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ADMINISTRATIVE ASPECTS OF THE WHITE PAPER

DR. HILL'S ADDRESS AT BRISTOL

A conference, to which were invited those interested in National Health Insurance and hospital and public health administration over a large area of the West Country, was held at the Council House, Bristol, on the afternoon of March 15. It was presided over by the Lord Mayor of Bristol (Alderman F. C. WILLIAMS), who was accompanied by the Mayor of Bath (Councillor J. PLOWMAN). The greatest interest was shown in the conference, which was attended by about 120 representatives of the insurance committees and health committees of Bristol and Bath and of the counties of Wiltshire, Gloucestershire, and Somerset, the Bristol Divisional Hospitals Council, and the Executive Committee of the Bristol Division of the British Medical Association, whose honorary secretary, Dr. H. M. Golding, was complimented on his success in arranging the gathering. The purpose was to hear an address by Dr. Charles Hill, Secretary of the British Medical Association, on administrative aspects of the White Paper. Dr. Hill also addressed a crowded meeting of practitioners called by the Division in the evening, when Dr. Victoria Tryon, chairman of the Division, presided. Between three and four hundred practitioners attended the evening meeting.

The LORD MAYOR, in introducing Dr. Hill, said that his own long experience of education had led him to be dubious of dual control; if anything of that kind were imported into health services it would need to be scrutinized very carefully if success was to be achieved.

Dr. HILL began by saying that, whatever might be said or written to the contrary, the approach of the medical profession to a comprehensive medical service was one of great interest and sympathy. For years it had pressed for a truly comprehensive service. He passed to a critical examination—critical because this was the right time for criticism—of the administrative proposals. The central administrative body of the proposed service was to be a Department responsible to a Minister, who in his turn would be responsible to Parliament. It was most unfortunate that it was not to be a Department responsible for *all* civil medical services. The non-medical functions of the Ministry of Health would remain with that Ministry, while other Government Departments would retain their various medical functions. No attempt was to be made to establish a "comprehensive" Ministry of Health.

Two new pieces of central machinery were to be set up. The Central Health Services Council was an advisory body, medical and lay, representing doctors, hospitals, and other groups of workers in the health field. It was evidently the desire of the Government that this body should be firmly established and regularly used, but it was not to be free to publish its own report or, in other words, to inform the public and Parliament of the advice which it had offered to the Minister, whether that advice had been accepted or not. It would be in the public interest that such a body should be free to inform the public what advice it had offered to the Minister. True, it might develop into a permanent attitude of criticism, but the risk was worth taking in view of the magnitude, complexity, and personal character of the vast service to be administered. The other body was the Central Medical Board, primarily, not wholly, medical in composition, with an autonomous civil service structure analogous to the Board of Control.

The Local Proposals a Compromise

It was also to be regretted, Dr. Hill continued, that the whole question of local government had not been examined with a view to recasting it on a more modern and sounder basis. The result of the failure to grasp that nettle was that the local proposals were compromise ones, presenting new difficulties and retaining old ones. There would be more local authorities, not fewer. The joint health authorities, representing the county and county borough councils in their area, and precepting upon those bodies for their expenditure, would own the local authority hospitals, be in contract with the voluntary hospitals, administer the clinic services which were of a hospital character, and would also plan the non-institutional services.

"These administrative proposals seem to carry with them the danger that medicine will be broken into several pieces. General practitioners will be under contract with a central body or both a central body and a local body; consultants, with local authorities or individual voluntary hospitals. School medical and infant welfare services will go wherever education goes, with the result that these last important services will not be administered from the centre or even from the joint authority, but by individual county and county borough councils, or, in many cases, lesser authorities. School medical inspection would be under one authority, and ultimately school medical treatment may be under another. Environmental medicine—the administration of the Public Health Acts—will remain with the present sanitary authorities, and not be brought into administrative association with the curative services, while the responsibility for the curative services will be divided between the joint health authority as regards their planning, the county and county borough councils as regards the administration of health centres."

Representatives of local authorities would welcome or distrust this fragmentation according to their approach to the whole question. He himself saw a real danger to the efficiency of preventive and environmental services by reason of the contraction of the sphere of interest of many doctors in the public health service. Most of them would lose not only status but that range of work which made for intellectual satisfaction. Medical officers of county and county borough councils would be left with environmental, school medical, and infant welfare services. Those working for lesser authorities would be left with environmental and possibly school medical and infant welfare services. Public health medical officers would be the only practitioners in the public service whose remuneration was not governed by national scales. The position of this important section of the profession would need to be safeguarded.

No Vocational Representation on Local Authorities

The advisory body to the local authorities was to be the Local Health Services Council. In theory it would be advisory not only to the joint authority but to the county and county borough councils, though he saw difficulty in bringing those bodies together. The Central Health Services Council was to be appointed by the Minister (the confidence in such a body would have been increased had it been an elected body, representative of the medical profession and the other interests engaged in the service), but there was no inkling as to how the Local Health Services Councils were to be established.

"I think it is to be regretted that a place on a non-elective basis on the administrative bodies has not been accorded to vocational representatives—that is to say, representatives of medical practitioners, voluntary hospitals, and other groups. The pure doctrine of democracy might have been diluted to admit of this. It is one thing to be a member of an advisory committee to a statutory authority and another thing to be a member of the authority itself; one thing to tender advice by memorandum and another to speak from one's place on a board or committee. Even if there could not have been vocational representation on the authority itself, there might well have been, on the analogy of the proposals in the Education Bill, such representation on committees to which certain functions were delegated."

Dr. Hill said he knew that that remark in the case of his present audience might fall on stony ground, but he reminded them that it was proposed to take over the whole of the medical services, personal and impersonal, with all their complexity, and he thought that minority vocational representation would be in the public interest.

Back to the Collection Plate

The voluntary hospitals had been shabbily treated in the White Paper.

