The Rock Carling Fellowship 1963

Doctor and Patient

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Chapter 1

INTRODUCTION

Medical Ethics; The Standards of Medical Practice

I am grateful to the Nuffield Provincial Hospitals Trust for the honour of being elected to the second Rock Carling Fellowship, and thus being persuaded towards the end of my career in the active practice of medicine, to spend some time thinking about the medical profession and writing down thoughts which have been developing since I graduated in medicine 42 years ago. I was given a very free hand to write about what I pleased but it was suggested that medical ethics might be the main theme. This I felt had two dangers, first that I might be led into considerations of the philosophy of ethics, which I am not competent to discuss, and secondly that it might lead to an undesirable temptation to moralize. In correspondence with Mr. Gordon McLachlan, whose help in many things I am happy to acknowledge, he suggested that my terms could be interpreted as the ethos of medicine, which I take to mean the characteristic spirit of the medical profession and its guiding principles. Nevertheless ethics firmly comes into every decision which a doctor has to make and will thus always distinguish medicine from science, however 'scientific' medicine may become, and so I found a third way of looking at the scope of the monograph which I hoped to write, namely that it would deal with the standards of medical practice, and it did not take long to recall

that the Royal College of Physicians, of which I had so lately been the President, was founded by Henry VIII in 1518 for the very purpose of upholding, maintaining and improving the standards of medical practice in the City of London. To this day I believe that the aim and purpose of the Royal College of Physicians is the same (though it has extended its scope beyond the boundaries of the City of London, and that anything which affects the standards of medical practice is the concern of the College. Of course in the day of its foundation, the incentives to doing good were largely negative ones and the functions of the College were initially conceived in terms of the suppression of malpractice and the punishment of the wrongdoers. In the words of the Charter: 'Whereas we consider it the duty of our Royal Office by all means to consult the happiness of the people under our rule we have thought it to be chiefly and before all things necessary to withstand in good time the attempts of the wicked, and to curb the audacity of those wicked men who shall profess medicine more for the sake of their avarice than from the assurance of any good conscience, whereby very many inconveniences may ensue to the rude and credulous populace.' But although the President and the Censors of the College were given certain powers in the punishment of the medical quacks of the day, even as far as their imprisonment, it was clear that Henry expected the Fellows of his College also to improve the standards of medicine by their own example; for the Charter goes on: 'We will and command to be instituted a perpetual College of learned and grave men who shall publicly exercise medicine in our City of London and the suburbs and within seven miles from that City on every

side: whose care it will be, as we hope, both for their own honour and in the name of the public benefit, as well to discourage the unskilfulness and temerity of the knavish men whom we have mentioned by their own example and gravity, as to punish the same by our laws lately enacted.' And in the Act of 1522 confirming the Charter the famous words occur: 'that no person of the same politic body and commonalty aforesaid be suffered to exercise and practise physic, but only those persons that be profound, sad, and discreet, groundedly learned, and deeply studied in physic.'

This was the beginning of medicine as an organized profession in this country and Henry VIII expected it to be governed by those whose learning, wisdom and professional competence was beyond dispute in the context of that day and age. The College was not to be just a Guild to look after the interests of the doctors but was clearly charged to look after standards. If we interpret the words 'learned and grave men' to mean men who have both knowledge and a sense of responsibility, we have at once the two essential requirements for any doctor.

This monograph will confine itself to medical practice, that is to the art and science of healing, the work of those whose task it is to make immediate and individual decisions about sick persons who come to consult them, for it is in this that I have spent most of my life, even though teaching and research have claimed some of my attention. I shall not speak of the great branch of preventive medicine in our profession, partly because I have no experience of it, and partly because my predecessor in this Fellowship was pre-eminent in that field. Neither shall I speak of research and science in the laboratory.

I start from the axiom that it is impossible to practise good medicine unless you derive satisfaction from the task. It follows that clinical medicine should be so organized that all its branches are interesting and worthwhile, and that good work can be done without unreasonable haste. These I believe are far more important factors in determining the contentment and raising the standards of the profession than purely financial rewards, but there is another important factor which determines whether men find satisfaction in and do good work in their profession—a subtle though sometimes dangerous factor which we call morale. In some hospitals, as in some ships and some factories, men and women are on the whole happy and content. Nurses complete their training and stay on; patients do not linger unnecessarily in hospital beds. Recent studies, to which I shall later refer on morale in hospitals, have shown how much it depends on the leadership of those at the top. In General Practice the units are smaller. Naturally there are contented and discontented partnerships, but there is a more important and widely distributed morale in a society or a profession and it is something for which the leaders of the profession have a great deal of responsibility. If there seem to be times, as there have been in recent years, when the morale of the medical profession has been low, my first examination of the situation would not be whether another 14 per cent or 24 per cent should be added to the doctors' pay, though that might be important, but it would be to see what the medical politicians of the profession were telling their members and what their own relations were with the Ministry of Health.

The chapters which follow are to some extent independent of each other and the material presented is of course only the author's selection of what could be written in a monograph of this scope. If the monograph as a whole is found to have more significance than the sum of its parts, this will be because each of the topics has in its own way a bearing on the standards of medical practice of the present day.

In order that it shall read as much like a narrative as possible I have not diverted the reader's attention by references and footnotes. These are to be found in the Appendix.

Chapter 2

DOCTOR AND PATIENT

It is unnecessary to recite the story of the unprecedented and accelerating progress of medical science of the last 40 years, which has brought health, survival, recovery from illness, and relief from suffering to young and old. It must be clear to anyone who is interested either in the science or the practice of medicine that it is a far more satisfying task than it was when I qualified in 1921, when children suffered from rickets and marasmus and died of gastro-enteritis, and young adults died of pneumonia and tuberculosis and septicæmia, and surgical patients of peritonitis, and we had no remedies to offer them. You felt quite a hero sometimes seeing cases of advanced tuberculosis or doing a lumbar puncture on a patient with meningococcal meningitis, knowing that you were at risk and that if you acquired the disease you could die from it. Occasionally when I was a hospital resident I would be asked by a doctor who worked nearby to do an evening surgery for him. He was thought to be a good doctor because he had a flair for knowing when someone was really ill, but the evening surgery consisted of a queue of dirty people who came for useless medicines for which they (the women at any rate) had to pay a few shillings which they could ill afford. There were no facilities for examining a patient in the surgery and the doctor's last words to me, after explaining my duties, were: 'The great thing is to get rid of them.' Yet he was a kindly fellow and well liked by his patients. If that was a sample of medical practice of the 1920s, and of what it meant to

the doctor, those who say that the profession of medicine has deteriorated have a difficult case to make out. Personally I don't believe them. For the wealthier patients most of the work, as compared with what we do today, was equally useless, though I am sure it did not seem so either to doctor or patient. When pneumonia at any age was a dangerous adventure and the most you could do was to help the processes of nature, hoping that they were on your side, agonizing decisions would have to be made as to whether the patient should have two pillows or three, whether he should be sponged down if his temperature exceeded 103°, whether giving morphine for his pleuritic pain would lessen his chances of recovery, what his diet was to be, and how much fluid should be forced into him. When penicillin takes over, all these decisions become trivialities. But that was what medicine largely consisted of together with the dispensing of large numbers of mixtures whose action, if any, was on symptoms rather than on disease.

The doctor–patient relationship varied, as it does today, according to the personality of the patient and his social status and education, as well as with the personal qualities of the doctor. In the 'best' type of practice where the monetary rewards adequately compensated the doctor for his arduous life and for the unreasonable demands of a few of his wealthy patients, the doctor–patient relationship was on the whole a satisfactory one, but it would be too much to claim that professional decisions were never influenced by financial returns. In some lucrative practices operations such as appendicectomy, tonsillectomy and hysterectomy seemed to be performed on a remarkably high proportion of the population. The division of mankind into private

patients on the one hand and hospital or panel patients on the other was much more in evidence than it is today. The latter were often very decently and devotedly served by doctors in varying types of practice and by the consultants and residents of the hospitals (the huge intermediate class of registrars and senior registrars was almost non-existent in those days) but in some cases the standards of working class General Practice were frankly appalling, and in hospital patients were expected to be grateful but undemanding; to be seen but not heard. There were some surgeons (I am glad to say that I don't remember it amongst physicians) who seemed to have no regard for patients' feelings, and would discuss the consequences of serious disease in front of students by the bedside as if the patient were an animal or a savage, uncomprehending of the English language, and whose manner to the average patient was brusque to the point of rudeness. Amongst the physicians, the frequent demands of private practice would make inroads into the time they spent in hospital work, all of which was of course unpaid.

Great changes have occurred since those days, due to the social revolution of our time, to the impact of medical science and discovery and to the advent of the National Health Service, and these three influences we must examine a little further. Some say that the status of the doctor has changed, and of course those who say it mean that it has changed for the worse. It is really the patients who have changed. Ordinary people now have greatly improved standards of living and are educated or at least informed. Even those who seek the least enlightened of television programmes cannot escape being occasionally instructed, if only by the accident of listening to the wrong programme.

They subscribe to a Health Service which is theirs and are no longer the objects of charity, and rightly expect in this modern age a quality of service which their forbears would not have been in a position to command. Doctors who cannot keep abreast of social change are misfits in such a society and are in fact gradually dying out.

The very achievements of medical science in the cure and relief of disease have brought some dangers for personal doctoring however. Young men trained in the techniques of science may become more interested in the disease than in the patient. This is a particular danger in whole-time Professorial units, partly because of their preoccupation with mechanistic science and partly because they are out of touch with medicine as it exists in the community. I remember how remote I felt from real medical practice when I became a Professor and no longer saw patients in their homes with General Practitioners. This would matter little or not at all if these units were not now dominant in the education of undergraduate medical students. But of course the decisions and successes of scientific medicine *are* in fact less personal than those of former days and it is less important who makes them. The patient is inclined to look for a scientific miracle rather than for personal advice.

The high cost and complexity of specialist techniques brings many people into hospital where the depressing effect of the institution on individuality and personality begins to work and patients put themselves at the disposal of the hospital machine. That these are the effects of science rather than of the Health Service is shown by the same tendencies being at least as noticeable in hospitals in the United States.

Although these potential dangers of scientific medicine have to be pointed out, I have no doubt that the general regard for patients as individuals is much better in hospitals today than it was 40 years ago and this I ascribe largely to the change in the standards and sophistication of the patients themselves. Most In-patients are deeply grateful for the care and attention they receive. (Porritt report, appendix.)

The influence of the National Health Service has been twofold. It has contributed to the levelling process in that the great majority of persons have elected to be National Health Service patients of their doctors rather than private patients, and it has made the financial relationship between doctor and patient less important. In general or hospital practice it is now possible to earn at least a decent income without being dependent on private fees. The effect of this has been mostly beneficial. It has relieved the General Practitioner from the irksome duties of accountancy. It has taken away from the doctor–patient relationship the feeling that the doctor's recommendations may be influenced by the financial rewards, and it has given to the doctor the freedom to say 'I will visit you again tomorrow' without considering the cost to the patient, but if it has decreased the incentive of the doctor to do his best for the patient, the doctor must take the blame. That it is not necessary for this to happen is proved without doubt or question to me by my recent study of good General Practice, which will be described later.

