not well in the hospitals. Certainly a few remote and isolated small hospitals had doubtful reputes, but our own sizable local general hospital was well accepted and admired.

Our senior partner, affectionately known as the Old'un, with his usual inscrutable wisdom decided to take a holiday during the first two weeks of July and asked me to be responsible for his patients in his absence. He had seen many changes in general practice in his time, was not impressed, and reckoned that they rarely benefited patient or doctor and were always to the detriment of the practice of medicine.

"They" take charge

The NHS sprang into existence early for me. I was awakened by the telephone soon after 5 am on 5 July 1948. It was one of my partner's patients, a well known tub thumper. My caller delivered a rasping pious cum political homily on the rights of patients. I vaguely remember that in future "they" were going to re-organise the medical profession. As soon as I was able to explain that I was not his usual doctor he rang off and I went back to sleep. This was the only unusual event that day, which otherwise passed like any other. Yet a few of the patients I saw then still remain in my memory.

A young woman called me out to her small boy who was covered in measles rash and had a high temperature, a hacking cough, and streaming eyes. The child recovered fully after some hectic days and several more visits. As I left on the last occasion the mother told me with gratitude how marvellous it was to be able to call in a doctor for a really sick child—something she would never have dared to do in the past. When I expressed surprise she told me that with the appallingly low and uncertain wage her husband earned as a kitchen worker she could not afford even the medical club payments, would never risk running into debt, and had no wish for charity. For her the NHS was a real and well deserved blessing.

Later that day I visited one of my ex-private

patients, a well to do shop owner. He had an acute abdominal emergency, and I had him admitted to a private nursing home where he incurred considerable private fees. He also required long continuing care from me, which was all covered by the modest annual capitation fee. The NHS provided him with an unneeded windfall, but it was argued that many of those whom we never saw would compensate for him. Before long these non-attenders were diminishing rapidly.

Lastly, I remember visiting a dear old soul previously on the free list. He was bed ridden and had ample time to cultivate a long series of trivial and possibly imagined symptoms. In future we would be getting something in addition to the occasional pheasant that still came our way.

Third party intervenes

However, a shadow was stretching gradually over family doctor practice as we had known it. It was as though our patient-doctor relationship was being "bugged" by a third party (the "they" of my first early morning caller). This irked me enough to cause me to move a few years later to a different occupation in the British Medical Association headquarters in Tavistock Square. Some of my colleagues also felt the apparent insertion of a third party between patient and doctor. One even took the trouble of keeping two sets of clinical notes for each patient. The first set was written at length in his personally detailed fashion, the other contained the very minimum he considered necessary and permissible to pass on to others through official channels when obliged to do so.

More than two decades later when I retired from the BMA staff I made another move and became an Anglican priest. During the past 15 years, again in a semirural and predominantly middle class environment, I have collected newer impressions of the relationship between the family doctor and patient. It was encouraging to find that so many patients still have a direct warm contact with their own doctor. Very few seemed conscious of officialdom straying in and, being usually fit, doubted if they had anything they would not want disclosed. Of the general practitioners who broached the ethics of this subject with me most thought it part of the job, as they had never known otherwise. Only very rarely did I come across a patient or doctor who had reservations.

It would be foolish to generalise from my limited experience in a narrow sector of society, and it may be quite different for inner city or multiethnic areas. Nevertheless, I still have the firm impression that the patient who comes to his own general practitioner with his troubles does so readily, freely, and quite confidentially.

A patient's relationship with his family doctor is still a very personal bond between them, quite unaffected by any overriding organisation.

Free health care—at a price

S F Raistrick

This is the story of general practice in a small Yorkshire mill town where the introduction and development of the NHS accompanied postwar changes in trade and economics. The mills are silent now. Gone are most of the mean streets with the "back to back" where four houses, each with an outside toilet, shared a common

yard. Gone too are the undernourished children, the rickets, and scarlet fever. I can remember the "fever van" trundling down the street to take some luckless child to six weeks of isolation, leaving a home draped with blankets soaked in a solution of carbolic.

Before 1948 general practitioners often worked

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single handed, relying on friendly colleagues for holiday cover. Partnerships of more than two were unusual, and partners covered the work of the practice day and night. Group practices and deputising services in their present form were unknown. The general practitioner was a family friend who knew his patients by name and their occupations and home conditions. He knew the drunk and the beaten wife who appeared regularly on Monday morning with a black eye caused by "bumping into a door, doctor."

The general practitioner's wife was a vital part of the practice. She was regarded in the profession as a cross between an angel and a doormat. In the days when servants were no longer available she answered the door bell and manned the phone, unpaid, for 24 hours a day. She built up a great deal of good will and was as well known to the patients as the doctor himself. Families attended particular practices generation after generation, and this provided the doctor with an almost complete family history. On marriage, however, it was accepted that the boy changed to the doctor of his bride's family (it was unusual for them to leave the district).

