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THE PRACTITIONER AND THE PUBLIC

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Time has brought many changes in the relationship between the practitioner and the public. In the earlier periods of the development of medical practice in this country these changes were the result of influences at work in the ranks of the profession itself, but of late years they have arisen as the outcome of an altered attitude of the public mind to questions of health.

In no period have these changes been so marked as in the years of the present century.

INTERVENTION OF THE STATE

Coincident with the rapid advance in surgery and medicine and the development of hospital and subsidiary medical services, there has been a great increase in the concern of the State for the national health and a quickening of public interest in the prevention of disease. These changes have not been without profound influence on the position of the general practitioner. Not only are the medical schools turning out men better equipped than ever in technical skill and knowledge, but in his sphere of practice the young practitioner will generally find means at hand in the form of hospitals and special clinics for the full exercise of his abilities. This is all to the good, alike for public and practitioner, but perhaps a passing note of regret may be allowed in one particular. Under the old conditions the isolation of the practitioner in many districts, the necessity for dealing with every situation single-handed or with the minimum help of neighbouring colleagues, created a type of man, self-reliant, skilful, observant, who must surely be ranked among the best that the profession of medicine has produced. Nowhere in the history of medicine have the praises of these men been sung. They have lived and worked and died, often in the remotest parts of this island, unhonoured save in the lasting esteem and memory of the community which they served so faithfully. To each, and not a few still living, we pay a tribute of honour before devoting our attention to the altered conditions of our time.

One of the most important factors in this respect was the passing of the National Health Insurance Act of 1912. It is only natural that the practitioner should at first

sight consider the financial side of this change the most important. The settled reasonable remuneration for work that was previously grossly underpaid or not paid for at all, and the replacement of a discredited service that every practitioner avoided, if possible, by an honourable one that he could enter with satisfaction, gave him every inducement to work with his best efforts. There are, however, two underlying principles in the Act which more than any previous health legislation profoundly affect the relationship between the practitioner and the public. The first of these is the recognition by the State, after the most careful consideration, that the best form of medical attendance in the interest of the public is that supplied by a *general practitioner service*. Secondly, and arising directly out of this, the practitioner for the first time is brought into direct relationship with the State. The type of service he is required to render has to be envisaged and maintained, and here arises also for the first time some measure of definition of the range of a general practitioner's duties, a standard which must in future be recognized in a wider field in all matters of dispute.

Thus by virtue of the National Health Insurance Acts a new relationship between the practitioner and a large section of the public has arisen, and no great vision is required to foresee other and still more important changes likely to arise in the future. Obviously the work begun must be continued to a logical conclusion; as and when economic conditions make it possible the existing system must be extended to the dependants of the insured, and specialist services added to complete the scheme; nor will such extensions cease until in some way or another, involving the linking up of a multitude of independent schemes of domiciliary, institutional, and insurance character, every member of the public can command at a cost within his means a complete system of medical attendance. To this end the State, the hospitals, and the profession are steadily working, and the family practitioner must ever be the most important factor in its success.

With these general observations we turn to the more personal and individual side of the relationship under review.

FIRST STEPS IN MEDICAL PRACTICE

The medical student, after a long and tedious training under a curriculum which has been steadily extended until it has reached a serious state of overloading, finds himself at long last duly qualified and registered. If he is wise and fortunate in having spent further time in resident appointments or extended hospital experience, he will have gained some insight into the more personal side of his work, and also have had valuable training in responsibility. He will now for the first time find himself confronted with the problem of dealing with the public face to face, in the hope of earning a living.

Possibly he will realize for the first time, at any rate more clearly, that an entirely new outlook on his work presents itself—that he must turn from the study of disease in humanity to humanity in disease, from the contents to the container. He will further realize that his training has done very little if anything at all to fit him for this important step in his career. He has acquired his knowledge, but only learnt to apply it under conditions which are entirely different from those he is now faced with. His only consolation in this dilemma is the knowledge that everyone else in his profession has had to experience the same difficulty. With this problem to face he will, if he is wise, seek some method of gaining an insight into the working conditions of ordinary practice before he sets up on his own.