It is perhaps in the consultant service that this changed financial relationship has had its major impact. The young consultant of my early days was wholly dependent for his

income upon his private practice. Of course he built up his reputation through his hospital work and in the long run it paid him to do it well, but the measure of success was the private practice, the elegant motor car, the well-furnished consulting room. All this has changed. Although private practice can still be rewarding both financially and in experience, the young man of today does not particularly seek it, and often says he doesn't want it. His first aim is a good hospital appointment preferably with opportunities for research and teaching. Adequate payment of medical staff is essential in an efficient hospital service but it does lessen the dependence of the consultant on the General Practitioner, and personal medicine suffers whenever this collaboration weakens. From a lifelong battle against impersonal medicine in hospital and from my recent study of good General Practice in this country, I have come to the conclusion, which will be unpopular with my hospital colleagues, that the doctor–patient relationship is better in General Practice, and it is interesting to note that in the Gallup Poll recorded in the Appendix to the recent Porritt report about 75 per cent of patients of all classes were satisfied with their General Practitioners, whereas only 60 per cent felt that they had been treated as individuals in hospital out-patient departments.

Imaginary examples of what I call impersonal and personal medicine may be given in relation to a patient who, in her doctor's estimation, requires hospital investigation and treatment. Mrs. Jones consults her General Practitioner because of symptoms of dyspepsia. Without listening properly to her history he prescribes some medicine and tells her to return in a week or ten days. She is no better

and instead of spending the necessary time with her he prescribes something else: she is still no better. His practice is so organized that he has neither the time, the patience, nor the facilities for examining the woman properly and so he fills up a form of request for consultation to the local hospital on which he says: 'To medical out-patient clinic. Please see Mrs. Jones, ? dyspepsia.' After a delay of some weeks, Mrs. Jones is seen in the out-patient department, but as no direct appeal has been made to any named consultant, she is seen by the Registrar who listens to her story, examines her, and arranges for investigations to be done. After three weeks' delay a barium meal is reported as negative, and after another three weeks' delay a cholecystogram is done, which is also negative. She is put on a waiting list, probably quite unnecessarily, for admission to hospital and after three months is admitted and now sees a consultant for the first time. Whatever the nature of her illness, her condition will not have benefited by the treatment she has received up to date. Mrs. Smith, on the other hand, goes to a good doctor whom she knows she can trust. She tells him about her symptoms and his suspicions are at once aroused because she has never before complained of dyspepsia. Then and there he hasn't the time to devote to a rather difficult case in a somewhat anxious and emotional woman and so he sees her the next day at greater leisure. He considers that investigation at hospital is necessary and he writes to the local consultant: 'Dear John, I would like you to see Mrs. Smith as soon as you can' (here follows a short statement of her symptoms and background). 'It may turn out to be psychological but I have a feeling that we may be missing some serious organic

disease as she has never been a complainer of dyspeptic symptoms in the past. I would be grateful if you could make a point of seeing her yourself.' You may imagine that the subsequent history of Mrs. Smith is somewhat different from that of Mrs. Jones.

Brotherston in a thoughtful article entitled 'Towards new incentives' points out that the incentive of financial gain and private practice is less important than it used to be. Most doctors he feels do not look upon research and teaching as incentives to good medical practice. He rightly points out that 'In the individual doctor–patient relationship (and in the absence of all fees) the doctor–patient behaviour tends to be different where the doctor is dealing with a patient whose individual esteem he is concerned about. This can come from social friendship, from social status, or from simple social face-to-face relationship. But it is a very potent mechanism. On the larger scale the expectations of the more educated and articulate patient now coming to hospital have some influence on thinking about hospital surroundings. Here, however, a cultural lag is evident. It is astounding how tolerant the general public is of poor conditions in the Health Service. . . . In the long run an educated public opinion is the most powerful weapon for improvement in the service and therefore the most powerful ally of the profession. Unfortunately there is a real risk that the profession may not recognize this alliance and may resist it.'

Put in another way, the real lesson of private practice was (and still is) the challenge of patients who do not see themselves as the passive recipients of medical charity. If the incentive of private practice goes, what takes its

place? Doctors who really enjoy their work and get satisfaction from it do not need any other incentive, but they should at least expect a just reward, and not have to work against disincentives. The subject will be considered again in relation to General Practice.

Students are not bored, but respond with interest when teaching includes considerations of the patient's personality in relation to illness, and of the ethical nature of the decisions which have to be made. It is something they have often sought in vain in medical teaching. Teachers should acknowledge and show by example that scientific thinking is a necessary but not a sufficient condition of good doctoring. It needs other qualities: warmth, feeling, compassion, humour, patience, integrity, understanding. Qualities about which science is silent.

Chapter 3

THE ORGANIZATION OF MEDICAL CARE

Medicine may be said to be organized in three tiers. The first contains the most highly specialized skills such as cardiac surgery which require almost a whole village of their own, in which dwell engineers, electronic technicians, skilled anæsthetists, respiratory physiologists, blood transfusion experts, and teams of special nurses, to say nothing of the surgeons themselves, and the physicians, with their own array of technicians, who investigate the patients prior to surgery. The whole set-up, to use the contemporary jargon, is so expensive that it can only be developed in large centres of population and certainly not in every market town of the islands of Britain. Indeed we may take some pride in the fact that Britain, which has had the financial misfortune to win two wars within some 30 years, can afford such luxuries at all and even lead the world in some of the techniques. For biologically these are luxuries, aiming at the relief of suffering and return to useful life of the few, but almost irrelevant to the health of the community.

At a lower level of specialization are the general physicians and surgeons, the pædiatricians, gynæcologists, dermatologists and others, who deal in larger numbers, do not require such a complex organization, and are now available in every general hospital in Britain. They deal in disease which is of sufficient seriousness or obscurity to demand diagnostic skills or technical expertise in treatment which is not readily available in general practice.

The development of these specialities was assisted during the nineteenth century by the building of special hospitals, for instance for women, for children, for diseases of the skin, for the chest, for nervous diseases. In recent years these have become an anachronism. Their very isolation from the progress of medical science in other spheres has made them an impediment to the furtherance of their own specialty. Their days are numbered.

At the third level (or the first according to how we see it) is the doctor of first access, the General Practitioner as we still anachronistically call him in Britain. He is better called the personal physician (Fox), or the family doctor.

In this country the role of the specialist and of the family doctor are almost clear-cut and separate in this respect, that the doctor or first access is the family doctor, and that the specialist or consultant does not see patients unless they have been referred to him either from a family doctor or from another specialist. A further examination of this system and how well it can be made to work with a consideration of the scope and training of the family doctor will be made in the chapters which follow. This system is not, however, the only one which can be made to work, and it is important to consider the present trends in other countries because the organization of medical care is one of the serious problems of medicine at the present time.

The most important alternative to the British system of General Practice is that which has been developing for a good many years in the United States and other affluent societies, especially in their large urban centres. Here the General Practitioner or family doctor seems to be dying out completely and is replaced by a series of specialists.

The basic argument in favour of this system at first sight seems irrefutable, namely that no one man can comprehend the whole of medicine and that the patient broadly knows what kind of specialist to consult. In a few instances he may go direct to a cardiologist or a rheumatologist or an orthopædic surgeon or an allergist, but in most cases the patient is not as highly selective as that and if he is an adult he consults an internist for all ordinary 'medical complaints' whether they be sinusitis, dyspepsia, anæmia, or coronary thrombosis. The internist thus becomes the doctor of first access and is no longer a consultant in the British sense of the term. It is said that on the average not more than 20–25 per cent of his patients are referred to him by other doctors. The internist deals with all minor and common complaints and the diseases in early stages which are seen in Britain by the General Practitioner. The differences are that he has, or is said to have, a more thorough training in internal medicine and he has given up pædiatrics obstetrics, psychological medicine and minor surgery, which are still practised to some extent by most of the family doctors of Britain. He also usually has access to hospital beds. The internist, although he may be repeatedly consulted by the same patient does not adopt the patient for continuing and comprehensive care, and is not a family doctor in our sense. If in the same family a child is ill it is taken to a pædiatrician who now becomes a kind of General Practitioner, but confining his practice to a certain age group. It is said that only 12 per cent of his patients are referred from other doctors. A large number of families will also be in regular touch with a psychiatrist and a child psychiatrist and will have to make separate arrangements

for obstetrical care and advice. A variant of this organization is the group practice in which each member of the group is himself a specialist.

Commenting on this pattern of medical practice in the United States Dr. Kerr White of the Department of Epidemiology and Community Medicine of the University of Vermont says: 'Increasing specialization has wide public acceptance and support in most parts of the country, particularly the larger urban centres where the cult of the expert is held in higher esteem.' . . . 'The system works but the dissatisfaction mounts. Frightened by the declining status, availability, and alleged inadequacies of the General Practitioner, many patients turn to one or more busy specialists in order to obtain the 'best' medical care available. Other patients turn to Christian Science, chiropractors, naturopaths and quacks of various kinds. Many turn to osteopaths who . . . in some States seem to be rapidly supplanting General Practitioners in the provision of primary, continuing, medical care.' . . . 'The extent and sources of the apparent dissatisfaction have not been adequately studied, although there seems widespread agreement both within and without the profession, that they exist.' Most internists of the American pattern are busy seeing patients by appointment in their offices or in the hospital, and house calls are decreasing so that most specialists decline to make them, emergencies being answered through a telephone service, the patient being usually admitted direct into hospital. This is partly because the Blue Cross and many commercial hospitalization insurance plans will pay for services given in hospital emergency rooms but not for office or home visits. Kerr

White goes on to say that the conscientious internist or pædiatrician, in order to maintain a reasonable standard of living for his family, 'must see a predetermined number of patients on a fee for service basis each working day and has not time for health education or preventive care or counselling about personal problems.'

Rorie, in a recent personal study of practice in America, was depressed that 'Social value was measured invariably in terms of worldly wealth.' 'Few practitioners,' he says, 'could see that one could do reasonably good quality medicine without a constant financial incentive.' 'In spite of this, however, many practitioners are disturbed by the present situation, and in speaking to the average patient I had no doubt that he is dissatisfied with the present state of affairs, and will eventually make his demands felt in the political field. A final influence in the physicians' life is the constant threat of litigation which hangs over his head. Premiums for defence were at the level of $200 per annum, rising to double this figure if surgery, anæsthetics or convulsive therapy were included in the risk.' (In Britain this is about $9.) Other points made by Rorie are that practitioners in America often see 50 or more patients in a day and he regrets that the average internist has little training in, or interest in psychiatry. He was told that 'Modern medical practice is based on a smooth flow of patients through a complex clinical setting. Emotionally disturbed patients, with their unreasonable demands in time, disrupt this flow and produce a financial loss.'

It seems clear that in a country of free enterprise, professional practice organization and behaviour can be dictated by the dollar, which may well become a greater tyrant

than the State. I admit to having quoted criticisms of the way in which medical practice is developing in North America, but it will be noted that they are not my own and that the main source is an American Professor. At first sight the American system seems to be the logical outcome of specialization, and it tends to be held up as an example by those who are opposed to anything approaching what they call 'socialized medicine.' Rorie and all others who have visited the United States are of course loud in their praises of the hard work, friendship, hospitality and efficiency of the American doctor. It may well be that the best of their internists have better training and give better service than the British patient gets from the *average* General Practitioner, but before we adopt a system which is leading to severe criticism of the medical profession, and which opens the door to the exploitation of the patient by the unscrupulous doctor, we should examine our own system with care and sympathy and above all, ask the question whether the 'average' General Practitioner of this country could not be very greatly improved and still remain a personal doctor, for it seems to me that there are great merits in the idea that everyone should have a personal physician to whom he can turn for unbiassed advice. The next chapters will therefore examine General Practice in this country and will also see whether some of the better features of both systems of practice could be combined. Before we close this chapter we must of course concede that other systems for the provision of medical care can be devised.

