Medicine and the state : the relation between the private & official practice of medicine, with special reference to public health / by Sir Arthur Newsholme.

MEDICINE AND THE STATE

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INTERNATIONAL STUDIES

On the Relation between the Private and Official Practice of Medicine, with Special Reference to the Prevention of Disease

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MEDICINE AND THE STATE

THE RELATION BEWEEN THE

PRIVATE & OFFICIAL PRACTICE *of* MEDICINE

WITH SPECIAL REFERENCE

TO PUBLIC HEALTH

by

SIR ARTHUR NEWSHOLME

K.C.B., M.D., F.R.C.P.

WITH FOREWORD BY

WILLIAM H. WELCH,

M.D., LL.D.

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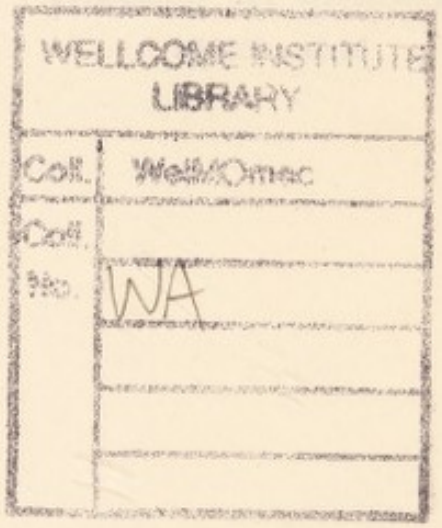

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FOREWORD

By WILLIAM H. WELCH, M.D., LL.D.

Having been greatly interested in these "Studies" from their inception in 1928, I am glad to respond to the request to write a Foreword to this volume on *Medicine and the State*, concluding the series of International Studies by Sir Arthur Newsholme, conducted for the Milbank Memorial Fund, "On the Relation between the Private and Official Practice of Medicine, with Special Reference to the Prevention of Disease." This final volume, as explained by the author in his Introduction, is independent of the three preceding volumes of the *International Studies*, although its conclusions are based chiefly on the facts collected and analysed in these volumes.

The circumstances which aroused the special interest of the Milbank Memorial Fund in the very lively, present-day question of the sphere of the private physician in the field of public health have been indicated by Mr. John A. Kingsbury, the Secretary of the Fund, in his Foreword to the preceding volumes. Not the least of the many important services rendered by the Milbank Memorial Fund to the promotion of public health has been the generous support given Sir Arthur Newsholme in his studies in the vast and difficult field covered by the four volumes of the series now completed.

In Sir Arthur Newsholme the Fund had the great good fortune to secure an investigator and student of the problems to be attacked of unrivalled qualifications for the task. Following several years' experience in private practice, Sir Arthur served for nineteen years as Medical Officer of Health of Brighton, acquiring there by his contributions and work a reputation which led to his appointment as Principal Medical Officer of Health of the Local Government Board, his service in this capacity terminating with the creation of the Ministry of Health. Following this he

rendered invaluable aid for two years in launching the new School of Hygiene and Public Health of Johns Hopkins University as Lecturer on Public Health Administration. During this latter period he acquainted himself with public health conditions in America. Not merely his official positions and activities, but also his many published contributions in separate works, in reports and in journals have placed Sir Arthur among the foremost authorities in sanitary science and art in the world.

The readers of this volume, as well as of his other publications, cannot fail to be impressed with Sir Arthur Newsholme's command not only of the problems of public health but also of those of medicine in general, of society and government. They will recognize an unusual combination of powers of critical judgment with those of constructive suggestion based upon broad humanitarianism united with practical consideration of what is attainable under existing conditions. Their interest will be sustained by a lucid and often vigorous English style interspersed with occasional epigrams and aphorisms. Random selections of such pithy statements, which might be indefinitely multi plied, are: "Average humanity has not yet learned to use communal privileges with due regard to communal economy in the absence of a personal motive for carefulness," or "the creation of new and independent machinery whenever a new need emerges has been the bane of satisfactory and economic progress," or "patients have little skill in assessing medical skill; and their choice of doctor may depend on the cut of his coat, on his social qualities, and sometimes, alas! on his plausibility in explaining phenomena which he has not accurately analysed," or "the family physician, potentially and sometimes actually, is the most important single agent engaged in medical work," or "health is worth whatever expenditure is efficiently incurred in its maintenance or to secure its return."

Although perhaps sufficiently evident from the titles of the volumes in this series, a word may not be out of place in this connection concerning the scope of these studies

and conclusions. They are concerned with the whole field of medical services, both curative and preventive, to the community, and include consideration not merely of the medical branches of public health work in relation to the private practitioner, but also of private, insurance and hospital practice. Indeed, a main purpose has been the collection and presentation of facts and conditions with a view to their utilization in efforts and proposals looking to the unification, combination and co-ordination of all the varied medical services for the greatest benefit to the community.

Notwithstanding this broad outlook especial attention has been given both in the three volumes of surveys and in this final volume based on these surveys to the various developments, agencies and tendencies which have caused friction between private practitioners and public health authorities. The evidence drawn from inquiries made in different European countries and the statements and opinions expressed by Sir Arthur Newsholme on this controversial subject are of great significance and will attract wide attention.

There can be no dissent from Sir Arthur's remark that "the increasing accuracy and complexity of medical science . . . is a chief cause of the modern problems of medical care with which this volume is concerned" or, from the conclusion following his international inquiries, "that in every country as civilization advances and the public conscience is aroused, not only is public health work in its limited sense increasingly developed, but there is also a corresponding increase in communal effort towards satisfactory and complete medical care for the sick."

There will be also wide approval of the statement that the family, not the individual, should be the unit in private practice, but how far short we are from realization of that ideal of family practice pictured by Sir Arthur when the family doctor will concern himself with prevention as well as with treatment and will find provided for his needs consultant, specialist and other auxiliary services!

Inasmuch as the surveys were limited to European countries, the discussions, proposals and conclusions of the present volume relate only to conditions in these countries, in all of which sickness insurance in varying form exists. All that need be said in this connection concerning the application of European medical and sanitary practice to conditions in America has been expressed by Mr. Kingsbury in his Foreword to the preceding volumes and by Sir Arthur Newsholme in his Introduction to the present volume and in occasional incidental remarks in the text.

During the period when Sir Arthur was pursuing his survey in Europe and preparing the volumes for publication, many of the problems here considered, which in recent years had become increasingly urgent, were engaging the attention of the American Committee on the Costs of Medical Care, which during the past three or four years has spent upwards of a million dollars on its inquiries. Sir Arthur's studies, already published, have been of great value to the Committee, and there is little doubt that his conclusions will be most suggestive in the preparation of the Committee's final report and recommendations.

The three volumes of this series already published, and especially this final volume on *Medicine and the State*, constitute a contribution of the first importance to the elucidation of essential problems of modern private and public medicine and hygiene. No discussion of these problems can hereafter ignore the facts here collected for the first time in compendious form and the views authoritatively presented. Not only physicians, sanitarians, nurses and social workers, but all interested in the solution of a group of social problems of high importance as well as complexity are indebted to Sir Arthur Newsholme for these significant studies and to the Milbank Memorial Fund in making the investigations and publication possible.

WILLIAM H. WELCH

February 1932

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INTRODUCTION

In three volumes of *International Studies on the Relation between the Private and Official Practice of Medicine, with Special Reference to the Prevention of Disease*, I have set out a brief outline of facts ascertained by me in the course of an investigation into medical practice in a number of European countries. The inquiry was made for the Milbank Memorial Fund of New York, and was intended to show the actual conditions of public and private medical work in the countries visited by me, in the hope that some light would thereby be thrown on the best methods "to ensure co-operative service between the private practitioners of medicine and public health authorities in conserving the health of the public".

The inquiry, being the work of one person, could not possibly be exhaustive in its scope. It inevitably followed the method of sampling, those parts of medical practice being selected in which, in various countries, the greatest difficulty had been experienced as to the relative functions of private and public (including hospital) medicine. The investigation was based on the assumption that, in future practice, blundering experiment and erroneous procedures can best be avoided when one knows what others have done and what has been the outcome of their practice.

The present volume is independent of the three volumes mentioned above, although the conclusions stated in it are based chiefly on the facts previously collected and analysed. Where the facts previously set out shed light on the problems discussed in this volume, I have summarised them; but for a more complete account the fuller statement in those volumes should be consulted.

I am solely responsible for the contents of the present volume. Many opinions are stated in it which are essentially controversial; and although they are based on the experience of a long professional life, I fully realise the perplexing

and sometimes conflicting factors which appear to impel observers to opposing conclusions.

The general plan of the volume is as follows: In the first part are brought together general considerations as to medical care, and the machinery for obtaining this care and its cost; this is followed by a review of national provisions for medical care of the very poor, of hospital treatment in relation to private practice, and of insurance medical practice.

In the second part I have given an outlined description of the four chief medical services instituted in recent years by public health, including educational, authorities, namely the medical care of maternity, of childhood and youth, and the treatment and prevention of tuberculosis and venereal diseases.

The third part comprises a more general review with critical discussion of the relation between hospital authorities, public health authorities and insurance authorities respectively and private medical practitioners, as bearing on the future of private medical practice.

Some surprise may be felt at the relatively large space devoted to hospitals and hospital policy. A study of the growth of the forms of medical practice which are not private medical practice justifies this. In most countries the fear has been expressed by private medical practitioners that they are being subjected to "encroachments" by public agencies, and that there is risk of private medical practice being almost "squeezed out" of being. Among public agencies I include hospitals and clinics whether organised by voluntary or by official bodies. To whatever extent this fear is based on facts, a study of the historical facts and of the contemporaneous experience of European countries shows that—assuming that the domiciliary care given in insurance medical work is regarded as private medical practice—it is hospitals which have been responsible on the largest scale for the "encroachments" on private medical practice. Before public authorities began

to organise medical treatment on a considerable scale—beyond providing hospitals for the destitute and for acute infectious diseases—general and special hospitals of charitable origin had already detached a large part of total medical practice from private practitioners of medicine. The needs calling for this segregated development are set out on page 76 *et seq.*: here I content myself with drawing attention to the historical sequence of events, in order to stress the point that to a preponderant extent "encroachments" on private medical practice have been initiated by and continue to be due more and more to the activities of social workers and of medical practitioners themselves, impelled by the opportunities for exercise of special skill and by the benefits which accrue from this treatment of patients in hospitals.

Hence, even if these "encroachments" be regarded as something more than the inevitable consequence of the growth of medical science, it will be remembered that hospitals are chiefly responsible for them.

In the preceding paragraph I have, for the nonce, excluded the various national systems of insurance for medical treatment from the list of "encroachments" on private medical practice, and have assumed that insurance medical treatment is not the so-called State Medicine. But inasmuch as in insurance medical work group or national conditions of employment are in force, and the personal freedom of contract between doctor and patient is thus limited, insurance medical practice in European countries, in its compulsory and semi-national varieties, has become a form of Group Medicine which is State Medicine. As conducted, it is almost everywhere consistent with continued private medical practice; and thus the antithesis between State Medicine and private medical practice is seen to fail. They can and do co-exist.

Let me state the sense in which I use the terms Group Medicine and State Medicine. A number of doctors may practise in a group, the patient paying for each consul-

tation or visit made by any member of the group as if a single doctor alone were engaged, though possibly at a modified rate. This is an important form of Group Medicine. But with this exception the various forms of Group Medicine and State Medicine embrace all medical activities which are not the exclusive result of a direct contract between an individual doctor and an individual patient.

Within the latter category are included the attendance of all its work-people by an industrial firm; the medical work of a voluntary insurance society; in Britain the arrangements for the medical care of postal officers and police constables; the medical provision, domiciliary and institutional, made by public assistance or public health authorities; the Swindon scheme (Volume III of *International Studies*, p. 236); the Highlands and Islands scheme in Scotland (Volume III of *International Studies*, p. 471); and the provision by trades unions and other organisations of special medical treatment and convalescent homes come in the same category. All of these are examples of Group Medicine, viewed from the standpoint of the "consumers" of medical skill. On the other hand, private practice still exists, not only in its ordinary forms, but also when a group of doctors—the "caterers"—supply medical care to any person who applies for it, whether the caterers are paid according to the number of "medical acts", or whether they contract to give medical attendance for a fixed periodical payment.

In reviewing the chief varieties of medical practice, and in attempting to indicate their relative merits, an obvious precaution needs to be emphasised. A method of medical supply may be good in principle, although in practice it works with friction and inefficiently. Severe criticism of certain aspects of insurance medical practice will be called for, but the insurance principle as applied to medical care is good; and what is needed, when the principle is applied badly, is reform and not annihilation.

In apportioning credit and criticism I cannot hope to satisfy either of the schools of thought, represented by

those who wish for a State[1] system of medicine in the fullest sense, that is, a service worked by whole-time medical officers; or the body of general practitioners of medicine who wish to be left alone, and who resent every additional so-called encroachment on their work.

Nor can I satisfy those who bring forward "cut-and-dried" schemes of medical co-operation and supply, which are either not related to things as they are or only slightly so. Long experience of private and hospital medical practice, and still longer experience of public health administration, have convinced me that the only method of advance which is permanently satisfactory is broad-based on what already exists. It is true that development or progress at any one point of an existing organisation means some lop-sidedness. The experience of the lowly amœba is repeated in human social experience. Whenever food is assimilated by the amœba a temporary distortion of shape occurs. But there is a vital co-operating whole; whereas in social life confusion, friction, extravagant use of energy to attain a given result, or even failure to function, are apt to occur when separate organisms attempt side by side to undertake unrelated or overlapping duties.

In the following chapters I have endeavoured to deal with the various pseudopodia of the amœbiform development of medicine, each of them in relation to the rest, and still more in relation to the welfare of the public who, all will agree, are the persons primarily and chiefly concerned. And for this reason I cannot—as I have said—expect the approval of zealots of any medical faith. But through this attempt I may, I hope, have helped towards a higher appreciation of the unity of medical practice,

[1] The word "State" is used in the sense of a national unit of government. In Great Britain and Northern Ireland there are three State medical services for all official medical work (public assistance, public health, and insurance). In Germany there are 18 federal States, and some medical provisions are special to each State. Identical sickness insurance provisions apply to the whole of Germany, as they do to the whole of Great Britain. In the term State Medicine I include the medical activities of municipalities and other local authorities, and of voluntary charitable organisations. For other definitions of a State Medical Service, see pp. 252 and 256.

general and specialised, institutional and domiciliary, preventive and curative, and of the importance of intimate and daily co-operation between the different agencies concerned.

One point stands out with special clarity from my inquiries. All reforms and advances in the practice of medicine, including those described or adumbrated in this volume, if they are to be applied to a large part of the population in any country known to me, call for one of two lines of action, generally for both. They necessitate some subsidisation of the necessary medical care out of general taxation or the exaction—experience shows the need for compulsion if this exaction is meant to be universal—of weekly payments while in health to ensure personal and familial medical care when illness comes. The scope of each of these two forms of compulsory provision for contingent needs (for taxation, of course, is compulsory) is illustrated in European experience. This will be evident to those who read this volume, still more if the three volumes mentioned at the beginning of this introduction have been perused. No scheme of compulsory medical insurance for wage-earners has hitherto given without assistance from State funds all the medical aid which the sick need; and throughout Europe aid from the products of taxation has been needed to ensure adequate hospital provision, over and above the insurance funds secured by contributions of the employed, the employer, and the State.

These points are exemplified particularly in British experience; but in other countries, including the Scandinavian and the German, the same conclusion is reached.

