BRITISH MEDICAL JOURNAL

LONDON SATURDAY MAY 27 1961

THE ELEPHANT AND THE WHALE THE WINCHESTER ADDRESS*

BY

The Rt. Hon. J. ENOCH POWELL, M.B.E., M.P.

Minister of Health

In fable and in Scripture, and nowadays occasionally in the House of Commons, the lion and the lamb lie down together; but an alliance between the elephant and the whale is found neither in proverb nor in nature, for they are animals which belong to different elements. In human affairs, on the other hand, co-operation and conflict between people and professions with widely different background and outlook are situations of common occurrence. These situations are a fascinating study, which the politician neglects at his peril; for his peculiar calling brings him constantly into such juxtapositions.

There would be material for whole volumes in the strange relationship between politicians and civil servants. If the civil servants had a Winchester Address, that relationship might well furnish a theme. But here to-night, as the guest of the British Medical Association, I have presumed to take for my subject the strange bedfellowship into which your profession and my trade have been thrown by the National Health Service. We might both gain something in understanding and tolerance by pausing to reflect upon it; and if any member of the public is listening, he might chance upon the explanation of this or that which had puzzled him.

Purpose of N.H.S. Act

Most of the great Acts of the 1945-50 Parliament began with a resounding statement of their purpose; and the National Health Service Act, 1946, was no exception. "It shall be the duty of the Minister of Health," so it opens, "to promote the establishment of a comprehensive health service designed to secure . . . the prevention, diagnosis and treatment of illness and for that purpose"—that is, the purpose of promoting the establishment of such a service—"to provide, or secure the effective provision of, services" as set out in the Act.

Upon a careful examination of these words it will be found that the responsibility of the Minister is subtly limited. He is not made responsible for "the prevention, diagnosis and treatment of illness"; he is made responsible only for the establishment of a service "designed to secure" those desirable results. If he can claim that the service which he erects is apt for securing "prevention, diagnosis and treatment," then he has discharged the burden laid upon him by Parliament. Hence derives the doctrine, tenaciously upheld since the inception of

the Service, that for clinical decisions the Minister of Health has no responsibility.

Here then is an apparently clear-cut division of function: the politician provides the framework and the doctor follows his profession within that framework. But this sharp division is too austere to exist as a practical reality. It is not possible to erect and maintain a framework within which medicine can be practised without making some value judgments on the practice of medicine itself. It is not possible to accept full clinical responsibility for the individual patient and abjure opinion upon the administrative and political structure within which that responsibility is discharged. Convinced as I am that in principle the division of function between you and me is vital and should be strenuously upheld, I still say that the boundary is inevitably fuzzy, and that mutual exploration and understanding of this fuzziland on the border is a valuable exercise.

Fuzzy Borderland

In the individual treatment of a single patient it is easy enough to keep the Minister at arm's length. But the instant one goes beyond the individual it ceases to be so easy. Is this treatment right for Mrs. Smith? "I don't know," says the Minister; "not my business." Is this the right treatment for all or many of those in Mrs. Smith's condition? "I still don't know," says the Minister; "but *if it is*, I must see that they can get it." Or, again: Is this doctor a good one? "How should I know?" says the Minister. But put the question in another form: Ought these to be the qualifications of a doctor employed in the National Health Service? "I don't know," says the Minister, "but obviously I must find out." Or yet again: Is this a promising line of research into the cause of cancer or subnormality? "Thank heavens I don't have to decide," says the Minister. Is this a line of research which the Government ought to support with cash and facilities? "I don't know myself," says the Minister for Science, "and yet I must see that a decision is come to somehow."

In all these instances, and in a thousand others, the politician resolves his dilemma not by taking the professional decision himself but by adopting or creating a professional adviser, whose advice, within the strictly professional field, he then accepts. The professional committees of the Central Health Services Council will advise him on the merits of treatments and methods, and whether there is any special provision he ought to make, so that they can be applied in the National

* Delivered on May 24, 1961, before the Winchester Division of the B.M.A. in the New Hall, Winchester College.