("Hear, hear.") Without the warm co-operation of these hospitals there could be no effective service. The Government's policy was to have complete hospital benefit as part of the comprehensive service, and not, as in the Beveridge proposal, a limitation to treatment, leaving the patient to find the "hotel" costs. Clearly the Government was right in that position, but it meant the end of contributory schemes as we knew them, for it would not be possible to obtain money from the public on the basis of services rendered or as an insurance for services to be rendered in the future. The Government's policy also was that as a condition of its continued autonomous existence the voluntary hospital must itself find a proportion of its moneys.

All this meant that the voluntary hospital would be thrown back on the "Spare a penny for the hospital" system, and that in an atmosphere of hospital-service-free-to-all. It was a pity that the voluntary hospitals were not offered a separate and properly established advisory machinery, together with, at the periphery, a local advisory body representing both the public hospitals and the voluntary hospitals. The sooner the two groups got together the sooner there would be evolved a new type of hospital combining the best of both.

"It would be a mistake to press too hard the principle of 'the more we pay, the more we control,' for the simple reason that we must all recognize that not only do the voluntary hospitals carry out a magnificent service to-day but they have a tradition of service and of freedom which it will be most valuable to preserve."

The Health Centre

Passing to the administrative aspect of the general practitioner service, Dr. Hill said that the Government had in mind the development of non-institutional practice on the lines of Health Centres. Possibly group practice would find its best expression in such centres, but of the various types of centre which might have been set up the Government had chosen merely the communal surgery—the most elementary of possible forms. He warned his audience lest they should imagine that the setting up of a Health Centre would work some magical effect. After all, there were many conditions which demanded the privacy of the doctor's home or the patient's home. Many would have to travel miles to see the doctor, whereas they travelled at present only yards; and with, say, six or eight doctors practising in a busy communal surgery on a winter's evening there might well be 300 or 400 people waiting—a circumstance not without its epidemiological dangers. Experiment was necessary before the best type of Health Centre could be evolved, and he did not think that this scheme would encourage such experiment.

Doctors were suspicious of the Health Centre proposal because attached to it was the principle of remuneration by "salary or similar alternative." A very large majority in the medical profession was opposed to allowing the profession to become a branch of the central or local government service. There was something in this set-up suggestive of employment on a whole-time salaried basis under local authorities, which, in relation to some forms of medical practice, would make for a lower and not a higher quality of service.

He turned to discuss the functions of the Central Medical Board. It was to be concerned with the welfare of the medical profession—which he had always regarded as primarily the concern of the B.M.A. It was to secure the arrangement of postgraduate courses—a job that wanted doing, though it might have been better done by a body representing the medical schools and others. But one of the powers of the Board, stated both in the White Paper and in the Summary, and advanced without any supporting argument, was to require newly qualified doctors to give full time to public service in their early years.

"The medical profession is not standing for that. After the long years of training, to be faced with civil direction in peacetime—well, please leave that out! These men would no doubt be directed to the Health Centre service, with its salaried or similar method of remuneration. A Minister, by means of these directions, would be able to change the whole character of the general practitioner service by a series of actions which he need not report to Parliament, making the service increasingly a whole-time one under local authorities. It is a pity that the Health Centre conception—a good conception—is surrounded with some suspicion because it might be the means of encompassing what the majority of the profession regard as an undesirable end."

In conclusion Dr. Hill mentioned the danger of the public being led to believe that health was a matter of hospitals and doctors. Nutrition and housing and a proper standard of wages meant more than any White Paper or blue-print of health services. He pointed out the meagreness of the contribution which the Government made to medical research—£250,000 a year to the Medical Research Council—yet "the discovery of penicillin in St. Mary's Hospital Laboratory may well be worth more than all the proposals in this report."

"We want, not only a reorganization of the health services, but a fresh approach to the problems of disease on the part of the average citizen. The public are too much disease-minded and not enough health-minded. People must learn to find the same drama in the achievement of positive health as they find at present in the discussion of their complaints. The medical profession wants a comprehensive service. It believes it has a view-point to offer. It believes it has valid criticisms to make. But it wants a really comprehensive service and is ready to co-operate in its evolution." (Applause.)

At the close of the address questions were asked by members of the local authorities present. The first question was whether, in view of the fact that so many people in all professions were to-day educated at public expense to a very large extent, it was really very shocking that in their early years they should be required to obey civil direction. Dr. Hill agreed it was true that the Government through the University Grants Committee found a proportion of the cost of educating members of the profession. Subsidies were provided for most forms of higher education, but he could not agree that this should carry for any group in the community the obligation of obedience to civil direction, of which, he thought, after this war they would have had enough for the rest of their lives.

A Bristol alderman asked whether this provision would not relieve the student from anxiety as to his subsequent career. Dr. Hill agreed that there should be opportunity for men on qualification to find, without undue financial impediment, the kind of work they were fitted to do, and steps should be taken with that object in view. But this was not to say that they should be required to enter a form of service which taken as a whole was not in accord with the traditions under which medical practice hitherto had registered its highest achievements.

Answering another questioner, he agreed that there might be dangers that as a result of qualities social and sartorial rather than clinical and professional a doctor might attract patients to himself. It might be difficult for the public to appraise the clinical qualities of doctors. But, after all, a vast amount of illness was psychological in character, or had a strong psychological element, and that doctor was likely to be the best who was really trusted by his patient. "The patient is better able to judge the qualities of a doctor than any committee sitting in this Council House." ("Hear, hear.")

A councillor said he could not see anything in the White Paper to suggest shabby treatment of voluntary hospitals. It seemed to him that they would be in a better position than now; they were being favoured in comparison with the municipal hospitals. Dr. Hill repeated the points made in his earlier remarks. They were left to raise money under unfavourable conditions: they were to be in contract with the body owning the other kind of hospital; the voluntary hospitals had no board—except as a minority element on an advisory committee—to express their views.

