A tropical station that is unhealthy on account of malaria during some months of the year is usually looked upon as a necessary evil. The evil is mitigated in part by the removal of a portion of the garrison to a hill station, and by the provision of anti-malarial measures. This seems to be the narrow view, and it is time that we began to think big about the malarial problem. One is apt to forget that many stations which contribute largely to the admission rate for malaria were chosen in the old days when it was necessary to keep troops within striking distance of a possible storm centre, such as a turbulent Native State, the distance being two days' march or less. And we accept the fact that the station is there, and has always been there, and that a European garrison is essential.

We should remember, however, that mobility and communications have been revolutionized in the last few years by the advent of aircraft, tanks, motor lorries and armoured cars. Also, the dimension of mobility is no longer distance—it is time. Thirty miles was once two days' march, but by using post-war methods of transportation, troops can be concentrated at a greatly increased distance in much less time. Moreover, they arrive fresh, and not fatigued by a long march in hot weather.

In most countries where malarious stations still exist healthy hill stations exist also, within two days' distance of storm centres. Thus the elimination of malaria from the European soldier in peace is not entirely a question for the doctor, as the administrator could do so much by rearranging many peace stations in the light of post-war transportation facilities, without detracting from the positions demanded by the requirements of strategy.

The ideal peace station should be somewhat in the nature of a cold store, where expensive, perishable articles can be kept without undergoing deterioration. The British soldier is expensive both to create and maintain, and he is perishable if he is not properly looked after. As it is a matter of financial and strategical importance that he should always be ready for active service in the event of trouble arising unexpectedly, we should aim at keeping him free from a disease like malaria, a prince of casualty-producers.

The point is whether more could not be done towards the eradication of malaria by viewing a peace station in the light of a cold store. Not
everywhere, but in some localities, it should be possible to close a
station during the malarious months, and so have a malaria-free force
up in the hills, with a few motor lorries standing by for emergencies.
It is towards the wider conceptions of its utility, such as this, that hygiene
is advancing, summoning to its aid any new military developments that
can simplify disease prevention; anti-malaria measures are not limited to
the provision of mosquito nets and the destruction of breeding places. It
is trivial to look at these big problems through a microscope. We have
got to stand right away and get the wide, broad view. The medical
man who has not been gifted with a scientific mind need not feel
himself handicapped, for there is an unlimited field for anyone who cares
to develop the administrative side of the profession. He has to think
big, and try to solve health problems by means of modern developments.
There is abundant room for the growth of medical statesmanship.

OUR UNIFORM AND OUR BADGE.

It has been suggested that the Circle might be able to get information
on one or two points connected with the badge and uniform of the
R.A.M.C. Twenty-seven years is a short space of time, and there must be
several readers of the Journal who can relate the circumstances that led
up to the adoption of facings of dull cherry, and the creation of a badge
that has since been borne in honour by thousands in peace and war over
most parts of the globe. And whose inspiration was it to select a motto so
peculiarly appropriate?

With regard to the laurel wreath that encircles the rod of Æsculapius,
it may not be generally known that this was a mark of special distinction
in the British Army, having been granted to the 34th for Fontenoy, the
five regiments that fought at Minden, and the 57th for Albuhera, in
commemoration of the gallantry displayed by these regiments. As the
laurel wreath on our badge is stated to represent "the achievements of
the Medical Service of the Army," it is probable that this circumstance
was realized when the badge was designed; intentionally or otherwise, it
was bestowed upon a Corps eminently worthy of receiving a special
distinction.

SCARLET versus BLUE.

Another point raised was the question of uniform—whether we should
have scarlet or blue. At the end of the war officers were asked for their
opinions on this question, and I think that most were in favour of blue,
but with red facings on account of being a Royal Corps. At that time, no
one quite realized that the world of our day would be so desperately
hard-up.

When you go beyond khaki, the utilitarian, to seek for a colour, the
chances are that you dip into a history book. Scarlet is essentially British,
while the blue uniforms of many regiments in the Army are due to
continental influences, as Hussars and Lancers. Some of these influences
are Teutonic in origin. Also, it was the colour worn by the departments of the Army. Thus in the Crimean days the Army Hospital Corps, administered by the Commissariat Department, had a blue uniform.

On the other hand, the officers of the Army Medical Department wore scarlet, with black velvet facings, as late as 1883. Several officers serving at the close of the Great War joined in the days of scarlet tunics. Scarlet can be seen also in the Millbank portraits; it disappeared when the Army Hospital Corps and the Army Medical Department became the Medical Staff Corps and the Medical Staff respectively, the reason being, perhaps, that the State did not bear the cost of the change of colour to blue, as it would have done if the men had been given the scarlet uniform of the officers.

Blue, therefore, lacks historical significance—it may never have been worn by us in the presence of the enemy—whereas scarlet is the colour of the old uniform of the Medical Service. On this count scarlet leads.

As regards scarlet facings to blue uniform, there appears to be no "Royal" significance attached. Facings of this colour are worn by several non-royal units, as can be seen best by a perusal of the 1914 Army List.

However, we should remember that the British Army, after its series of victories at the close of the Napoleonic epoch, began to pay too much attention to its wearing apparel; in consequence, it dwindled in war efficiency in the decades following Waterloo. Dress must remain within its proper perspective, and in the above I am attempting to treat the question in its historical aspect only. I may have made misstatements, which welcome correction. Living abroad, one is unable to look up references. But I suggest to those who are acquainted with such matters that this Journal should contain information on these and similar subjects. Our Journal is a permanent record in which facts and opinions can remain stored and indexed for those who want to investigate the history of the Corps in future years. The Journal constitutes our Archives, in which everything of interest, scientific, professional, historical and even sartorial, deserves a place.