I have unfortunately no personal knowledge of medical practice in Russia. In Czechoslovakia, which I recently

visited, the aim of the Health Service with regard to personal medical care was to provide every family not only with its own practitioner, but also with its own pædiatrician. McKeown, in this country, has suggested something similar in the sense that personal doctors might be divided into obstetricians, pædiatricians, general physicians and geriatricians. Experiments in the provision of medical care from hospital centres have been made in the United States and elsewhere. They would not be popular in this country and there is no likelihood of their being introduced. It has to be remembered that the absence of a National Health Service and the existence of an 'indigent'—mostly Negro—population in the States provides useful raw material for these schemes and for experiments in the teaching of 'Medical Care' in which students, often unaccompanied (though supported by consultation with their tutors), carry out much of the home visiting.

Chapter 4

GENERAL PRACTICE

For a number of reasons morale in General Practice in this country seemed to sink to a low ebb both before and immediately after the introduction of the Health Service, and this was partly the symptom of a process which had been going on for a long time. Specialization and the staffing of hospitals with consultants (which was already complete in the big towns 40 or 50 years ago) seemed to have robbed the Practitioner of much of what he had done in the past, and to have taken serious illness out of his hands. He was often not properly trained for his job and therefore easily made to feel inadequate and insecure. His true place in Medicine, if he had one at all, was ill-defined. There are signs of a notable improvement in morale during the last few years and without making dogmatic statements as to cause and effect we can at least note that this has coincided with the foundation of the College of General Practitioners. It now seems to have been rediscovered that General Practice is a respectable occupation, that it is a satisfying way of life for those who like it, that many of the good General Practitioners of today prefer to practise under Health Service conditions and that really good General Practice can be very good indeed. These views, however, are not universally accepted and every now and then converse statements are made which seem to set the General Practitioner back again. They are usually made either by consultants or medical educators who have never been in General Practice or by what I call, without apology, the

dismal section of the British Medical Association which seems to make the worst of British Medicine in order perhaps to prove that Charles Hill was right about the iniquities of Aneurin Bevan.

For many years in consulting practice I was in close touch with a large number of General Practitioners and for several years now I have had friendly contacts with their College, and I have been Chairman of the Medical Research Council committee for research in General Practice. Through these contacts I have come to have a very great respect for the best General Practitioners and for the importance of their work. Personal doctoring has always appealed to me.

The present Minister of Health, Mr. Enoch Powell, once said to me that he conceived it to be an important part of his duty to find the ways in which the money available for the Health Service could best be deployed. I would like to go a little way towards helping him to deploy some more of his resources towards General Practice, not because I think he is unappreciative of its importance but because, like many others, he may not be quite certain how the money should be used. Secondly I would like to try to help Universities to understand General Practice. With these objects in mind I felt that I must have more first-hand knowledge of good General Practice myself and I therefore set out to visit a number of General Practitioners, hand-picked by myself with the help of some colleagues. I regret that I have not had time to visit more, for I know that for every one I have visited there must be many more even in my own region, whose work is of similar quality. Several important surveys of General Practice have been made in

recent years. There was one made for the British Medical Association by Stephen Hadfield and this was closely followed by the study of good General Practice made by Stephen Taylor (now Lord Taylor) for the Nuffield Provincial Hospitals Trust. They are now about ten years old, which in Medicine is a long time. There is the devastating Collings report, now happily out of date, and the Peterson report on General Practice in North Carolina. The admirable Gillie report on the field-work of the Family Doctor has just been submitted in draft form to members of the Central Health Services Council. There are books by Fry and by Hodgkin and others. Against these sources the only merit of my own study is that it is personal.

The kind of questions which I wanted to answer for myself were these. Is the General Practitioner's work important and necessary? Are there things which he can do better than anyone else? Can he practise good medicine under the conditions in which he works, or is he only doing badly what some specialist might do better? Is his work different from hospital medicine and if so in what way? What proportion of patients can he treat without reference to consultants? Has he something to teach which we cannot teach in hospitals, and if so, what is it and are some new principles involved? When and how should General Practice be taught?

I visited doctors in different kinds of practice, a rural partnership at least 50 miles from a University centre, a working-class practice, a good suburban practice, a Health Centre practice. One practice was single-handed, one of the doctors was a woman. I sat in during surgeries and accompanied the doctors on their visits. I must remind

the reader that I only speak of highly selected Practitioners and I know only too well that standards in General Practice can fall far short of what I am going to describe.

The first impression is the importance of personal care. The patients seemed to want to come to see their doctor and only to flinch when the idea of a hospital visit occasionally had to be mooted. They respected the doctor and were obviously grateful. One of the doctors was shortly going away for a fortnight's holiday and this he had to explain to many of the patients and I became almost tired of listening to their good wishes to him for an enjoyable holiday which he so much deserved. There is no doubt whatever that these patients appreciate having a personal doctor, look upon him as a friend, and his personal relationship is far closer than it can ever be in hospital even under the best possible conditions. The second conclusion is that what has been said about the continuing care of the General Practitioner as opposed to the episodic care of the specialist is also a reality. A great deal of what the General Practitioner does is a kind of follow-up clinic, as we in hospital would say. The diagnosis has already been made and the principles of treatment decided, supervision and continued care and treatment are now necessary. In this kind of work the doctor accumulates great knowledge, often better than we have in hospital, of the relative value of various remedies and their different applications: for instance, in the treatment of common infections, skin diseases, epilepsy, hypertension, rheumatism, depression, insomnia and pain. He also acquires an insight into the personalities of his patients. Indeed there was a real danger of his work being hampered during my visits by his telling

me about their personal and family histories. To anyone interested in people this, of course, is one of the things which makes General Practice quite fascinating. Anyone not interested in people should not be in General Practice. Thirdly, the scope of General Practice is, of course, very wide. I was impressed with the knowledge of the doctors in fields where I knew little or nothing. There is a good deal of pædiatric and geriatric practice, midwifery, antenatal work, preventive inoculation and psychiatry, for instance, and an intimate knowledge is needed of the Social Services available in this country.

No one man can know all these branches of medicine in depth and so we must ask whether General Practice is unsatisfactory because a great deal of it deals superficially with minor illness, or chronic incapacity, while active serious disorders are referred to specialists. Some of it of course is trivial, some of it is repetitive and some is therefore boring, or might be, though I cannot say that I was ever bored on any of my visits, but much of it is a very good sample of general medicine. In any case the knowledge of the average specialist is not always very deep. Most of us have only one narrow subject, if any, on which we can speak with authority: even then we might easily be confounded if we were asked the wrong question. Some of our work is boring and repetitive, by the very fact that it is specialized. I would rather sit in at a hundred doctors' surgeries than watch a morning's batch of tonsillectomies or a gynæcological clinic. Moreover, the General Practitioner can readily make a special study in depth of some part of his work, thus developing a field of interest just as we do in hospital. Apart from any special study, the very variety of

what he sees is attractive. His contacts with the specialist should be consultation and collaboration and not a mere handing over of responsibility. A good General Practitioner knows his consultants personally and makes this collaboration a reality. Wild statements that a General Practitioner's work consists of seeing neurotic surgery-attenders and signing certificates and passing patients to specialists are completely untrue as far as the practices I visited are concerned.

I was of course asking myself whether the work which the doctor was doing seemed to be adequate and whether he was spending enough time with his patients. Rather to my surprise I answered both questions affirmatively. With regard to time, there are a few people who come in for the repeat of a prescription or for a certificate and take only one or two minutes. There is an intermediate group who may take fifteen minutes, and there are a few who require much more and who may have to come again by special appointment. Taking all in all, the doctors I visited were usually seeing seven or eight patients per hour in their surgeries and seeing them adequately without any appearance of hurry. They did not know that I was timing them. Many of the home visits took no longer except of course for travelling time, and were no less adequate. It really only takes a few minutes to see that a child with measles is not developing bronchopneumonia or otitis media, and yet the visit may be very important.

I asked myself whether the decisions made were responsible ones and challenged the doctors on their reasons for them. I was very satisfied about this, and believe it to be the hallmark of the good doctor. I think we should often speak

about decisions in General Practice rather than diagnoses. Confronted with new illness the doctor may not be able to make an immediate diagnosis, but he has to make decisions based on experience. In most cases treatment based on probable but unconfirmed diagnosis can safely be given and the patient seen again. A hypothesis is being tested, which is scientifically respectable behaviour, and the General Practitioner is in an ideal position to do this, for he can see the patient several times in the day, or the next day, or the next week, as he chooses.

With his knowledge of the previous history of his patients and his knowledge of the self-limiting nature of most diseases, the kind of 'complete' physical examination of the patient which we teach students in hospital is usually unnecessary and out of place. The doctor can judge from the history what examination is appropriate to a patient with a headache for instance, remembering that he has a second chance which we do not always get in a hospital consultation.

I did not visit any General Practice during times of epidemic. These must be times when the variety of illness is less obvious but the variety of complications and personal reactions to illness must be infinite. They can be periods of great stress and overwork. General Practitioners' hours of work are long. It is not unusual to start before nine in the morning and finish at eight or eight-thirty at night. During busy times there may be no interval except a brief one for meals, but in less busy times there might be two hours to spare in the afternoon. On the other hand, with a well-organized partnership these hours are only worked on four days in the week. On the other two weekdays, with any

luck, the doctor may be finished by lunch time and if there is a duty rota he will be free from Saturday midday until Monday morning on two weekends out of three, or three out of four, unless by his own choice he visits some seriously ill patient. In addition to this there are evening calls and night calls. I discussed with several doctors the system of group practice with each partner specializing in some subject. In general this was not favoured, for it works against personal and continuing care. Each doctor in the partnership should have his own patients they thought, though, of course, each might have a special interest.

I have now asked at least ten of the best doctors I know whether they find General Practice an intellectually satisfying and worth-while job. These are men whose intellectual quality is at least equal to that of specialists on University and Teaching Hospitals staffs. Not one of them even hesitated in giving me an affirmative answer, or wanted to qualify it. And now perhaps I must ask myself whether I would have been satisfied to be in General Practice? This is a difficult one. I suppose I was ambitious and that a consulting practice and a teaching hospital appointment offered more. I was also influenced by the words of one of my old teachers who belonged to a generation in which it was possible to have been in General Practice and later become a consultant at a teaching hospital. He said to me: 'You have a curiosity, don't go into General Practice because you won't be able to satisfy it.' I have no doubt that his advice was good but I think times have changed and will change even more. Recent years have shown that there are opportunities in General Practice

for men who have a curiosity: indeed there are already some outstanding figures in General Practitioner research. In many ways I envy the General Practitioner of today for his great therapeutic opportunities in personal medicine.

The last question is: Do I go to a General Practitioner when ill? The answer is I don't need to because I am quite a good doctor myself and do not usually seek advice at all for the illnesses which take most people to their doctors. I have been heard to say that it is dangerous to have an illness investigated until you know what it is, so I usually keep away from hospital colleagues also. What I am quite sure about is that I rejoice that my impecunious children can consult a good General Practitioner about my grandchildren, without regard to cost and that he in turn has access to good consultants and hospital facilities even in the rather unsophisticated parts of Britain in which they live.