Another alderman suggested that the doctor with a fixed salary and appointed hours would be in a very much envied position as compared with his colleagues, for he would be able to give greater attention to the scientific study of his job. Dr. Hill acknowledged the force of these attractions or temptations, but said that the attitude of the profession was this—that medicine would not yield to the organization of doctors in the way suggested. A patient might have one doctor in the daytime, another on relief duty in the evening, and a third on call at night; but in the same illness that would be a wrong principle, for continuity was essential to a good job of work. A whole-time salaried system would discourage some of the best work in the profession, which demanded conditions of freedom. As for payment, the capitation method as opposed to salary was not, after all, so difficult; it had been the method used in insurance practice for more than thirty years. One thing which it was absolutely necessary to preserve in the public interest was the principle that the first loyalty of the doctor was to his patient. "We must adhere as closely as we can to the principle that it is the patient who employs the doctor and selects the best doctor he knows."

"The quality of medicine depends on the quality of its entrants. Whatever you do, do nothing which will result in denying to the profession its due proportion of the best brains of the new generation. That will be the result if medicine is looked upon as a rigid and stereotyped form of service." (Applause.)

The LORD MAYOR said that the conference had listened to a stimulating address. For one word in particular—the word "health-minded"—he would always be grateful.

A vote of thanks was moved by the Mayor of Bath and seconded by Dr. Victoria Tryon.

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WHITE PAPER ABSTRACTED

The third in the series of abstracts of certain parts of the White Paper; the others were published on March 4 and 11 respectively.

(3) PROFESSIONAL GUIDANCE IN LOCAL ADMINISTRATION

The Government has rejected the suggestion of the Medical Planning Commission that on the local administrative authorities themselves, or on their committees administering specific services, there should be a number of non-elected members with knowledge and experience of medical and health matters. This rejection is in contrast to the provision in the new Education Bill that every education committee, while having a majority of local authority members, shall include persons of experience in education.

It has seemed to the Government that in the administration of health services, whatever may be said for such co-option on the ground of efficiency, it would contravene the doctrine of democratic responsibility. The fact remains that the Joint Boards, with an entirely local authority membership, will have very large powers—the planning and oversight of all services in the area and the administration of hospital services—while their constituent county and county borough councils will be responsible for other clinic and domiciliary services, and for the provision, maintenance, and equipment of Health Centres, and will be parties, with the Central Medical Board, to the contract with doctors practising at Health Centres.

Local Health Services Councils

The highly technical nature of the administration calls for an innovation in local government. At the right hand of the Joint Board (or, in the exceptional cases where no combination of authorities has been found necessary, of the existing authority) there will be set up a Local Health Services Council, repeating in the local framework the machinery of the Central Health Services Council which advises the Minister. These local councils will be statutory, consultative, and advisory bodies. The last word will, of course, lie with the body charged with administration, but it will be guided by the technical and professional advice available through the local council.

Each of the councils, covering the area of its joint authority, will be representative of the professional interests concerned in the service. Its constitution and membership remain at present undecided. The White Paper considers that if all professional interests are fairly represented there is no reason why the pattern should be precisely uniform throughout the country. In Scotland the equivalent bodies will be known as Local Medical Services Committees, having somewhat different function and organization to suit the different local arrangements.

Consultation with Expert Body

The Joint Authority will be required to consult the Local Health Services Council in preparing area plans and in making any subsequent alteration of them. When it gets down to its first task—that of assessing in detail the hospital needs and resources of the area—it will be in close consultation with the council, which will assist it in arriving at a balanced scheme of hospital facilities. The Joint Authority, in considering general practitioner arrangements, in so far as these relate to number and distribution of general practitioners to meet the needs of its area, will have the advantage of consultation with the Local Health Services Council.

The Local Health Services Council will be free not only to advise and guide but to initiate within its own expert province. It may bring to the notice of the Joint Authority an inadequacy in any branch of the comprehensive service of which it becomes aware. "What is wanted," says the White Paper, "is that there shall be, in each area, some new provision for the organized expression of the views of the expert and for ensuring that the local administration can get the fullest advantage from it." It is important to bear in mind that each of these councils has the right to submit its views not only to the Joint Authority but direct to the Minister, presumably on the rejection by the Joint Authority of its advice. It can carry to the Minister its objection to a plan when it comes up for central approval.

The council may also submit its views to other local authorities within its area—e.g., county and county borough councils (p. 20 of White Paper). This is an important provision. These constituent authorities, although hospital and consultant services have been transferred to the Joint Authority, have very great powers and duties in respect of clinics and Health Centres, but apparently they will have no advisory body of their own. Like the Joint Boards, they will depend on the Local Health Services Councils.

Another local expert body, not of an advisory but of a minor executive character, will be the Local Committees of the Central Medical Board, the organization which concerns itself with the distribution and welfare of general practice. These local committees will be set up in each area. If they follow the plan of the Central Medical Board, their membership will be mainly professional, but they will include local authority members. They will take over such minor functions of the former Insurance Committees as remain to be assigned.

Next Week: The Voluntary Hospital and its Future.

FROM THE PRESS CUTTINGS

"The White Paper on the national health service has brought acute disappointment to the country's research workers. . . . It did not say how research might be extended nor how the financial means of extending it were to be found."—*Manchester Evening News.*

"No voluntary hospital would be forced into the national health service; no medical man would be forced into it, and no one would be forced to be treated by what would probably be called the national doctor and the national hospital. Everybody would be free agents—but it might be that there would be no alternative."—Dr. W. McLaine, reported in the *Peterborough Standard.*

"He's the servant of his patients
When he's master of his fate,
But he's master of his patients
When he's servant of the State."

