Correspondence

Letters to the Editor should not exceed 500 words.

Medical Consultation

SIR,—While few will quarrel with the view of Dr. D. Grant and his colleagues (*The Times*, 8 August) that the National Health Service should provide skilled and sympathetic medical advice that [is] *entirely free at the time of the consultation* (my italics), even fewer really believe in a system whereby a person can demand free advice from an expert at any time of the day or night without any cost or inconvenience to himself whatsoever. Medicinal therapy often accompanies the advice and may consist only of a few aspirins—these will cost the patient 2s. This absurd system makes the doctor cheaper than the aspirins.

Dr. Grant *et al.* are unduly preoccupied with the “trivia” of medicine, but what is trivial to the practitioner is not trivial to the patient and may not, indeed, even be trivial to another practitioner. Symptoms have to be assessed by careful history-taking and close interrogation—often a more lengthy and laborious a process than is a physical examination. How many solicitors have 40 consultations a day? (And they do not have to wait for their clients to undress and dress again, nor do they have to bide their time to examine a fractious child.) Yet for a medical consultation Dr. Grant and his co-signatories believe that the fee must surely be trivial. Human nature being what it is, so long as the fee is trivial so will be the service given. The present situation is thus the direct outcome of the National Health Insurance Scheme and its stupid capitation-fee system, which encouraged the cult of the “bottle” and tempted practitioners to capitalize on the power of the placebo. Quantity became the measure of their skill and success: head-hunting ceased to be regarded as unethical and became the sole objective in some practices.

Modern drugs are neither cheap nor harmless, and symptoms need careful evaluation before they are prescribed. When patients realize that each visit involves them, as it ought to, in a searching interrogation, a physical examination, a frank discussion, and often no prescription, and that this will be followed by a further encroachment on their own time in order to get the fee paid or reimbursed, the consultation will act as its own deterrent in frivolous cases, while the genuine sufferer—imaginary or real—will welcome the extra time and interest taken over his complaint. (There will always be the case who comes too late—through fear or any of a dozen other reasons.)

As to finance, it is probable that the saving on drugs alone would offset any increase in costs from running a fee-per-item-of-service system. It is also probable that lax certification would be greatly reduced, and no one can even hazard a guess at the annual cost of this item. The only doubtful factor is that we may not now have the medical personnel to implement such a service, as it would inevitably mean smaller practices.

One thing is certain, it would stop the brain drain. A really good National Health Service would almost certainly reverse it.

Let us heed the words of the late Sir James Spence¹: “The real work of a doctor is only faintly realized by many lay people. It is not an affair of health centres, or public clinics, or operating theatres, or laboratories, or hospital beds. These techniques have their place in medicine, but they are not medicine. The essential unit of medical practice is the occasion when, in the intimacy of the consulting-room or sick-room, *a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it.*” (My italics.) In brief, the consultation is the currency of the practitioner, and health legislation since 1911 has served only to debase it. Our first need, therefore, is to restore its status. When twentieth-century medicine is allied to nine-

teenth-century professional standards we shall have a National Health Service worthy of British clinical medicine—than which there is none better. Patient and practitioner will recover their mutual respect and the politicians will cease to have a vested interest in the health of individuals—an interest great enough to have united political thought as nothing else has done since the end of the war.

My colleague Dr. John H. Hughes (22 August, p. 506) argues from a false premise in his opening sentence to an erroneous conclusion in his last. The financial barrier should *not* be introduced to cut down the doctor's work but to make him worthy of his hire. That he is “worthy of demand” is entirely fortuitous, as the system has created the demand and the “medical product” has to supply it—in progressively increasing quantities.—I am, etc.,

Aberystwyth.

S. T. H. JENKINS.

REFERENCE

¹ Spence, J., *The Purpose and Practice of Medicine*, 1960, p. 273. Oxford University Press, London.

Practice Expenses

SIR,—I wish to associate myself with your correspondents who decry the latest suggestion that payment toward ancillary help is to come from the Central Pool, i.e., to the detriment of the general payment to all practitioners. Is this then the outcome of months of negotiation, paper work, supplements, vociferous speeches, and circulars, that the Ministry is making a magnanimous gesture of diverting our moneys into different channels?

The general discontent surely is simply that rising costs of living and accommodation simply mean that we must have more money quickly, not sidetrack diversions to the benefit of a few large partnerships at the expense of the smaller men.

I respectfully suggest that the question of partial help of this nature is of very secondary importance. Do please get on with the job in hand, i.e., increasing the overall salary of the G.P.—I am, etc.,

Birmingham 5.

G. JACOBS.

SIR,—As a young practitioner I would like to welcome the outline proposals of the Minister for the employment of ancillary help in general practice (*Supplement*, 22 August, p. 121). This help, without sacrifice of income, will surely be of great advantage to the group or the single-handed practitioner.

If we wish to continue the Pool system there is no point whatsoever in demanding that this should be extra money, as we are already in theory repaid 100% of our expenses. This at present averages out at £1,500 per practitioner, of which only £250 is for ancillary help (about £5½m.). If under the new proposals every practitioner would employ help for 60 hours per week at 5s. per

hour (approximately £750 per annum) there would be an additional £11m. added to the Pool, bringing the amount for ancillary help to £16½m. Of this £9½m. would be returned direct and £7m. would remain for distribution as capitation and other fees—an increase of £1½m. on what is distributed at present in repayment of the expenses of ancillary help. So, in fact, a doctor could have £500 paid directly and at the same time increase the expenses factor in the Pool.

In the General Medical Services Committee (*Supplement*, 29 August, p. 123) and in correspondence, anxiety has been expressed about the doctor's wife who can never get out, about the gardener, about the car-cleaner, and the boiler-stoker. Surely with these proposals our wives can be like normal wives and no longer the practice drudge, or do they really wish to become the paid practice drudge? One point must be made clear: if we are merely going to try to line our own pockets by pseudo payments to wives and families the whole scheme will fail, and we will have no one to blame but ourselves.—I am, etc.,

West Horsley,
Surrey.

D. O. WILLIAMS.

SIR,—I see three ways of entering any “direct reimbursement” in my tax return. (1) I enter the net cost to me, and each year the Pool is reduced by the direct reimbursement. (2) I enter the full cost of help but claim relief for the net cost to me. This maintains the Pool, cheats no one, and helps me to have ancillary aid. (3) I claim my gross expenses and enter the reimbursement plus tax relief on the income side. When this lifts me into the surtax bracket the Ministry will have a good laugh.