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THE WHITE PAPER

MASS MEETING OF LONDON PRACTITIONERS

ADDRESS BY DR. CHARLES HILL

A general meeting of the Metropolitan Counties Branch of the British Medical Association was held in the Great Hall, B.M.A. House, Tavistock Square, on Sunday afternoon, March 5, when Dr. Charles Hill, the newly appointed Secretary of the Association, gave an address on the White Paper. Sir CRISP ENGLISH, president of the Branch, was in the chair, and there was an overflowing attendance of approximately 1,200, many standing throughout the two hours' proceedings.

Dr. HILL, who was warmly greeted on his first public appearance after his appointment, said that the starting-point of the present discussions was the Beveridge report with its Assumption B. The White Paper was the Government's first thoughts in translating that Assumption into action. It was the Government's stated intention to provide a comprehensive service for all who wanted it, irrespective of income limit. The proposed service was not to be restricted to "those who need it." He then proceeded to give a summary of the White Paper—the administrative structure, the hospital and consultant services, the general practitioner set-up, and the clinic and other services. He believed that the general reaction of the profession would be that the Principles set out in the section headed "Principles" in the general summary—the three "freedoms" mentioned there—were worthy of full support, but the real test would be the extent to which those freedoms found expression in the administrative machinery and arrangements. Whenever he spoke of Principles it would be to the freedoms in the section headed "Principles" on page 47 of the White Paper to which he referred—namely: (1) Freedom for people to use or not to use these facilities at their own wish; no compulsion into the new service, either for patient or for doctor; no interference with the making of private arrangements at private cost, if anyone still prefers to do so. (2) Freedom for people to choose their own medical advisers under the new arrangements as much as they do now; and to continue with their present advisers, if they wish, when the latter take part in the new arrangements. (3) Freedom for the doctor to pursue his professional methods in his own individual way, and not to be subject to outside clinical interference. (4) The personal doctor–patient relationship to be preserved, and the whole service founded on the "family doctor" idea.

Comprehensiveness—But Not at the Top

The proposal for a corporate body was not accepted by the Government. But whereas comprehensiveness was preached in all other directions, there was no comprehensiveness at the centre, and the medical services of the Government would remain distributed among a multitude of Departments. He wished as much courage had been shown in dealing with the internal as with the external structure.

An advisory body, the Central Health Services Council, was to be set up, and to this, it was clear, the Government attached considerable importance. But it had been wisely said of advisory bodies that "many were chosen, but few were called." The council, of both medical and lay members, would be appointed by the Minister, not specifically elected for the purpose by the professional organizations, which was wrong. Another cause of misgiving was the non-acceptance by the Government of the view that this body should be free to publish its own report and to comment on draft regulations.

At the periphery, instead of the fundamental recasting of local government which had been hoped for, there was a compromise. There would be not fewer local authorities, but more. It was clearly desirable that hospital services should be dealt with regionally, but it was regrettable that in creating this new type of body, the Joint Authority, the Government had been unwilling to dilute the democratic principle by including, in the public interest, some non-elected professional and expert members. There were to be local advisory bodies on a statutory basis, but apparently the co-option of non-elected members on committees of the Joint Boards was not favoured. More would be heard on this point.

On administration as a whole he was tempted to say that the arrangements split the profession into four groups: general practitioners in "separate" practice; general practitioners in Health Centre practice; consultants appointed by voluntary hospitals; and consultants appointed by local authorities. There was also a group whose position must be viewed with considerable anxiety—namely, their public health service colleagues.

Health Centres: Some Misgivings

To pass to general practice, still in critical vein. So far as "separate" practice was concerned, the changes from the existing order were not substantial. In Health Centre practice they were considerable. The Association had urged that Health Centres should be initiated for a period of experiment with a view to discovering the right type of group practice for the future. This might be: (1) the "Dawson" centre, with general practitioner beds of cottage hospital type; (2) the diagnostic centre, concentrating on special methods of investigation, and possibly treatment; (3) the true health centre, in which both preventive and curative services were integrated; or (4) the communal surgery. It was clear that it was the fourth and least advanced of these types which was adopted in the White Paper. As matters stood there would be no guarantee of genuine experimentation unless the Minister determined, in a way hitherto unknown in Ministers, to bring his influence to bear on authorities submitting schemes to him.

Dr. Hill also reminded his audience that the establishment of Health Centres, with compensation for loss of selling value of practices to doctors transferring to such centres, would immediately affect the capital value of all general practices in this country. Men entering their profession would be faced with the alternative of buying a practice or entering a Health Centre, where nothing had to be paid, and the dilemma of most of them on that issue would be solved quite speedily. The number of buyers would fall and the capital value of all practices would deteriorate. This immediately brought up the whole question of the desirability of continuing the custom of buying and selling practices and of wholesale compensation for loss of capital value.

An Authoritarian Touch

When practitioners participated in group practice in Health Centres remuneration was to be "by salary or similar alternative." The Government would need to be converted on that issue. He saw nothing inconsistent with group practice in continuing a method of remuneration within the Health Centre which bore relation to the amount of work done or responsibility accepted. On the whole there was much that was sound and attractive in the Health Centre conception, but their attitude must be tinged with caution lest a form of Health Centre, without sufficient experiment, be pushed by those who sought in the long run not Health Centres but a particular form of salaried employment under local authorities. ("Hear, hear.") Care must be taken that this was not the thin end of the wedge.

Two things made him suspicious (and an attitude of suspicion was a natural one on this eve of change). The Central Medical Board's consent was necessary before new practitioners could participate in the service or existing practitioners start in new areas. The argument was that practitioners must be prevented from going to areas already sufficiently staffed. There might be a case to be

made out for that contention, but the White Paper went on to advocate the general position that such approval must be given to every practitioner desiring to enter the public service. The Central Medical Board would act under the general direction of the Minister. It was admittedly a civil service structure and would be an integral part of Whitehall administration.