—From a letter in the *Daily Telegraph.*

"It is not a rigid or arbitrary plan."—Mr. Churchill, reported in the *Times.*

"When they [serving doctors] come back, are they to be subject to a number of insidious processes under a Central Board largely composed of civil servants?"—From a letter in the *Liverpool Post.*

QUESTIONARY TO THE PROFESSION

Before formulating its policy on the problems raised by the White Paper the Council of the B.M.A. is seeking the views of every U.K. practitioner, whether a member of the Association or not, whether civilian or Service doctor, whether at home or abroad. To this end the Council has utilized the services of an independent expert body, the British Institute of Public Opinion, in drawing up a Questionary designed to seek opinion on the most important points raised in the White Paper. The Questionary, which is reproduced below, is being sent to every member of the profession concerned, with a copy of the White Paper and an Analysis of the White Paper in relation to the principles approved by the Association prepared by the Council (see last week's *Supplement*).

THE BRITISH INSTITUTE OF PUBLIC OPINION

NOTE: All page references are to the White Paper, Cmd. 6502. "Principles," refers to the proceedings of the Representative Meeting, September, 1943. Principles are not necessarily quoted in full.

Please put a ring round the number for the appropriate answer—e.g., (3). "D.K." stands for "Don't know." Please mark very clearly.

1. The Representative Meeting, September, 1943, voted by a majority that any National Health Service should be confined to 90% of the public—the remaining 10%, the upper income group, being excluded.

The White Paper proposes that the National Health Service (N.H.S.) should include everyone—the 100% proposal—but that no one should have to use it.

Should or should not this basic proposal *of the White Paper* be accepted?*

Should 1
Should Not...................2
D.K. 3

2. The White Paper proposes that complete hospital and specialist services shall be available to everyone in a general ward, free of charge (p. 9). Do you agree or disagree with this proposal?

Agree 1
Disagree 2
D.K. 3

3. Suppose a patient wants to choose his own hospital, or go into a private or semi-private ward, should he be able to pay a "hotel charge" and still receive free medical attention under N.H.S.?

Yes 1
No 2
D.K. 3

4. Do you think that an N.H.S. patient should be able to arrange to have private treatment on a specific occasion:

(a) From his own N.H.S. Dr.?

Yes 1
No 2
D.K. 3

(b) From another Dr.?

Yes 1
No. 2
D.K. 3

5. Principle D: "The profession rejects any proposal for the control of the future medical service by local authorities as at present constituted."

Do you consider that the White Paper observes or infringes this Principle?

Observes 1
Infringes 2
D.K. 3

6. Principle E: ". . . no administrative structure should be approved which does not both permit and encourage free choice as between doctor and patient."

Do you consider that this Principle is left intact or is impaired by the provisions of the White Paper?

Left Intact....................1
Impaired 2
D.K. 3

*Some of the forms that have been sent out do not contain the words in italics, and doctors' attention is drawn to this omission to obviate any ambiguity.

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7. The White Paper suggests a Central Health Services Advisory Council, having the right to offer spontaneous advice to the Minister, who will have to submit his Annual Report of their work to Parliament. The Council will not have the right to publish an Annual Report (p. 13).

Should or should not the Council have the right to publish an Annual Report?

Should 1
Should Not.....................2
D.K. 3

8. The Central Health Services Advisory Council will not have the right to publish their advice without the consent of the Minister.

Should or should not the Council have the right to publish their advice at their own discretion?

Should 1
Should Not.....................2
D.K. 3

9. (a) The White Paper envisages as the central administrative structure the Minister of Health, the Ministry of Health, plus the Central Health Advisory Council.

Do you think that this arrangement is satisfactory or unsatisfactory?

Satisfactory 1
Unsatisfactory 2
D.K. 3

(b) **If UNSATISFACTORY:** What alternative would you suggest? ....
....

10. The White Paper says hospital and specialist services should be planned and partly run by joint boards covering large areas (p. 15).

Do you think that this is a good or bad thing?

Good 1
Bad 2
D.K. 3

11. (a) The Joint Boards will represent the constituent local authorities, though there will be Local Health Service Councils to advise them (p. 19).

Do you think that this arrangement is satisfactory or unsatisfactory?

Satisfactory 1
Unsatisfactory 2
D.K. 3

(b) **If UNSATISFACTORY:** Would you like to see:

a Doctors and other health workers directly represented on the Joint Boards?

Yes 1
No 2
D.K. 3

b Medical faculties of Universities directly represented on the Joint Boards?

Yes 1
No 2
D.K. 3

c Voluntary hospitals directly represented on the joint boards?

Yes 1
No 2
D.K. 3

12. The White Paper proposes that, subject to conditions arranged nationally, specialists and consultants should be employed whole-time or part-time and paid by the hospital authority (p. 25).

Do you agree with this proposal or should they be employed by the Central Medical Board?

Hospitals 1
C.M.B. 2
D.K. 3

13. (a) "The Board must (also) be able to require the young doctor during the early years of his career to give his full time to the public service where the needs of the service require this" (p. 35).

This provision applies potentially to all young doctors.

Do you regard it as reasonable or unreasonable?

Reasonable 1
Unreasonable 2
D.K. 3

(b) What should be his initial salary, per annum? £.............

14. (a) The White Paper proposes that general practitioners should be under contract with a Central Medical Board (p. 29).

Do you agree or disagree with this?

Agree 1
Disagree 2
D.K. 3

(b) **If DISAGREE:** What alternative do you suggest? ....
....

15. The White Paper says that doctors working from Health Centres should have a contract jointly with the Central Medical Board and the local authority owning the Health Centre (p. 31).

Do you agree or disagree?

Agree 1
Disagree 2
D.K. 3

16. (a) The White Paper suggests that subject to initiation locally and "in the last resort to the decision of the Minister," Health Centres will be set up and maintained by county or county borough councils.

Do you approve or disapprove of the principle of Health Centres?

Approve 1
Disapprove 2
D.K. 3

(b) **If APPROVE:** What form of Health Centre would you most prefer to see:

1 Communal doctors' surgery, the type envisaged in the White Paper? 1
2 Cottage hospital type, with beds? 2
3 Purely diagnostic, investigation, centre?.......3
4 A centre where both preventive and curative work is done, including, e.g., maternity and child welfare, school medical treatment? ..4
5 Other? 5

17. "There is, therefore, a strong case for basing future practice in a Health Centre on a salaried remuneration or some similar alternative which will not involve mutual competition within the Centre" (p. 32).

