure to curb it. There is good reason to believe that the best use is not made of the beds already available. Beds which could be used for a succession of early cases may be blocked for long periods by chronic, though still infectious, cases unlikely to benefit from active treatment or may be used for cases inaccurately assessed or even inaccurately diagnosed outside, because of the lack of diagnostic facilities in some chest clinics. The result of the combined operation of these factors is that the period of time between diagnosis and the commencement of institutional treatment is increasing so that at present it is from seven to nine months in most regions. There is need therefore for Regional Boards through their technical advisers to watch and compare the length of stay in their several sanatoria.

5. The recent introduction of new forms of treatment, the results of which are encouraging, will demand a revision of tuberculosis schemes and recent advances in knowledge of the pathogenesis of the disease may influence views on the prevention of the spread of infection. These important changes must be recognised by those formulating policies to be adopted by the several authorities. This can be possible only if there is a willing spirit of co-operation and a free exchange of information between all concerned.

6. After reviewing the whole field, the Committee advised the Minister:—

(a) To reduce the extent of tuberculous infection, the staffing and equipment of Chest Clinics should be brought up to a standard that would ensure efficiency in diagnosis and treatment and would also counter some of the causes of the waiting list for sanatorium beds.

(b) Mass radiography should be pursued, with close liaison between Hospital Boards and local health authorities as regards propaganda, operational planning, and results of surveys. It should be regarded as bound up with the diagnostic and clinical functions of tuberculosis clinics and chest physicians.

(c) There should be more scrupulous attention to the duty of notifying tuberculosis, and an increase of effort in case-finding.

(d) To relieve the shortage of beds and the long waiting lists for institutional treatment, Hospital Boards should be urged to set aside for tuberculosis cases a proportion of the medical beds in general hospitals, where possible in a separate unit. The use of infectious disease hospitals should also be considered.

(e) To encourage more nurses to undertake tuberculosis nursing, all nurses should be made better informed about the disease and some training in the nursing of chest diseases should find a place in general training (subject to full training in tuberculosis nursing for those who later wish to specialise in it). There should be provision to save nurses who contract tuberculosis from consequential financial difficulty, and they should be afforded every opportunity of finding employment in sanatoria.

(f) For chronic infectious patients who are ambulant it is desirable to provide hostels affording domiciliary care and medical supervision. The provision of "night sanatoria" for patients with a prospect of recovery and capacity for industrial employment is also to be advocated.

(g) There should be special centres (serving all regions) for treatment of rare categories of tuberculous cases, e.g. tuberculosis of the eye or skin, or tuberculosis complicated with other conditions. Research in new forms of treatment should be carried out at such centres.

(h) In each region there should be centralised (bed bureau) control of institutional admissions and discharges.

(i) Facilities for sheltered employment for disabled tuberculous persons are necessary, such as "Remploy" factories sponsored by the Ministry of Labour and National Service under the Disabled Persons (Employment) Act. Village Settlements serve this purpose, but there is a limit to this method of rehabilitation.

(j) There should be co-operation between the tuberculosis service and paediatricians, child welfare authorities, and education authorities in dealing with children suffering from or susceptible to tuberculosis, e.g. through open-air schools.

7. We accepted these findings, but asked the Committee to reconsider certain parts of the report in order to underline the importance of the role of the general practitioner in any comprehensive scheme for diagnosis, treatment and re-ablement of the tuberculous, and also to stress that all nurses whether or not engaged on tuberculosis work should be tuberculin tested and that negative reactors should be offered B.C.G. vaccination.

8. In the course of its report, the Committee particularly stressed the need for the closest co-operation between Regional Hospital Boards, Boards of Governors and Local Health Authorities in securing a completely integrated tuberculosis service. The Committee also emphasized the need for full co-operation between Boards of Governors, Regional Hospital Boards and the Local Health Authority service in promoting and carrying out research in tuberculosis and stressed that teaching hospitals should continue to take an active part in the treatment and management of tuberculosis cases so that medical students, both undergraduate and postgraduate, should have the opportunity of studying all aspects of the disease. We drew this part of the report to the attention of our Committee on Co-operation (para. 20).

9. An attack on the problem of securing more tuberculosis beds in hospitals and sanatoria was made later in the year by the Standing Nursing Advisory Committee. We had previously asked this Committee to consider to what extent the nursing services could be improved by greater co-operation between teaching hospitals and Regional Hospital Board hospitals. The Committee decided to consider as the most urgent matter within this remit what help the teaching hospitals could give towards the staffing of tuberculosis sanatoria. It subsequently proposed that each teaching hospital with nurse training facilities which had not already set aside in blocks or wards at least 10 per cent. of its total beds (excluding those set aside for midwifery and chronic sick) for pulmonary tuberculosis patients, should be invited to assist by seconding student nurses up to about 5 per cent. of its total nursing staff. This secondment was urgently required to enable more beds to be opened in sanatoria situated in the same Regional Hospital Board area as the teaching hospital.

10. The Standing Nursing Advisory Committee worked out the secondment scheme in some detail. It proposed that the General Nursing Council should be consulted about any arrangements proposed. No student would be seconded to any sanatorium in which the recommended precautions for the safeguarding of the nurses' health were not being carried out and the teaching hospitals would instruct their students about precautions to be taken before sending them to the sanatoria. It was hoped that it might be possible to second trained staff where this was necessary to secure a ratio of one S.R.N. to two student nurses at the sanatorium. The period of secondment of the student nurse should be for three months during which systematic teaching would be carried out by the sanatorium staff. Detailed suggestions were made as to uniform, discipline and leave.

11. We welcomed these proposals as making a specific contribution towards the problem of staffing empty beds in sanatoria, but we felt it necessary to emphasize that the secondment proposed should be voluntary.

### **Hospital Administration**

12. As recounted in our previous report (paragraph 15) we decided to review the whole field of hospital administration under the National Health Service but to do so in two parts (i) external administration, and (ii) the internal administration of the individual hospital. The first part of this review was carried out by the Committee which we set up in 1949 to "review the organisation of the hospital services under the National Health Service Act, 1946, but not matters concerning the administration of individual hospitals, and to make recommendations."

13. This Committee made an interim report on unit costing which is referred to in our previous report (paragraph 16) and presented its final report in June, 1950. The Committee reviewed the general administrative structure of the hospital service; the control of finance; the control and establishment of staff; the relations of the Minister to the Regional Hospital Boards, of the Regional Hospital Boards to Hospital Management Committees, and of Hospital Management Committees to House Committees; and the principles on which members of Regional Hospital Boards, Hospital Management Committees and Boards of Governors should be chosen.

14. As to the general administrative structure it concluded that it is far too early to put forward any suggestions for radical alterations in the administrative structure of the hospital service, and that no immediate major change is required at present either in the number or the functions of Regional Hospital Boards or Hospital Management Committees. It would be deplorable to make now any radical change which disrupted the bodies which, after being created only three years ago, have assumed, with a substantial measure of success, responsibility for running the hospital services. Nevertheless the present groupings and areas should not be considered sacrosanct and when further experience has been gained, a comprehensive review of the present areas and groupings should be made.

15. The Committee also made a number of recommendations on specific points which we accepted and on the basis of which we advised the Minister that:—

(i) The area committees of Regional Boards should in due course be abolished or Regional areas should be redrawn so as to avoid the need for these Committees.

(ii) The Ministry should discourage Regional Boards from making the boundaries between one Board and another watertight.

(iii) The Ministry should in special circumstances allow Regional Boards to administer convalescent homes and if necessary other ancillary units in the areas of other Regional Boards.

(iv) A review of Regional Board areas and Management Committee groupings should be made when more experience of the working of the Service has been gained.

(v) The Ministry should consult with the Treasury in order to devise means by which the capital allocations of Boards could be spread over more than one year.

(vi) Each Hospital Management Committee should receive an allocation of money to be spent on small capital works.

(vii) The Ministry should at regular but infrequent intervals collect detailed and comparable statistics of the administrative and clerical staffs employed by Regional Boards, Hospital Management Committees and Boards of Governors and should use these statistics for inquiring into excessive staffing.

(viii) In consultation with its Regional Board each Hospital Management Committee should work out establishments for all grades of staff appointed by it. Regional Hospital Boards should have authority after full consultation with Hospital Management Committees to approve or disapprove these establishments. Within these establishments, Hospital Management Committees should have power to make appointments and fix gradings, including the power to make appointments additional to establishment, subject to a financial maximum.

(ix) Regional Hospital Boards should consult with Hospital Management Committees before laying down establishments for specialist staff.

(x) The Ministry should undertake some more effective measures of consultation before issuing circulars on any but the most detailed or urgent matters.

(xi) Notes of meetings held at the Ministry at which advice is given to Regional Boards' or Boards of Governors' Chairmen or officers should be available for perusal by members of Regional Boards and Boards of Governors.

(xii) Decisions on changes of use of non-mental hospitals should continue to be made by Regional Boards but the Boards should consult the Ministry at an early stage before implementing decisions which are likely to give rise to serious local opposition.

(xiii) Secretaries of Hospital Management Committees should not necessarily have charge of the administration of a particular hospital. It is desirable, wherever possible, that their offices should be within a hospital in the group.

(xiv) Regional Boards, Hospital Management Committees and Boards of Governors should implement the Regulation\* requiring them to make standing orders providing that members who have a pecuniary interest, direct or indirect, in any matter should disclose their interest and not take part in any discussion or vote on any such matter. If necessary the Ministry should issue model standing orders on this subject.

(xv) The Ministry should bear in mind the desirability of appointing at least one general practitioner and one Medical Officer of Health to each Regional Board.

---

\* National Health Service (Regional Hospital Boards, etc.) Regulations, 1947 (S.R. & O. 1947, No. 1298), Schedule, para. 10.

(xvi) There should be a degree of interlocking membership between Regional Boards and Hospital Management Committees.

(xvii) The Ministry should bring the King's Fund hospital information service to the notice of all hospital authorities.

16. As the work of the External Administration Committee drew to a close we appointed an Internal Administration Committee:—

“To consider and report on the existing methods of administration in individual hospitals with particular reference to

(i) matters of finance, staff and supplies ;

(ii) the extent to which differences in the work undertaken at different hospitals call for differences in their administrative organisation ;

(iii) the extent to which administrative duties should be undertaken by medical and nursing staff.”

This Committee met six times before the end of the year and has had discussion with members of representative organisations.

### Prescribing

17. We gave an account in our previous report (paragraphs 18-24) of the advice given to the Minister up to the end of 1949 with regard to wasteful or unnecessary prescribing. The need for concern on this subject has in no way diminished. The monthly cost of drugs and dressings prescribed in the National Health Service rose from £2.3 m. in 1948-49 to £3.25 m.\* in 1949-50. Accordingly means of reducing this cost without harm to the patient have continued to engage both the English and Scottish Councils and their Committees.

18. The Joint Sub-Committee, set up by the Standing Medical and Pharmaceutical Advisory Committees, together with the Scottish Medical, Pharmaceutical and General Practitioner Standing Advisory Committees, to give guidance on the definition of drugs for the purpose of National Health Service prescribing (previous report, paragraph 18) has now considered the classification of toilet preparations. It has recommended the following general principles for the guidance of doctors:—

(a) As it is unethical for a doctor to order a preparation of unknown composition, preparations of undisclosed composition should not be prescribed.

(b) Preparations used normally for toilet purposes, even if their composition is disclosed, should not be prescribed. Examples of such preparations, such as toothpaste and cold creams, were given.

(c) Certain proprietary toilet preparations, such as medicated soaps and barrier creams, should not normally be prescribed.

The Joint Sub-Committee's report was accepted by the Standing Advisory Committees and the Council expressed no view thereon. The Joint Sub-Committee is now considering disinfectants and antiseptics.

---

\* These figures include hospital and general practitioner services (including a small sum for rota payments to chemists and superannuation payments). The annual figures were: July, 1948—March, 1949 (9 months) £20·96 m.; April, 1949—March, 1950 (12 months) £39·0 m.

19. The Joint Committee which we set up, together with the Scottish Health Services Council "to consider whether it is desirable and practicable to restrict or discourage the prescribing by general practitioners giving general medical services under Part IV of the Act of:—

(a) Drugs of doubtful value or of unethical character ;

(b) Unnecessarily expensive brands of standard drugs "

produced an interim report in 1949 (previous report, paragraph 24). It held three meetings in 1950 and submitted a second interim report to the two Councils which established certain general principles in the prescription of proprietary preparations. We accepted the recommendations of this report and advised the Minister that:—

(a) There should be no absolute restriction on the prescribing by a general practitioner of any drug which, in his opinion, is necessary for the treatment of his patients.

(b) As the responsibility for prescribing should rest solely with the practitioner, it is undesirable that medicinal preparations advertised direct to the public should be prescribable in the Health Service.

(c) All drugs and preparations described in the British Pharmacopoeia, the British Pharmaceutical Codex and the National Formulary should be freely prescribable (except those classified as foods, toilet preparations, or not drugs for National Health Service purposes by the Definition of Drugs Joint Sub-Committee, see para. 18). These drugs are referred to below as "standard".

(d) Proprietary preparations can be divided into the following six categories:—

(i) New drugs of proved value not yet standard.

(ii) Proprietary brands of standard drugs, singly or in combination.

(iii) Standard preparations, and new remedies of proved value, in elegant form or vehicle.

(iv) Qualitative and/or quantitative modifications in the composition or combination of standard preparations, or new remedies of proved value, which are not accepted as therapeutically superior to preparations included either alone or in combination in the British Pharmacopoeia, the British Pharmaceutical Codex or the National Formulary.

(v) Preparations not in the British Pharmacopoeia, British Pharmaceutical Codex or National Formulary which, in the Committee's view, have not been proved of therapeutical value.

(vi) Preparations which are a combination of (iv) and (v).

(e) Proprietary preparations in Category (i) should be freely prescribable, and preparations in Categories (ii), (iii) and (iv) should be prescribable provided that:—

(i) they are not designated as foods, toilet preparations, or not drugs for National Health Service purposes by the Definition of Drugs Joint Sub-Committee ;

(ii) they are not advertised direct to the public ; and

(iii) satisfactory arrangements for price are made between the Health Departments and the manufacturers.

Preparations in Categories (v) and (vi) which consist of or contain drugs of doubtful value should not be prescribable.

The Committee is now proceeding to classify proprietary preparations into the various categories suggested in the report.

