SUPPLEMENT TO THE
BRITISH MEDICAL JOURNAL
LONDON SATURDAY AUGUST 19 1944

MEDICAL SERVICES IN CONTINENTAL COUNTRIES

4.—YUGOSLAVIA

Yugoslavia has a population of about 16 millions. In the interwar period the population increased by more than 4 millions. The birth rate is one of the highest in Europe, but is now declining. The death rate, although it has lately fallen, is also one of the highest in Europe; in the immediate pre-war quinquennium it was exceeded only by Soviet Russia and Rumania. The control of infectious diseases has been a great problem. Smallpox and typhus disappeared during the interwar period, and there was a striking diminution in the incidence of malaria, from which at one time over a million people were said to be suffering. A number of antimalarial stations and auxiliary centres were established, and this antimalarial work indirectly did something to combat tuberculosis, which remains the chief scourge of the country. Tuberculosis claims 30,000 victims yearly, and one death in eight is said to be due to this disease. The State has tackled the tuberculosis menace with great energy, along the lines of both curative and preventive treatment, and a large number of dispensaries and sanatoria have been established.

The last war left what is now known as Yugoslavia in a very poor condition; in the schools between 30 and 40% of the children were found to be physically defective, and 70% of army recruits unfit for service. The doctors then in private practice were almost the sole agency in the country for combating disease, including the widespread epidemics, mostly of scarlet fever. In the kingdom of Serbia at the end of the last war there were only twenty-four public health officers. The call for curative medicine was so insistent that there was almost no energy to spare for preventive work. But the spirit of preventive medicine remained alive. Following the setting up of a medical faculty in Zagreb (Croatia) in 1917 and in Belgrade and Ljubljana at a later date, the desire was manifested for an up-to-date national medical service. A Ministry of Health was created, which ten years later was amalgamated with the Ministry of Social Welfare. The Ministry is divided into four departments charged respectively with public health, hospital services, social welfare, and general administration. The medical service is outside politics, and is said to be less made use of by politicians than the other branches of Government.

Government Assistance

Funds were provided by the Government to maintain and improve existing health institutions and to establish new ones. A considerable proportion of the reparations paid in kind to Serbia by the Germans after the last war consisted of equipment for hospitals and medical schools. Within a few years over 300 social medical institutions, including sixteen tuberculosis sanatoria, also bacteriological laboratories, institutes for research into epidemics, antimalaria centres, trachoma centres, and maternity, infant, and child welfare centres were established. There is a central hygienic institute at Belgrade, and each of the provinces has its institute of hygiene responsible for the health service in its own territory. The Rockefeller Foundation gave great assistance, and made it possible to establish other social medical institutions outside those planned by the State.

In Yugoslavia there are now[1] about 200 civilian hospitals, staffed by more than 1,000 doctors. The public hospitals are run by the State or the municipality, workers' benefit societies, religious orders, or other social organizations. The Belgrade municipal hospital is a modern building with 150 beds. In the public hospitals, which are open to all, the patients pay according to their means, the poor receiving treatment free, but no one paying more than the actual cost of treatment. There are also private hospitals or nursing homes, run for those who can afford fees. There are a number of special hospitals, and at least a skeleton service has been built up in all fields of medicine.

The Government has also set out to assist various forms of local initiative, such as village health co-operatives and other friendly societies, the idea being to bring these isolated communal efforts into a comprehensive scheme covering the whole community. In the course of a few years 149 rural health centres have been established. These health centres co-operate with the rural district and parish doctors in combating infectious diseases and in other health activities. These are also centres of health propaganda. Each of them has a maternity and child welfare centre; a school polyclinic, a dispensary for tuberculosis, and a clinic for venereal diseases, with a mobile unit if necessary. Tuberculosis officers in 1938 examined a total of some 56,000 persons and re-examined 66,000. Free medical attendance is provided for the poor, and, on the occasion of serious epidemics, for everyone.

Social Insurance

Social insurance is effected through various friendly societies, which are only partly under the Ministry of Health and Social Welfare; some are under the control of other Ministries. The number of persons insured in 1938 was 700,000. The insurance covers sickness, maternity, accident, invalidism, infirmity, old age, and death. The premium is paid half by the insured person and half by the employer. The insured person is entitled to 26 weeks' free treatment and medicines. Treatment is given in hospitals and sanatoria and at home, and if given at home the insured person receives two-thirds of his wages. Workers' families are entitled to similar benefits and their wives to a maternity allowance.

The health co-operatives already mentioned are a feature of Yugoslav life and serve as another form of social insurance. Up to 1939, 134 of these had been formed, and nearly 100 were still functioning, with over 65,000 members. They are a form of public medical service. Each household-member pays a maximum of 120 dinars (say, ten shillings) a year to secure all necessary medical attention for the family. One result of the co-operatives is to bring more doctors into the villages, which might be medically deserted were it not for this nucleus of established income.

The Medical Profession

Before the foundation of Yugoslavia it was necessary for Serb, Croat, and Slovene doctors to take their medical degrees abroad. Three medical faculties have now been established in the country. The number of professors, readers, and lecturers in the medical faculty of Belgrade is 74, in Zagreb 93, and in Ljubljana 15. The complete medical course lasts for five years, after which the intending doctor undergoes one year's hospital training. Upon its termination he is entitled to start in private practice, and to join, if he so desires, the public health service, the social insurance organizations, or the health co-operatives, and in any of these capacities he is allowed to carry on private practice. If, however, he wishes to work in a preventive institution or health institute he loses the right to private practice, but receives a special allowance in compensation. The right to practise a special branch of medicine is granted to those doctors who have been attached to hospitals as specialists for a period of at least three years. If at the end of that time the doctor has passed the necessary competitive examinations he is enabled to become the head of the department in his hospital which is concerned with that special branch of medicine, but only after working for a certain period in the national service as prescribed by law. As a result of the increase in the number of doctors, vacancies in the larger towns tend to be filled up first, and doctors go there in excess of the number required; but in the villages the reverse is the case, with the result that a number of town doctors have not enough to do, while others in the villages are overworked. Many villages have no doctors at all.

