The most productive screening method is clearly information from the heroin users themselves. However, for this to be a feasible method a community-centred treatment unit is needed. Without such a unit and a nucleus of local users in treatment we would not have been able to exploit this method effectively.

Each screening method on its own has a limited value. In order to detect the maximum number of early cases all of them should be used concurrently. A built-in check on the information obtained is provided if this procedure is followed. If we were to recommend one technique that would give the maximum information for an initial assessment of the extent of heroin use in a given population, we should suggest the combined use of jaundice and casualty (amphetamine) surveys. These are simple to carry out, they allow the investigator to estimate the time of the occurrence in his population, and they provide independent and objective medical indicators of heroin use in young people.

Summary

A survey to estimate the prevalence of heroin abuse in young people in Crawley New Town showed that 8.50 per thousand boys and girls and 14.75 per thousand boys in the age group 15–20 were "confirmed" users.

Five methods of population screening were used. Each has been evaluated in terms of its efficiency as an early detector of heroin abuse. Normal channels of referral to the psychiatrist for treatment of heroin abuse are shown to be inefficient, and it appears that more patients could be brought into treatment earlier by using the screening methods described. It is suggested that hepatitis and amphetamine overdoses in young people are useful early indicators of possible heroin abuse.

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WINCHESTER ADDRESS

Sir Bruce Fraser on "The Doctor and the Administrator"

The fourteenth Winchester Address was given by Sir Bruce Fraser in the New Hall of Winchester College on 23 May. Sir Bruce was Permanent Secretary to the Ministry of Health from 1960 to 1964. Below we print extended extracts from his address.

"Let me plunge straight into my central theme and say that the most important thing which doctors and administrators have in common is the desire to serve. I know that this sounds trite and priggish, but I am not going to be frightened off saying it again—the desire to serve. That can include of course the desire to excel, the desire to make changes, and the desire to give leadership. Nothing is worth while which gives no scope for those. What it does not include is the desire to dominate: that may be all right in some walks of life—though I think very few—but it is usually fatal to good medicine or good administration. Let us not be afraid of clichés here. If we say that a doctor wants 'to serve the cause of suffering humanity,' or that an administrator wants 'to serve the public interest,' we are apt to put these phrases in inverted commas to show that we are much too sophisticated to be taken in by them. But why should we not admit to ourselves when we are in the Palace of Truth—in front of our shaving-mirrors, shall we say, or even in the Hall of Winchester College—that these things are exactly what we do want to do? A doctor or an administrator without the desire to serve is in the wrong profession.

"Political considerations have, or ought to have, comparatively little effect on the doctor—I mean national politics, not medical politics. Whatever his own political views, he can flourish professionally under many different forms of government—even under a mild dictatorship. It is only when dictatorship seeks to control professional standards, methods, or ethics, or denies full scope to scientific truth, that the profession needs to rebel. I am over-simplifying, I know, because in our democracy, which is very far from a dictatorship, politics have entered, and quite properly entered, into many matters of concern to the profession, such as prescription charges and private practice. But I think I can illustrate the point in general by inviting you to consider the 10 men who have been Ministers of Health since the war. If doctors of all political views were to elect the best three by ballot, I think it would be found that not all the three were of the same political party, not all now alive, and not all now out of office.

"The administrator is not only more concerned than the doctor with political considerations; he must also, in a democracy, be more responsible to public opinion, which is not the irrelevant mumbling of his inferiors but the voice of his ultimate masters, whose money he accepts and whose interests he serves. He also has to live with the fact that those masters are hard to please, and that the rewards which success may bring him will never include popular acclaim. Doctors stand very high in public esteem; in a recent opinion poll they came second only to nurses in the list of praiseworthy occupations. Administrators came nowhere—literally nowhere, for no one even mentioned them.