Health Service. If such a committee advises him to get, say, some oral vaccine against influenza and make it available for everyone over 75, he doesn't argue: he gets some and makes it available, though he does not, and cannot, insist that doctors use it. If the General Medical Council declines to approve the qualifications of practitioners trained on astrological principles, then the Minister of Health declines—ever so politely—to employ them in the National Health Service. The selection of research projects for support is one which the Minister for Science gladly leaves to the Medical Research Council.

Now, there is no use denying that by the very act of accepting the professional advice the politician has taken a decision and exercised an act of judgment, not least in the selection of the person or body by whose advice he is to be guided. And this is still true even though there may be no other tolerable solution to his dilemma. The adviser in these circumstances will certainly be respectable, august, safe, and therefore, in the nature of things, rather elderly; and this very fact will increase the natural irritation of those who contend that influenza vaccine confers immunity for life if given before the age of 10, or who have personally experienced the benefits of astrological medicine. Nor will the politician escape, in the eyes at any rate of some of the public, the appearance of taking responsibility for matters clinical.

If anyone wishes to add a rider, that this only serves to emphasize how important it is that there should always be a substantial amount both of research and of treatment which is not financed by the State and for which the Minister is not responsible, I should be the last person to argue against him. I would ask only not to be diverted from my present train of thought and pass on to consider another part of the fuzzy borderland—that which concerns the recruitment and rewards of the medical profession.

Market in Doctors

The National Health Service replaced a system which largely consisted of professional private enterprise, modified, albeit profoundly, by two factors: the tradition of altruism and the National Health Insurance Scheme, alias "the panel." Subject to these two factors, something not unlike a market in the economist's sense operated to keep the supply of doctors equal to the effective demand and to enable the ablest and most successful of them to earn, if so inclined, the biggest money. The National Health Service has very largely, and quite deliberately, destroyed this market, which therefore has to be replaced by an artificial mechanism not only for determining the amount as well as the system of remuneration, but also for regulating the supply of trainees for the profession and securing some financial reward for distinction.

I need not say much about remuneration, which has for so long been until recently the scene of border warfare between profession and politician. I will only observe that here the doctor found himself in the situation of all who are confronted by that unique employer the State, whose ability to pay, but not his will to pay, is for practical purposes unlimited. The acceptance of the Pilkington recommendations and of their detailed application, and the establishment of the Review Body, have veiled—and long may they continue to veil—the essentially artificial nature of the resultant

figures; but this situation, as I have said, is not peculiar to the medical profession and does not involve their status as a profession. This is involved, on the other hand, in the recruitment of the profession and the recognition of distinction.

Recruitment and Distinction

There is a sense in which the recruitment of all professions which are entered through a university is controlled to-day by the Government, in that, while the demand for university places exceeds the supply, the University Grants Committee can effectively influence the number of places provided in various courses. The Government already meets at least three-quarters of the cost of educating a doctor; and, where the State is also the principal potential employer at home for the products of this education, then the call for the Government to decide how many it needs and provide the academic means of meeting this and the other needs becomes as inevitable as it is embarrassing. A voice in its own recruitment is among the principal marks of a profession, and the indirect but unavoidable influence of Government upon the size of the medical profession is one of the frontiers where the doctor and the politician meet. The one attempt which has been made at a quantitative assessment, in the Willink Report four years ago, was not borne out by experience; and, though some revision of the statistical basis of that assessment is obviously needed and is being made, both the doctor and the politician have an interest in the power of Government to influence the size of the profession being used with reserve and with restraint.