A sea voyage as ship's doctor is an attractive way of having a holiday without expense, also a healthy change, with a prospect of seeing something of the world before being tied irrevocably to one particular district, but it will not help to solve his main difficulty. This can only be done by engaging in locumtenent practice for some months, during which he will gain not only experience in presenting himself to the public as a doctor, but also get an insight into the methods of running a practice, and forming some opinion of the type of work he finds most attractive and for which he feels best suited.

The conditions of practice vary considerably in different parts of the country by reason of variations in occupation and employment. Between the opposite extremes of a densely populated mining district and a truly rural area lie every shade of special and mixed type of community, for the varying reasons—industrial, social, and climatic—that influence the collection of humanity into groups. The doctor seeking to establish a practice will often prefer to settle in the kind of district with which he is familiar. More often chance puts in his way an opening which decides the question. In any case he remains an individual with a medical training of uniform character calculated to fit him to deal with disease and its prevention, but the method by which he applies his knowledge in earning a livelihood will in no small way contribute to the measure of his success. This will depend on the man himself, his character, personality, and general make-up, more than anything else.

DOCTOR AND PUBLIC: RECIPROCAL EXPECTATIONS

Just as "the man in the street" is familiar to us all as a non-existent individual, so "the public" and the "average doctor" are equally imaginative expressions for group denomination, and remain useful definitions of expression, well understood by all. What, then, does the average doctor expect of the public, and, equally important, what does the public expect to get from the doctor? The first question can be fairly easily answered in terms that are constant. The doctor invites the public to come to him for advice in the prevention and treatment of disease, in return for remuneration which will afford him a means of livelihood. He expects to meet every variety of disease in every variety of human beings,

and in very different circumstances, and he has been trained to that end.

It is, however, very much to the point also to consider what the public expects from the doctor, and that is not an easy question to answer, because no two members of the public expect quite the same. Expectations vary with the personal equation of the patient. There are, however, certain general points which are constant in the attitude of the public to the profession.

Once established in practice the doctor is always in the public eye. Certain obligations he cannot escape. Where he lives, how he lives, must conform to accustomed ideas of the profession. His occupation is a serious one, which must in some degree be reflected in his manner, and even in his dress. The motor car has done much to alter the old rigid views in this respect, but there still remains the essential need of a residence, and other signs of established prosperity, that will tax his financial resources at the outset to a greater extent than in most other walks of life.

The first and most outstanding feature of his life will soon be brought home to him, and like many other things in life, however well envisaged beforehand, will not be understood until learnt by experience. His vocation will mean that his time is never his own. He is on duty twenty-four hours of the day and seven days in the week. He is a servant of the public, and is expected to respond to its needs at any moment of the day and night. His plans, his time-tables for the day must be recast again and again if need be. The public as a whole understand how he is inconvenienced by calls at irregular hours, and as a whole intend to spare him in this respect, but when illness comes (accidents, of course, are another matter) a household is so disorganized, the domestic machinery so upset, that general considerations on sparing the doctor are apt to go by the board, and in *this particular case* the matter is urgent and the doctor must come at once. Hence many an urgent message from the patient turns out to be far from urgent from the doctor's point of view.

It must, however, be remembered that the public are not really qualified to understand when a matter is urgent from the medical point of view. In a large measure this will be dictated by the degree of anxiety aroused, the temperament of the patient or relations, and the importance of the individual in his own estimation or in that of his family.

Very little will teach the practitioner to take all this for granted, and accept the unnecessary and inconvenient as part of the day's work. There remains, however, the necessity for the doctor to have his hours of leisure for the good of his health, mental as well as physical. He must arrange that an urgent call shall receive prompt attention. Carelessness in this respect the public will not lightly excuse, and if he himself is not available someone must by arrangement accept his responsibilities. Many doctors make a habit of taking certain days or half-days for recreation, and it is a good habit to educate patients in this respect, but in any case a doctor with a good practice should by some means or other be within reach of a message.