Again, of all the phrases in this Paper—a Paper well written and persuasively argued—one that stood out, without any argument being advanced for it, was that the Central Medical Board should have power to require newly qualified doctors to give full time to the public service in their early years if necessary. When this war was over they wanted as citizens to be rid of civil direction and conscription, and, anticipating the verdict of the profession as a whole, the Association was not prepared to accept this measure of civil direction and conscription in relation not only to those young men who desired to enter the public service but to every newly qualified practitioner. (Applause.)

"It can be inferred that by administrative procedure under control of a quasi-corporate body of civil service structure—even though a majority of its members are doctors—bit by bit there can be introduced, insensibly and imperceptibly, the one thing to which we are fundamentally opposed—a whole-time salaried service under central or local government. In a leading article in the *Journal* it was stated that there was 'more than a hint here of authoritarianism'—a masterpiece of understatement. We are determined not only not to have that kind of service now, but to watch for any procedure by which it might be insidiously introduced. (Renewed applause.) There was some reason to fear at one time that this White Paper might propose a whole-time service method. For such blessings as we have already received let us be truly thankful. We can approach this report with a sense of immediate relief, but if we couple with that a determination to scrutinize every possible tendency in this direction we shall be doing no more than our job." ("Hear, hear.")

One crucial thing was not dealt with in the White Paper—namely, the machinery by which the doctor could pick out the person genuinely desirous of coming privately. Scrupulous care would be necessary to evolve a procedure which would avoid abuse and permit private practice to continue as the public desired it. On the consultant side it must be secured that those who of their own free will decided not to go into the general wards—which was their right—but to obtain their consultant service privately, should be regarded as having placed themselves outside the scheme both for treatment and for accommodation and amenities. If there was to be any chance of consultants continuing successfully on a part-time basis their position in relation to treatment in private wards must be secured.

Passing of Contributory Schemes

Contributory schemes as they had been known hitherto would have no place in the financing of voluntary hospitals in the future. If every citizen was granted free hospital treatment when he needed it the contributory scheme as an organization of insurance would go. The hospital, to remain voluntary, must in part finance itself, yet it would have lost, perhaps to be replaced by Government grant, the contributory source of its income. It would be thrown back on the old methods of public appeal unrelated to services rendered. It was wrong that these hospitals were not given a proper place in the proposed administrative or advisory procedure. The Joint Board, owning the local authority hospitals, would naturally have a particular pride in their development, with obvious results.

In summing up, Dr. Hill said that until the publication of the White Paper the profession was divided into two groups: the majority wholly opposed to a particular form of employment of the medical profession under the State, and a minority in favour of a State salaried medical service. Such controversies had now less relevance than in the past. The crucial document was the White Paper. The Principles of the White Paper as set out in the section headed "Principles" in the summary on page 47 of the main Paper were such as the profession could accept; *it was in the translation of those Principles into detail that they would have much of profound importance to say.*

"Rightly or wrongly, well or badly advised, the public is seeking what we ourselves have sought for many years—an elaboration of our medical services. You may think, as I do, that it is a pity that we should be called on to devote our thought and time to this subject when we are approaching the critical stage in the bloodiest war in history. But we must face the reality of the situation—that a scheme has been put forward. There are grave omissions from the scheme. There is insufficient regard to the fact that the country's health depends more on housing, nutrition, education, and so forth, than on doctoring. There is not enough recognition of the governing fact of insufficient personnel in the medical profession, both now and after the war; also of the fact that the service of the medical profession to the community is conditioned by medical knowledge. Why does not the White Paper attach itself to much more generous Governmental aid for medical research? But the Principles in this White Paper are principles we can accept. We want those Principles—those freedoms—to permeate the discussions and govern the negotiations which are to follow."

The present time was one for studying the White Paper. This period of study came before the stage of policy-making. At no time did the profession stand in greater need of leadership, and that leadership would be provided by the British Medical Association. But the Association wanted to be the leader of an informed profession, not of the scattered cohorts of individualists who, while honestly expressing their views, did not join in the team activities of the profession as a whole.

These were but preliminary reactions. There was more to be learned of what the Government meant, and more to be conveyed to the Government of what the profession meant with a view to the elaboration of a policy which would be in the best interests of the public and enable the profession in the best way to realize its ideals of service. (Loud applause.)

Many Questions

At the conclusion of his address Dr. Hill was occupied for an hour in answering written questions which were sent up from the floor. (The first communication to reach the platform was from Sir Wilson Jameson, Chief Medical Officer of the Ministry of Health, who was present at the meeting, and sent up not a question but a request, in view of the virulent smallpox outbreak at Mount Vernon Hospital, that practitioners should keep in mind during the next few weeks the possibility of an extension of the outbreak, and, where necessary, take advantage of the assistance offered by local medical officers of health, the L.C.C., and the Ministry of Health.)

The first question was whether there was any justification in the White Paper for the inference that the doctor's salary would be £500 a year. Dr. Hill said that he did not take too seriously the calculations attached to White Papers. His own calculations had resulted in a more optimistic figure as the average salary. But he suggested that the amount of remuneration was one for later consideration. Principles came before pay.

On several questions relating to Health Centres he said that the worst possible service would be to encourage the creation of more and more "out-patient departments," with their crowded waiting-rooms. If he wished the new service ill, and to preserve private practice for private gain, he would be tempted to advocate the type of Health Centre—the communal surgery—which figured in the White Paper. It would be a fraud on the public to represent that as a real advance.

Asked whether privacy in hospital should be dependent on the financial position of the patient, he said that, putting aside certain cases which demanded privacy on account of the clinical condition, there were, after all, differences of income in this world, and so long as that state of society existed it was reasonable that those who could pay for such amenities should have them, provided always that the quality of the service was the same. And no one had ever contended that medical men varied their service according to whether it was rendered in a public or a private ward.

