PERSONAL VIEW

The ghost of Beveridge must be smiling benevolently as it watches the gradual unfolding of Todd, Seebohm, Salmon, "Cogwheel," and Maud. In fact I can hear it saying to itself, "I told you so—I knew this would happen if I left old Parkinson around long enough." At first sight there may not be an obvious link between these reports. It is only when we add the Green Paper that the picture comes into focus and the interrelationships become defined.

Now that's a pretty far-reaching statement and I think needs some justification. Rather like the man on the touchline, I suppose it's easier in the peripheral hospital to see some, though not all, of the facets of medical football. A brief and perhaps unorthodox summary might not be out of place even at the risk of offending those who already know.

Todd.—Here is a real attempt to get away from the "Jack of all trades" of older days with emphasis on good preclinical and clinical training ending in a registrable degree. Subsequently the keynote is vocational training in one branch, be it general practice or neurosurgery, with the appropriate steps, assessments, and details of postgraduate degree outlined for all variants of a medical career.

Salmon.—Purports to rationalize and standardize nurse training and career structure on civil service lines, with suggestions about managerial responsibility and delegation—that is, "Who does what?" The difficulty seems to be to discover who does what at the grass roots.

Seebohm.—Proposes measures long overdue which, I hope, will properly integrate county and local authority functions in relation to disability, disablement, disease, and distress.

"*Cogwheel.*"—Otherwise Salmon in miniature for hospital medical staff—and not so miniature either. So far we have an English "Cogwheel" and a Scottish "Cogwheel." Perhaps with the present nationalist tendencies we can look forward to a Welsh "Cogwheel" as well.

Maud.—Yet to come, but will probably contain the most controversial proposals, with appeal for a business approach for local government and distress for local politics.

Green Paper.—Ties up welfare for regional board, county, and local authority—let's hope the knot doesn't hurt too many too much. Presumably area (? health) boards will tie themselves to regional government, and so on and so on.

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The underlying theme of all the above is organization of total medical care, with subsequent fitting of the resultant proposals into a social structure. The conclusions in each of the six reports are majority judgements on the evidence presented. I purposely include Maud, as the proposals therein, to be economical, must be correlated with those of the Green Paper.

It's inevitable that social medicine, now so closely linked with social security, should take the lead in integration of medical services—the question of politics couldn't matter less. Social medicine (public health as it was) has the advantage of a tailor-made system asking to be extended. The guide lines of its organization are stimulated in "Cogwheel" (hospital doctors) and Salmon (nurses), and the connecting link is Seebohm (community and social workers). Thus within less than a decade we've on our doorstep a proposed massive reorganization of the N.H.S. under the newly projected Ministry of Health and Social Security.

If the above is a correct interpretation, then I suppose we might divide doctors into Drs. (Organization), Drs. (Community), and Drs. (Technical), in that order of importance. I use the word "importance" reluctantly, and am not sure whether it relates more to the patient or to the system (somehow I think the system will win). Drs. (Comm) will presumably replace the present general practitioner, and in traditional service jargon his title could read, "Physician—Community—for the use of."

It is interesting to watch the pendulum swing. Before 1948 the doctor was protected from his patients by the fee necessary to see him; as a result many would-be patients suffered. The doctor, however, suffered many other patients to keep the wolf from the door and the shine on the Rolls. Today the trend is still to protect the doctor, but this time with a ring of health visitors, social workers, district nurses, and—last but not least—the well-trained receptionist. He has the protection, and now the premises in the shape of a health centre, and lo—the job is done—he's become a consultant community physician. Well, why not?—it seems the only honourable way out.

Our friends the lawyers laugh and say it could never happen to them. I am not so sure. There is a distinct parallel between today's legal aid and the Lloyd George panel. The frustration of the legally aggrieved, outside the present legal aid, may well find an answer in a National Legal Service sponsored by a "legal" Beveridge with, of course, a legal B.U.P.A.

Drs. (Tech) have perhaps been the most recalcitrant group. After all it's hard to step down from the pinnacle of the voluntary hospitals with their prima donna status into the humdrum life of a mere technician. With the passage of years, however, the process is almost complete, and we now have a more rational Dr. (Tech). He not only recognizes that there are others who can do his job equally well, but, what is more important, he recognizes the need to seek the help of other disciplines in the overall care of his patient.

Drs. (Org) will assume prime importance because they will infiltrate and control the other two groups to a greater or lesser degree. Management, more than medicine, highlights the career of Drs. (Org). Their actual technical knowledge will need to be very general, and rarely specific. Their ability to grasp the important outlines of medical progress without the responsibility of the minutiae of clinical treatment grooms them for directorships in the service of medical care. Nevertheless, even at this level they will still be subservient advisers to the administrators. One of their principal tasks already begun will be to standardize Drs. (Tech) and Drs. (Comm), which is apparently proving quite difficult.

Besides doctors and administrators there are many other groups of people involved in total welfare. In the war it was said that it took nine people to keep one Spitfire in the air, and nowadays it takes nine people to return one patient to full health. Should the reader have browsed this far, I need hardly remind him that these nine will also be administered, organized, and standardized in due course. As a Dr. (Tech) working on the periphery, I have no objection to being organized in this way, provided I can be free to do the job I have been trained to do, and to have the freedom to make professional decisions which are in the best interests of my patients.

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Medicine today is big business, and by and large doctors are not renowned for having hard business heads. This isn't to say, however, that the art of medicine would be buried in a slough of administration—far from it. Here I think our sheet anchor is the Todd report. Some say it is pie in the sky—maybe, but, to change the metaphor, I think we have got to mould it to become the cornerstone of future medicine. Today we lead the world in medical care. The Todd proposals can only increase that lead, and, by exporting both product and knowledge beneath whatever colour skin, we can ensure fuller benefits to people elsewhere as well as at home.

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