opportunities for research and study into the beginnings of diseased processes.

The *spa* was another application of the same idea but on a larger scale, where the patients rest from their ordinary avocations. Natural waters were a useful adjunct, but were quite subsidiary to the climate, position, and careful organisation of régime and environment, mental and physical. Many of the most successful spas in Europe were those whose waters had no special qualities. Amongst the features needed were the following: good natural position—the whole resort planned so as to present the various treatments efficiently though pleasingly and in an environment of beauty and repose; physical culture in its various forms, with ample accommodation for games which, though remedial, would be attractive; baths and all forms of hydrotherapy; electrical treatments; music and other entertainments which rest and divert, but do not excite, the mind; suitable dietaries so arranged as to be attractive and not irksome. Natural waters, though advantageous as an addition, were in no way a substitute for the foregoing necessities. The running of such a spa presupposed guidance and control by the doctors, acting in conjunction with a far-sighted municipality ready to spend adequate capital in laying out its resort on generous and comprehensive lines, and hotels designed and administered for those in search of health. Spas needed clinics, special hotels, and sanatoria, all working together for a common object. The need and opportunity were great, with many of the continental resorts henceforth closed to us. Resorts fulfilling the conditions laid down for city sanatoria had a great future of usefulness and should be brought within the reach of all classes. They would repay their cost many times over from the increased health and robustness of those visiting them and on account of their wide usefulness.

THE CASE FOR A STATE MEDICAL SERVICE RE-STATED

BY THE PRESIDENT AND HONORARY SECRETARY TO THE STATE MEDICAL SERVICE ASSOCIATION,

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THE suggested Ministry of Health has aroused considerable interest amongst the public in matters affecting the health of the nation, and it has vividly brought before the medical profession the great question as to how it can best serve the community as guardian of its health and physical well-being.

Both lay and medical men are realising that with the formation of a Ministry of Health changes in the relation of doctors to the public must quickly follow, and it is recognised that some form of organised medical service will be called for. Just as in the past there has been a hopeless multiplicity of Government departments concerned with matters of health, leading to waste of energy and money and a lack of efficiency, so has there been a similar want of organisation in local administration and in the various services rendered to the public by the medical profession.

All are agreed that organisation is called for centrally, locally, and amongst individual members of the profession, and at the present time much discussion is going on as to the particular lines such organisation should follow. Under the circumstances it is not surprising that suggestions for a State Medical Service should receive their share of attention, and it may be of some use to state the case for such a service once again and to see how far other opinion is leading towards that solution.

The Five Essentials.

In order to build up a system of preventive and curative medical treatment which will secure to *all* the maximum measure of health the following reforms are essential:—

1. A Ministry of Health with a president of Cabinet rank, assisted by an advisory medical board.
2. A Medical Research Service.
3. A widened and improved Public Health Service.

4. Close coöperation between the preventive and curative medical services.

5. A Public Clinical Service.

There is very little disagreement of a serious nature in the medical profession regarding the first three suggestions, and as regards the third it is now generally recognised that in the future there must be a much closer coöperation between the Public Health Service, which serves the community, and any clinical service which will serve the individual. The scope and aim of preventive medicine should embrace much of what is now differentiated as curative medicine, and clinical medicine should include much preventive work. The higher development of scientific medicine is to prevent disease in communities rather than to cure it in individuals, and therefore both the preventive and clinical services should work together for this end.

The necessity for a better organised clinical service is also now widely admitted on general principles, but there is considerable divergence of opinion as to the nature, extent, and functions of such a Public Clinical Service. Before stating the views of the State Medical Service Association it will be well to epitomise those of some other associations of medical men.

Views of the British Medical Association.¹

The British Medical Association is in favour of a Ministry of Health the administrative functions of which should be carried out by members representing on an equal footing the preventive and clinical sides of medicine, and in each administrative area there should be whole-time administrative medical officers for both clinical and preventive purposes.

In each local area the medical staff should be of the following classes: (a) exclusively for administration and inspection; (b) resident medical officers to institutions and those in charge of special clinics; (c) pathologists; (d) those engaged in giving advice and treatment to individual persons otherwise than under (b). Class (a) should be whole-time salaried officers; (b) and (c) should be salaried officers, either whole-time or part-time; whilst (d) should not be salaried officers, but should be remunerated either for actual items of work done or for the number of persons for whom they accept responsibility.