Chapter 5

REQUIREMENTS AND INCENTIVES FOR GOOD GENERAL PRACTICE

It is a very striking thing, which was noticed ten years ago, in Taylor's study, that the good practitioner is not one who is constantly grumbling at his terms of service, but if you question him he does think that the present system of payment is bad in that the incentives are wrong. If you spend money on your practice, improving the premises and the equipment and the ancillary services, it simply costs you more because allowable expenses are calculated on an average. Similarly, if you want the maximum pay for the minimum of work, you accumulate as many patients as possible on your list and pack them off to hospital as soon as they seem to be ill. As a system this seems to be quite intolerable. A good deal of thought has been put into the question of payment for General Practice and discussions have broken down mainly for two reasons: first, because no acceptable alternative to the capitation fee has been found and secondly because the profession, represented by its spokesmen on that democratic body, the British Medical Association, has resisted attempts at differential payment for good General Practice. Perhaps the greatest failure of the recent report of the Porritt Committee is its lack of courage in grasping this, the most important problem of the Health Service of the present day. As far as basic remuneration is concerned the two obvious alternatives to the capitation system are the fees for item of service and the whole-time salary. The Porritt

committee was probably right in turning both these down because the first is so easily exploited by the unscrupulous and the second so dangerous an encouragement to mediocrity. But this should not mean that good General Practice must go unrewarded.

When the Health Service started, an attempt was at once made to upgrade the derelict and bankrupt hospitals of Britain, but no comparable attempt was made to upgrade the premises and equipment of the General Practitioner. There are interest-free loans (which have to be paid off) for the improvement of premises, but these only apply to Group Practice and not to the single-handed Practitioner. They are thus an encouragement to Group Practice which is a good thing, but doctors are individuals and partnerships are not always happy, and there are some people who do their best work on their own. There are at least three ways in which money should be spent on improving standards of General Practice. First, the minimum requirements at least for premises, equipment and secretarial help should be provided (with proper safeguards against misuse of the money) just as they are provided for doctors in hospitals. Equipment should ideally include a sterile syringe service (this is available at cost through the local hospital in some areas already), but need not include elaborate apparatus or laboratory facilities if these are freely available to practitioners through the local hospital or preferably in a General Practice diagnostic centre. Doctors working in groups might have more equipment, for instance an electrocardiograph. Secondly, there should be differential payment in General Practice just as there is in the hospital service so that good General Practice is rewarded

at a level significantly above the average, and above the basic level for consultants. This would provide a financial incentive without adopting the fee-for-service system. It is admitted that selection would be quite impossible if it were attempted on the lines of the Merit Awards for consultants, but the many alternatives should be explored, for instance the doctor or group practice might apply for an award giving *a priori* reasons and submit to periodic inspection. Adequacy of postgraduate training would count in selection. If teaching in General Practice were more generally organized, doctors selected as teachers might be paid at a higher rate, not based on hours of teaching but by virtue of being selected. Thirdly, the number of General Practitioners should be gradually increased over the next 20 years so that doctors will be able to make a reasonable living by seeing fewer patients. This will mean the training of more medical students and possibly the creation of one or more new medical schools, and a better orientation of teaching towards General Practice. The upgrading of standards in General Practice will not be brought about simply by money and time, however. The training of the General Practitioner before and after qualification will be considered in the next chapter. If he had more postgraduate experience —especially in internal medicine—before entering practice than he has usually had today, he would improve both in competence and in confidence, and might at least equal the American Internist in knowledge while still remaining a family doctor. Opposition to General Practitioner beds in hospitals would disappear and so more acutely ill patients would remain under their own doctor's charge. Thus might the best features of American and British practice be combined.

Chapter 6

THOUGHTS ABOUT MEDICAL EDUCATION

It is generally believed that the medical curriculum could be greatly improved. This view is so firmly held that in every Medical School in Great Britain and in most other countries, committees meet regularly to find out what form the improvements should take, and how to put them into operation. It must be confessed that they have met with little or no success. It was thought that the compulsory pre-registration year, which compels every graduate in medicine to do at least one year's further training in hospital before he even gets on to the Medical Register, and has the full privileges of a doctor in practice, would make the task of the medical educator easier: at last, he said, we are freed from the old notion that we must produce the complete doctor, fully able to take charge of all patients and diagnose all diseases from the day that he is qualified: no longer need we play for safety and be forced to teach a little of everything lest the newly-fledged doctor should meet with some emergency the day after qualification with which he has never been taught to deal. At last, they said, we can teach the principles of medicine knowing full well that our graduates will have this further experience under supervision before they are let loose on the public. The pre-registration year has now been in force for 15 years but still the medical curriculum has not been noticeably reformed. No revolutionary change has been seen to take place. All medical educators know the reason: it is because their colleagues insist on continuing to teach unnecessary

facts about subjects which are of little or no importance. When each blames the other it is just possible that they are looking for the wrong thing. It is in fact even possible that the medical curriculum isn't so bad after all and this I believe to be the case. Improvements, of course, can always be made. Throughout the course students should be taught much more about man as an individual, about his behaviour in health and disease, about human society, about psychology and evolution; but this is gradually happening in the more enlightened schools. In clinical subjects the student needs to be taught the elementary principles of diagnosis and the scientific principles as far as they are known, which underlie our present understanding of disease and of its treatment. But in addition he must be introduced in the broadest possible way to the realities of human disease. He must see medicine in all its branches, surgery, gynæcology, obstetrics, pædiatrics, and because even then he will not have seen a small fraction of disease as it really exists, and will not have seen it in its natural setting in the community, he must see disease in General Practice.

A little more might be said on the question of teaching principles. I once heard of an engineer who said that if he had his University training over again, he would spend it entirely in the study of mathematics, for he held that the engineering problems are easy if you can understand the mathematics on which they are based. How seriously he made the statement, and how successful an engineer he would have been if he had spent his training in that way I cannot say, but I can imagine that it might be more successful in engineering than in medicine. I suppose any clever

person who had a knowledge of the basic principles involved in the construction of a motor bicycle could in time improve on any yet made, but the principles underlying the construction of a guinea-pig or a human being are for the most part unknown, and the pattern of its behaviour in disease cannot therefore be predicted from a knowledge of the principles but only from experience. Indeed, practical knowledge based on experience is gradually building up the data from which the underlying principles are being discovered. I once heard a well-known medical teacher trying to answer the criticism that in teaching hospitals we often teach on rare disorders. 'I can teach the principles of medicine', he said, 'as well on a case of tumour of the 8th cranial nerve as on any other case in medicine.' What he meant no doubt, was that he could teach the methods by which the patient's symptoms and signs could be ascertained and the deductions which could be made from the data which, together with a basic knowledge of anatomy, could be interpreted as indicating the presence of a tumour in a certain situation. He chose, of course, a good example. The weakness of the case is that in the next patient which the student came across there may be no way in the present state of knowledge of deducing what the signs and symptoms could possible mean from a basic knowledge of anatomy and pathology. Take that very important and common condition, duodenal ulcer, for instance. One of the most important pointers to the diagnosis, the one which best distinguishes it from other conditions with which it might be confused, is the history of intermissions. Patients with duodenal ulcer will nearly always tell you that they have had the symptoms for many

years but that there are long periods in which they are completely free from pain. Nobody knows why this is so, nobody could possibly have predicted it from our present very incomplete knowledge of duodenal ulcer and its causes, so this is a piece of diagnostic information of the greatest importance to the practising doctor which can only be learnt by experience. Examples could be multiplied. No amount of knowledge of virology or of tumours of the 8th cranial nerve could teach a student what kind of illness should make him suspect that he may be dealing with the earliest symptoms of poliomyelitis.

No teachers agree on what they mean by principles. Surgeons may mean asepsis and anatomy. Physicians may mean the biochemistry of disease. Some of these things must be taught to train the mind and increase the understanding, but students are not easily deceived and do not need much insight to suspect that the Krebs cycle is as relevant to the practice of medicine as Anglo Saxon grammar is to the appreciation of Shakespeare's plays. None of the teachers usually mean ethical principles, yet much illness is unwittingly caused by doctors through neglect of them.

As soon as we have disposed of the fiction that all we are trying to do in the clinical years is to teach principles, and as soon as we have admitted that we must also give the student, under guidance, his first initiation into human disease and heighten his powers of observation by the breadth and variety of his experience, the case immediately collapses, if ever there were a case, for not giving the student experience of General Practice prior to graduation, for it is in General Practice that his widest experience of

disease can be obtained, disease which he will never see in hospital, disease in early stages and in late stages with all its social implications. It is the field work which, as in the study of all natural phenomena like geography and geology and botany, at once makes sense of what under the artificial conditions of the University or the teaching hospital the student has been trying to learn about. Students who have spent a fortnight with a good General Practitioner usually come back refreshed and with new enthusiasm, freed, if only for a short holiday, from what Susser has called the conditioning effect of institutions in which students come to perceive all medical problems as hospital problems and to accept hospital values as representative medical values.

Until recently, General Practice has been the only branch of medicine which has not been taught during the undergraduate years and yet it is that branch of medicine which will eventually claim about 50 per cent of the students. There are certain reasons why it has been neglected, and several reasons beyond those already given why it should be taught. It has been neglected partly because in days gone by the diagnostic methods and treatment which a physician taught in his wards were not very different from what the student could later do in General Practice. Today this is not the case. Medical science and specialization have combined to ensure that patients admitted to advanced Professorial Units in teaching hospitals are highly selected and most of the methods used for their investigation could not possibly be used in General Practice. Secondly, the new whole-time University teachers who are now responsible for so much of the undergraduate

teaching have almost no contact with General Practice or with General Practitioners and cannot be expected to understand its importance. What principle of medicine is there, they sometimes ask, which General Practice can teach and which we cannot teach in hospital? The question, as I hope I have pointed out, is a false one. We do not teach General Practice primarily to teach principles (though I think some principles can well be learnt there, especially the principles of community care) we send them to broaden their experience of medicine. You have only to compare a day's work in a General Practice with a round of the wards in a Professorial medical department, as I have recently done, to see the contrast. But there is at least one principle of medical teaching which can best be illustrated in General Practice. It is always acknowledged by the best teachers that authoritarianism with its savour of omniscience should be avoided and that we should teach and admit the limitations of knowledge; nowhere will the student more readily learn the limitations of knowledge (and the limitations of his teachers) than in General Practice.

There are still other reasons for teaching General Practice. One is that half the students will probably *not* enter General Practice and for them it is a particularly important experience. Another reason is that the methods of handling patients and the appropriateness of certain methods of examination are different in General Practice from what they are in the kind of serious or obscure disease treated in hospital. It is important that students should learn this from doctors who are obviously of the first quality, otherwise when they go into General Practice they will try to adopt the techniques of the hospital, they

will inevitably fail, and will develop a kind of guilt complex, as Crombie has pointed out, which may easily spoil the early formative years of their General Practice experience. Finally, it is possible, and it used to be probable, that a graduate going into General Practice for the first time may get into a partnership of bad doctors who have developed slovenly methods. If the student has no experience of the standards of really good General Practitioners he may adopt the methods of those around him without realizing that much better work could be done.