In reply to another inquirer he said that the question whether, provided fair compensation was paid, the custom of buying and selling practices should be allowed to disappear was one on which the opinion of the profession was being sought in the questionary which, along with the White Paper itself, and an analysis of it, would be issued to every member of the profession within the next few days.

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One questioner was anxious about the possible exercise of political influence in the control of the service locally. Dr. Hill replied that no assurance could be given in that respect except that the final approval of local authority schemes rested with the Minister, who would be responsible to Parliament for the service. The profession looked to Sir Wilson Jameson to do his best to secure that sound medical opinion was faithfully represented and patiently heard in that Ministry.

A phrase in the White Paper which interested one questioner was "salary or similar alternative" as the form of remuneration for those who participated in group practice in Health Centres. Dr. Hill said this looked like salary and nothing else. It might mean salary plus a capitation element, or that the capitation fees received in the group practice were aggregated and shared among the doctors according to a scheme approved by themselves. He hoped that it would be possible to give the words "similar alternative" a much wider interpretation or the salary notion dropped.

In answer to another inquirer he said the White Paper, like the Beveridge report, seemed to be firmly based on the "free for all who want it" principle. He agreed, in reply to another question, that it would be necessary very closely to scrutinize the contractual obligation into which the Health Centre doctor entered with the county or county borough council (the Central Medical Board being a third contracting party).

One question handed up read: "Is not the much-publicized freedom of the doctor to remain outside the service illusory?" to which Dr. Hill replied: "Of course it is. In a service which provides for the whole community how can more than a few remain outside? But I do imagine that the scheme may permit in some areas of one member of a partnership staying outside while another partner enters the service."

"Can consultants doing part-time work expect a pension?" to which the answer was: "They can expect anything they like; but the White Paper recognizes the possibility of discussions between the profession and the Government on a superannuation-for-all basis. It would be easier to introduce a scheme in relation to consultants than to general practitioners, because it is easier to attach a pension scheme to a fixed salary, even a part-time one, than to the fluctuating emoluments from capitation arrangements."

In reply to another question Dr. Hill said that if the medical profession really desired a salaried service and showed that desire in the independent questionary about to be conducted, that would guide the policy adopted by the Association. But, as he saw the issue, the young men in the profession, particularly those who had been in the Forces, would have had enough of regimentation and would desire the freedom which the profession had hitherto enjoyed.

Someone else wanted to know whether there would be any restriction on osteopathic and other forms of unqualified practice. Dr. Hill said that the public policy had been to distinguish between those who were qualified and those who were not and leave the public to choose, but if private practice as it was desired by the public was discouraged by the Government, clearly those people who must do something different from the rest would be thrown into the arms of unqualified practitioners.

Dr. E. A. GREGG, in moving a vote of thanks to the speaker of the afternoon, congratulated Dr. Hill on his appointment as Secretary, and the Association on having him as its spokesman.

The gathering then dispersed. It was probably the largest meeting of London practitioners since the introduction of the National Health Insurance Act.

WHITE PAPER ABSTRACTED

The second of a series of abstracts of certain parts of the White Paper. The first appeared last week at page 37.

(2) THE NEW JOINT AUTHORITIES

Under the proposals in the White Paper local government is not superseded, it is enlarged. The new health services will be planned—and, so far as the hospitals and associated services are concerned, administered also—by authorities covering areas of the country large enough to ensure:

(1) That the population and financial resources of the area are sufficient for the provision of the services on an efficient and economical basis.

(2) That the provision can be viewed as a single problem, blending town and country requirements.

(3) That there are available within the area the full range and variety of services, or all but the most unusual of them. (A few highly specialized services may be the subject of an inter-area arrangement).

The majority of present areas—counties and county boroughs—are too restricted to achieve these ends.

There are three ways of securing local administration of enlarged areas. The first is by setting up a directly elected body for the sole purpose of administering the health service. This is open to the objection that a one-purpose authority might not arouse sufficient interest among voters: moreover, it would create, if generalized over all social services, an impossible complexity of separate authorities with separate functions.

The second is by establishing a directly elected body for administration of a group of services—for example, education, public assistance, and police—as well as health. This would mean a major alteration in the structure of local government and would have to be preceded by a comprehensive inquiry and by legislation. "The machinery of the new health service cannot await this long-term policy."

The third is to secure joint action by means of a combination of existing counties and county boroughs for this purpose. This last method is the one chosen by the Government. It is open to some objections, but the answer is that the "need to settle areas of proper size and resources for certain aspects of the health service is urgent."

Combinations of Existing Authorities

County and county borough councils will be combined over convenient—but by no means necessarily uniform—areas, and Joint Boards will be formed:

(1) To administer hospitals and associated services,[1] and

(2) To plan the entire comprehensive service for the area, some parts of which, in addition to hospitals, may be administered by the Joint Authority itself, and others by the county or county borough councils separately.

A few areas, of which the County of London is the most obvious example, may well continue to function as single units; in other cases the unit may be the geographical county—that is to say, the administrative county plus the county boroughs; in others again two or three small counties may be joined together.

The boundaries of the area will be settled by the Minister after consultation with local interests. The members of the new Joint Boards will be members of their constituent councils. There is no provision for non-elected members, nor for committees of the authority to which such members might be co-opted. The Joint Authorities will own and administer the existing municipal and county hospitals and will be in contract with the voluntary hospitals. Isolation hospitals, which in the counties are now mostly administered by minor authorities, will be transferred to the new Joint Boards and form part of the general hospital system.

Programme for the Joint Boards

No branch of the health services will be excluded from the new Joint Boards. They will examine the health needs of their areas and after due consultation will submit a plan to the Minister, including proposals as to the exact allocation of responsibility for providing the various services covered. They will assess in detail the hospital needs of their area and the resources available, and work out arrangements adapting and supplementing existing resources. The aim will be to obtain a complete hospital and consultant service, partly by the direct provisions of the boards themselves, and partly by arrangement with voluntary hospitals.

