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THE CHANGING FACE OF MEDICINE*

BY

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To the layman reading his daily paper, and in particular the ponderous and often pontifical pronouncements of our politicians, must come the belief that he lives in an era when all is well with medicine. I wonder if he is right. Why so often is the medical father of to-day relieved when his son, sometimes perhaps with a little persuasion, chooses a different career? The reason is that in this age of rapid transformation medicine has not escaped. The foundations upon which our work was built have been rudely shaken, and I sometimes wonder whether the structure above is beginning to totter. I would like to draw attention to several of the factors which I think may be playing their part in this change so far as it affects specialist practice, for I would not presume to speak of the worries which attend the general practitioner. Some of the causes are naturally of our own making; others have been thrust upon us through this new health service under which we work. I propose to treat my subject under four main headings: (1) undergraduate training; (2) registrar appointments and training; (3) changes in consultant practice; and (4) the law and medicine.

1. Undergraduate Training

It is always a good thing to raise the standard of anything, and with that end in view the course in medicine has been increased to one of six years. This step—I think an unnecessary one—might have been excusable had the extra year been devoted to clinical study rather than to the basic sciences. It was thought that by giving more time to the subjects at the beginning of the medical course the boy or girl in the last year of school might benefit from a broader education at that stage. The opposite result has, however, obtained, in so far as the schoolmaster, hearing of this additional year spent on the basic sciences at the university, has got the idea that still more attention should be given to those subjects at school, and as a result the whole idea has been nullified. It was interesting to hear some two years ago, from one vitally concerned in this change at the University of Edinburgh, an admission that a mistake had been made and that this further year of study should have been devoted to the end of the course rather than the beginning, and yet this mistake is apparently allowed to be perpetuated indefinitely.

I think it is true to say that Edinburgh, unlike some medical schools in the south, has always laid stress on

providing the undergraduate with a solid foundation of theory on which to build his clinical study. There may be great value in this—indeed, it may be the correct approach and the best method of ensuring a sound training. But are we satisfied that this is not being overdone, that the medical undergraduate course is not too intense, too overcrowded? With increasing knowledge and an ever-widening research it is inevitable that there is nowadays more to learn; but, even allowing for this, there is sometimes the feeling that there is too much teaching, too much spoon-feeding, and that more good might derive from a less concentrated course of lectures and tutorials which would leave the student a little precious time to think for himself. Again, I would say there is an element of danger in instruction which lays too much emphasis on diagnosis made by the “back-room boys of medicine.” How often, on asking a simple clinical question requiring an equally simple and straightforward clinical answer, are we advised, in a pitying sort of way, to have some fantastic biochemical investigation carried out; or, if it be a question of the head going through the pelvic brim, to have the patient x-rayed! It is singularly unfortunate that an assessment of the patient by the bedside appears nowadays to be deemed less essential and is becoming more carefree and haphazard. At the end of university training there is an invaluable year in hospital and then two years in the Services, when the mind of the doctor, so far as things medical are concerned, might in the average case be a complete vacuum. Postgraduate courses are nowadays popular and are an essential stimulant to the general practitioner, who, overburdened by the trivialities of present-day routine—trivialities encouraged by the attitude of the Welfare State mentality—has little time to keep abreast with advances in his subject. It is a sad reflection, though, that so many young men take those courses simply because during two years of Service life they have forgotten much of the teaching of their undergraduate days.

2. Registrar Appointments and Training

Suppose now that one of those doctors, finished with his National Service, wishes to specialize in obstetrics and gynaecology. At this stage he does three things. Assuming that he has done six months' medicine and six months' surgery in his year in hospital following graduation, he now spends another two years as house-surgeon in obstetrics and gynaecology. Then he becomes a registrar, and finally he prepares for the special examinations which are necessary. This last phase of

*The Presidential Address read to the Edinburgh Obstetrical Society on November 10, 1954.

specialization takes up another five or six years at least, so from the day he started medicine he will have spent some fifteen years in preparing for his specialty. But his programme is not yet complete—there is often a dreary wait before a suitable and congenial consultant post offers; indeed, the wait may prove too long and he may eventually be offered, and forced to accept on economic grounds, some junior post where he may carry out efficiently and conscientiously the work of a consultant without being granted the title. Is there any other profession which calls for such a prolonged period of preparation and apprenticeship? I wonder whether the layman, still reading about the improved status of the specialist, realizes all this.