Bearing in mind that "The doctor practising in a Centre will not be debarred from private practice outside it" (p. 31), what method of remuneration would you like to see adopted for doctors working in Health Centres?

Salary 1
Small Basic Salary plus Capitation Fees...........2
Capitation Fees...............3
Pooling of Capitation Fees..4

18. If a doctor is not working in a Health Centre, but in "separate" practice, how should he be remunerated in a National Health Service?

Salary 1
Small Basic Salary plus Capitation Fees..........2
Capitation Fees...............3

19. (a) "... the doctors taking part in the scheme must be assured of an adequate and appropriate income" (p. 80).

In your opinion (a) How much (net—with all expenses paid) do you think a general practitioner (of, say, 40) should get from all sources, at 1939 prices?

i Without a pension, per annum £...........
ii With an adequate pension at 65, p.a. £.............

(b) How much (net—with all expenses paid) do you think a consultant or specialist (of, say, 40) should get from all sources, at 1939 prices?

i Without a pension, per annum £.............
ii With an adequate pension at 65, p.a. £.............

20. "Any practitioner wishing to set up a new—or take over an existing—public service practice in a particular area will seek the consent of the (Central Medical) Board. The Board will then have regard to the need for doctors in the public service in that area, in relation to the country as a whole, and to the general policy for the time being affecting the distribution of public medical practice. If it is considered that the area has sufficient or more than sufficient doctors in public practice while other areas need more doctors, consent will be refused. Otherwise it will usually be given without question" (p. 33).

Is it reasonable or unreasonable that the Board should possess these powers?

Reasonable 1
Unreasonable 2
D.K. 3

21. The White Paper says nothing about the position of doctors in municipal hospitals in relation to medical superintendents. Do you think it desirable or undesirable that they should be clinically subordinate to a medical administrator?

Desirable 1
Undesirable 2
D.K. 3

22. "The Government have not overlooked the case which can be made for the total abolition of the sale and purchase of publicly remunerated practices. The abolition would, however, involve great practical difficulty and is not essential to the working of the new Service now proposed. The Government intend, however, to discuss the whole question with the profession, to see if some workable and satisfactory solution can be reached" (p. 35).

Do you think that the sale and purchase of publicly remunerated practices should continue or cease?

Continue 1
Cease 2
D.K. 3

23. Should the principle that all general practices may be sold and purchased be maintained or abandoned, on the assumption that adequate compensation is paid to existing owners?

Maintained 1
Abandoned 2
D.K. 3

24. With the introduction of a National Health Service such as is contemplated in the White Paper, do you think that it will or will not be possible for private practice to continue:

(a) For a general practitioner?

Yes ....
No 2
D.K. ....

(b) For a consultant or specialist?

Yes ....
No 2
D.K. ....

25. It is usual that people being paid by the State are debarred from politics or standing for Parliament. Is it desirable or undesirable that special provision should be made to safeguard these political rights of doctors entering a National Health Service?

Desirable ....
Undesirable 2
D.K. ....

26. (a) Would you care to say whether you incurred a debt in setting up your practice?

Yes ....
No 2
Rather Not Answer ....

(b) Would you estimate how much of the debt is outstanding? £.............

27. Would you care to give the occupation or profession of your father?

Medicine ....
Company director, higher professions, Civil Service—higher grades..............................2
Salaried—Clerical, salaried—manager, teacher, proprietor retail business, farmer..............
Skilled artisan, clerical—weekly wages, shop assistant, Civil Service—lower grades..........4
Others—weekly wages, factory, transport, mining, and so on.......................................

28. If a National Health Service as contemplated in the White Paper is introduced, would you regard medicine as an attractive profession for your child?

Yes ....
No 2
D.K. ....

29. With the introduction of a National Health Service, do you think that the quality of the country's medical service will be enhanced or will suffer?

Enhanced ....
Unaffected 2
Suffer ....
D.K. 4

30. On the whole, are your reactions to the White Paper favourable or unfavourable?

Favourable ....
Unfavourable 2
D.K. ....

PERSONAL DETAILS

1. Man ....
   Woman 2
2. Age: Up to 29...
   30-49 2
   50 and over ....
3. Year of registration:

During the war..1	1900-1909*......6
1935-1939......2	1890-1899.......
1930-1934.......3	1880-1889.......8
1920-1929.......4	Prior to 1880....
1910-1919........5	

4. Single 1
   Married ....
   No. of children:
   Under 16 years of age..............................
   16 years of age and over...........................
5. Nature of Professional Work:
   MARK BOTH SECTIONS A and B.
   A. Peacetime work: (only one answer is to be given):
   (a) Consultant or Specialist..........................
   (b) General Practitioner...............................2
   (c) Other
   B. Present work: (only one answer is to be given):
   If not on Service: Classify yourself in the branch of work in which you are predominantly engaged.
   If on Service: Classify yourself in the branch of work in which you were predominantly engaged immediately prior to entering the Services.
   (1) Consultant or Specialist..........................
   (2) General Practitioner:
   (a) National Health Insurance.......2
   (b) Not N.H.I. ....
   (3) Whole-time Voluntary Hospital.....4
   (4) Whole-time Local Authority General Hospital ....
   (5) Whole-time Local Authority Special Hospital 6
   (6) Whole-time Public Health Service....7

*In the questionary as posted to the profession this appears incorrectly as 1906.