The relationship between doctor and patient is a close and personal one. The patient wants his own doctor, not a substitute, and is likely to feel aggrieved if he is disappointed. This close relationship goes to the very root of general practice. It is as well understood by the doctor himself as by the patient, and it is this very distinct understanding that has given rise to a confusion of ideas in the public mind which may be generalized under the title of "medical etiquette." This term expresses something of which the public is very suspicious, and which it is apt to reckon absurd, old-fashioned, and designed to advance the profession to its own inconvenience. Doctors, as

has been said, recognize this close personal tie between themselves and their patients, and it is a point of honour with them to do nothing that could damage or weaken it in another doctor's practice. The doctor seeks to observe the precept, "Whatsoever ye would that men should do unto you, even so do unto them." The public has a perfect right to go to the doctor of its choice, to change from one doctor to another, but there is a right and a wrong way of exercising this right. And it is generally when the wrong way is being contemplated that we hear criticisms of medical etiquette, which is, after all, only another name for good manners as between members of an honourable profession. The bond between patient and doctor must be definitely broken before a new bond with a new doctor is forged, and the reluctance of the patient to face the delicate task of severing the first connexion is generally the cause of his objection to medical etiquette.

THE QUESTION OF FEES

The most difficult problem that besets a doctor in establishing a practice is that of deciding the fees to be charged for his attendance. There is, of course, in any locality a general standard of fees, which, however, varies considerably in different places, but the application of the standard to different individuals is a delicate matter. The public is apt to complain of its ignorance in this respect, and there is much unnecessary, though understandable, reticence in this matter on both sides.

No other profession is expected to give its services so freely without fee or reward. This is partly due to the high standard of generosity that long tradition has led the public to expect, and in part to the fact that the doctor renders services that are a necessity to the community, and it is unthinkable that lack of means to pay should deprive any individual of his most pressing need in time of sickness.

The realization of this need by the public and the profession is the foundation on which our wonderful system of voluntary hospitals has been based. Great as the changes are through which our hospital system is passing the fundamental principle remains that the public should receive the benefits of this form of medical aid at a cost within its means.

Let it here be noted as a fact that will give great surprise to most members of the profession, a fact for which, nevertheless, the present writer can vouch—namely, that a considerable section of the public do not know, or even believe, that the medical staffs of our hospitals give their services free. They cannot believe that somehow or another the doctors do not get some financial advantage from sums subscribed to hospitals.

Hence the problem which year by year grows greater in relation to the medical staffs of hospitals. As contributory schemes grow, and as step by step patients of a better economic position make use of our hospital system, the question arises, how far and for how long are the doctors to go on giving their services for nothing? What system can be devised which recognizes the limited means of the patient, but, from the medical point of view, recognizes also the fact that he is capable of paying *something* for his medical attendance while in hospital?

In ordinary practice the difficulty is more easily met: the doctor makes out his usual charges for attendance and then scales them down to meet each particular case, and the principle that the patient's ability to pay must be taken into account is recognized.

But medical attendance has grown to be something much more than the simple relationship so far indicated. The machinery of health services has grown, and continues to expand rapidly. Specialist services of all kinds, institutional and domiciliary, are now a recognized adjunct to ordinary medical attendance. The cost of these ser-

vices, by reason of equipment and specialized training, is necessarily high. The hospital class of patient receive these auxiliary services either free of charge or at a reduced cost in proportion to their means. The private patient must pay heavily for them, and does indeed do so, if he has the means. There remains, however, an intermediate group of those whose means are limited, who are in danger of having to go without facilities which have passed from the luxury category to the essential. The only way such range of treatment can be secured for this class is through the personal representation of the family doctor to the specialist. The need for providing systematically for this class of the public is now being recognized, and consultants' boards are being set up of specialists who will see at reduced fees persons of limited means on their doctor's recommendation. Such a scheme protects the hospitals on the one hand from exploitation, and on the other brings remuneration to specialists which otherwise would be lost.