The lack of doctors in country districts is partly made up by giving free medical training to suitable candidates, with a proviso attached that they shall spend from three to five years in a country practice before seeking more remunerative work in towns. But the peasants unassisted cannot afford to pay for their services, and even if the young medical man is subsidized his best efforts are apt to be frustrated by the ignorance of the people. It must be remembered that Yugoslavia

[1] The present tense is used, but the conditions described are those obtaining before war brought about the partitioning and dismemberment of Yugoslavia.

is a poor country. It has been said that on paper it has perhaps the most perfect organization in Europe for safeguarding health, but Government funds are inadequate for carrying out the programme. Four-fifths of the population are peasants, and more than half of these own less than five acres, so that over very large rural areas little can be raised by local taxation.

Yugoslavia has some 6,000 medical practitioners, of whom 10% are women. Before the war those of them who held appointments were distributed as follows:

Ministry of Health and Social Welfare	6
Provincial administrations	33
Preventive services	313
Official appointments in provinces and municipalities	1,197
State hospitals	364
Social and insurance institutions ..	1,700

Many of these, of course, in addition to their public appointments practise privately. Private doctors who do not serve under the social insurance organization have become fewer and fewer. The aim is, frankly, to absorb every medical practitioner into one phase or other of national health service for at least half his time, leaving the other half for private practice. This is brought about by economic pressure, for doctors who are isolated from State and insurance schemes are faced with shrinking practices. From the public point of view the effect of this policy has been to give the population the fullest opportunity to avail itself of the best medical service, specialist and other, through national or communal institutions on the payment of a nominal fee. Of course, the right to consult any private practitioner remains. It may be added that there has been a Society of Serbian Doctors since 1878, and there are Croatian and Slovenian doctors' societies.

The move towards a complete or almost complete national medical service is held to be justified on the ground that the doctors, being brought into assured and non-competitive employment, become increasingly indifferent to private gain. It is admitted that many practitioners in the towns are likely to be worse off under a salaried system, but this is compensated for by the increased facilities for co-operation, the use of provided equipment, the greater satisfaction in the work, and, generally, increased efficiency of the service. The growing number of medical journals and books is pointed to as witnessing to the new spirit which is abroad. But the immediate advantage of a controlled and directed medical service in a country like Yugoslavia is in bringing about an increase in the number of doctors working in the villages and a more equal distribution of general practitioners and specialists all over the country. Even as it is, the peasant population, four-fifths of Yugoslavia, has a service of only something like 1,000 doctors, while the 20% of townspeople have more than 5,000.

It would be ungracious to conclude this article without a tribute to the forward spirit in public health in Yugoslavia which has manifested itself during the interwar period.

The compiler of this article desires to express his acknowledgments to the Royal Yugoslav Embassy in London and to Dr. Milosh Sekulitch, one of Yugoslavia's most eminent medical men, who has used part of his time in this country to write a book on Yugoslav health services, the MS. of which the compiler was permitted to read. No responsibility, however, must attach to Dr. Sekulitch for any deductions in this article.

BRITISH MEDICAL STUDENTS' ASSOCIATION

REPLIES TO QUESTIONARY

[A questionary on the White Paper was recently issued to medical students by the British Medical Students' Association, the actual distribution being undertaken by the medical schools. About a quarter of the total number of students replied, and we publish below the results. As will be seen, some of the questions were those put to doctors by the British Institute of Public Opinion, whose permission to use them and help in preparing others are acknowledged by the British Medical Students' Association.]

Q. 1.—*With the introduction of a National Health Service, as described in the White Paper, do you think that the quality of the country's medical service will be enhanced or will suffer?*

	Percentage
Enhanced	49
Suffer	36
D.K.	14

Q. 2.—*The White Paper proposes that complete medical services, including hospital and specialist services, shall be available to everyone free of charge (p. 9). Do you agree or disagree with this proposal?*

	Percentage
Agree	72
Disagree	25
D.K.	2

Q. 3.—*Do you consider that the White Paper places doctors under clinical control of local authorities?*

	Percentage
Yes	67
No	18
D.K.	14

Q. 4.—*The White Paper envisages as the central administrative structure the Minister of Health plus the Central Medical Board. Do you think that this arrangement is satisfactory or unsatisfactory?*

	Percentage
Satisfactory	41
Unsatisfactory	40
D.K.	16

Q. 5 (a).—*The Board must be able to require a young doctor who decides to enter the public service to give his full time to that service during the early years of his career in cases where the needs of the service require this. Do you regard this as reasonable or unreasonable?*

	Percentage
Reasonable	53
Unreasonable	45
D.K.	2

Q. 5 (b).—*What should be his initial salary in the public health service per annum (1939 value)?*

Average salary, £560 per annum.

Q. 6 (a).—*Do you approve or disapprove of the principle of Health Centres?*

	Percentage
Approve	89
Disapprove	8
D.K.	2

(b).—*If approve, what form of Health Centre would you prefer to see commonly used?*

(1) As outlined in the White Paper (p. 30) providing for "individual consulting rooms, for reception and waiting rooms, for simple laboratory work, for nursing and secretarial staff, and . . . in varying degree . . . recovery and rest rooms, dark rooms, facilities for minor surgery, and other ancillaries."

(2) As above, plus a few beds.

(3) Purely diagnostic, investigation centre.

(4) A centre where both preventive and curative work is done, including, e.g., maternity and child welfare, school medical treatment.

(5) Other.