"For my part, I think this is absolutely right. It is healthy that people in general—and the press too—should be critical of their *fonctionnaires*, even unfairly critical, provided of course that the criticism is not malicious or deliberately tendentious. Such an attitude keeps the administrator on his toes and thus actually increases the effectiveness of his service to the community. It is equally desirable that people in general should hold doctors in high regard, both individually and collectively. For the patient's confidence in his doctor is a very valuable factor both in diagnosis and in therapy, and the potential patient's confidence in doctors collectively is important to the success of preventive medicine, immunology, and prophylaxis. So the doctor's high place in public esteem, no less than the administrator's low place, actually increases the effectiveness of his service to the community. . . .

Are Doctors Over-administered

"I do not think it can be said that the medical profession, or the National Health Service as a whole, is over-administered. Not every doctor would agree with me, but I think it is if anything under-administered. I mean by this that in all areas of the Service, and not only where doctors are responsible, performance could be more efficient, progress more rapid and more sure-footed, if individual effort (which fortunately abounds) were more consistently supported by co-ordinated thinking and planning, by more attention to statistical research, and by more administrative experiment. The great benefits which lively and inventive administration could bring

have been neither appreciated clearly enough nor sought eagerly enough.

"This is partly due to the fact that 20 years ago there was a real fear, in the medical profession and elsewhere, that the creation of the Service would stifle clinical freedom and individual independence in a cocoon of red tape: as a result doctors were suspicious of administrative initiative from the centre and administrators were nervous about attempting it. At the start both attitudes were certainly natural and probably right; as time has gone on they have become increasingly outmoded, and, I am glad to say, steadily weaker. There will always be a danger that the doctor will take as mere officiousness what is really creative helpfulness, and that the administrator will take as mere obstruction what is really healthy scepticism. There are two other dangers for the administrator—firstly, that he will imagine he is being useful when he is merely being busy; and, secondly, that he will be too scared of the doctors to do his job properly. Both these dangers are very real and apply *mutatis mutandis* to many fields of administration other than the Health Service.

Reform of the Pool

"Nothing was ever more meticulously founded on agreement with the profession, both in principle and in detail, than the pool system of general practitioners' remuneration. Every provision had been accepted by their accredited representatives; many they had themselves warmly advocated to the Pilkington Royal Commission or strenuously insisted on in negotiations with the Ministry. This extended to the provision whereby practice expenses were reimbursed in full to general practitioners as a whole but reimbursed unselectively, so that those who spent less than the average got too much back and the rest too little. This was undoubtedly unfair and was not conducive to practice efficiency. An attempt to put it right, not by reducing any of the overpayments, but by giving to the underpaid the lion's share of the next pay increase, nearly led to a revolution. Before long the profession was loudly condemning, without hesitation or discomfort, without qualification or compunction, nearly everything that they had themselves previously advocated, and was insisting on many quite new principles such as the conversion of general practitioners into an overtime class. All this may be quite right; it is certainly a striking lesson in how unexpected may be the consequences of an attempt at evolutionary reform.

"The collective view of the profession was against prescription charges until 1964. Then, by an odd coincidence, it was reversed in favour of keeping them, just when a party pledged to their abolition seemed likely to win the next general election. The new Government abolished them, then decided to restore them with wide exceptions; and the profession must have been sorely perplexed, uncertain whether to oppose the charges or the exceptions, or both. It is as if a chameleon found himself first on a red pillar box, then on a green billiard table, and then on a piece of Fraser tartan.

"I am not sure that the profession was at its best when it successfully resisted in 1956 proposed restrictions on the prescribing of heroin; or when it urged during the 1950s that the profession was in danger of getting overcrowded and that the medical schools should reduce their intake. Fortunately the policy of reducing intake was never fully implemented and was reversed, in my view rightly, without formal consultation with the profession. Some people hold that what we suffer from is not so much a shortage of doctors as an excess of patients. I see the point but will not argue it. Fortunately we do not suffer, and never have suffered, from a shortage of *aspiring* doctors. It is places in medical schools, not candidates for those places, which have been in short supply.