There should be hospitals, clinics or treatment centres, and pathological laboratories within each area, with possibilities of consultations open to all who are entitled to the advantages of the public scheme. Voluntary hospitals would be necessary and should be encouraged. Visiting practitioners and consultants at both public and voluntary hospitals should be paid for their services in proportion to the number of patients coming under the public scheme for whom they accept responsibility.

Views of the Panel Medico-Political Union.²

The Panel Medico-Political Union is in favour of a Ministry of Health, but against any form of whole-time State medical service for general practitioners. It would support any improvement of the present State service in any direction which would conduce to the public welfare. It favours a large extension of hospitals and the formation of public clinics and treatment centres. It sees no reason why consultants, specialists, and pathologists should not be salaried officers, whole-time or part-time. It insists that the principle of free choice of doctors and free choice of patients is one of vital importance and must at all costs be retained. If it can be properly safeguarded, the union has no quarrel with a whole-time salaried State service confined to its proper sphere.

Views of the London Panel Committee.³

The London Panel Committee is in favour of a comprehensive scheme of coöordinated provision of preventive and curative treatment of disease for all classes of the community. Under the local authorities there should be established two distinct departments of the medical services, the one dealing with the public health services, the other with individual health questions, both preventive and curative, with close coöperation between the two services. It desires to see the public health services improved.

With regard to the clinical service, it is opposed to any system of whole-time medical officers except administrators, resident medical officers, and practitioners specially devoting

¹ "A Ministry of Health," The British Medical Association.

² The Medical World, March 1st, 1918.

³ The Medical World, March 8th, 1918.

themselves to limited sections of professional work. It considers that medical assistance in the home should be given by a part-time service of general practitioners remunerated by capitation grants and assisted by a part-time service of consultants and specialists.

Finally, as regards institutional treatment it would have municipal hospitals established with general practitioners on the staff, such hospitals to be linked up with the voluntary hospitals, thus leading to the easy transference of patients from the one hospital to the other.

Views of the Society of Medical Officers of Health.

The Society of Medical Officers of Health, being of opinion that many forms of treatment (as for tuberculosis and venereal diseases) are in reality preventive measures, claim that all such measures come under the heading of preventive medicine, and that they can be best dealt with by an extension of the powers of existing Public Health Departments.

Points of Agreement and Disagreement.

It is thus seen that all these bodies are in favour of some form of clinical service so coördinated as to bring within the reach of all such patients as would come under the public scheme the benefit of easy access to consultants and specialists and of institutional treatment. The importance of "free choice of doctor" is insisted upon, whilst a salaried service of general practitioners, either whole-time or part-time, is opposed. All schemes imply some limit to those entitled to the benefits of the service, presumably by means of an income limit.

Views of the State Medical Service Association.

The State Medical Service Association is in entire agreement with these bodies as to the necessity of a complete and well-organised clinical service, including general practitioners, consultants, specialists of all sorts, and pathologists.⁴ It would go further and also include within the organisation of the service dentists, midwives, nurses, and dispensers. Differences of opinion, however, occur when it comes to part-time medical officers remunerated by capitation grants and to the question of excluding patients whose incomes are above a specified limit; for advocates of a State Medical Service are of opinion that no permanent system of medical service can be satisfactory that is not free and open to all and that is not officered by whole-time salaried practitioners. The reasons for these views may be briefly summarised.

A Free and Open Service.

The Public Clinical Service should be free and open to all:—

1. Because health is of national importance, and likewise disease is a national danger. The health of the individual is consequently of national concern.

2. Because health and not the purse is the factor determining the needs of the individual. Disease being no respecter of persons, science in dealing with its prevention and cure cannot afford to be so.

3. Because a service organised for the poor is bound to be unpopular and inefficient, even as the Poor-law service has been in the past.

4. Because modern methods of diagnosis and treatment are becoming so elaborate and costly that people of even considerable means are quite unable to afford them.

5. Because an enormous amount of disease remains undetected and untreated, as shown by medical inspection of school children and medical examination of recruits.

6. Because the service should be in a position to seek out disease in its beginnings and to watch over contacts in cases of infectious diseases, which is impossible under any system of private practice in which the doctor has to await the call of the patient, who may be far advanced in illness before he thinks fit to send for him.

A Whole-time Salaried Service.

The service should be a whole-time salaried service in order—

1. To secure the fullest possible coöperation and mutual help between all practitioners in any given area. This is impossible under a system of remuneration by fees or by capitation grants.

2. To secure a good distribution of practitioners according to the needs of a locality. A comparison has often been made between Bermondsey and Hampstead to show the present inequalities.