Some will say, "But look—nowadays the resident appointments are associated with more adequate remuneration than in the past," and will remind me that, as compared with the honorarium of £25, raised ultimately to £40, which a clinical tutor of my time received in the gynaecological wards of the Edinburgh Royal Infirmary, his counterpart, the registrar of to-day, receives a princely salary and his financial position is secure so long as he holds his appointment. I wonder if this security is altogether a good thing and whether registrar appointments should be whole-time.

In the old days a clinical tutor's hospital appointment was part-time. To close the financial gap between starvation and a moderate degree of comfort he gave private tuition to the Fellowship candidate, to the final-year student, and on occasion even to the nurse. He might also conduct special classes for the various examinations. It was his privilege to assist his chief in private, and in addition he began to get the occasional private case himself, very often the obstetric patient unable to afford the fee of a more senior man. From all this the clinical tutor derived much benefit and a much wider experience. To-day the registrar appointment is whole-time; an introduction to private practice is therefore not possible, and even the assisting of his chief outside of hospital has on occasion been questioned.

The present-day system breeds a mentality whose horizon is bounded by the hospital walls. There is little awareness of the world outside, and the young registrar often has little or no desire to go through the monotonous routine of private tuition. The whole approach has tended to become more lethargic and more lackadaisical. The younger folk may not approve of this observation, but it is true nevertheless. They are losing some of the greatest thrills which we who were fortunate enough to work under another system experienced: the enormous satisfaction of making headway—financial headway, to take it at its lowest value, for I would not underrate the importance of that for one moment; making headway, then, by our own initiative, ability, and "private enterprise." There is no doubt whatever that almost any nationalized industry which lacks competition to keep it on its toes goes downhill—one does not need to look far to see that—and medicine will be no exception if a whole-time salaried service comes to pass. Already there is a levelling-up process taking place whereby the unsuccessful specialist of the past, through his hospital remuneration and the decline in private practice, will be on almost equal terms with his more able and more capable colleague. Once that happens and there is no real reward for merit, something will have gone out of the profession.

Now, I consider this to be of tremendous importance to the future of medicine. There is no doubt that a section of our politicians wish private practice to die out, and the quicker the better. They want instead a whole-time salaried State service. To my mind this would be a disaster of the first magnitude for the doctors and for the country. Rather should an active and virile private practice in friendly rivalry with the Health Service be our safeguard. I am quite sure that this system of whole-time registrar appointments, in so far as it denies the right to carry out, and finally kills any desire to take part in, private practice, is playing into the

hands of the politicians. There is, too, another point. Whereas the clinical tutor of bygone days had his introduction to private practice during his five years of appointment, and therefore had something to fall back on when his tutorship expired and before he gained a position on the honorary staff, the registrar of to-day has no such introduction, and may well find himself in dire straits in the gap between.

May I digress for a moment to venture comment on the question of research, upon which ever-increasing stress is being laid. It is well known that nowadays, when applicants for a specialist post are being considered, first importance is given to any research that the individual may have carried out and the number of publications to which his name may be attached. Indeed, it is the advice of the senior consultants to the very junior that they must write and write and keep on writing if they want their application to be successful. It sometimes, nay quite frequently, matters naught, when the candidates are being discussed, whether the research was of practical worth, of particular brilliance, or, on the other hand, of no value whatever; it counts for nothing that, to many members of a varied appointing body, the publications might as well have been written in a foreign language with which they have become somewhat out of touch. The articles may be so much rubbish—they often are; the important point is that one very special candidate may have written more or is thought to be potentially a more likely research worker than another, and he is invariably the successful applicant. There is no doubt whatever that that is the position to-day, and it applies to most specialties. We have come to a pretty pass when such a situation can obtain that a first-rate clinician and a sound and experienced operator may be passed over just because he has not put pen to paper as often as another.