	Percentage
(1)	27
(2)	17
(3)	9
(4)	33
(5)	3

Q. 7.—*The White Paper says that doctors working from Health Centres should have a contract jointly with the Central Medical Board and the local authority owning the Health Centre, although the local authority would not have power to terminate the contract (p. 31). Do you agree or disagree?*

	Percentage
Agree	41
Disagree	40
D.K.	16

Q. 8.—*Should payment in a N.H.S. be by salary, by capitation fees, or by a combination of both?*

	Percentage
Salary	34
Small basic salary plus capitation fees ...	53
Capitation fees	10

Q. 9.—*Any practitioner wishing to set up a new or take over an existing public service practice in a particular area will seek the consent of the [Central Medical] Board. The Board will then have regard to the need for doctors in the public service in that area, in relation to the country as a whole and in relation to the general policy for the time being affecting the distribution of public medical practice. If it is considered that the area has sufficient . . . in public practice while other areas need more doctors consent will be refused. Otherwise it will usually be given without question. Is it reasonable that the Board should have these powers?*

	Percentage
Reasonable	65
Unreasonable	31
D.K.	3

Q. 10.—*Should the sale and purchase of general practices be maintained or abandoned on the assumption that adequate compensation will be paid to existing owners?*

	Percentage
Maintained	37
Abandoned	50
D.K.	12

Q. 11.—*Is it possible for you to set up in practice without incurring a debt?*

	Percentage
Yes	19
No	63
D.K.	16

Q. 12.—*Have you incurred a debt in order to obtain your medical training?*

	Percentage
Yes	23
No	74

Q. 13.—*The N.H.S. will require an increase in the number of doctors. Do you think from your contacts with others that financial assistance will or will not be required to enable larger numbers to enter the medical profession?*

	Percentage
Yes	77
No	15
D.K.	7

Q. 14.—*Do you think that the type of service outlined in the White Paper will or will not necessitate modifications in the present medical curriculum?*

	Percentage
Yes	44
No	38
D.K.	16

Q. 15.—*Some people paid by the State are debarred from politics or standing for Parliament. Do you agree or disagree that provision should be made to safeguard these political rights of doctors entering an N.H.S.?*

	Percentage
Agree	90
Disagree	5
D.K.	4

Q. 16 (a).—*Have you read the White Paper?*

	Percentage
Yes	57
No	3
In part	40

Q. 16 (b).—*On the whole are your reactions to the White Paper favourable or unfavourable?*

	Percentage
Favourable	51
Unfavourable	40
D.K.	7

Q. 17 (a).—*Would you enter the National Health Service as it is described in the White Paper?*

	Percentage
Yes	71
No	43
D.K.	15

(b).—*If yes:*

	Percentage
Whole-time	24
Part-time	13
D.K.	8

Details of Sample

a.—Total number of replies 2,588

	Percentage
Men	73
Women	26

b.—Year of course:

	Percentage		Percentage
First	4	Fourth	22
Second	22	Fifth	21
Third	19	Sixth	10

c.—Occupation/profession of father:

	Percentage
Medicine	21
Company director, higher professions, independent	38
Salaried, manager, teacher, farmer, proprietor of retail business	28
Skilled artisan, clerical, weekly wages	4
Others, weekly wages, factory, transport, mining, etc.	2

d.—What type of post do you hope to obtain under the present system?

	Percentages
Consultant	34
General practitioner	28
Whole-time salaried	26

Detailed Analysis of Question 16 (b)

	Favourable (Percentage)	Unfavourable (Percentage)	D.K. and Blanks (Percentage)
Total	51	40	9
Men	47	43	10
Women	61	32	7
Occupation of father:			
Medicine	38	52	10
Company director, higher professions, independent	50	41	9
Salaried, managers, shop proprietors	73	18	9
Skilled artisans	73	18	9
Others	73	20	7

Detailed Analysis of Question 1

	Enhanced (Percentage)	Suffer (Percentage)	D.K. and Blanks (Percentage)
Total	49	36	15
Men	45	39	16
Women	57	26	17
Occupation of father:			
Medicine	37	46	17
Company director, higher professions, independent	49	38	13
Salaried, managers, shop proprietors	57	27	16
Skilled artisans	64	20	16
Others	77	18	5

Correspondence

The White Paper

SIR, — Reading and re-reading the White Paper by the sunny shores of the Mediterranean, six weeks away from mail, daily newspapers, and the *British Medical Journal*, I have hesitated to write to you commenting upon it because any comments of mine may well be very much out of date before you receive them. But I find that the ordinary soldier is as interested in it as is the medical officer—I have now been asked to speak about its proposals at six different meetings or discussion groups—and I have not been able to avoid coming to some conclusions in regard to its general principles.

The Minister of Health has disclaimed with some show of emotion the suggestion that the impulse behind the White Paper is political rather than social. What I dislike most about it is that it is neither one thing nor the other. If the Government had made up its mind to adopt the complete Beveridge Scheme, with its implications of a whole-time State Medical Service and the abolition of private medical practice and of the voluntary hospitals, we doctors would at least know where we were, and would be able to make a stand for fair conditions of service, compensation for liabilities and loss of private practice, and the assumption of full responsibility for the voluntary hospitals by the State. I imagine, however, that this was too much for the great Conservative majority in the Government to swallow, and the White Paper appears to be a subtle attempt to manœuvre the doctors and the voluntary hospitals into such a position that they will have to accept unconditionally the Government's terms. Already I have had letters from non-medical friends in England—friends of the most moderate political views—complaining that the doctors are showing themselves "reactionary" and "obstructive."

It seems to me nonsense to say that the White Paper is issued "to assist discussion" when it has already been "decided" by the Government that a comprehensive National Health Service will be available to everyone in England, Scotland, and Wales, irrespective of means. If the first paragraph of the White Paper is accepted by the profession—and apparently the Minister of Health assumes that it is going to be accepted without any discussion—that is the end of private medical practice and of the voluntary hospitals. Before I read the White Paper I had imagined that any Government might find it necessary on political grounds to include the whole population in a national health scheme, because nowadays no Government could exempt the small richer section of the population from a social security tax which the large poorer section would have to pay. But I read that only 27% of the cost of the suggested National Health Service is to come from a direct "social security" contribution or tax, and the other 73% from rates and taxes payable by all citizens, so that this is quite easily adjustable.

