REORGANIZATION OF THE MEDICAL SERVICES OF THE ARMED FORCES

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I apologize for suggesting improvements in medical services that have weathered two great wars with honour, but I do so in the belief that a system of the type I describe might be more suitable in a future war and would make medicine in the armed Forces in peacetime more attractive than at present. I suggest that the medical services of the Royal Navy, Army, and R.A.F. should be preserved, as each Force has its particular problems, but that these services should be relieved of their responsibility for providing permanent hospitals. They would continue to administer preventive medicine but would retain control only of medical inspection rooms, field ambulances, casualty clearing stations, and similar mobile or semi-mobile units.

All permanent hospitals at home and abroad would be taken over by a new service to be known as the "National Health Defence Service." The director-general of this service (a civilian or an ex-Service chief) would be appointed by, and be responsible to, the Minister of Health. Under him would be three deputy director-generals appointed by the director-general of each of the three medical services. These deputies would be either retired officers or those still on the Active List and seconded for this duty.

The hospitals would be situated (1) in "safe" areas near large cities and (2) where there are normally large concentrations of Service men and women. In peacetime they would admit civilian as well as Service patients, but priority similar to that afforded seamen by the Seamen's Hospital Society would be given to Service personnel. In wartime these hospitals would be taken over as required by the Services, and they would accept air-raid casualties from neighbouring towns. The buildings would be constructed cheaply, but with adequate equipment, and would be capable of rapid expansion in time of war for training the staffs of base hospitals at home or overseas. During hostilities the command of base or permanent hospitals within the area of active operations would be handed over to the Service most concerned.

Staffing

National health defence hospitals in the United Kingdom would be staffed as follows:

House Officers.—Regular officers under training and newly qualified civil doctors serving under the same conditions as in civil hospitals.

Registrars and First Assistants.—Regular officers under training as specialists, and civil doctors serving under the same conditions as in civil hospitals.

Specialists.—Regular specialists on the Active List who are not required for the mobile units of the three Services and regular specialists who had elected to transfer to the "Home Only" list (to be described later) after fifteen years' service. There would also be part-time civil specialists.

Consultant Specialists.—Civilian specialists from the nearest centre who would visit their respective departments once a week. On the outbreak of war they would be given full duties as consultants or advisers.

The staffing of these hospitals abroad in peacetime would have to be carried out largely by Regulars.

Conditions of Service

Approximately one or two years after qualification officers would be recruited into one of the three Services as at present. During the first four years each would act as a general duty officer in any part of the world. At the end of this period those who wished to leave the Service, or who were not selected, would receive a gratuity. The others would be granted regular commissions. These officers would enter, partly by selection and partly by choice, one of the following three classes:

(1) general and administrative officers; (2) specialists in preventive medicine; and (3) specialists in curative medicine. All would receive four to five years' training as follows:

General and Administrative Section.—(1) Three and a half years as house-physicians and house-surgeons in a national health defence hospital, partly abroad and partly at home. The aim of this instruction would be to make the officer a well-trained general practitioner. (2) A twelve-months apprenticeship in preventive medicine abroad. (3) A three-months course in the Service aspect of medical subjects at the corresponding medical college. (4) A six-months course at a naval, military, or Royal Air Force staff college.

Preventive Medicine Section.—(1) A one-and-a-half-years apprenticeship in a national health defence hospital abroad in the specialties related to preventive medicine—i.e., pathology, medicine, dermatology, and venereal disease. (2) A one-year apprenticeship in hygiene abroad. (3) A two-years apprenticeship in civil and Service preventive medicine at home, with facilities for taking a diploma of public health. (4) A three-months general course at a Service medical college. (5) A six-months course at a naval, military, or Royal Air Force staff college.

Curative Medicine Section.—(1) A four-years apprenticeship as a registrar in the officer's chosen specialty at a national defence hospital at home, with facilities for taking a higher degree or diploma. (2) A three-months course at a Service medical college.