It must be obvious to the meanest intelligence that everyone who makes the decision to specialize is not destined to carry out original work or even to be a low-grade author. It has been said that a man should be given a taste for research before he is thirty or it may be difficult to get him started. This may be the grand ideal, but in actual fact the trainee of that age has already an overloaded plate and there may be no more space left for the non-essential trimmings. Do not therefore be too ready to condemn the young man as lazy; do not damn him just because he cannot write something "original." Let him work out his salvation in other ways—he will if he is given a sympathetic chance. Surely there is a place for both types in the scheme of things—the clinician and the research worker. After all, the main function of the average physician, surgeon, or gynaecologist is to alleviate suffering and heal the sick so far as lies in his power, and I would maintain that this should be the first concern of the vast majority. It seems rather dreadful that we have in these days to remind ourselves from time to time of our primary role. It is sad that in this present age of experiment we are sometimes apt to lose sight of the fundamentals of our calling.

3. The Changes in Consultant Practice

Now let us look for a moment at those of consultant status. Partly because of a changing outlook and partly as the result of this new system under which we work, we have been, as a class, divided and subdivided, and it is all-important to bear this in mind in the years to come if we are to present a solid front on matters of policy and on the improvement of the National Health Service. Most important of all, it would appear to me, is the chasm—unfortunately an ever-widening chasm—which divides whole-time and part-time appointments. I do not propose to discuss the relative merits of those appointments, for obvious reasons. Each has its own peculiar advantages. Let us all recognize those advantages and leave it at that—that would be the solution, but I am afraid it is not quite so easy. A year or two ago sarcastic, and indeed bitter, criticism was levelled at the part-time consultant. It is, of course, inevitable that we should criticize one another, but let such criticism not be tainted, let it be free of rancour.

In discussing this question with a general practitioner a month or two ago I was rather surprised when he said there would soon be a place for the general practitioner in the teaching of the undergraduate. He believed that if the whole-time specialist idea were to go on growing there would come a time when no consultant had contact with the patient outside of hospital, and something would be lost to teaching on that account. I sometimes wonder whether the influence of the whole-time teacher is not a little responsible for the too academic outlook of the present-day undergraduate. I am quite certain of this: the more we lose touch with the general practitioner—and the whole-timer is doing that now—the more will something vital depart from a valuable relationship. We need each other, we should get to know each other, and we should wish to help each other without hindrance of any kind.

We are divided again into four groups according to whether we have one of three grades of merit award or none at all. Following a letter to the *British Medical Journal** from Mr. John Simons on the subject of merit awards and stating that there was "considerable disquiet," Lord Moran replied in the same *Journal*† that this was "diametrically opposed to our experience." He describes in that letter the machinery involved in this labelling process—how, to begin with, in some areas small bodies advised the Awards Committee, and in other areas, notably "some of the London teaching hospitals," the task of recommendation was handled, at the request of the staff, by some of the senior members, who reported directly to the Awards Committee.

"There was a feeling that it was not fair to ask those who had been given this difficult task to submit their conclusions, which were obviously of a confidential nature, in open committee to perhaps as many as thirty members, for they were asked not merely to submit a list of names to fill vacancies; it was necessary to supply the Awards Committee with the reasons which had led to the choice of those names. And it was found that many consultants were not prepared to furnish these reasons save to the Awards Committee, where they could feel assured that the confidential nature of their report would be respected."