This being so, the need for unification of national and local medical services carried on at the expense of the taxpayer with the services provided out of insurance funds is obvious; and it is equally certain that the *nodus* of unification should be in the hands of the representatives of the taxpayers, namely, the public authorities elected by them.

I am aware of the difficulty associated with this conclusion, a difficulty especially seen in dealing with insurance

finance and medical practice, and I have, therefore, devoted some space to discussing whether democracy can be trusted for this work (p. 49).

This doubt illustrates a problem which persistently obtrudes itself, and which underlies the entire problem of medical care at the expense of public funds, including medical care and financial benefits under insurance for a third of the population in Britain, and an even larger proportion in some other countries.

This underlying problem is that of the ethical aspect of medical practice; and although my remarks on it are necessarily brief (p. 282), I regard the future of medicine and public health as in large measure conditioned by the level of moral worth of the people concerned.

This point arises especially in medical insurance work, necessitating medical certification of incapacity for work. The defects of this service arise largely from the common faults of human nature from which patients and doctors are not exempt; and these faults do not condemn the policy of sickness insurance, unless they prove to be irremediable and render insurance administration hopelessly extravagant.

With few exceptions, I have not ventured to suggest the application of any developments of European medical practice to the circumstances of the United States of America; and, with few exceptions, I have purposely avoided reference to American experience in which in some respects similar developments have already occurred.

The separate existence of its forty-eight sovereign States may imply that future developments of medical administration in the United States will occur on several lines. Local experimentation is good, if by this means extravagant and undesirable plans such as are exemplified in some European countries may be avoided before the entire country is committed to a given course. I venture, however, this general remark. In providing additional medical aid, in part at the public expense, it is important to provide first what is most lacking, and what the people themselves experience the greatest difficulty in securing. In these

respects, hospital provision, the service of consultants in difficult cases of illness, and the provision of ancillary diagnostic facilities take precedence over the provision by insurance of a family doctor.

Whether European experiences to a smaller or larger extent may be made applicable to American conditions is for the reader, and especially for the medical and lay administrators in the States, to determine. My task is completed by the present review of international experience and by a critical account of the advantages and defects of this experience. I have endeavoured, however, to make the investigation dynamic, and to indicate lines of evolution as well as to describe existent conditions.

But I have not engaged on a propagandist task. The aim throughout has been to favour what conduces to the public welfare and through that of each member of the community. I am profoundly convinced that in the fulfilment of this aim, what is best for each person, and especially for every patient, is also best for the doctor, and is in the highest interest of the entire community in which both patient and doctor are units.

It only remains for me to express my profound obligation to the Directors of the Milbank Memorial Fund. Throughout the prolonged investigations—the general results, of which have been published in three preceding volumes and in the present independent volume, in which are stated my main conclusions on medical policy—they have left me entirely free in the pursuit of my inquiry. The Milbank Memorial Fund is not in any respect committed to any opinions or conclusions stated in these pages.

ARTHUR NEWSHOLME

January 1932

PART I

CHAPTER I

GENERAL CONSIDERATIONS BEARING ON MEDICAL CARE

CIVILISED communities have arrived at two conclusions, from which there will be no retreat, though their full realisation in experience has nowhere been completely achieved.

In the first place, THE HEALTH OF EVERY INDIVIDUAL IS A SOCIAL CONCERN AND RESPONSIBILITY; and secondly, as following from this, MEDICAL CARE IN ITS WIDEST SENSE FOR EVERY INDIVIDUAL IS AN ESSENTIAL CONDITION OF MAXIMUM EFFICIENCY AND HAPPINESS IN A CIVILISED COMMUNITY.

The requirements for securing medical care, including the hygienic care of individual health, must vary according to national and local circumstances, but no responsible person denies or doubts the necessity of providing adequate medical care irrespective of the ability of the individual to pay for it.

Past history and the international experiences which have been summarised in my three recent volumes of *International Studies on the Relation between Private and Official Practice of Medicine, with Special Reference to the Prevention of Disease*, leave no doubt that everywhere we have arrived at these universal postulates.

When medicine was an empirical art, swayed by doctrines often mistaken; when the possibilities of surgery were very restricted, and when hospitals were in the main merely lodging-houses for the sick, the medical part of the problem of care of the sick was relatively unimportant. Lodging and nursing with the provision of medical simples commonly were the most the patient could expect, and any additional service the patient received might easily signify ignorant or even mischievous meddling. For the destitute poor emergence from this position has been slow

and gradual; and the history of medical, especially institutional, aid available to this class up to the middle of the nineteenth century is one of overcrowded hospitals, unchecked contagion, unskilled nursing, and inadequate and oft-times unscientific medical care. And the same conditions prevailed, though to a lesser degree, in both the domiciliary and the institutional medical care of all classes of the community.

Medical empiricism has had some triumphs, but, in so far as treatment has been based on doctrines, it generally has been maleficent. It is chiefly in the last eighty years that medicine has gradually emerged from its pre-scientific condition, and that treatment has come to be governed more and more by accurate knowledge of human physiology and pathology, the indispensable conditions of satisfactory medical care. It is unnecessary here to trace the steps by which medicine has come out of darkness into light. The subject has been dealt with fully by many authors, and I have given a sketch of it in two small volumes, *The Evolution of Preventive Medicine* and *The Story of Modern Preventive Medicine* (The Williams & Wilkins Company, Baltimore, Maryland, U.S.A.).

Stages of Medical Advance

Surgery has achieved spectacular progress. The Listerian antiseptic treatment of wounds has vastly extended the field of cure of disease. Recovery from accidental injuries, and from conditions included in the former limited range of imperative surgical intervention, as, for instance, operations for strangulated hernia, has become universal in so far as the intervention itself is concerned; and many conditions formerly inoperable and incurable have been rendered operable and curable. The achievements in the directions of improved health and prolongation of life have been colossal.

The increase of specialism in medicine is correspondingly great. Specialist medical help is increasingly demanded by all classes. As knowledge has extended and become more

technical it has ceased to be possible for a single medical practitioner, however well-trained he may be and however diligently he strives, to keep pace with the growth of knowledge in all parts of his work, or to acquire the necessary specialised skill to utilise such knowledge. Dentistry has become an almost separate profession; ophthalmology in the main is a specialist problem; while the more serious forms of operative surgery are rightly relegated to those who devote themselves chiefly to such work. (See also pp. 40 and 262.) New developments of physical science have led to specialism in roentgenism, and in treatment by radium, X-rays, sun-baths, or electricity. And this list is far from exhaustive. Thus duodenal ulcer is now less frequently treated by merely prescribing for indigestion than in the past; and the family doctor more and more calls for the aid of the pathologist in securing examination of his patients' blood, as a means of diagnosis, and as a basis for the treatment of diabetes, syphilis, and other diseases.

ALL THESE NEW DEVELOPMENTS CALL FOR CO-OPERATION BETWEEN THE GENERAL MEDICAL PRACTITIONER AND CONSULTANTS to an extent not previously dreamed of, and the adjustment of this co-operation evidently is a delicate task, involving intricate financial and other problems.

The increasing accuracy and complexity of medical science then is a chief cause of the modern problems of medical care with which this volume is concerned. But progress in science would not have been followed by action to the extent already attained had it not been associated with the development of "a large sympathy of man with man" (Simon), and with the growth of representative government, making action based on this motive generally practicable.

The growth of the SENTIMENT AGAINST SUFFERING has been more rapid and of wider scope since the last decade of the eighteenth century than in any previous period of human civilisation. In Great Britain it showed itself as a by-product of the missionary work of John Wesley; and the work of John Howard in prison reform, of Wilberforce

and his co-workers in securing the abolition of the slave-trade in British West Indies, and of Lord Shaftesbury in many branches of industrial and sanitary reform, owed much to the revival of evangelical Christianity. There began then a rebellion against an exclusively economic outlook on social relations which is still in full tide. The reform of the barbarism of our earlier criminal law had a similar origin; and in dealing with crime, destitution, industrial evils and lack of sanitation, or with medical neglect, there has been introduced THE DRIVING POWER OF MERCY; and the increased sensitiveness of the public conscience has made avoidable suffering repugnant to national sentiment. Twinges of conscience have been the greatest antiseptic in our time in promoting physical as well as moral health.

In no branch of social work has there been greater improvement than in that of medical care; and though it may not in all respects be fully realised in practice, there is an unanimous acceptance of the axiom that NO SICK HUMAN BEING MUST BE ALLOWED TO LACK ALL THAT IS PRACTICABLE AND REALLY NECESSARY FOR HIS SKILFUL AND HUMANE TREATMENT AND FOR HIS EXPEDITIOUS RETURN TO HEALTH, or failing this for his comfort while ill. In this, as in other respects, there is gradually being established what Lord Passfield and Mrs. Sidney Webb have called a NATIONAL MINIMUM, in which each person must participate. This is being applied to sanitation, to housing, to education, to safety, and even to hours of work and wages, as well as to medical care.

The *growth and extension of representative government*, for local as well as for national affairs, has expedited the needed action. Those needing some aid in sickness are a majority of the community in most countries; and because of this there is an increasing tendency to provide the needed aid at the expense of the communal purse.

Medical aid by Governments was preceded by and is still associated with similar aid given by charitable organisations, though in most countries the greater part of such service is now provided at the expense of the taxpayer.

Altered economic circumstances have largely conduced to the same end. Urban is largely replacing rural life, and even those dwelling in rural districts can now be brought into touch with skilled aid. Large-scale industries have multiplied, and their proprietors are beginning to realise that efficiency and output in large measure are dependent on the health and welfare of the individual worker. The increase of extra-domestic work—for women as well as men—has meant the provision of medical arrangements beyond those obtainable at home; and so, not only has industrial hygiene advanced, but also special doctors and nurses have been provided who devote themselves to the medical care of industrial and commercial employees. (On other instances of segregated medical care, see pp. 130, 190, 197, 215.)

Universal elementary education has largely increased the demand for medical aid. The hygienic schoolmaster is abroad. Sometimes he has been flamboyant in his methods and excessive in his promises; and there can be little doubt that hygienic instruction integrated with every part of school life is more fruitful of results than intensive campaigns for a specialised purpose. However, both are valuable. Universal systematic medical inspection of school children and younger children and the detection of defects and disorders which otherwise would go neglected are even more important in all countries at the present time. Perhaps the general effect on the life and welfare of the families concerned, and especially on their attitude to health and medical needs, is still more valuable than the direct benefits of school hygiene and medicine.

There has grown up an increasing realisation that a large proportion of total medical work is belated, and is comparable to locking the stable door after the steed has been stolen. This has been abundantly demonstrated in school medical work, which has hitherto been obliged to concern itself too largely with the "end products" of disease. Hence action has been urged and partially taken to secure earlier diagnosis and earlier treatment of the sick and thus to reduce the duration and severity of illness. We may regard it as

axiomatic that THE PREVENTION OF UNFITNESS OR ITS CONTINUANCE IS A MAIN FUNCTION OF PUBLIC HEALTH in its widest sense. Whether medical treatment necessitated by this extension of preventive medicine should continue to be an organic part of official public health work is discussed on page 64.

The Linking of Communal and Personal Medicine

The forms of medical work hitherto envisaged relate to the individual patient. But the impetus to increased medical care of the individual has grown in no small degree out of communal measures for public health. By public health work I mean the organised efforts of communities to secure a greater degree of well-being of the people acting either through their official governing bodies, or through voluntary associations, which function in default of the official bodies and may serve as pioneers to stimulate official action. These official and quasi-official efforts have been directed toward removing the more serious preventable causes of disease that are controllable by general action. Chief and foremost among such measures have been the institution of safe communal water supplies, the removal of organic refuse from houses and their entourage, the establishment of drainage and sewerage, the abatement of nuisances, of industrial dust, of smoke nuisance, general improvement in housing, and protection of milk and other foods. The isolation of the infectious sick and the quarantine of contacts are both individual and communal measures. These and similar measures have been very effective in reducing disease, especially dysenteric and enteric diseases, in preventing epidemics due to milk or shell-fish contamination, and more widely in improving the health of the people.

When public health workers perceived that their work, while eminently successful in many directions, failed partially to reduce infant mortality and puerperal complications, their work was extended to the supervision of the work of midwives, and to the various branches of infant welfare work. Milk depots, schools for mothers and infant con-

sultations, associated with home visits by health visitors, were inaugurated, and a phenomenal decrease in child mortality has been experienced. Infant welfare work was concerned with hygienic advice and with the treatment of minor ailments. The effectiveness of the hygienic advice given has been enormously increased by our improved knowledge of nutrition and dietetics, especially of protective foods, and thus rickets has been added to the list of disappearing diseases, and the general standard of infantile health has been vastly improved.

Personal hygiene has secured triumphs over disease in the individual as striking as those previously attained by measures of environmental hygiene affecting the health of the aggregate of mankind. And by the marriage between personal and communal hygiene, the individual medical adviser—the family doctor whenever practicable—has it in his power to become an officer of health as well as a physician for the sick.

The different aspects of medicine, including preventive medicine, indicated in the preceding paragraphs overlap historically and in current practice. The progressive transformation of Medicine into Preventive Medicine has many aspects. Thus it is concerned with:—

1. The treatment of grave disease and its early detection as a means for more expeditious treatment;
2. The removal of external menaces to health by sanitation and social measures;
3. The isolation of the infectious sick and immunisation against infection;
4. The treatment of minor ailments, such as caries of teeth or septic foci, which may result in more serious illness;
5. Physiological treatment of those in health with a view to increased fitness and the prevention of illness. In this category comes much antenatal and maternity care, the hygiene of infancy and childhood, and the use of physical agencies, e.g. exercises, sunlight, etc., in improving health.

One must guard against exaggeration of our present knowledge and power. Much disease remains the causation and means of prevention of which are unknown, and

prompt treatment is the nearest approach attainable to personal hygiene. Thus a vast number of surgeons can successfully remove a diseased appendix or remove adenoids; but we still do not possess accurate knowledge as to the prevention of either of these conditions.

From the preceding elementary sketch of the circumstances of our problem the following general conclusions emerge.

Summary of General Considerations Bearing on Medical Care

1. The health of every individual is a social concern and responsibility.

2. Medical care in its widest sense is an essential condition of maximum efficiency and happiness in a civilised community.

3. The new developments of medicine call for co-operation between the general medical practitioner and consultants.

4. No sick person can be allowed to lack all that is practicable and really necessary for his skilful and humane treatment, and for his expeditious return to health, or failing this for his comfort while ill.

5. Whether it be due to belated diagnosis or neglected treatment, the prevention of continued unfitness is a main function of public health.

6. Vastly more can now be done to treat disease successfully, to prevent its later consequences, and to prevent its recurrence, than has been possible in the past.

7. The extent and complexity of professional skill required for this end have vastly increased.

8. These changes profoundly affect and modify the relationship between the private medical practitioner and his patient.

9. The changes are especially seen in the increased treatment of sickness among all sections of the community in general and special hospitals; and they have, more recently, been accentuated by the increasing part which public authorities now take in the diagnosis and treatment of illness.

CHAPTER II

MACHINERY FOR SECURING THE PREVENTION AND TREATMENT OF SICKNESS

If the quasi-axiomatic statements set out in Chapter I, page 29, be accepted as our starting-point, we can next consider the means for accomplishing the work to be done and for meeting the expense which will be incurred (Chapter III).

Evidently the duty felt by social well-wishers to prevent, or failing this to curtail and diminish, the suffering associated with ill-health, involves (1) the provision on an adequate scale of the necessary agents and agencies to this end; and (2) for those unable to pay or able to pay only a part of the cost, adequate financial aid from taxes, from insurance, or from charitable funds. The mechanism to be considered in this chapter cannot be maintained in efficient working order without the necessary funds.