Officers from the general and administrative and from the preventive medicine sections would then return for duty with their respective Service. Men and women in the curative medicine section would continue to work in national health defence hospitals at home or abroad, but a few would be required for semi-mobile establishments. Officers in the general and administrative section would gain experience in administrative posts and do clinical work in areas where the employment of specialists would be wasteful. Those in the preventive medicine section would be employed in their specialty or in administrative work.

On completion of fifteen years' service all regular officers could elect to transfer to a list called "Home Only." Posts would be guaranteed. Those who transferred to this list would be employed in the following ways:

General and Administrative Section.—As administrators in the national health defence service or in specially reserved posts in civil practice.

Preventive Medicine Section.—In administrative posts in the national health defence service, and certain posts in the civil health service would be reserved for such officers.

Specialists in Curative Medicine.—In permanent posts in their specialty in a national health defence hospital.

Officers transferred to the "Home Only" list would be able to continue in the national health defence service or a civil health service until the age of 60 or 65. On retirement their years towards pension would be assessed from the date of enlistment with the Services. They would be available for active service on the outbreak of war, and in periods of necessity other than war they could also be called on. This period of recall would not include more than one and a half year's foreign service.

Officers selected for high administrative posts at the end of fifteen years could be offered inducement to continue in the Services as long as required. The nursing services of the armed Forces would be brought into line with the system I have suggested for the doctors.

Advantages

In addition to answering most of the criticisms of the present system these proposals have other advantages. The total cost to the State of all medical services (civil, the suggested new defence service, and the medical services of the Royal Navy, Army, and R.A.F.) should be less than at present. In the first instance Service doctors would be employed in peacetime to full advantage, and would continue to be gainfully employed until the age of 60 or 65. Secondly, the waste caused by separate permanent hospitals for the three Services would disappear. Finally, the employment at small stations of well-trained medical officers of the general and administrative section instead of specialists would be more economical than

the present system, which requires a full complement of specialists in areas where their work is light.

The national health defence hospitals would not be an additional burden of expense to the State, as the number of civilian hospitals needed would be reduced. If war broke out a chain of hospitals capable of rapid expansion would be available in safe areas outside large cities. These national health defence hospitals would be centres of co-operation between Service and civilian doctors and between medical officers of the three Services. This liaison would lead to uniformity of organization, methods of treatment, and types of equipment. Possibly the medical services of the Forces would become merged into one at some future date.

Many civilian and Service doctors believe there is no necessity for Service hospitals in any form in the United Kingdom in peacetime. They consider that all naval, military, and R.A.F. patients could be treated in civil hospitals or if necessary in separate Service wards. This outlook is dangerous. Under such a plan all Service organization would rapidly fall into disuse and on the outbreak of war there would be no effective hospital system capable of rapid expansion to meet the demands of the Services at home or abroad.

My grateful thanks are due to many civilian and Service doctors for their advice, and especially to my commanding officer, Colonel Wm. C. McKinnon, for his willing and helpful criticisms. I am grateful to the Director-General, Army Medical Services, for permission to publish.

STREPTOMYCIN

Available on Prescription

The following notice has been issued by the Ministry of Health.

Scarcity of streptomycin in this country has hitherto imposed a strict control over distribution and limitation of its use to certain conditions. Production has now increased to such an extent as to enable streptomycin to be made generally available on prescription through the usual channels as from November 1, 1949. After November 1 the only administrative controls over this antibiotic which will be operative will be those imposed by the Therapeutic Substances Act, which concern its manufacture, and those under the Penicillin Act, which make its procurement subject to medical prescription.

Hitherto the use of streptomycin in this country has been mostly limited to a controlled study, in an institution, of its effects in certain categories of cases. The extension of these categories has been notified to the profession in press notices issued at intervals during the past two years. Though supplies will be adequate in future for domiciliary use, it is still important that the drug should be employed only in conditions, or to combat infections, in which its efficacy is known. This implies a knowledge of the susceptibility of the infected organism to the antibiotic as well as of the actual condition which it is proposed to treat. Unless this knowledge is possessed before the institution of treatment the reason for any apparent inefficacy of the antibiotic may be difficult to ascertain. An example of the apparently anomalous action of streptomycin is that, whereas it provides the only effective treatment for tuberculous meningitis, it has not been shown to have any specific value in the treatment of chronic pulmonary tuberculosis, both of which conditions are caused by an organism known to be sensitive to the action of the antibiotic. If, therefore, treatment is based on analogy and not on ascertained facts disappointment may be caused both to the practitioner and to the patient. The proper place for the experimental trial of this antibiotic in unusual conditions is the hospital, not the home.