The recognition of distinction in a profession which is purely hierarchical presents no special problem, even when the paymaster is a public purse. In academic life, for instance, or in the administration there is a recognized and public graduation marked by status, rank, and pay; and, while in no walk of life is it true that status, rank, and pay alone are complete and sufficient indices of merit, the ladder is there for those who wish to attempt the climb rather than rely on other and less overt ways to satisfy or sublimate their ambition. But where a profession, like the law still and medicine until lately, is in part commercial—it will be understood that I use the term in a special sense—the big rewards are competitively earned in a monetary form. Hence the grave problem of recognizing distinction which was created when the National Health Service largely swept away the commercial motive and severely limited the monetary rewards to be competitively won. In the hospital service the "distinction awards" are the device which has been adopted to replace artificially the commercial prizes to which reputation and diligence could previously aspire. Though manifestly better than none, the device is inherently imperfect, and is yet another of those frontiers where, if the doctor and the politician do not directly meet, at least the profession and the system do. The politician here is very thoroughly "earthed" by the Distinction Awards Committee, whose decisions he automatically implements; yet he cannot, and indeed should not, thereby escape identification with the system which makes the device necessary.

Breach of Contract

The border regions explored so far may seem obscure and difficult. They are plain and open compared with that which we must now enter, which is sometimes mis-

called "discipline." A profession disciplines itself (within the law); and the medical profession is no exception, the august tribunal of the General Medical Council presiding over the good name of the profession, with the statutory sanction of the *Register* at its command. There, if anywhere, the word "discipline" may be spoken unreprieved. In the border country between profession and administration the proper word is "breach of contract."

The contract of service is the specific nexus between the doctor and the Minister, or, to be more precise, the Minister's agents and instruments. In the case of the general practitioner this contract is for the "rendering to his patients of all proper and necessary treatment." The party who gives the contract is entitled here, as anywhere else, to have it fully and properly performed, or, failing that, not to pay for what has not been performed, and even to be indemnified for gross and inconvenient failure to perform. This is the simple idea which underlies the whole structure of arrangements which are often misnamed disciplinary and which the public is absolutely convinced *are* disciplinary. A doctor, let us assume it, fails to fulfil his contract: the consequence is that a part of his remuneration is withheld. But this simple relation of cause and effect is heavily overlaid, and it is worth uncovering. Let us follow the process.

A complaint that the contract has not been fulfilled is made, not usually by the giver of the contract, but generally by a third party, the object of the contract, the patient. It is as if a building complained to a local authority that the builder had built it faultily. The facts are then established by a partly professional body, the Medical Services Committee. On the basis of these facts the giver of the contract, the executive council, decides whether there has been a breach and determines the amount to be withheld from remuneration in consequence. Both the decision and the amount are liable to review on appeal by the superior employer, the Minister. Acceptance of this system of determining breaches and withholdings is part of the contract itself.

Publication of Disciplinary Decisions

The decisions both of the executive council and of the Minister are made public, either simultaneously or successively, without the name of the party held to be in default but with varying amounts of detail, such as often suffice to identify the party, if identification by other means has not occurred.

It is small wonder that the public is convinced (as indeed the press usually tells them) that a doctor has been found guilty of an offence and fined, and then, not unnaturally, they want the name published, as theirs would be if they were fined for speeding, and the more thoughtful may well go on to wonder at the curious sort of court by which an Englishman is tried if he happens to be a doctor.

Now, you and I understand perfectly well that this is a misconception; that if the doctor has committed an offence against the law he stands to be prosecuted for it in the ordinary way like anyone else, and nothing in the procedure for breach of contract under the National Health Service protects him; that if the doctor has damnified any person other than the National Health Service he can be sued for damages in a civil action, and again nothing in the procedure just described protects him; that consequently his name and the associated

particulars ought no more to be blazoned in public than those of the decorator who agrees to knock £10 off his contract price for painting a house because he admits having made a mess of the ceilings. And yet, you and I too must wonder.

A Triangular Relationship

The thing which causes our wonder is the relationship in which the doctor and the politician are here placed by the needs of the Health Service, a relationship already foreshadowed in the period of National Health Insurance. The contract between them is a contract for the performance of services not by one to the other but by one to a third party; and that third party, the patient, is someone with whom the contract is intended to leave the professional and personal relationship of the doctor unimpaired and unaffected. This is the heart of the difficulty. The grievance for which the Minister seeks redress is a breach of contract; but that breach of contract may, or may not, consist in a different grievance—that, namely, of the recipient of professional services against the person rendering them to him.

