To me the most striking common factor in services is the whittling away of many professional freedoms, which all add up to a big debit. Consider the tuberculous patient. Possibly a poor case for freedom, but he still has a trace; up to the point of public danger he may refuse treatment, but the price has gone up recently. In the official "Model Leaflet: Allowances and Grants" we read: "These allowances will be paid . . . *provided* that he follows a course of treatment advised by the tuberculosis officer of the local authority" (my italics). Is this a "model" of things to come? Together with the patient's waning right of free choice goes the doctor's right to retire from a case. Another freedom that I value is the right to prescribe as I think best. This has never been strong in services, and under wartime drug restrictions it is in danger of vanishing.

Another freedom that is ebbing is the freedom to give one's personal best to each patient. I regard this as crucial. I have met service administrators who exert direct pressure, although insidiously because they will not put it in writing, to scamp the work and speed the flow of human cattle through their clinics. When I challenge I am told that "the mass method is the only way," or that "there is a shortage of doctors," but in any case "it is an order." I have tasted this in every service pudding I have eaten. Like the flavour of weevils it cannot be disguised by any amount of jam. The point is that we have not yet seen a service that sets out to put the interests of the individual patient first. I have always thought and taught that this is the first thing in therapeutics—the foundation stone that is still solid after 2,500 years. The mass method of approach is satisfactory for animal work, and most laboratory workers recognize that it cannot be directly or completely applied to man because man is something more than animal. That its attempted imposition on man is unsatisfying to patient and doctor alike I have no shadow of doubt.

The freedom to set up experiments to test a theory is one that I value too, including man within voluntary and human limits, and experiment by definition includes control for measurement. Prof. Ryle states his belief in his theory but admits "until we have tried it neither Lord Horder's assumption nor mine can be proved the more correct." Therefore I assume that he considers the 100% service plan to be in the nature of an experiment. But where is his control? What is left from 100% for any kind of comparison under equivalent conditions? Does he accept Lord Kelvin's definition that "science is measurement"? If so, he has thrown away his yardstick. I can picture plenty of political control in a 100% service, but because it rules out scientific control from the start I submit that it is not an experiment and therefore could never prove anything. The only comparisons left would be the results on the health of the next generation to set against that of the present and of the past, which would contain so many enormously variable factors as to be scientifically fantastic and totally invalid.

Finally, to be constructive, let me welcome discussion and plan. Let us collaborate and organize to improve by all means. Let us indeed try a unified national service. But I press that this is too big either to be measured by the yardstick of science or "bossed" by the big stick of politics. By what, then, could it be controlled? I suggest that it could be balanced by a principle, and the only one that is big enough is freedom. If I am right, this means that we must not agree to a 100% service under any circumstances. The only prescription that is likely to prevent the monster medical machine from becoming a myxoedematous monstrosity is adequate dosage with freedom; to be available at all times, and at every stage: freedom for the patient to seek private aid without penalty, provided only that in certain cases he does, in fact, take some specialist advice; freedom for the doctor to work in the service or get out and earn a reasonable living at his profession on his own, responsible, as of old, only to his patients, subject only to his conscience and his King.

Would this not put the service on its mettle and the private profession too? Let them vie with each other to serve the nation in friendly rivalry, and I think both will live and flourish healthily. But if it so happens that England lets this freedom go, either by default under hasty wartime legislation or by direct vote after due time for consideration, then I for one will reckon it to be the greatest disaster in the history of medicine. I will then pack my traps and sadly restart my travels in pursuit of freedom, even, as Sir Walter Langdon-Brown has suggested (*Daily Telegraph*, July 28, 1944), as far as the wilderness.—I am, etc.,

Lee-on-the-Solent. J. W. DE W. G. THORNTON.

SIR,—Lord Horder (March 17, p. 357) postulates a number of axiomatic truths that no one will question. At the same time this eminent authority gives expression to some strong protestations of a controversial nature. For example, the sponsors of the White Paper are arraigned as accessories in a course that must ultimately lead, so it is contended, to "regimentation and control by the State." The evidence adduced in support of this indictment hardly rises above the level of the hypothetical. It is noteworthy that no recognition is made of those doctors who have indicated their reactions to the White Paper as favourable (Q. 30 of Questionary) or have plainly signified their approval of a "salaried remuneration or some similar alternative which will not involve mutual competition" (Q. 17 and Q. 18 of Questionary). Is it considered that they are lacking in "good brains and healthy ambition" simply because they are not attracted by the adventures—and the hazards—of competitive private practice?

The health centre, according to Lord Horder's conception, takes the shape of a hospital out-patient department where the Ministry pays for the services of the specialists. That is very different from the health centre of the White Paper, which is designed for a "group" of general practitioners working together. And now that some public health authorities have laid claim to the same label for their clinics, the appellation "health centre" does not make for clarity. It seems high time to discard the term in reference to "grouped" general practice, for which "consulting centre" might be better.

I would beg leave to deprecate the emphasis on the sentiment that "we"—the medical profession—"stand for sane knowledge, selflessness, and mercy in a world gone mad." That is a high standard, but is it not a little unsympathetic to the rest of the population? Why "a world gone mad"?—I am, etc.,

St. Annes-on-Sea. JOSEPH PARNESS.

SIR,—The last paragraph of Prof. Ryle's letter states by far the most important point in the controversy. He says: "*Until we have tried it* neither Lord Horder's assumption nor mine can be proved the more correct" (my italics). Let there be no misunderstanding: once medicine is nationalized there would be no return from the disaster, both to the community in general and to the medical profession, which many of us believe it would bring about. It would be impossible to say: "We find this experiment a failure; let us go back to the *status quo*."

The Church of England is a very good example of political control. The bishops are, I believe, appointed on the recommendation of the particular political party which is in office at the time of a vacancy. In my view, the chaotic condition of the Church to-day is due largely to the unfortunate practice of many of the bishops, who seem to mistake theology for politics. So it would surely be if our profession were nationalized. May it never happen.—I am, etc.,

Birmingham. ERIC W. ASSINDER.

SIR,—Prof. J. A. Ryle (March 31, p. 456) aims high if his media Utopia is to contain administrators who will not interfere with clinicians. He leaves out of account human frailties, not the least of which in the "administrator type" is the "itch" to interfere beyond their zone of usefulness.

I was once called upon during my Army service to give an explanation of my treatment of a case of fractured femur by a splint other than a Thomas splint. My first explanation—an oral one—that I had been offered a Thomas splint and refused to use it was not accepted, and I was asked to put the matter in writing. My written explanation was accepted, but I received a cautionary note to the effect that the Thomas splint had been manufactured in large quantities for the Army for treatment of this type of injury, that I knew the usual channels of procedure when a departure from Army technique was involved, and in future I was to use those channels. The time-lag would, of course, have been unpleasant for my patients, and irksome to me, so from that date the usual Army technique was adhered to.