I was present at the Annual Representative Meeting in 1942 when the discussion took place on whether a National Health Service should be available to the whole population regardless of income limit or only to those below the National Health Insurance limit. The voting was approximately equal—94 to 92, if I recollect aright—showing that the Representatives had not really made up their minds on this subject (as they had on a whole-time salaried State Medical Service) and had not begun to realize its repercussions. But if—as the White Paper rightly insists—there must be no differentiation made by the doctor between public patients and private patients, and—though there is less justification for this proposal—the doctor who has a large number of private patients will be penalized by being allowed a correspondingly lower income from public patients, private practice will undoubtedly fade away within a very few years, in spite of honeyed words from Mr. Willink to the contrary.

As for the voluntary hospitals, we are told that, while they will receive from the Government "part" of the cost of the public patients who are treated in them, they must "still look substantially to their own financial resources, to personal benefactions, and the continuing support of those who believe in the voluntary hospital movement." It is admitted that half the present income of the voluntary hospitals comes from patients' payments, either direct or by contributory schemes: I notice that Mr. Willink said at Birmingham that he hoped that a way might be found "so that the fine existing hospital contributory schemes did not have to end completely." Surely he cannot be so naive as to imagine that workpeople will continue to pay weekly hospital contributions in addition to weekly Government contributions ("stamps" or wage deductions or whatever it is to be) which are to ensure free hospital treatment as well as other benefits? The White Paper, indeed, uses threatening words to the voluntary hospitals: "If public funds were to be used to guarantee the voluntary hospitals' financial security, the end of the voluntary movement would be near at hand."

The crux of the matter would appear to be: Are private medical practice and the voluntary hospital system worth preserving? If the answer is "Yes," not all the persuasiveness of Mr. Willink should allow the medical profession to accept the Government's "decision" about the comprehensiveness of the scheme without the authority of a general election behind it. One recognizes that the Prime Minister's promise of October 13, 1943, that "far-reaching changes of a controversial character" would not be made by the Government "unless proved indispensable to the war" or without a general election, would not to his mind

apply to such a matter as this White Paper because both the Conservative and the Socialist wings—not to mention the Liberal tail—of the National Government are agreed upon it. Would this same predominantly Conservative Government ever consider nationalization of the mining industry or the banking profession "non-controversial"? Of course not. Nationalization of the medical profession is quite a different matter—there is no political kick behind it. Or is there? If the destiny of the medical profession is to be decided on the political field it would appear that the doctors should take their coats off and get down into it before it is too late.

The Medical Planning Commission was a wise conception in that it aligned the Royal Colleges beside the B.M.A., otherwise in my opinion it was a mistake, because setting it up suggested that the B.M.A. had no policy of its own for a National Health Service, whereas the grey book on *A General Medical Service for the Nation* (1938) set forth a simple and statesmanlike plan, free from possible controversy (except from professed Socialists), which can well bear comparison with the White Paper of to-day, even although it antedated the Beveridge scheme. It can be summarized in a very few words: extension to dependants and others of like status of the present National Health Insurance scheme, with consultant and specialist services added, and the assumption by the State of the hospital costs of State patients. The important thing about private practice, I take it, is the feeling of responsibility towards his individual patient that it engenders in the doctor. The method of working the National Health Insurance scheme that has been evolved over thirty years has apparently managed to preserve this feeling with reference to the panel patient, without undue State control and without any bias in favour of the State as against the patient ("deterrent certification"). It seems a pity to discard this well-tried method of working in favour of a brand-new one with a multiplicity of committees and an aura of "political" suspicion about it, for it can hardly be denied that a ladder that leads by easy stages from the family doctor and the consultant directly up to the Minister of Health—a political appointment—is essentially political control, however it may be disguised by the words "democratic responsibility."

One thing I have always liked about the profession of medicine is that there is a niche for everyone in it: one realizes that some doctors dislike living by charging fees to patients and others dislike getting into debt to pay for a practice even though it gives them independence later on; but fewer than half the doctors on the *Medical Register* are in general practice, and those who would prefer a salaried life have a wide range of choice for their activities.

As I have said before, however, the whole affair is putting the cart before the horse. The White Paper's estimate of the cost of this comprehensive, grandiose, and "free" scheme—no, Mr. Willink has wisely withdrawn the word "free," I see—is £148,000,000 a year. But of course the chief cause of disease is not a medical one at all: poverty is the chief cause of disease in this great and wealthy country of ours—malnutrition, bad housing, and unemployment. And in time of war—God help us all—there is less disease, because unemployment has disappeared, wages are higher, and feeding is wiser. Would it not be better for everybody to let Lord Keynes, Lord Catto, and Sir John Anderson have a shot at this problem, and stop worrying the Minister of Health?—I am, etc.,

On Active Service. R. SCOTT STEVENSON.

SIR,—Dr. Wilfred Shaw (July 22, p. 19) states and repeats that "what matters fundamentally in a health service is the provision of maximum efficiency in diagnosis and treatment to every patient." So far as a National Health Service is concerned the only suitable comment on this dictum is a flat contradiction, for the first and most important function of any genuine health service is the prevention of disease, injury, and "unfitness" by removal, so far as possible, of all the known causes of those conditions.