If the reasons for teaching General Practice during the undergraduate years are accepted, and to my mind they are overwhelming, then more experiments should be made with University General Practice centres, and it is an important milestone that the first Chair in General Practice has just been created. But my recent study of General Practice has taught me that although these centres may make a valuable contribution to teaching and to research into the methods of General Practice, there is a great deal to be gained for the student if he goes (one at a time) to spend a fortnight living with a good General Practitioner. This also has the important effect of distributing the load. General Practice is a very individual matter and cannot be well taught to groups of even three students, let alone five or ten, and no General Practitioner should be compelled to teach the whole year round as we unfortunately do in hospital. The University General Practice centre, then, unless it were of enormous proportions, could not cope with the necessary teaching of, say, a hundred students a year even if they were only to do from two to four weeks each in General Practice.

If General Practice teaching is looked after, it seems that the medical curriculum may not be as bad as we thought. What is wrong then with medical education, for there is no doubt that in the past we have turned out many second-rate doctors (in addition to many first-rate ones). I think the fault lies in postgraduate training. It is generally conceded that for a man to become a competent specialist in medicine, surgery, psychiatry, or any other clinical branch of the profession, he needs about nine years training after graduation. Some may do it in less, but eight to ten years is probably the average before a man becomes a consultant in our Health Service, and yet we are content for a man to go into General Practice after one year's postgraduate training in hospital. Of course many do more than this and many take trainee posts in General Practice before they are fully established, but the good General Practitioner needs competence and confidence in many branches of his profession. I see no reason why he should not be required to do at least three years, and preferably four or five, in hospital training posts before entering General Practice. Unquestionably he will be a better man if these posts have included experience under supervision in medicine, pædiatrics, obstetrics and casualty work as a minimum requirement, and specialties such as psychiatry, ear, nose and throat and ophthalmology as valuable extras.

If all I have said about teaching in General Practice is true, why should this period be spent in hospital? It could perhaps, for preference, be spent, or partly spent, in the kind of post which has lately been devised, with the help of the Nuffield Provincial Hospitals Trust in the Wessex region, in which a man is trained in hospital work, and in

General Practice, during the same period, but in hospital not only are the opportunities for supervision better, but the concentration of experience of serious disease is far greater than in any General Practice. The fact that influenza may be a hundred times more common than cancer does not mean that the trainee should see a thousand cases of influenza for every ten cases of cancer. The wide experience of the more serious diseases and their treatment which he will receive in hospital and the mastering of diagnostic skills by frequent practice will stand him in good stead for the rest of his life. Moreover, he will be able to undertake the treatment of a greater variety of disease either at home or in hospital. If the General Practitioner of the future were a man who had done five years' postgraduate training in hospital, there is no doubt that the whole status of General Practice would improve, and the public would have direct access to a higher quality of medical care. It is an important provision that training standards in regional hospitals should be greatly improved. Moves in this direction have already been made, and the Nuffield Provincial Hospitals Trust has played a part in initiating them.

Chapter 7

THE MORALE OF THE PROFESSION

The old country doctor who practised in isolation and rarely read a medical text-book or journal from qualification onwards was an independent fellow whose mood and morale probably depended on his day's work, and on his wife, and his relations with the Vicar. But medical science and social change have led to a greater organization of the profession and doctors today cannot escape being members of a group. They become affected by matters which influence the group as a whole and begin to react according to the rules of group behaviour. In determining group behaviour no influence is as important as morale, difficult though it may be to define, and at times when morale is high the daily work is carried out with zeal and fortitude which are not in evidence when morale has been allowed to flag. Such elementary facts should be known to all who have the privilege of leading, commanding, or otherwise influencing their fellow men, for nothing is so important for morale as leadership. In relatively immature societies, like the boy scouts, the qualities required by a leader are fairly easy to define, but in more complex intellectual societies, like Universities and professions, the necessary qualities are more subtle if only because the community is more difficult to convince.

The evidence seems to be strong that morale in the medical profession was low in the years which followed the introduction of the National Health Service but that the lowering of morale was greater amongst General Prac-

titioners than amongst the consultants and specialists. The point has already been made that this was an extension of a process which had been going on for a long time, because modern medicine and surgery had led to the exaltation of the specialist. Complaints from the General Practitioners were heard long before the National Health Service, but were emphasized when the service provided specialist staffing not only for the hospitals in the great cities but also for the small hospitals in country towns. Moreover General Practitioners whose practices were in flourishing suburban districts where incomes mainly depended on private fees suffered financially when 90 per cent or more of their patients elected to have their medical attention provided by the Health Service.

The consultants, on the other hand, were to be paid for the first time for work which they did in hospital and this was likely to offset any reduction in private fees. This made it possible for young men to become specialists without going through years of hardship, penury and debt. Many new posts for specialists became available soon after the war when the young men who had returned from the Forces were completing their training.

Apart from these obvious differences between the two branches of the profession other important factors were at work. The history of the years which preceded and immediately followed the inauguration of the Health Service has been ably studied and recorded in two books by American sociologists. The British Medical Association had declared itself in full favour of the establishment of a comprehensive Health Service and had played an important part in its early planning, but, it seemed to some, that as

soon as the Government began to take it seriously and it became clear that such a Health Service might actually come into being, the British Medical Association's attitude changed. The Beveridge report of 1943 first aroused its suspicions and a great deal of dissatisfaction was later expressed on the provisions of the White Paper of the coalition Government of 1944. But by the time the National Health Service Bill was actually being drafted a new Socialist Government was in power with Mr. Bevan as Minister of Health and it may have been natural under the circumstances that the profession became fearful lest the scheme might lead to the establishment of a whole-time salaried service, to the disappearance of private practice and to Government interference with the doctor's right to choose how he prescribed for his patient. There were also more specific objections to the new Bill, though on some of these the Council of the British Medical Association was not at one with the majority of the profession. In spite of this opposition the Bill with a number of amendments was passed into law in November 1946, but discussions between the Government and the profession on the terms and conditions of service had still to take place before the day appointed for the Service to start, namely July 5th, 1948.

It was now that the greatest opposition of the British Medical Association was staged. Mass meetings were held at which the most paranoid fears were mooted and a bitter enmity was built up against Mr. Bevan and all his works. Doctors were to abstain from joining the Service, the Council of the British Medical Association was even to be given a mandate to refuse to negotiate any further: if a

Health Service were to be established, the profession was told, it would lead to the endless signing of certificates, direction of doctors by the Government and every possible interference with professional liberty. An impasse was rapidly being reached, and the Presidents of the Royal Colleges wrote to Mr. Bevan in cool and unemotional terms expressing the fears of the profession on some of the terms of the Act and the hope that he would give them assurances on certain points. On all these points assurances were given and the decision of the British Medical Association not to continue negotiations with the Ministry of Health was reversed. The campaign, however, went on.

Lindsey in his book *Socialized Medicine* says: 'Driven by a fear that fed upon a sharp distrust of the Ministry of Health and the Labor Party, the leadership of the medical profession resorted to techniques that at times approached the level of demagogism. The absolute need the Association felt for solidarity among its membership may explain the rabid appeals and provocative allegations that characterized some of the editorials of the *British Medical Journal* and speeches of the officials from Tavistock Square.' After a year of rather fruitless meetings, a Representative Meeting of the British Medical Association in January 1948 declared that the National Health Service Act in its present form was 'so grossly at variance with the essential principles of our profession that it should be rejected absolutely by all practitioners.' 'This blunt rejection of the law,' Lindsey says, 'sparked an all-out campaign by the leadership of the Association to build up a solid phalanx of resistance. The *British Medical Journal* was already active in maligning the new program by catchword phrases and innuendos and

in otherwise putting the worst possible construction on the Act.' (I quote from the words of an American Historian based on his own documentary researches and published many years after the events were over.)

The questionnaire of February 1948 revealed a conclusive victory for the leaders of the British Medical Association, but their jubilance was much criticized in the responsible press.

The Minister of Health who undoubtedly could be brusque and provocative, adopted a more conciliatory tone, and gave more assurances even to the extent of sponsoring further legislation ruling out a full-time salaried service, but he refused to yield on any of his principles, including the abolition of the sale of goodwill in medical practices. The British Medical Association held another questionnaire which now showed two-thirds of the General Practitioners against the Act, but only a slender majority who would be unwilling to accept service if it came into operation. It was clear that any further opposition would lead to a debacle. At a special meeting on May 28th the Chairman of Council of the British Medical Association, Dr. Guy Dain, favoured acceptance of the National Health Service as the only course, saying that the Association had won numerous concessions, which of course was true. Lord Horder, leading a strong minority, condemned the Council for its policy of betrayal.

The Service was inaugurated on the appointed day, but the ill will which had been engendered lived on. Only a few months before, the doctors had been told that the Act was 'grossly at variance with the essential principles of our profession'. Now suddenly Dr. Dain was saying 'The pro-

fession will do its utmost to make the new Service a resounding success . . . There will be no shortage of goodwill.' It was too late for statements of that kind. The harm had been done. A generation of doctors had been taught to disparage British Medicine, to regard the Ministry of Health as its enemy, and to speak of the Health Service in terms of contempt. The profession had been brought down to the mentality of strike action, a mentality which reared its ugly head again in the pay claim of 1956–57.

Undoubtedly the British Medical Association won a number of concessions but they were so much in the nature of modifications and assurances and so little did they affect the major provisions of the Act that it seems inconceivable that the same concessions could not have been won by peaceful negotiations as between men of honour: by the kind of means in fact which the editorials of the *Lancet* and which Lord Moran in the Royal College of Physicians had repeatedly advocated. Moran was blamed for splitting the profession, but even if that were so, what more could have been achieved? That there should be a Health Service was the expressed wish of the people of Britain embodied in an Act of Parliament. It had been endorsed by all parties. Whatever party were in power it would come about, and the role of the profession as Moran had said, was to make it as good a Health Service as it could be and not to wreck it.

The main spokesmen for British Medical Association policy at the time were old men. The Chairman of the Council, who is virtually the leader of the British Medical Association, was 76 when the Act was passed. The Treasurer was even older. The President, Sir Hugh Lett, who it

must be confessed is not so important politically as the Chairman of Council was 70, Lord Horder was 76, and the moving spirit in a political sense was Charles Hill, at that time Secretary of the British Medical Association.

It is difficult to think that leadership had nothing to do with the difference of morale in the two branches of the profession. The methods of the B.M.A. were those of the trades unionists, not appropriate to the leadership of a great profession. Their only success could have been to make an Act of Parliament unworkable. Subsequent history does not seem to show that this would have been desirable. If they failed in this, they could only succeed in starting the Health Service with the greatest possible amount of ill will between the doctors and the Ministry. Even recent leading articles in the *British Medical Journal* still show traces of the same attitude towards the Ministry and the Health Service, which is no doubt one of the reasons why American visitors are amazed to the point of unbelief when they come to this country and find that the majority of patients and doctors positively approve of the Health Service, as the Porritt report showed, and that young men training for hospital careers for the most part do not wish to enter private practice.

In recent years General Practice seems to have found a new morale. The renaissance of General Practice has been described. General Practitioners are feeling a new confidence. They have begun to define their sphere in the profession. They find it largely independent of what specialists do in hospitals, but at least as important, and this change has taken place without any revolutionary change in the Health Service conditions for General

Practitioners, apart from an increase in pay barely sufficient to compensate for the inflationary trends of recent years. Is it too much to believe that this again has something to do with leadership? If so, the College of General Practitioners might modestly claim some of the credit though they will probably have the wisdom not to do so.