## **Co-operation between Hospital, Local Authority and General Practitioner Services**

20. We set out in our previous report (paragraphs 30-31) our reasons for concern about the difficulties arising from the administration of the National Health Service through three separate agencies. In March, 1950, we appointed a Committee to consider and to make a report:—

(a) on existing forms of co-operation between (i) Regional Hospital Boards, Hospital Management Committees, Boards of Governors; and (ii) Local Authorities; and (iii) Executive Councils;

(b) whether it is possible to formulate any general principles on which co-operation might be promoted between these authorities.

This Committee met four times during 1950.

### **The General Practitioner Service**

21. In October, 1950, we received a remit from the Minister requesting us to advise him whether the existing arrangements for engaging in general practice under the National Health Service are such as to enable general practitioners to provide the best possible standard of service. In December, 1950, we appointed a Committee:—

“to advise whether the existing arrangements for engaging in general practice under the National Health Service are such as to enable general medical practitioners to provide the best possible standard of service and, in particular, to advise upon:—

(i) The range of work and standards of practice which should be expected from the general practitioner by the public and medical profession.

(ii) Types of general practice.

(iii) Mode of entry into general practice.

(iv) Non-medical help.

(v) Equipment and environment.

(vi) Method of remuneration.

(vii) Liaison with hospital and specialist services.

(viii) Liaison with local authority services.”

At the turn of the year the Committee had not yet met.



## PART II.—HEALTH CENTRES

### 1. Introduction

22. As mentioned in our previous Report (paragraph 12) we appointed a Committee in December, 1948, "to consider and make recommendations on the lines along which health centres should be developed under Section 21 of the National Health Service Act".

23. In the course of its inquiry the Committee visited the surgeries of a group of doctors working in partnership, a large local health authority building providing accommodation for different types of clinics, two hospital rehabilitation departments and the pharmaceutical department of a health centre. At the Committee's invitation a number of individuals with experience of the management of health centres or of a group practice or of related services, attended its meetings for informal discussions and a memorandum was prepared about a teaching general practice at Edinburgh. The Committee was grateful for the valuable help and information which it received from all those who assisted in this way. The Committee also obtained useful information from a study of a number of reports on health centres and group practice which have been issued in recent years by various bodies and individuals and from examining some preliminary plans for health centres which had been prepared by certain local health authorities.

24. The Committee asked for and received the advice of the Standing Medical Advisory Committee on the value of some degree of specialisation within the field of general medical services by doctors at health centres, and of the Standing Pharmaceutical Advisory Committee on the technical problems connected with the provision of pharmaceutical services at health centres.

25. The Committee presented two interim reports which were mentioned in our previous report (paragraph 14—the need for legislation to permit treatment of private patients at health centres and safeguarding of practices of doctors entering health centres). The Committee presented a third interim report in June 1950, on the setting up of health centres in new towns and on new housing estates. In these places the problems of establishing health centres in areas covered by existing medical practices did not exist. We agreed with the Committee that health centres ought to be provided in such places concurrently with schools and other public services. If the opportunity were lost and doctors were allowed to establish themselves in independent practice, it would be many years before the lost ground could be regained. We accordingly advised the Minister that a circular should be sent to local health authorities and local housing authorities urging that, during the first stage of the erection of a new estate, accommodation should be provided for group practice in health centres and that doctors' houses with special surgery accommodation should not be provided.

26. The Committee presented its final report to us in December 1950. We adopted this report subject to minor amendments and advised the Minister that health centres should be developed on the lines which it laid down.

## 2. Limits of the Enquiry

27. In the present difficult economic circumstances of the State, any ambitious scheme for the immediate development of health centres throughout the country is unlikely to be implemented and would be of little practical value to the Minister. Yet these contemporary difficulties should not be allowed to obscure the full possibilities of the health centre conception. This part of our report has, therefore, been prepared in two main sections: one of these sets out a long term plan for the development of health centres of ideal type; the other makes recommendations on the steps which in our view should be taken now towards the implementation of the long term plan and also suggests a few expedients which might be adopted to secure immediately some of the advantages of health centre provision.

28. Section 21 of the National Health Service Act, 1946, describes health centres as premises provided, maintained, equipped and staffed by local health authorities at which facilities shall be available for all or any of the purposes listed in the section. These are:—

“(a) for the provision of general medical services under Part IV of this Act by medical practitioners;

(b) for the provision of general dental services under Part IV of this Act by dental practitioners;

(c) for the provision of pharmaceutical services under Part IV of this Act by registered pharmacists;

(d) for the provision or organisation of any of the services which the local health authority are required or empowered to provide;

(e) for the provision of the services of specialists or other services provided for out-patients under Part II of this Act; or

(f) for the exercise of the powers conferred on the local health authority by section one hundred and seventy-nine of the Public Health Act, 1936, or section two hundred and ninety-eight of the Public Health (London) Act, 1936, for the publication of information on questions relating to health or disease, and for the delivery of lectures and the display of pictures or cinematograph films in which such questions are dealt with.”

29. The reference to “all or any” of these services gives scope for much variety in the sizes and types of health centres which may be provided under the section. The Committee’s inquiry was limited to the development of health centres which include accommodation for general medical services or general dental services or pharmaceutical services provided under Part IV of the Act (that is, services for which facilities could not be provided by local health authorities under any powers other than those in section 21 of the Act). In this report the use of the term is confined to such centres since it would create confusion to describe, as health centres, buildings housing only clinics of the type which local authorities have for long provided first under Public Health Act powers and, since the appointed day, as part of the duty of the local health authorities under various other sections of the National Health Service Act.

30. The inquiry was also limited to health centres in urban areas. The conclusions reached, however, in considering the problem in relation to urban circumstances, particularly as regards the density of population necessary to support a health centre (see paragraphs 38-42) suggest that there is likely to be a very limited scope for health centres (as defined in paragraph 29) in country districts.

### 3. Long Term Plan for the Development of Health Centres

#### General

##### *The Scope of Health Centres*

31. The Committee heard during its enquiries much evidence of the unnecessary isolation of the several parts of the Health Service. It was told of general practitioners who do not know the other doctors and dentists practising in the same neighbourhood and have limited knowledge of the local health services available for their patients. There were complaints of inadequate exchange of reports between the general practitioners and the maternity and child welfare and school health service clinics and of the lack of opportunity for general practitioners to talk to the hospital specialists to whom they referred their patients and to gain knowledge of the latest treatment of cases. There was frequent mention of the need to make it easier for midwives, health visitors and home nurses to meet doctors to discuss their patients. Usually there was no failure of good will between the members of the several services; it was chiefly lack of time and of opportunity which prevented closer co-operation between them.

32. We have concluded that one of the most valuable functions of the health centre would be that of providing a natural meeting place for all those working in the health services of the neighbourhood by bringing surgeries, clinics and offices of the curative and the preventive services into one building to which doctors, dentists, midwives, health visitors, nurses and others would be obliged to go in the course of their daily work.

33. Not only would propinquity make it much easier for members of the various services to meet to discuss and to exchange information but it should similarly be easier and quicker for patients to obtain the various local health authority services when these are recommended by the doctor and for clinic patients, found to be in need of treatment, to procure this from their medical practitioner.

34. These considerations weigh heavily in favour of the comprehensive type of health centre and this view is strengthened by studying the location of health centres. Where the density of population is sufficient to justify the provision of accommodation for a group of general practitioners there would also be a need for local health authority clinics (paragraph 39 below).

35. For both these reasons therefore, we believe that the ultimate aim of health centres should be to shelter all or most of the services mentioned in paragraph 28. In some places, however, geographical and other considerations might warrant the inclusion in one health centre of certain facilities intended to serve the areas of several health centres as well as the basic services needed for the immediate area.

36. For many years it will be necessary, in judging the practicability of providing a comprehensive health centre, to take account of clinics and hospital out-patient departments already occupying satisfactory premises in the neighbourhood and other local circumstances. Subject to these qualifications we recommend that:—

(i) General medical services and some local health authority services should be provided at all health centres.

(ii) General and priority dental services should normally be provided at health centres but, where it is geographically convenient, one dental department might serve the areas of several health centres.

(iii) Pharmaceutical services should be provided wherever local circumstances indicate a need.

(iv) The services of specialists or other services provided for out-patients not requiring special accommodation and expensive equipment should be provided at a health centre wherever the demand would justify clinics being held.

(v) The services of specialists or other services provided for out-patients requiring special accommodation and expensive equipment should be provided at health centres only where the demand would ensure the accommodation and equipment being used to such an extent as to be in all the circumstances economical, including the specialist's time. In particular, X-ray apparatus—other than dental X-ray—should not be provided if adequate facilities are readily available elsewhere.

(vi) Because of the common fear of infection, tuberculosis clinics should not be held at health centres unless a separate entrance and separate waiting and other accommodation can be provided.

37. Where good clinic buildings already exist and a health centre is provided mainly for the provision of general medical services, it is very desirable that accommodation for the staff of the local health authority's domiciliary services should also be included wherever it is practicable to do so. Such a health centre should, if possible, be placed on a site large enough to permit the subsequent addition of accommodation for clinics; failing this, the health centre should be sited near and linked functionally with the maternity and child welfare clinic serving the neighbourhood.

#### *Location of Health Centres*

38. Two main considerations must govern the location of health centres: the minimum population which would justify the provision of a health centre and the maximum distance which it is reasonable for patients to travel.

39. We find it difficult to make precise recommendations on these questions because the size of the area and the population which a health centre could conveniently serve must be much affected by geographical features, lines of communication and other factors. Later in this report, however, we recommend that accommodation should be provided at a health centre for from 4-8 general practitioners (paragraph 60). Assuming the number of patients on each doctor's list to be on average about 2,500, the minimum population which a health centre could conveniently serve would be around 10,000. A population of this size would also need a maternity and child welfare clinic.

40. The size of the area which could be covered by one centre has been variously estimated but, in our view, people using a health centre—whether visiting their doctor's surgery or attending clinics—should not normally be required to travel more than about half a mile from their homes.

41. We therefore recommend that health centres should generally be so placed as to serve 15,000 to 20,000 persons—but in any event not less than about 10,000 persons—living within roughly half a mile of the centre.

42. We appreciate that on this basis some parts of urban areas, for example, those which are mainly industrial with a comparatively small resident population, would be classed as unsuitable for health centres. In our opinion, however, it would be uneconomical to provide facilities in a health centre for fewer than four general practitioners except in areas where the consulting suites could also be used part-time for clinic services. (See paragraph 137.)

43. Where new communities are being planned with a community centre, we see many advantages in siting the health centre nearby.

### *Accommodation, Equipment and Staff*

44. We have decided not to make detailed recommendations on the accommodation, equipment and staff required in health centres. There is as yet little experience of the working of these centres on which recommendations could be based and it would in our view be unwise to prescribe in advance such matters as the size of the rooms, the numbers of staff and the many items of equipment required for the various purposes of a health centre. There should, moreover, be scope for experimentation. We therefore propose to confine our recommendations to the type of work to be done in health centres and the type of accommodation and staff it will require. With the exception of some references to useful fixtures and furniture (mainly in relation to accommodation for Part IV services) there are no recommendations on equipment.

45. It is important that the site and design of any new health centre should allow for later extension in case in future this should be found necessary. Attention should also be given to flexibility of design which would enable rooms to be used for different purposes at different times of the day where this is practicable, and to the supply of folding doors or other movable partitions where this would make the accommodation suitable for more than one purpose.

46. It is desirable to restrict the number of entrances into a health centre to simplify supervision; one main entrance and possibly a goods entrance should usually suffice but the site and the number of storeys to the building will naturally affect the arrangement of entrances. At the main entrance there should be an enquiry office and a clerk.

47. The main office or offices for clerical and typing staff of the centre might adjoin or be combined with the enquiry office; the size of these offices will depend on the extent to which the various services find it convenient to use general staff for their clerical and typing work. It might be found convenient to provide recording apparatus of the dictaphone type for general practitioners, who must sometimes deal with their correspondence at times when a shorthand typist could not easily be available. This might often lead to economy of staff. If the health centre includes a telephone exchange, a telephone operator will be necessary. Some simpler arrangement, such as the house exchange system supplied by the Post Office, may be found satisfactory, particularly in the smaller centres, but whatever type of arrangement is made for telephone calls it is important that wherever a health centre includes accommodation for general practitioners, an adequate number of external lines should be provided.

48. There should be at least one common room, with facilities for light meals, which would give the staff of the various services an opportunity to meet and discuss their work.

49. Each health centre will need a small isolation room and at least one spare room for visiting specialists, trainee assistants, overflow waiting and other occasional uses.

50. Other general requirements are lavatories and W.Cs. for staff and patients, cloakrooms or lockers for staff, one or more cleaners' rooms with sink and cupboards, and a boiler house and fuel store. There should be shelter for prams and bicycles and parking for cars, one or more public telephone boxes and a caretaker's residence. Where the circumstances of the area warrant the inclusion of a bedroom for a night duty doctor (see paragraph 78), a garage should be provided for him.

51. It may be found necessary to designate an officer to deal with correspondence addressed to the centre generally, to be in charge of establishment matters (calling on the general maintenance staff of the local health authority

for repairs as necessary), and to exercise general supervision over the non-professional staff, clerks, cleaners, caretakers, etc. A separate room might be required for this officer.

52. A fair proportion of the storage accommodation will be in the pharmacist's department. There will, however, be need for a central store of blankets, linen, etc., and possibly facilities for mending, unless the local health authority have some central arrangements for this. A clerk or other officer might be responsible for this store and for getting the linen, etc., laundered and mended or, alternatively, the health visitor in charge of the clinic and the doctors' receptionists might look after their own units.

53. Arrangements will have to be made for the disposal of soiled dressings and the removal of rubbish and the maintenance of other essential services.

54. Arrangements will also be required for dealing with messages received at night.

55. Recommendations on the problems and requirements of the individual services for which facilities may be provided at health centres are given in the succeeding sections.

### General Medical Services

56. The public provision of consulting rooms and other facilities for doctors in general practice is one of the most novel and important aspects of the health centre idea. It raises a number of questions which seem to us fundamental to any satisfactory appreciation of the problem—such as the desirability or otherwise of group practice and of the association of doctors in financial partnership—but which, while of special importance to health centre practice, nevertheless apply in some measure to the whole field of general medical practice.

57. In view of various misconceptions which have received publicity about the type of service which might be available at health centres, it may be well to summarise the existing legal and administrative arrangements governing the provision of general medical services at health centres.