Rational attack on sickness, that is, attack which is scientifically directed and adequate, depends in the first instance on our knowledge of the causation of disease, including a full knowledge of the auxiliary conditions which favour its onset. Insanitary dwellings, defective drains and closets, impure or inadequate water supply, dusty occupations, overwork, alcoholic indulgence, gluttony, and more general dietetic errors and deficiencies, as well as persistent mental stress, all come under this heading.

Unfortunately we are still ignorant of the causation and means for the prevention of many diseases. This to some extent is true of cancer. In the prevention of certain communicable diseases, for instance, catarrhs, influenza, and pneumonia, we are almost completely impotent; and of many chronic conditions, as, for instance, arterio-sclerosis, we know relatively little, except in so far as they owe their origin to earlier acute or chronic infective diseases.

THE APPLICATION OF ALL KNOWN PUBLIC HEALTH AND SOCIAL MEASURES CONDUCING TO THE DIMINUTION OF SICKNESS IS OF ESSENTIAL IMPORTANCE IN THE ORGANISATION OF THE COMMUNITY, as thus the task of the physician and surgeon can be correspondingly decreased.

It is equally evident that THERE IS NEED OF CONTINUED AND EXTENDED RESEARCH, to find out the secrets of nature and to track out the sources and contributory causes of the illnesses which we are still unable to prevent, or of which our treatment as yet is futile.

Nevertheless our knowledge of prevention of disease is already vastly more extensive than our application of this knowledge, as Dr. William H. Welch, of Johns Hopkins University, has repeatedly emphasised; and therefore educational measures, including those already mentioned (p. 33), form an indispensable part of the task of the medico-hygienic reformer. A few further comments on EDUCATIONAL WORK IN HYGIENE are relevant here. A warning has already been given against the occasional extravagances and exaggerations of popular propaganda: these may be as futile as the undiscriminating distribution of health pamphlets and leaflets. My own view is that the four most fertile forms of educational work in hygiene are:—

1. Health teaching to those actually engaged in caring for the sick, whether physicians or nurses, and students for such future work.
2. Health teaching to those who, at infant welfare centres or elsewhere, deliberately attend in search of such teaching.
3. Health teaching to the members of official health organisations and of voluntary agencies who organise public health measures and the care of the sick.
4. Health teaching as a systematic part of school life.

The first-named of these is fundamentally important, and a note or two may be made on it here, as it has direct bearing on the new orientation which has come to medicine.

It is important that the medical student should be taught every subject in his curriculum from the point of view of preventive as well as of clinical medicine, in order that he may become a medical officer of health within the

range of his private practice. One great difficulty in the past has been the doctor's inadequate acquaintance with the normal infant; and for this reason the increasing attendance of medical and other students at child welfare centres is particularly important.

The trained nurse, while nursing the sick, should similarly be the means of teaching and demonstrating the personal hygiene of diet, cleanliness, and ventilation. Instruction during sickness is more effective than at any other time. For the mother and her infant, the work of the health visitor is similarly influential, for it comes at a time when maternal love is fully enlisted.

The properly trained midwife has even more influence in the critical ten days after the infant's birth; and it is especially important that her counsel should dovetail with that given by the health visitor and at the child welfare centre.

The family doctor's opportunities for important hygienic work are almost unlimited; and if his education as a medical student and if the conditions of his employment are improved, this can be realised, and a large part of the work in personal hygiene now necessarily undertaken by health visitors and at child welfare centres will then become redundant.

In most communities neither educational work in hygiene nor general medical work is effectively systematised. A considerable share of the responsibility for this partial failure rests on the heads of families, who, in part because of carelessness and in part through inability to visualise the importance of adequate medico-hygienic care, neglect to secure it. Inadequacy of medical aid and discontinuity in medical work are still serious causes of failure to obtain medical aid when required.

Inadequacy of Medical Aid

The insufficiency of present provisions for caring for the sick is more fully discussed in Chapter III, and further illustrations of inadequacy will be given in each succeeding chapter. The inadequacy may be in promptitude, in dura-

tion, or in quality of aid, including the lack of auxiliary services, or in some other respect.

Discontinuity in Medical Work

This form of inadequacy of medical aid is extremely prevalent, and a short sketch of some of the forms of discontinuity is given at this point.

Obviously medical care is not the only need in sickness; and much of the value of the doctor's care is lost through unsatisfactory nursing, or in consequence of inability to obtain or to prepare satisfactory or adequate food. Similarly much sickness is the result of destitution or of minor degrees of inability to obtain satisfactory food or other attention. Success in the treatment of illness may depend on securing the cessation of alcoholic or other dietetic habits inimical to health, or in bringing about a change in conditions of work. Illness may need also to be attacked by securing better spiritual health, giving an altered personal outlook. These are illustrations of failure on the social side of illness. Some of the chief failures are set out in the following schematic statement:—

Causes of Discontinuity in Medical Work

1. On its social side, due to inability to influence—

poverty,
alcoholism,
bad personal habits,
unsuitable work, etcetera.

2. Because the medical practitioner is unable, or for any other reason does not, concern himself with

Preventive Factors, including those under 1.

3. Because there is no general system of systematic medical and hygienic examination of—

infants,
pre-school children,
boys and girls aged 14–16 years,[1]
insured persons,[1]
and others.

[1] These two apply especially to British conditions and other countries with similar sickness insurance arrangements.

4. Because the doctor in attendance at various stages of illness is out of touch with other doctors concerned with the same patient. This occurs especially in—

the relation of the family doctor to consultants and hospitals.

5. Discontinuity exists not only between private doctors and the medical provision made by voluntary agencies, such as—

voluntary hospitals,
official hospitals, and
public health clinics,

but also between each of these organisations.

6. Similar discontinuity exists between—

the provision of an insured member of a family,
the provision for an industrially employed member of a family (industrial medicine),
the provision for school children,
the provision for patients in tuberculosis or venereal disease clinics

and that for other members of the same family.

Thus the value which attaches to the acceptance of the family as the most satisfactory medical unit is partially lost.

The general absence of family hygienic work is deplorable. Even the person insured against sickness fails to be examined and advised by his own doctor, except when he is definitely ill. The introduction into insurance medical practice of a proviso for such hygienic examinations would greatly increase its value; though this practice would, in present conditions in many countries, still sin against the ideal that the family should form the medical unit.

The Family Doctor

The most important single agent engaged in medical work is the competent and conscientious family medical practitioner. He is found in every considerable community; and the usual relationship between doctor and patient is competent to secure his attendance when needed without any external intervention. He is, and I think will continue to be, an essential and indeed a chief factor in efforts for securing improved health for a community. But even now he does not suffice alone. For it is common ground that—

1. Not every member of the community has a family doctor. The relationship is often non-existent in urban communities, and for the poor may be lost even in rural districts. To this extent the fort has never been occupied or has already been abandoned, though possibly not irrevocably.

2. There is needed also a local or county medical officer of health and a sanitary organisation to prevent diseases which are preventable by communal action.

3. There must be means for securing the isolation of the infectious sick; and this is often impracticable in the patient's home.

4. Aids to diagnosis must be provided in illness of doubtful nature.

(*a*) The medical officer of health must be available for consultation, if infection is suspected.

(*b*) Such pathological aids to diagnosis as Wassermann, Widal, and other tests, as for diphtheria or tubercle bacilli, must be available, and these the private practitioner can seldom provide.

5. For other doubtful illnesses and for grave disease medical consultations must be available. These are necessary not only for the well-to-do but also for the patients who in this particular are poor. They are needed—

(*a*) at home—in serious cases; and

(*b*) at hospitals or other consultation centres.

6. For a rather high proportion of total cases of illness hospital treatment is required. This may be needed because specialised treatment is called for in addition to that given by the family doctor; and often also because of unsuitable home conditions, lack of nursing, or poverty.

This incomplete summary illustrates, but does not exhaust, the statement already made that the family doctor cannot meet all the needs of all his patients. That the doctor himself realises the frequent need of consultative and institutional aid is demonstrated by the fact that, as a rule, he is the person who endeavours to obtain these for his patient.

It may be accepted, then, as axiomatic that ADEQUATE MEDICAL CARE FOR A LARGE PROPORTION OF THE TOTAL NUMBER OF SICK PERSONS NECESSITATES THE ORGANISATION OF MEASURES AND OF INSTITUTIONS BEYOND THE POWER OF

THE INDIVIDUAL PRIVATE MEDICAL PRACTITIONER TO PROVIDE.

This additional aid, as we shall find later, can be secured (*a*) by charity where the patient cannot otherwise afford to pay for it; (*b*) by local authorities using public funds; or (*c*) by means of co-operative effort of the beneficiaries on provident or insurance lines apart from or aided by taxation.

The Teaching of History and of International Experience

All these three forms of co-operative action have been illustrated in the past, and are seen in contemporary international experience. In Volumes I to III of my series, *International Studies on the Relation between the Private and the Official Practice of Medicine*, I have sketched the many forms of medico-hygienic activity found in different European countries, and have shown the historical development of some of these activities. This has been done more fully for Great Britain in Volume III, as may be seen under such headings as Public Assistance, Child Welfare, Midwifery, Nursing, the Treatment of Venereal Disease and of Tuberculosis and Sickness Insurance. In some countries one or another of these activities is more developed than in others; but international experience is uniformly consistent in showing an inflowing tide of increased co-operative effort. The fact that different countries show different stages of development justifies one in regarding them as instances of contemporaneous history as much as if they occurred in sequence. In public health work this variation is especially visible; but in midwifery work, in the provision of hospital and consultative services, in sickness insurance work, and in other instances nearly every stage is visible from the earliest to the fullest development of national or sectional, of official or voluntary, co-operative medical work.

Such a study brings us inevitably to the conclusion that IN EVERY COUNTRY, AS CIVILISATION ADVANCES AND THE PUBLIC CONSCIENCE IS AROUSED, NOT ONLY IS PUBLIC

HEALTH WORK IN ITS LIMITED SENSE INCREASINGLY DEVELOPED, BUT THERE IS ALSO A CORRESPONDING INCREASE IN COMMUNAL EFFORT TOWARDS SATISFACTORY AND COMPLETE MEDICAL CARE FOR THE SICK.

Illustrations of this general statement are given in the chapters which follow.

Many forms of co-operation are described in Volumes I to III of *International Studies*.

Voluntary Co-operation

In every country, and especially in Western countries, charitably minded persons have combined for philanthropic purposes before public authorities took on similar work. The NURSING OF THE SICK is an especially outstanding instance. Originally this was the work of religious sisterhoods, some untrained in nursing. One must recall the debt which the world owes to them. Their supersession in some European countries has been followed by a great dearth of nurses, by the employment in hospitals of half-trained nurses, and by inability to supply an adequate staff of public health nurses. There has been a falling off in the social quality and standard of education of nurses in these countries. But neither religious devotion nor a good general education can entirely compensate for the absence of training: and in a few years, in the countries concerned, trained nurses should be forthcoming who will not lack in devotion to their work.

District nursing in Great Britain remains almost entirely in the hands of trained nurses employed by voluntary associations, which are partially subsidised by local authorities; and its success (see Chapter XIV, Volume III, of *International Studies*) is the most striking illustration of voluntary work which nearly meets the needs of the community.

A similar evolution is visible in hospital provision, but with a difference. Religious bodies, and, later, the more general charitable public, supplied hospital treatment which, in Britain and other countries, was nearly always less par-

simonious and more efficient than the provision made by poor-law authorities. The preponderance of voluntary over official provision no longer continues in most countries; but in Belgium and the Netherlands hospital provision is still largely in the hands of religious and other voluntary organisations, who receive some payment for their work from official taxes as well as directly from patients. In Britain, while voluntary provision has increased, the number of hospital beds provided by public funds is now much greater than the number provided by voluntary effort.

Successful voluntary medical work has been undertaken in many countries, especially for tuberculosis and child welfare, for the details of which reference may be made to Volumes I to III of *International Studies*, and to later chapters in this volume. Where national finances permit it, the tendency is for these and allied special medical services to become official or to be undertaken by sickness insurance societies.

Official Provisions

In European countries the main feature of recent years is the increasing provision of hospitals and clinics by official bodies or by large insurance societies. In Scandinavian countries these official arrangements, except for tuberculosis, have almost completely superseded voluntary efforts. The same can, in large measure, be said of Austria, Hungary, Jugo-Slavia, Czecho-Slovakia, and Poland.

It may be stated generally that IN EVERY COUNTRY THERE IS A STEADY TREND IN THE MEDICO-HYGIENIC SERVICES TOWARDS THE SUPERSESSION OF VOLUNTARY EFFORT BY OFFICIAL (INCLUDING INSURANCE) PROVISION. This means that the demands in every country for hospitals, clinics, etc., have vastly increased, and thus voluntary efforts furnish a diminishing proportion of the total medical aid. In some countries voluntary provision is almost nil.

This shifting of the burden from charitable donations and bequests to taxes and insurance funds does not imply diminution in the total volume of voluntary work or in

the number of voluntary workers. In democratic countries the antithesis between voluntary and official organisations does not involve this result; for a very large part of official work is done by unpaid voluntary workers, the elected representatives of the people. This statement does not apply to technical work: and here a real contrast exists; for the medical staff of voluntary hospitals, except junior residents, are usually unpaid, while the corresponding staffs of official hospitals are salaried.

Official Organisations

This leads naturally to a review of government in its bearing on medical work.

Those who have read Volumes I to III of *International Studies* will have noted that considerable space has been devoted to a statement of THE GOVERNMENTAL METHODS OF EACH COUNTRY. Theoretically, nearly all European countries west of Russia are democratically governed, i.e. by the elected representatives of the adult population, who vote the taxes which pay for medico-hygienic and other activities, control the direction of work, and in theory at least regulate its administration through paid officers. This democratic control may be full-blooded and entire as in Great Britain, or partial and limited as in France, and still more limited in Italy, with various intermediate grades. Local detailed administration similarly may be fairly autonomous, or it may be strictly limited by control of the central Government of the country. The local executive officers may be appointed by the local council or by the Government, and the mayor or prefect may be centrally or locally appointed, with obvious consequences on local executive work. These variations limit or extend the possibilities of voluntary work by socially minded members of each locality. In a democratic country voluntary social work may be "voluntary work in a municipal setting" (Mrs. Sidney Webb), or it may be carried out entirely by voluntary agencies. Great value attaches to the work of voluntary workers who help to carry on official organisations. The elected unpaid repre-

sentatives of local authorities take part in municipal work and come especially into this category; but, in the official work of school hygiene, of infant welfare centres, of care-committees for tuberculosis, etc., in Great Britain a vast amount of further voluntary work in a municipal setting is done by social workers who are nominated to work in social agencies of official origin, although the workers in question have not been elected by the ratepayers.

In many branches of medico-hygienic work in foreign countries, and in Britain, also in district nursing work, there is also much "official work in a voluntary setting", the Government or a local authority subsidising the work carried on by a voluntary hospital, or by a voluntary child welfare or tuberculosis or nursing association.

It is to be hoped that both types of voluntary work will persist, and that the second type will continue to receive encouragement. There will always be ample social work waiting for social workers to do, work which is outside regulated official limits. The true rôle of voluntary workers is to supplement official activities and to initiate and demonstrate the practicability of promising new work. This doubtless will continue to be their function indefinitely.

But, although this is the case, the present tendency is for well-established medico-hygienic work to come within the net of official management. This is true in most countries, and would, I think, be true in all parts of Europe were it not that in some countries separate hospitals and clinics for Protestants and Roman Catholics are perpetuated by religious barriers.