They will consider also the needs of general medical practice and provide for the linking of general practitioners with hospital, consultant, and other services. The practitioner's contract is with the central body, the Central Medical Board, but the Joint Boards will be responsible for ensuring that all the services in the area are fully open to the participating practitioners. Finally, the Joint Boards will plan the services which are appropriately given in clinics, such as maternity and child welfare, or by domiciliary arrangement, such as midwifery and home nursing. In some cases the boards will themselves provide and administer these clinic services; in others they will allocate them to their constituent county and county borough councils; there will be no hard-and-fast rule.

In all that they do the boards will be advised by Local Health Services Councils, the reproduction locally of the consultative machinery proposed for central administration.

Next week: *Professional Guidance in Local Organization.*

1 "Associated services" include tuberculosis, venereal diseases, mental, and cancer services, etc., which are of the nature of hospital extension or out-patient activity.

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GENERAL MEDICAL COUNCIL

SPECIAL INTERIM SESSION

A special session of the General Medical Council was opened on Feb. 29 under the presidency of Sir HERBERT EASON, mainly for the purpose of hearing two disciplinary cases, one of them the re-hearing of the case which has become widely known, consequent upon appeal proceedings up to the House of Lords, as the Spackman case.

A new member, Dr. Myles Keogh, representative of the Apothecaries' Hall of Ireland, was introduced and took his seat.

The Council considered in the absence of the respondent the case of Malcolm MacLean, registered as of Lawrence Street, Glasgow, against whom it had been found at a previous session that he had been convicted in 1941 of driving a car while under the influence of drink. The Council decided not to erase Dr. MacLean's name.

Charge of Assisting Men to Evade Military Service

The Council considered the case of David Davidson, registered as of Mile End Road, London, who was summoned on two charges of having assisted and conspired with others to assist men called up for military service to evade their liability by simulating epilepsy. The complainants, the Ministry of Labour and National Service, were represented by Mr. Gerald Howard, counsel, and the respondent by Mr. T. F. Davis, counsel, instructed by Bulcraig and Davis, solicitors.

Mr. Gerald Howard said that originally five cases were brought against this practitioner, but three of them had been dropped. The first of the two remaining cases concerned a man aged 29, who in the proceedings was called "E. F." In Feb., 1940, "E. F." met a man named Bloom, one of the persons with whom Dr. Davidson was charged with conspiring, who told him that for a certain sum of money he could procure his exemption from the military service for which he was shortly to be liable. "E. F." thereupon paid Bloom £175, and in April, 1940, Bloom took him to the corner of a street in London, where Dr. Davidson met him in a car and in the course of ten minutes' conversation in the vehicle told him that he was about to take him to see a specialist as a supposed epileptic, and instructed him what he should do in the presence of the specialist to simulate the symptoms of epilepsy, also that he should tell the specialist that he had suffered from fits for some years. The doctor then took him to Dr. Rowland Hill, to whom he repeated what Dr. Davidson instructed him to say. He was given a certificate by Dr. Rowland Hill stating that he was quite free from any signs of cerebral tumour and in excellent bodily health, that his epilepsy was the form seen in quite healthy people, but that it would need a long time of treatment—perhaps some years—before the slight mental dullness improved. At his medical board he produced this certificate, and Dr. Davidson himself wrote to the deputy chairman of the medical board stating that he had attended "E. F." professionally during the last five years for epilepsy, and that he had seen him at least four times in a true epileptic fit (grand mal). Eventually the board put him in Grade 4, but on some of the facts coming to light he was re-examined five months later and passed in Grade 1.

The second case, relating to "G. H.," aged 28, was somewhat similar. "G. H." collected £300, and gave it to one of three men (one of them Bloom) whose names were mentioned with Dr. Davidson's in the charge of conspiracy. Bloom introduced Dr. Davidson to "G. H.," and instructed him how to feign symptoms of epilepsy. Dr. Davidson subsequently took him to a specialist, Dr. Blake Pritchard, who, as a result of what Dr. Davidson said to him and of his examination of the man himself, who was simulating epilepsy under Dr. Davidson's instructions, wrote the history as recounted by the man, and added that there was nothing to suggest that his paroxysmal disturbances of migraine and epilepsy were due to any structural change inside his skull. As symptomatic treatment he suggested that he should have 1 gr. luminal in the morning and a capsule of epanutin in the evening. The charge against Dr. Davidson was that the statements he had made to Dr. Blake Pritchard, as a consequence of which he wrote the letter, were to his knowledge untrue. As a result of the certificate "G. H." was put in Grade 4 by the medical board, and seven months later was re-examined and placed in Grade 1.

Both men gave evidence. "E. F.," now a lance-corporal, said that when he first met Dr. Davidson in the car he asked him some questions about his life in general, and then told him he was taking him to see a specialist and that he should "act quiet." As instructed, he told the specialist that he had had fainting fits, incontinence, and other symptoms. He had previously been attended by a doctor (not Dr. Davidson) for "migraine and things like that." He did not know whether it was Bloom or Dr. Davidson who told him to wear a disk round his neck bearing the words, "Suffers from epileptic fits." He did not pay anything to Dr. Davidson. In cross-examination he agreed that at that time he was prepared to deceive anybody to achieve exemption. He denied defending counsel's suggestion that Dr. Davidson had attended him previously. Asked how he came to be re-examined, he said that, feeling very unhappy about the whole business, he went to Scotland Yard.