58. The terms on which a doctor takes service with an Executive Council under Part IV of the National Health Service Act are the same whether he works at a health centre or at his own private surgery. The Regulations\* require a doctor—whether working at a health centre or not—to give all treatment personally unless he is prevented by reason of other professional duties, temporary absence from home, or other reasonable cause. Treatment may, however, be given by a partner or assistant if reasonable steps are taken to secure continuity of treatment, unless the patient chooses to exercise his right to require the personal services of his own doctor. The payment to the doctor is mainly by way of an annual fee for each patient on his list.

59. Doctors are required to make a payment to the Executive Council for the facilities of the health centre, the Executive Council in turn paying the local health authority. The amount of the payment is a matter for agreement between the local health authority and the Executive Council, or failing agreement, for determination by the Minister.

---

\* The National Health Service (General Medical and Pharmaceutical Services) Regulations, 1948, (S.I. 1948, No. 506). The National Health Service (General Medical and Pharmaceutical Services) Amendment Regulations, 1948 and 1949, (S.I. 1948, No. 1448 and S.I. 1949, No. 577).

### *The Group of General Practitioners*

60. Where a health centre provides not only consulting suites but also ancillary accommodation such as a dressings room, clinical side room, and common room, the smallest economic unit would in our view be a group of four general practitioners. For a successful group working in co-operation, with possibly some differentiation of function, we consider that the number of doctors should not, as a rule, exceed eight. We therefore recommend that the number of general practitioners for whom accommodation should be provided at a health centre should normally be from four to eight.

61. The Committee gave a good deal of thought to the means by which general practitioners working as a group in a health centre could best use their particular aptitudes and experience, both within the field of general medical services and the local health and school health services. We believe that it would be of advantage to patients and doctors alike if these practitioners were encouraged to take special interest in, and attain greater experience of particular branches of medicine. We should like to see opportunities continued and extended for general practitioners to fit themselves for this type of intra-group consultation and to ensure that their knowledge is kept up-to-date.

62. The question of the value of some degree of specialisation within the field of general medical services was one on which the Committee felt the need for the advice of the Standing Medical Advisory Committee; that Committee replied that it was in agreement with the value of encouraging special interests among general practitioners in group practice and considered that such interest should be developed by associating general practitioners with the staff of hospitals wherever possible.

63. Another obvious field for the general practitioner with special interest in obstetrics or paediatrics is part-time employment in the clinics of the local health authority or local education authority. We consider that the tendency should be towards staffing clinics with part-time medical officers of the local health authority who are also general practitioners. For the next few years, however, the staffing of clinics should be flexible and local circumstances must influence the decision whether the staff should be mainly full-time medical officers or mainly part-time medical officers who are also general practitioners or hospital specialists.

64. We suggest that the arrangements for filling vacancies at health centres should be such as to secure that doctors are chosen who are likely to work amicably with those already practising there; and that it should be the aim to build up a group of doctors with special knowledge of different branches of medicine, including some who would be acceptable to the local health and education authorities for part-time employment in the maternity and child welfare clinics and the school health service. We think it would often be impracticable to select doctors for their experience or qualifications at the first opening of a health centre, when preference should normally be given to the doctors already practising in the area, particularly if they are already working in association with each other. Local health authorities might be associated by invitation in the selection of general medical and dental practitioners for health centres; this would be particularly useful in cases where there is a possibility of the practitioners being also employed part-time in a local health authority clinic.

### *Financial Association*

65. As mentioned in paragraph 58, there is no legal obligation on doctors at health centres to work in financial partnership, though the desirability of encouraging them to do so has been recognised. The White Paper on the

National Health Service Bill\* said that "Any group of doctors joining in practice from a health centre . . . will be encouraged—wherever possible—to enter into a partnership arrangement whereby their joint remuneration within the Service is pooled and then divided among them on some agreed basis of apportionment".

66. There is clearly a danger that if a number of doctors work at a health centre as individuals, this might lead to competition as between these doctors for patients. Lack of mutual confidence might then develop which would prevent the co-operation and interchange of knowledge and experience which a health centre is intended to foster, and would certainly prejudice the chances of forming the type of group practice described in paragraphs 61-64 above.

67. We feel, therefore, that some form of non-competitive financial association between the doctors working at a health centre is most desirable. There are, however, certain difficulties in the way of achieving this. Doctors are willing to work in partnership with others they consider of equal calibre, but are loath to accept partnership with practitioners whom they think to have a lower standard of skill or zeal, or who are temperamentally incompatible. We do not think it would be wise, in selecting doctors to work at health centres, to give absolute preference to those willing to work, in partnership (who might be less good as doctors than others not so willing) though with the qualification of "other things being equal" the advice would be reasonable.

#### *Assistants*

68. Whilst there would be no objection to doctors acting temporarily as assistants with a view to becoming principals at a health centre, we do not think that permanent assistants should be encouraged at health centres. Other general practitioners who wished to enter the health centre as principals would have reasonable cause for grievance if accommodation were occupied by assistants.

69. We, therefore, recommend that separate accommodation should not be provided for assistants, though a principal should not be barred from sharing his consulting suite with an assistant.

#### *Trainee Assistants*

70. We consider that health centres would be eminently suitable for the instruction of those trainee assistants for whose training the principal receives extra remuneration from the Executive Council. The principal and trainee would work together in the consulting room but it is desirable also to have for a trainee a separate consulting room with an inter-communicating door with that of his principal. The same waiting room should be used for the patients of both the principal and the trainee. The trainee would also gain experience in home visits and might be given some association with clinic work on the public health side.

#### *Training of Medical Students*

71. We wish to put on record our opinion that the use of health centres and the doctors practising therein could be most valuable as part of the education of medical students in the field of general practice.

#### *Charges to General Practitioners*

72. The Minister indicated during the debate on the National Health Service Bill that doctors in health centres would not be asked to pay an economic rent but a reasonable rent. The instructions which have been sent by the

---

\* Cmd. 6761 (1946), paragraph 57.



Ministry to local health authorities and Executive Councils in whose areas health centres have been provided state that the "Minister considers that the charge to be made to general practitioners should be a reasonable computation of what it would cost doctors to provide facilities for practice from their own surgeries in the neighbourhood of the centre . . . This computation will need to be made by the Executive Council in consultation with the local medical committee and the local health authority".

73. Such information as the Committee had suggests that there is a good deal of uncertainty in the minds of authorities concerned with negotiating these charges. The question of what constitutes a reasonable figure is one of some difficulty. On the one hand the payment made by doctors should not be too high lest they be deterred from entering health centres. On the other hand it should not be so low as to give health centre doctors an unfair advantage over their colleagues, as might be the case if a health centre doctor paid only the same amount as he had previously spent on facilities and services in his own surgery, irrespective of the standard of the facilities and services which he had provided for himself.

74. We are of the opinion that general practitioners at health centres should be required to pay what it would cost them to provide themselves with adequate facilities and services in the neighbourhood of the health centre and that it would be helpful to local health authorities and Executive Councils if the Minister were to express his view of what constitutes adequate facilities and services, so that the basis of calculation would be uniform for all health centres, whilst account would be taken of local variations in rent levels, etc. We therefore recommend that the Minister should consider this question in more detail and should lay down the principles and procedure to be followed by all Executive Councils and local health authorities when deciding upon the terms on which the facilities and services shall be made available. These terms should, in our view, include reasonable security of tenure for the individual general practitioners and an assurance that the rate of payment required from them would not be varied frequently. We further recommend that the consultations with the local medical committee by the Executive Council should come at an early stage. The local health authority providing a health centre will also wish to receive an assurance that the centre will in fact be used by general practitioners.

#### *Accommodation and Staff*

75. We recommend that each doctor should have his own consulting room (with lavatory basin, cupboard for diagnostic instruments and books, small sink with drainer, gas point for urine testing, desk, telephone and chairs) and a separate examination room large enough for a patient, nurse or receptionist and doctor (with examination couch and chairs). There should also be provided either a waiting room for each doctor's suite or, for the sake of economy and to ease the sharing of receptionists, one waiting room for two doctors. A single doctor's waiting room should be large enough to seat about 20 persons and a waiting room for two doctors about 30 persons. There is unlikely to be need for a special room for receptionists.

76. There should be a room for daily dressings and minor operations and also a clinical side room (with bench, cupboards, sink, gas and electric points, and a cupboard containing all the necessary outfits required for sending specimens to laboratories). A permanent official at the health centre should be responsible for the equipment of the side room and for seeing that the room is kept in order.

77. The number of auxiliaries required by a group of general practitioners can be determined only by experience ; at least one of them should be an experienced nurse and at least one a shorthand typist or a typist capable of transcribing from recording apparatus. It is important that doctors' personal staff, such as secretaries or receptionists, should be selected and remunerated with due regard to the highly confidential nature of their work and that the doctors should be allowed a prominent share in their selection (see also paragraph 123).

78. Generally it is desirable that doctors should live in the area in which they practise, and only where this is not done would accommodation for a duty doctor be necessary at a health centre.

#### **Dental Services**

79. Dentists providing general dental services at health centres receive remuneration from the Executive Council in the form of whole-time or part-time salaries or sessional fees. The salaries are net and dentists are not required to make any payment to the Executive Council for the use of the health centre facilities. The Executive Council make an agreed payment to the local health authority for the use of the health centre. Dentists in the maternity and child welfare or school health services hold salaried or sessional appointments with the local health or education authority. A dentist may be engaged in both general dental service and priority dental service at the same health centre, in which case he may have separate contracts with each body or, alternatively, a joint appointment may be made by agreement between the bodies concerned.

80. We are aware of the difficulties of obtaining dentists to take salaried posts in health centres (whether for general or for priority work) whilst remuneration for general dental services outside health centres is greatly disproportionate to the remuneration proposed for service in them, and the further difficulties resulting from the lack of uniformity between the salaries paid to dentists by Executive Councils and those paid by various local health and education authorities. Our recommendations on the facilities to be provided at health centres are made on the assumption that administrative action will in due course be taken to ensure that dentists are not discouraged from working at health centres solely by reason of disparity of remuneration.

81. We consider that the dental department of a health centre should have accommodation for both priority and general dental work : this would give elasticity in allotting individual surgeries to one or other of the services as required. There should also be co-operation between the priority and general services in such matters as dealing with emergency cases and assisting each other in case of absences for sickness or holidays.

82. While the present rate of demand for dental treatment obtains, the number of dentists required for the area of a health centre should be about half the number of doctors ; eventually an increased number of dentists will be required. As the larger dental departments are more economical in administration, however, one dental department might be designed to serve the area of more than one health centre where this is geographically convenient.

83. It is advantageous for dentists and technicians to work closely together and therefore a workshop should preferably be provided even where the dental department serves a small population ; alternatively, if on grounds of economy a group workshop is provided to serve several small health centre dental departments, it should be situated near enough to the health centres for the technicians to be on call to visit the dentists when required.

84. Great economy in dentists' time can be obtained by providing a spare surgery, so that the dentist may be giving treatment to one patient whilst another waits for a local anaesthetic to take effect, or where there are delays during the fitting of dentures.

#### *Accommodation and Staff*

85. The dental department of a health centre requires a surgery for each dentist and preferably one spare surgery. A mobile dental X-ray unit will be required unless a separate X-ray room is provided. Also required are recovery room(s), one or two waiting rooms, an interview room and a X-ray developing room. The accommodation should be of such a character as to permit expansion, e.g., for the use of such ancillary personnel as dental hygienists should their employment prove desirable as a result of the present experiment in their training and use (see paragraph 150).

86. The laboratory and workshop should contain two small compartments, one for plaster work and the other for polishing.

87. Storage accommodation will be needed in the dental department or elsewhere as convenient, for records, models and bulky consumable stores.

88. A chair-side attendant is necessary for each dentist while on duty; whether or not a clerk would also be required would depend on the size of the department and the use made of the general office. Dental technicians will be needed where the centre includes a workshop.

#### **Pharmaceutical Services**

89. Where pharmaceutical services under Part IV of the Act are provided at a health centre, the pharmacist is an employee of the local health authority, receiving payment by full-time or part-time salary or sessional fees as appropriate. He is required to apply for inclusion in the pharmaceutical list of the Executive Council and to enter into contract with the Council to provide pharmaceutical services under Part IV of the Act. It is made a condition of his employment with the local health authority that he shall arrange with the Executive Council for all payments due to him from that Council to be paid to the local health authority.

90. Patients are free either to take their prescriptions to a chemist's shop of their choice or to have them dispensed at the health centre.

91. There are differing views on the desirability of providing arrangements for dispensing patients' medicines at health centres. The need for these services is usually greatest during and after evening surgeries when most shops are closed. Apart from this, pharmaceutical services at a health centre may be needed at all times in those areas which are not well supplied with chemists' shops or where there is no shop pharmacy licensed under the Therapeutic Substances Act for dispensing solutions such as penicillin requiring special facilities for sterilizing.

92. We have concluded that for the time being local circumstances should mainly decide whether and to what extent facilities for pharmaceutical services should be provided at health centres, and that it is desirable that there should be more experience of this provision before firm conclusions are reached. We recommend that such experience might most suitably be obtained in areas where alternative facilities are clearly inadequate.

93. Where facilities are available at a health centre for dispensing patients' medicines, the pharmacist would also be responsible for the preparation of drugs and dressings used for the internal work of the centre and for the dispensing of solutions for injections. He would be available to the doctors

and dentists at the centre for consultation on pharmaceutical matters. The handling and storage of drugs covered by the Dangerous Drugs Acts should also be under pharmaceutical supervision. Where the dispensing of patients' medicines is not undertaken at a health centre, it will still be necessary for the local health authority to make provision for the internal pharmaceutical needs of the centre.

#### *Accommodation and Staff*

94. A health centre pharmacy should include a dispensary, with facilities for the preparation of aseptic solutions and with storage accommodation for drugs, dressings and sundries, and for gas and oxygen; also an inflammable stores room separate from the building. Where pharmaceutical services under Part IV of the Act are being provided, the size of these rooms will be larger and in addition there will be required a stock preparations room and a waiting room.

95. The number of pharmacists and dispensing assistants needed will depend upon the amount of work undertaken. At centres where pharmaceutical services under Part IV of the Act are not being provided the part-time services of a pharmacist may suffice. There should also be a porter-storekeeper unless other help is available for the moving of heavy stores.

#### **Local Health Authority Services**

96. Facilities may be provided at a health centre for the provision or organisation of any of the services which a local health authority are required or empowered to provide. These services are maternity and child welfare, domiciliary midwifery, health visiting, home nursing, vaccination and immunisation, ambulances, prevention of illness, care and after-care, and domestic help. (The local health authority also have power to permit the use of health centre accommodation by any voluntary organisation providing services under Part III of the Act.)

