Papers and Originals

Medicine and the Community*

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Two thousand four hundred years ago the people of Aegina decided to pay Democedes, the physician to Darius, an annual fee to provide medical advice. To-day the National Health Service still pays capitation fees to a general practitioner to provide medical care for that part of the people of this country for whom he undertakes to do so. The continuity and the intimacy of the relationship are very different, however, and, fortunately for us, the return for the payment is a good deal more effective. But circumstances, both social and scientific, are continually changing that relationship, and there is need of a considerable readjustment now.

The Profession and the Public

Some of these changes in circumstance will be my subject. I hope to bring out the nature of some of the consequential adjustments which are already appearing, or must soon appear, if the relation between the profession and the public is to remain as happy as it has been, much less improve, as it should. In spite of the strains which certainly do exist at present and which puzzle and concern many doctors and some patients, a P.E.P. inquiry recently reported that the medical profession stood well above any other in public esteem. The public-opinion survey carried out for the Porritt Committee on the medical services showed that 90% of the public wanted the service to continue, with or without modification, and four out of five thought they received good value from it. That is why, to quote Professor Titmuss, it costs a young doctor here only $6 to insure against legal action by patients, whereas in California it costs his counterpart $820 a year. Yet many doctors feel that their relationship with their patients is not right; that it is too exacting and sometimes pressed without the consideration they can reasonably expect. Some patients even display an apparent hostility or a sense of persecution. On the other hand, some who are observant criticize the way in which certain doctors deal with the public. These two points of view have to be reconciled in the interests of public and profession alike.

This is not meant to deny that general practitioners are sometimes rightly concerned about demands on their time that go beyond what they can or should be expected to meet. Under such pressure the doctors inevitably feel that some patients seek more than is reasonable, and a few do it in an ill-mannered—even an unacceptable—way. But this calls for education of and understanding in patients and potential patients—in fact, in the community. We should surely employ every means other than rigid rules or punitive retaliation if we want to preserve relations of mutual respect between doctors and patients. Many doctors have the knack of dealing with this situation informally and effectively; some do not, and most of them have a few patients who are not merely inconsiderate but incapable of accepting the relationship of mutual respect and consideration that is needed.

The effect of recent changes in society as a whole on doctor–patient relationships must first be recognized. The social barriers, which were more pronounced in England than in Scotland, have been at least greatly reduced. Younger people, especially, have acquired a new degree of economic and social freedom which affects their personal relations with doctors, as with everyone else. The manner of the patient towards his doctor is affected by this, even if his acceptance of the authority of the doctor, in some respects which affect him intimately, is not. Sometimes doctors have a wish for outward and visible signs of respect for their difference from other people that are not realistic in these times—even though they still have the essentially personal respect for the patient as a human being which every good doctor must have. I recently received a bitter complaint from a consultant friend who had overheard a verbal exchange between a general practitioner and a patient which he regarded as shockingly ill-mannered and disrespectful on the part of the patient. Yet, as recounted, it gave me the impression only of intended friendliness, in the egalitarian terms of present-day society. One may be called "Doc" rather than "Doctor," but that can mean friendliness rather than a kind of fear, and certainly no less respect. These are matters between individuals, and they vary accordingly; but collectively they have an effect on the actions of the organized profession and they can sometimes provoke the silliest kind of action from either side, even of the use, one-sidedly, of disciplinary machinery intended for quite other kinds of complaint.

Development of Scientific Medicine

The changes in medicine itself have produced much more profound changes in its relationship to the community. Even in the relatively recent past accurate diagnosis and prognosis were more prominent in medical minds than effective intervention in the course of the disease. In this century, and especially in the thirty years since I qualified, the effectiveness of treatment has been wholly changed by the progress of medical science, and it has been accompanied by the increasing recognition of social factors in disease.