This trend towards an official monopoly carries with it a danger, of which there are indications in Britain. There may be an exaggerated unwillingness on the part of elected representatives to allow outside workers to help them. This is unfortunate, and I hope is a temporary phenomenon. In Britain the Local Government Act of 1929 has meant that the local authorities have become heavily weighted by the vast additions to their already heavy burden in the supervision of various forms of hospitals. Unless some of

their duties are delegated, and non-elected workers who have leisure and ability are brought in to help in the increased work of supervision, control will increasingly fall into the hands of paid officials. These officials will be the last to desire this result; the best official always encourages the co-operation of voluntary workers, as well as of the elected members of local authorities. Executive detail necessarily is in his hands.

Whether the type of medico-hygienic work be chiefly official in a voluntary setting, or voluntary work in an official setting, IT IS APPROPRIATE AND INDEED INEVITABLE THAT THE GIVING OF OFFICIAL GRANTS OF MONEY MUST CARRY WITH IT A CORRESPONDING CONTROL BY THE REPRESENTATIVES OF THE TAX AND RATEPAYERS. Voluntary associations form a parallel case. The managing committee of the association represents the donors of subscriptions, just as the local authority represents the ratepayers, and these donors or ratepayers in the final issue determine the character and extent of the work.

This principle puts out of court the claim sometimes made that the public should supply the funds for medico-hygienic work, while the medical profession or their representatives conduct it. Definitions should be required when such a contention is made. Skilled medical work cannot be controlled by laymen, but in all business arrangements the representative lay power must be supreme. The medical staff and medical committees cannot be more than consultative, although, as is universally the case, their advice in medical details, subject to non-medical financial control, is always final. It is only by frank recognition of the fact that MEDICAL ARRANGEMENTS IN ALL MATTERS WHICH ARE NOT STRICTLY AND TECHNICALLY MEDICAL MUST CONFORM TO THE BUSINESS ARRANGEMENTS MADE BY THE FINANCIALLY RESPONSIBLE REPRESENTATIVES OF THE PUBLIC that smooth progress is possible. Happily this in the main is a *res iudicata*, and bolder claims made in earlier schemes of proposed medical reorganisation (see p. 106) are now (in Britain) almost a thing of the past. That such claims are

still made is seen in the following illustration. Mr. H. S. Souttar, surgeon to the London Hospital (*British Medical Journal*, 1929, ii. Suppl. 213), speaks of a future "medical service organised and controlled by the medical profession in partnership with the State". Presumably such a partnership would mean that the State would contribute a large share of the cost of the scheme; and on this assumption it is impossible to accept Mr. Souttar's subsequent statement as ever likely to be accepted by the elected representatives of the taxpayers. He remarks "if by (this medical service) is meant a medical service controlled by the State, I can assure you that nothing is farther from my thoughts". He then says: "The State would pay for the work done by it, and would only be interested in seeing that the work was properly done. We must for ever root out the miserable shibboleth which the bureaucrat is never tired of echoing, that State money must necessarily mean State Control."

Evidently here is a misunderstanding of terms. If the State is to "see that the work is properly done", it will control all non-medical circumstances of the work. The scheme as envisaged above would only be possible if it were organised by the medical profession without State aid, trusting to payments by patients for its maintenance.

Can Democracy be Trusted?

But although the principle is sound, that financial responsibility means control in all non-technical matters, can elected public authorities be entrusted safely with such responsibility? I do not hesitate to answer this question affirmatively for Great Britain. The management of voluntary hospitals is in the hands of laymen and laywomen, members of the professional staff sitting and advising with them in committees; and with this arrangement no more serious difficulty arises than is the common lot in all human affairs. The same is true for official hospitals and clinics. These also are controlled by lay committees advised by medical officials.

In my visits to foreign countries I have encountered instances in which it appeared to me that no such confident statement could be made. This has been particularly true in the case of polyclinics established either by the Government or by large insurance societies. In some instances I suspected favouritism and possible corruption in their very political management; in others there appeared to me to be undoubtedly megalomanic expansion of bricks and mortar and of over-specialised departments which had relatively little regard for the real needs of the patients themselves. In Britain the management of an official hospital may also be "too near the vote". This risk has been decreased by the substitution of committees of the county councils and county borough councils for the former boards of guardians. The new authorities are not elected for poor-law purposes alone, and the electing constituencies are greatly enlarged.

I cannot pursue the difficulties of democratic government here. They are many: some are shared by voluntary agencies, and especially by associated clinics under insurance societies. For the last-named (see Chapter VII) the safeguarding of the British system, in which all negotiations with the medical practitioners are made by the central Government, is efficient. But it is futile to scoff at democratic government and stand aside without attempting to help to improve it. The institution of "competitive" voluntary organisations and the refusal of so-called highbrows to participate in the rough-and-tumble life of representative bodies is not the solution. People get the government they deserve; and he who merely stands aside is among the chief enemies of reformed government.

Democratic government in large measure is still an aspiration imperfectly realised, and in large communities its difficulties are enormous. But it is only on the lines of representative self-government that, to use Mr. Stanley Baldwin's phrase, "every unit in the community can be made to count"; and it is by self-government, or by having a personal share in its responsibility, that "every unit is made

fit to count". In no department of government is this moral fitness more important than in that of medico-hygienic work.

Those who despair of "the citizen's part in government" should read Senator Elihu Root's brochure under this title. After describing the almost unbelievable extent of past corruption in government in England in the eighteenth century, he attributes the greater number of complaints which now find voice (not in England) to the demand of the people for a higher standard of morality; and we may fitly take as our motto in medico-hygienic work his aphorism that "pessimism is criminal weakness".

Summary as to Machinery Needed for the Prevention and Treatment of Sickness

(*The numbering of the paragraphs in the summaries attached to each chapter is made consecutive throughout the volume.*)

10. The application of all known public health and social measures which conduce to the diminution of sickness is of essential importance in the organisation of the community.

11. There is need of continued and extended research into the causation of diseases.

12. The most important branches of educational work in hygiene are those concerned with the better training of all health workers (doctors, nurses, midwives, and members of public health and voluntary organisations), and with hygienic teaching in school and college life.

13. There is a lamentable amount of inadequacy and discontinuity in the medico-hygienic provision for the community.

14. The family physician potentially, and sometimes actually, is the most important single agent engaged in medical work.

15. Adequate medical care for a large proportion of the total sick necessitates the organisation of measures and of institutions beyond what the individual private medical practitioner can provide.

16. In every country, as civilisation advances and the public conscience is aroused, not only is public health work in its limited sense increasingly developed, but there is a corresponding increase in communal or sectional effort towards satisfactory and complete medical care for the sick.

17. In every country there is a steady trend towards the supersession of voluntary effort by official (including insurance) provision in the medico-hygienic services.

18. It is appropriate and indeed inevitable that the giving of official grants of money for medical work must carry with it a corresponding control by the representatives of the tax and ratepayers.

19. Medical arrangements provided at the expense of the community must conform in all matters which are not strictly and technically medical to the business arrangements made by the financially responsible representatives of the public.

20. Pessimism is criminal weakness (Elihu Root) in democratic government. Every unit counts, every unit must be made to fit to count (Stanley Baldwin).

CHAPTER III

THE COST OF PREVENTION AND TREATMENT OF SICKNESS

ANY discussion on the cost of measures against disease should be preceded by a statement of the VALUE OF HEALTH, and the economic loss occurring when it fails. This is a well-tilled field, and I must in the main start from the assumption that HEALTH IS WORTH WHATEVER EXPENDITURE IS EFFICIENTLY INCURRED IN ITS MAINTENANCE OR TO SECURE ITS RETURN. This proposition I regard as almost self-evident; but if it is called into question appeal can be made to the abounding evidence confirming it. This evidence is summarised and extended in *The Money Value of a Man* by Drs. Louis Dublin and A. J. Lotka (Ronald Press Company, New York). The current brochures in course of publication by the Committee on the Costs of Medical Care, Washington, D.C., United States of America, are a mine of exact information from many angles on the value of health and on the costs of skilled aid in its restoration.

Measures which give longer life but not better health might not improperly be regarded with measured enthusiasm; but here again, without adducing evidence in these pages, I may be permitted categorically to state that after examining many statements I have seen no satisfactory evidence of impaired efficiency, mental or physical, as the consequence of increased application of medical science. (See also p. 119.)

As the result of medico-hygienic measures and of associated social amelioration, the average duration of life of every child has been greatly increased, and the larger part of this increased life is being lived during the working years of life. In Great Britain the prolongation of life holds good at every age right up to advanced old age. Tuberculosis takes not much more than a third of its former toll

on human life; and infant mortality is less than half that of forty years ago. The extension of life and the increased return to health which surgery and some branches of medicine have secured are enormous; and the social and financial gains which have accrued from the aggregate of medico-hygienic activities are almost incredibly great.

A very great share of the total poverty of the people is the result of sickness.

Tuberculosis is an important cause of poverty and the dependency which follows; but other disabling diseases also play an important part in creating social burdens. Progress in civilisation can be measured in part by the increasing elimination of waste in the expenditure of human energy, of which health forms an essential element. It is not suggested that physical health alone will bring an earthly millennium; for unemployment arising from non-medical causes and other factors bearing on even more fundamental aspects of the personality are also involved in the problem. Idleness is a great source of national waste; and the lack of moral fibre which sometimes goes with sickness may be an even more serious source of national loss than sickness itself.

The above and a multitude of other facts showing the vast drain by sickness on national resources must be set against the cost of a completely adequate medico-hygienic organisation for the prevention and treatment of sickness.

That THE COST OF SICKNESS IS OVERWHELMINGLY GREAT FOR A LARGE SHARE OF THE POPULATION is an accepted fact. There is abundant evidence on this point; reference may be made to the brochures issued by the Committee on the Costs of Medical Care. A few quotations and illustrations may be cited; but it will be remembered that in this volume we are concerned with costs only in so far as they hinder efficient service and endanger amicable relations between private medical practitioners and public and insurance medical services.

The quotations and illustrations are taken purposely from American sources, inasmuch as the financial position

and standard of comfort of the American worker in normal times are higher than that of most European workers.

Dr. Hugh S. Cumming, Surgeon-General of the United States, at a Conference on Public Health (Chicago, March 24, 1927), said:—

> Although the amount of honorarium has by no means increased in proportion to the increased outlay of the physician in obtaining and maintaining his position, it is, nevertheless, such that concededly the best professional services, even where available, are beyond the financial ability of a very large proportion of our public; furthermore, these requirements are not everywhere available, especially in our rural and small town areas.

Dr. Olin West, Secretary of the American Medical Association, speaking from the doctor's standpoint, has said that the one outstanding problem for the medical profession to-day is—

> the delivery of adequate, scientific medical service to all the people, rich and poor, at a cost which can be reasonably met by them in their respective stations in life.

This is the problem which led to the formation of the Committee on the Costs of Medical Care with a five years' programme of investigation by groups of medical and economic investigators. The brochures of this Committee already published emphasise the reality and the difficulties of the problem of private medical practice in relation to the means of the people; and when its final conclusions appear valuable guidance for the future can be expected.

In a presidential address, August 26, 1930, at the meeting of the British Medical Association in Winnipeg, Canada, Dr. Harvey Smith, Professor of Ophthalmology in the Manitoba Medical College, stated that the annual income of 90 per cent. of the families in the United States and Canada is below $2,000 a year, which makes it easy "to understand why the problem of sickness so often assumes the proportions of a financial tragedy". He quoted in the

same address a computation that 30 per cent. of patients are attended without charge by the medical profession, while a further 20 per cent. are treated at reduced rates (*Lancet*, August 30, 1930, p. 501).

In an earlier part of the same address he says:—

> Admittedly certain phases of practice are open to criticism, and the Æsculapian Guild is confronted with many problems pressing for solution . . . costs, unavailability of medical aid, and lack of qualification.

Later on he avers—

> it is becoming increasingly apparent that a readjustment of the economic basis upon which the members of the medical profession offer their services to the public should be effected, under which the principles will be exemplified that the labourer is worthy of his hire;

and, finally, he stated that in his judgment there is no possible solution except in "voluntary health insurance, instituted, organised, and controlled by the medical profession, and widely applied". (On control, see p. 49. The control must necessarily in part at least be in the hands of those who pay for the benefit, directly or through the Government, and not solely in the hands of those who may be called the caterers for the benefit.)

The movement in favour of insuring while well to secure medical attendance when ill is becoming more widely acceptable both with doctors and the public.

European experience as set out in Volumes I to III of *International Studies* throws much light on the inability of the people to supply themselves with medical care out of family funds. The problem of costs recurs all the time when discussing the relation between doctors and their patients, and is accentuated when publicly provided facilities for treatment make the problem triangular. Many schemes are in operation which give some partial easement of the triangular problem, as will be seen in later chapters.

The principle stated in special type on pages 32 and 54 being generally accepted, medical services have been subsi-

dised by the State in sparsely populated areas where a doctor cannot earn a livelihood, as in the Highlands and Islands scheme in Scotland (Volume III of *International Studies*, p. 471). In no other way can the principle come into practice in such areas.

The same principle has been accepted, as seen in Chapter IV, for the necessitous poor, urban and rural, in most countries, though the provision made is usually inadequate and unsatisfactory.

The vast growth of hospital treatment in all countries points in the same direction.

It is evident, furthermore, that DOMICILIARY TREATMENT IN A LARGE PROPORTION OF TOTAL SICKNESS IS UNABLE ON THE DOMESTIC SIDE AND SOMETIMES ON THE MEDICAL SIDE TO ENSURE FOR THE PATIENT SATISFACTORY AND EXPEDITIOUS CONVALESCENCE; and in view of the paucity of means of a large section of the population THE NECESSITY OF HOSPITAL TREATMENT PROVIDED BY PRIVATE CHARITY OR OUT OF COMMUNAL FUNDS, AIDED BY PARTIAL PAYMENTS BY SOME OF THE PATIENTS, must be accepted.

This is generally accepted for the poor. For the destitute poor some official (tax-paid) hospital treatment is given in most countries. It was preceded in time by, and is still to a large extent associated with, similar provision in charitably supported hospitals, and there has grown up in these a system of partial payment for those able to meet part of the expense of their treatment. Those for whom domiciliary medical attendance is provided under the British National Insurance Acts in a few instances also obtain some hospital treatment partially at the expense of the funds of the insurance society to which they belong. Latterly a modified insurance on voluntary lines for hospital treatment, when needed, has become popular in Britain (Chapter VI).

The class whose income is just above that of the insured are still very hardly placed. Their annual earnings may be taken as ranging between £250 and £800 (about $1,250 and $4,000 at par). For them protracted sickness, especially when institutional treatment is needed, means a paralysing

disability of debt, which may require several years to annul.

Other aspects of the recurring problem of medical costs will emerge in subsequent chapters; and further information as to medical fees and costs and methods of meeting them is given in Volumes I to III of *International Studies*.