Apparently, however, the majority of the profession (including the B.M.A.) accepts as genuine the Government's spurious hall-mark "A National Health Service," though the White Paper holds out no hope of improvement in the national health and stamina by any serious attempt to deal with the many well-recognized causes of disease which depend on living conditions. It passes them over with a brief reference and a hint that, if the nation accepts its present proposals, these matters may be dealt with by some other agency. As most of them are highly controversial it is much more probable, indeed pretty certain, that the Government would regard the acceptance by the nation of its proposals as a valid excuse for postponing any drastic action on these controversial matters for another generation or so; it may claim to have done all that is necessary in the eyes of the people and in the eyes of the profession. If that should happen the blame will rightly rest on the profession, which has failed in its duty to instruct the people on matters that are of almost vital national importance and on which it is the only competent judge. No one denies that a better and more comprehensive system of medical attendance could and should be instituted, but it should be part of a genuine health service and not be allowed to pass as a substitute for one.

Is it not the duty of the profession to instruct the public on these lines and to appeal to it in its own (the public's) interest to reject the present proposals *in toto* and demand a new approach to the question of the national, not merely individual, health? The hand of the extreme political parties is clearly visible in both the White Paper and its successor on another subject—a political *quid pro quo* in which the national health receives scant consideration.—I am, etc.,

Ambleside. J. PRICE WILLIAMS.

Three Principles

SIR,—In order to reduce the difficulties in our minds when we consider the White Paper and to assist us in the solution of the problems related thereto I would like to suggest that we give our main consideration to three outstanding principles.

1. *The Needs of the Patient.*—All will agree, I am sure, that the needs of the patient are to be considered first, last, and always. Herein must be included first of all opportunity and facility to prevent ill-health, but, if ill-health comes, the same opportunity and facility to diagnose and to treat it. As a major part of this problem is the very high incidence of so-called "functional illness," and because the emotional factor is now known to be so prominent in all illness, it is a matter of paramount importance that the physician–patient relationship be preserved—in fact, be improved if possible. Anything that in any way detracts from this intimate and most important relationship is a major loss to the service.

2. *"The Labourer is Worthy of his Hire."*—It may be assumed that no thinking person would deny to the doctor the absolute need for an adequate income. It should be one that will help him to keep abreast of the times in knowledge and ability, and one that will compensate him for long hours spent in his service often to the detriment of his health, other legitimate interests or obligations. But only as we have need of a physician does our gratitude reach such heights that we are inclined to pay generously for the service. Finance committees are likely to forget the cost in time and money of the undergraduate and postgraduate training of the doctor, and the multitudinous demands made upon him in his work, when they are sitting in conference trying to estimate the cost of a service that is to be paid for out of the coffers of a country already overburdened with taxation.

3. *Every Man has the Firm Right to be Judged by his Peers.*—In this our free and democratic country it should never be that the freedom of service of any man should be controlled by any other than those who hold equal status with him. In this case it should be a properly elected body of medical men.

It would seem to me that if every clause of the White Paper were judged and amended—because amended it would surely have to be—on the basis of its relation to the above three principles there would be evolved a service that would be second to none and a blessing to all concerned.—I am, etc.,

P. L. BACKUS.
Temp. Lieut.-Col., R.A.M.C.

First Considerations

SIR,—Dr. E. F. Hunt's letter (July 8, p. 8) has struck an almost silent note in the deliberations which have been held on the proposed State Medical Service—namely, salaries and conditions of service. With the suggestions he makes I would whole-heartedly agree, with the addition of one half-day a week off duty (which no doubt he omitted inadvertently) and compensation for the capital value of practices and houses, etc. I feel that no less than the standard set in Dr. Hunt's letter should be accepted in fairness to existing practitioners or in fairness to generations of doctors yet unborn.

In ordinary industrial matters when a contract is proposed between employer and employed surely the first matters considered are the hours of work and the rate of remuneration, yet in our discussions on a State service we spend a lot of time deliberating over details of administration, but seem to have very little, if any, time left for what is to many of us an all-important fundamental—i.e., whether or not we can afford financially to enter the service at all. Until hours of work, rates of pay, and capital compensation for practices, houses, etc., are settled many of us can only half-heartedly enter into the discussions of details.

I may add that I lack Dr. Hunt's experience of the Royal Navy, but have

been on the *Medical Register* for nineteen years, sixteen of which have been spent in general practice on my own account.—I am, etc.,

J. A. KENNETH DOUGLAS.

Neyland, Pembrokeshire.

Medicine and Administration

SIR,—May I add my appreciation of the articles of Squad. Ldr. Kelly and Dr. Geoffrey Bourne (June 3) to that already published.

As Dr. Bourne remarks, there is nothing inherently bad in a State system, just as there is nothing inherently bad in arsenic; each can be used to good or evil effect, but it puts an awful power in the hands of the user. Here we have a cogent argument against the system proposed by the White Paper, which places too much power in the hands of one person, and that person a political figure, liable to change with the whim of an electorate, or because a particular party has been defeated on another issue altogether, liable to be the subject of political manœuvring. All Ministers of Health cannot be good. There is a close analogy in the present controversy about medical superintendents. All with experience of municipal and similar hospitals know what difference can be brought about, in a hospital run on the usual lines, by a change in the medical superintendent, even though the clinical staff may remain unchanged in those municipal hospitals which have a permanent senior clinical staff. A good superintendent gets a good hospital, another gets only good food, another good surgery, another good pathology, etc., and a bad one vice versa. There is a similar state of affairs in military units and commanding officers. On the other hand, the voluntary hospital is as a rule an intermingling of several equally authoritative units; if one is bad, the badness is limited and does not affect the whole hospital, and the aggregate is as a rule good. For this reason, the voluntary hospitals as a whole are better than the municipal hospitals as a whole, for they do not depend on the individuality of one man. The White Paper would introduce the superintendent system to apply to the whole profession.