The development of scientific medicine, of course, began long before I qualified, but it happens that the introduction of sulphanilamide, the first really effective antibacterial drug after salvarsan, occurred at about that time, and the pace really began to increase. Similarly, the wider content of social medicine was beginning to be discussed, and it was only a little later that John Ryle became the first professor of social medicine—oddly enough at Oxford, where there was then no clinical school. The war threw us back on the pressing problems of organizing curative services with a greatly depleted medical force, but it also facilitated some developments which made subsequent general progress more rapid. In England, for instance, it led

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to an organized extension of laboratory services into peripheral hospitals, the provision of a national public health laboratory service, and some peripheral development of specialist services which might have taken much longer otherwise. Even the experience of the evacuation of children and of mothers from the major cities brought home some social lessons and incidentally aroused rural as well as urban populations to recognize the advantages of confinement in hospital. There were county areas where the home confinement rate dropped from 90% to less than half within four years. The Forces' need for specialist services also produced a greatly increased number of young trained specialists who were to be invaluable at the inception of the National Health Service.

Pattern of Change in the N.H.S.

We know much more about the pattern of change since 1948, because, for the first time, we have some national figures about services and the extent of their use. But our figures for the first year or two are not very accurate—which is a pity, as some of the most rapid changes occurred then. There had been some advance planning on the hospital side through surveys sponsored jointly by the Health Departments and the Nuffield Trust. Hospital boards started with a plan for an area service, and they were able to increase the number of specialists, to distribute them adequately to group hospitals for management, and to rationalize the use of hospital beds. Services such as radiology and pathology were provided throughout the groups, with centres for neurosurgery, thoracic surgery, plastic surgery, and radiotherapy for whole regions or subregions. Of course, the appointed day of 5 July 1948 brought no immediate new service, but it brought into being a system which could distribute what there was more fairly and provide for rational development. It is difficult for those in teaching centres to realize the extent of the progress that was made at the periphery. In Scotland, teaching hospitals provide a much larger share of the specialist services than in England because they are proportionately more numerous. In my own home town 50 miles (80 km.) outside London the specialist staff has increased more than tenfold since 1948.

There was no such radical change in general practice. The numbers of doctors were not greatly increased, since there was no additional money available for this purpose as there was in the case of hospital staffs. There was, however, a change of another kind ; since nearly everyone elected to become a health service rather than a private patient, the distribution of incomes from general practice sharply changed. The large industrial towns, where lists of 4,000 were common and practice expenses low, began to offer the largest incomes, while more attractive areas, where there had been a good deal of private practice with smaller lists and higher practice expenses, were comparatively much less rewarding. Many general practitioners who had staff appointments in general hospitals either turned wholly to hospital work or found that specialists had been brought in to take over all or part of it from them.

Thus, over a period of some two years a change that had been slowly taking place through the first half of the century—first in teaching centres, then in the other larger towns, now throughout the country—was completed. The clinical side of the profession was divided into specialists or consultants, engaged wholly or mainly in hospital wards, and general practitioners, only a minority of whom appeared at all in hospital, as clinical assistants or in charge of unspecialized work. This was not an arbitrary change initiated by the Health Service, it was the accelerated completion of a process of professional evolution made possible by Health Service finance. It already existed in, for instance, the Scandinavian countries, and it has occurred or is in process everywhere.

Unlike Scandinavia, however, we secured one essential safeguard for the relationship of general practice to the public. The general practitioner remains the originator of any form of medical care. In our Service he is the personal physician whom the patient consults ; he decides whether, and when, the patient should go elsewhere for diagnosis or treatment, and the patient so referred comes back to him. Nor does the specialist have, as in Eastern Europe, any authority over the doctor outside hospital ; he is the consultant—to be consulted or not as the general practitioner chooses.

Public Health Service

There is, of course, a third arm, the Public Health Service. I personally believe this to be a bad title, but I can't think of any better. This service consists of the doctors organizing local authority services which support both hospital and general practice as well as preventive and social services direct. Their work, too, was largely changed in 1948, because curative services were transferred to hospital boards. But that put the public health doctors in a position to organize the non-medical services that contribute so largely to domiciliary care—especially home nursing, midwifery, health visiting, and home help. It brought them into closer relation with their clinical colleagues, and it now puts them in a key position to help in the evolution of general practice if they will only see the opportunity before them—as some have. They still, of course, have those crucial responsibilities in the control of communicable disease of which Aberdeen has had ample demonstration recently ; but their main continuing function is likely to be in a much wider field of planning and of provision of supporting services. There are developments in preventive medicine—especially in the early detection of disease and the limitation of disability—which may be undertaken mainly by clinicians but will not be actively planned or promoted unless the community physician provides the driving force. Medical care is not now a simple matter of one patient and one doctor ; it has to be organized, and who is better placed for that purpose ?