3. To secure some regulation of the hours of work and regular holidays. With general practitioners all working together in a given area it would be possible for each of them to have certain hours "off duty" every day and generally one day a week and a regular annual holiday.

4. To secure that every practitioner should have, say, three months' education leave every third year.

5. To secure that men of age and experience shall not waste their time on work that might equally well be done by junior assistants or even trained nurses under supervision, time which might be employed in the more highly skilled departments of medicine and surgery.

6. To secure that there shall be no divided interests between a doctor's public and private work.

7. To secure freedom to all practitioners to give unfettered support to matters of importance to the public health. With members of public health committees or influential offenders against public health interests as private patients this is at present difficult.

8. To set the practitioner free from the competitive struggle and so enable him the better to devote his time to the advancement of knowledge.

Incidentally a whole-time salaried service would have further advantages. Practitioners would be relieved of a great deal of vexatious clerical work, of book-keeping, of sending out bills, and of haggling with patients over fees. There would be no bad debts and no necessity for debt-collecting agents. Salaries would be secure and regularly paid and doctors who have served the community would be entitled to a pension on retirement.

Central and Local Administration.

The scheme suggested by the State Medical Service Association would be centrally controlled and kept up to a high standard of efficiency by the Ministry of Health. It would be administered locally by the county and county borough councils and by the councils of the larger boroughs and urban districts. Hospitals for the use of the service would be greatly increased in number, partly by taking over and re-modelling the Poor-law infirmaries, partly by utilising many of the present military hospitals after the war, and partly by new construction.

The voluntary hospitals should be given the option: (a) of being taken over entirely by the Ministry of Health or the local authorities; (b) of receiving grants from the public authorities provided they were maintained at a proper standard of efficiency; or (c) of remaining on an entirely voluntary basis.

The local administering bodies would be responsible for the cost of their medical services, assisted by substantial "grants-in-aid" from the Ministry of Health according to the completeness and efficiency of the service.

The Service and Free Choice of Doctors.

The work of the clinical service would centre round the hospitals or treatment centres in close touch with the hospitals, and general practitioners would share the clinical work and form an integral part of the staff of the hospitals, so giving opportunities for specialisation. They would work in groups, the number in a group depending on the size and character of the locality to which it was attached. There would be senior assistant and junior assistant practitioners in each group, and promotion would be determined partly by merit and partly by length of service.

Patients residing within the area would ordinarily have the free choice of any of the doctors belonging to the group. In the best interests of both patients and medical staff it would be necessary to devise means for preventing an uneven distribution of work, and also for dealing with objectionable and frivolous patients. This could be accomplished by having a Committee of Assignment of doctors and patients, which would allow, as far as possible, free choice of doctors by patients and of patients by doctors, and this would give as much freedom of choice as there is in private practice at the present time.

In addition to the various grades of practitioners just mentioned, there would be junior to them such posts as clinical assistants, resident medical officers, and medical and surgical registrars, and senior to them there would be

⁴ The S.M.S.A. includes, of course, within these categories women as well as men, and considers that the former should stand on an equality with the latter in every respect.

many central and local administrative medical officers, to all of which posts practitioners should be eligible.

No Bureaucracy.

It will be of the utmost importance to make sure that the Public Clinical Service of the future shall not be organised and managed in any bureaucratic spirit, which might not only make the conditions of service intolerable, but might tend to stamp out individuality and initiative. There will be three interested parties—the tax-payers, the patients, and the doctors—all of whom must have a say in the administration of the service. The tax-payer must have a voice in the expenditure of public moneys, the patients must have a court of appeal if dissatisfied, and the doctors must be left to manage all purely medical matters and must be given the predominating voice in determining the conditions under which they will serve the community. The function of the central organisation must be to stimulate and suggest and see that an active progressive spirit is maintained, but freedom must be left to each local authority and medical group to expand and develop its plans.

The Transition Stage.

Whilst a service such as that indicated above is thought to be ultimately in the best interests of the public and of the medical profession, it is fully recognised that it would be impossible and unfair to existing interests to force it suddenly on to the profession by Act of Parliament. There must be a transition stage during which considerable latitude must be given to men and women now in practice.

It has already been suggested in many quarters that the medical benefits of the National Insurance Act should be extended to all dependents of those now insured and to all Poor-law patients. This may be the line eventually adopted, though it will be regrettable unless drastic amendments to the National Insurance Act be previously made. Later on, by gradually raising the income limit, the scope of the service could be widened more and more until at last no one would be excluded from the benefits of the service.