Furthermore, the White Paper preserves the present misconception of the relative importance of the administrator as it exists in all forms of Government service. Administration becomes the master instead of the servant, an end in itself instead of a means to an end. A medical service (I avoid that frightful term health service) must be based on clinicians, not administrators, if it is to be any good, and advancement must be the result of clinical practical ability in the chosen field, be it curative or preventive. The chiefs of the service must be clinicians, not administrators, and must be the leaders of thought and practice. It is agreed that administrators are necessary, but should bear to the clinical practitioners the relation of secretary, not of director.

Some will say, What of those of the profession who are good administrators but poor clinicians, are they then denied advancement? The answer must be Yes, for the profession we practise is medicine, and if not capable of attaining skill in the elucidation of the problems of diagnosis, treatment, cause, and, where possible, elimination of disease, then that person should change his profession to a secretarial one if he desires advancement beyond the limited posts which would be available in a medical service.

As regards payment, there is a vociferous element in every walk of life which works only to gain money, the members of which have no interest in their work otherwise; but I believe the majority of the profession is not greatly concerned whether paid by salary, capitation fee, or private fee, so long as the income is compatible with the responsibilities of the practitioner. The laity pay us a great compliment inasmuch as they do not realize as a rule how heavy this responsibility is. Only on the few occasions when a doctor's error of judgment results in loss of life, in delay in recovery, or in chronic invalidism do they realize the fact that their doctor so often holds the balance of their lives. Personally, I feel that many favour payment by salary and abolition of the sale and purchase of practices, but not Government control of the profession. Nor is it at all clear why this control is necessary in order that the Government should act as banker to the people to pay for their doctors and hospitals. In this respect the Highlands and Islands Medical Service is worthy of more consideration as a model. Apropos of Surgeon Vice-Admiral Sir Sheldon Dudley's remarks at the Harveian lecture, I would suggest that this service (the Highlands and Islands) would be a more profitable source of inspiration for a national medical service than the medical branches of the fighting Services.—I am, etc.,

Ambersley. L. W. ALDRIDGE.

Bureaucratic Medicine

SIR,—I wish to call attention to E.M.S.I./474, the first paragraph of which reads as follows: "The War Office have informed us that they are receiving numerous requests for unauthorized proprietary preparations, which have been prescribed for Army patients by consultants at E.M.S. hospitals, and point out that it would save them considerable embarrassment if E.M.S. consultants would, whenever possible, prescribe *B.P.* or *B.P.C.* preparations."

It will be noted that the E.M.S. consultants, who are not juniors but are men of standing in the profession, are criticized for prescribing preparations which they consider necessary for the welfare of their patients, because by so doing they cause "considerable embarrassment" to the War Office. I think the consultants will know how to treat this instruction, which is an example of bureaucratic interference which the medical profession will have to expect should it ever allow itself to come under State control.—I am, etc.,

Isleworth, Middlesex. J. B. COOK.

Fund for Returning G.P.s

SIR,—Some of us who live in a suburb of London have been discussing the prospects of our neighbours who are serving with the Forces. In spite of the Protection of Practices Scheme their income has decreased every year. Of course this has been inevitable because there have been no new patients to offset the losses, while the effect of bombing has been to cause the evacuation of more and more patients, including the financial cream, to areas where the scheme is of no assistance.

The net result will be that what is left of their practices will be too small to provide a living. In addition their houses are likely to be damaged or even destroyed, and their instruments and cars beyond repair. Most of them are too young to have accumulated any considerable savings, and they may have commenced practice on borrowed capital.

We think that a fund amounting to at least £100,000 should be raised among ourselves to help these practitioners and others who have suffered comparably. It is suggested that each of us working in these districts could contribute not less than £5 out of the extra income which we have received owing to their absence. Doctors in reception areas who are not having to share their fees could be expected, and I am sure would wish, to contribute on a very much higher scale. If we all do our share there ought to be no difficulty in raising what is necessary. For my own part to open the fund I am willing to give £100.

Although the prime motive of this proposal is brotherly love there is another side to it: no man should be obliged to support a State scheme merely because he could make a living in no other way.—I am, etc.,

London, S.E. GENERAL PRACTITIONER.

Facts v. Chaos

SIR,—Recently we heard some more on the wireless about the National Medical Service: again all what the patient and the Ministry want; not a word about the working conditions of the doctor. Have the B.M.A. got a list of necessities for the doctor's comfort as well? We should like to be reassured on this question.

First, if everyone is to have the doctor he wants and every mother will be able to have for her child free syrup of figs, gripe water, teething powders, cough mixtures, etc., if she calls at the surgery first for a prescription, can it be explained how the wait in the waiting-room can possibly be shortened and the doctor be given decent hours and conditions of work?

Secondly, when at present a large percentage of specialized jobs are done by persons in general practice and in the future specialists are going to be provided for all, how can the wait in hospitals be shortened, because the G.P. will obviously not run the risk of doing a great many of the anaesthetics, operations, and maternity work he now does?

Thirdly, it is obvious that all medical men will have to have a clerk, and who is paying for this, not to mention motor-cars?

Fourthly, when is the question of the sale and compensation of practices going to be settled? Do the planners—presumably whole-time men—understand the distress and worry this is causing concerning our hard-earned savings, which in the case of ill-health or death at present are nearly worthless through uncertainty?

In conclusion one may say that G.P.s. who will always have to do additional work at night, should expect a five-day week with reasonable holidays. Even then will not all students become disillusioned before qualification and refuse G.P. work; which must become a monotonous kind of sorting-house job with a perpetual headache in favour of the easier and more regulated work of some specialty once the experience is gained from a few years of hospital work? Where are sufficient doctors going to be found?—I am, etc.,

Torrington. E. H. WALKER.

BRITISH MEDICAL ASSOCIATION

SCOTTISH COMMITTEE, SESSION 1944–5

Election of 3 representatives by the Group of Seven Divisions comprising Orkney, Shetland, Caithness and Sutherland, Inverness, Outer Islands, Ross and Cromarty, and Argyllshire.