Specialization

The changes that have occurred in the last dozen years have partly arisen from scientific progress and partly promoted it. Since the division between special and general practice was completed there has been a rapid increase in the number of consultants and an even more pronounced differentiation between the specialties. Junior hospital staffs have increased even more. The greatest rate of increase in consultants has been in the smallest and newest specialties, and in pathology, radiology, anaesthetics, and psychiatry. In fact, the subdivision of medicine that separated general from specialist practice is going on to separate specialties within medicine and surgery. You may have to decide not just that a surgeon is needed, but that he must be a chest surgeon, and, further, a chest surgeon who leads a team operating a cardiac by-pass machine. Moreover, one specialist by himself is not enough ; the precise diagnosis for the cardiac surgeon is made by a cardiologist with the help of a radiologist and perhaps a clinical physiologist, and the actual surgery is accomplished with the aid of a skilled anaesthetist after some careful provision for use of blood, determined by the pathologist. So much measurement, instrumentation, and investigation is needed that the new specialty of clinical physiology or clinical measurement has emerged. In fact, specialization does not make the specialist more self-sufficient—it makes him more dependent upon colleagues. Not only are more medical specialists needed, but non-medical scientists—chemists, physicists, engineers, mathematicians—and a host of skilled technicians.

Scientific investigation as a part of medicine has increased so much in diversity and amount that it cannot be expressed in simple terms. Precise objective records can now be made of many different factors in health and disease. The range of

chemical investigations of blood and other body fluids is continually increasing and the methods have become more rapid and precise. Physiological monitoring can be done by machines more accurately and more continuously than by clinical observation. Machines are used for counting blood cells and for other haematological work. Automatic analysers are beginning to be used for multiple chemical analyses of serum and plasma, again with great consistency and much greater speed than a technician could achieve. Electro-physiological records from heart, brain, or muscles are more widely used, more complex yet better understood. A vastly greater amount of information can be provided about every patient in a hospital —if this is needed. For instance, a patient in a respirator can be monitored by frequent or continuous blood-gas estimations rather than by simple—and fallible—clinical judgment.

Specialist–Patient Relation

This means that the relationship between specialist and patient is in some sense changed. The doctor does not rely simply on his own experience and clinical observation. He has to take into account an ever-increasing array of facts and give to each its due weight in his final judgment. At the same time he has better guide-lines to control his treatment, and that means that he can go further with less risk, either in surgery or in the use of drugs. There is less guesswork, and although the treatment may be more radical or more severe it can be safer.

More intensive therapy means more intensive observation of the patient ; that means more medical time in hospital work and a greater need for trained nurses. In the thirteen years to 1963 hospital medical staff at registrar level and below has increased by 54% and at senior registrar and above by 29% in England and Wales ; the figures for Scotland were 78% and 51%, and the Scottish levels were higher before this increase began. By contrast the man-power in general practice has increased in Great Britain by only 9% in the last eleven years. Hospital beds actually in use have not increased in that time in England and Wales. Hospital doctors are not idle, and this means that here, as in other countries, more intensive—and there is evidence to show more effective—medical care is being given in a shorter time. The total medical man-power in hospitals is increasing so much faster than in general practice that there will soon be more working in hospital than in general practice. That again is not peculiar to this country ; in Sweden the proportion is roughly three doctors in hospital to one outside.

Consequence for the Doctor

There is a consequence for the doctor in all this that has a bearing on the main theme. In many, perhaps in most, patients the whole array of information is still small enough for ready comprehension. In some, and especially in some specialties, it is rapidly approaching the limit. Continuous physiological monitoring, for instance, can quickly provide so great a mass of material as to obscure its value. Lord Brain in his presidential address to the British Association last year said, "Automation will make little difference to doctors, midwives, nurses, and schoolteachers." I am not sure he was right for doctors and nurses or even schoolteachers. It surely will be possible to use automatic data-processing to sift some of this mass of scientific observation, just as junior staff have done for their seniors in the past, and certainly with greater accuracy over a large volume of material than human appraisal can give. I have seen it being done in a chemical laboratory using a ten-channel automatic analyser ; and in at least one American centre automatic screening of electrocardiograms is being tried. Of course the computer will not take over from the doctor, but there will be more and more situations in which it can help.