Experience of the National Health Service is too brief to show whether this curious triangular relationship is inherently unstable; meanwhile, I am certain that the administrator ought to hold firm against any action or any attitudes, however tempting, which would turn him into an instrument of professional discipline, of civil redress, or of criminal sanction. The stand taken upon breach of contract can easily be represented as doctrinaire or legalistic: I believe that all my predecessors were right in choosing to stand upon it, and that it is the only line on which doctor and politician can march together tolerably.

Drug Bill

Contract also provides the formula for the relationship of doctor and politician in a matter which has attracted public attention more continuously perhaps than any other within the confines of the National Health Service: the cost of prescribing, or, more generally, the drug bill. The politician is here the purchaser, the customer of the pharmaceutical trade and industry, in that he is held responsible by Parliament for every penny spent on medicine in the National Health Service. Unlike any other customer, however, he neither decides to buy nor consumes what is bought: the deciding is done by the doctor, the consuming by the patient, and only the residual function of finding the money remains to the Minister. Both the doctor and the patient are insulated virtually completely—and intentionally insulated—by the very principle of the National Health Service, from all consideration of the cost. Even that thin fuse-wire, the two shilling prescription charge, conveys, and is designed to convey, no indication of relative cost, and very little of absolute cost. Thus the politician is in the classically embarrassing position of being responsible for that which he does not control, and the industry is in an equally classical "soft selling" position of having purchasers who do not pay for the goods they order.

Freedom to Prescribe

Nowhere is the doctor's claim to absolute and unconditional independence stronger than in deciding what treatment his patient ought to be given. If he cannot decide that, what *is* he to decide? And in the National Health Service he is free to decide it without regard to

his patient's means. Clearly in the individual case there is no standing place for the politician—short of a general and arbitrary limitation of the Service itself, by a limitation of the medicines prescribable, or freely prescribable, within it. On the other hand, the doctor binds himself by contract to the politician's instruments, the executive councils, that he will prescribe in a particular way—namely, not excessively; and, since this may not be judged on the individual case, it must be judged on the sum total, by comparison of a doctor's total prescribing with some norm of "good prescribing." But—and here we are at the tantalizing paradox—the criticizable total prescribing is made up of uncriticizable individual prescribings: if it is excessive in cost or quantity, individual patients must have been given more, or more costly, medicine than they ought to have been, and compliance with the norm can be secured only by altering numerous individual professional judgments. The paradox is enshrined in the famous words: "Without prejudice to the doctor's right to prescribe whatever he thinks necessary in any individual case, a doctor may be called upon to justify the cost of his prescribing." Thus the doctor and the politician gingerly approach one another from opposite sides of the frontier. The politician does so with a more than usually heavy professional shield. The question is raised, in tentative form, by medical officials of the Ministry, and the issue of fact is decided by a purely professional body, the local medical committee, before the sanction for breach of contract is applied.

Prevention, with excessive prescribing as with other complaints, is held to be better than cure; and from the beginning the Minister has not considered it to be outside his province to transmit general advice to doctors which might be helpful towards good, and not excessive, prescribing. The word "transmit" is carefully chosen, because it will if possible be purely professional advice—like that of the Joint Committee on Prescribing (better known as the Cohen Committee) or the *Prescribers' Journal* of Professor Rosenheim's editorial committee—which the politician finds himself in duty bound to pass on to doctors who are prescribing within the National Health Service.

These professional shields are utterly desirable and logical; but they cannot alter, nor entirely disguise, the fact that this is yet another section of the no-man's land between profession and politician. The paradox at the heart of it may be ignored in practice; the politicians may (like this one) be no less deeply devoted than the doctors to the principle of professional independence and unfettered clinical judgment; but the paradox exists nevertheless, and exists as an inevitable corollary of the National Health Service itself.