Family Earnings and Medical Care

The incapacity of a large part of the community to provide medical care applies to domiciliary as well as to institutional treatment, when more than casual help is needed. This is obvious in view of family earnings. In England an unskilled labourer does not earn more than 45s. a week, a skilled workman 65s. to 70s. On such a wage the payment of the rental of a satisfactory family-house strains his resources; much less can he pay directly at the time, or immediately after sickness ends, for the cost of medical attention in sickness for himself or his family. Even in the United States the discrepancy between earnings and ability to pay medical costs for a large part of the total population is not very dissimilar from that in England. Valuable facts bearing on this statement are contained in *Paying Your Sickness Bills*, by Dr. Michael M. Davis (University of Chicago Press, 1931). In Volumes I to III of *International Studies* are given instances from other countries; but in these the inability to meet medical needs is even greater than in English experience. We may then conclude that THE PROBLEM OF MEDICAL CARE HAS CEASED TO BE ONE WHICH CAN BE SOLVED BY DIRECT FAMILY PAYMENTS, AND IT HAS BECOME ONE OF DETERMINING THE BEST METHOD FOR SECURING SATISFACTORY MEDICAL CARE WHEN NEEDED BY PROVIDENT MEASURES, SUPPLEMENTED PERHAPS BY COMMUNAL AID (TAXES). There is only one alternative to this conclusion, namely, that such aid when needed by those who cannot themselves pay for it shall be supplied entirely at the expense of the entire community (taxation). Private charity is no longer able to meet the need.

By "provident measures" I mean savings over a protracted period made by the recipient to ensure medical

treatment when ill. These measures may be personal; but then are seldom adequate. Efficient provident measures almost necessarily mean group insurance to secure medical treatment. It is arguable that if medical care is provided out of taxes, this is a form of insurance. It is so if all taxpayers become thus entitled to treatment. In practice in no country are the insurance payments adequate to furnish complete medical aid, and in all countries they are supplemented by money contributed from taxes. Thus taxation and insurance are intermingled.

Summary of the Cost of Prevention and Treatment of Sickness

21. Health is worth whatever cost is properly incurred in its maintenance or to secure its return.

22. For a large section of the population the cost of sickness is overwhelmingly great.

23. Domiciliary medical care in a large proportion of total sickness, for domestic and sometimes also for medical reasons, cannot ensure for the patient satisfactory treatment and rapid convalescence; and hospital treatment is needed.

24. The cost of hospital treatment is beyond the means of a large proportion of the total population, and we must accept the necessity of private charity, of provision through insurance schemes, and of subsidisation of hospital treatment out of communal funds derived from taxation proportional to means.

CHAPTER IV

DOMICILIARY MEDICAL CARE OF THE NECESSITOUS

In the last chapter it has been shown that satisfactory domiciliary and institutional treatment of sickness cannot be paid for directly by a considerable proportion of the total population in most communities.

THE COMMUNITY AS AN ENTITY HAS AN IMMEDIATE AND VITAL INTEREST IN THE TREATMENT AS WELL AS IN THE PREVENTION OF SICKNESS; and the organisations regulating community life, therefore, find it necessary to intervene and to make good the inadequacies and imperfections of family endeavour.

For disease is a main cause of destitution, as is seen daily when the wage-earner suffers from serious sickness or dies. It is seen in the distress of his wife or widow and orphans. And in families in which the mother's sickness or death occurs, it is scarcely less calamitous.

This economic motive—the desire to prevent or curtail incapacity and dependence—has been a vital factor in impelling communal arrangements for medical care of the sick; and, along with the motive of mercy, it has been the driving force for public health measures. The first public health measures in England were dictated in part by an aroused communal conscience, more by the panic resulting from cholera epidemic, and most of all perhaps by realisation of the wastefulness of disease and its economic results. Inertia was overcome in the effort to protect personal health and the public pocket.

Medical aid at the public expense does not stand alone. Through sickness insurance it is associated with financial aid to compensate for temporary loss of wages (Chapter VII); for widows and orphans in Britain and more or less in other countries there are pensions and money allowances, thus diminishing the strain of illness and to some extent obviating its protraction or extension.

The destitution or poor-law authority in most countries gives weekly money allowances to destitute families. In fact, it has become a generally accepted principle that NO PERSON OR FAMILY SHALL BE ALLOWED TO DIE OR SUFFER SERIOUS HARM THROUGH LACK OF SHELTER OR FOOD OR MEDICAL CARE. Here, however, we are concerned only with medical care. Existing arrangements for this may next be summarised. In European countries medical official aid is controlled by the authority concerned also in other branches of local government. In Britain the Public Assistance Authority until recently was a Poor Law Authority (Board of Guardians) elected by the ratepayers, separately from the Local Authority (County Council, Borough Council, or District Council) which is concerned with public health and the more general problems of local government. Now the Public Assistance Authority has become the Public Assistance Committee of the County Council or County Borough Council, and some of its duties have been transferred to the Education, Public Health, and other Committees of the same local authority.

National Arrangements for Domiciliary Medical Public Assistance[1]

GREAT BRITAIN.—Legally every destitute person is entitled to shelter and food and to such care as is needed to maintain or restore health. Hospital treatment for the destitute sick is considered in Chapter V. Here we may outline the arrangements for their domiciliary treatment. Each parish or union of parishes has a district medical officer (D.M.O.) who is paid by a fixed salary rather than in direct accordance with the number of patients he treats. The D.M.O. nearly always is a local general practitioner, and has also private patients. In a few districts he is a whole-time official either for domiciliary medical work or for this along with duties at the public assistance hospital.

This domiciliary work is described more fully in Volume III of *International Studies*, p. 88. It has steadily declined in amount, especially since the National Insurance Act was passed. Some of this work has been well done, some badly; and the work fell into some disrepute. Suggestions have been made for its transfer

[1] For similar information as to international midwifery see Chapter VIII.

to insurance practitioners, in which event every destitute person would choose his doctor as an insured person does (see p. 43, Volume III, of *International Studies*).

IRELAND.—There is a highly developed public assistance medical service in Ireland, both for domiciliary and for institutional treatment, and as perhaps half its population receive medical aid from this service, it approximates to a realised State Medical Service. Indeed several commissions of inquiry, after investigating the Irish system, have recommended its extension and improvement so as to convert it into a national service (see Volume III of *International Studies*, p. 543). The present service is gratuitous for patients, its cost being defrayed from general taxation.

THE NETHERLANDS.—In the Netherlands medical assistance is not regarded as a State or provincial function, and is limited to instances in which voluntary religious organisations, which are active, do not suffice. Amsterdam has four divisional medical officers for the poor.

DENMARK.—There are district medical officers who are general practitioners and also act as medical officers of health, and have important supervisory duties in each district. They treat at home the poor who are not provided for by insurance; 66 per cent. of the total population are insured. In Copenhagen there are special district medical officers for the poor; elsewhere this work is done by general practitioners.

SWEDEN.—A system has been developed in Sweden under which each district has a doctor appointed and paid by the central Government. He is under obligation to attend the inhabitants in his district for fees fixed by the Government, while his fees for attending the poor are paid by the local authority.

NORWAY.—Every district has a medical officer who, while exercising some general supervision over all medical and allied work and acting as local medical officer of health, also attends the sick poor in rural districts. The medical officer is paid for each visit or consultation by the local authority on a fixed tariff. In larger towns special medical officers for the poor are appointed, and in Oslo patients are allowed a free choice of doctors, these being paid according to a scale. Of the population of Norway, 14 per cent. are medically attended by district medical officers. Eligibility for free medical aid is decided by a special officer in each area.

GERMANY.—Arrangements for the poor vary in different German States. Each municipality has its own plans free from State intervention. Insurance practice has largely replaced public medical assistance, and insurance doctors commonly undertake

medical work for the poor. In cities there are special doctors for the poor, who also engage in insurance and private practice.

AUSTRIA.—Each commune is required to provide general medical and midwifery services for the poor. If the commune cannot afford these services the province gives financial aid, which takes the form of an annual salary, as in England.

SWITZERLAND.—Each canton has local self-government, and each district has a district medical officer, who undertakes vaccination and some medical care.

BELGIUM.—In each commune there is an assistance committee appointed by the local authority and some medical treatment of the poor is organised.

FRANCE.—In all provinces medical attendance on the poor is organised on the plan of free choice of doctor, subject to an official scale of charges. The administration of medical relief is hemmed in by regulations (see Chapter II, Volume II, *International Studies*).

ITALY.—There is gratuitous medical provision in each commune for the sick poor. A single doctor may be appointed for this purpose. Each communal authority is required to pay doctors and midwives who attend needy persons whose names have been entered on the communal register of the poor.

JUGO-SLAVIA.—There is little private medical practice. Each commune is required to pay a communal doctor, who attends the sick poor gratuitously, and who also is a local medical officer of health. In the province of Zagreb, for a period of one year, free medical aid was given to all applying for it.

HUNGARY.—As in Italy, France, and Jugo-Slavia, each commune in Hungary is required to provide a doctor for the poor. These doctors can charge those not in this category, according to a scale fixed by the local council.

POLAND.—Medical arrangements for the poor vary and, except in towns, are inadequate.

It will be seen that in each country some provision is made for domiciliary treatment of the sick poor. This is often unsatisfactory and likely to be belated, as, for instance, by the rule that the head of the household must have his name on an official register of the poor, which is revised year by year. Evidently this restriction, unless waived for urgent cases, may have serious effects. In Great Britain a medical visit by a district medical officer is not strictly conditional on previous inquiry by the official lay relieving officer, or on entry in an official register. In some other

countries eligibility for free treatment at home or in the doctor's surgery is liberally interpreted. The system in Ireland is the most elastic of all.

Should there be a Special Medical Officer for the Poor?

The conception of a doctor available in every parish for those in need is as attractive as that of a spiritual pastor in every parish, and such a doctor is provided in most countries. It is agreed, however, that this restriction of the poor patient to one doctor is sometimes unacceptable; and in some countries it is a historical fact that only those compelled to do so utilise his services. The "taint of the poor law" is regarded as attaching to the district doctor's services, as well as (to a rapidly decreasing extent) to treatment in what in Britain until recently has been known as the poor-law infirmary.

The British Medical Association has expressed its view (Volume III of *International Studies*, p. 43) that the principle of free choice of doctor should be extended to the domiciliary attendance on public assistance patients. Insurance doctors could undertake this work in the course of their practice in accordance with a scale of payment to be officially defined. (See also Volume III of *International Studies*, p. 297, for Dr. Martin's advocacy of this plan for Gloucestershire.)

It must be noted, however, that since the introduction of sickness insurance this separate work for the necessitous has greatly decreased; and now the duty of the district medical officer to certify which patients are suitable for institutional treatment bulks more largely than medical attendance on the destitute who live at home.

Should Public Health Work and Public Assistance Medical Work be Combined?

In European countries, excepting Britain, there have been hitherto no separately elected public assistance authorities; and Britain has now ceased to be an exception. The question, therefore, becomes one only of distribution

of public assistance medical work and of public health work among the committees and the officials of each local authority. The public health committee and its medical staff certainly should not be burdened with monetary relief or the management of non-medical institutions. But should the management of hospitals and allied institutions and of domiciliary medical attendance come under the public health committee and be controlled executively by its medical staff?

Much can be said in favour of a separate medical and hospital committee for this work, with a medical superintendent who would be in complete control clinically, but related to the medical officer of health in his position as head of the executive medical staff, and as chief medical adviser of the council on the administrative side. If this is not done it can be urged that the detail of administration of various branches of clinical work may swamp the more directly preventive work on which the medical officer of health should be engaged. Remembering the various general and special hospitals, mental hospitals, lying-in institutions, clinics for children (school and pre-school), vaccination by public officials, etc., we can realise that there is risk of this.

The obvious results obtainable from treatment may, and often do, appeal more readily to the medical mind than the investigation of social and industrial conditions and of local epidemiological problems which form the supreme work of the medical officer of health; and thus it may happen that progress in preventive work may be temporarily retarded by the recent fusion which has occurred in British administration. Nevertheless, I cannot regard any administrative scheme as satisfactory which does not place the medical officer of health as chief of the executive medical staff of every local authority. This is necessary in order to secure the best adaptation of means to end, and to ensure that preventive even more than curative methods of investigation and action may continuously guide the work in every hospital and institution. This is practicable, even though in the largest cities each hospital staff is substantially autonomous in its adminis-

tration. Each hospital doctor, including the superintendent of the entire hospital administrations, would have full responsibility, subject to reference to the medical officer of health, and through him to the public health or hospital committee when points of policy arise.

We are now in a position to discuss the supremely important problem of the giving of medical aid at the public expense.

What Principles should Govern Medical Aid?

1. The aid must be given promptly and not be impeded by the intervention of any non-medical official. The dual object in view, to aid recovery and to reduce and curtail suffering, implies the need for an elastic machinery for medical aid and nursing, whether at home or in an institution.

Insurance medical work has greatly decreased the call for gratuitous medical assistance; and, prior to this, voluntary hospitals and dispensaries, especially in towns, had undertaken much of the work which would otherwise have needed to be done by the destitution authority.

But the special need remains, and is not likely to disappear in the early future. Whatever method of medical aid at the public expense is adopted, the condition set out above ought not to be neglected.

2. Although machinery for medical aid for the necessitous everywhere exists, there is universal need for its improvement almost beyond recognition by the institution of thorough, instead of partial, investigation and treatment. Public medical assistance has nowhere and never been the invaluable means of advancing personal hygiene and public health which it could be made. To secure this end—

3. A social as well as a thorough medical investigation is needed in every case of relief, and ACTION SHOULD BE TAKEN TO REMOVE SOCIAL OR OTHER EVILS ASCERTAINED IN THE COURSE OF THE INVESTIGATION. In this way only is it practicable for THE COMMUNITY WHEN GIVING CHARITY

TO OBTAIN IN RETURN SOMETHING FOR SOMETHING. In other official medical activities this object is partially attained. It is attained when infectious patients are isolated at the public expense; when health advice as well as treatment is given at an infant consultation; and when, as in the school medical service, the health of the entire family is definitely improved. In official tuberculosis work the family is always regarded as the unit, and it has always been officially held that the treatment of a tuberculous patient can only be successfully undertaken with knowledge of his economic and other social circumstances.

The same should hold good in the domiciliary treatment of all the sick poor, and it may be added of every insured person; but it does not. Medical treatment does not cover the entire need of the patient; and a district nurse or a public health nurse could render invaluable service by providing accurate knowledge of family and industrial circumstances, in the light of which the doctor could treat his patient. The lay relieving officer, who in England visits the necessitous poor before recommending monetary aid, is concerned with a determination of the financial competence of the family. Much more than this is required. For example, the destitution may, though less often than in the past, be due to the drunken habits of a member of the family, perhaps of the patient himself. Control is difficult; but persistent friendly visitation is required, including the force of moral suasion; and it may become necessary in extreme cases to exercise coercion. Much good has resulted in Czecho-Slovakia, Poland, and Austria from the work of anti-alcoholic dispensaries, which is described in Volumes I and II of *International Studies*. Drunkards are referred to these dispensaries by the police, and this semi-coercive action has merged into sympathetic co-operation and reform in many cases.

Whatever the cause of social breakdown in the family, if this cause is controllable, it is important that continuance of FINANCIAL AID, NOT OF MEDICAL AID, SHOULD BE MADE CONDITIONAL ON THE REFORM OR ATTEMPTED REFORM

WHICH AN INTENSIVE STUDY OF EACH CASE OF ILLNESS HAS SHOWN TO BE DESIRABLE OR NECESSARY.

I know of no country in which medical aid to the necessitous is in practice associated with the intensive inquiry and subsequent action which are obviously needed if medical aid is to be fully beneficial.

Tuberculosis and syphilis are two diseases which account for a large part of the sickness among the necessitous. Much more can be done to control both these diseases than is commonly done, but the well-known though neglected lines of familial and social action needed to supplement medical care need not be detailed here.

It is only by following the course of action here indicated that charitable and official aid, medical and financial, can avoid continuing to be, as Professor F. G. Peabody, of Harvard University, has put it:—

> "Simply the unreflecting expression of the sheer emotion of pity". Rational charity, on the other hand, "directs this emotion along definite economic lines".