We cannot close a chapter on morale without some reference to morale in hospitals, for a hospital, like a ship or a battalion or a steel works, is a unit in which a large number of people work, doing jobs which carry different degrees of status, responsibility, and financial reward. It is evident to all of us that in the crudest terms some hospitals are good and some are bad, and those who have studied the problem find that although in some large hospitals standards vary between individual units, the general trend is for morale and efficiency to be good or bad throughout the hospital. A group in Manchester under the guidance of Professor Revans of the Department of Industrial Administration and with the help of the Nuffield Provincial Hospitals Trust has been examining this problem. Their preliminary results are of great interest, and those who work in hospitals should read them carefully and might even come to welcome the fact that laymen are taking an interest in the morale and efficiency of hospitals which we in the profession have so often tended to neglect. The group has endeavoured to study by statistical methods the difference of attitude of members of the nursing staff towards their work and their seniors and juniors and to relate them to measurable things such as sickness incidence, nurse wastage, length of patient stay, waiting list and so on. Some of the correlations are remarkable. Surprising though it may seem at first sight,

the hospitals with the large waiting lists are not usually the popular ones to which everyone wants to come but are more likely to be the inefficient ones in which nobody seems to care how long patients stay. In the same hospital it will be found, probably, that the wastage of nurses is very high and that even those who complete their training do not stay on to be staff nurses and sisters, that the relations of the medical staff to the Management Committee are not happy, that nurses hesitate to communicate with ward sisters, that ward sisters complain that the medical staff do not take them into their confidence, and that their own relations with the Matron are far from good. We all know only too well the hospitals in which even before you enter the porters and telephonists have given the impression of being disinterested. The responsibility for this state of affairs does not, however, rest with the porter or the telephonist. The heads of the three main branches of hospital work set the standard for the rest of the hospital. They are the Chairman and Secretary of the Management Committee, the Matron, and the consultant staff. The responsibility rests firmly on their shoulders.

Chapter 8

HUMAN EXPERIMENT

Human experiment is as old as the history of medicine. Doctors have given new remedies for the first time, and many of them did more harm than good. Since the discovery of anæsthesia and the understanding of bacterial infection, new surgical procedures have been devised with increasing frequency. Occasionally the ambition to be the first to perform a hazardous operation successfully may have influenced the surgeon's judgement, but criticism on the grounds of medical ethics did not usually arise.

There are several reasons why the question of ethics in relation to human experiment has become almost suddenly and urgently important in our own generation. First, of course, there has been a general awakening of social conscience. More importantly, the new remedies, operations and investigative procedures have much more power for good and harm. Thirdly, new methods of prevention, such as poliomyelitis vaccine, have brought the benefits, and also the dangers, of medical science not only to the individual sufferer but to the community at large. We ask an individual, or the parent of a child, to accept an unknown risk (even if animal experiment suggests that it is a very small one) not only to protect himself or his child from a somewhat remote possibility of serious disease but also for the benefit of others. Fourthly, and very importantly, the new clinical science has shown how much human experiment can throw light on questions of a purely scientific nature. The careful investigation of a patient with renal failure

may greatly help the understanding of the function of the kidney. Such knowledge, gradually accumulated over the years, may eventually help patients suffering from kidney disease, but the immediate acquisition of the knowledge is not at all likely to help the patient who is the subject of the experiment. This type of experiment, although very valuable, especially raises questions of justifiable risk and of the consent of the patient. Fifthly, there has been developed for the first time the concept of clinical research as a profession, which carries the implication that however devoted the medical man may be to the causes of humanity and the individual, his avowed aim is discovery rather than treatment. Thus for the first time we have a possible divorce between the interests of science and of the patient.

In recent years there have been some responsible and noteworthy discussions on human experiment. McCance points out that man is the only mammal for which a vivisection licence is not required in this country, but he says: 'The use of man as one's experimental material raises all kinds of issues, moral, ethical and legal, which have never really been faced. . . . Anything done to a patient which is not generally accepted as being for his direct therapeutic benefit or as contributing to the diagnosis of his disease should be regarded as constituting an experiment.' After discussing various aspects of experimental medicine McCance goes on to say, 'Every one working experimentally with normal human subjects, or with patients, must remember not only his responsibility to the subject or patient, but also his responsibility to the discipline of experimental medicine. One irresponsible experimenter can do great harm to medical science.' McCance's discus-

sion, now 12 years old, is still so relevant that it could be quoted in full. It seems to gain in significance by being written by one who, although a pioneer in experimental medicine, has rarely taken therapeutic control of patients himself. McCance accepts the situation, common in most hospitals, that the patient trusts the staff of the hospital, and the investigator, knowing this usually dispenses with the formality of asking for 'permission', when his experiments simply involve procedures which are commonplaces of clinical practice, but he should take the patient or parent into his confidence over anything more elaborate, and this is where his conscience and judgement become important. On the subject of the patient's consent, a memorandum issued by the Medical Research Council in 1953 and recirculated in 1962 says: 'To obtain the consent of the patient to a proposed investigation is not in itself enough. Owing to the special relationship of trust which exists between a patient and his doctor, most patients will consent to any proposal that is made. Further, the considerations involved are nearly always so technical as to prevent their being adequately understood by one who is not himself an expert. It must, therefore, be frankly recognized that, for practical purposes, an inescapable responsibility for determining what investigations are, or are not, undertaken on a particular patient will rest with the doctor concerned. Nearly always his judgement will be accepted by the patient as decisive.' This is an important statement, for patients cannot possibly understand the issues involved and their consent may become a kind of placebo to the experimenter's conscience. Bradford Hill in his recent paper on the ethics of clinical trials shares this view

that the patient's consent does very little to relieve the experimenter from full responsibility. Nevertheless his individual co-operation and consent should always be sought if the experiment is going to subject him to any risk, discomfort or inconvenience whatever in a cause only remotely connected with the diagnosis and treatment of his case. Fox would go further and say that when in pursuance of research some part of normal treatment is to be withheld or some unestablished method applied or fresh symptoms caused or adventitious danger incurred, consent for an experiment ought to include the approval of a doctor acting on the patient's behalf. Fox, quoting Van Noordwijk, says: 'Scientific research demands an objective attitude, a certain aloofness with regard to the subject under investigation, which in fact conflicts with the doctor-patient relationship.' Fox differentiates between the physician-friend and the physician-experimenter who have different attitudes and interests and he feels that the investigator whose purpose is research should not usually be in medical charge of the patient. Dornhorst, whom Fox quotes, holds the other view, that the patient's best protection against excessive or improper investigation is the fact that the investigator is personally responsible for his welfare.

It is the essence of human situations that there is never a ready and universal solution. There are clinical investigators whose care and advice I would unhesitatingly seek if I were ill but there are others whose attentions I would studiously avoid. Now that Universities have so much say in the choice of physicians and surgeons in teaching hospitals they should show the greatest care in selecting

men of the right personality. A famous University which has several times consulted me about senior appointments in medicine asks whether the candidate is a good research worker, teacher and colleague, but fails to ask whether he is a good doctor whose clinical judgement patients and colleagues alike will respect, and whether he is a responsible and humane person.

In most discussions on the ethics of clinical experiment, the assumption seems to be made that the experiment itself is scientifically a good one: the only question asked is whether it is justifiable to carry it out. This begs a very large question, for it is much more justifiable to carry out an investigation which is going to give the answer to an important question than it is to carry out an investigation which may give the answer to a trivial question, or an investigation which is unlikely to give any answer at all. Unfortunately there is a good deal of investigation which is scientifically bad, usually because the investigators naïvely believe the material of their experiment, namely ill human beings, to be far more homogeneous than it actually is and that they can control variables which turn out to be quite uncontrollable. A good many years ago a clinical scientist in this country, regretting the lack of training in scientific method of most clinicians, chose the operation of resection of the sympathetic nerve roots for high blood pressure as his example and pointed out our inability to assess its value because no controlled trial had been done, that is, no series of patients had been selected from which a random choice would be made, one half the number being operated on and the rest acting as controls. As he said, this may sound an immoral proceeding, but it would seem even

more immoral to use on a large scale a remedy without establishing whether it benefits or harms the patient. At first sight this seems a very logical plea for the introduction of a controlled trial, but a little further thought shows that it is quite impracticable and would in fact not give the desired answer. With reasonably homogeneous material like healthy children developing whooping cough, for instance, a controlled trial of a remedy is a wise and practicable possibility, but with hypertension, as every clinician knows, no two cases are alike. Assuming that the two groups are matched for age and sex and height of blood pressure, and as far as possible for symptoms and complications, there will always be some who in some subtle way seem to be more robust or more ill than others. There are some who are red in the face and others who are pale, as Volhard pointed out many years ago and their subsequent behaviour differs. It is impossible to get properly matched controls. But this is only the beginning of the dilemma. As Bradford Hill so properly points out, a controlled therapeutic trial is only justifiable if the investigator is genuinely neutral and ignorant in his mind as to which treatment is the better. If it is a question of comparing Prednisone with Phenylbutazone in rheumatoid arthritis, the clinician may very well be neutral and with a clear conscience will advise patients to have one kind of tablet or the other according so some random selection, preferably not knowing until the results are recorded which patient had which, but if we are comparing a medical regime with a serious operation, or to put it more cynically, comparing the effects of slow deterioration with the possibility of sudden death, the situation is quite otherwise. No responsible clinician can

ever say, certainly in a disease as serious as hypertension, that he has no opinion whatever to offer the patient as to whether an operation is advisable or not. Even if the Physician-experimenter could argue himself into such a state, the patient would intervene and reduce the trial to a travesty of medical ethics. I can imagine a conversation like this: First patient. 'Doctor, I'm very worried about this operation. I knew somebody who died during the second stage of it. I know it may be advisable, but I do want to live a little longer because of my family. Do you think I need really have it?' Doctor: 'I am quite sure that in your case it is absolutely the best treatment.' Second patient: 'Doctor, I've heard of an operation being done for this high blood pressure and I know someone who has been greatly improved by it, don't you think I could have this operation?' Doctor: 'In your case I am absolutely certain that operation would be the wrong treatment.' Perhaps the really ethical doctor in charge of this trial would say: 'My dear madam, in this Unit these decisions are not a matter of judgement, they depend upon whether one of our technicians has drawn a red or a black card from the pack.'

Perhaps my presentation of the situation is a little dramatized, but the point is that this is not a situation in which the controlled trial is justified or is going to give the answer. Clinicians experienced in the treatment of high blood pressure already knew, albeit somewhat imperfectly, its natural history and the prognostic indications of the clinical findings. What needed to be known was whether sympathectomy could, with reasonable safety, produce a significant fall in blood pressure such as would not be

obtainable by the medical measures then in vogue, and whether the fall of blood pressure would be lasting. The extent of the sympathectomy necessary to produce a satisfactory fall in blood pressure had also to be determined. All this information could gradually be found out by advising surgery in cases in which the outlook seemed bad but the immediate state of the patient was judged to be safe for operation. Once the facts were established clinicians would know whether in their judgement of the individual case, the operation was likely to be worth while. Their judgement would not of course always be right, but neither would it if the proposed random trial had been carried out. What went wrong in the sympathectomy epoch was not the lack of a random trial but the enthusiasm of surgeons untrained in the management of hypertensive disease and ignorant of its natural history. Many instances could be quoted of controlled trials which are bound to fail because of the variability of the case material. The Medical Research Council trial of the long-term use of anticoagulants in myocardial infarction was unsatisfactory for this reason.