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(7) Whole-time Government Service (e.g., Home Office, Ministry of Health, etc.) 8
(8) Whole-time Teacher....9
(9) Whole-time Research....10
(10) Whole-time Non-Government Post 11
(11) Medically qualified Dental Surgeon..12
(12) Retired 13
(13) Unclassified 14

6. If G.P.: Method of acquiring practice:
Built up own....1
Purchased existing....2
Acquired (not purchased) existing.... 3

7. **Place of Practice**: Mark both Sections A and B.
A. Scotland 1
Wales 2
England 3
Services 4
Abroad (non-Services) 5

B. Town of 50,000 or more....1
Other 2

8. Please mark any of these attended:
A. **Elementary** 1
Secondary 2
Public 3
B. **University** 1
[Not Medical School]
Medical School....2

THE NATIONAL HEALTH SERVICE

The following statement has been issued by the Socialist Medical Association.

A complete health service for all on equal terms has been the demand of the Socialist Medical Association since its inception, and in so far as the White Paper proposes such a service we welcome it warmly. That the service is to be for 100% of the people is both a recognition that health is a national asset and a reaffirmation of the basic principle of medicine—equal care for all. The comprehensive nature of the provisions, especially the provision of free hospital treatment and maintenance and of a consultative service in home and hospital, will prove a welcome relief to all classes, lead to an improvement in our hospital services and a steady rise in the standard of medical care generally.

The most promising feature of the White Paper proposals is that National Health Insurance ceases to be a method either of providing a service for part of the community or of excluding part of the community from the benefits of organized medicine. There should be, under the proposed service, nothing to prevent every citizen obtaining complete medical care at all times.

On three points the need for compromise, which is inherent in coalition government, has led to weaknesses which we hope will be removed at a later stage, and on which the public must speak with no uncertain voice. We would have preferred a much greater unification of all the services than appears likely under Joint Hospital Boards and while two hospital systems are preserved. Co-ordination of the services will be an advance on our present unplanned arrangements, but a complete service could be more rapidly developed by the administration by regional authorities of a national plan prepared by the Ministry of Health. The preservation of two hospital systems working on a somewhat different basis will have to be watched very carefully, lest it lead to inefficiency through the perpetuation of small semi-independent units. The function and duty of a hospital should be to provide for the whole of the institutional care of the population it serves, subject only to any specialization laid down by the planning authority for the area. Voluntary hospitals will receive nearly all their current income from the State health funds, and the spending of that public money must carry with it a proportionate amount of public control.

There can be no question that it is in the interest of the individual, the community, the service, and the profession that all doctors should be salaried officers working at and from Health Centres and hospitals. The compromises suggested by the White Paper are a departure from that principle which weakens the scheme and leaves a possibility of financial competition within the profession. We would urge the Government to make its terms and conditions for whole-time salaried service at Health Centres, and its proposals for compensation and for the abolition of the buying and selling of practices so attractive that few doctors will want to remain outside the Health Centres. While appreciating the time-lag necessary for planning and building Health Centres we think that a community should have the right to set up a salaried service without regard to the slower procedure of the White Paper, which leaves too much of the decision in the hands of individual practitioners. We must watch also the extent to which the prevention of disease and the promotion of health can be achieved by this service. Many details of how the environmental, school, and individual services are to be linked with the general practitioner service need to be worked out.

With the provisions for study leave we are in full agreement, but would like greater emphasis placed on research, in which every section of the service must play a part. There are proposals in the White Paper which we cannot endorse and some parts we shall, after further study, suggest should be changed, but we believe the establishment of a universally available comprehensive health service without economic barrier is a great step forward. If it is an earnest of the Government's intention to implement the Atlantic Charter's call for "freedom from want," then we may yet build up a system in which health is possible for all and medical care is sufficient to maintain it.

Correspondence

White Paper: Need for Reflection

SIR,—The White Paper is before us and there will be a natural and very human tendency for each one of us to direct our attention to whatever particular part of it claims our special interest. Before we concentrate upon detail every one of us should sit back, as it were, and answer for himself two essential questions.

1. Is the scheme outlined in the White Paper going to benefit the general public? If so, can such benefits be made available to the public without fundamental changes in the status and traditions of our profession?
2. Is the scheme likely to be of any benefit whatsoever to the profession as a whole?

The responsibility placed, and rightly placed, upon each doctor to answer these questions is great. Plenty of time is required for reflection. If we once assent to this scheme there can never be any drawing back. Our liberty of action, not only as doctors but as citizens, will be curtailed and we shall never be able to regain it.

Let us remember 1912, and let us be quite frank about it. The offer of a seven-shilling capitation fee enticed us to capitulate, but thirty years later it only stood at nine shillings and the cost of living had nearly doubled. No one can deny that 1942 found us disgruntled and aggrieved. We felt the keenest disappointment that while we were not entirely dependent for our livelihood upon the N.H.I. we made such a sorry business of righting our grievances. If we accept the White Paper in principle we *shall* be *entirely* dependent upon the Government for our livelihood. What possible hope shall we then have of being able to keep our end up? We must not be too influenced by any terms offered us at the outset. They did not seem too bad in 1912. The means to resist this proposed revolution in our professional life is still with us. Let us look before we leap.—I am, etc.,

Calne, Wilts. C. EDE.

Some Reactions to the White Paper

SIR,—The members of the Local Health Services Council, to be appointed legally by the local authority, should be elected representatives of the interests concerned. The members of the Central Health Services Council, to be appointed legally by the Minister, should be elected representatives of the Local Health Service Councils. When a local authority submits a plan to the Minister it should also send its plan to the Local Health Services Council, so that an appeal can at once be made if necessary. The Act should also clearly state that the Minister must consult the Central Health Services Council if a Local Health Services Council appeals against a plan. Then if the Minister decides against the advice of the Central Health Services Council the matter can be raised in Parliament.

A plan submitted by a local authority should only state the minimum necessary requirements, and no attempt should be made to state a maximum number of doctors required for an area. The only reason for the Central Medical Board withholding consent to an application should be if there are areas with insufficient doctors, and there should be a limit put to the time for which such a refusal of consent could prevail. A new doctor could meantime be found to replace the doctor applying. No doctor should be kept away for long from the place of his choice, nor made to remain for long in an area against his wishes.—I am, etc.,

Carlisle. GERALD SHEEHAN.