97. We consider that all these services, with the exception of ambulances, could conveniently be located at health centres, but whether or not a particular service should be included in a particular health centre must depend on local circumstances.

98. Ante-natal, post-natal and child welfare clinics should, as a rule, be provided at every health centre but where consultative clinics, held by specialist obstetricians or paediatricians, are provided—whether by the local health authority or by the Hospital Board—they might, where locally convenient, be designed to serve the area of more than one health centre.

99. In our view, the ambulance service should not normally be associated with a health centre as it can be more conveniently administered over a wider area.

100. It would also be possible for a local health authority to include in a health centre accommodation for any services which they may provide directly or by arrangement with a voluntary organisation in connection with their duties under the Mental Deficiency Acts, but here again a wider area is more suitable and it would usually be wasteful to make provision for these services in health centres.

#### *Maternity and Child Welfare*

101. Local health authorities already have considerable experience of providing for the care of mothers and young children, and we understand that a memorandum is about to be issued by the Ministry giving guidance on the planning of accommodation for clinics. In the circumstances, we do not

propose to make any detailed recommendations on the requirements of these services which—apart from the possibility of sharing certain rooms with other services and making use of common facilities such as offices and staff rooms—are similar whether provided at a health centre or elsewhere.

### *Domiciliary Services*

102. The health visitors, midwives and home nurses working within the area of the health centre would need an office, equipped with desks and filing cabinets for the home visiting record cards.

103. Provision should be made, for the use of local midwives and home nurses, of one or more duty rooms, with steam sterilizers for instruments, where they could prepare their labour or nursing bags. This room could also serve as a place where the doctors could contact nurses and midwives at specified times. The probability is that patients would book the midwife at the midwife's place of residence, or when she attended the ante-natal clinic but, if not, the health centre could conveniently be used for this purpose and one of the clinic interview rooms in the maternity and child welfare department would serve.

104. Where it is convenient for the domestic help service to be organised from a health centre in the local health authority's area, the domestic help organiser should be provided with a separate office.

### *Care and After-care*

105. We recommend that an officer should be appointed to a health centre to help general practitioners with the socio-medical aspects of their work. This officer might be engaged partly as an assistant to the doctors and partly for the local health authority's care and after-care service. In addition to dealing with individuals referred by the medical staff as requiring some kind of personal case work, this officer could also be called upon to give information to patients requiring the assistance of other statutory or voluntary social services. The socio-medical worker would need to use the clerical and typing staff of the centre and would require a separate room.

106. It would probably be convenient to keep at the health centre a loan cupboard from which midwives and home nurses working in the area could draw for their patients. Some of the larger and less frequently borrowed articles such as bathchairs might, however, more conveniently be kept at a central loan store of the local health authority.

### **Hospital and Specialist Services**

107. Where the services of specialists or other services provided for out-patients under Part II of the Act are available at health centres, the appropriate hospital authority takes the responsibility for the provision of hospital equipment, drugs and dressings, either directly or through the local health authority. The hospital authority also take responsibility for the appointment of all medical, dental, medical auxiliary, nursing and hospital records' staff working at the centre for the purpose of providing Part II services. This may, when convenient, be done by arranging with the local health authority for the use of local health authority staff. The local health authority recover from the hospital authority charges by way of rent for the accommodation used for Part II services and also charge for the use of any equipment or staff which the local health authority have arranged to provide.

108. There are both advantages and disadvantages in providing specialist services at health centres. On the one hand, it would bring specialists and general practitioners into closer relationship; they would get to know each other personally, and it would be educative for both. The specialists would be given first-hand information about the home economy and industrial conditions under which the patient lives and works, and the general practitioner would be kept in closer touch with the latest developments of medical science and the type of case which ought to be referred to a specialist. It would relieve congestion in out-patient departments of hospitals and it would in some localities save the patient a long journey.

109. On the other hand, the consultant's effectiveness should not be reduced by his having to attend at an undue number of places or by having his time wasted in unnecessary travelling. It is important, too, to avoid where possible the duplication of premises and special apparatus, or the uneconomical provision of professional assistance. The specialist who needs large apparatus or equipment for diagnostic investigations in his particular field, would have to refer most of his patients to his hospital out-patient department and so cause two attendances by the patient where one might have sufficed. Unless, therefore, there is adequate work at a particular centre or at a group of centres, which are near to each other, too much of the specialist's time may be spent in travel.

110. We, therefore, recommend that the principle of attendance of specialists at health centres, particularly where they are at a considerable distance from a hospital, should be approved, but that each specialty should be considered separately in regard to the frequency of attendance needed and the nature of the apparatus and assistance required in the particular specialty.

111. In deciding which of the services customarily given at hospital out-patient departments should, in future, be provided at health centres, we think that the following principle may provide a rough guide. Attendance for diagnostic examination and investigation or for forms of specialised treatment that can be carried out without the need for many repeated visits should be arranged at hospital. Repetitive attendances for treatment (particularly for such items of service as dressings, injections, etc.), could best be made at health centres.

### *Rehabilitation*

112. There may be a case for the provision at health centres of physiotherapy requiring little or no apparatus for patients who require regular treatment and only occasionally need to see the physical medicine specialist. An additional advantage of physiotherapy at health centres would be the corresponding economy in transport. Whilst, however, there remains a shortage of trained personnel, it may continue to be necessary for the majority of physiotherapeutic proceedings to be concentrated in hospital or at a limited number of health centres which, for this purpose, would serve an area wider than the normal.

113. The main advantage of providing rehabilitation treatment at a health centre is the convenience of the patients and it would not, therefore, normally be required at centres which were reasonably near to a suitable hospital.

114. Where rehabilitation treatment is given at a health centre, it should be under the direction of the hospital and specialist service as a sub-station of a hospital in order to ensure prescription and supervision of treatment by a specialist and to minimise the risk of the prolonged use of facilities for patients unlikely to receive further commensurate benefit from their continued use.

### *Accommodation and Staff*

115. The accommodation and staff required will naturally depend on the type and extent of the services given. We do not think, however, that any elaborate provision for specialist services at health centres will normally be required; consulting rooms set aside for the examination of eyes, ears, nose and throat in the maternity and child welfare or school health service departments could be used by specialists visiting at the request of general practitioners.

### **Information**

116. The Act provides that there may be facilities at health centres for the publication of information on questions relating to health or disease and for the delivery of lectures and the display of pictures or cinematograph films in which such questions are dealt with.

117. The lay public are generally eager to have information about health and disease—they want to know how they can avoid serious illness. Whilst many clinicians agree in principle that their work is helped if suitable information is given to the public, a substantial number hold the opinion that such instruction gives rise to excessive fear of disease or of a particular disease and, in consequence, to neurosis. A further difficulty is that of reaching agreement on the content of the message. To be effective, it must be dogmatic and authoritative, and without the provisos and exceptions which are generally necessary to make it scientifically correct.

118. Nevertheless, we believe that there is much useful educational work which can and ought to be done, particularly in such matters as the education of parents in bringing up young children, the advocacy of immunisation against diphtheria and of vaccination and care of the mouth. Leaflets to convey stock advice given to persons with common ailments are valuable to doctors: not in substitution for the giving of the advice verbally but to remind the patients when they get home of what the doctor said. Small monthly health journals are suitable for use in health centres, especially if they also contain local supplements giving doctors' surgery hours, times of clinics, and other local news of topical interest. Many good documentary films are now available and could well be shown in health centres. Small exhibition stands with the material changed from time to time, booklets, leaflets and posters, all have their place in a programme of health education.

119. We, therefore, recommend that some health centres should include a room where lectures, demonstrations (e.g., on household shopping and cooking, for which a small kitchen is needed) and film shows can take place and where exhibition material may be shown. It should not be necessary to set aside a room for this purpose alone (see paragraph 45). Doctors and dentists who wish to invite their patients to hear lectures on health from them should be encouraged to do so; they should also be invited to make suggestions for special leaflets. The dietician from a nearby hospital might attend the health centre regularly to give advice on, for example, the different diets prescribed by general practitioners. Leaflets and booklets and a health magazine should be available for judicious distribution.

### **Management**

120. The health centre is a building maintained, equipped and staffed by the local health authority, but the services provided there may be the responsibility of a number of different bodies and individuals. The local health authority, local education authority, Executive Council, Regional Hospital Board and Board of Governors may each be responsible for some of the services provided at a health centre and the individual general practitioners retain their personal responsibility for their patients.

121. We believe that it is vital to the success of the health centre idea that satisfactory arrangements should be built up for consultation and co-operation between these various interests at all stages of health centre management.

122. We, therefore, recommend that any statutory body or committee of such body, which is responsible for the provision of a health centre or for the organisation or provision of services at a health centre, should arrange for representatives of the other bodies also concerned to join in its discussion to the maximum possible extent.

123. We also recommend that each health centre should have a professional committee, including general medical and dental practitioners, clinic medical and dental officers, and the Medical Officer of Health or his representative, to deal with such matters as duty rotas, surgery hours, allocation of the rooms and use of ancillary services. The professional committee would report any matters which needed further action to the appropriate body: the local health authority or Executive Council or other authority responsible for providing services or (in the case of disputes between practitioners) the Local Medical or Dental Committee. The appropriate executive bodies would be well advised to give the professional committee the opportunity of sending a representative to support, in person, any recommendation which the committee consider to be of special importance. This is particularly important for general practitioner users of health centres who are not employees of the local health authority. Representatives of the professional committee should also be invited by the local health authority to be associated with the selection of the personal assistants of the general medical and dental practitioners.

#### **School Health Services**

124. County Councils and County Borough Councils are both local health authorities and local education authorities. We consider that the provision of accommodation for school health services in the health centre building would be both convenient and economical, and that the regular association of the staff of the school and local health services with the practitioner services would be of mutual benefit.

#### **4. Immediate Practical Programme**

125. It is clear that the present economic difficulties of the country will make it impracticable to undertake the provision in many urban areas of comprehensive health centres of the type which we have described in the previous sections of our report.

126. We have therefore considered what measures could be taken during the interim period which must elapse before new building can be freely embarked upon to obtain immediately some of the advantages which health centres are intended to provide and to ensure as far as possible that no new obstacles to their satisfactory introduction are created.

127. The objects of the immediate programme should be:—

(a) To encourage non-competitive group practice at once and in every possible way and to bring doctors into under-doctored areas by the provision of suitable accommodation of simple and economical type for group practice only.

(b) To build a few comprehensive health centres, varying in design, and to study and gain experience from the construction and management of these centres.



(c) To ensure that large new communities are planned to have health centres from the beginning and so to discourage the start of individual practices in separate houses which impedes the ideal of group practice in health centres.

(d) To plan future health centre requirements of the country so that the most essential sites may be reserved and the scheme implemented as opportunity occurs.

#### (a) Simple Health Centres for Group Practice

128. We feel that there has been a tendency to underrate the importance of health centre accommodation for general practitioners who, given suitable facilities, might lessen the calls on the hospital and local health services. Simple health centres for group practice—which need not necessarily be in new buildings—would be valuable both for the impetus which they could give to good standards of medical practice in the areas in which they were provided and for the useful experience which could be gained from them of the problems involved in the management of health centres.

129. The most suitable areas for first experiments are those where there are already satisfactory clinics—and where, therefore, the building of a comprehensive health centre would not be justifiable—but health centres of this type might also, we believe, attract practitioners to under-doctored areas.

130. The existence in an area of a group of doctors anxious to work in a health centre and preferably willing to combine in some form of non-competitive financial association would, in our view, justify special search being made in that area for premises which could be adapted at small cost for the purpose.

131. Our Committee considered, in some detail, the minimum requirements of a simple health centre for four to eight general practitioners, and our conclusions are given below.

#### *Accommodation*

132. The minimum requirements are:—

##### *For each doctor:*

1 consulting room.

1 examination room with couch, small table and chair for attendant or relative.

Pegs for hanging clothes and wall cupboard.

##### *For each two or exceptionally three doctors:*

1 waiting room.

##### *For the centre as a whole:*

Nurse's treatment room (with couch, sink, sterilizer, washhand basin, cupboard, dressing trolley).

Combined enquiry room and general office.

Caretaker's residence or other arrangements for dealing with messages at night and weekends.

Simple facilities (gas ring and cupboard) for making tea in one of the rooms.

133. The provision of a nurse's treatment room, as suggested, would permit the consulting rooms and examination rooms to be smaller and would not, therefore, be extravagant. The evidence submitted to our Committee was to the effect that a nurse's treatment room was a most important provision which should be made to facilitate the work of group general practice in a health centre. The clinical side room could be dispensed with, urine testing being done either in the consulting rooms or in the nurse's treatment room. A common room, although desirable, is not essential.

#### *Staff*

134. Clerk-receptionists should be provided in a ratio of one to two or three doctors (depending on the size of the practices). This would be sufficient to include general reception and telephoning for the centre as a whole. It will probably be necessary to have split duties. There should also be a nurse to do dressings, injections, etc., though she would not necessarily be available at all the surgery hours.

#### *Sharing of Accommodation*

135. We see no objection to the sharing of a consulting suite by two or more general practitioners if the doctors concerned agree.

136. Consulting suites might be used for clinics when not in use by the general practitioners.

137. Whilst we consider that normally it would be uneconomical to provide health centre accommodation for fewer than four general practitioners, an exception to this might be made where a smaller number of consulting suites could be used part-time for clinic services. This dual use would be particularly suitable in compact areas of new development with little or no accommodation for health services and a population of less than 10,000.

### **(b) Comprehensive Health Centres**

138. It would not be possible for us to estimate how many comprehensive health centres of the type which we have described the country could afford to provide during the next few years. We consider, however, that it is most important that some health centres of this type should be built now, notwithstanding the financial circumstances of the time. The experience gained from the building and management of these first health centres would be of the greatest value in planning the widespread provision of health centres when this becomes possible in the future. They should normally be erected in areas where the existing accommodation for health services is seriously inadequate.

### **(c) New Communities**

139. A new community such as a new town or large new housing estate is a particularly suitable situation for a health centre because accommodation for health services must be provided in that or some other form and—there being no vested interests—the circumstances are favourable for the creation of co-operative group practice. It is, however, in our view, most important that health centre accommodation for general practitioners should be provided during the first stage of the erection of a new town or new estate. Any delay has the result that new doctors put up their plates on the estate and compete for patients among the incoming population. At first the group practice accommodation could be used part-time for clinics, separate clinic accommodation being added as the population increases. We understand that some housing authorities are still providing houses with special surgery accommodation for doctors on their new estates. We recommend that this should

be discouraged and that whilst doctors might be permitted to practise temporarily from the larger Council houses intended for higher income groups or for large families, it should be on the understanding that the houses would revert to exclusively residential use when a health centre was established in that area.