"G. H.," a bombardier, said that he was informed by Dr. Davidson or by Bloom what to say to Dr. Blake Pritchard. He himself had wanted to get into the Army, but his family had been anxious that he should remain in civil life. Asked how he came to tell Dr. Pritchard that he had had fits for some time, he said that he was told by Dr. Davidson or by Bloom what to say. After he had been graded 4 by the medical board he went to see Dr. Davidson and told him that he wanted to get into the Army, but the doctor said that in view of his exemption it was impossible for him to get in, and he could do nothing for him. In cross-examination it was suggested to him that he himself had approached Dr. Davidson and had said that he would like to have a specialist opinion on his condition, but he said that that was not his suggestion. He agreed that he had told Dr. Pritchard that he had had sick headaches for as long as he could remember. It was Bloom, not Davidson, who coached him in the simulation of epilepsy.

Dr. Davidson, giving evidence in his own defence, said that he had formerly practised in the East End of London, and later at Totteridge. At the outbreak of war he offered his services to the military authorities, and until he was called up for the R.A.M.C. in May, 1942, he served in the Home Guard. After joining up he was sent to North Africa, and, anticipating that he might be away for years and that his London practice would not be resumed, his wife sent away all his record papers in a salvage drive. He had seen "E. F." several times before these events, having been called in to see him by his brother, and on one occasion at least he was recovering from a fit. His brother and mother were anxious about him because there had been a case of cerebral tumour in the family. It was for that reason he decided to take him to Dr. Rowland Hill, to whom he gave an outline of the case so far as he knew it, and Dr. Hill saw the case with him. Dr. Hill was paid three guineas by the man himself, and he (Dr. Davidson) was paid half a guinea for accompanying him. He had never received any money from Bloom. He thought that "G. H." also was a case for a neurological opinion. All he received in that case was half a guinea for accompanying the man to see the specialist, and 4s. 6d. when he attended later at his surgery. He was cross-examined concerning the absence of his records, but said that his practice when he joined up and went abroad amounted to very little; any purchaser would have had to start afresh, as he himself would have done. He agreed that he made no inquiries as to previous medical attendance on these young men, but he had attended one of them ("E. F.") on previous occasions. He admitted that he told Dr. Rowland Hill that "E. F." had epilepsy, and that what he had said largely influenced Dr. Hill. "It is plain to you," asked Mr. Howard, "that if your story is true the stories of 'E. F.' and 'G. H.' are totally false?" to which he replied "Yes."

After consideration *in camera* the Council found that the facts in the case of "E. F." and certain of the facts in the case of "G. H." were proved. In relation to the facts so found the Council judged Dr. Davidson to have been guilty of infamous conduct in a professional respect and instructed the Registrar to erase his name from the *Medical Register*.

Correspondence

The White Paper

SIR,—There are two points which I hope doctors will keep in mind in their discussions regarding the above. The first is that it would be grossly unfair to restrict the use of Health Centres to practitioners prepared to accept a salary and avoid competition with their fellows. As it stands the White Paper is heavily weighted in favour of driving doctors into a salaried service. I believe these centres to be the lines along which the ultimate development of general practice must take place. They would solve some of the problems created by the inevitable future shortage of doctors, not to speak of domestic servants. More and more use could be made at such centres of non-medical personnel for urine analysis, blood-pressure readings, blood counts, and the like. To suggest, however, that competition between doctors at such centres is undesirable is, to quote a now famous phrase, just "bunk." Practitioners, I submit, must be admitted to these centres to work on a capitation basis if they so desire.

The second point I would like my colleagues throughout the country to stress is that practitioners and other doctors not at present employed by the public health authorities must and can be "employed" by a "neutral" body, so that they are neither civil servants nor local authority officials. At present two-thirds of our profession are neither one nor the other, and their status must not be altered. Their voices, to speak as citizens or doctors on health or other matters, must not

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be muzzled, and they must have the right to stand as candidates for Parliament or local councils if they wish.

Some may question if this status of full citizenship can be maintained. My answer is that the miners as a class have been pressing for many years for nationalization of the mines. They may or may not gain their point once the war is over, but I am quite certain they will not submit to muzzling if they do. Doctors, while pressing for years for improved medical organization but of a type which would maintain and even enhance the human dignity of patient and practitioner alike, have always been as a class against strict "nationalization." It would surely be intolerable for the Government or the public to wish to muzzle them.—I am, etc.,

Glasgow. J. INGLIS CAMERON.

The White Paper and the "Voluntary Principle"

SIR,—Before there has been time for the dust raised by a "debate-over-details" to obscure our view of important basic principles, I wish to raise a protest against the uncritical acceptance of what seems to me to be a dangerous fallacy. On page 23 of the White Paper we are told that the Government aims at preserving the voluntary principle in hospitals: but that it is prepared to take no steps towards their preservation unless "they look substantially to their own financial resources." Thus, the White Paper assumes that the provision of substantial financial resources is or should be the sole function of voluntary hospital associations.

By what line of argument can such a view be justified? Is the sole difference between a voluntary and a "State" hospital the *source* from which its finances are derived? Has the voluntary principle contributed nothing of value to our hospitals except hard cash? These hospitals arose originally as the outward expression of the impulse of Christian charity—i.e., of concern, neighbourly love, and mutual service. The cash was incidental but necessary: it was not to raise money that the voluntary associations were formed, but to give service.

If I read the White Paper aright, it will be a positive handicap in the future to be a voluntary hospital. The mere fact that the hospital is *administered* by a voluntary committee should not prevent it (in my view) from receiving *the same State-aid per bed* as a State hospital—provided the hospital produces the required facilities, conforms to proper standards, and is subject to State inspection. The analogy of the "private" or the Church schools does not apply to the voluntary hospitals, save in the hypothetical case of a "Christian Science Hospital," for example. In my view, the voluntary principle should begin to operate after, and not before, certain *basic financial needs* have been provided *by the State*. Under the Beveridge scheme it is proposed that each individual shall receive "basic security": if he wishes for more than that he must insure for it. So also every efficient hospital should receive a basic "rate per bed." In my view it is the amenities, such as extra facilities for diagnosis and treatment, a larger staff, comforts for the patients, and above all an atmosphere of real comfort and concern for the individual patient—it is these things that should be the concern of voluntary associations and of "charitable" bequests. Indeed, I hope that every hospital will be rescued from the non-voluntary anonymous condition and become related to a band of voluntary supporters in its vicinity. Charity is more than money, and in that "more" lies its highest value.