DIPLOMA OF PUBLIC HEALTH.

Note supplied by Lieutenant-Colonel J. A. Anderson, Professor of Hygiene R.A.M. College.

When the General Medical Council drew up the new rules for Diplomas in Public Health, which came into force in January, 1924, it was at once seen that they would place officers of the Royal Army Medical Corps under a disadvantage for obtaining this qualification.

The following is a short summary of the Regulations issued by the General Medical Council, including the courses of study required to allow a candidate to sit for either Part I or Part II of this examination:

Rule 1.—A period of not less than two years must elapse between the attainment by a candidate of a registrable qualification and his admission to the final examination for the Diploma in Public Health.
Rule 2.—The curriculum for the Diploma in Public Health shall extend over a period of not less than twelve months subsequent to the attainment of a registrable qualification.

Rule 3.—Every candidate shall produce evidence of having attended, not less than five months at an approved institution, practical instruction in (a) Bacteriology and Parasitology (including Medical Entomology), especially in their relation to diseases of man, and to those diseases of lower animals transmissible to man; (b) Chemistry and Physics in relation to Public Health; (c) Meteorology and Climatology.

At least one hundred and eighty hours must be devoted to Course (a), of which one hundred and fifty hours shall be spent in the laboratory.

At least ninety hours must be devoted to Course (b), seventy hours of which must be spent in the laboratory.

At least ten hours must be devoted to Part (c).

Rule 4.—Every candidate must produce evidence of having received not less than eighty hours at an institution, or from teachers approved by the Licensing Board, instruction in: (a) Principles of Public Health and Sanitation; (b) Epidemiology and Vital Statistics; (c) Sanitary Law and Administration; (d) Sanitary Construction and Planning.

Rule 5.—Every candidate must produce evidence of attendance for three months on the clinical practice of a recognized hospital for infectious diseases, and of having obtained instruction in administration. There shall be thirty daily attendances, of not less than two hours each week.

Rule 6.—Every candidate shall produce evidence that for six months he has been engaged in acquiring a practical knowledge of the duties, routine and special, of public health administration under the supervision of a medical officer of health, who shall certify that the candidate has received during not less than three hours on each of sixty working days, practical instruction in these duties, and those relating to: (a) maternity and child welfare service; (b) health service for children of school age; (c) venereal disease service; (d) tuberculosis service; (e) industrial hygiene; (f) inspection and control of food, including meat and milk.

The certificate referred to in Rule 6 can only be given by a whole time medical officer of health, or a medical officer of health of a sanitary area having a population of not less than 50,000, or in Ireland the Medical Superintendent Officer of Health of a county or borough having a population of not less than 50,000.

The examination consists of two parts, Part I and Part II. In each part all specified subjects must be passed at one time.

Part I is practical, written and oral in the subjects referred to in Rule 3.

Part II is practical, written and oral in the subjects referred to in Rules 4, 5 and 6. It will thus be seen that the curriculum is a very full and exacting one. Up till quite recently a certain number of officers were able to go up for this examination under the 1923 Regulations, having
started their studies prior to December 31, 1923. Now no officer will be able to do this who cannot produce satisfactory certificates that he started work for the Diploma of Public Health prior to the end of 1923, and these certificates must be approved in each case by the Examining Body.

With regard to Part II, it is impossible to state what certificates would be accepted in lieu of those referred to in Rules 4, 5, and 6, as each case would be judged on its own merits by the authorities concerned, and this also applies to the certificates referred to in Rule 3, as only certain laboratories are recognized.

The most serious obstacle to officers in the Royal Army Medical Corps is the fact that in order to sit for Part II they must obtain a certificate for six months' practical instruction in public health routine from one medical officer of health. It should be noted that a certificate from two or more medical officers of health is not accepted.

It would appear that under the new regulations the only officers who will have an opportunity of obtaining the necessary certificates will be those who specialize in hygiene, and possibly an officer home on long leave from the West Coast.

The Diploma of Public Health is granted by so many examining bodies that it is impossible to give details of them all in these notes. As in all cases the subjects required are more or less the same, and the courses of study must conform to the regulations of the General Medical Council, it is only proposed to deal further with the London and Cambridge Diploma of Public Health.

There are three examinations a year for the London Diploma of Public Health; Part I is held during the months of March, June and December, and Part II a few days later. The fees for the examination in each part is ten guineas (£10 10s.) except in the case of candidates possessing the Diploma of the Conjoint Board, when the fee is six guineas (£6 6s.). Examinations are held at Cambridge University twice a year during the months of April and September. The fee for the examination for either part is six guineas (£6 6s.).

A new series of regulations have been drawn up by Cambridge University which makes it obligatory to take out the full course of training for the Diploma of Public Health at the University itself. As far as it is known there is only one exception to this rule, which is the case of the Royal Army Medical College, which course of studies has been accepted by the authorities.

There is one great advantage in taking a Cambridge Diploma of Public Health, which is the fact that the Diploma of Public Health and the Diploma of Tropical Medicine and Hygiene are amalgamated in Part I, which is the same for both qualifications.

This is a decided advantage, as it allows a candidate to pass in Part I, and afterwards qualify in Part II, of whichever diploma he wishes to take, the usual tendency being to pass in both subjects.