Finally, it must be remembered that the eventual judgement in a clinical trial in which controls are used is an arbitrary one, the result being usually deemed 'statistically significant' because it was unlikely to have happened by chance more than once in 20 such trials. Why not 17 or 26? The fact is that there are some therapeutic situations which lend themselves to controlled clinical trials and others which don't, and still others, perhaps the majority, in which a controlled clinical trial is unnecessary, for instance, in the modern treatment of malaria, meningococcal meningitis, pneumonia, pyloric stenosis, diabetes,

pernicious anæmia, myxœdema, thyrotoxicosis. In all of these there are clinical or laboratory tests which will rapidly tell whether the treatment is effective. Where even more difficult decisions have to be made, for instance, on the value and danger of operations in heart disease or in ulcerative colitis, random selection is not the right way to make them.

I have given much thought to the use of placebos in clinical trials. There are, of course, two types of placebo trial: the one in which the patient does not know whether he is having the treatment or the placebo and the other in which neither the patient nor the doctor knows (the double-blind trial). The ethical difficulties of the latter situation can sometimes be overcome, as Bradford Hill has pointed out, by the doctor in charge knowing which treatment the patient was having but by the results being judged by another doctor who is ignorant of the treatment received. In the Medical Research Council trials of streptomycin in pulmonary tuberculosis the x-rays were judged by doctors who did not know which cases had been given streptomycin. I have come to the conclusion that the use of placebos is never justified without the full knowledge, co-operation and consent of the patient. In the majority of cases the use of a placebo can be avoided by comparing the new remedy with the treatment at present in use, thus aspirin, phenylbutazone and steroids would be compared with each other in the treatment of rheumatoid arthritis. In the Medical Research Council trial on anticoagulants these were given to one set of patients in adequate dosage and to the 'control' patients in doses so small as to be deliberately ineffective. This was to me a new departure

in which a kind of double-blind eye was turned on medical ethics, the doctors deceiving themselves that they were not deceiving the patients.

In cases of dangerous disease where a specific remedy is thought to have been found, as for instance tetracyclines in typhus, the results, if of any use, will speak for themselves and no controlled trial is necessary. The occasions must be few in which the patient's co-operation in a placebo trial could be asked in cases of serious disease, but with minor illness and with symptoms not thought to be dangerous the patient's co-operation is usually easy to obtain. Good examples are in the trial of remedies for the common cold or for migraine, or for intermittent claudication, and even for angina pectoris, for although here the underlying disease is serious the outlook is not thought to depend on the frequency of attacks of pain. It is especially in minor conditions that psychological factors are apt to be active and placebo trials are therefore appropriate.

In this chapter on human experiment we have dealt mostly with therapy. Some of the most difficult ethical problems arise not in therapy where the intention at least is to do the patient good, but in the investigation of disease where the benefit to the patient is less direct. It is difficult to say whether the man who first did a percutaneous liver biopsy displayed great moral courage or an unusual indifference to his patient's welfare, yet it has proved to be a valuable means of diagnosis in selected cases. Potentially dangerous methods of investigation can usually be tested by animal experiment, and later applied first in cases of dangerous disease where the incurring of risk is more

justifiable than in trivial illness. Dangerous investigational procedures employed solely for the benefit of science and without benefit to the patient are never justifiable save in rare instances where a complete explanation can be made to an understanding and intelligent patient, himself probably a doctor who is willing to collaborate. As Kety has so elegantly said: 'The scientist or physician has no right to choose martyrs for society.'

Chapter 9

DRUGS

I forget where I heard the story and I may have got it wrong, but from memory it was about a Chinaman who was recently asked what he thought were the major effects of the French revolution of 1789. He said he thought it was too early to say.

The discoveries which have transformed medical practice have been preventive and therapeutic: the preventive measures may be personal such as inoculations against diphtheria, tetanus or poliomyelitis, or community measures such as nutrition and hygiene, which have almost disposed of rickets and typhoid fever. Therapeutic measures also become preventive, for tuberculosis promptly and efficiently treated lessens the danger to relatives and companions, and so the disease dies out. Advances in therapy and prevention have not usually come from the professorial departments of medicine, which have been more occupied in studying the physiological and biochemical disorders of disease. Instead they have come from medical scientists in non-clinical departments and from the large and progressive drug firms who spend untold fortunes on research. In recent years many new drugs have originated in the laboratories of the drug firms, for instance, the sulphonamides, the newer antibiotics, tranquillizers, anti-depressant drugs and cortisone derivatives: others owe their origin to research workers in University departments, but have been developed, investigated, improved and made practicable by the wealth and research potential of pharmaceutical

industry, with which no University department has the money and resources to compete. Competitive industry in turn depends on big profits which attract the necessary capital. The dramatic advances in surgical treatment of recent years, although developed by surgeons, physiologists and engineers, are only made possible by modern antibiotics and anæsthetics which the drug firms produce.

In a society in which the economy depends on free enterprise and the profit motive, one cannot complain that the drug firms are too wealthy. They run great risks, many of them depend on large sales of only one or two drugs for their main profits and if a rival firm produces something better the profits can quickly turn to losses. It has been pointed out as a further weight to the argument for the drug firms that the communist countries have not produced any of the important new remedies. This is true but may not be fair comment, because in a communist society the resources can be directed into chosen channels. The bomb was dropped on Hiroshima, and Russia conceived the notion, rightly or wrongly, that her survival depended on competing with America in the development of the engines of modern war, which in turn led to an interest in space craft, the success of which has been phenomenal. If the peace of the world had been more assured and the Russians had chosen to turn their enormous resources of natural wealth and scientific enterprise and efficiency into therapeutic medicine, it is possible to speculate that the cure of cancer might be within reach. As the Chinaman said: 'It is too early to say.' Given a capitalist society the drug firms must be allowed their profits, which means that all the devices of competitive industry, including advertising, will

continue, unless they become so objectionable or harmful that they have to be suppressed by law. What seems to be an inevitable corollary is that some small drug firms, who do little or no research, and whose ethical standards are sometimes questionable, who make money out of putting new compounds of old drugs in attractive packages, must also be allowed to flourish, for there seems to be no way of making a clear boundary between the one and the other.

A good many laymen still regard a drug as something undesirable which 'normal' people, healthy in body and mind, should eschew. They hold forth on the evils of tranquillizers and the lack of mental stamina in modern society, while drinking their coffee, sipping their brandy and smoking their cigars. To the doctor anything is a drug which modifies bodily or mental function by chemical means, foods being usually excluded from the definition. Drugs fall into different categories and attract varying degrees of approval or disapproval. No ethical problems are involved in the use of Vitamin B_{12} for pernicious anæmia or of insulin for diabetes, unless the patient is a rabid anti-vivisectionist, for it must be confessed that all modern remedies depend on animal experiment. All powerful drugs against serious disease have undesirable effects and dangers, occasionally mortal dangers, and the decision to use them must rest with an educated and responsible profession. The responsibility of prescribing nowadays is a far greater one than it was when I qualified, for then there were very few drugs with specific effects; the rest were useless but generally harmless. The habits of doctors vary, but so long as decisions are made with a full sense of responsibility, it is difficult to say that one doctor is more

right than another. Most would use antibiotics for every child with tonsillitis. Some would point out that most cases get better without them. The answer may be that if in only one case in a hundred a child is protected from mastoid disease or acute nephritis, the antibiotics are justified. This is a responsible view point. No planned controlled trial can really be done because you cannot expect a doctor to withhold a drug in the efficacy of which he believes. Only time will tell. This is a good example because antibiotics are expensive. It is easy to estimate the drug bill. It is quite impossible to estimate even the financial gain of rescuing a few children from invalidism, hospital treatment or deafness.

What of the hypnotics which help you to sleep and the drugs which affect the mood, especially the tranquillizers and the anti-depressants? We are probably only in the early stages of their development. Some will make out that all such drugs are harmful and that their widespread use is pernicious. If those who hold this view are teetotallers, non-smokers, and do not stimulate their minds by caffeine from tea or coffee, they have a right to their opinions, but we live in an unnatural society which advances more quickly than we can adjust to it, and, unlike most animals, we live into the post-reproductive age and even into old age. In the natural state we were probably not meant to last so long. The realization that endogenous and reactive depression are at the root of many of the symptoms of the middle-aged and elderly is a comparatively recent one, and the discovery of drugs which influence these conditions, if they can be made more efficient and less dangerous, may be one of the greatest advances of the century. It is too early

to say. One of the most responsible General Practitioners I know, who is interested in this kind of illness, is certain that these drugs are opening up a new chapter in the treatment of common psychological disorders, especially in middle-age. Most psychiatrists would agree. Moreover, there is little evidence that most of these drugs are drugs of addiction in the sense that they produce a compelling need for the patient to keep taking them.

One of the most powerful drugs of addiction ever discovered is tobacco taken in the form of inhaling cigarettes. Once you see a young fellow deeply inhaling a cigarette you can lay a fairly safe bet that he will smoke something like 20 cigarettes a day (and of course have to pay for them) for the rest of his life. People who inhale cigarettes regularly, and these are about three-quarters of the male population of Britain, know quite well that they can't give up. They will cut their cigarette consumption to 10 or 5 if it is affecting their health, and within a month or two they will be smoking 20 again. Only a very few will stop altogether and even they know that they daren't attempt a return to smoking 'in moderation' for within a matter of weeks the addiction would be as strong as ever. All these facts are well known to the tobacco manufacturers. The association between heavy cigarette smoking and cancer of of the lung is one of the most firmly established scientific facts in medicine today. Some may think this is a digression from the subject of this chapter, but we are speaking of drugs, and because one is bought from a slot machine and another obtained by prescription from a doctor and paid for by the National Health Service this does not mean that they are two different things. Only by considering them

together can we keep a sense of proportion. A society which allows the advertising of cigarettes and the purchase of cigarettes by teenagers from slot machines, and is horrified at the prescription of tranquillizers for depressive illness can hardly be called a rational society which has profited by the scientific discoveries of the age. It will be time to tackle the drug bill when we have tackled the cigarette bill (all tobacco being imported) and the lung cancer and coronary thrombosis and chronic bronchitis bills which result from it.

The dangers of drugs are very real, and every new addition to the drug list has undesirable potentialities. Unexpected tragedies are bound to occur from time to time. The drug firms are as anxious as the medical profession and the public that every reasonable precaution should be taken against a repetition of the tragedy of thalidomide, but the tobacco manufacturers congratulate themselves that their profits continue.

I joined the profession when science was beginning to invade clinical medicine, and in the very advanced medical school in which I was brought up we were taught that there were only about half a dozen drugs in the whole pharmacopœia which had any action at all: digitalis, morphine, quinine in malaria, intravenous arsenic in syphilis, thyroid in myxœdema, some sedatives. This was almost the whole range. The rest were placebos, bottles of medicine given because the patient demanded them. In the enlightened knowledge of new science we thought then that the patient should be educated to understand more about his symptoms, to realize what could and could not be done for his illness, to change his way of life and his

eating and drinking habits, and to be weaned from his bottle of medicine. But the patient usually won: he had some faith that the magic of medicine could do more for his illness than he could do by his own efforts. Today the task of the doctor is even harder because the range of effective remedies is enormously greater. Quite apart from the symptomatic remedies which affect pain and mood and the specific remedies, we have drugs with important physiological effects such as lowering of blood pressure; and diuretics which transform the life of the patient threatened with heart failure. Confronted with a patient whose symptoms are more than trivial and cannot be dispelled by a simple explanation, it is almost inconceivable that the doctor cannot think up some remedy which at least offers a prospect of relief, and it is even more inconceivable that his patient will not expect him to do so. Of course doctors ought to know the cost, value, action and potential dangers of the remedies they are using, but there is little evidence that money is being squandered on drugs in this country because of the National Health Service. Indeed, the evidence may be on the other side. It may be that patients in the United States and other countries do not always get adequate treatment because of their obligation to pay for it. As Gordon Forsyth has said: 'Obviously some attempt must be made to justify the drug bill and obviously such attempt will appear to some practitioners as an interference in professional freedom. To set things in their true perspective, however, it should be remembered that a privately financed system may also set limits to professional freedom, in that nothing inhibits a doctor's freedom more than the patient's inability to pay for the treatment prescribed.'