Lord Moran goes on to say that the "master principle" which has guided them from the beginning in their selection for awards has been to tap as many sources of information as possible. "So only," he continues, "can we hope to eliminate prejudice and attain to some degree of accurate appraisal." He speaks of the successful working of the awards system, asks the question whether he is entitled to make any such claim, and concludes his letter thus: "It is indeed a remarkable achievement, which has its roots in the good sense of our people—an achievement, I think, beyond the reach of more selfish countries." It did not occasion much surprise to find in the next few weeks replies of very contrary opinion to this letter in both the *British Medical Journal* and the *Lancet*.

Cloaked in such diabolical secrecy as those awards are, it is often difficult to get at the truth, and, not unnaturally, the wildest rumours run riot, but enough is known to say that wrongful decisions have been made. There are three questions I would ask Lord Moran: (1) Is the original percentage of awards in the three grades being adhered to? (2) What is the number of consultants in the teaching schools of England and Scotland, and how many awards in each grade have been given to the men in those schools? (3) What is the number of consultants in the teaching schools of London, and how many awards in each grade have been given to the men in those schools? The answer to those three questions would be more than interesting. The suggestion is often made that certain regions—and now I refer particularly to the larger medical schools—have been dealt with more generously than others, implying that the standard of the specialists and of medicine in one area is infinitely

superior to that in another. This I do not accept. We have no grouse whatever against the individual who is deemed worthy of a top-class award either by himself or by his fellows—let him have it by all means and good luck to him; our grouse is against a system which works so ineffectively and, so often, quite unfairly. The problem of improving this system is indeed a difficult one, because it is often impossible to get at the truth; the individual is afraid to complain—he feels that by so doing he makes his colleagues aware that he is a disappointed man; he is afraid also that by open complaint he may prejudice his chances for the future. Our national reserve and upbringing are no doubt responsible for the feeling that it is bad form to discuss this subject labelled "confidential," and so we tend to keep quiet about it. Silence therefore has been wrongly taken as approval of, and acquiescence in, the whole idea. It is unfortunate that it should be so. There is indeed grave disquiet in regard to the mechanism by which the awards are made, and unless we air our grievance openly and in a sufficiently large body there is little chance of having this part of our house put in order.

I gather that in Scotland there is a committee with representatives from different regions and from different specialties. Their opinions go to headquarters in London, where, I suppose, the recommendations are confirmed or rejected. Now, I would ask, what does the surgeon or physician on the committee know of the relative merits of one obstetrician as against another? The answer is, very little or nothing at all. They therefore have to be guided by their obstetric colleague, for I believe there is only one on the committee, and what can he know about the relative merits of his colleagues in regions far removed from his own? Again the answer is, very little or nothing at all. This whole question—a very vital question to most of us, for it affects not only our annual income but, what is more important, our pension—therefore is decided on hearsay and vague impressions—surely a Gilbertian situation.

What is the solution to all this? So far as I see it there are three alternatives. The first is that the whole scheme, born of unimaginative and insensitive mortal, be cast out and the money saved added to the consultants' ordinary salaries. I don't suppose that this is possible. The second is that a merit award should really be a merit award, and given from time to time—on the basis of an annual award—for particularly good work done in a single year. As things are at present, a man who has been given a top or even a second grade merit award is apt for the remainder of his active professional life to sit back and lose any desire to repeat his epic performance. The third possibility is that the mechanism by which these awards are made be radically changed. This could be done in many ways, but here is one method which, I think, is worthy of attention. Considering Scotland only, I would suggest that every year two or three representatives from each specialty in each of the four teaching schools be chosen. In obstetrics, for example, that would mean eight or twelve consultants, as senior as possible, getting together annually. They would discuss the various candidates in their own specialty and forward to the committee the names suggested. The claims from the various specialties could then be settled on a seniority basis. If the present Scottish committee is to remain, with important function, then there should be more than one representative for the major specialties. This enormous and onerous task is quite outside the capability and compass of one individual no matter how extraordinary he may be.

4. The Law and Medicine

I am quite prepared for criticism of, and even open disagreement with, much that I have said. I would be surprised, however, were there not unanimous approval of my final remarks, for an exposition of the changing face of medicine would not be complete without mention of the changed relationship between doctor and patient and between patient and hospital.