The same fallacy underlies the proposals (p. 31) for the establishment of Health Centres. Why should only the Joint Authority be permitted "to make proposals for their establishment"? It is because the Joint Authority alone can provide the cash! If this be the only reason, it is a very bad reason. Suppose the voluntary association that conducted the Peckham Centre wished to establish a new "Health Centre," they could not do so—not even if they came with money in hand, still less if they needed an advance of capital. In other words, *free voluntary experiment* in the conduct of Health Centres is to be hampered at the very time when the utmost freedom of experiment is needed. Under these terms the Health Centre experiment will become either stereotyped or stillborn. In my opinion voluntary bodies are more likely to possess the vision, imagination, drive, and adventurous spirit required for fruitful experiment than any Joint Area Committee, no matter how elected.

I hope, therefore, that wherever a group of doctors is found prepared to co-operate with a local voluntary health centre committee, no obstacles will be placed in their way. Why should these centres not be related to "community councils," to co-operative guilds, to friendly societies, to religious organizations? Such councils would not stop at "medicine," they would move out into the fields of hygiene and reproduce most of the features of the Peckham experiment. The position of the doctors in such a service would be similar to or better than that of the doctors in a Joint Authority centre. I know under which aegis I should prefer to serve! In this matter, as in the case of the hospitals, the State should make financial provision on a "cost per patient" basis equally to voluntary and to State health centres. No handicap should be put in the way of voluntary centres provided their standards of service are good.

The voluntary principle is not yet dead; but the White Paper (as it stands) will certainly kill it. The voluntary principle is the democratic principle. The State principle leads direct to bureaucracy and has always done so.—I am, etc.,

Worcester. HOWARD E. COLLIER.

Controversial Legislation

SIR,—The Prime Minister, in a Parliamentary answer to me (*Hansard*, March 3, 1944), queries my "assumption" that the proposals for a National Health Service detailed in the White Paper (Cmd. 6502) are "controversial" and consequently are covered by the pledge he gave in Parliament (*Hansard*, Oct. 13, 1943) that his Government would not introduce "controversial" legislation "not indispensable to the war effort" until after a general election. He makes the novel claim that the controversiality of these proposals "can best be tested by obtaining the sense of the House upon them in debate," and an opportunity for this is promised at some future unspecified, but probably near, date.

I should be the last to belittle the influence of the House of Commons after a membership of nearly twenty years, but I submit that the free Press of this country is at least as authoritative a guide to public opinion, and no one who has studied the Press, both lay and medical, during the past two years can question the existence of widespread opposition to some of the major proposals of the White Paper. But the test preferred by the Prime Minister suggests the advisability that every effort should be made by the medical profession to inform individual M.P.s, by personal approach in each electoral Division before the forthcoming debate, of the fears entertained by the vast majority of practising doctors regarding some of the changes contemplated.—I am, etc.,

House of Commons. E. GRAHAM-LITTLE.

Clinics or Health Centres?

SIR,—Would it not assist discussion if a distinction were made between a "clinic" and a "health centre"? Surely a centre for group practice should be termed a "clinic." Of these there might, and certainly should be, several in the larger towns. As buildings they would not need to be extensive.

The "health centre" should house all activities concerning public health, research, rehabilitation (mental and physical), and health education. All these are highly specialized subjects and should employ whole-time specialists. There would, of course, be a close liaison between it and the clinics. Infant and maternal welfare and a department for mental disorder would also be there. Thus the clinics would be clearly denominated for dealing with the normal routine of a G.P.'s practice.—I am, etc.,

Penn, Bucks. S. HENNING BELFRAGE.

Research in the New Health Services

SIR,—Many comments have been made on the Government's proposals for providing medical services for all members of the community. One very important point, however, appears to have been overlooked. Even if every person in this country were to have the best of medical attention the average expectation of life would only be increased by a small amount—four or five years. Moreover, this increase would arise chiefly from a decrease in infant mortality. These proposed reforms, highly desirable as they are, can only leave us little better than we are now.

The last thirty years have seen valuable advances in medical science, but even with sulphonamides and penicillin the great mass of diseases are still largely, if not entirely, intractable. With our present limited knowledge we have little other than palliative measures for dealing with diseases such as tuberculosis, cardiovascular disease, chronic renal disease, cancer, to quote a few of a very long list. How very little, too, is known of the causes of old age!

No one can know how far from or close we may be to the solution of these problems. Of one thing, however, we can be sure—the rate of progress will be more or less proportional to the amount of money made available by the State for research purposes. The amount now allowed for this is some £200,000 per annum, which works out to about one penny per person per annum on a population of nearly fifty millions. Nothing will seem stranger to posterity than this lack of vision and imagination in a matter which so directly and vitally affects the interests of all of us. The public, including members of Parliament and Ministers of State, are as a whole very ill-informed with regard to medical matters. There are many medical men also who regard research as a secondary matter that can be left to look after itself.

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There is at the present time a vast amount of the most promising work the verification, elaboration, and application of which are delayed indefinitely purely from lack of funds. Even work on cancer, as we have heard lately, is held up for this reason. The new health services are to cost some £150,000,000 per annum. If a sum as small as 10% of this were spent annually on fundamental research in biochemistry and chemotherapy we should see in the next decade or so an advance in our knowledge greater than that achieved in the last five hundred years. Surely the time has come for the medical profession to make a loud and sustained demand that research should receive the support and encouragement to which it is entitled.

Perhaps what is needed is a society to educate statesmen and the public by means of propaganda in the importance of research.—I am, etc.,

London, S.W.4. B. DOHERTY.

