Royal Commission on the N.H.S.

SIR,—Two main arguments were adduced by those who at the Annual Representative Meeting opposed the Dunbartonshire/Guildford/Cornwall proposition calling on the Government to set up a Royal Commission on the National Health Service. They were: (1) that the appointment of such a commission now would adversely affect the present negotiations on the general-practitioner Charter, since the Government would happily seize on its existence as an excuse for delay; and (2) that the profession would have no say in the choice of members, the implication being that the Government would select those known to be sympathetic to its own point of view.

These, I imagine, were felt by their users to be the arguments of *Real Politik,* intended to put the R.B. on its guard against the starry-eyed idealism of Clydeside and Cornwall. I find them unconvincing. Even in the unlikely event of the present Government agreeing at once to accept this proposition it would take many months before the Commission could start on its task, and two, three, or even four years after that to complete it. Is it seriously suggested that the Minister and his colleagues would attempt to delay or shelve the present negotiations for that length of time? One cannot see Mr. Robinson in the role of Samson, pulling down "the sacred temple of the National Health Service," to use Mr. Wilson's rather fanciful description.

As to the second argument, apart from the implied indictment of a time-honoured procedure for reviewing national policy in this country, it surely lays us open to the charge that we are not prepared to submit our case to impartial examination. It may be that a Royal Commission is not the most suitable instrument for the purpose of such a review; I for one would have preferred a motion in the more general terms of that proposed by the City of Edinburgh Division as long ago as the S.R.M. in 1957 ("That this Meeting, believing that there is evident need for a reappraisal of the assumptions on which the present National Health Service is founded, urges the Government, in association with the profession, to set up a committee to undertake a fundamental review of the Service and to make recommendations"). The precise wording of any such resolution, however, is less important than its intent.

I should have thought it would be much to the credit of the Association to come out strongly now in favour of a truce to mutual recrimination between politicians, administrators, patients, and doctors and of a concerted attempt to understand how, why, and where things have gone wrong. Along with many others I believe that all the evidence suggests that we are saddled with legislation which is out of date and ought to be repealed and replaced with something more up to date and practical. But I know that others no less well-intentioned think otherwise. Surely an attempt should be made to resolve these differences by rational process? If it is not, then the issue will be determined by nothing more reliable than the clash of political prejudice. This would not only be unsatisfactory in itself, since it would leave a residuum of unresolved conflict of opinion, but it could very well also insidiously impair the standing and quality of medical practice, research, and teaching in this country.—I am, etc.,

Gorebridge, Midlothian. E. R. C. WALKER.

Putting Things Right

SIR,—It is becoming increasingly obvious that even if the doctors never do resign from the Health Service it will grind slowly to a halt on its own unless radical reform is instituted with celerity. Too few doctors are accepting responsibility for too many people, and there seems nothing in the immediate future to curb this trend. It therefore befits us to be prepared in advance for this eventuality. Many of us believe that the solution lies in the formation of some system of insurance practice of private origination. This could be worked alongside National Health practice, assuming that complete collapse of the Health Service, as it is to-day, did not, in fact, occur. It could also replace National Health practice if this did disappear.

Whichever way it goes, it seems clear to me that an increasing number of people in Britain are becoming aware of the deficiencies of State-run practice, and are both able and willing to pay more for a better service. Whilst it is true to say that the population has become indoctrinated to the idea of a "free" service, it is equally true to state that people are getting used to having more money to spend and to paying for the better things of life. Thus I believe it would be right and proper to explore the possibilities of instituting some type of insurance scheme. The B.M.A. scheme, whilst excellent as far as it goes, has one glaring fault. It will do nothing to prevent abuse of the service; nothing to prevent large surgeries. In fact, exploitation may be encouraged and demands be more excessive. This used to happen in the pre-1948 days of the "clubs."

This leads me to advocate a type of scheme whereby the patient is not completely absolved from responsibility. There are several such forms that this could take. In each case the individual pays premiums to an insurance company. He is also responsible for payment of the doctor, according to a scale of fees based on an item-of-service payment. The individual then claims a refund of disbursement according to one of the following schemes: (1) he is refunded the total fees paid up to a certain limit in one year (the limit can vary according to the premium paid); (2) he is refunded a proportion of every fee paid—e.g., 75%; (3) he is refunded all by a small fixed sum of every fee incurred.

A "no-claim" bonus could, if desired, be incorporated into the scheme whereby the individual would procure a reduced premium by virtue of having made little or no demands on the scheme.

The above is only an outline of the insurance scheme, but I am sure it is not impractical. At the recent Annual Representative Meeting at Swansea Dr. Ivor Jones dismissed such a scheme out of hand as being completely unacceptable by any insurance company. I cannot but feel that this idea has not been explored deeply enough. One knows of such projects in other countries which seem to work satisfactorily. Moreover, there are such arrangements operative in this country which apply to hospital and specialist expenses, and I am sure these could be extended to incorporate general practice expenditure.