The Prince of Wales, speaking in the Albert Hall at the British Medical Association centenary dinner a little more than a year ago, referred to this problem in the following words:

"The golden portal will never be reached until the general community can obtain full advantage of practical and wise preventive medicine with home and hospital treatment, medical and surgical, of the most skilful available, and at a cost in keeping with family needs."

Such a statement envisages something more than the linking up of the various health services into a general scheme. It means not only the full supply of all specialist needs: it means also that the patient's ability to pay is a most important consideration.

It is here that the family doctor, with his close knowledge of his patient's position and needs is the important link. He must identify himself not only with the health interests of his patient but with his financial interests as well. And in fact he does so, not only, as has been said, by taking into consideration his patient's ability to pay in reducing his own fees, but very often by obtaining specialist services also at a reduced cost.

It is an age of specialism, and specialism within specialism. The ranks of specialists steadily increase, and though many may rise to a well-deserved and established reputation that makes their position pre-eminent, there must remain those less fortunate, yet highly trained and competent, who, while waiting their turn to come to the front, would do well to remember the needs of this particular and deserving class faced with the alternative of seeking the aid of charity or finding a sum of money beyond its means for what is a necessity of life.

It is not to be supposed that a stage will ever be reached when a doctor's or specialist's charges will be exempt from adverse criticism by the public. The patient has a right to know clearly what these charges are, and there is too much reticence on the subject on both sides; but after all the public is well protected by the competition between doctors.

THE PRINCIPLE OF INSURANCE

When medical charges are under discussion one not infrequently hears the observation that it is a pity that doctors are not paid by results instead of by attendance. Such comments, generally coupled with a reference to the wisdom of the Chinese in this respect, show the not uncommon lack of clear thinking on medical matters. The argument from the lay point of view sounds very convincing and unanswerable. There can be very few doctors in general practice who cannot claim justly to have saved lives and also to have prolonged them. The exact remuneration that individuals might put upon their lives would open a field of speculation not easy to contemplate, but

it could safely be assumed (at any rate before the event) that the figure would err on the side of generosity, and the surgeons in particular would hardly object to such an arrangement.

The main issues in respect of the payments of medical charges remain very clear. The doctor has spent much time and money in acquiring the skill which enables him to supply something which is a necessity to the public. Some can pay him an adequate fee, others can pay him something, and again others nothing at all. To each and all he must give his best and get sufficient reward to provide him with a livelihood befitting his position, and a recompense for what he has spent in preparation for his profession. The altered economic conditions of the country are tending to increase the number of those who can pay something, with a corresponding decrease in the other two classes—with the inevitable result that the only solution of the problem for those of more limited means is by way of some form of insurance.

A little more than twenty years ago this fact was recognized by only a limited section of the more provident working classes. Friendly societies, slate clubs, and groups of individuals insured themselves for medical attendance and sick pay under a system which had many advantages for the worker, but which, to put it at its highest, had very few for the doctor.

The passing of the Insurance Act in 1912 was a revolution in the relationship between the profession and the public. Like most revolutions its full significance was but vaguely recognized, and only by those of long vision. For the first time the State, hitherto content with accepting a responsibility towards the destitute, enlarged its outlook and extended its concern to the health of the community as a whole.

The worker was compelled to insure, the employer made to accept a share of responsibility, and the State guaranteed not only to share the cost but to provide the necessary medical service. Twenty years have seen this scheme established as a permanent success. Looked at askance at first by the profession, with many imperfections, the general principles are now accepted by all as sound, and the necessary machinery for improving the system has steadily developed. It is now the duty of the whole profession to see that the service is improved continually to meet the growing demand for the fullest kind of medical attendance. Insurance on these lines must extend not only to the dependants of those already insured but to other classes of the community.

Such extension to be a success must be attractive to both parties, and will need the best brains of the profession and the public if it is to prove itself not only a system of medical treatment but the greatest example of preventive medicine yet evolved. Preventive medicine cannot develop as it should without the co-operation of the public, and this is much more likely to be fostered under an insurance system. Good health should be the right of every citizen, and the doctor's responsibility is not discharged by treatment alone. The patient has a right to know why he is ill as well as the steps he must take to get well. Not until he insists on this point as a matter of course will preventive medicine come into its own.