Long hours and low fees

Surgery premises were not always ideal. Waiting rooms were inadequate and uncomfortable, being fashioned from part of the doctor's home; and the stock of medicines in the dispensary was governed by the enthusiasm of the doctor. Dispensing practices largely disappeared after the war and were not allowed by the NHS in 1948 if there was a pharmacy less than three miles from the surgery. Surgery hours were extensive to meet the needs of the workers. Sunday morning was left free for minor operations, such as circumcisions, performed on the patient's kitchen table. Open ether was the anaesthetic of choice, and the mother had usually ensured that there was a good fire burning to warm the room.

Fees were absurdly low by today's standards. Immediately before the war a consultation, with or without medicine, cost 2/6d (12½p), a visit without medicine 3/- (15p), and a visit with medicine 5/- (25p). The general practitioner adjusted even these charges according to his patient's ability to pay. Another well known figure in the practice was "the doctor's man"—a book keeper and collector, who, having written up the accounts, collected weekly from patients until their debt was cleared. As there was no pension a retiring doctor, when selling his practice, retained his book debts for income in his advancing years.

I was always impressed with the respect and affection earned by general practitioners. Patients were self reliant and would not trouble the doctor for minor ailments, which were treated with mother's remedies. If these failed the local ministering angel, usually a retired nurse, advised her flock. Next in line to be consulted was the local pharmacist, who "made up a good bottle." "New fangled injections" were frowned on—the patient was being denied treatment until "a bottle" was prescribed. A visit by the doctor was a matter of importance. The patient was washed early, the sheets were changed, and both were given a splash of eau de cologne. A bowl of hot water, soap, and a clean towel were always available for the doctor's use—a lesser standard would not satisfy the fastidious housewife.

A diagnosis of pneumonia meant a long vigil for the family and neighbours until the crisis. Those who have not practised in the days before antibiotics cannot appreciate the drama of a desperately ill patient passing into peaceful sleep, his life no longer in danger. It was strange how underfed ragged children ran about, often barefoot, apparently immune to winter coughs and

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A MESSAGE TO THE MEDICAL PROFESSION FROM THE MINISTER OF HEALTH

On July 5 we start, together, the new National Health Service. It has not had an altogether trouble-free gestation. There have been understandable anxieties, inevitable in so great and novel an undertaking. Nor will there be overnight any miraculous removal of our more serious shortages of nurses and others and of modern replanned buildings and equipment. But the sooner we start, the sooner we can try together to see to these things and to secure the improvements we all want.

On July 5 there is no reason why the whole of the doctor-patient relationship should not be freed from that most of us feel should be irrelevant to it, the money factor, the collection of fees or thinking how to pay for an aspect of practice already distasteful to many practitioners. Yet it has been vital, if this is to be the new situation, to see that it did not carry with it either any discouragement of professional and scientific freedom or any unfair worsening of a doctor's material livelihood. I sincerely hope and believe we have secured these things. If we have not we can easily put that right.

The picture I have always visualized is one, not of "panel doctoring" for the less well-off, nor of anything resembling dole-doctoring, but rather of a nation deciding to make health-care easier and more effective by pooling its resources—each sharing the cost as he can through regular taxation and otherwise while he is well, and each able to use the resulting resources if and when he is ill. There is nothing of the social group or class in this—and I know you will be with me in seeing that there does not unintentionally grow up any kind of differentiation between those who use the new arrangements and those who, for any reason of their own, do not. Let this be a truly national effort. And I, for my part, can assure you that I shall want vigilantly to watch that your own medical and scientific freedom is never at risk of impairment by the background administrative framework, which has to be there for organizing purposes, but in which your own active participation is already secure.

In this comprehensive scheme—quite the most ambitious adventure in the care of national health that any country has seen—it will inevitably be you, and the other professions with you, on whom everything depends. My job is to give you all the facilities, resources, apparatus, and help I can, and then to leave you alone as professional men and women to use your skill and judgment without hindrance. Let us try to develop that partnership from now on.

It remains only to wish you all good luck, relief—as experience of the scheme grows—from your lingering anxieties, and a sense of real professional opportunity. I wish you them all, most cordially.

ANSURIN BEVAN

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colds. When they met a virulent or massive infection, however, they had little resistance and died within days. The visiting bag was always well stocked with diphtheria serum and throat swabs.

In those days outside help for the general practitioner came only from the loyal district nurse and district midwife, who were pillars of the community. A consultant's domiciliary visit was an event indeed. There was a preliminary meeting at the surgery to discuss the case. The general practitioner then accompanied the consultant to the home, where, after appropriate introductions, the "specialist" visited the sick room. When the examination was completed the two doctors retired to discuss the case and fee. Their final departure was invariably witnessed by those neighbours who chanced to be dusting the back of the piano.