I am certain that for a scheme such as I have outlined above to prove acceptable it should be offered at the outset. It would not be popular if it were launched any appreciable time after the present B.M.A. scheme, which as it stands would maintain the principle of "free for all."

Whilst entirely agreeing with those who say we cannot afford a "free" health service any longer, I want to be quite sure that any proposed alternative rectifies the present faults. Apart from any financial gain, we must ensure that any change does not induce us to "jump from the frying-pan into the fire."—I am, etc.,

London S.E.24. CYRIL JOSEPHS.

SIR,—Your editorial (3 July, p. 1) strikes a welcome note of realism amid the discordant cacophony of current medico-politics. In it you have dared to voice the opinion that even a full agreement on the Charter, including the matter of remuneration, will not cure the malaise from which general practice suffers to-day.

Much discussion of general practice in this country seems to be based on faulty premises which are accepted without any question. It is assumed that doctors are discouraged from entering general practice because of poor remuneration and bad working conditions; that these factors are responsible for the present discontent among established practitioners; that for the same reasons many are emigrating; that the coming of the N.H.S. is basically responsible for this current state of affairs.

How much truth is there in all this? I have shown elsewhere[1] that no more than one in three or four enter general practice because they have a positive desire to do so. The rest have had other ambitions but have failed to achieve them for one reason or another. The commonest motivation has been a desire to earn more money at an early age to support a wife and family. The N.H.S. has changed none of this, for the cult of early marriage has neutralized the effect of higher pay for trainee consultants. Increased remuneration may well tempt more into general practice, but they will be no less frustrated by it than their predecessors and will have an equal desire to be out of it.

Again, is there any evidence that emigration is higher among general practitioners than amongst consultants and research workers? Surely this is all part of the "brain drain" occurring in all professions and based on the vastly better economic prospects offered in other countries. There is no possibility that remuneration in this country can be raised to levels that would have any effect on this, a fact that must be accepted when planning for the next few decades.

The only way to make general practitioners happy in their work is to raise their status and to enable them to practise in a manner appropriate to a world of advancing science and technology. Recent speakers from abroad have told us how these ideals are being pursued elsewhere, and the College of General Practitioners has published a scheme for vocational training in general practice

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extending over a period similar to that now required for the training of consultants. All this is of much greater importance than the contents of the Charter but generates far less steam, since it largely concerns those who will come after us rather than ourselves.

One thing is certain ; there will be no real cure as long as general practice continues to be crippled by competition and inefficiency, resulting in a profligate waste of time and energy. Only when it is properly organized on similar lines to the consultant services will it be able to offer a satisfying and elevating career to those who follow it. The Charter can take us only a very short distance towards this goal, and it will be a disaster if the profession is led to think that it can solve the major problems of general practice to-day.—I am, etc.,

Margate. M. CURWEN.

REFERENCE

[1] Curwen, M., *J. Coll. gen. Practit.*, 1964, **7**, 38.

Future of S.H.M.O.s

SIR,—Since its inception the S.H.M.O. Group has kept pressing for recognition that many S.H.M.O.s were doing consultant work and were filling gaps due to low consultant establishment. The first acknowledgment of this was made in 1959 by the Whitley Council decision, M.D.B. Circular No. 41, which made a special salary award of £550 per annum to those S.H.M.O.s who were filling consultant posts and doing consultant work. This unfortunately split the S.H.M.O.s into two groups. Some who appear to merit the award were unsuccessful in their applications.

For several years there have been attempts to increase the S.H.M.O. salary scale to 80% of that of the consultants. This ultimately was accepted as B.M.A. policy and agreed by the Central Consultants and Specialists Committee and the Joint Consultants Committee. The Whitley Council did not accept that this was a matter within its terms of reference and recently it was turned down by the Review Body.

The implementation of the Platt Report on Hospital Medical Staffing under the terms of H.M.(64)94 has now produced further divisions of S.H.M.O.s:

(1) Those who were in receipt of the special award under M.D.B. Circular No. 41 and as a result of personal review have been upgraded (about 480*).

(2) Those in receipt of the special award who have not been upgraded (about 200*).

(3) Those who were not in receipt of the special award and who have not been given an opportunity of applying for personal review (about 1,200*).

The S.H.M.O. grade has been officially discontinued, but all S.H.M.O.s who have not been upgraded may retain on a personal basis their present salary scales and conditions of service as long as they remain in their present posts. These posts, however, in most cases will be downgraded to "assistant" posts. Those in receipt of the special award under M.D.B. Circular No 41 will retain this "so long as they continue to occupy the consultant post and to carry out consultant work for all or a substantial part of their time," H.M. (61)119, para. 30.

* These figures are very approximate.