In accordance with the Standing Orders of the Scottish Committee, nominations for these 3 vacancies shall be in writing, and may be made (*a*) by a Division or (*b*) signed by not less than three members of the Group. Nomination forms have been sent to the Hon. Secretaries of the Divisions in the Group, and can also be obtained on application to the Scottish Office.

If more than 3 members are nominated the election shall be by voting papers sent by post from the Scottish Office to each member of every Division in the Group.

Nominations should be sent to me at the Scottish Office, 7, Drumsheugh Gardens, Edinburgh, not later than Aug. 26, 1944.

R. W. CRAIG,
Scottish Secretary.

Branch and Division Meetings to be Held

HARROW DIVISION.—At Kodak, Ltd., Headstone Drive, Wealdstone, Sunday, August 27, 3 p.m., address by Dr. Charles Hill: The B.M.A. and the White Paper. To be followed by a general discussion. All medical practitioners, including serving officers, in the area of the Division are invited to attend.

Meetings of Branches and Divisions

PADDINGTON DIVISION

The inaugural meeting of the Paddington Division was held at Paddington Town Hall on Aug. 1. Mr. A. M. A. Moore, chairman of the Metropolitan Counties Branch, opened the proceedings by complimenting Paddington on its initiative in forming its own Division at the present time. Dr. G. de Swiet was elected the first chairman, and Dr. G. M. Gray honorary secretary and treasurer. Dr. L. Zeitline and Dr. Ethel Emslie were the two other members so far elected to the Executive Committee, which has power to co-opt a member of St. Mary's Hospital staff and other representative members of the profession in the borough. Dr. de Swiet in a short speech thanked his fellow members for the honour they had conferred upon him, and said that during the last 21 years it had given him great satisfaction to serve his profession on various committees and bodies. These were critical times for the doctors, who would have to do a good deal of hard thinking before taking any important decisions affecting both the practice and the teaching of medicine.

Dr. Charles Hill, Secretary of the B.M.A., then spoke on "Present Problems before the Profession." He dealt with several aspects of the White Paper and enlarged on the policy of the B.M.A. and the views of the profession. With the replies to the Questionary to hand, he said, they would be able to give expression to the opinions of the members. He remarked that the profession showed a slight majority in favour of the 100% of the public being included in the new national health scheme. On questions of administration he was suspicious of the proposed Central Health Services Council, which might become a mere façade. There was a general aversion of general practitioners to enter into commitments with local authorities. Health Centres should be experimental at first, should develop a sense of real partnership between its members, and not become a communal surgery. Compensation for practices was a thorny problem and would require much discussion. Finally he advised all members to trust their representatives in their pending negotiations with the Minister.

A hearty vote of thanks was moved by the chairman to Dr. Hill for his brilliant address and to Mr. Moore and Dr. L. G. Glover, hon. treasurer of the Branch, for their help in augurating the Paddington Division; this was passed in the usual manner by those present.

B.M.A. LIBRARY

The following books were added to the Library during March and April, 1944:

Bailey, H.: Physical Signs in Clinical Surgery. Ninth edit. 1944.
Bailey, H.: Emergency Surgery. Fifth edit. 1944.
Bailey, H. (Editor): Surgery of Modern Warfare. Third edit. 6 Parts. 1944.
Ballenger, H. C.: Manual of Otology, Rhinology and Laryngology. Second edit. 1943.
Cotterell, A.: R.A.M.C. 1944.
del Campo, G. C., and Gallardo, F. P.: Tecnicas de Laboratorio en el Tifus Exantemático. 1943.
Dogra, J. R.: Handbook for Emergency Commissioned Officers of Indian Medical Service. 1943.
Enock, A. G.: This Milk Business. 1943.
Ewart, E. D.: A Guide to Anatomy. Fifth edit. 1943.
Fordham, M.: Life of Childhood. 1944.
Garrison, F. H.: A Medical Bibliography. Revised by Morton, L. T. 1943.
Goodenough, F. L., and Maurer, K. M.: Mental Growth of Children. 1942.
Hahn, E. F.: Stuttering. 1943.
Harris, I.: The Woof of Life. 1943.
Hirschman, L. J.: Synopsis of Ano-Rectal Diseases. Second edit. 1942.
Hollender, A. R.: Office Treatment of the Nose, Throat, and Ear. 1943.
Holt, L. E.: Care and Feeding of Children. 1943.
Huff, E. G.: Manual of Medical Parasitology. 1943.
Jokl, E.: Medical Aspects of Aviation. 1943.
Lawrence, R. D.: Diabetic Life. Thirteenth edit. 1944.
Lieber, E. E.: What to Eat and Why. 1941.
Lowy, S.: Psychological and Biological Foundations of Dream Interpretation. 1942.
McCarrison, Sir R., and Moore, D. F.: Food. 1943.
Montague, M. F. A.: Edward Tyson, M.D., F.R.S., 1650-1708. 1943.
Ockerblad, N. F., and Carlson, H. E.: Urology in General Practice. 1943.
Pearce, E. C.: Textbook of Orthopaedic Nursing. 1943.
Plesch, J.: Blood Pressure and its Disorders. 1943.
Pohle, J. F.: The Kenny Concept of Infantile Paralysis. 1943.
Rigler, L. G.: Outline of Roentgen Diagnosis. Second edit. 1943.
Roesler, H.: Clinical Roentgenology of the Cardiovascular System. Second edit. 1943.
Roxburgh, A. C.: Common Skin Diseases. Seventh edit. 1944.
Schoenheimer, R.: Dynamic State of Body Constituents. 1942.
Scott, G. R.: Secrets of Keeping Healthy and Living Long. 1943.
Sears, W. G.: Materia Medica for Nurses. 1943.
Smart, J.: Handbook for Identification of Insects of Medical Importance. 1943.
Soper, F. L., and Wilson, D. B.: Anopheles Gambiae in Brazil, 1930-40. 1943.
Stern, E. M.: Mental Illness. 1942.
Strong, O. S., and Elwyn, A.: Human Neuroanatomy. 1943.
Sze, S.: China's Health Problems. 1943.
Truby, A. E.: Memoir of Walter Reed: The Yellow Fever Episode. 1943.
Wiener, A. S.: Blood Groups and Transfusion. Third edit. 1943.
Zondek, H.: Diseases of the Endocrine Glands. Fourth edit. 1944.