INDIVIDUALISM AND INDIVIDUALITY

The rapid increase in public medical services and hospital contributory schemes indicate the lines on which medical attendance will surely develop. However slowly such changes come, and whatever form they take, in one respect there can be no doubt as to their influence on the general practitioner. Inevitably he is drifting away from the old isolation of his position in the health machinery of the country. His whole training and professional work make for strong individualism, which tends

to make him difficult to fit in an organized service. He lives too often self-centred in the small ambit of his own practice, which absorbs both his time and his interest. In his training his whole time and attention is spent in a medical training which never touches on the broad issues of health in relation to the public as a whole.

But in one particular he must always remain the strong individualist—namely, in his relationship to the individual patient. This is a sacred bond which must never be weakened. No one must ever be allowed to come between himself and his patient in the matter of treatment, except with the consent of both parties. The profession will never tolerate any system which contravenes this principle. He is the one direct point of contact between the profession and the public, a contact that must always be intimate and personal. However much the attitude of the public to health matters may change, and education in this respect is advancing rapidly, there will always remain this last link unaltered and unbroken.

In this close relationship the life-work of the practitioner is carried out, and it is here that the individuality of the doctor has full play. Speaking generally, it might be supposed that infinite as are the attitudes of patients to doctors, that of the doctor to patient would be more or less uniform, for all doctors have had the same training on broad lines, and they all approach health questions from the same angle of view. As a matter of fact the reverse is the case. The individuality of the medical man is reflected in his contact with humanity, and probably no two doctors would approach the same patient in quite the same way. It is difficult to obtain the views in general of the public on the attitude of the doctors to their patients, but comments in the Press and elsewhere often indicate a common complaint. This is that doctors as a whole adopt an air of mystery about their art and, in giving advice, treat their patients as if they were little children.

This criticism is doubtless well founded. Whatever the reason, the habit appears to the patient unnecessary, irritating, and devised by the doctor to gratify the sense of his own importance. The patient feels that as *he* supplies the temperature, symptoms, and signs of disease, they are in a sense *his* property, and should not be withheld from him. From the doctor's point of view the explanation probably lies in the difficulty of bridging in words the wide gap between his own expert knowledge and the technical ignorance of his patient. Even if he appreciates the difficulty, not every doctor possesses the facility of expression required to meet it; and of course it would very often be far from the best interests of the patient to give him the information he desires. Perhaps this is one reason why doctors themselves generally make such bad patients.

Much can be done to meet this criticism of mystery-making. Every patient is more likely to accept advice and act upon it if he is told in simple language the reason of his malady and the method and purpose of his remedies. If there is any truth in this general criticism of the manner adopted by doctors to their patients the increasing education and interest of the public in health matters will soon bring about the desired change.

The Acts of Parliament which govern the practice of medicine in this country are framed to safeguard the interests of the public and not the profession. The register of the names of those who are qualified in the eyes of the law to treat sick people is for the benefit of those who wish for a guarantee of training and education designed to that end in the individual whose advice is sought. The public is free to take advice from the individual, qualified or unqualified, of its choice, but it is wisely given the opportunity of distinguishing between the two.

No other country is as generous in the liberty allowed to unqualified medical advisers. Those who possess medical degrees granted in other countries can practise here without serious disadvantage so long as they do not pretend that they are *registered* in this country. Even in the significance of the word *registered* there is now some danger of misapprehension in the public mind. The term is now used in a wider sense than formerly by reason of the maintenance of a register by groups of individuals engaged in occupations auxiliary to medical practice.

CONCLUSION

In conclusion, the doctor setting up in general practice will find the public well disposed towards him. Not only is he engaging in an occupation that by its very nature excites the sympathy and good will of all, but he inherits the great traditions which generations of medical men

have established before him. It is unthinkable that he will not reverence these traditions and play his part in maintaining them.