Chapter 10

THE GOVERNMENT OF THE PROFESSION

The Porritt Committee reported that the overwhelming weight of opinion showed that there was no wish to disturb the broad concept of a comprehensive National Health Service and were in favour of its being responsible to a Government department rather than to some kind of independent corporation, and I do not propose to examine this question any further. It follows that standards of medical practice are bound to be influenced by the total amount and the distribution of the sums which Parliament decides can be spent on salaries, buildings and equipment in the National Health Service, and an enlightened profession confronted by the ever increasing costs of medical care will always be seeking to increase the sums available. It would be nice to see more of the money devoted to experiments rather than necessity, but some useful experiments have been made often with the help of non-governmental funds. The decisions are finally political ones, much influenced by the Minister of Health who should be in the closest touch with professional opinion. The leaders of the profession should therefore be on the most friendly of terms with the important officers of the Ministry. The greatest force in successful negotiation is goodwill. Once it is lost the other party to the discussion becomes an adversary and builds his defences, which at length become so strong as almost to invite the use of the disruptive power of threats. This is bad negotiation. A professional body which speaks of 'head-on clashes with the Ministry' is admitting its own failure.

I propose, however, to deal not with the Ministry of Health but with some matters which more directly influence the standards of individual practice. The Government of most British Universities (that is all except London, Oxford and Cambridge, which for various reasons are atypical) follows a fairly standard and generally satisfactory pattern. First there is a body of experts, usually called the Senate, consisting of Professors and other heads of departments with some representation of other members of the University staff. For the most part it is not democratically elected, but its members sit there by virtue of the fact that through achieving distinction in their chosen subject they occupy important University posts. This body has wide powers to determine professional policy with regard to teaching and research, and makes professional appointments. Its scope is wide and it is advised by the several boards of Faculties. Secondly there is a business group, usually called Council, whose function is to interpret the needs of Senate in terms of money, buildings, and other practical things. It is a small highly selected body of efficient persons such as business men and lawyers who are devoted to serving voluntarily the cause of the University. It is not elected democratically. Thirdly, there is a built-in safeguard against autocracy and oligarchy, a large body of people representing interested parties who must be satisfied that the University is developing in desirable directions and is not unduly favouring any particular section of society whether geographically or socially. This body is usually called the Court and is important in giving elected representatives of interested parties an opportunity to state their views. It is too big to be efficient in the sense

of a real governing body and it meets comparatively rarely, for instance once or twice a year. Fourthly, there are the permanent officials, namely the Vice-Chancellor, the Registrar and the Bursar and their respective staffs who are, so to speak, the civil service of the University.

It would seem that a hospital or a hospital group has essentially the same governmental needs as a University but lacks this pattern of organization. Hospital management committees, Regional boards and Boards of Governors, seem to be an ineffective mixture of the four ingredients of University government, with too little of its first element (the experts) and too much of its third (the relatively inefficient and inexpert onlookers). I would think that hospitals could be much better managed by groups of medical experts advising a small highly selected executive council consisting mostly or entirely of laymen. There should also be a large meeting of the representatives of interested bodies once or twice a year to hear the reports of the Council and give their approval, or make their suggestions, and occasionally their protests. The whole organization would be kept in motion, of course, by an efficient team of permanent officials.

A University is organized to find its standards from the top, and this should be the aim of bodies which govern the medical profession. Much lip service is paid to democracy because in politics it seems to be the only safeguard against other and worse forms of government. But democracy is only good if it is not carried too far. In this country, Parliament is democratically elected but the government is not. This is the same whichever party is in power.

In all human affairs minorities are important and require

special consideration. There can of course be minorities of vice, squalor or avarice, but there can also be minorities of intellect, artistic merit, professional skill and originality of ideas. As a devotee of Chamber Music, I could not be expected to favour a society in which the provision of entertainment depended upon a majority vote. In the professions minorities are especially important, particularly in the improvement of professional standards, with which this monograph deals, because these standards are constantly being reset by those whose work and skill is better than the average. Such men are not themselves always interested or talented in the techniques of government and leadership, but those who are leaders should fearlessly favour whatever seems to be to the benefit of professional standards, if necessary opposing those whose concern for the majority and the average leads to the support of mediocrity.

I would like in the most understanding of terms to ask my friends in the British Medical Association whether they have not sometimes fallen into the pitfalls common to democratic institutions, for to the outsider they seem in serving the majority to have failed to devise or even to accept neasures which sought to differentiate between good and bad in the standards of medical practice. They have another danger to contend with in trying to cope, as they valiantly do, with the whole profession including its rank and file, namely that those who come to medico-political meetings do not always represent the views of those who are the most devoted to their patients and to the advance of medicine. The latter, often the cream of the profession, need special consideration. Their interests may

never be consulted at all, if it is left to them to act. Leaders should therefore take special care to know their views and thoughts. Henry VIII did not found his College on democratic lines, and although the Royal College of Physicians has often been criticized both fairly and unfairly, it is not bedevilled by having to decide professional standards on average practice.

If the majority of readers disagree with the points of view which are here expressed they will help to prove the point. The present standards of the few, if nurtured and encouraged will become the future standards of the many.

Chapter 11

EPILOGUE

If anyone ever reads this monograph, especially in its more controversial chapters, opinions may be sharply divided between those who think that it is written with high impartiality and those who find it full of prejudice; but no one is likely to doubt that it is written by a physician devoted to clinical medicine.

Doctors differ amongst themselves. Physicians are different from surgeons. You realize this within a few minutes of being in their company: not their individual company perhaps but in the company of physicians or surgeons as a group. Surgeons, I suspect, see themselves in a setting of glamour, conquering disease by the bold strokes of sheer technical skill. Physicians quietly remember that they were educated gentlemen, centuries ago, when surgeons and apothecaries were tradesmen. They see themselves as the traditional thinkers of the profession. But there are some who combine the virtues. There is a select body of surgeons with the most humane standards of medical practice, men of cultivated mind whose opinions are at least as important as their hands. Such a one was Ernest Rock Carling and we made him, to his great delight, a Fellow of the Royal College of Physicians.

APPENDIX

Notes and References

Chapter 2

pp. 18 & 19, and Porritt report. *A Review of the Medical Services in Great Britain*, published in 1963 by Social Assay, 56 Kingsway, London, W.C.2, on behalf of the Medical Services Review Committee set up by the British Medical Association with the Royal Colleges and other professional bodies. Appendix 3 of this report gives the result of a Gallup Poll of the public on their views of the National Health Service. It is important reading. About 75 per cent of all social classes were satisfied with their General Practitioners, about 80 per cent saying he gave them adequate time. About 75 per cent of those who had been In-patients described their treatment as very good, and about 90 per cent as either good or very good. Of those who had been hospital Out-patients only 60 per cent answered favourably when asked if they felt they had been treated as a person or as a case. Over 80 per cent were satisfied with the Health Service as a whole.

p. 21. Brotherston, J. H. F., *Lancet*, 1963, 1, 1119.

Chapter 3

p. 24. Fox, Sir T. F., *Lancet*, 1960, 1, 743.

p. 26. White, Kerr L. Working Paper on General Practice in the U.S.A. for Expert Committee on General Practice, W.H.O. Geneva, July 1963.

p. 27. Rorie, R. A. B., *Lancet*, 1963, 1, 97, but some of my quotation is from a longer report in typescript, submitted to the Nuffield Foundation and the Council of the College of General Practitioners.

p. 29. McKeown, T., *Lancet*, 1962, 1, 923.

Chapter 4

p. 32. Hadfield, S. J., *Brit. med. Jour.*, 1953, 2, 683.

p. 32. Taylor, S. (Now Lord Taylor). *Good General Practice*, 1954. Oxford Univ. Press.

p. 32. Collings, J. S., *Lancet*, 1950, 1, 555.

p. 32. Peterson, O. *et al.*, *J. Med. Education*, 1956, 31. Part 2 of No. 12, pp. 1–165.

p. 32. Fry, J., *Clinical Medicine in General Practice*, London, 1954, J. & A. Churchill.

p. 32. Hodgkin, K., *Towards Earlier Diagnosis*, E. & S. Livingstone, Edinburgh. In the Press.

This is particularly interesting in giving the relative frequency with which diseases were suspected or diagnosed in 10 years of General Practice.

Chapter 5

p. 39. Taylor: see note under Ch. 4.

p. 39. Porritt Committee: see note under Ch. 2.

p. 40. Remuneration and expenses in General Practice are discussed by Evans, E. O., *Lancet*, 1963, 1, 373.

Chapter 6

p. 46. Susser, M., *Lancet*, 1963, 1, 315.

p. 48. Crombie, D. L., *Lancet*, 1963, 1, 209.

Chapter 7

p. 52. The two books are *The English Health Service*, H. Eckstein, Harvard University Press, 1959, and *Socialized Medicine in England and Wales*, Almont Lindsey, University of N. Carolina Press, 1962.

p. 53. Having listened myself to a meeting conducted by Charles Hill I feel that bitter enmity is no overstatement.

p. 54. Bevan made it clear in his reply that he wanted the profession's help and advice.

p. 55. Dr. Guy Dain—now Sir Guy Dain.

p. 57. Charles Hill—now Lord Hill, Chairman of the Independent Television Authority.

p. 57. Eckstein in his more recent book *Pressure Group Politics—the Case of the British Medical Association* (George Allen and Unwin, 1960) analyses some of the successes and failures of the British Medical Association in terms of the results achieved, but fails to comment on the effect on morale which may be caused when a professional organization adopts Trades Union tactics.

p. 57. It should be explained to the non-medical reader that although the British Medical Association claims to speak for the whole profession there are no rules about this. Membership of the British Medical Association is not obligatory. Specialists tend to turn more to their own Colleges for leadership, and General Practitioners to the British Medical Association.

p. 57. Yet personal relationships between the British Medical Association and the Ministry at officer level are often very good.

p. 57. Porritt Committee: see appendix, Ch. 2.

p. 57. Renaissance of General Practice. See Hunt, J. H., *Brit. med. Jour.*, 1957, 1, 1075.

p. 58. The adjustment of Patient, Nurse and Student to hospital life. Not yet published.

Chapter 8

p. 61. McCance, R. A., *Proc. Roy. Soc. Med.*, 1951, **44**, 189.

p. 62. Medical Research Council paper 53/649, recirculated 1962.

p. 62. Hill, Sir A. Bradford, *Brit. med. Jour.*, 1963, 1, 1043.

p. 63. Fox, Sir T. F., *Medico-Legal Jour.*, 1960, **28**, 132.

Chapter 9

p. 77. Forsyth, G., *Medical Care*, 1963, 1, 10.

Chapter 10

p. 78. Porritt Committee: see Appendix, Ch. 2.