If this new need does arise for the doctor's work, there is also another need in his relationship to the patient. Because there are so many more doctors, and their technical allies, associated with patient-care, it becomes increasingly difficult to maintain the old personal relations between one responsible clinician and the patient. Many more complaints have been made against the hospitals—not necessarily the hospital doctors —than against general practitioners. That is partly because the family doctor is chosen by the patient and as such is less likely to be attacked than an institution. But it may also represent the failure of many patients to identify anyone in hospital as " their doctor " and to get into close communication with him. The commonest type of complaint made against hospitals clearly stems from lack of understanding of what was or could be done. Patients may be frightened ; they may be hostile because of their need to conceal fear ; some may even occasionally be stupid ; and many are worried because they are uninformed.

Consequence for the Patient

There is a different consequence for patients, in the growth of science in medicine. Many patients know more about medical matters now ; they know that precision, born of scientific investigation, steadily increases in medicine ; they know, through popular media, something about the nature of those investigations ; they want the answers or an interpretation of them. They often have a highly distorted concept of the nature of possible results. This is not a justification for transmitting a host of unintelligible findings, but it is a reason why many patients expect something definite in the information they are given ; it is also a reason why an attempt should be made to supply this. There was a time when medicine was the doctor's private mystery ; no one now tries to keep it so. It was, after all, often a cloak for medical ignorance of pathological processes, or a deliberately chosen means of assuring the patient. But there is a need for the profession as a whole to think more seriously about this problem of communication—between themselves and the associated professions as well as with the patients. This relationship is a difficult one. Some doctors accomplish it relatively easily, some with great stress, if at all. With certain patients it is virtually impossible. In some respects it is easier in general practice because of more continuous contact—in some more difficult ; occasionally the imposing image of the hospital makes it easier there. It is, however, a relationship for which students are too little prepared. Conditions of overwork obviously make it less possible, and under such conditions the doctor, to whom so many unburden themselves, may well begin to feel that the last one really is the last straw. There is a vocational motive behind most students' choice of medicine, and most of us must occasionally have the feeling that this motive in some way sets us a little apart. It can at times give an impression of tiresome self-satisfaction to our friends outside medicine—much more so to our critics. Yet we need it as a reassurance when a particularly grievous responsibility for someone else's life or health weighs too heavily. The greater popular knowledge of medicine will sometimes help us here.

Grouping of Specialist Services

The changes in medical science require larger hospital units because specialist services must be grouped if they are to be efficient. The district general hospital helps to create the impression of remoteness, and this impedes understanding. Yet, away from the group, consultation is practicable on a limited scale, nursing can be provided in a home or a small hospital, but a full general hospital service cannot. This leads inevitably to a conflict of social convenience and medical efficiency, wherever the population is dispersed. Only a few can have the convenience of hospital service in the same street. Many more can have it within a 5-mile (8-km.) radius. In England few have to travel 20 miles (32 km.), still fewer an

hour's journey in a car. Even in Scotland the number living a really long journey away cannot be large. The community has to face the fact that the local cottage hospital cannot provide a general hospital service, and major medical treatment must be concentrated if it is to be efficient.

This change of concentration has hardly had its parallel in general practice ; yet medical science has not only changed in hospitals, it affects general practice too. The use of the new tools of medicine has developed in general practice, though more slowly. Diagnostic services are used irregularly and fully by perhaps only 10% of doctors. In fact, the pattern is so irregular that there is clearly no general agreement about what it should be. That is not surprising, because the needs of general practice are scarcely taught at all ; many teachers have no clear idea what these needs are: they are fully preoccupied with teaching hospital medicine, and the best deployment of diagnostic aids in general practice may be very different. We must face the fact that general practice has not been organized on a basis that would encourage any other result.

Professional Contacts

Hospital doctors are constantly meeting colleagues in their own and other specialties and they have working with them a continual succession of young men recently from the schools. These young men have mostly had less didactic teaching than their predecessors of thirty years ago and much more encouragement to probe, learn, and criticize. Their seniors cannot help learning from them, perhaps even more than from their colleagues. A comparable opportunity occurs in general practice only when a new member joins a group perhaps once in half a dozen years or more. In single-handed practice not even this occurs, and the very fact of being single-handed is an obstacle to part-time work in hospital, attendance at meetings or courses, and any other method of refreshment of knowledge. Reading alone cannot suffice. General practitioners are therefore increasingly moving toward practice in groups—especially the younger among them. In England and Wales 95 new group-practice loans to the value of more than £600,000 were made in 1963 alone. Only a quarter of the general practitioners in England and Wales were single-handed in 1963, and a sixth were in partnerships of four or more (not necessarily all effective groups). This method of promoting professional exchange is therefore moving, if slowly and under real financial difficulties.