Individual Cases and the General Law

The paradox, as I have said, is that of independence in the particular coexisting with answerability in the general. This brings me, as I look back over all this border country which we have surveyed together, to reflect upon a characteristic difference between the doctor and the politician as human types, which is repeatedly borne in upon me in my contacts with your profession and which I believe we could well recognize explicitly to our mutual benefit, and, if not understanding, at least respect. It is this. The doctor is by disposition, by training, and by practice concerned with individual cases. Not only the family doctor, in whom

this might well be expected, but the consultant and even the researcher and the teacher are preoccupied with individuals to a degree that appears to the observer as astonishing as admirable. Now, this attitude is the antithesis of the politician's. This might sound strange when one thinks of the politician culling his votes one by one, and listening patiently to the misfortunes of Mrs. Jones and the injustices of Mr. Smith; but on reflection it will be realized that the politician is all the time concerned with the general consequences of individual decisions. He instinctively asks himself what will be the total cost to the nation if Mrs. Jones is paid another shilling or whether the net effect of altering the law in Mr. Smith's favour may not on balance be to the public disadvantage. The consideration of such consequences or implications as these, which is an essential element in the politician's duty, has no counterpart in the professional activity of the doctor. With no more than pardonable sharpening of the antithesis, one might say that for the doctor the general law is only relevant so far as it helps the individual, while for the politician the individual case is only relevant so far as it illuminates the general law.

Closely allied with this contrast between the two types is, I believe, another. The doctor takes his characteristic professional decisions not only for individuals but as an individual, on his own single and ultimately unsharable responsibility: he is used to practising reliance on his separate judgment; indeed, this independence of judgment is one of the attractions, I am told, of a doctor's life. The politician is in the opposite case. His duty, and his whole hope of success, lie in carrying as many others as possible with him: his individual judgment only becomes significant when allied to persuasion. He cannot, so to speak, prescribe medicine for a patient unless his Cabinet colleagues and the Party agree, nor can he institute a course of treatment unless a majority votes for it. To sharpen the antithesis again, the politician practises the subordination of individual judgment, the doctor glories in the development and exercise of it. I am told on good authority—I should not venture to make such an observation on my own—that the reasonableness and charity which characterizes doctors as individuals is often strangely absent when they are gathered together in committees and organizations. If the observation should by any chance be true, it would be fully explained by this trait of the doctor's character which contrasts so sharply with the politician's.

Conclusion

Thus the borderland between profession and administration is also the borderland between two types of men in whom training and practice have promoted very different habits of thought. I have argued that the boundary cannot be done away with: it must be lived with. I have also argued that living with it is easier, rather than harder, if the inherent dilemmas and contrasts are recognized and understood. I will close by a reference, and a grateful reference, to an arrangement which I believe helps the process very materially.

No other department, not even the Service departments with their parallel civil and military staff, has anything really similar to the parallel medical and administrative staffing of the Health Departments, which projects the boundary line right into the counsels—one might even say, into the mind—of the politician

himself. Like all boundaries, and like this boundary line outside, this parallelism contains the possibilities of friction; but, what is more important, it affords an irreplaceable instrument of discussion and mutual comprehension, which is even more valuable than the tendering of expert advice and technical information. This instrument depends for its effectiveness upon the medical profession inside the Departments being as perfectly as may be in tune with the profession outside and as fully representative and characteristic of the profession's outlook and mind as can be devised. I will not here enter into the various ways in which this condition can be maintained and guaranteed, but will content myself by saying that the politician has good reason to be zealous and grateful for it.

Self-analysis is an exercise to be indulged in sparingly, especially in public. This evening I have gone further still, and ventured upon a joint self-analysis of my own profession and another, at least of their points of contact and connexion. I have essayed it only because I believed that such analysis might contribute something to the mutual understanding and co-operation on which the success of the National Health Service is conditional.