"But there is one very important exception to what I have been saying. The profession has never yet let itself down when thinking collectively about professional ethics. Its record here is entirely beyond reproach in its consistent adherence to the highest standards, and it has never had reason to fear any pressure from outside to lower them. Recent developments in life-supporting machines and what is called 'spare-part surgery' have set the profession some very difficult ethical problems of an entirely novel kind.

"Some of what I have been saying may have seemed unduly critical of some sections of the medical profession, or of some of its attitudes; worse still, I may have seemed to glorify the administrator and his role without stressing sufficiently that in playing his role he is at least as likely as the doctor to muff his lines or forget his characterization. I want to assure you as eloquently as I can, indeed more eloquently than I can, that this is by no means my intention. For a man addressing a captive audience, under B.M.A. auspices, to deliver a diatribe against doctors would be both cowardly and discourteous, and in dealing with the medical profession there are few people who have less reason than I for either cowardice or discourtesy. This is not only because I happen to owe a great deal to the doctors who have looked after me and my family. It is because my official duties used to bring me into close contact with the profession, both its leaders and its rank and file; and during that happy time—certainly the happiest years of my life—I not only made many medical friends but also received a stern and fascinating education, which taught me two things above all.

Two Revolutions in Medicine

"Firstly, an immense respect for the profession. To the layman they could certainly seem exasperating, particularly in their conservation. But even the layman must admit that the medical profession has successfully undergone two different and simultaneous revolutions in the last 25 years, an organizational revolution and a scientific revolution; and that on the scientific side they are very far from hidebound. Indeed, the general practitioner tends if anything to be too ready, rather than not ready enough, to assume that every newly marketed drug is better than anything previously available. There may well be some things in the profession's record over recent years which they themselves might have wished better; if so, it is they who have the best right to say so. There is certainly much more which must command profound admiration from the laity in general; and from a layman who has been as close to them as I have the admiration is, I assure you, the more profound for not being unwary.

"Secondly, I was taught what a lot I had to be humble about. I learnt—and, as compared with anything I had known before, it was almost like learning a new dimension—what an enormous contribution the administrator ought to be making, what a lot of improvement was needed, how much of it could never happen unless he identified the goal and found the right path to it and joined hands with others in pressing resolutely along it. And I learnt that, in my case at least, this is much easier said than done. The further I stumbled among the foothills the wider became the vista of mountain ranges unscaled and indeed unmapped. For any administrator in a worth-while job—and mine was pre-eminently that—it becomes obligatory as time goes on to lay more and more stress, not on what has been done, but on how much is still to do.

How Doctors Differ from Laymen

"I have stressed some of the similarities which exist between the doctor and the administrator, and between their respective ideals and difficulties, because I think they are sometimes inadequately recognized. But I have marked some of the differences too, and I would not have you think that I underestimate them or consider that they ought not to exist. On the contrary, the doctor's power to serve depends precisely and peculiarly on the difference which marks him off from the layman, and on his unwavering consciousness of that difference—his scientific training, his medical experience, and his Hippocratic oath. I would say in this context, quite as enthusiastically as in any other, *Vive la différence!*

"But this would be an unconstructive plea with which to end. To identify similarities and differences between doctors and administrators is not nearly as useful as to urge their co-operation. I have expressed my admiration for doctors who are also administrators, who demonstrate that the two skills, the two different motives for service, can fruitfully co-exist in the same man. But only relatively few administrative doctors are needed, and, though I have urged that clinicians should themselves do more administration, I certainly am not pleading that they should spend a high proportion of their time away from the patients for this purpose. No, my plea rather is for more co-operation between doctors and administrators, for mutual trust and understanding, and, above all, real friendliness, the sort of friendliness which is not damaged, but rather strengthened, by a bit of mutual criticism and even leg-pulling. I know that such co-operation can work, for I have seen it working. But I know too that it is not as close or as widespread as it might be. So my final word is *Vive la différence!*—yes, but even more important, *Vive la compagnie!*