Much more is being done through organized postgraduate work. In the last three years rapid progress has been made, mainly through efforts by the doctors themselves, in developing postgraduate centres at regional hospitals. Many have collected or subscribed to voluntary funds to provide buildings ; many have also paid running costs. The initial drive was provided by the Nuffield Provincial Hospitals Trust, which organized a conference and then contributed over £300,000 to begin the implementation of the recommendations then made. This work is crucial. It is even more important than the rapid increase in attendance at postgraduate courses organized by the universities, which were attended by nearly a quarter of all general practitioners last year. Then, too, for a decade the College of General Practitioners has organized symposia and research, and the B.M.A. has arranged annual clinical meetings. Therefore improvements that must affect most practitioners some of the time have been made.

Causes of Dissatisfaction

Yet there are obviously causes, other than those of remuneration, of serious dissatisfaction with general practice among its exponents. Moreover, some of the dissatisfaction occurs among those who have done most to promote good general practice. Some say that the content of general practice has deteriorated ; most say that they are overworked ; most agree that the system of gross remuneration reflects what doctors as a whole spend on their practices but does not return to the individual what he has himself expended. This produces in some, at least, of the doctors enough resentment of their present circumstances to threaten relations with the community they serve. It also threatens the repute of the profession as a whole if it is intemperately expressed.

I am not going to talk about remuneration except to say that the negotiated system that has developed is so complex that it is seldom understood and manifestly no longer gives satisfaction. I do want to consider for a moment the question of overwork. I am sure it is more real, for many, than some of the statistical studies suggest. One study seen recently gave the average week's work with patients as just under 40 hours. But that takes no account of the time which must be spent on practice organization and on the continuing study by reading, meetings, hospital visits, or discussion that must be undertaken by any doctor who wants to remain an effective physician. Even one domiciliary consultation could add an hour. There could well be a total of 50 or more hours, and there are many more when the doctor is on call. Only a third of doctors in the sample had better than every other week-end off. Moreover, an influenza epidemic or even a heavy snowfall could add a lot to the load. General practice is certainly undermanned and even less likely to gain man-power at an optimum rate than the hospitals. Better practice organization might reduce some of these difficulties, but we will need to look to measures long used in Scandinavia to reduce the calls on medical time to a level which will allow doctors to be as free to keep up their standards by study as we and they would wish. Essentially this means a process of dilution, with sharing of the load by other professions—especially nurses, midwives, and health visitors working within the group.

Shortage of Doctors

Although remedial action is being taken we will be short of doctors for a long time to come, and we certainly have to make the best use of all the medical time we have. There is no prospect of a quick increase, and we cannot envisage an indefinite period during which doctors as a class work excessive hours or omit the postgraduate study they all require.

There is thus the pressure of shortage, as well as of professional needs, to urge better organization of general practice. That may come soon with much more rapid growth of group practice, so that the community gets its medical care from group general practices, each working with a district general hospital, which must be a medical centre for reference, with organized postgraduate learning, and with opportunities of consultation with specialists. But the relationship of general practitioner to specialist is not that of assistant ; it must be one of equality. The logic of the division into general and specialist practice is that the two are partners, necessary to each other and doing different things. The general practitioner is the personal physician all the time ; he uses the specialist only when the patient needs him.

The professional content of general practice has changed and will change more. It is a common but baseless gibe that the practitioner is just a signpost to the hospital. Actually, he is carrying out more active treatment with every passing year. The nature of the drugs used alone shows that. But there are other changes, as yet little appreciated, in the offing. The practitioner is consulted more readily now, and he sends to hospital for further consultation little if any more than he used to: most of the increased out-patient attendances are due to trauma, antenatal care, or population growth. The new activity now emerging is screening for pre-symptomatic disease. Cervical cytology has been admirably studied in and reported from this city. Hypochromic anaemia has been the subject of reports from several places. Diabetes and glaucoma have been surveyed

in Bedford. Already many doctors organize preventive inoculations and well-baby clinics in their own practices. The concepts of the family doctor and the practice population lead inevitably to such work, and so to a new, largely unexplored relationship between doctor and community. This will become the next phase in the relationship of medicine to the community —that the doctors' concern is as much to prevent disease and limit disability as to treat the individual illness.