OUTBREAK OF E.C.H.O. TYPE 9 INFECTION IN A CHILDREN'S HOME

BY

F. L. CONSTABLE,* M.D., B.Sc.

Lecturer in Bacteriology, University of Edinburgh

AND

L. F. HOWITT, M.B., Ch.B., D.P.H.

Assistant Medical Officer of Health, City of Edinburgh

During the summer of 1959 outbreaks of febrile illness in children were reported in the *British Medical Journal* from areas as far apart as Glasgow, by Landsman *et al.* (1960), and Much Wenlock, Shropshire, by Parton (1960). The Glasgow outbreak was found to be caused by E.C.H.O. type 9 virus, and, although no specimens were examined in the Much Wenlock incident, the medical syndrome there seemed to be very similar to that described in Glasgow. There have been several reports of E.C.H.O. 9 virus causing "aseptic meningitis" in members of the same family. Rotem (1957) tabulated the number of cases occurring in families and found that the highest incidence in one family was five cases. Two or more cases in 25 houses were found by Garnett *et al.* (1957) in a survey carried out during an epidemic in East Suffolk.

In August, 1960, a number of residents in a children's home in Edinburgh developed a febrile illness, and the causative organism was found to be E.C.H.O. 9 virus. This outbreak in a closed community gave an opportunity to study some of the epidemiological features of this virus infection. It was found that out of a total of 27 children resident in or closely connected with the home 17 showed clinical signs of infection, and out of 10 adults connected with the home only 2 were affected.

*Now in the Department of Bacteriology, Royal Victoria Infirmary, Newcastle upon Tyne.

History of Outbreak

A 5-year-old boy, living in a residential children's home, complained of abdominal pains during the forenoon of August 11; at noon his temperature was 102.6° F. (39.2° C.) and he had developed neck stiffness. Next morning his temperature was normal, but his tonsils were inflamed. The following morning, the third day, he started vomiting. By noon his temperature had risen to 103.8° F. (39.9° C.), he showed signs of meningeal irritation, and he was transferred that afternoon to the Edinburgh City Infectious Diseases Hospital. He was diagnosed as a case of "aseptic meningitis," and E.C.H.O. 9 virus was later isolated from his stool, but not from the cerebrospinal fluid, which was also examined.

On the same day, the third day, a 5-year-old girl developed a severe frontal headache and her temperature was found to be 101.2° F. (38.4° C.). From the third to the eighth day, a period of six days, 13 children were similarly affected; thereafter the number of cases diminished, and from the ninth to the sixteenth day three more children and two adults were affected.

The most common presenting symptom was abdominal pain—11 out of 17 children being affected this way; of these 11, 4 also complained of severe frontal headaches. Two young children, aged 3½ and 2½, were diagnosed as cases because they were flushed and were found to have temperatures of 100.6° F. (38.1° C.) and 100.2° F. (37.9° C.) respectively. Apart from the initial patient, who was admitted to hospital, all the children were nursed in the home.

TABLE I.—Presenting Signs or Symptoms

		0-4 Years	5-9 Years	10-14 Years	%
Abdominal pains only	Male	—	3	—	41.2
	Female	—	2	2	
Headaches only	Male	—	1	—	23.5
	Female	—	1	2	
Abdominal pains and headaches	Male	—	2	1	23.5
	Female	—	—	1	
Fever only	Male	2	—	—	11.8
	Female	—	—	—	
Total	Male	2	6	1	
	Female	—	3	5	

Temperatures were recorded twice daily when the symptoms or signs (shown in Table I) were notified, and in each case it was elevated, the average being 100° F. (37.8° C.). The acute stage was deemed to be terminated when two successive normal temperatures were obtained, and this took place at a minimum of two days to a maximum of six days after onset of symptoms, with an average of four days. During this acute phase a few other signs and symptoms were noted. Vomiting occurred in nine cases, seven during the third day of illness and two during the fourth day. Four children who had vomiting also complained of neck pains. The first patient also complained of a sore throat, and one girl, aged 14, developed on her face, neck, and trunk a faint reddish-pink blotchy rash, which lasted two days.

Even when a normal temperature was attained the children had not fully recovered; they were left with a general feeling of lassitude, and it took on the average two to three weeks for them to regain their normal health. In two cases there was a subsequent rise in temperature. In a 3½-year-old boy the temperature was