* June 26, 1954, *Supplement*, p. 359.

† July 17, 1954, *Supplement*, p. 69.

The compensation payments made by National Health Hospital Authorities, largely resulting from claims for damages by patients, have risen from £7,560 in the period July, 1948–March, 1949, to £152,590 in 1953. This startling information was given in the House of Commons in answer to a question asking how much money the Ministry of Health had paid each year "in damages for neglect or inefficient medical or nursing treatment." Commenting on the figures, the questioner went on: "Is this not further evidence that the Health Service under State control breaks down when individuals are relieved of personal responsibility?" That question, of course, comes from a man who has no knowledge and less understanding of the doctor's worries and anxieties for his patient which are part of his heritage and his tradition. It is good to know that the Minister of Health replied: "Personally I both resent and repudiate that," and continued that he was certain that there had been absolutely no deterioration in care since the start of the National Health Service. Why then, if this be true—and I am sure it is—do we find headlines in the daily press featuring with ever-increasing frequency the actions brought by patients against the surgeon or against the hospital? I would say the main reasons are three in number.

(1) Free legal aid enables the individual to bring an action without risk of financial loss. If he loses his action the expense is borne by the State; if he wins he stands to gain. There is therefore no deterrent, and he probably gives little thought to the possible effect of such an action on the future of the unfortunate doctor. For, make no mistake, even should he lose his action and the doctor be vindicated, some of the mud which has been flung is liable to stick.

(2) There is the idea, all too prevalent, that nowadays it is the Government—the State if you like—that is being sued, not the doctor, for after all the doctor is merely the servant. This may in part be true, and where some doubt exists the jury may well take the line of reasoning that the State is wealthy and can well afford to pay the poor claimant something. What the jury, and, I fear, sometimes the more learned judge, are apt to leave out of reckoning is that the State is big enough to surmount and quickly forget such unpleasantness, but the poor doctor is damned for all time.

(3) In this present age, and in every walk of life, there is prevalent a desire to get something for nothing. One can hardly blame the man in the street for this, for such an outlook is being bred and fostered by the ideas behind the Welfare State, giving rise to a new mentality.

These are the factors which are responsible for this never-ending litigation. We must therefore ask ourselves, "What is the effect of all this?" and "What is the solution?" The effect is seen at all levels of hospital staff appointment from the most junior to the most senior. The young resident is often unwilling to undertake the responsibility of a casualty department because he is only too well aware of the pitfalls and dangers which may crowd the very beginning of his medical adventure. His more senior colleague, the anaesthetist, is burdened down by the fear of "death on the table," and anaesthetics suffer as a result. The surgeon finds that he is loath to undertake the "risky" case. In former days he would have gone ahead and in all probability done enough to make the last days of a patient's life more comfortable and more bearable. Now he is apt to adopt the attitude that as "something may happen" it would be safer to do nothing at all, and he sends the patient home to end his or her days in misery and pain. There is no doubt that this is happening to-day; I have done it myself. Again, he feels that by making a wide resection to eradicate disease and cure the patient some important structure may be subjected to trauma. And so he pulls up short; his work is rendered incomplete and the disease remains. On occasion in the old days there was a spirit of adventure about some surgical operation: some new procedure "came off" and a great advance was made. Now the surgeon may be unwilling to take this risk: he has to think of his own safety too. The advance of medical science will never be

stopped, but initiative is being stifled, and the advance may well be slowed down if the surgeon is forced to work under the continual threat of retribution.

The solution is more difficult. The first essential is mutual trust and confidence between patient and doctor. The second is a change of outlook on this matter by the legal profession. The law has not been very helpful or sympathetic to us in those trying years, and expert evidence by eminent medical men would appear sometimes to have counted for nothing. The judgment has sometimes seemed harsh and bitter. A different attitude from our legal friends is of first importance, and I would go so far as to submit that many cases should be flung out at the beginning and never allowed to be heard in open court.