New developments

What changes did the NHS bring and how have they affected the doctor and patient? Most of us are familiar with purpose built health centres, appointment systems, and the employment of receptionists and a secretary. For me, an efficient secretary cum practice manager ensured harmony in the office, coordinated meetings with ancillary workers or colleagues, and anticipated the needs of patients. Elsewhere staff have been known to create barriers of ignorance, arrogance, and indifference; and in such practices the patient has as much chance of speaking to the Almighty as he has of speaking to his general practitioner. The introduction of disposable syringes was another milestone, as were visits to the health centre by pathology technicians. No more boiling of syringes, no more trips to the laboratory with a single specimen, specimens were collected and disposed of by the technicians.

In line with changes in industrial attitudes we saw changes in medical practice such as much shorter working hours and a lessening of night work. The whole structure of remuneration altered. The "panel" was extended to include wives and children, who had previously been private patients. The "doctor's man"

disappeared, and the retention of book debts was replaced by a pension linked to practice size and length of service.

The price to pay

After the first rush for free aspirins, spectacles, and trusses demands from patients eased; but there was, until the introduction of fiscal deterrents, a section who expected medical supervision and prescriptions for trivialities. Patients are better informed about their bodies and the drugs they take. The press explains all, and television plays its part. One can imagine an enthusiastic do it yourself man sitting back with his pint and pipe thinking that the heart transplant he is watching on the screen is perhaps "not all that difficult after all." Affluence is reflected in living conditions and diet. This brings health problems not often seen 40 years ago—for example, obesity, alcohol dependency, anxiety states, and illnesses contracted abroad.

Could the parents of a child with cystic fibrosis

afford the prescriptions for a month's treatment today? Both doctor and patient must be thankful that they are not faced with this problem. Before vitamin B₁₂ the patient with pernicious anaemia faced not only a financial hurdle but also the physical problem of eating 1 lb of raw liver daily. The NHS has been a boon to both general practitioners and patients. Probably its troubles are because it was designed and is worked by humans for humans. Because of its massive structure and enormous cost it cannot escape from political overtones.

The general practitioner can still expect a secure living and a pension on retirement. He can expect laboratory facilities, and highly trained hospital staff readily available to assist in the care of his patients. The patient can expect the wonders which he reads about or sees on television. He can be confident that, in illness or accident, the finest brains in the country are available to him and his family without a lifetime of debt. The price to be paid is measured in less personal attention and longer waiting lists. As a famous consultant said recently—more science and less art.

Interviews with consultants

Tessa Richards

It's hardly possible to celebrate the 40th anniversary of the NHS without noting the current dissatisfaction with the service. But critics should remember that at the time of its inception in 1948 the variation in the quality of medical care and the inequitable access to care was nothing short of scandalous. Extending care, free of charge, to cover all members of society was a remarkable achievement and one that had an immediate impact on the lives of thousands of people. But what of the impact of the NHS on hospital clinicians? Paradoxically, this was not huge, for the service was introduced at a time of dramatic advances in treatment and these in conjunction with the changes brought about by the war had as much or more impact than the NHS. In this article three consultants I interviewed recount their experience.

Dr A the psychiatrist

In the 1930s, as from the turn of the century, patients with mental disorders were treated free of charge in large, some 2000 beds or more, strictly regimented, highly secure, asylums—registered mental institutions. Most of the incumbents were psychotic, most having been admitted following certification (despite the provisions of the Mental Treatment Act, 1930), which carried an enormous stigma. This and the prevailing prejudice towards those with mental disorders deterred people with minor mental disorders from seeking help. In effect this meant that few people with neuroses got any treatment at all, unless they could afford to go to one of the handful of prestigious private mental hospitals. St Andrews, Northampton, for example, which unashamedly advertised its services for "the upper middle classes only."

One of the most frustrating aspects of our work, which was solely on inpatients, was that we had no say in what patients were admitted. Most were chronic schizophrenics or patients suffering from various forms of dementia, including, of course, general paralysis of the insane. Admission records were

immensely detailed, however, and it was mandatory to write equally detailed follow up notes at set intervals. I later found these invaluable for research. I could never have carried out comparable research with today's scrappy records.

Such detailed records were kept to comply with the regulations laid down by the Board of Control (the external body that supervised all the mental hospitals in the country), whose commissioners would turn up from time to time, completely unannounced, and inspect the hospital. In their turn they had to prepare an annual report which was submitted to the Lord Chancellor.

Well staffed by well trained and highly dedicated nurses, many of whom lived in houses adjacent to the hospital and passed their profession on to their sons and daughters in dynastic fashion, self sufficiency was the order of the day. From the hospital farm, market garden, and bakery to the provision of comprehensive medical care including surgery, these hospitals were effectively autonomous. The patients, under appropriate supervision, did most of the work on the farms and gardens and cleaned the wards; you could eat your dinner off the floors. And this not only provided an excellent form of occupational therapy for a few patients but also resulted in the hospital and its