At first, therefore, it may be necessary and probably beneficial, in order to avoid one medical service for the rich and another for the poor, to have part-time medical officers of the Public Clinical Service. On the passing of any Act of Parliament establishing a public service all registered medical practitioners might be given an option, to be exercised within a reasonable time, of becoming either a part-time or a whole-time medical officer, but anyone qualifying and electing to join the service after the passing of the Act should be accepted only as a whole-time salaried officer. In this way there would gradually be built up a whole-time salaried medical service.

As regards the method of remuneration of those electing to serve as part-time medical officers, it may be either by salary or by a capitation grant, only in the latter case the number of panel patients allowed should be strictly limited, as the practitioner's time would be partly occupied in private work. Those electing to devote their whole time to public work should be paid by salary, which should be based upon their previous professional status, and they should be guaranteed a pension and some compensation for the capital value of the practices which they abandoned. The latter could take the form of a capital sum on retirement or an increased pension.

Even when the public medical service became free and open to all, there would probably always be a few patients who would prefer not to avail themselves of it, and similarly there may always be a few medical men who would prefer not to enter the service. There would be no objection to the latter competing for the former in private practice, provided always that they conform to all laws passed on behalf of public safety and national health.

Now is the Time.

In conclusion, it may be pointed out that there are several reasons why a Public Clinical Service should be considered at the present time.

In the first place, the war is depleting the ranks of the medical profession by death and disablement, and at the same time conscription is so denuding the medical schools that there must be a serious shortage of doctors in the near future which it will take many years to make good, and the evils of which can only be overcome by organisation and coöperation.

Alongside the shortage of doctors, the work which must be undertaken is likely to increase. There will, unfortunately, be a large number of soldiers permanently disabled for whom medical supervision will be necessary, and there will be many widows and orphans unable to pay doctors' fees, but whose health must be preserved for the sake of the rising generation. Again, it is not improbable that there may be outbreaks of bacterial disease introduced into this country by the home-coming Army.

Again, some 10,000 medical practitioners have left their peace-time work and joined the R.A.M.C., and, in spite of the good intentions of their colleagues who have remained at home, their practices, to all intents and purposes have passed into other hands. A practice can be left in charge of a colleague for six months or so without very serious damage, but not so for three or four years. When the men of temporary rank in the R.A.M.C. return they will have little heart to set to work to rebuild their lost practices, but they will probably be ready and willing to continue to serve the community by administering to the needs of the civil population under conditions of work not unlike those under which they have served the military forces.

Lastly, at the end of the war there will be a great number of well-equipped temporary hospitals, nursing staffs, and a large accumulation of motor ambulances, motor-cars, surgical instruments and appliances, and pathological and X ray outfits which could be utilised with great economy for the establishment and maintenance of a Public Clinical Service, and for special hospitals and sanatoria required by the preventive branch of the National Service.

Some form of Public Medical Service is bound to come in the near future, with whole-time salaried medical officers, if only because from the administrative point of view it will be so much less complicated and so much more economical than any form of part-time service. It is therefore urgently necessary that all practitioners should unite to ensure that when it does come it shall be a service that shall be honourable to the best traditions of the profession and of the greatest possible service to the community.

MEDICINE AND THE STATE.¹

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THE proper relationship which should subsist between the State and the profession of medicine is a question in which a constantly increasing number of medical men as well as of the general public is beginning to take an active interest.

Present State of Opinion.

At the time of the introduction of the Insurance Act the medical profession, so far as it had given thought to the matter, was roughly divided into three parties holding diverse views upon this subject.

An extreme right party held that beyond securing the proper education of registered practitioners, and providing from amongst them a service of sanitarians to safeguard our system of drainage and to control epidemics of disease, the State should leave the medical profession a free hand to carry out its beneficent work in absolute independence of all Government control.

An extreme left party saw salvation in the proposal of the Fabians that the State should become the direct employer of every medical man to whom it granted registration, and should make itself responsible for seeing that its medical servants faithfully carried out its instructions in offering to, or forcing upon, each member of the community such medical ministrations as the State deemed necessary for the maintenance of his physical health.

Between these two sections was a larger central party who, recognising the impracticability, whatever they might think of the idealism of these extremists, held that the time had arrived for the State and medicine to enter into an honourable partnership in order to secure that the benefits of our rapidly advancing medical science should be made available for the population as a whole as well as for each individual, irrespective of wealth or social position.

¹ An address to the Southwark Panel Practitioners' Association, May 31st, 1918.