SERVICE REPLIES TO THE QUESTIONARY

Replies to the Questionary are still coming in from doctors serving with the Forces, and the British Institute of Public Opinion is prepared to continue to receive them until the end of September. In the report published on Aug. 5 (*Supplement*, p. 25) the replies were weighted in order to represent the views of the whole profession. The views of Service doctors are, therefore, fully represented in the report, but it is proposed to publish in early October a supplementary report on the tenor of the replies received from Service doctors since July. It is hoped that Service doctors who have not yet sent in their replies will do so as soon as possible, or send a letter expressing their attitude towards the White Paper proposals.

H.M. Forces Appointments

ARMY

Col. N. Cantlie, M.C., late R.A.M.C., to be D.D.M.S. of a Command, and has been granted the acting rank of Major-Gen.

Col. (Temp. Brig.) (acting Major-Gen.) H. C. D. Rankin, C.I.E., O.B.E., V.H.S., late R.A.M.C., to be Temp. Major-Gen.

ROYAL ARMY MEDICAL CORPS

Major (now Lieut.-Col.) V. J. Perez, O.B.E., has been granted the acting rank of Major-Gen.

LAND FORCES: EMERGENCY COMMISSIONS

ROYAL ARMY MEDICAL CORPS

War Subs. Capts. J. B. A. Gibson, A. B. King, and H. Le Vay have relinquished their commissions on account of ill-health, and have been granted the honorary rank of Capt.

War Subs. Lieut. D. T. Davies has relinquished his commission on account of ill-health and has been granted the honorary rank of Lieut.

To be Lieuts.: W. B. Armstrong, H. R. Blades, W. B. N. Bomford, B. T. Bowen, W. Brand, D. L. Bridgewater, R. W. L. Calderwood, W. G. Canning, M. Conway, J. T. Cunningham, A. B. McL. Currie, R. Dallachy, J. Dawson, E. A. Evans, A. D. J. Farquharson, J. Fraser, J. F. Fraser, L. Glass, G. F. Green, K. O. Harrison, A. R. Hodgson, R. H. Jackson, J. Lapraik, N. Lewis, R. H. Little, M. Macaulay, P. G. McBoyle, A. Mackay, N. M. Mann, A. Manson, A. J. P. Oldham, F. T. Page, J. C. F. Poole, J. M. Rees, A. Sakula, L. S. Simons, N. S. Slater, W. P. McK. Telfer, S. M. Vine, J. G. Ward, T. J. C. Warriner, I. E. Whitchill, E. A. Williams, R. E. Wirgman.

WOMEN'S FORCES

EMPLOYED WITH THE R.A.M.C.

War Subs. Capt. (Mrs.) B. M. Moodie has resigned her commission.

The following have been granted commissions in the rank of Lieut.: Isobel H. M. Blyth, Margaret E. Browne, Catherine E. P. Clark, Isobel J. Cochrane, Gladys C. Collings, Gwendoline M. Edwards, Margaret C. Leitch, Doris A. R. Lunn, Joan I. McCracken, Janet E. McPherson, Dilys M. Rees, Olga C. Rollason, Eirian Spickett.

ROYAL AIR FORCE

Air Cdre. H. L. Burton, K.H.P., has retired.

Squad. Ldr. (Temp.) F. V. Maclaine to be War Subs. Squad. Ldr.

RESERVE OF AIR FORCE OFFICERS

Squad. Ldr. H. V. Thomas has relinquished his commission on account of ill-health, retaining his rank.

ROYAL AIR FORCE VOLUNTEER RESERVE

Fl. Lieut. (Temp. Squad. Ldr.) R. J. Owen has resigned his commission, retaining the rank of Squad. Ldr.

Flying Officers G. A. Bell, S. A. Bond, K. H. Dalrymple, J. G. K. Dean, L. H. Hutchinson, W. J. Murphy, D. M. Prinsley, J. D. T. Steele, A. N. Whiteside, to be War Subs. Fl. Lieuts.

To be Flying Officers (Emergency): S. S. Rose and E. A. Waldron.

BIRTHS, MARRIAGES, & DEATHS

The charge for inserting announcements under this head is 10s. 6d. This amount should be forwarded with the notice, authenticated with the name and address of the sender, and should reach the Advertisement Manager not later than first post Monday morning to ensure insertion in the current issue.

BIRTHS

ANNAN.—At the Argyll Nursing Home, Darlington, on August 10, 1944, to Ailie (*née* McGregor), wife of W. Gillies Annan, M.D., F.R.C.S., a son.

HACKETT.—On July 26, 1944, at Shardeloes Maternity Hospital, Amersham, Bucks, to Beattie (*née* Shaw), wife of Wing Cmdr. C. J. Hackett, R.A.F.V.R., a son.

RUSSELL.—On July 31, 1944, at the West Glamorgan County Hospital, to Maud (*née* Lovis), wife of Surg. Lieut. J. E. Russell, R.N.V.R., a daughter—Carol Jennifer.

At the last meeting of the Bristol Study Group on Medical Planning the following resolution was carried unanimously: "That this Study Group is of the opinion that in any comprehensive medical service there should be established an active relationship between general practitioners and their locality hospitals on the lines suggested in the interim general report of Medical Planning Research, and that it regrets that neither the White Paper nor the B.M.A. in its criticism thereof makes reference to an innovation that would ensure a marked improvement in conditions of practice and prove of value, alike to doctor and patient."