In a letter to *The Times* of October 26, 1954, S. Cochrane Shanks, President of the Medical Defence Union, stated that the number of claims for alleged medical negligence submitted to them in 1953 had increased by 80% as compared with 1947. He goes on:

"Of the total claims during this period only one-third were justified, in that the union settled without going to court or lost the action in the courts. In the remaining two-thirds the plaintiff either abandoned the claim or lost it in the courts. Of the cases coming to court the same ratio obtains: the union successfully defended two-thirds and lost one-third.

"It is evident from the above figures that many of these claims are unjustified, and as the plaintiff is now legally aided in about 80% of all cases the successful defendant is usually unable to recover any of his costs. In two recent cases, successfully defended by the Medical Defence Union, the union's costs exceeded £10,000, none of which was recoverable. The legal aid scheme makes proper and desirable provision for the impecunious plaintiff, but the question arises whether it should not be extended to cover the taxed costs of a successful defendant when the plaintiff is legally aided. Alternatively, there might be adopted in England the practice which already obtains in Scotland of allowing a prospective defendant, through his solicitor, to submit evidence as to why a certificate of legal aid should not be granted to the plaintiff. . . .

"All three defence societies accept it as their duty to pay proper compensation for real negligence on the part of their members. Equally they feel concerned at the drain on their funds, and even more so at the damage to the good name of their members, by unjustified claims and legal actions."

In a magnificent article* on this subject Bryan McFarland, Professor of Orthopaedic Surgery at Liverpool University, has written:

"No one is suggesting that the doctors should be immune from criticism or protected from retribution when they have erred. No one is suggesting that an injured person should be denied the right to proper compensation. What is suggested is that the machinery for settling these issues should be such that the doctor should only be put 'on the spot' if in the minds of responsible members of the legal and medical professions he has been negligent.

"It would not be difficult, for instance, for the merits of a case to be judged by a tribunal such as deals with appeals under the National Insurance Scheme—a tribunal nominated by high authority and consisting of two medical men with a lawyer as chairman. If such a tribunal were to decide that there was a case to answer then the doctor should have to answer it. If on the other hand it was thought that no particular doctor had been negligent but that the hospital system or arrangements or staffing as a whole had behaved inadequately, then the hospital would have to answer. If it was thought that the damage resulted from something 'going wrong' in which no negligence was involved, then neither doctor nor hospital would have to answer."

* *Liverpool Daily Post*, May 6, 1954.

This solution might not be acceptable to the law, but I feel sure the medical profession would welcome such a compromise.

I have but touched the fringe of the subject. One could ask whether, with the enormous cost to the country which this new service entails, the patient has benefited in the essentials of treatment; whether the vast administrative wheel, which often grinds so slowly, might be made smaller and yet more effective; whether the endless committees, which force the public-spirited to spend almost as much time in the train as in the hospital, are so necessary; and whether great power and influence vested in the hands of a few satisfies our democratic ideals. Those are but a few of the problems.

It has fallen to our generation to work out and put into practice this new regime in medicine. Changes, whether we like them or not, are taking place around us all the time and we have to make the best of them; but, with the highest ideals ever before us, let us see that it is the best. Let there be honesty and frankness among us and let us frown on intrigue—for there is much of that in medicine at the present day—and cast it out. Let gentle suasion never steer us away from a true sense of values, and, above all, let us never forget that our first aim should be to heal and cure the sick.

YOUTH LOOKS AT GENERAL PRACTICE*

BY

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It might be of interest to the profession to know what a recently qualified doctor, and therefore one without specialist training and with only a short experience as a practitioner, thinks of some aspects of general practice to-day. The views I express are my own and not necessarily those of the younger generation as a whole. Furthermore, if any of my comments appear unduly critical of those older and wiser than myself, they are in no way intended as an impertinence, and I hope will not be so regarded.