Despite these assurances it is obvious that S.H.M.O.s who are not upgraded will incur a loss of status. They may retain their present salary scale and conditions of service and may still retain the title of S.H.M.O., but it appears fairly obvious that in many cases they will no longer be regarded by their colleagues as senior hospital medical staff. There is a further real danger that when hospital medical staff salaries are reviewed any award made may not include the S.H.M.O. scale. This view is supported by para. 19 of H.M.(64)94, which states: "S.H.M.O.s who retain on a personal basis their existing salary scales (with or without allowances) and conditions of service will, when their posts are regraded as medical assistant posts, have the opportunity of transferring to the scale and conditions of the medical assistant, if and when that scale overtakes their protected salary."

It appears to be the view of the Central Consultants and Specialists Committee that the conditions which have been approved for S.H.M.O.s not upgraded are just and adequate. In my opinion this is far from true and I would suggest that the S.H.M.O. Group should pursue the following points:

(1) Personal review for all S.H.M.O.s who so desire, with a view to assessment for upgrading to consultant status.

(2) An investigation of the criteria by which the various regional hospital boards' review committees based their decisions. This would appear to be justifiable, judging by the diversity of results of the different regional hospital boards.

(3) A national review appeals committee (as in Scotland) for those S.H.M.O.s who have not been upgraded by regional hospital boards after personal review.

(4) Retention of the S.H.M.O. grade as an integral part of hospital medical staffing as a temporary basis so long as any existing S.H.M.O.s remain in their present posts, with a proviso that no new appointment should be made into the grade during this interim period. This would safeguard:

(*a*) retention of senior hospital staff status, and

(*b*) inclusion of the S.H.M.O. salary scale in any salary award made to hospital medical staff during the interim period.

(5) Negotiations with the Review Body should be re-established regarding fixing a salary scale for S.H.M.O.s at 80% of the consultant scale. When this was last considered by the Review Body it decided that it saw no reason to link the two scales of these grades in any way and to depart from the previous recommendation of the Royal Commission so long as there was no evidence that the work and responsibilities of S.H.M.O.s had changed. It is in fact true that the work and responsibilities have not changed, but it also appears true that the Royal Commission did not in fact recognize and appreciate the work and responsibilities which S.H.M.O.s were undertaking. The extent of this consultant work and responsibility, which has for many years been undertaken by S.H.M.O.s, is well demonstrated by the recent reviews of consultant establishments undertaken in connexion with the implementation of the Platt Report. This has revealed a great shortage of consultants. Despite this the work has been done and it is reasonable to assume that it has been done largely by S.H.M.O.s.

(6) M.D.B. Circular No. 60, dated November, 1964, has discontinued the granting of any new allowances to S.H.M.O.s, which was originally sanctioned under M.D.B. Circular No. 41. In view of the shortage of consultants, which is likely to exist for some time, it is obvious that many S.H.M.O.s will still continue to be required to do consultant work. Attempts should therefore be made to permit further awards under the terms of M.D.B. Circular No. 41.

(7) Many S.H.M.O. posts are being recommended for downgrading to medical assistant posts and additional medical assistant posts are also being recommended. It appears that in some instances medical staff committees and regional consultant and specialist committees are being asked to approve these posts without having prior knowledge of the consultant establishments which have been approved by the Ministry of Health in their areas and regions. This is not in accordance with the safeguards which were agreed in connexion with the establishment of medical assistant posts, and it is hoped that the committees concerned will refuse to consider any such recommendations before they have all the necessary information.

I would further suggest that if the S.H.M.O. Group does not get support in these matters from the normal negotiating machinery—that is, from the Central Consultants and Specialists Committee and the Joint Consultants Committee—the Group should use other channels, such as direct approach to the British Medical Association Council or, if necessary, direct communication with the Minister of Health.—I am, etc.,

N. STRANG,
Chairman of the S.H.M.O. Group,
Newcastle Region.

Backache

SIR,—It has long been a favourite saying of mine that the discovery that the common cause of sciatica[1] and of pain in the back[2,3] is a disk lesion has done patients more harm than good. Mr. Dillwyn Evans (24 July, p. 222) shares this wry sentiment. However, the suggestion at the panel discussion at Swansea that we should go back to "fibrositis" (debunked in 1945) is a retrograde step that fills me with dismay.

Though there may prove to be some reassurance to the patient in the return to this term, there is great danger to doctors. As it is, "treatment" of backache at many centres degenerates into measures applied to the muscles (heat, massage, exercises) even after a diagnosis of an articular lesion has been made by the prescriber. If we are to go back to "fibrositis," all hope that backache will eventually be treated rationally fades. This is an important matter ; for the millions of patient-hours and the thousands of physiotherapist-hours wasted annually present the N.H.S. with a huge bill for which it gets no return. Meanwhile, lay manipulators cash in.—I am, etc.,

London W.1. JAMES CYRIAX.

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"Kiss of Life"

SIR,—Is it too late to expunge that wretched expression "the kiss of life" from our language ? It is most unpleasant that the necessary physical contact for an urgent therapeutic procedure should be associated with an act of affection, in order to try and induce a sense of drama.

No doctor would ever use the phrase, and one wonders if it has been taken up in any other language.—I am, etc.,

Northampton. E. E. T. TAYLOR.

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