4. Early treatment and treatment as long as medically desirable should be encouraged.

Early treatment is especially important; and in encouraging this THE SEPARATION IN THOUGHT AND IN ACTION OF MEDICAL FROM OTHER FORMS OF PUBLIC ASSISTANCE IS IMPORTANT. Medical aid seldom creates a demand for further medical aid. In this respect it differs from monetary aid. This is the general experience, though in exceptional instances the doctor-seeking habit may be formed. Against this two remedies can be relied on to be successful, (*a*) a minimum prescription of drugs, and (*b*) measures to prevent duplication of visits at various clinics, in the absence of reference from the previous medical adviser.

Early treatment of disease means also co-operative measures of general hygiene and public health, and this illustrates the inseparability of the different branches of public medical work.

Venereal diseases and tuberculosis illustrate this fact

particularly well, but dental disease is another important example; and the radical cure of hernia and of varicose veins shows how surgery may become a chief handmaid of preventive medicine in avoiding protracted disability.

Summary on Domiciliary Medical Care of the Necessitous

25. The entire community has an immediate and vital interest in the treatment as well as in the prevention of sickness.

26. The principle is accepted that no person or family shall be allowed to die or suffer serious harm through lack of shelter or food or medical care.

27. Every illness treated at the public expense should be investigated socially as well as medically, in order that action can be directed to the removal of social or other evils, when ascertained. It is only thus that the community in giving charity can obtain in return something for something.

28. When financial as well as medical aid is needed, the financial aid should be made conditional on the reform or attempted reform which an intensive study of each case of illness has shown to be desirable or necessary.

29. In giving aid to the necessitous and in organising such aid medical care must be free from the inhibitory element, which may be proper to non-medical care.

CHAPTER V

HOSPITALS AND MEDICAL CARE

In Chapter II (p. 42) it has been stated as an axiom that a considerable proportion of the sick require institutional treatment in order that they may have complete help and exceptional skill. This treatment may involve admission into a hospital, or be limited to consultation and treatment at what is known as a dispensary or clinic. In this chapter the problem of indoor hospital treatment is discussed.

Even before medicine had become scientific, the need for hospital treatment had been appreciated and partially met.

The earlier hospitals were often little more than free lodging-houses for the sick poor. From these leper asylums became differentiated, and in the Middle Ages these institutions were distributed throughout Christendom. The need for special asylums for the insane was recognised at an early date, and these now form a large percentage of the total hospital accommodation in most countries. I do not propose to discuss this provision, for in connection with it difficulties rarely arise as to the relative work of private medical practitioners and of the institutional medical staff.

General hospitals were first provided in the Middle Ages. St. Bartholomew's Hospital and St. Thomas's Hospital in London were opened respectively in A.D. 1123 and 1200. In the eighteenth century the number of general hospitals rapidly increased. In the same and in the early part of the nineteenth century, hospitals for the isolation of "fever" cases were initiated, and gradually became a chief means of controlling typhus and smallpox. Vaccination has also provided an essential aid in the control of smallpox. To-day the provision at the public expense of hospital treatment for all persons suffering from the chief infectious diseases who cannot be satisfactorily isolated at home is regarded as the duty of public health authorities in most countries.

The present relation of hospitals of various categories to each other, and their relation to private medical practitioners, and to the members of the public requiring hospital treatment, is complicated and somewhat inchoate.

In most communities there is need for greater co-operation, for arrangements which will prevent overlapping or a hiatus in provision, and especially for a closer co-operation between the staffs of these hospitals and private practitioners of medicine. This is especially necessary in view of the rapid increase of official hospitals provided at the expense of the general tax- and ratepayer, and in view of the need to co-ordinate the work of these hospitals with that of voluntary hospitals. The last-named for generations have supplied public needs which otherwise would have had to be met out of taxation. The varieties of hospitals may be classified as:—

1. Charitable (voluntary hospitals).

Provided for the poor by subscriptions of the beneficent public, or/and endowed by permanent gifts. These hospitals are—

(*a*) general, for all diseases;
(*b*) special, for one disease or diseases of a particular part of the body, or of a special age-group.

2. Official (supported from rates and taxes).

These include—

mental hospitals (asylums), for the insane and feeble-minded;
public assistance hospitals, for the necessitous;
isolation hospitals, for the infectious sick;
maternity and child welfare hospitals and clinics;
tuberculosis hospitals and sanatoria;
venereal disease clinics with hospital beds;
orthopædic hospitals;
and many others.

3. There is much additional provision at

clinics and dispensaries

which may be attached to one of the above institutions or may exist separately.

Provident dispensaries in which payments on a weekly basis

(whether well or ill) entitle families to medical treatment have been largely superseded by the more general provision made in national sickness insurance schemes.

4. Self-supporting hospitals,
   or sections of hospitals for the well-to-do.

The above enumeration is not complete. For our purpose we need not consider convalescent institutions. Nor does the classification represent natural divisions. Thus in most hospitals payment is now required from the patient or his responsible relative in accordance with means. It will give us a wider purview if we first outline

National Methods of Hospital Provision

The more detailed facts for different countries are given in Volumes I to III of *International Studies*. Before giving this outline we should have in mind the general principle which should govern hospital provision. It may be stated thus:—

THE ADMISSION OF PATIENTS TO A HOSPITAL FOR TREATMENT SHOULD BE DETERMINED ON MEDICAL TESTS ALONE. THE OLD IDEAS AS TO CHARITABLE RELIEF FOR THE *SICK* MUST GO. Payment according to means whether determined by a hospital almoner or provided on an insurance basis must never inhibit or delay the hospital treatment of any patient needing it. Thus the motto of the old Edinburgh Infirmary, *patet omnibus*, may be regarded as universally applicable, when interpreted as meaning that hospital treatment must always be immediately available for all for whom it is needed on medical grounds.

The following outline of international practice should be considered in the light of the axiom stated above. The special arrangements made for clinics for maternity and child welfare and for tuberculosis, etc., are given in subsequent chapters.

GREAT BRITAIN.—Legally every necessitous person is entitled to gratuitous hospital treatment when on medical grounds this is needed. The hospital provision in the smaller poor-law

infirmaries has been unsatisfactory. It is now improving. That in the large towns is of high quality; in some it is quite equal to the best provision in voluntary hospitals. Public assistance hospitals are now available for the general public, payment being assessed in accordance with family circumstances.

Voluntary hospitals in Britain are primarily for the necessitous, and in this respect cover the same field as public assistance (official) hospitals. But a great change has occurred in their utilisation. Their voluntary character, in so far as this means general free treatment, has disappeared except for the very poor; and patients are expected to contribute according to their means. The practice of contributing while well a weekly sum which gives a partial promise of hospital treatment when needed has grown very rapidly, and sums thus contributed on a voluntary semi-insurance basis now form an important part of the total income of voluntary hospitals.

IRELAND.—There is a more general provision of free medical treatment by the destitution authority in Ireland than in Great Britain, though the quality of this treatment in institutions does not, as a rule, equal that available in Britain.

In Great Britain and Ireland no hospital provision is made under their insurance schemes; but some insurance societies pay for a limited amount of hospital treatment for their clients.

THE NETHERLANDS.—Municipalities must provide hospital treatment for the necessitous; they often contract with religious bodies to undertake this treatment. Co-operative action to provide hospital treatment through voluntary insurance has become extensive. Nearly all wage-earners are insured for medical help in sickness; and the insurance societies help in paying for hospital treatment (Volume I of *International Studies*, p. 27).

DENMARK.—There is an admirable system of municipal and county hospitals throughout the country. Charges for treatment are made according to means. Insurance societies pay 70 per cent. of the charges for hospital treatment of the entire population. The charges represent only a fraction of the cost of this treatment, the balance coming out of local taxation. Patients are divided into three classes according to payment. All infectious cases are treated free of charge. Hospital doctors are nearly all whole-time officers (Volume I of *International Studies*, p. 56).

SWEDEN.—The hospital system resembles that of Denmark. Provision is made out of national or local funds, payment being made by individual patients according to means. Hospital doctors are almost all whole-time officers. In both Sweden and

Denmark there is an almost lavish provision of hospitals, although both countries are relatively poor. The standard of professional provision in these hospitals is very high.

The municipality of Stockholm has established polyclinics at its hospitals, and some similar polyclinics have been established elsewhere. At these clinics patients are received for a small fee, independently of private doctors (Volume I of *International Studies*, p. 92).

NORWAY.—Like the other Scandinavian countries, Norway has practically no voluntary hospitals. There is one State-provided hospital in Oslo; elsewhere the larger hospitals are provided by the county councils, and patients pay according to means. No distinction is made for insured patients. There are no polyclinics. The medical staff of hospitals are paid (Volume I of *International Studies*, p. 115).

GERMANY.—Most German hospitals are supported out of public funds, many partially or entirely out of insurance funds. The communal authorities are required to provide hospital treatment for the poor. Medical teaching is done in State-supported hospitals, also in municipal hospitals. In larger cities there are some voluntary hospitals, which may belong to one religious denomination. Municipalities pay for the hospital treatment of the very poor; others pay according to means. About 65 per cent. of the patients in the hospitals are members of insurance societies, but the funds of these societies commonly do not pay much more than half of the cost of each patient. Usually hospital doctors are salaried, and do not engage in private practice. There are private hospitals for the well-to-do (Volume I of *International Studies*, pp. 139, 186).

AUSTRIA.—The hospital system is maintained by the taxpayer, subject to what can be recovered from patients. Insurance societies pay a part of the charge for insured patients. These charges do not cover cost. There is a complete system of hospitals for the entire country (Volume I of *International Studies*, p. 200).

SWITZERLAND.—Each cantonal government maintains the hospitals of the canton. Charges for treatment are graduated. Polyclinics are found in a few centres, for expert assistance to the poor and for clinical teaching (Volume I of *International Studies*, p. 230).

BELGIUM.—Each community provides hospital accommodation. Thus in Brussels each of its nine boroughs has an independent official municipal hospital. Patients are charged according to means. The staff is usually on a part-time basis. Much treatment in hospitals and at polyclinics is organised by

federated insurance societies (Volume II of *International Studies*, p. 35).

FRANCE.—Hospitals are provided by the municipalities, and treatment is free for the necessitous, who are duly certified by the doctor in attendance or the mayor. For others, graduated charges are made. Much of the hospital provision outside Paris is inadequate and unsatisfactory. In Paris hospitals conditions vary greatly, some hospitals being among the best in the world (Volume II of *International Studies*, pp. 60, 69).

ITALY.—In Milan the municipal hospital is supported partly by public funds, partly by gifts, and partly by payments by patients. Communal hospitals are provided in other districts with varying arrangements.

It is unnecessary to describe the hospital arrangements in Jugo-Slavia, Hungary, and Poland. In all of them provision is made chiefly or entirely by means of taxation, while payment is exacted according to means, some of it from insurance funds.

REVIEW OF HOSPITAL PROVISION IN VARIOUS COUNTRIES

In every country, even the poorest, some hospital provision is made for the necessitous. In many countries hospital provision for these cases has been highly unsatisfactory; and it remains so in the rural districts of many countries. This is especially so WHERE THE HOSPITAL FOR THE DESTITUTE DOES NOT ALSO ADMIT PATIENTS ABOVE THE OFFICIAL POVERTY-LINE. The separation of hospital accommodation for the official poor from that in voluntary hospitals and for other classes is apt to be associated with vastly inferior medical care for the former. Happily, in Britain for instance, this is now disappearing; and with the extended use of municipal hospitals for all classes this duality is doomed.

The method of deciding who is necessitous and therefore entitled to gratuitous treatment varies greatly. In France previous registration at the mayoralty is required to ensure free treatment, though in Paris this condition is relaxed. In Britain patients have usually been seen by the medical officer of the district, after the private doctor has asked for his patient's admission; but this condition has commonly been relaxed, and always in urgent cases.

In some countries, and in particular the Scandinavian, official hospitals serve the whole community, well-to-do and poor, and in these the standard of treatment is wonderfully high. Denmark and Sweden, in particular, set an example to the world in efficiency and amplitude of provision.

The conditions in voluntary hospitals vary greatly. In Britain they fulfil a duty which is valuable and perhaps irreplaceable; but although voluntary hospital accommodation is increasing, the proportion of voluntary to total hospital provision is steadily decreasing. Furthermore, voluntary hospitals may almost be said to have ceased to be "voluntary" in the former sense of the word, except in the fact that their visiting staff remain unpaid. More and more demands have been made on the accommodation of voluntary hospitals, which they have been unable completely to meet. Hence they have become chiefly hospitals for acute operative and accident cases, though even in these respects municipal and county official hospitals serve the same end and are more widely distributed.

Voluntary hospitals have ceased in Britain to treat exclusively or chiefly the necessitous. Patients of all classes may be admitted without distinction, patients being expected to pay according to their means. The question of payment does not arise until after the patient is admitted. The only modification needed to this statement relates to patients admitted under a hospital contributory scheme (p. 95). The details of growth of this changed policy in Britain may be seen in Volume III of *International Studies*, p. 69.

The picture on the continent of Europe has been profoundly modified by national systems of sickness insurance. Most of these systems include some payment for hospital treatment of the insured, though this never covers the full cost. In several countries this is a subject of controversy.

The General Case for Hospital Treatment

The history of hospitals is one first of CARE for the sick, then with advance in medicine and surgery, of increasing

CURE, and, lastly, of PREVENTION. The last stage now overlaps with the needed care and cure. Early and scientific treatment increases the proportion of patients cured, curtails the duration of their illness, and can be and often is made the occasion for advice which will prevent the recurrence of the particular illness. This is also true of the work of the private practitioner.

Hospital treatment when needed should be given irrespective of the question of public assistance (see axiom, p. 68). Neglected disease creates the necessity for monetary assistance, and to allow prompt and satisfactory treatment to be impeded by official restrictions implies the creation of a radically vicious circle of evil.

The advance of preventive medicine is largely responsible for increased hospital accommodation, only less so than the remarkable advance and specialisation of clinical medicine. The increasing use of hospitals may be regarded as *primâ facie* evidence of their value. About half of the total deaths in London occur in institutions for the sick (hospitals and asylums), including half the deaths from tuberculosis; and in provincial England this proportion is also large. In other countries the same phenomenon is observed. Although it is difficult to give a quantitative statement of the benefit which hospital treatment confers on a vast number of patients in earlier recovery of health and in the avoidance of a fatal result, it is indubitable that hospital treatment has been a very large factor in improving the standard of health and in increasing the longevity of the people.

Among the services rendered by hospitals may be mentioned:—

1. The TREMENDOUS DOMESTIC RELIEF secured by the removal of the patient to a hospital, especially when the case is acute or an operation is needed. For the wife of the patient prolonged sick nursing may mean a physical breakdown. Furthermore, nursing in the home is seldom efficient unless a trained nurse is obtained. This for the majority of families is prohibitively costly when added to the direct medical expenditure.

The further difficulty arises, especially in town life, that in an apartment-house, or even in a small separate house, a room often cannot be allotted for the patient, much less for the nurse.

2. In a large proportion of cases of sickness THE POSSIBILITIES OF INFECTION are minimised by removal to a hospital. This is so for acute respiratory as well as for specific febrile diseases. It is still more true for cases of tuberculosis during the repeated febrile exacerbations of the disease. So true is this that in this disease, in my judgment, THE PATIENT SHOULD AS A RULE TEMPORARILY RESIDE IN A SANATORIUM AND THERE BE SYSTEMATICALLY INSTRUCTED AND TRAINED IN HIS MANNER OF LIFE, BEFORE SANCTION IS GIVEN FOR HIS LATER TREATMENT AT HOME IN A SEPARATE BEDROOM. It is thus that he can be expected to cease to be a frequent source of risk to the other dwellers in his home.