#### **(d) Planning**

140. Most local health authorities have, at the Minister's suggestion, not yet submitted to him proposals for carrying out their duty to provide health centres. We realise that the preparation of these proposals by all local health authorities would involve a considerable amount of work, both for the authorities and for the Executive Councils and Regional Hospital Boards who would be consulted. The advantages of this course are that if the ultimate health centre needs of the authority's area were planned now, suitable sites might be reserved throughout the area and the more urgent part of the plan might be completed as and when financial and building difficulties permitted. The disadvantages are that by the time it is possible to provide sufficient health centres to cover the whole country, movement of population, new building, etc., would have made parts of the plan obsolete. There is also a limit to the amount of land which can be reserved indefinitely in popular sites whilst, in course of time, equally suitable sites might become available elsewhere.

141. Despite the difficulties involved, we consider that the main outlines of each local health authority's plan should be drawn now. In some areas there is a need for comprehensive health centres ; in others satisfactory clinics already exist and the immediate need is for health centres mainly for group practice. We think that local health authorities should try to reserve sites at least in those areas which would require comprehensive health centres.

142. We, therefore, recommend that local health authorities, in co-operation in suitable cases with neighbouring authorities, should consider now what will be the ultimate health centre needs of their areas and should obtain the Minister's approval to their general proposals so that they may reserve or acquire suitable sites as opportunity occurs.

### **5. Summary**

#### **Limits of the Inquiry**

143. (i) The inquiry was divided into two parts (the long term plan and the immediate practical programme). In both parts the inquiry was limited to urban health centres including accommodation for services provided under Part IV of the Act. (Paragraphs 27-30.)

#### **Long-Term Plan**

##### *General*

(ii) The ultimate aim of health centres should be to provide facilities for all or most of the services listed in Section 21 of the Act. (Paragraph 35.)

(iii) Health centres should generally be so placed as to serve ten to twenty thousand persons living within about half a mile. (Paragraph 41.)

(iv) The design of health centres should be flexible and should allow for later extension. (Paragraph 45.)

(v) *Accommodation :*

- Entrance Hall.
- General and Enquiry Office(s).
- Common room for staff with facilities for light meals.
- Isolation room.
- Spare room(s).
- Lavatories and W.Cs., male and female, for staff and patients.
- Cloakrooms or lockers for staff.
- Storage for equipment, linen, etc.
- Cleaners' room(s).
- Shelter for prams and bicycles and parking for cars.
- Public telephone call box(es).
- Caretaker's residence.
- Boiler house and fuel store. (Paragraphs 46-50.)

(vi) *Staff :*

- Clerks, typists, (supervisory officer), (telephone operator), caretaker, cleaner(s) and other maintenance staff as necessary. (Paragraphs 46, 47, 51-54.)

*General Medical Services*

(vii) There should normally be accommodation for from four to eight general practitioners. (Paragraph 60.)

(viii) The arrangements for filling vacancies at health centres should be such as to secure that doctors chosen are likely to work amicably with those already practising there ; it should be the aim to build up a group of doctors with special knowledge of different branches of medicine, including some who would be acceptable to the local health and education authorities for part-time employment in the maternity and child welfare clinics and the school health service. (Paragraph 64.)

(ix) Doctors at health centres should be encouraged to work in financial partnership. (Paragraph 67.)

(x) Health centres are suitable for the instruction of trainee assistants or of medical students but permanent assistants should not be encouraged. (Paragraphs 68-71.)

(xi) The Minister should lay down the principles and procedure to be followed by all Executive Councils and local health authorities when deciding upon the terms on which the facilities and services shall be made available. (Paragraph 74.)

(xii) *Accommodation :*

- Consulting room
- Examination room } for each doctor.
- Waiting room for each doctor or shared by two doctors.
- Clinical side room.
- Room for daily dressings and minor operations. (Paragraphs 75-76.)

(xiii) Accommodation for a duty doctor should only exceptionally be necessary as doctors should normally live in the area in which they practise. (Paragraph 78.)

(xiv) *Staff :*

- Doctors' auxiliaries as required, including one experienced nurse and at least one shorthand typist or typist capable of transcribing from recording apparatus. (Paragraph 77.)

### *Dental Services*

(xv) The dental department of a health centre should have accommodation for both general and priority dental services. It might serve the area of more than one health centre. (Paragraphs 81-82.)

(xvi) There should be a dental workshop in or near a health centre dental department. (Paragraph 83.)

(xvii) *Accommodation :*

One surgery for each dentist and preferably one spare surgery.

One recovery room for each two surgeries.

One or two waiting rooms.

Interview room.

X-ray developing room.

(Workshop).

(Paragraphs 85-87.)

(xviii) *Staff :*

Chair-side attendants.

(Clerk).

(Technicians).

(Paragraph 88.)

### *Pharmaceutical Services*

(xix) Local circumstances should for the time being mainly decide whether or not pharmaceutical services under Part IV of the Act should be provided at health centres. There is need for more experience and this should preferably be gained in areas where alternative facilities are clearly inadequate. (Paragraph 92.)

(xx) It is necessary to make provision for the internal pharmaceutical needs of the centre. (Paragraph 93.)

(xxi) *Accommodation :*

Dispensary with facilities for the preparation of aseptic solutions.

Storage accommodation for drugs, dressings and sundries, gas and oxygen.

Inflammable stores room (separate from building).

\*Stock preparations room.

\*Waiting room.

(Paragraph 94.)

(xxii) *Staff :*

Full-time or part-time pharmacist or \*pharmacists.

\*Dispensing assistant(s).

Porter-storekeeper or other help for moving heavy stores.

(Paragraph 95.)

### *Local Health Authority Services*

(xxiii) All local health authority services except ambulances could conveniently be located at health centres but whether or not a particular service should be included in a particular health centre must depend on local circumstances. (Paragraph 97.)

(xxiv) An officer should be appointed to help general practitioners with the socio-medical aspects of their work. (Paragraph 105.)

---

\* Required only when pharmaceutical services under Part IV of the Act are being provided.

(xxv) *Accommodation and Staff :*

(a) Maternity and child welfare.

No recommendations are made in view of the proposed issue of a memorandum by the Ministry. (Paragraph 101.)

(b) Domiciliary services.

Office(s) for health visitors, midwives and home nurses and possibly for a domestic help organiser.

Duty room(s) for midwives and home nurses.

Use of clerical and typing staff. (Paragraphs 102-104.)

(c) Care and after-care.

Room for socio-medical worker.

Use of clerical and typing staff.

Loan store. (Paragraphs 105-106.)

*Hospital and Specialist Services*

(xxvi) The principle of the attendance of specialists at health centres should be approved, each specialty being considered separately in regard to the frequency of attendance and the nature of the specialty.

(Paragraph 110.)

(xxvii) Repetitive attendances for treatment customarily given at hospital out-patient departments (e.g., dressings, injections, etc.), could be made at health centres.

(Paragraph 111.)

(xxviii) Physiotherapy requiring little or no apparatus might well be given to certain types of patient at health centres.

(Paragraph 112.)

(xxix) Where rehabilitation treatment is given at a health centre it should be under the direction of the hospital and specialist service. It should not normally be required at health centres near to suitable hospitals.

(Paragraphs 113-114.)

(xxx) *Accommodation and Staff :* This must be dependent on the type and extent of the services provided. Elaborate provision should not normally be required.

(Paragraph 115.)

*Information*

(xxxi) Some health centres should include a room suitable for part-time use for lectures, demonstrations, film shows and displays of exhibition material. Other methods of health education should also be employed.

(Paragraph 119.)

*Management*

(xxxii) It is vital that there should be consultation and co-operation between the local health authority, local education authority, Executive Council, Regional Hospital Board and Boards of Governors, and general medical and dental practitioners concerned with a health centre.

(Paragraph 120.)

(xxxiii) Any statutory body or committee of such body which is responsible for the provision of a health centre or for the organisation or provision of services at a health centre should arrange for representatives of the other bodies also concerned to join in its discussions.

(Paragraph 122.)

(xxxiv) Each health centre should have a professional committee to deal with such matters as duty rotas, surgery hours, allocation of rooms and use of ancillary services.

(Paragraph 123.)

### *School Health Services*

(xxxv) The provision of accommodation for school health services in health centres is recommended. (Paragraph 124.)

#### **Immediate Practical Programme**

(xxxvi) Simple centres for group practice should be provided in areas where there are already satisfactory clinics, in under-doctored areas and in areas where there are both premises which could be cheaply adapted and a group of doctors anxious to work in a health centre. (Paragraphs 128-130.)

(xxxvii) The minimum accommodation and staff required for simple group practice centres are :—

##### *Accommodation :*

Consulting room }  
Examination room } for each doctor.

Waiting room (shared by two or three doctors).

Nurse's treatment room.

Combined enquiry and general office.

Cloakroom and sanitary accommodation.

Caretaker's residence or other arrangements for dealing with messages at night and weekends. (Paragraphs 132-133.)

##### *Staff :*

One Nurse.

One clerk-receptionist to two or three doctors. (Paragraph 134.)

(xxxviii) Consulting suites might be shared by two or more general practitioners, or might be used for clinics part-time. (Paragraphs 135-136.)

(xxxix) A few comprehensive health centres should be built. (Paragraph 138.)

(xl) New communities should be provided with health centres from the start. (Paragraph 139.)

(xli) Local health authorities should consider now what will be the ultimate health centre needs of their areas and should obtain the Minister's approval to their general proposals so that they may reserve or acquire suitable sites as opportunity occurs. (Paragraph 142.)

## PART III

144. All matters on which Standing Advisory Committees have advised the Minister have been considered by us but throughout this part of the Report no mention is made of the fact in cases where we expressed no view on the advice tendered.

### Standing Medical Advisory Committee

145. The Committee held four meetings during 1950. It has given general advice on medical matters referred to it by us and other Standing Advisory Committees. In particular it has been closely concerned with the methods of securing economy in prescribing mentioned in Part I of the Report, and has joined with the Standing Nursing Advisory Committee in considering how to control infection in hospitals on which advice was given to us as mentioned in paragraph 159.

146. *Children's Hospitals.* Most of one meeting was devoted to a discussion on the hospital care of children. No formal advice was given to the Minister, but the need was recognised for improvement in the standard of hospital care for children. It was felt that a useful means of securing improvement would be to establish a new hospital or a number of smaller demonstration units to experiment and disseminate knowledge of proved methods in the management of sick children.

147. *Use of Heroin.* Heroin is regarded as the most dangerous of all drugs of addiction. Following an expression of grave concern by the Expert Committee on Drugs of the World Health Organisation on the alarming increase in the use of this drug, the Minister asked the Committee to consider its use in this country. The Committee did not think that heroin addiction presented any serious problem in the United Kingdom, but decided to seek the views of the British Pharmacopoeia Commission. The Committee then agreed with the Commission's view that although heroin is still claimed by some practitioners to be of great value as a sedative after operations and in inoperable malignant disease, and to a lesser degree in severe paroxysmal cough, the advantages so claimed do not outweigh the grave consequences of widespread addiction in certain countries. The Committee, therefore, advised the Minister that a prohibition of the use of heroin in this country would be justified if international agreement were reached to prohibit the sale and manufacture of heroin throughout the world.

148. The Committee has also considered the use of cortisone; the treatment of cosmetic disabilities in the National Health Service; and certain detailed points on the economical use of drugs and dressings in hospitals.

### Standing Dental Advisory Committee

149. The Committee met six times during 1950.

150. *Co-operation between authorities providing dental services.* The Committee has considered at length the need for co-operation between authorities providing dental services under the National Health Service. It reached the view that some of the problems which arise in providing dental services are due in whole or in part to the inadequate number of dentists to meet existing demands for treatment, and can be met under existing conditions only by an increase in available dental manpower. At the same time,



however, the Committee considered that co-operation between the authorities responsible for providing the services might well lead to a better use of available resources. The Committee made its views known to our Committee on Co-operation (see para. 20).

151. *Oral Hygienists.* The Committee still has under consideration the position of ancillary dental workers. It is continuing, through its Sub-Committee (see previous report, paragraph 40) to observe the experiment in the training and use of oral hygienists at the Eastman Dental Hospital. The Committee has submitted to the Minister a statement on the progress of the experiment and has recommended that it should be issued to interested organisations and bodies. The statement notes that the Committee will await the result of the experiment before making any recommendations.

152. *New Zealand Dental Nurses.* The Committee has received from the Minister the Report of the Mission, which was sent to New Zealand as a result of the Committee's recommendation that first-hand information should be obtained about the work and training of New Zealand Dental Nurses, and is considering its implications.

153. The Committee has advised the Minister on a number of matters relating to the use of certain dental materials and drugs in the general dental services provided under the National Health Service (see Appendix II). It still has under consideration the survey of statutory scientific agencies and other bodies available for carrying out dental research, and the organisation of refresher courses for general dental practitioners.

#### **Standing Pharmaceutical Advisory Committee**

154. The Committee held four meetings during 1950. In the earlier part of the year it completed consideration of questions relating to prescribing in the general practitioner and general pharmaceutical services which are dealt with elsewhere in the Report.

155. *Pharmaceutical Manpower.* The Committee has attempted to discover whether there will be, in the immediate future and later on, enough pharmacists for the purposes of the National Health Service. The Committee consulted the Pharmaceutical Society of Great Britain in regard to the investigations which the Society had undertaken on the general question of pharmaceutical manpower. Subsequently we invited the Committee to consider in particular the shortage of hospital pharmacists. Having reviewed the information obtained from the Pharmaceutical Society and figures submitted by the Ministry as to the staffing position in hospital pharmacies, the Committee recorded its concern at the shortage of qualified staff in all branches of pharmacy and advised the Minister to discuss with the Pharmaceutical Society how the shortage could be relieved. It also requested the Hospital Sub-Committee to investigate whether more economical use could be made of qualified staff in hospital pharmaceutical departments.

156. *Hospital Sub-Committee.* The Hospital Sub-Committee has also presented an interim report on the four questions referred to it:—

- (a) Manufacture in hospitals.
- (b) Pharmaceutical research in hospitals.
- (c) Standardisation of accommodation and equipment.
- (d) Central syringe sterilisation service.