Discouraging Unity ?

SIR,—In your issue of Feb. 19 Dr. E. C. Atkinson writes complaining of an article in the *Sunday Express* by Dr. Stark Murray. Dr. Atkinson does not agree with the views expressed, which does not surprise me, and then gropes round to find some good reason why the article should not have appeared.

His first complaint is that Dr. Murray, as a member of the Medical Planning Commission, should not have written for the lay press. When I became a member of this Commission I specifically asked if I was permitted to say whatever I liked, and was told that this was so. Moreover, I have read in the lay press articles, similar in character, by Dr. Dain and other members of the Medical Planning Commission.

Dr. Atkinson goes on to complain that Dr. Murray "preaches views counter to 90% of the profession in Great Britain." I very much doubt this statement, but let that pass. In close juxtaposition and in the same letter we are told with truth that in the past much valuable thinking and research have come from individuals and not from teams of doctors, and in proof of this the work of Lister, Harvey, Ross, Koch, Curie, Hunter, Ehrlich, and Metchnikoff is cited. But if these distinguished scientists had refrained from publishing their views until they had been accepted by 90% of the profession, how much poorer would the world be to-day!

No, the visions of a minority of one generation may become the settled convictions of the majority of the next, and a profession that vigorously opposed the "panel" in 1911 may demand its extension in 1944.—I am, etc.,

SOMERVILLE HASTINGS.

Northwood, Middlesex.

Planning and Policy

SIR,—The long-expected White Paper is now in our hands. What we see there is not a scheme to deal with a probable emergency immediately following the cessation of hostilities. The Minister of Health has taken pains to show that it would take many years to bring the greater part of his proposals into operation. Does it not seem strange that so much time and energy should be spent in planning a dim and distant future at a time when we are supposedly engaged in a life or death struggle demanding the application to one purpose of everything we have got? Is there any connexion between this anomaly and the following statement published a year or two before the outbreak of war in *Planning*, the organ of that policy-forming organization generally known as "PEP": "We have started from the position that only in war, or under threat of war, will a British Government embark on large-scale planning"? It looks as if the planners are convinced that for them it is now or never. It is therefore pertinent to ask whose policy is expressed in the White Paper? Obviously it is not the policy of the electorate generally or of the medical profession as a whole. Otherwise it would not have been considered necessary to make such elaborate use of wireless and Press from the moment of its publication to influence public and medical opinion in its favour.

The above questions demand immediate and comprehensive answers. If the public and the medical profession should allow themselves to be caught up in never-ending discussions of details before policy has been clearly defined, this generation would richly deserve to have all the soul-destroying conditions imposed upon it which, there is reason to fear, are being prepared by the long-term planners (many of them good-intentioned people) for our children and children's children.—I am, etc.,

Bexley, Kent. E. U. MACWILLIAM.

H.M. Forces Appointments

ROYAL NAVY

ROYAL NAVAL VOLUNTEER RESERVE

Prob. Temp. Surg. Lieuts. W. F. M. Fitzgerald, M. Kamill, J. S. Young, F. R. St. C. Assinder, L. W. Carstairs, A. A. B. Coia, G. H. R. Burnock, H. G. Frampton, R. Moorlan-Feroze, R. G. Moore, H. A. B. Nicholls, W. T. Rees-Jones, P. M. Roemele, E. H. Back, J. W. Betts, W. L. Bilsland, J. B. Blacklay, J. F. B. Carter, J. R. W. Catto, N. S. Craig, A. G. Harrold, D. W. Huish, J. G. Murray, C. R. McD. Redwood, H. R. J. Ritchie, I. B. Sim, W. Stephen, A. R. Taylor, C. H. C. Upjohn, W. A. Wilson, C. R. Wood, J. N. Anderson, J. R. Briggs, J. P. Chalmers, D. A. Dixon, W. Edgar, R. A. Fisher, R. Lake, I. McKechnie, J. Macfie, W. B. Martin, (Miss) P. Milligan, J. R. Moffat, I. Payne-James, S. Peel, D. R. Rigg, (Miss) A. M. L. Whitehouse, A. W. Williams, and G. Smith to be Temp. Surg. Lieuts.

ARMY

War Subs. Major (Acting Col.) P. Wiles, R.A.M.C., and War Subs. Capt. (Acting Col.) W. R. Russell, R.A.M.C., to be Consultants and have been granted the local rank of Brig.

ROYAL ARMY MEDICAL CORPS

Lieut.-Col. T. I. Dun, D.S.O., M.C., from R.A.M.C., to be Col.

Major (Temp. Lieut.-Col.) J. D'A. Champney to be Lieut.-Col.

TERRITORIAL ARMY

ROYAL ARMY MEDICAL CORPS

2nd Lieut. A. W. Merrick from R.A., T.A., to be Lieut.

POSTGRADUATE NEWS

The Fellowship of Medicine announces: (1) Final F.R.C.S. surgical demonstrations, Wed., March 22, 29, and April 12, and Tues., April 4, at 2 p.m., at St. Mary Islington and Archway Hospitals; (2) Final F.R.C.S. Surgical demonstrations at London Homoeopathic Hospital, 2.30 p.m., Sat., March 25 and April 29; (3) Week-end course in surgery, Hillingdon County Hospital, Sat. and Sun., April 22 and 23; (4) Revision course in anaesthetics: Lectures daily at Royal Cancer Hospital, demonstrations at various London hospitals, April 17 to 29.