3. For a large proportion of patients, especially surgical cases, THE NET COST OF HOSPITAL TREATMENT IS MUCH LOWER THAN THAT OF EQUALLY EFFICIENT TREATMENT AT HOME. Standard appliances are available without being specially provided. The same remark applies to surgical treatment for patients for whom out-patient treatment suffices. What an economy of effort and cost would accrue if a health centre or emergency treatment centre were arranged in every populous district at which minor accidents, wounds, etc., could receive first aid!

When local medical practitioners have learnt the fundamental lesson that, in modern circumstances, IF THE FAMILY IS TO CONTINUE TO BE THE UNIT OF MEDICAL PRACTICE, THEN A TEAM OF MEDICAL PRACTITIONERS, AND NOT AN ISOLATED PRACTITIONER, SHOULD BE THE UNIT ON THE MEDICAL SIDE, this and allied co-operative work will become practicable, at least in populous districts.

This economy of effort and availability of all possible skill in hospitals is a phenomenon of "big business". As has been pointed out (Dr. H. P. Newsholme, *Lancet*, November 9, 1929), it is a problem with two faces, as in

the antithesis between individualism and socialism, between the small shop and the multiple emporium, between the combine and the self-contained business, and on the personal side between the individual and the group, between self-expression and group membership. The gains are in concentration and centralisation of effort and in reduction of overcharges; and there is, furthermore—

4. The fact that the hospital physician and surgeon can often supply special skill which in a minority of cases cannot reasonably be expected from the family doctor. The last point necessarily opens up the recurring problem of

Specialisation in Medicine

Specialism undoubtedly has fundamentally modified the whole of medical practice and greatly changed the position of the family doctor. The continuing trend in modern medicine is, partially or wholly, to remove some branches of practice temporarily, and some more permanently, from the care of the general practitioner, and to oblige him, in his patient's interest, to consult with specialists and with physicians and surgeons of consultant rank in an increasing proportion of the cases remaining in his care.

In recent years public health authorities have taken some part in this process of abstraction; but they are not primarily or chiefly responsible for the course of events. The process is inevitable in the development of medicine; and private practitioners themselves—let it be said in their honour—have been the chief agents in producing it. It is in the main owing to their realisation of the needs of their patients that consultations with experts are more frequent and that an increasing number of their patients go to the special departments of hospitals or are admitted into their wards. In the Annual Report of the Medical Research Council for 1930–31 is given a recent illustration of the need for specialist help. It is agreed that insulin is invaluable in the treatment of diabetes, but it is added that "a large number probably are not receiving insulin under proper conditions of biochemical control and diabetic balance."

Radiological methods of diagnosis and treatment have assumed great importance in many diseases. Their use has become almost ubiquitous; so much so that no one radiologist can be expected to have specialist skill in all branches of radiological work. Thus radio-therapy is an almost separate specialty in radiological work.

Any branch of medicine or surgery will furnish similar illustrations; and it is evident that, in the minority of the total cases of illness which present special difficulties, the differentiation of knowledge and skill implied in specialism must be utilised if the patient is to have a "fair deal".

The growth of specialism implies the need for co-ordination and co-operation in medical practice, and the greatest lack in present medicine is the imperfect development of these.

Drawbacks of Hospital Treatment

Of these—

1. Discontinuity in medical work has already been noted in Chapter II.

2. The expense of hospital treatment is a heavy burden on taxpayers and voluntary contributors. This objection is only apparent; for cases really needing hospital treatment are usually more economically treated in a hospital than at home, given equal efficiency; and the burden is borne with relative ease if anticipated on a provident or insurance basis.

3. Occasionally there is point in the contention that in hospitals the disease is treated rather than the patient, though this I am confident is exceptional. The story of the negro, who was informed by the hospital doctor that his blood gave a positive Wassermann reaction, and who answered, "Yes, Massa; but I'se also a sick man", illustrates this occasional lack in hospital work.

4. A further alleged drawback is the diminishing scope of the general practitioner's work and the corresponding decline in his all-round competence. It is doubtful if this contention is valid. The growth in complexity of

medicine has necessitated specialisation and hospital treatment in a large proportion of cases. If in such cases the practitioner retained the patients at home they would suffer, and he would not gain except in pocket. There is truth in this objection in so far as patients go unnecessarily to consultants and to hospitals, and in so far as the general practitioner to the utmost extent that is practicable fails to keep in touch with his hospitalised patient. The general question raised by this remark is discussed later (p. 97).

Over-hospitalisation

In Denmark practically all surgical work and a very high proportion of its medical work are done in hospitals, and this position appears to be generally accepted as normal by the private medical practitioners of that country. He is expected to send particulars as to his patient when the latter enters hospital, and the hospital records are sent to him on completion of the case.

The fear of over-hospitalisation expressed in some quarters arises from the heavy burden to the community of the maintenance of hospitals; but in Denmark I could not ascertain any expression of opinion that with better home nursing many of the hospital patients might be treated in their homes.

In Britain there is still a deficiency of hospital beds, which is greatest in the more scantily populated counties and the widely spread suburbs of great towns; but the utilisation of public assistance hospitals for the general public, and the elevation of their standard of work when this is needed, will go far to alter this in towns. In country districts there is still needed a linking-up of smaller public assistance hospitals and cottage hospitals with large general hospitals.

It is true, however, that given trained nursing, domestic help, and a separate bedroom, a large range of patients now treated in hospitals might be treated satisfactorily at home. I would not give pneumonia or major surgical cases as good instances of possible successful home treatment;

but many common ailments might with adequate organisation receive home treatment. In the future such an operation as appendicitis may come within the capacity of more general practitioners, as it is now of many. The treatment of varicose veins by consolidation should come similarly within the general practitioner's competence. The use of insulin in diabetes sometimes has been rendered futile by the inexperience of the practitioner in the collateral chemical tests which are needed. But this need not continue. Antenatal work has been largely neglected by practitioners, and still more often done perfunctorily; but this need not continue, and when doctors are engaged by expectant mothers official antenatal clinics will in time become superfluous, unless a consultation is desired by the private doctor.

The difficulties of private medical work are great in many cases. Even assuming that the medical skill of a single doctor suffices, bedroom accommodation and appliances are often unsatisfactory, and pecuniary difficulties are great. Some partial reduction of the strain on hospital accommodation in the larger hospitals is being secured, and might be further developed—

1. By increased provision of convalescent homes;
2. By attendance at the out-patient department of the hospital when convalescent, and especially
3. By the general practitioner resuming his domiciliary care of the patient at an earlier stage, with the aid of a district nurse;
4. By the further development of smaller (cottage) hospitals attended by general practitioners, who would act in accordance with the limitations suggested on page 93.

Clinics and Polyclinics

Similar remarks apply to the resort of patients to the out-patient departments of hospitals, to municipal clinics, and to the polyclinics in foreign countries. The last named in large measure supersede the private practitioner, and may be first considered.

Such clinics of municipal origin are most highly developed in Sweden. Polyclinics are attached to the general hospitals

in Stockholm which patients are allowed to attend without reference from a private doctor, paying a small sum for each consultation. In similar clinics where medical students are taught no charge is made. Naturally objection has been raised, but ineffectively, by local doctors. The work as thus carried on is obnoxious to the private practitioner, and the patient in some instances suffers because of the discontinuity of medical care.

In Zurich, Switzerland, there are similar polyclinics for poorer people attached to the University hospital, the expense being borne by taxation.

In other countries polyclinics have developed chiefly in connection with insurance medical services.

An example is given from Austria on page 214, Volume I, of *International Studies*; and similar organisations, including polyclinics and smaller treatment centres or ambulatories, are described in Volume II of *International Studies* (p. 190, Hungary; p. 208, Poland; and p. 241, Czecho-Slovakia). In general these polyclinics and ambulatories are well organised, and give both general and specialised treatment of high quality. There is some waste of patients' time in waiting, but less than is frequent in the out-patient departments of some voluntary hospitals in Britain. The fact that specialised skill is available in all departments of medicine under one roof is admirable; but the common lack of adequate co-ordination between domiciliary medical work and that in the polyclinic is deplorable. In several countries patients are treated at polyclinics without any reference from or to the private practitioner, and there is evidence of redundant and extravagant work, due to the uncontrolled wandering of patients from clinic to clinic.

Observations on official clinics for special diseases and on "social hygiene clinics" are made in subsequent chapters.

Out-patient Departments

Many voluntary hospitals in Britain continue to be overburdened with out-patients. In some large hospitals out-patients are only seen when they bring a letter from the

private practitioner who has seen them already, or this rule may be limited to insured patients. The practitioner receives a letter respecting the patient in due course. This rule does not apply to accidents and emergency cases. In other hospitals excessive numbers are seen by the medical staff, and there is much waste of time not only for the patient, but also for the skilled physician who should be more usefully employed. In out-patient departments there is a steady incursion of chronic sufferers, many of whom are "social misfits". Some of these may have been sent by the insurance doctor, who is tired of their pertinacity; others have left him for advice which they think will do more for them. Some do this justifiably, because of neglect on the part of the private practitioner to devote time and care to them, or because he has not himself proposed a consultation or accepted his patient's suggestion of one. Some out-patient departments still give drugs, commonly in the form of "stock mixtures", to an extravagant and even mischievous extent, in lieu of a prescription which should follow a study of each patient's real needs. So much so that out-patient departments of hospitals some years ago were described as "largely shops for giving large quantities of medicines". This remains true in only a minority of cases. When the medical staff are willing to confer with the pharmacist of the hospital, it is often possible to simplify and cheapen the cost of medicaments, to the advantage of the patient as well as of the hospital funds.

A new evil has arisen in Britain in recent years. Hospital contributory schemes sometimes lead weekly contributors to imagine that they have the right to demand medical advice at out-patient departments of hospitals, especially in their specialist divisions. This is a valuable but limited privilege; and it should be used chiefly as a means of consultation between the hospital doctor and the private, usually insurance, doctor. It is only thus that its full utility can be realised. How to secure this limitation, short of forbidding the attendance of patients except after reference from their own doctor—which would be going too far—

is a difficult problem; but some restriction is needed in the interest of good work. Social workers inform me that exceptional instances of gross neglect by the private doctor occur in which sending the patient independently to a hospital is the only available remedy.

Protracted waiting is endured by patients attending out-patient departments in Britain and polyclinics in other countries. In a hospital attached to a medical school, more waiting may be necessary than in other hospitals; but, speaking broadly, there is still a scandalous amount of unnecessary waiting in the out-patient departments of many hospitals. Furthermore, out-patient hours are rarely arranged to suit the convenience of workers, and a working man or woman may lose more in wages by his attendance at a hospital than would be needed to pay a fee to a private practitioner.

It would be practicable to reduce this waiting period in hospitals by arranging for special appointments, by increasing the junior medical staff who should be salaried officers, and by reducing the waiting time after the medical interview before the medicines are dispensed. Practical action on these lines is greatly needed. The subject is discussed in an article on "Reasonableness, or Hospitals as Factories", by Dr. A. R. Friel (*Lancet*, March 14, 1931).

The proposal of the British Medical Association that dependents of the insured should obtain the medical benefit of the National Insurance Act, if adopted, would bring something like seven-eighths of the British population within its scope; and with efficient working of the extended medical benefit, the need for out-patient treatment at hospitals would disappear, except for consultations and emergencies.

The Council of the British Medical Association, in a recent memorandum (*British Medical Journal, Supplement*, February 21, 1931), have given their opinion:—

> That while there should be adequate opportunities for consultation purposes between the private practitioner and members of the visiting medical staffs at out-patient departments, practi-

tioners should not countenance the use of that department by their patients, except in the ways laid down in this memorandum.

That no person, except in cases of emergency, should be accepted for treatment as an out-patient at a voluntary hospital unless he brings a recommendation from a private medical practitioner, a provident or other dispensary, a public clinic, or from a public assistance medical officer of a local authority.

Even though some limitation to this proposed embargo on out-patient hospital treatment may be necessary, it is clearly undesirable that medical work which can be done by the insurance doctor, and for which he already receives remuneration, should be transferred to others at the public cost or that of charity.

Summary on Hospitals and Medical Care

30. The admission of patients to a hospital for treatment should be determined on medical tests alone. The conception of charitable relief for the SICK poor on a deterrent basis is inexcusable.

31. In tuberculosis the patient, as a rule, should temporarily reside in a sanatorium and there be systematically instructed and trained in his manner of life, before sanction is given to his later treatment at home with a separate bedroom.

32. For many patients the net cost of hospital treatment is much lower than that of equally efficient treatment at home.

33. The growth of specialism implies the need for co-ordination and co-operation in medical practice, and the greatest need in present medicine is the development of this interrelationship.

34. Reform of many out-patient departments of hospitals is needed.

CHAPTER VI

HOSPITAL POLICY AND PRIVATE MEDICAL PRACTICE

FROM the contents of Chapter V it will be seen that both voluntary and official hospitals have rapidly increased the amount of treatment they give, not only to the necessitous, but also to a very high proportion of the sick of all classes. The benefits of this increasing hospital provision are undoubted; but existing arrangements present anomalies and even abuses which call for reform. In discussing in the following pages these anomalies and abuses, we necessarily touch at many points on the relation of private medical practice to hospital work.

VOLUNTARY OR OFFICIAL HOSPITALS

In discussing this relationship I necessarily do so chiefly from the standpoint of British experience, but the problem is international, and much of what is written applies generally in European experience, except in one particular. This is in the tenacity with which Britain clings to the "voluntary hospital system", and the aversion with which any suggestion of its possible obsolescence is received.

As already stated, there is no reduction in the number of voluntary hospital beds in Britain, but these beds are now fewer in number than hospital beds provided out of taxation. Burdett, in 1893 (*Hospitals and Asylums of the World*, Volume III), wrote of England as "the home of the voluntary system"; but although he characterised their out-patient departments as little better than "schools of pauperism" (p. 57), he opposed the replacement of voluntary by State hospitals as being "a loss to the whole community in the lessened moral sense which State institutions create". He was clear that "all thoughtful men must, therefore, set their faces against any attempt to interfere with the voluntary hospitals". It may be remarked

at once that there has been no such general attempt, except in the polemics of academical discussion. The supplementation of voluntary by official hospitals has occurred through the force of medical economic considerations, backed by the inability or unwillingness of present-day taxpayers to support voluntary hospitals to the same extent as in the past. Sir Ernest Graham-Little, M.D., urges the preferential claims of voluntary hospitals, in view of their independence and charity, and because they are not "stereotyped, inelastic, and departmental" like official hospitals. The British Medical Association favours the retention of voluntary hospitals. In its Memorandum on Hospital Policy, 1930, it is stated:—

> The Association recognises that the essence of the voluntary hospital system has been its independent and voluntary management, and is satisfied that this has proved to the advantage of the public, and has fostered the advancement of medical science; and holds that in the interests of the community it should be maintained.

"The only fault of the voluntary hospitals", says Mr. H. P. Orde, "is that there are not enough of them"; while Mr. E. W. Hey Groves, professor of surgery in Bristol University (*Lancet*, May 3, 1930), on the other hand describes voluntary hospitals as "dependent upon the bondage of mendicancy", and especially notes the frequency of inadequate number of beds and long waiting lists of patients. He is, furthermore, doubtful as to the difference in administrative capacity of hospital committees of voluntary and official hospitals. I agree in doubting the accuracy of this contrast so often made. The "bureaucratic control" of members of municipal hospital committees is sometimes compared unfavourably with that of the lay boards of voluntary hospitals, which "attract to themselves persons of wide culture and interests". But "the category of a hospital is determined much more by the standing of its visiting staff" than by the character of its buildings or the source of its income.