I think it is fair to say that all these doctors in or out of hospital are to some extent under pressure. Medicine is open-ended ; there is always more you can do, even if it is only to continue learning. In fact, the only way the conscientious doctor can avoid this is by deliberately pacing himself to what he can do well and using non-medical assistance where he can. Lord Brain asked, " Are we then to envisage a state of affairs in which the industrial part of our population enjoys compulsory leisure, while the professional part continues to be overworked ? " To some extent the hospital doctor can pace himself by devices like the waiting-list for in-patients and the appointment system for out-patients. In some ways this just pushes more back on to the general practitioner ; but so does the other device, already used but likely to be used further still, of shortening stay. Increasing turnover, out-patient surgery, and short stay after confinement have the same effect. What can the family doctor do to ease his load ? He too can use the device of an appointment system and he can use ancillary help in his practice and work with local authority nursing, health visiting, and midwifery staff, provided they too can work on a practice basis. He can join with colleagues in group practice premises, share ancillary help, and at least gain the priceless benefit of professional exchange of knowledge, while reducing the tiresome restrictions of standby periods on his life. Other professional workers, especially the nurse and health visitor, can work with the general practitioner, not as his attendant or minion but as allied professionals. The doctor–nurse partnership is the norm in hospital ; it can become the sensible and economic partnership outside. But the general practitioner is more vulnerable than his specialist colleague and his difficulties are less understood or less considered by a population of patients to whom he is much closer. The corporate action of the group is needed to ensure that this is organized.

Public Reaction

How will the public react? Concentration on groups will mean that general medical services are available at fewer points and therefore some people will have to travel farther for them. They already go further still for the less commonly needed hospital services. They will certainly have much less distance to travel than the people of, say, Sweden or Canada. If they really want good general practice, and the continuity of personal medical care that British general practice gives, in my judgment they have no choice. Dr. Brotherston's description of general practice as a "cottage industry" will remain unless we can get way from conditions which more or less impose it.

There is a danger at this time that the attitude of organized medicine might be represented as actually hostile toward the public it serves, though such critics always say it isn't true of their own doctor. Doctors as a whole are aware of these difficulties, but sometimes are inclined—as we all are when faced with such difficulties—to look for fault in " them " rather than for, at least, a partial explanation in the unforeseen complexities arising from the changes in their own profession.

The public are perhaps a little too ready to accept that " busyness " for a doctor is part of the natural order of things, rather than something which will have to be abated, even at the cost of a somewhat more selective service to themselves. They don't always accept that they may have to see other doctors or nurses from the group rather than their " own." The other party to this has to be Government, faced with the problem of generalizing service at the highest level of efficiency possible in circumstances where social and scientific advance endlessly raises the cost in man-power and money alike. It must be possible to reach solutions, and I believe this will be done, but they will have to be solutions of forward-looking change—not simply patches to preserve things as they are. It is twelve years since the post-Danckwerts settlement made the one departure in principle we have so far had from the original 1948 arrangements. That is too long. There is, of course, no simple solution, and both sides have to accept change ; but this time it may have to be a more radical change than any yet.

Conclusion

We have distinctive aspects of medicine in Britain that are worth preserving because they make for better service, at least in the present state of medicine. The most important of these is the balance between general and specialist practice and the fact that neither now fears encroachment from the other. This balance can be preserved if general practice can be reorganized from within so that it can make the best use of the opportunities of the new district general hospitals and of collaboration with the other health and welfare services. But the relationship between medicine and the community in this country is not commercial. Whatever the impression a reader from abroad might obtain from our press, the present troubles are not primarily about money. A reorganization of medical work is required so that doctors, especially those in general practice, are enabled to do a better professional job and meet an ever more sophisticated public demand for medical service, without assuming a growing overload, which of itself must reduce both efficiency and satisfaction in their work. They also require a public response, especially from a small group which now makes occasional unfair demands. Community health is a joint enterprise dependent on a mutual confidence to which we must all contribute. It can neither be bought nor be imposed.