In many ways he may count himself in these days a fortunate member of the community. With all its disadvantages and inconveniences he remains a man engaged in the work of his choice. Work of intense interest and great variation which can satisfy the desire to utilize his ability to the full. All his life he can feel that he is gaining experience, adding alike to his store of knowledge and to his knowledge of humanity. Using his great opportunities well, he can take rank among the best educated members of the community: educated in the true sense of the word from the cradle to the grave, in an honourable and honoured profession. To all those who at this time are embarking on some stage towards the career of general practice we offer our congratulations and good wishes for success.

THE PROFESSION OF MEDICINE

INTRODUCTORY

For long past it has been usual to preface the main contents of our annual Educational Number with some remarks by way of guidance to those who contemplate entering the profession of medicine. What we have to say here will follow the lines laid down in previous years; but it must be borne in mind by readers of each subsequent section that not only the methods of medical education but even its purpose are under close scrutiny in various responsible quarters. The medical curriculum is a subject of discussion to-day in nearly every country of the world. For over seven years it was deliberated upon by a Commission, working under the auspices of the Association of American Medical Colleges, which issued an exhaustive final report towards the close of 1932.¹ At about the same time, on the initiative of the University of London, a Medical Curriculum Conference was set up, with officially appointed representatives upon it of the Universities of Oxford, Cambridge, and London, and of the two English Royal Colleges and the Society of Apothecaries. Further, the Council of the British Medical Association, recognizing that, while the teachers and examiners are intimately concerned in this problem, the most important product of a medical training is the general practitioner, appointed a Committee on Medical Education to make a general survey of the present course of study from this as well as from other points of view, and the committee has already issued an interim report.² In Canada also, where medical education had long been under discussion in academic circles, the subject has lately had free ventilation among the profession generally through a series of signed articles written by teachers and practitioners for the *Canadian Medical Association Journal*. One of the chief criticisms directed against the medical courses of to-day, both in this country and in America, is that efforts are everywhere made to provide instruction in too many subjects in too great detail. As Sir Norman Walker wisely said in his Presidential Address at the last meeting of the General Medical Council:

"We should not forget, when considering proposals for making new grafts on the curriculum, that one of the most useful of the gardener's implements is the pruning-knife."

¹ Final Report of Commission on Medical Education. Office of the Director of Study, 630, West 168th Street, New York.

² Interim Report of Committee on Medical Education, *British Medical Journal Supplement*, June 24th, 1933 (p. 286).

The first object of the Educational Number, 1933, is to inform prospective students and their parents of the steps that must be taken in order to become a registered medical practitioner under the existing order of things. The second is to assist those wishing to know what a medical career has to offer, and others who, having already decided to study medicine, are uncertain about the line of work for which they are best suited. This introductory article is meant to serve as a clue to the great body of information contained elsewhere, but it also gives an opportunity of reviewing briefly some aspects and tendencies of medical study and practice, and of directing attention to a few points that might not occur to anyone without some experience of the medical life.

Intending students will find in the pages that follow an account of the course of training required of them at the present time, the places where it can be obtained, and the bodies which test the knowledge gained and confer degrees or diplomas entitling successful candidates to become legally qualified medical practitioners. Sections are included also on post-graduate study, on the higher qualifications, both general and special, and on most of the varied spheres of work open to registered medical men and women at home and abroad. The details given are founded on official information, and arranged along the customary lines.

PORTALS OF THE PROFESSION

The *Medical Register* is the official statutory list of legally qualified medical practitioners kept by the General Medical Council. There are many ways in which admission can be obtained to the *Register*. No fewer than twenty-seven bodies—eighteen universities and nine corporations—either separately or jointly, issue registrable qualifications, and the number of teaching institutions is even larger. Nevertheless, the medical courses of the various universities and schools in Great Britain and Ireland run on parallel lines, and the obligatory curriculum is much the same for all students. But the individual teaching and examining bodies have different standards and requirements and bestow different qualifications, and the choice should therefore be made early, so that a definite plan may be followed. The possession of a university degree is generally regarded as an advantage in practice, yet a considerable proportion