A National Health Service

SIR,—May I direct attention to the nature of the system proposed for the nationalization of medicine. By the strangest of paradoxes the Government of this country, fighting to the death to liberate a continent from an evil political ideology, seeks to administer to its own people a large dose of the totalitarian poison, astutely and speciously concealed by a flavour of pious aspirations. In denouncing the White Paper I would emphasize that the distinguishing mark of the Fascist philosophy has been the exaltation of the "State" above the natural freedoms and rights of the individual and the family, and that the actual tyranny is exercised by a political clique or caucus, working through a subservient bureaucracy.

The White Paper assigns the central direction of the national health service to a single political personage, a Minister of Health, who is to be advised by a Central Health Services Council, composed of individuals appointed by him after various consultations. The proceedings of this council are to be governed by the Minister, with neither a safeguard to ensure that the council will be really representative of the professional organizations nor a freedom to publish its views, independent of the Minister. A special creation of the Minister, called the Central Medical Board, will be the executive machine for the dragooning of the rank and file of the medical profession.

Whatever its deficiencies, the existing system of local government does and did provide for some kind of democratic control over personal public services. One would have expected that the logical and appropriate measure for the remedy of the admitted deficiencies would have been the reorganization of the areas and functions of local government. Instead, the war is seized as the opportunity to set up Joint Hospital Boards, representative in theory of major local authorities, but

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in practice absolutely repugnant to everyone experienced in local government. Such statutory boards, entirely under the control of the Minister, are intended, with the aid of inspectors of the Ministry, to regiment consultants and specialists into harmony with hospital plans approved by the Minister. Family practitioners, recognized in the White Paper to be in the front line, are ultimately to be subjected to a procedure in all respects similar to the present practice of the Ministry of National Service.

It is admitted by the Government that the present health services are good and have been steadily improving. That they are so deficient in organization as to require the drastic changes proposed in the White Paper requires much more explanation than is offered. Ignoring the many contentious details of the paper, I submit that the whole scheme exhibits an authoritarian character which should lead to its emphatic rejection by the members of the free and noble profession whom it seeks to enslave.—I am, etc.,

Gateshead. JAMES GRANT.

Health Service Centre

SIR,—The general lines of Health Centre development are so vitally different from the picture of a Health Service Centre which I have put forward for thirty-three years that I feel that a brief summary might be published at this moment as a reminder.

A Health Service Centre is not a central surgery. In my scheme the family doctors will continue to see their patients at their own consulting rooms for their primary consultation (a questionary designed by the doctor for the patient to fill in at his leisure economizes time); it is the further and fuller investigation of a patient which should be carried out at the Health Service Centre, which is equipped with both ordinary and extraordinary means of investigation and staffed by a team of doctors. Investigations include *x*-ray, pathological, psychological, and all the special departments.

The small general hospital forms part of the Health Service Centre; this has beds for in-patients, and further examination, observation, and treatment—including rehabilitation—can be carried out. The centres are planned to provide a council chamber (with alternative uses for lectures, etc.) where the Local Medical Advisory Council meets. The members of this council include representatives of all branches of the medical services in touch with the life of the individual—the medical officer of health, the school doctors, the factory doctors, the clinic doctors, the consultative clinic doctors, consultants, etc., with the power of co-option for any special purpose of school teachers, priests, representatives from industry, and representatives from the local authority. From such an administrative centre would be organized home nursing, district nursing, health visitors, almoners, and other specialized departments at present under the jurisdiction of the medical officer of health.

The unit of life is the family, the unit of health services is the group, the unit of institution the Health Service Centre with the small general hospital as the important part of it, and the unit of organization the Health Service Council (the Medical Advisory Council).—I am, etc.,

Teddington. P. W. L. CAMPS.

MEDICAL WAR RELIEF FUND

FIFTY-SIXTH LIST

Amount previously acknowledged £52,009 17s. 4d. and £100 3½% Conversion Stock and £40 3% Defence Bonds.

Individual Subscriptions

£3 3s.—Dr. J. H. Crofton, Ware (2nd donation); Major M. N. S. Duncan, R.A.M.C.

£2 2s.—Capt. N. Bickford, R.A.M.C. (11th donation); Major W. Happer, I.M.S., and Mrs. Happer (21st donation).

£1 11s. 6d.—Dr. T. B. Evans, Prestatyn (20th donation).

£38 0s. 10d. ($170.05).—Canadian Medical Association, per Dr. Frank Patch (amount already sent £2,176 1s. 3d.); Dr. William Oliver, $10.00; Dr. M. R. Johnstone, $5.00; Dr. R. T. Atkinson, $10.00; Dr. C. Biro, $10.00; Dr. G. H. Hames, $5.00; Dr. W. S. Holmes, $50.00; Dr. A. B. MacDonell, $10.00; Dr. R. H. MacDonald, $25.00; Dr. E. R. Myers, $5.00; Dr. F. E. Wait, $15.00; Dr. S. Marinker, $25.00; Bank Interest, $0.05.

£19 6s. 6d.—Medical staff, Hoylake and West Kirby Cottage Hospital.

£5 5s.—Maxillo-facial Unit Staff Mess, Queen Victoria Hospital, East Grinstead, per Capt. Banham.

Local Medical and Panel Committees

£100.—Derbyshire (5th donation).

Total: £52,184 11s. 2d. and £100 3½% Conversion Stock and £40 3% Defence Bonds.

Correction.—In the Fifty-fifth List, under the entry "**£125.**—Rhymney Valley Medical Association" the name of "Dr. T. J. O. Sinnott, £10 (2nd donation)" should have been added.

Sums for Books for Prisoners of War

Amount previously acknowledged £114 18s. 6d.