## Standing Ophthalmic Advisory Committee

157. This Committee did not meet in 1950.

## Standing Nursing Advisory Committee

158. This Committee met on four occasions during 1950.

159. *Nursing Techniques.* In 1949 the Committee was asked by the Minister to consider methods of obtaining and collating information regarding approved nursing techniques ; methods of disseminating this information to hospitals and nurses in the National Health Service and the techniques to be recommended (previous report, paragraph 56). Early in 1950 the Committee forwarded to us a report and five memoranda on the subject of cross-infection in hospitals.\* At our request further consideration, particularly on the medical aspects, was given to the report and memoranda by a Joint Sub-Committee of the Standing Nursing and Medical Advisory Committees. The papers, having been revised and approved by the parent Committees, were again submitted to us. We accepted the revised report and advised the Minister that hospital authorities should invest a medical officer in each hospital with special executive responsibility for the control of infection, while the matron should control nursing techniques with that end in view. There should be an advisory Committee on Control of Infection on which there should be representatives of the medical, surgical, pathological and nursing staff and of the Medical Officer of Health of the local sanitary authority. This Committee would consider the measures to be taken to prevent the spread of infection from members of the hospital staff and visitors ; the instructions to be given to members of the staff dealing with patients, in particular to nurses who are a potential source and means of spread of cross-infection ; and arrangements for regular statements of infections occurring in the wards. The report was accompanied by a series of memoranda on nursing procedures. These memoranda were to be issued either with or without adaptation by hospital authorities, in a suitable folder, to individual members of the trained nursing staff. The matron was to be responsible for seeing that they were kept up to date. The memoranda dealt with the method of bed isolation nursing ; the prevention of infection in surgical cases ; masks and disinfection. Later the Committee forwarded to us two more memoranda on the disinfection of spring interior and latex foam mattresses and the use of articles and clothing by patients in common. Further memoranda are being prepared on the techniques which might be recommended in the sterilization of syringes and in children's wards. We felt that there is still room for much more research on cross-infection in hospitals and we advised the Minister to invite the Medical Research Council to bring this view to the notice of its Committee on this subject.

160. *Protection of Nurses from Tuberculosis.* A Joint Sub-Committee was set up by the Standing Tuberculosis and Nursing Advisory Committees to consider the precautions which should be taken in sanatoria and other hospitals to safeguard the nursing staff against tuberculous infection. Through the courtesy of the King Edward's Fund for London, the Joint Sub-Committee was able to make comments on the revised "Memorandum on the Supervision of Nurses' Health" which was being prepared for issue by the Fund. The Joint Sub-Committee has asked the Nursing Techniques Sub-Committee to prepare in the series of memoranda on infection in hospitals a memorandum on the procedures to be adopted in the nursing of tuberculous patients.

---

\* These memoranda were based to a considerable extent on papers prepared by the Medical Research Council.

161. The recommendations made by Assistants, including those at present by teaching hospitals of student nurses, and to a percentage to be determined with in Part I. Attention is now being given to the chronic sick and the pæ, to whom this report was submitted by co-operation between teaching and Regbut made no comment on the The Committee has also considered the divies in mental hospitals. We cubicles in order to secure privacy for ward patients which might arise in imple-graph 58); the training of nurses in geriatrics; the red that recommendation sections of geriatric departments (previous report, par. provision of accommodation for the sister in charge of a *teaching Hospitals.*

**Standing Maternity and Midwifery Advisory Committee**

162. The Committee held two meetings during the year. as well as

163. *The Maternity Services.* The Committee continued its consideration of the place of the maternity unit in the hospital service. In connection with this the Committee examined the principles upon which arrangements for the care of babies born in maternity hospitals should be based, and decided that special consideration should be given to the question of the care of premature infants and sick and injured babies throughout the country. An investigation into prematurity has been undertaken by a joint committee set up by the Royal College of Obstetricians and Gynaecologists and the British Paediatrics Association and the results of this will have a close bearing on the Committee's consideration of the subject. The Committee has not reached the stage at which a report can be made to us.

164. *The Position of the Head Midwife of the Maternity Department of a General Hospital.* The Committee considered complaints that some head midwives in the maternity departments of general hospitals were unduly subject within their own proper sphere to detailed control by matrons. The Committee agreed with the Standing Nursing Advisory Committee to set up a Joint Sub-Committee and this Sub-Committee produced a report which was agreed by both the parent Committees and considered by us. We consequently advised the Minister that the Nursing Advisory Sub-Committees of Regional Hospital Boards should include a practising midwife and that Boards of Governors and Hospital Management Committees, which had not already done so, should establish Nursing and Midwifery Advisory Committees. As recommended by the two Standing Advisory Committees, we also invited our Committee on the Internal Administration of Hospitals to consider and report on the suggestion that the matron of a maternity hospital or the Superintendent midwife of a maternity department should be a member of the Nursing and Midwifery Advisory Committee for the hospital group; and asked it to invite the Central Midwives Board and the Matrons' Council of the Royal College of Midwives to submit evidence.

**Standing Mental Health Advisory Committee**

165. The Committee met six times during the year.

166. *Mental Nurses.* The Committee's major task during the year was to consider the nurse staffing of mental hospitals and mental deficiency institutions. A fact-finding inquiry revealed a serious and growing shortage of female nurses of every grade—though to a much less extent of male nurses. The numbers of female qualified nurses were falling sharply with no possibility of remedy within the next few years; all grades showed a predominance of losses over additions. It was evident that the core of the problem was

### Standing Ophthalmic

157. This Committee did not meet. A vicious circle had set in, since depleted hours and less satisfying work for those

### Standing Nursing

158. This Committee met on 14th June 1947. Immediate needs seemed to be investigation of what could be more economically organised and what a bold departure from tradition—a review

159. *Nursing Techniques*; and more careful selection of recruits with the Minister to consider methods unlikely to stay. The Committee has strictly approved nursing techniques at neither we nor any of our associated Committees hospitals and nurses, and conditions of service which remain the responsibility be recommended Councils (see previous report, paragraph 2). After careful committee forward the Committee advised the Minister that:—

An experiment should be made in the selection of new student entrants to mental hospitals and mental deficiency institutions, when the Final Report on an experiment being undertaken by the National Institute of Industrial Psychology has been received and considered.

(b) The training scheme of the Working Party\* is not suitable to mental hospitals and institutions, which should continue to be training schools, as now, for mental nurse training, but other (experimental) schemes of training are not excluded.

(c) Job analysis should be extended as quickly as possible to mental hospitals to enable the possibility of (d) to be considered.

(d) A shortened training course limited to the essentials of what the mental nurse ought to know for the efficient discharge of her duties would not only in itself be desirable but would do much to attract recruits for training.

(e) It would not be consistent at the present juncture to consider increasing the period of training of mental nurses so as to obviate further training before a nurse could be regarded as eligible for promotion to senior posts for which both mental and general training is now normally required; but experimental schemes of training, which are now made possible by the Nurses Act, 1949, should be encouraged with this possibility in view.

(f) (i) Enrolled Assistant (Mental) Nurses as such should not be employed in mental hospitals and institutions.

(ii) A date should be envisaged after which no more nursing assistants should be engaged as such.

(iii) After that date all entrants should be required to undergo training for registration.

(iv) Those who are found to be unsuitable for training or who cannot pass the Preliminary examination should be offered a non-nursing appointment.

(v) In future, appointment as a whole-time nursing assistant would be limited to those who had passed the Preliminary examination, had completed the full course of training and had sat for, but not passed, the Final examination.

(vi) Existing Nursing Assistants who are considered by age and educational standard capable of passing the qualifying examinations should be required to undertake training without variation of their grading and pay.

\* Working Party on the Recruitment and Training of Nurses. (Report published in 1947 H.M. Stationery Office, price 2s. 6d. net.)

(vii) The number of Nursing Assistants, including those at present employed, should be strictly limited to a percentage to be determined of the total nurses employed.

The Standing Nursing Advisory Committee, to whom this report was submitted, approved recommendations (a)-(e) but made no comment on the proposal not to employ enrolled assistant nurses in mental hospitals. We drew the Minister's attention to the difficulties which might arise in implementing this proposal at the present time and considered that recommendation (f) (ii) should be read together with (f) (i).

167. *Psychiatric in-patient units in connection with Teaching Hospitals.* The Committee considered a proposal that Boards of Governors should be urged to provide units for the in-patient treatment of psychiatric patients of both sexes, because of their value for teaching and research as well as treatment. The principle of this proposal had already been accepted by the Minister who had advised Boards of Governors to that effect. The main consideration centred round the question whether the units should come within the scope of the Mental Treatment Act. On the one hand it was pointed out that unless voluntary and temporary patients were included the units would not provide a sufficient range of psychiatric cases for teaching purposes, and on the other it was represented that the units would function more successfully if free from any association with mental hospital legislation. After carefully reviewing all the considerations the Committee advised the Minister that:—

(a) Boards of Governors should be requested to give high priority to the provision of psychiatric in-patient units in or near to teaching hospitals, perhaps by arrangement with the appropriate Regional Hospital Board in suitable cases;

(b) it should be left to Boards of Governors to decide whether or not provision should be included for voluntary and temporary patients under the Mental Treatment Act

(c) the desirable size of a unit is about sixty beds but a beginning could be made with not less than twenty; and

(d) facilities for occupational therapy should be provided but the opening of a unit should not be delayed pending the availability of full facilities.

168. *Employment of non-medical psychotherapists in the National Health Service.* The Committee devoted a considerable amount of its time to this question and memoranda were received from a number of interested organisations which revealed sharply divergent views. After lengthy consideration (in conjunction with a member of the Scottish Medical Advisory Committee) of the many and complex issues arising, some of which were beyond the Committee's terms of reference, it was decided to offer no advice to the Minister at present and to review the matter in two years' time.

169. *Links with mental health work in the fighting Services.* The Committee considered whether the National Health Service should offer specialist assistance to the Ministry of Labour in its task of the medical examination of those called up for national service. It had in mind the undesirability of drafting into the fighting services men and women who, on psychiatric grounds, were unsuitable for training or service and whose mental condition therefore was likely to suffer permanent harm in consequence; and that, as substantial numbers of the total discharges from the Forces were on psychiatric grounds, and responsibility for their medical and psychiatric

treatment after discharge rested on the National Health Service, there was need for close co-operation between the Services and the National Health Service. The Committee advised the Minister to approach the Minister of Labour on the subject.

170. *Other subjects.* The Committee has also had on its agenda—

- (a) the after care services of local health authorities ;
- (b) research in mental health ;
- (c) the development of Consultant services ;
- (d) foster-home care of mental patients ;
- (e) preventive psychiatry ;
- (f) day-hospital schemes ; and
- (g) registrar grades in psychiatric hospitals.

#### **Standing Tuberculosis Advisory Committee**

171. The Committee held three meetings during the year. Its main task has been the completion of its review of the present organisation of the tuberculosis services under the National Health Service Act and the presentation of its report which is dealt with in Part I.

172. *Notification of Tuberculosis.* The Committee was asked by the Minister for its views on the terms of new regulations under the Public Health Act, 1936, which he intends to make to replace the existing Tuberculosis Regulations of 1930. These Regulations are now out-dated both in form and substance and are out of accord with the present structure and operation of the tuberculosis services. At the close of the year the Minister, at the Committee's suggestion, was obtaining the views of outside representative organisations on the terms of a definition of tuberculosis satisfactory for the specific purpose of notification.

#### **Standing Cancer and Radiotherapy Advisory Committee**

173. This Committee met once in 1950.

174. *Cancer Publicity.* The main business of the meeting was to consider the reference back by us of the Committee's previous recommendation that it was undesirable at the present time for any cancer publicity to be carried out directly to the general public (see previous report, paragraph 76). We had suggested that this recommendation implied that local health authorities should omit any reference to cancer in their general health propaganda, and the Committee agreed that this had not been intended. It decided to revise its recommendation to read:—

“It is undesirable at the present time for any cancer publicity to be carried out by the Minister directly to the general public”.

We subsequently expressed the view that no publicity should be carried out by any central government organisation directly to the general public.

175. *Technical Sub-Committee.* The Committee's Technical Sub-Committee held one meeting during the year, at which the main business was to consider the principles upon which radium should be distributed among hospitals. Recommendations on this will go forward to the main Committee early in the New Year. Other matters considered by the Sub-Committee were the use of radioactive cobalt in lieu of radium ; arrangements for the calibration of X-ray dosimeters ; and beta-ray apparatus. The Sub-Committee also decided to review the current list of standard radium containers and the list of hospitals authorised to hold radon.

## APPENDIX I

MEMBERS OF STANDING ADVISORY COMMITTEES AND COMMITTEES OF THE COUNCIL  
AS AT 31ST DECEMBER, 1950

### STANDING MEDICAL ADVISORY COMMITTEE

(a) *Members appointed by the Minister after consultation with the Council*

	<i>Period of Office Until</i>
Miss JANET AITKEN ... ..	31.3.53
W. RUSSELL BRAIN, Esq.* ... ..	Whilst President of the Royal College of Physicians
Professor ROBERT CRUICKSHANK† ... ..	31.3.53
Sir STEWART DUKE-ELDER‡ ... ..	31.3.53
J. A. BROWN, Esq. ( <i>Vice-Chairman</i> ) ... ..	31.3.52
Professor DAVID CAMPBELL ... ..	Whilst President of the General Medical Council
Sir ERNEST ROCK CARLING ... ..	31.3.52
Professor Sir HENRY COHEN ( <i>Chairman</i> ) ... ..	31.3.52
Sir ALLEN DALEY ... ..	Whilst Chairman of the Council of the Society of Medical Officers of Health.
H. G. DAIN, Esq. ... ..	31.3.51
E. A. GREGG, Esq. ... ..	Whilst Chairman of the Council of the British Medical Association.
W. V. HOWELLS, Esq. ... ..	31.3.53
H. JOULES, Esq. ... ..	31.3.51
Professor A. J. LEWIS ... ..	31.3.52
Professor HILDA N. LLOYD ... ..	Whilst President of the Royal College of Obstetricians and Gynaecologists
W. G. MASEFIELD, Esq. ... ..	31.3.51
W. N. PICKLES, Esq. ... ..	31.3.51
Professor Sir HARRY PLATT ... ..	31.3.51
Professor Sir JAMES SPENCE ... ..	31.3.52
C. W. WALKER, Esq. ... ..	31.3.53
Sir CECIL WAKELEY ... ..	Whilst President of the Royal College of Surgeons

(b) *Members appointed by the Minister after consultation with representative organisations*

SOMERVILLE HASTINGS, Esq., M.S., F.R.C.S., M.P. ... ..	31.3.51
ROBERT LEECH NEWELL, Esq., M.D., F.R.C.S. ... ..	31.3.52
WYNDHAM PARKER, Esq., C.B.E., M.C., M.B., Ch.B., D.P.H. ... ..	31.3.51
JAMES RALSTON KENNEDY PATERSON, Esq., C.B.E., M.C., M.D., F.R.C.S., F.F.R., D.M.R.E. ... ..	31.3.53
WILLIAM GILCHRIST PATTERSON, Esq., M.D., M.R.C.P., D.P.H. ... ..	31.3.52

At 31.12.50 there was one vacancy on the Committee.