WEEKLY POSTGRADUATE DIARY

BRITISH POSTGRADUATE MEDICAL SCHOOL, Ducane Road, W.—*Daily*, 10 a.m. to 4 p.m., Medical Clinics, Surgical Clinics and Operations, Obstetric and Gynaecological Clinics and Operations. *Daily*, 1.30 p.m., Post-mortems. *Mon.*, 10 a.m., Course on "War Surgery of the Abdomen" commences. *Tues.*, 10 a.m., Paediatric Clinic; 11 a.m., Gynaecological Clinic. *Wed.*, 11.30 a.m., Medical Conference. *Thurs.*, 12 noon, Gynaecological Conference; 2 p.m., Dermatological Clinic; 2 p.m., *X*-ray Demonstration on "Intrathoracic Neoplasm." *Fri.*, 12.15 p.m., Surgical Conference; 2 p.m., Neurological Ward Clinic; 2 p.m., Sterility Clinic.

FELLOWSHIP OF MEDICINE, 1, Wimpole Street, W.—*West End Hospital for Nervous Diseases*: Mon., Tues., and Fri., 2.45 p.m., M.R.C.P. course in neurology. *Department of Anaesthetics, Radcliffe Infirmary, Oxford*: Daily, Revision course in anaesthetics. *St. Stephen's Hospital (Rheumatic Unit)*: All day, Sat. and Sun., March 18 and 19, Week-end course in rheumatism.

EDINBURGH POSTGRADUATE LECTURES.—At Edinburgh Royal Infirmary, *Thurs.*, 4.30 p.m. Prof. Stanley Davidson: Prevention and Treatment of Cholecystitis and Cholelithiasis by Diet and Biliary Antiseptics.

DIARY OF SOCIETIES AND LECTURES

ROYAL COLLEGE OF SURGEONS OF ENGLAND, Lincoln's Inn Fields, W.C.—*Mon.*, 4 p.m. Prof. A. J. E. Cave: The Female Urinary Tract; *Tues.*, 4 p.m. Prof. J. Leigh Collis: Aetiology of Cerebral Abscess as a Complication of Thoracic Disease; *Wed.*, 4 p.m. Prof. Cave: The Prostate and its Adnexa; *Fri.*, 4 p.m. Prof. Cave: The Femoral Canal and Femoral Sheath.

ROYAL SOCIETY OF MEDICINE.—*Tues.*, 2.30 p.m., Section of Psychiatry; 4.30 p.m., Section of Experimental Medicine and Therapeutics. *Thurs.*, 5 p.m., Section of Dermatology. *Fri.*, 4.45 p.m., Section of Radiology; 5 p.m., Section of Obstetrics and Gynaecology.

BRITISH INSTITUTE OF RADIOLOGY.—At 32, Welbeck Street, W., *Fri.*, 2.30 p.m. Meeting of Medical Members. *Sat.* (March 18), 2.30 p.m. Ordinary meeting.

CHADWICK TRUST.—At London School of Hygiene and Tropical Medicine, Keppel Street, Gower Street, W.C., *Tues.*, 2.30 p.m. Dr. S. A. Henry: Medical Supervision in Industry in Peace and War.

MEDICAL SOCIETY OF LONDON, 11, Chandos Street, W.—*Mon.*, 4.30 p.m. Discussion: The Dangers and Difficulties of Intravenous Therapy.

NATIONAL COUNCIL FOR MENTAL HYGIENE.—At Caxton Hall, Caxton Street, S.W., *Tues.*, 5.15 p.m. Miss L. V. Southwell: Problems of the Adolescent Girl as seen in Boarding Schools.

ROYAL EYE HOSPITAL, St. George's Circus, S.E.—*Mon.*, 4.30 p.m. Prof. Samson Wright and Dr. David Slome: Physiology of the Eye.

ROYAL INSTITUTE OF PUBLIC HEALTH AND HYGIENE, 28, Portland Place, W.—*Wed.*, 3.30 p.m. Dr. Wilfred Pearson: Aspects of Disease in Children.

ROYAL SOCIETY OF TROPICAL MEDICINE AND HYGIENE.—At Manson House, 26, Portland Place, W., *Thurs.*, 3 p.m., Air Commodore T. C. Morton, R.A.F.: Heat Effects in British Personnel in Iraq.

B.M.A.: Branch and Division Meetings to be Held

BRISTOL DIVISION.—Two meetings to be addressed by Dr. Charles Hill, Secretary of the B.M.A., Wednesday, March 15. (1) At the Council House, Bristol, 3 p.m.: The White Paper on a National Health Service. (2) At the Physics Lecture Theatre, the Royal Fort, the University, Bristol, 8.30 p.m.: The White Paper. Non-members of the B.M.A. in the area of the Division are invited to attend.

NORTH OF ENGLAND BRANCH.—At Royal Victoria Infirmary, Newcastle-upon-Tyne, Thurs., March 16. 2.15 p.m., Clinical demonstration in the out-patient department by Dr. S. Thompson and Mr. W. E. M. Wardill. 3.45 p.m., Mr. Harvey Evers: The Forceps, the Curette, and the Ring. Members of H.M. Forces stationed in the area.

SOUTHAMPTON DIVISION.—At Royal South Hants and Southampton Hospital, Wed., March 15, 3.30 p.m. Annual general meeting: Sir Kaye Le Fleming: The White Paper.

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

COSIN.—On Feb. 25, 1944, to Pamela Cosin (*née* Keenlyside), wife of L. Cosin, F.R.C.S., a son—Benjamin.

GLASSOW.—At Corbridge, Northumberland, to Winifred, the wife of Capt. Frank Glassow, M.A., M.B., M.R.C.S., R.A.M.C., a daughter.

ROSS.—On Feb. 29, 1944, at Luton, to the wife of Dr. Thomas Ross, a daughter.

TREVETHICK.—On Feb. 26, 1944, at Sister Needham's Nursing Home, Sheffield, to Judith, wife of Fl. Lieut. R. A. Trevethick, M.B., Ch.B., R.A.F.V.R., a son.

MARRIAGE

BARER—BRIGGS.—On March 4, 1944, at Watford, Robert Barer, Lieut., R.A.M.C., to Gwenda Briggs, M.B., B.S.

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