Streptomycin has two main disadvantages. These are: (a) certain toxic effects which may be permanent; and (b) the evolution during treatment of strains of the infecting organisms which have developed a resistance to streptomycin. It has been thought that the substitution of dihydrostreptomycin for streptomycin itself would reduce the danger of the occurrence of toxic sequelae. The evidence at present suggests that, though the appearance of toxic effects may be somewhat delayed, dihydrostreptomycin may manifest them on its own account. It is

therefore most important to employ adequate doses from the beginning of treatment, and in certain conditions it may be preferable to give larger doses than usual for a period not exceeding one week, as serious toxic effects do not appear to develop within that period. In any case, if the expected therapeutic response is not obtained in that time, reconsideration of the treatment is indicated.

No benefit has hitherto been recorded in the prophylactic administration of streptomycin with the object of preventing spread of infection following surgical intervention.

MEDICAL DEFENCE UNION

The annual report of the Medical Defence Union, which was presented to the general meeting of the Union on September 20, gives a synopsis of the many questions having a legal aspect which may confront the practitioner, and mentions some interesting cases in which the perversity of patients, the accident of circumstance, and sometimes the failure of the practitioner to take precautions resulted in difficulties. Of the cases passed to the Union's solicitors during the year, 69 in one form or another involved the issue of professional negligence. Of these 69 cases, 13 were fought out in court, where two were lost and 11 were won. In a further 16 cases it was thought necessary to make *ex gratia* payments in settlement of claims on the clear understanding that no admission of negligence was made; in 39 cases allegations of negligence were expressly withdrawn or abandoned in face of the knowledge of the interest of the Union in the matter and on the issue being formally challenged. Not a few accusations of negligence arise when an account is disputed by the patient.

Requests for Sterilization

It is mentioned that members are from time to time approached by patients with a request for sterilization. Counsel's opinion on this matter was first sought some years ago, but owing to the time which has elapsed since then, and the changes in medical thought and social conscience, it was felt that a new opinion should be taken. The opinion is that sterilization on eugenic grounds alone is illegal, but that it is not so if there are valid therapeutic reasons—in other words, if there are conditions which may imperil health or life if sterilization is not performed. This places sterilization on the same basis as abortion and calls for similar safeguards (including a second opinion and the written consent of the patient) on the part of the practitioner.

The Practitioner and Ancillary Examinations

In his presidential address at the annual meeting Mr. St. J. D. Buxton touched on the question of the responsibility of the practitioner concerning ancillary examinations. He pointed out that the patient knew little or nothing about the work of specialists, and if a practitioner acted on an x-ray, pathological, or other report which happened to be erroneous, though given in good faith, he might be charged with negligence, with the other doctor as co-defendant. Hence it was of the utmost importance that consultation with those carrying out ancillary examinations should be made, at least whenever there was doubt, for the sake of both patient and doctor.

He also mentioned that members frequently ask advice regarding inquests, and during the year legal representation had been afforded in 20 instances. Practitioners were sometimes accused during inquest proceedings of negligence in the treatment of the deceased, but such allegations had been successfully refuted. Action had also been taken by the Union to ensure that practitioners received their statutory fees for evidence of medical fact or opinion given at inquests.

Mr. Buxton intimated his desire, having been re-elected president for several years, to give place to another member. After placing on record its sense of the value of Mr. Buxton's exceptional services, the meeting proceeded to elect as the new president of the Union Mr. Ivor Black, F.R.C.S.

In view of the upward trend of all costs, the meeting agreed to a recommendation of council to increase the subscription rate from January 1, 1950, to £2 per annum except for the first