\* Dr. Brain succeeded Lorn Moran as President of the Royal College of Physicians in April, 1950.

† Professor Cruickshank succeeded Professor Barnard as a member of the Committee in April, 1950.

‡ Sir Stewart Duke-Elder succeeded Mr. Aleck Bourne as a member of the Committee in April, 1950.

## STANDING DENTAL ADVISORY COMMITTEE

(a) *Members appointed by the Minister after consultation with the Council*

	<i>Period of Office Until</i>
F. J. BALLARD, Esq. ... ..	31.3.52
Professor R. V. BRADLAW ( <i>Chairman</i> ) ... ..	31.3.53
J. LAUER, Esq. ( <i>Vice-Chairman</i> ) ... ..	31.3.53

(b) *Members appointed by the Minister after consultation with representative organisations*

COLIN VICTOR ARMITAGE, Esq., F.D.S.R.C.S., L.D.S.R.C.S.E.	31.3.51
MILLICE ALBERT FREEMAN, Esq., M.C., L.D.S.R.C.S. ...	31.3.51
SIR WILLIAM KELSEY FRY, C.B.E., M.C., M.D.S., F.D.S., M.R.C.S., L.R.C.P. ... ..	31.3.53
THOMAS HINDLE, Esq. ... ..	31.3.52
Professor HUMPHREY FRANCIS HUMPHREYS, O.B.E., M.C., T.D., D.L., M.D.S., M.B., Ch.B., F.D.S.R.C.S., F.S.A. ...	31.3.51
Professor WILLIAM CHARLES WALLACE NIXON, M.D., F.R.C.S., F.R.C.O.G. ... ..	31.3.51
JOHN FREDERICK PILBEAM, Esq., F.D.S.R.C.S. ... ..	31.3.51
JOHN ALFRED TOLLER ROWLETT, Esq., L.D.S.R.C.S. ...	31.3.53
Professor MARTIN AMSLER RUSHTON, M.D., F.D.S.R.C.S. ...	31.3.52
TERENCE GEORGE WARD, Esq., M.B.E., F.D.S.R.C.S., L.R.C.S., L.R.C.P., L.R.F.P. and S.G. ... ..	31.3.51
Professor ARTHUR GORONWY WATKINS, B.Sc., M.D., F.R.C.P.	31.3.52
Professor FRANK CLARE WILKINSON, M.D., D.D.Sc., M.Sc., B.D.S., F.D.S.R.C.S. ... ..	31.3.52

## STANDING PHARMACEUTICAL ADVISORY COMMITTEE

(a) *Members appointed by the Minister after consultation with the Council*

	<i>Period of Office Until</i>
Alderman W. J. TRISTRAM ( <i>Chairman</i> ) ... ..	31.3.52

(b) *Members appointed after consultation with representative organisations*

Professor HARRY BERRY, B.Sc., Ph.C., F.R.I.C., Dip. Bact. (London) ... ..	31.3.53
JAMES OGSTON DAVIDSON, Esq., M.P.S. ... ..	31.3.51
PAUL DOBSON, Esq., Ph.C., D.B.A., F.S.M.C. ... ..	31.3.51
PATRICK JOSEPH GIBBONS, Esq., M.B., B.Ch., B.A.O., N.U.I.	31.3.52
JOHN GILMOUR, Esq., M.P.S. ... ..	31.3.51
CHARLES HERBERT HAMPSHIRE, Esq., C.M.G., M.B., B.S., M.R.C.S., L.R.C.P., B.Sc., F.R.I.C.E., Ph.C. ... ..	31.3.53
JOHN CAPEL HANBURY, Esq., M.A., B.Pharm., Ph.C., F.R.I.C.	31.3.51
JOHN BARCLAY HOUGH, Esq., M.P.S. ... ..	31.3.52
HUGH NICHOLAS LINSTED, Esq., O.B.E., Ph.C., M.P. ...	31.3.53
GEORGE ARTHUR MALLINSON, Esq., O.B.E., M.P.S., F.S.M.C.	31.3.52
DONALD EDWARD SPARSHOTT, Esq., M.A., M.P.S. ... ..	31.3.52
Professor EDWARD JOHNSON WAYNE, M.D., Ph.D., F.R.C.P.	31.3.53

R. H. HENRIKSEN, Esq., served on the Committee as Vice-Chairman till October, 1950, when he resigned from the Council and the Committee. At 31.12.50, there was a vacancy on this Committee.



## STANDING OPHTHALMIC ADVISORY

*Period of Office Until*

(a) <i>Members appointed by the Minister after consultation with the Council</i>	
Miss JANET AITKEN ( <i>Chairman</i> ) ... ..	31.3.53
Sir STEWART DUKE-ELDER ... ..	31.3.53
(b) <i>Members appointed by the Minister after consultation with representative organisations</i>	
GEORGE WILLIAM BLACK, Esq., M.B., B.S., F.R.C.S. ...	31.3.53
MACDONALD CRITCHLEY, Esq., M.D., F.R.C.P. ... ..	31.3.52
OGILVIE MAXWELL DUTHIE, Esq., M.D., F.R.C.S. ... ..	31.3.51
GEORGE HENRY GILES, Esq., F.B.O.A. (Hons.), F.S.M.C., D.Orth., F.I.E.S. ... ..	31.3.52
REGINALD AFFLECK GREEVES, Esq., B.A., M.B., B.S., F.R.C.S.	31.3.51
JOSEPH RICHARD HOWARD, Esq., F.A.D.O. (Hons.), M.Inst.B.E. ... ..	31.3.53
DAVID HERBERT LEWIS, Esq., F.B.O.A., F.S.M.C., D.Orth. ...	31.3.53
OSWALD GAYER MORGAN, Esq., M.A., M.Ch., F.R.C.S. ...	31.3.52
ALBERT EDWARD TURVILLE, Esq., F.B.O.A., F.S.A.O., D.Orth.	31.3.52
STANLEY MAURICE WELLS, Esq., F.S.M.C., D.Orth. ...	31.3.51
OSCAR WILLIAMS, Esq., M.B., B.S., M.R.C.S., L.R.C.P. ...	31.3.53
FRANK MAX WISEMAN, Esq. ... ..	31.3.51

## STANDING NURSING ADVISORY COMMITTEE

(a) <i>Members appointed by the Minister after consultation with the Council</i>	
	<i>Period of Office Until</i>
Miss C. H. ALEXANDER ( <i>Chairman</i> ) ... ..	31.3.53
F. J. CABLE, Esq. ... ..	31.3.52
Sir WYNNE CEMLYN-JONES ... ..	31.3.51
Miss N. B. DEANE ... ..	31.3.51
The Hon. ARTHUR HOWARD ... ..	31.3.53
H. JOULES, Esq.* ... ..	31.3.51
Miss E. J. MERRY ... ..	31.3.52
F. S. STANCLIFFE, Esq.† ... ..	31.3.53
(b) <i>Members appointed by the Minister after consultation with representative organisations</i>	
Miss CLARA FLORA STATIA BELL, S.R.N. ... ..	31.3.51
COLIN FRASER BROCKINGTON, Esq., M.A., M.D., B.Ch., D.P.H. ( <i>Vice-Chairman</i> ) ... ..	31.3.53
ERNEST DAWSON, Esq., S.R.N., R.M.N., R.M.P.A. ... ..	31.3.53
Miss MURIEL MARY EDWARDS, M.V.O., S.R.N., S.C.M. ...	31.3.52
Miss LILLIAN ISABEL GALE, S.R.N., R.S.C.N. ... ..	31.3.53
Miss FRANCES GOWLAND GOODALL, O.B.E., S.R.N. ...	31.3.52
Miss EVA MARY HILLIER, S.R.N., S.C.M. ... ..	31.3.51
Mrs. GLADYS CECILIA JONES ... ..	31.3.51
Miss CONSTANCE MARY PANK, S.R.N. ... ..	31.3.51
Provost RALPH MONTGOMERY FULLERTON PICKEN, C.B.E., B.Sc., M.B., Ch.B., D.P.H.‡ ... ..	31.3.53
Miss KATHERINE MARY ROE, M.B.E., S.R.N., S.C.M., H.V.S.D. ... ..	31.3.52
Miss AMY ELLEN AYLWARD SQUIBBS, S.R.N. ... ..	31.3.52
Miss MARGARET JANE SMYTH, S.R.N., S.C.M., M.T.D. ...	31.3.52
Miss JANE ETHELWYN THOMAS, S.R.N., S.C.M., T.A. ...	31.3.51
Miss BEATRIX JULIA WALL, S.R.N., R.M.N. ... ..	31.3.53

\* Dr. Joules succeeded Mr. Clayton Fryers as a member of this Committee in March, 1950.

† Mr. Stancliffe succeeded Alderman Bradbeer as a member of this Committee in March, 1950.

‡ Appointed to a vacancy in April, 1950.

## STANDING MATERNITY AND MIDWIFERY ADVISORY COMMITTEE

(a) *Members appointed by the Minister after consultation with the Council*

	<i>Period of Office Until</i>
Miss JANET AITKEN ... ..	31.3.53
A. W. BOURNE, Esq. ... ..	31.3.53
Miss N. B. DEANE ... ..	31.3.51
W. V. HOWELLS, Esq. ... ..	31.3.53
Professor HILDA N. LLOYD ( <i>Chairman</i> ) ... ..	Whilst President of the Royal College of Obstetricians and Gynaecologists
Miss E. J. MERRY ... ..	31.3.52
Professor Sir JAMES SPENCE ... ..	31.3.52
Mrs. D. THURTLÉ ... ..	31.3.53
C. W. WALKER, Esq. ... ..	31.3.53
Alderman W. E. YORKE ... ..	31.3.51

(b) *Members appointed by the Minister after consultation with representative organisations*

Miss MILLICENT N. FENSOM, S.R.N., S.C.M., M.T.D. ...	31.3.52
Miss ELIZABETH FRANCES GORE, S.R.N., S.C.M. ... ..	31.3.53
Miss DOROTHY MURIEL HAYWARD, S.R.N., S.C.M. ... ..	31.3.52
Miss JEAN McIVER MACKINTOSH, M.D., D.P.H., D.P.A. ...	31.3.53
Mrs. FLORENCE REBECCA MITCHELL, O.B.E., S.C.M. ...	31.3.53
Miss MAY O'CONNOR ... ..	31.3.53
Councillor WILLIAM ONIONS, J.P. ... ..	31.3.53
ERIC WEST SCORER, Esq., O.B.E. ... ..	31.3.51
Miss ADA ELLEN STEWARD, S.R.N., S.C.M., M.T.D. ...	31.3.52
ARNOLD WALKER, Esq., F.R.C.S., F.R.C.O.G. ( <i>Vice-Chairman</i> ) ... ..	31.3.51
Miss MARY WILLIAMS, S.R.N., S.C.M., M.T.D. ... ..	31.3.51

## STANDING TUBERCULOSIS ADVISORY COMMITTEE

(a) *Members appointed by the Minister after consultation with the Council*

	<i>Period of Office Until</i>
Sir WYNNE CEMLYN-JONES ... ..	31.3.51
Professor Sir HARRY PLATT ( <i>Chairman</i> ) ... ..	31.3.51

(b) *Members appointed by the Minister after consultation with representative organisations*

Majot LINDSAY EDWARD BURY, C.B.E., J.P. ... ..	31.3.51
Sir BRUNEL COHEN, K.B.E. ... ..	31.3.52
Miss MARGARET STEWART COLTART ... ..	31.3.51
PETER WILLIAMS EDWARDS, Esq., M.B.E., M.B. ... ..	31.3.53
FREDERICK HALL, Esq., C.B.E., M.D., D.P.H. ... ..	31.3.51
PHILIP MONTAGU D'ARCY HART, Esq., M.A., M.D., F.R.C.P.	31.3.52
Professor FREDERICK ROLAND GEORGE HEAF, M.A., M.D., F.R.C.P. ... ..	31.3.53
PETER KERLEY, Esq., C.B.E., M.D., F.R.C.P., F.F.R. ...	31.3.52
Miss DORIS LAMBERT, S.R.N., S.C.M. ... ..	31.3.52
WILFRED SHELDON, Esq., M.D., F.R.C.P. ... ..	31.3.51
Miss AMY ROSETTA SPALL, S.R.N., S.C.M. ... ..	31.3.53
CLEMENT PRICE THOMAS, Esq., F.R.C.S. ... ..	31.3.53
Sir ROBERT ARTHUR YOUNG, C.B.E., M.D., F.R.C.P. ( <i>Vice-Chairman</i> ) ... ..	31.3.51

## STANDING MENTAL HEALTH ADVISORY COMMITTEE

### (a) *Members appointed by the Minister after consultation with the Council*

	<i>Period of Office Until</i>
C. F. COMER, Esq. ... ..	31.3.52
Sir ALLEN DALEY ( <i>Chairman</i> ) ... ..	Whilst Chairman of the Council of the Society of Medical Officers of Health
Professor A. J. LEWIS ... ..	31.3.52
W. G. MASEFIELD, Esq. ( <i>Vice-Chairman</i> ) ... ..	31.3.51
Sir CECIL OAKES ... ..	31.3.51

