

said Dr Hart, single handed practice could be dangerous both for the doctor and the patients—there had to be some means of escape for both of them. The solution did lie in groups—but organised in such a way that continuity had been assured. “That depends first of all on a record system as a means of communication between doctors: and on a policy that says that the first requirement of this practice is not that it should give doctors a quiet life or that they should be protected from patients—the first demand is that patients should not be seen without their records and that decisions should not be taken in ignorance by the dispenser, doctor, or receptionist.”

“What we should oppose in the present trend, and what is bad,” said Dr Hart “is for there to be a partnership of 6-12 doctors with no one taking real responsibility for the patient.

Certainly we should expect patients to take some responsibility for their own health; but that should not mean a wife sitting up all night with a sick husband waiting until 8 o'clock when she could send for her own doctor—that is absolutely wrong.” The best compromise was, he thought, a rota system manned by GPs. There was something to be said for commercial deputising services, if they were manned only by experienced GPs—but in general doctors should be alarmed at the speed with which these services had grown. Personal service was still the most precious thing in general practice.

“My wholesalers have just gone back to manufacturing Gladstone bags so that we can all look like Dr Finlay. That is telling us something about what doctors want to be like and what they think patients would like us to be like.”

## *What I would say to the Royal Commission*

### Compelling needs of our hospitals

MICHAEL ELDERKIN

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The outstanding problem of the NHS is the low morale of those who work in it. The undoubted success of the service over its first 20 years depended largely on the dedication of its staff at all levels, but especially on the traditional unselfish attitudes of nurses and doctors who undertook long hours and a lot of responsibility without undue preoccupation with pay. Morale is probably at its lowest among senior hospital doctors, who used to provide the stimulus and set the standards for the whole profession. Increased militancy and acquisitiveness in all sections of society, coupled with the effects of inflation, have eroded the financial security of doctors.



Michael Elderkin

At a time when the Review Body no longer appeared to be independent of political influences the country was overtaken by the present economic crisis. This timing was particularly unfortunate for the profession because it had at last become obvious that there was an urgent need to iron out some of the disparities between the salaries and career earnings of hospital doctors and general practitioners, which were already interfering with recruitment into the specialties.

#### Professional behaviour and pay

Recent undignified attempts to get round the Government's pay policy have resulted in increased preoccupation with hours of work. Differences within the profession have meanwhile been exploited by politicians. The introduction of a closed contract for junior hospital staff with the idea of professionals working overtime has done terrible harm and it will be seen as a very high price to pay for the short-term benefit of a rise in salary. The consequent pay increases for junior staff, combined with the present freeze on previously agreed incremental payments, have seriously eroded differentials, leading to some injustices among younger consultants, who on occasions receive less than their juniors. The fact that consultants have even considered a closed contract, after seeing the damage that has already been done by the juniors' contract, is a clear indication of the disarray of the medical profession, which is tearing itself apart by internal squabbling.

Meanwhile the standing of the profession in the community has been severely shaken by the ill-judged use of sanctions, which are distasteful to most doctors and to the public. Owing to political naivety and apathy among most conscientious doctors, our medical politicians and organisations are at present mainly representative of militant discontents.

Clearly the remuneration of doctors needs to be improved, and suitable differentials in the pay structure must return within the hospital service. While correcting the present absurd injustices, the opportunity needs to be grasped before it is too late—to sweep away the concept of the closed contract for juniors and seniors alike, and pay professional men and women at a rate which takes into account their unusual and exacting hours and responsibilities. Such changes will need more money but improvements in pay alone will not be enough: as a first step towards a return to normality, the medical profession, in common with other health care workers, needs to re-examine its standards of behaviour. There is surely a case for the inclusion of every doctor in a ballot before controversial decisions are taken which might affect the collective behaviour of the profession.

Every hospital worker deserves good conditions of work, but

a way must be found whereby improvements can be achieved without using the welfare and comfort of patients as the bargaining point.

### Finance, organisation, and private medicine

The NHS has always been underfinanced and more money must be found from general taxation so that patients can receive free medical treatment and advice when they need it. More use should, however, be made of the fund of goodwill and voluntary labour which is present locally. Demand for services will always tend to outstrip supply and so, with limited national resources, some monitoring of the cost and usefulness of services and staff at every grade needs to be accepted.

Some of the best medicine is practised from poor premises but this is a tribute to the staff rather than an excuse to go on doing this. There is clearly a case for pruning extravagant prestige schemes and for concentrating on the building of practical, functional, and adaptable hospitals according to local needs. Economies can be made in prescribing and by using five-day wards, as well as providing adequate facilities for outpatient investigation. The possibility of charging for board and lodging, rather than for medical care, is worth exploring. It should be possible to allow savings in one financial year to be carried over to the next, and it would be beneficial if local economies in one field could be seen to benefit other local approved projects.