The student of to-day working for his "finals," and faced with a compulsory year in hospital followed by two years' National Service, probably does not give much thought to general practice, though he may well be thinking of it rather vaguely as a future career. In fact I would suggest that many final-year students and "neo-graduates" rather tend to have a leaning towards some specialty. This is not unnatural, since the training is almost entirely in the hands of specialists, and this despite the fact that many of the students are destined to become general practitioners. The year of compulsory internship may accentuate any specialist leaning, as by now the young doctor is even more closely bound by the hospital tie. However, it is not easy to become a consultant these days, and, if a man is contemplating taking a wife, it is difficult to marry on a resident's or S.H.O.'s salary. Furthermore, the thought of the high failure rate in the F.R.C.S., M.R.C.P., and other specialist examinations may deter him from pursuing his choice. So, rather unwillingly perhaps, he plunges into the unknown and looks for a job in practice, leaving behind him, probably for good, the world

of starched aprons and white coats. His idea of what is involved is, more than likely, rather vague, since he has had no specific training for general practice. I myself had had the advantage of being reared in a medical household, but despite this my knowledge of the job to be tackled was far from clear. I cannot say I was very enthusiastic. I had been told by friends with some slight experience that all was not well. The hospital swallowed all the clinical interest. The hours were long and tedious, and the day was spent coping with queues of "not-so-very-sick" but demanding people out to see what they could get for nothing. And so, by now not quite so confident, I crossed the threshold with a background of three residencies and National Service completed.

Initial Difficulties

What were my initial difficulties and worries?

First, I think, would my knowledge be sufficient? I had no idea what measles looked like, or mumps. When I was a resident there had always been someone else to take the ultimate responsibility of the patient. Now it was to be my turn. How would I fare? What on earth would I prescribe? I realized with horror I could not really write a prescription. I imagined that I would meet with much more of the hospital type of illness than I actually did. However, with this kind of illness I found that my knowledge was sufficient; but when it came to bronchitis, influenza, childish febrile conditions, rheumatism, tonsillitis, old age and its problems, and so on, I discovered I was not so clever. Their mysteries were all contained in a closed book which had to be opened and studied closely page by page, and yet this was to be the bulk of my everyday work.

Prescribing turned out to be easier than I had anticipated. The local chemist proved a great help, and there was always the *National Formulary*. However, the temptation to prescribe proprietaries with their easily remembered names was the severest trial. Furthermore, the persistent pestering of the drug firms via the post and the traveller would break down the ideals of all but the very righteous. Nowadays there seems to be no need to write an old-fashioned prescription at all: there usually turns out to be a proprietary equivalent, which is supposed to be as cheap and equally efficacious. At least, so say the manufacturers' travellers.

Restrictions Imposed by the N.H.S.

My early reaction to the volume of trivial complaints brought to me was, This is not medicine at all: a fourth-year medical student could cope. There seemed to be so many people to be seen that even when one had separated the wheat from the chaff there was not time to deal properly with the wheat.

The cessation of clinical control of patients removed to hospital under the National Health Service seemed to me a great loss. On the other hand, it was often not a bad thing to be relieved of the responsibility and worry, allowing one to concentrate on the ordinary run of everyday work. The fact that it was found necessary to refer to hospital anyone requiring even a simple diagnostic investigation proved a great irritation to the late house officer who had so recently himself had the power to order many of these investigations. And the delay in waiting for out-patient appointments was most frustrating. Often weeks would elapse before the answer to a clinical problem arrived by post on one's desk.

In many cases it appeared to me superfluous for the hospital officer to enter into the picture at all. He merely seemed to act as a middleman anyway. Why should I personally not have more direct access to such investigations as "x-ray chest," "straight x-ray abdomen," blood counts, and minor biochemical and pathological investigations? More important still, it appeared to me that the patient must think that, because he has been sent to hospital for all but the very trivial, the G.P. is only good for this. I

*An address given to the Southern Medical Society of Glasgow on November 25, 1954.