### (b) *Members appointed by the Minister after consultation with representative organisations*

CLAUDE BARTLETT, Esq. ... ..	31.3.51
EDWARD JOHN MOSTYN BOWLBY, Esq., M.A., M.D. ... ..	31.3.51
NOEL HAWLEY MICHAEL BURKE, Esq., J.P., M.R.C.S., L.R.C.P., D.P.M., D.M.R.E. ... ..	31.3.52
DESMOND CURRAN, Esq., F.R.C.P. ... ..	31.3.53
WILLIAM SUTHERLAND MACDONALD, Esq., M.C., M.B., Ch.B., D.P.H. ... ..	31.3.53
Mrs. KATE FLORENCE MCDOUGALL ... ..	31.3.51
Alderman MERVYN PAYNE ... ..	31.3.51
JOHN RAWLINGS REES, Esq., C.B.E., M.D., F.R.C.P., D.P.H. JOHN IVISON RUSSELL, Esq., M.D., F.R.F.P.S.G., D.P.M., M.P.C. ... ..	31.3.53
Professor PHILIP EWART VERNON, M.A., Ph.D. ... ..	31.3.52
Miss BEATRIX JULIA WALL, S.R.N., R.M.N. ... ..	31.3.53
DENIS JOHN WILLIAMS, Esq., D.Sc., M.D., F.R.C.P. ... ..	31.3.52

## STANDING CANCER AND RADIOTHERAPY ADVISORY COMMITTEE

### (a) *Members appointed by the Minister after consultation with the Council*

	<i>Period of Office Until</i>
Sir ERNEST ROCK CARLING ( <i>Chairman</i> ) ... ..	31.3.52
Professor Sir HENRY COHEN ... ..	31.3.52
W. V. HOWELLS, Esq. ... ..	31.3.53
H. JOULES, Esq. ... ..	31.3.51

### (b) *Members appointed by the Minister after consultation with representative organisations*

Sir HAROLD ESMOND ARNISON BOLDERO, M.A., D.M., F.R.C.P. ... ..	31.3.51
Professor EDWARD CHARLES DODDS, M.V.O., M.B., M.R.C.S., F.R.C.P. ... ..	31.3.52
Professor ERNEST FINCH, M.D., M.S., F.R.C.S. ( <i>Vice- Chairman</i> ) ... ..	31.3.52
KENNETH IVOR JULIAN, Esq., C.B.E. ... ..	31.3.52
Professor HILDA NORA LLOYD, B.Sc., M.B., Ch.B., F.R.C.S., F.R.C.O.G. ... ..	31.3.53
Professor WILLIAM VALENTINE MAYNEORD, D.Sc., S.Inst.P. ... ..	31.3.53
Professor JOSEPH STANLEY MITCHELL, M.A., M.B., Ph.D., B.Ch. ... ..	31.3.52
VICTOR EWINGS NEGUS, Esq., D.Sc., M.S., F.R.C.S. ... ..	31.3.52
JAMES RALSTON KENNEDY PATERSON, Esq., C.B.E., M.C., M.D., F.R.C.S., F.F.R., D.M.R.E. ... ..	31.3.53
JOHN ARTHUR STALLWORTHY, Esq., M.A., M.B., Ch.B., F.R.C.S., M.R.C.O.G. ... ..	31.3.51
MATTHEW JOHN STEWART, Esq., M.B., Ch.B., F.R.C.P., F.R.F.P.S. ... ..	31.3.53
CHRISTOPHER JOHN LESTER THURGAR, Esq., M.B., B.S., F.R.C.S., L.R.C.P. ... ..	31.3.51
Professor ROBERT MILNES WALKER, M.B., M.S., F.R.C.S., L.R.C.P. ... ..	31.3.51
Professor BRIAN WELLINGHAM WINDEYER, F.R.C.S., F.F.R.	31.3.51

Professor ROBERT McWHIRTER, F.R.C.S.E., attends this Committee as an observer on behalf of the Scottish Health Services Council.

Mr. CLAYTON FRYERS and Professor BARNARD served on this Committee till 31.3.50. At 31.12.50 there were two vacancies on this Committee.

## HEALTH CENTRES COMMITTEE

### *Members of the Council*

F. J. BALLARD, Esq.  
Sir ERNEST ROCK CARLING.  
Sir ALLEN DALEY.  
R. H. HENRIKSEN, Esq.  
F. MESSER, Esq. (*Chairman*).  
Mrs. D. THURTLÉ.

### *Co-opted Members*

G. O. BARBER, Esq., M.A., M.B., B.Ch.  
A. BEAUCHAMP, Esq., M.B., Ch.B.  
D. CAMERON, Esq., M.R.C.S., L.R.C.P.  
L. FINDLAY, Esq., G.M., M.D., D.P.H.  
Capt. S. H. HAMPSON, M.B.E., M.C., J.P., M.A., LL.B.  
Miss M. E. HOLLINGWORTH, S.R.N., S.C.M., M.T.D.  
R. D. LAWRENCE, Esq., M.A., M.D., F.R.C.P.  
Professor J. M. MACKINTOSH, M.A., M.D., F.R.C.P., D.P.H.\*  
Professor R. H. PARRY, M.D., B.S., F.R.C.P., D.P.H., K.H.P.  
A. TALBOT ROGERS, Esq., M.B., B.S. (*Vice-Chairman*).  
Miss B. SHENTON, M.B.E., S.R.N., S.C.M., H.V.Cert.  
Professor F. E. TYLECOTE, J.P., M.D., F.R.C.P., D.P.H.

## HOSPITAL EXTERNAL ADMINISTRATION COMMITTEE

### *Members of the Council*

Alderman A. F. BRADBEER.  
F. J. CABLE, Esq.  
Sir ALLEN DALEY.  
S. C. FRYERS, Esq.,  
The Hon. ARTHUR HOWARD.  
F. MESSER, Esq. (*Chairman*).  
Sir OWEN MORSHEAD.  
Major-General Sir HAROLD WERNHER (*Vice-Chairman*).

### *Co-opted Members*

E. C. F. BIRD, Esq.  
R. A. MICKELWRIGHT, Esq., F.H.A.  
W. G. PATTERSON, Esq., M.D., M.R.C.P., D.P.H.

## HOSPITAL INTERNAL ADMINISTRATION COMMITTEE

### *Members of the Council*

Miss C. H. ALEXANDER.  
Alderman BRADBEER (*Chairman*).  
F. J. CABLE, Esq.  
Sir ERNEST ROCK CARLING.  
Dr. H. G. DAIN.  
Dr. MASEFIELD.  
Sir OWEN MORSHEAD.  
F. S. STANCLIFFE, Esq. (*Vice-Chairman*).

### *Co-opted Members*

E. C. F. BIRD, Esq.  
P. H. CONSTABLE, Esq., M.A., F.H.A.  
Dr. A. A. CUNNINGHAM, M.D., D.P.H.  
Miss L. A. D. EVANS, S.R.N.  
L. T. FELDON, Esq., F.H.A., A.C.I.S.  
J. H. KITCHEN, Esq.  
H. LESSER, Esq., C.B.E., LL.B.  
Dr. J. R. MURRAY, M.D., D.P.M.  
H. TRUSSON, Esq., F.C.I.S., F.H.A.  
Dr. J. WATT, M.A., M.D., D.P.H.

---

\* Resigned February, 1950.

JOINT COMMITTEE ON PRESCRIBING ON FORM E.C.10

*Members of the Council*

Miss JANET AITKEN.  
J. A. BROWN, Esq.  
Professor Sir HENRY COHEN (*Chairman*).  
Alderman W. J. TRISTRAM.

*Members co-opted by the Council*

Professor E. C. DODDS, M.V.O., M.D., F.R.C.S., F.R.S.  
Professor D. M. DUNLOP, M.D., F.R.C.P. (*Vice-Chairman*).  
F. GRAY, Esq., M.B., Ch.B.  
J. C. HANBURY, Esq., M.A., B.Pharm., Ph.C., F.R.I.C.  
P. HAMILL, Esq., M.D., D.Sc., F.R.C.P.  
Professor CHASSAR MOIR, M.D., F.R.C.S., F.R.C.O.G \*  
Sir HENRY SOUTTAR, C.B.E., F.R.C.S.  
D. E. SPARSHOTT, Esq., M.A., M.P.S.  
JOHN THWAITES, Esq., M.B., B.S.

*Members of the Scottish Health Services Council*

G. MACFEAT, Esq., O.B.E., M.B., Ch.B.  
W. D. D. SMALL, C.B.E., M.D., F.R.C.P.E.

*Members co-opted by the Scottish Council*

Professor S. ALSTEAD, M.D., F.R.C.P.  
A. SMITH POOL, Esq., L.R.C.P., L.R.C.S.  
J. H. RAMSAY, Esq., Ph.C.

COMMITTEE ON CO-OPERATION BETWEEN HOSPITAL,  
GENERAL PRACTITIONER AND LOCAL AUTHORITY SERVICES

*Members of the Council*

Sir ERNEST ROCK CARLING.  
Professor Sir HENRY COHEN (*Vice-Chairman*).  
Sir ALLEN DALEY.  
The Hon. ARTHUR HOWARD.  
Dr. W. V. HOWELLS.  
Professor HILDA LLOYD.  
F. MESSER, Esq. (*Chairman*).  
Sir CECIL OAKES.  
Alderman W. E. YORKE.

*Co-opted Members*

F. HALL, Esq., C.B.E., M.D., D.P.H.  
Capt. S. H. HAMPSON, M.B.E., M.C., J.P., M.A., LL.B.  
K. I. JULIAN, Esq., C.B.E.  
R. A. MICKELWRIGHT, Esq., F.H.A.  
Councillor WILLIAM ONIONS, J.P.  
Professor R. H. PARRY, M.D., B.S.(London), F.R.C.P., D.P.H.  
W. G. PATTERSON, Esq., M.D., M.R.C.P., D.P.H.  
E. W. SCORER, Esq., O.B.E.  
A. TALBOT ROGERS, Esq., M.B., B.S.(London).

---

\* Temporarily replaced January to July, 1950, by Professor W. C. W. Nixon, M.D., F.R.C.S., F.R.C.O.G.

COMMITTEE ON GENERAL PRACTICE UNDER THE NATIONAL HEALTH  
SERVICE

*Members of the Council*

W. RUSSELL BRAIN, Esq.  
J. A. BROWN, Esq.  
Professor Sir HENRY COHEN (*Chairman*).  
H. G. DAIN, Esq.  
Sir ALLEN DALEY.  
E. A. GREGG, Esq.  
W. V. HOWELLS, Esq.  
Professor HILDA N. LLOYD.  
W. N. PICKLES, Esq.  
Sir CECIL WAKELEY.  
C. W. WALKER, Esq.

*Co-opted Members*

G. O. BARBER, Esq., M.B., Ch.B., M.R.C.S., L.R.C.P. (*Vice-Chairman*).  
S. C. BARNES, Esq., M.B., Ch.B.  
N. F. BAYLIS, Esq., F.C.I.I., F.C.I.S.  
B. CARDEW, Esq., L.M.S.S.A.  
Miss ENID HUGHES, M.D., B.S., L.R.C.P., D.P.H., R.C.P.S.  
Alderman Mrs. V. F. KING.  
A. TALBOT ROGERS, Esq., M.B., B.S.  
E. W. SCORER, Esq., O.B.E.  
STEPHEN TAYLOR, Esq., M.R.C.S., L.R.C.P.  
J. S. THOMAS, Esq., M.R.C.S., L.R.C.P.  
H. P. TRAVIS, Esq., A.H.A.

## APPENDIX II

### SCHEDULE OF ADVICE TO THE MINISTER GIVEN BY THE COUNCIL AND STANDING ADVISORY COMMITTEES FOR THE YEAR ENDING 31ST DECEMBER, 1950

<i>Date</i>	<i>Advice given by</i>	<i>Advice</i>
19. 1.50	Dental S.A.C. ... ..	Oral Hygienists: A statement should be issued to the professional press about the experiment in the training of oral hygienists. See para. 151.
8. 2.50	Tuberculosis S.A.C. ... ..	Organisation of the Tuberculosis services: see paras. 1-8.
21. 2.50	Mental Health S.A.C. ... ..	Links with mental health work in the fighting services: see para. 169.
3. 3.50	Pharmaceutical S.A.C. ... ..	} Definition of Drugs: see para. 18.
14. 3.50	Medical S.A.C. ... ..	
10. 5.50	Council ... ..	Prescribing: see para. 19.
13. 6.50	Council on report of its Hospital Administration Committee.	Hospital Administration: see para. 15
13. 6.50	Council on report of its Health Centres Committee.	Health Centres in New Towns and on New Housing Estates: see para. 25.
13. 6.50	Council on report of its Cancer and Radiotherapy S.A.C.	Cancer Publicity: see para. 174.
15. 6.50	Dental S.A.C. ... ..	Conditions with respect to materials. The use of translucent silicate cements in fillings in anterior teeth and in cavities in first and second pre-molars not involving the occlusal surface should be allowed under the National Health Service.
15. 6.50	Dental S.A.C. ... ..	Drugs prescribable by Dentists: Mistura Magnesium Sulphatis Alba N.F. should be prescribable by dentists under the National Health Service.
22. 9.50	Mental Health S.A.C. ... ..	Supply of nurses in Mental Hospitals and Mental Deficiency Institutions: see para. 166.
22. 9.50	Mental Health S.A.C. ... ..	Psychiatric in-patient units in connection with Teaching Hospitals: see para. 167.
18.10.50	Council ... ..	Secondment of Nurses by Teaching Hospitals to T.B. Sanatoria: see paras. 9-11.
18.10.50	Council on report of Nursing and Maternity and Midwifery S.A.C.'s.	Status of head midwife of the maternity department of a general hospital. See para. 164.
16.11.50	Dental S.A.C. ... ..	Drugs prescribable by Dentists: Mouth washes containing morphine salts should not be prescribable by dentists under the National Health Service.
16.11.50	Dental S.A.C. ... ..	Oral hygienists: see para. 151.
27.11.50	Pharmaceutical S.A.C. ... ..	Shortage of qualified pharmacists: see para. 155.
12.12.50	Medical S.A.C. ... ..	Use of heroin: see para. 147.
12.12.50	Council on report of Nursing S.A.C.	Nursing Techniques: see para. 159.
12.12.50	Council on final report of its Health Centres Committee.	Health Centres: to be developed along the lines indicated in the Committee's final report: see Part II.

PRINTED AND PUBLISHED BY HIS MAJESTY'S STATIONERY OFFICE

To be purchased from

York House, Kingsway, LONDON, W.C.2      429 Oxford Street, LONDON, W.1

P.O. BOX 569, LONDON, S.E.1

13a Castle Street, EDINBURGH, 2      1 St. Andrew's Crescent, CARDIFF

39 King Street, MANCHESTER, 2      Tower Lane, BRISTOL, 1

2 Edmund Street, BIRMINGHAM, 3      80 Chichester Street, BELFAST

or from any Bookseller

1951

Price 1s. 6d. net

PRINTED IN GREAT BRITAIN