It is often said that the NHS should be taken out of politics, but clearly this is absurd when one considers the cost of the service and the political importance of health care. It might be possible to find a way to insulate the NHS from doctrinaire party politics by the introduction of some form of public corporation.

The 1974 reorganisation was designed to enable expansion of the Health Service, especially in the way of co-operation with the social services. Unfortunately it occurred at a time of economic stringency when there could be no significant expansion, and we are left with a top-heavy organisation. If there were mistakes, these must be corrected. Do we need so many administrative tiers and could we dispense altogether with one, such as the area tier? This kind of simplification would save the cost of many salaries and perhaps it would speed decision making.

We need to prune the management structure of the hospital service and reduce the number of administrators while constantly improving their quality. It would be a mistake, however, to believe that they are any less well-motivated than others in the Health Service. There has been a proliferation of time-consuming committees, while the position of the consultant has been gradually eroded and direct executive action taken out of his hands. We need to return to the traditional role of the consultant as leader of a team, as shared responsibility delays effective action. Co-operation with the social services needs to be increased, but with that service in a clearly stated supportive role to the Health Service.

Paediatricians are concerned about the lack of a proper career structure for those doctors who work in the community child health service. There is a fund of expertise and experience among those who staff the service, but, at present, a great lack of leadership. The Court Committee is deliberating about this at present and should be able to guide the Commission about the links which should be forged with the hospital paediatric services.

Obviously the Commission must study and advise on the place of private medicine in Britain and its relationship with the NHS, and it would be cowardly and ridiculous to pretend that this politically sensitive but highly important subject could be omitted from any credible review of the problems of the NHS. Aneurin Bevan's arguments in 1946 for the retention of private beds in NHS hospitals are still relevant today. If it is decided to separate private from NHS beds there must be a case for exceptions for the super-specialties, where equipment and facilities are particularly expensive.

### Nursing administration, medical staffing, and medical education

The introduction of the Salmon structure for nursing led to a lowering of the status of the ward sister and introduced a new breed of committee nurses, who are divorced from patient care and who are apparently no longer allowed to "act down." The result has been a lowering of morale among nurses and a lower standard of nursing on the wards, while wasting many experienced trained staff. The career structure of nurses needs to be reviewed to avoid any further decline in standards, and there is a need radically to prune the present extravagant nursing administrative structure.

Ever since the start of the NHS we have relied on foreign graduates to fill many of the junior hospital posts, especially in the less attractive specialties such as those in the casualty service. Now we are seeing a reduction in the numbers of foreign doctors coming to Britain and the output of our own medical schools is increasing. Will these home-produced graduates be willing to fill the same unattractive posts? This seems distinctly unlikely unless there is a major change in the career structure of hospital staff grades so that the available doctors can be sensibly deployed in satisfying career jobs doing essential routine service work, recognising that many will not become consultants. Conditions of service need to be made attractive to encourage British graduates to stay in this country, but those who qualify with the help of grants might reasonably be expected to work for several years in the NHS, or repay the grants before emigrating.

Roughly half our new graduates will soon be women. This seems absurd and perhaps needs correcting when so few women doctors continue in full-time work and many give up medicine altogether. Nevertheless, a fulfilling career structure for women doctors who want to practise needs to be devised to avoid wastage, and this means proper consideration of job-sharing and part-time contracts.

### Five minutes as a witness

It is unfortunate that the Commission does not include among its members either a peripheral consultant or a junior hospital doctor, while it does have two general practitioners. This will make it all the more difficult to sift the mass of evidence which it will receive and give full weight to the compelling needs of the hospital service.

I hope that with the help of better financial arrangements, improved administration, and the avoidance of waste, the opportunity will be grasped to fashion a new and improved Health Service to such a standard that the desire for private medicine will wither and die. We need a new climate in which there is more co-operation and trust among politicians, the DHSS, and the medical profession. It will not help to dodge difficult issues and a study in depth is required. There is some urgency, however, and an early interim report would help to restore flagging morale.

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*A couple's infertility has been traced to the spermicidal quality of the cervical mucus. Oestrogen treatment and vaginal douching have been tried unsuccessfully. Is any other treatment known?*

Cervical hostility to spermatozoa probably has multiple causes, few of which are known or understood. A possible cause is an antigen-antibody reaction, the antibodies perhaps being locally produced. On this assumption it has been thought that if seminal fluid is prevented from regularly reaching the cervix then antibody production might be diminished. Abstinence from intercourse is therefore one possibility, but a more common recommendation is the use of a condom for three to six months. Fertility has sometimes followed this practice.