Cheques, payable to the Medical War Relief Fund, should be sent to the Hon. Treasurer of the Fund, British Medical Association House, Tavistock Square, London, W.C.1.

POSTGRADUATE NEWS

The Fellowship of Medicine announces: (1) Revision course in anaesthetics, from April 17 to 29, lectures daily at the Royal Cancer Hospital, practical demonstrations at various London hospitals. (2) Final F.R.C.S. surgical week-end course, Hillingdon County Hospital, April 22 and 23, all-day. (3) Fina F.R.C.S. surgical demonstration, London Homoeopathic Hospital, *Sat.*, April 29, 2.30 p.m.

A series of postgraduate lectures will be given in the West Medical Theatre of Edinburgh Royal Infirmary on Thurs., April 13, May 4 and 18, and June 1, 8, and 15, at 4.30 p.m.

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 Recent Advances in the Medical Aspects of War Injuries 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 the Oesophagus. *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.—*St. Mary Islington Hospital*, Wed., 2 p.m., F.R.C.S. clinical demonstration.

DIARY OF SOCIETIES AND LECTURES

ROYAL COLLEGE OF SURGEONS OF ENGLAND, Lincoln's Inn Fields, W.C.—*Tues.*, 4 p.m. Prof. A. Sorsby: Blindness in Childhood: Past Achievements and Present Problems; *Thurs.*, 4. p.m., Prof. Sorsby: The Sulphonamides in Ophthalmology: Their Use and Limitations.

NATIONAL COUNCIL FOR MENTAL HYGIENE.—At Caxton Hall, Caxton Street, S.W. *Tues.*, 5.15 p.m., Miss Olive Willis: The Teacher's Approach to the Problems of the Adolescent Girl.

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., Prof. E. Sprawson: Diet as it Concerns the Teeth and Gums.

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

BLYTH DIVISION.—At Thomas Knight Memorial Hospital, Blyth, Sunday, March 26, 3 p.m. Agenda: Discussion on the White Paper, etc. All medical practitioners, including serving officers, in the area of the Division are invited to attend.

DUNBARTONSHIRE DIVISION.—At 39, Elmbank Crescent, Glasgow, Wednesday, March 22, 3.45 p.m. Discussion on the White Paper. All medical practitioners, including serving officers, in the area of the Division are invited to attend.

GOOLE AND SELBY DIVISION.—At the Nook, Snaith, Sunday, March 26, 3 p.m. Discussion on the White Paper. All medical practitioners, including serving officers, in the area of the Division are invited to attend.

LEIGH DIVISION.—At Boar's Head Hotel, Leigh, Sunday, March 26, 2.30 p.m. Agenda: Discussion on the White Paper, etc. All medical practitioners in the area of the Division are invited to attend.

MID-CHESHIRE DIVISION.—At Altrincham General Hospital, Sunday, March 26, 3 p.m. Meeting. The White Paper and Questionary.

NORTH OF ENGLAND BRANCH.—At Royal Victoria Infirmary, Newcastle-upon-Tyne, Thursday, March 30, 2.15 p.m., Clinical demonstration in the out-patient department by Dr. K. B. Rogers and Mr. F. McGuckin; 8.45 p.m., Address by Sir R. Stanton Woods: Physical Education and Re-education. Members of H.M. Forces stationed in the area of the Branch are invited to attend.

NORTHERN IRELAND BRANCH.—Joint meeting with Ulster Medical Society at Whitla Medical Institute, College Square North, Wednesday, March 29, 8.15 p.m. Dr. Geoffrey Bourne: Hospital Diets.

PERTH BRANCH.—Meetings, to which all medical practitioners, including serving officers, in the area of the Branch are invited, will be held on Sunday, March 26, at 3 p.m., at the following places to discuss the White Paper. *Perth:* Station Hotel. *Highland District:* Cuil-an-darach (Logierait Poorhouse). *Central District:* Crieff Cottage Hospital. *Western District:* Dr. McBride's house, Woodside, Doune.

ROCHESTER, CHATHAM, AND GILLINGHAM DIVISION.—At Guildhall, Rochester, Sunday, March 26, 3 p.m. Discussion on the White Paper. All medical practitioners in the area of the Division are invited to attend.

ST. MARYLEBONE DIVISION.—At 11, Chandos Street, W., Tuesday, March 28, 5 p.m. Discussion on the White Paper.

WORCESTER AND BROMSGROVE DIVISION.—At Worcester Royal Infirmary, Sunday, March 26, 2.30 p.m. Discussion on 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

CLOTHIER.—On Feb. 25, 1944, at the Belgravia Chelsea Nursing Home, London, to Ella, wife of Major J. G. Clothier, R.A.M.C., a son.

GAISFORD.—On March 18, 1944, to Mary, wife of Wilfrid F. Gaisford, M.D., F.R.C.P., of Rowington, nr. Warwick, a daughter.

GODDEN.—On Feb. 17, 1944, at Rubislaw Nursing Home, Aberdeen, to Mary, wife of Dr. Wilfred J. Godden, Redhills, Annan Road, Dumfries, a daughter.

KENYON.—On March 10, 1944, in Manchester, to Marjorie (Dr. Landau), wife of Ralph E. Kenyon, F.I.C., a daughter.

PURCE.—On March 13, 1944, to Eleanor (*née* Frankel), the wife of Dr. James Purce, of The Lodge, Basford, Stoke-on-Trent, a son.

ROGERSON.—On Sunday, March 12, 1944, at The Limes, Hartshill, Stoke-on-Trent, to Bettie (*née* Freeman), wife of Dr. C. H. Rogerson, a son.

DEATH

STARLING.—On March 16, 1944, Helena Sarah, loving and beloved wife of Edwin A. Starling, M.B., M.Ch., of 77, London Road, Tunbridge Wells. No flowers.

The Home Secretary announces that Drs. M. J. McNiff, R. M. Geldart, and I. F. McLeod are once more authorized persons for the purposes of the Dangerous Drugs Act.

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