1. In British experience the voluntary system is more readily available for the education of medical students. This arises from the freedom from local official control, and in part from the fact that admission to a voluntary hospital is not restricted by the residential considerations which apply to hospitals maintained by local authorities. This restriction is not essential in official hospitals, and has been abandoned in the treatment of venereal diseases at official hospitals. Municipal and county hospitals, furthermore, treat patients suffering from chronic common and incurable diseases to a greater extent than voluntary hospitals, and medical teaching, to be complete, must include such patients.

2. It is important that the staff of a hospital should be available for consultation purposes for all who cannot afford this service in private practice; and voluntary hospitals have hitherto given this facility to a much greater extent than official hospitals. At official clinics (tuberculosis, venereal disease, and infant consultations) such consultation facilities form a special feature; and the frequent lack of such facilities is not an intrinsic defect of official hospitals.

3. Voluntary hospitals hitherto have been better adapted than official hospitals for research in medical science.

4. Official hospitals are staffed by whole-time surgeons and physicians, though the practice of employing visiting surgeons, physicians, and specialists is extending. The visiting staff of voluntary hospitals in Britain are unpaid, and as a rule only junior residents are paid; both the residential and visiting staffs of official hospitals are paid for their services.

5. The voluntary hospital, however, suffers in efficiency by being an isolated unit, not falling in with a general scheme of hospital provision. Its work is apt to overlap with that of other voluntary hospitals; and in regard to overhead charges and special scientific equipment its expenditure is inadequately controlled, except perhaps in London, where King Edward's Hospital Fund exercises partial control. In being governed by laymen it resembles the official hospital; but, in the latter, expenditure is more effectively supervised.

This isolation and separateness of each voluntary hospital is a serious drawback. It has the further incidental drawback that each hospital is apt to compete with others for subscriptions; and in this competition large figures as to the number of patients unfortunately form a part of the appeal. This appeal to numbers in part explains the inflated out-patient statistics.

None of these points need necessarily differentiate voluntary from official hospitals, and the requirements of a good and adequate hospital service can be met under either system, if it is financially supported to an adequate extent, and if the conditions set out on page 77 are met.

Voluntary hospitals do not at present meet the needs of the community either in definite division of work, in localisation, in avoidance of overlapping of effort, or in adequacy of provision. They are now rather less dependent on "mendicancy" than in the past, but to the extent to which their income is derived from contributions of patients, aided by subventions from public health authorities, the difference between voluntary and official hospitals decreases.

Voluntary hospitals in England are not always well distributed for the convenience of patients. In London they are chiefly in its central districts, and for this reason the public assistance hospitals which exist in every district of the metropolis are now doing a large part of the work which was formerly done by voluntary hospitals. It may be stated with assurance, however, THAT THE STATE WILL NOT ADD OFFICIAL TO VOLUNTARY HOSPITALS UNLESS IMPELLED TO THIS BECAUSE VOLUNTARY HOSPITALS ARE INADEQUATE FOR PUBLIC NEEDS. The two systems, voluntary and official, are likely to continue and to find more and more their relative sphere of utility, which will vary with local circumstances. Premature attempts to insist on a "well thought-out" scheme of co-operation are not to be encouraged. No scheme will fit all local circumstances. No scheme which assumed the medical inferiority of official to voluntary hospitals is likely to prosper. But there is every reason for co-operative effort between voluntary and official hospitals. This is already largely attained, and particularly so in the use of official ambulances.

Duplication of provision in voluntary hospitals occurs on a large scale, especially as between the special (ophthalmic, throat and ear, gynæcological, children's) departments of general hospitals and similar accommodation

provided in hospitals devoted solely to one of these conditions.

The lack of co-ordination and apportionment of work between different voluntary hospitals is deplorable; and the remedy is difficult so long as each hospital charity is independent. King Edward's Hospital Fund has done something to remedy this inco-ordination in London, by making its yearly grants of money (see Volume III, *International Studies*, p. 67) conditional on adjustment and reform.

The Relation between Voluntary and Official Hospitals

These do not now differ in respect to the exaction of payment by patients in proportion to their means.

There is already much co-operation between the two types of hospital. Official hospitals must admit all found medically in need of hospital treatment; voluntary hospitals can select and reject patients for various reasons. Hence an official hospital may be required to receive from a voluntary hospital a patient with cancer of inoperable character; and official hospitals tend to receive a much larger proportion of cases of chronic rheumatism and bronchitis, and generally of patients for whom recovery is not expected, than do voluntary hospitals. The suggestion often made that municipal hospitals should receive chiefly the classes of disease just indicated, while voluntary hospitals receive acute surgical and medical cases is not in accordance with possibilities. Geographical reasons and deficiency of accommodation in voluntary hospitals negative it. Public assistance hospitals in large centres of population have now reached a standard which enables them to treat satisfactorily all cases of illness. Classification of cases in a general hospital, whether voluntary or official, should be within the institution rather than by separate institutions. This applies even to tuberculosis, subject to this disease being treated in separate wards. In making this statement I assume that the municipal, like the voluntary hospital, has a consultant staff paying frequent visits,

as well as its whole-time and highly skilled residential staff. As to the classification of hospitals, primary and auxiliary, see page 103.

Staffing of Hospitals

In voluntary hospitals in Britain the staff, except the junior residents, are part-time medical officers, who have usually been gradually trained into hospital work by a system somewhat resembling an apprenticeship. This has possible advantages over the official system of a whole-time permanent resident medical officer, even when he has an adequate staff of assistants, some of them with skill in special departments of medicine.

In large official hospitals in Britain visiting consultants are now being appointed in increasing numbers and are paid a salary, on the basis of number of visits made. Hospitals in most parts of Europe, being chiefly official, are nearly always staffed by doctors who devote themselves entirely, or almost entirely, to their hospital work. In Britain the position of the honorary doctors who are responsible for the care of patients in voluntary hospitals is being fundamentally changed by the admission of patients under contributory schemes and of patients for whom local authorities pay; and the British Medical Association has repeatedly indicated that for such patients the hospital doctor is undertaking work for which he should receive a monetary return. In some voluntary hospitals arrangements are made for this. Sometimes a portion of the sums paid into the hospital exchequer is allocated to the doctors, who may divide it among themselves, or who may use it for new apparatus, additions to the medical library, etc. In a few instances a definite proportion of the payments made by patients is handed over to the medical staff.

In my view there should be a frank acceptance of the PRINCIPLE OF PAYMENT TO THE PRESENT HONORARY MEDICAL STAFFS OF HOSPITALS. Suggestions in this direction have been made. Among these may be cited the useful recommendation that the number of beds allotted to junior

physicians and surgeons should be increased, senior consultants treating chiefly picked cases. This would ensure greater individual care of patients, and would aid medical research. Honoraria to the junior consultant staff would be greatly in the interest of medical science.

Cottage or District Hospitals

In smaller voluntary hospitals, and particularly in cottage or district hospitals, the visiting staff consist of general practitioners in the district, and varying degrees of inadequacy for specially difficult work arise. In many of these hospitals there is "something gravely wrong"; they—

> are responsible for turning out a great deal of bad surgical work, and I suspect that a similar statement might be truthfully made about their work in medical and special departments. . . . This is really no reflection upon the professional attainments of the staff. They are being asked to carry out an impossible task, that of being general practitioners and also specialists at the same time (E. W. Groves, see p. 88).

This criticism is aimed at the surgical work of small hospitals, and carries with it a wholesome warning against rash attempts at carrying out unaccustomed major surgical work. But the main function of district hospitals is in purely medical work; and for this the general practitioner can undertake treatment successfully in hospital which would be impossible in the patient's home. There is the further point that district hospitals engage largely in the treatment of road injuries; and in these cases the best accessible skill must be utilised, a consultant being called in when necessary.

District hospitals have increased in number, and even though sometimes they "embody many of the worst features of the voluntary system", the need for them is undoubted. But their grading is necessary; they should undertake chiefly emergency work which a general practitioner can reasonably undertake, and they should be organically linked up with large voluntary hospitals which have a staff of the consultant type. Cottage hospitals may

be defined as auxiliary hospitals in which treatment is given by general practitioners, and they render valuable service if used in accordance with this definition. They give a valuable opportunity for team-work among practitioners.

As Mr. C. E. S. Fleming (*British Medical Journal, Supplement*, May 4, 1929) has put it:—

> More than anything else the family doctor needs the opportunity to practise what he has learned, and to learn what he should practise.

Lord Dawson of Penn has also emphasised the greater importance of providing the general practitioner with the means to help himself than of making available consultants and specialists to help him. Both these statements are true, subject to the condition that the general practitioner refrains from undertaking treatment and particularly operations in which he has not already acquired skill. The limit here suggested is not a fixed point. Its determination is difficult; but in any doubt the welfare of the patient must determine the decision. The work of the specialist of yesterday may be that of the general practitioner to-day. And even now much treatment is being given in the larger hospitals which might equally well be given either at home, in cottage hospitals, or in convalescent homes. The larger hospitals would then treat a larger proportion of cases requiring special skill. But both in medical cases requiring special consultative skill, and still more in major operations, it is imperative in the public interest that the district hospital should act, like the conscientious and intelligent private practitioner acts. In special cases he should serve as a clearing-house and a link for obtaining co-operative aid.

Payments by Hospital Patients

The methods of hospital provision and payment for treatment in various European countries are indicated on page 72; and for a fuller statement of British methods

the reader is referred to Chapters III and IV, Volume III, of *International Studies*.

The present position of hospital provision in Britain is one (1) of gradual disappearance of the difference in function between voluntary and official hospitals respectively; and (2) of introduction to a rapidly increasing extent of partial payment for the services rendered, either by direct assessment according to the financial ability of the family, or by prior family payments on an insurance or provident basis.

In other European countries the sickness insurance organisation pays for some of the cost of hospital treatment of the insured; in Britain this is only exceptionally done. Present insurance contributions do not admit of more adequate hospital provision. This has been one of the motives leading to the growth of

HOSPITAL CONTRIBUTORY SCHEMES to which a large proportion of wage-earners and others whose income does not exceed the compulsory sickness insurance limit (often there is no definite limit) contribute, on the understanding that when sick the contributor and his family shall have a consultation with an expert or receive in-patient treatment if in the view of the hospital doctor this is needed, and if the facilities needed are available. It is not intended that this provision should apply to minor ailments; but some patients belonging to a contributory scheme resort to the out-patient clinics of voluntary hospitals in preference to visiting their own insurance doctor (see p. 84).

Most hospital contributory schemes are built on weekly contributions of a small weekly sum (usually 2d. or 3d.) by the head of the family. These sums are collected weekly by the employer when wages are paid, or are received by an unpaid volunteer secretary. The employer may contribute an equal or a smaller amount; but contributions are not made by all employers. Voluntary hospitals now receive a large share of their total expenditure from various kinds of hospital contributory schemes.

The contributions never cover more than a part of the

cost of hospital treatment; and voluntary hospitals continue to be dependent in part on invested funds, on annual subscriptions, and on payments received from local authorities for work undertaken in their behalf. But the total contributions made under these contributory schemes have greatly eased the financial position of many voluntary hospitals in Britain.

When payment for a patient is not vouched for under a contributory scheme, the hospital almoner or some other official assesses payments which are expected to be made by the head of the family concerned. The payments thus asked for are graduated according to the family income; they rarely cover the entire cost of hospital treatment. The absence of any graduation of payment in hospital contributory schemes is a weak point in their organisation, though any attempt at graduation would complicate their work and render the schemes less popular. Hospitals are entitled to ask for a supplementary payment, if they consider the patient can afford to pay more than his insurance arrangement has supplied.

These contributory schemes raise new medical and administrative problems. The workers who contribute large aggregate sums—even though the amount never suffices to pay more than part of the cost of treatment—are likely to claim through their associations some share in the government of the hospitals concerned, and indications of this are already seen in the management of some smaller hospitals. If there is interference in medical care, and especially in the teaching of medical students and nurses, harm will result; but with the spread of intelligence and public spirit this risk will decrease.

Fear has been expressed that contributory schemes may scare away charity. But it is evident that the contributions do not cover the entire cost, and that a large number must always remain for whom gratuitous treatment is required. There is no essential difficulty in combining charity and providence.

The course of future hospital development cannot be

forecasted with any approach to accuracy. The voluntary system is imbedded in British life, and its continuance is probable. This will require increased payments by patients. Poorer patients who have not contributed to a hospital scheme by reason of poverty or otherwise will increasingly resort to official hospitals, where they will be called upon to pay according to means. Geographical as well as other considerations will aid this course. There will, however, I am confident, be no sharp line of demarcation between voluntary and official hospitals, and both are likely to continue in large towns, though elsewhere—except perhaps the cottage hospitals—official hospitals may alone survive.

Paying Wards in Voluntary Hospitals

These also are rapidly increasing in number; and fear is sometimes entertained that they threaten the adequate fulfilment of the voluntary hospital's primary function—that of care of the sick poor. With an increase in the number of beds in official hospitals, and enhancement of their efficiency, this fear can be ignored. As long as voluntary hospitals continue to be the main centres for the teaching of medical students, the State has also a direct interest in maintaining free beds in voluntary hospitals. Ere long it may be hoped that both official and voluntary hospitals will be used for medical education. They are already so used for the training of nurses, and occasionally for medical students.

Treatment by Private Practitioners in Hospitals

In some cottage or district hospitals the general practitioner continues to treat his patient after he enters the hospital. Subject to the considerations advanced on page 93 medical objections to this practice disappear. In larger hospitals, unless administrative arrangements are carefully organised and loyally accepted by the practitioner, chaos in hospital routine may follow this practice. The special case of maternity hospitals is considered on page 176.

The case of patients in a paying bed or a paying ward

requires separate consideration. Should these patients be the exclusive care of members of the hospital staff? If paying patients are not administratively separate in all respects from others, the closed system of staffing of all large hospitals, both voluntary and official, precludes the private practitioner from continuing to be responsible for treating his patient while in the hospital. It may be doubted whether he desires to do so, except rarely. He loses financially in fees by sending his patient to the hospital; but this he has understood, and has agreed to it in the interest of his patient.

It is, of course, most important that he should give the hospital the full benefit of his previous knowledge of the patient; and he may reasonably expect to receive a medical report of his patient's condition while in the hospital, and a notice of the date of his return home. This can be, and sometimes already is, arranged, and there is need for definite organisation to this end.

Three cases arise: (*a*) If the hospital has no resident medical officer the private practitioner can often continue to be responsible for his patient while in the hospital, calling in any consultant he desires. (*b*) If the patient is admitted to a paying section of a hospital having both public and private wards, the private practitioner may take the same position. (*c*) In larger hospitals which have resident and visiting medical staff the position, according to Dr. Alfred Cox, secretary of the British Medical Association, should be that—

> the patient should be under the responsible care of a member of the visiting staff in association with the private practitioner of the patient, who would have free access to the patient and should have such share of the responsibility and treatment of the patient as may be agreed upon between the two doctors concerned (*The Times*, May 30, 1930).

This is a moderate statement of the view of the British Medical Association as regards the hospital treatment of the patients of private practitioners. The problem is one between the private practitioner and the hospital authority.

For poorer patients, including all medically insured for domiciliary medical care (already one-third of the total population in Britain), the practitioner rarely objects to his patient receiving hospital treatment by its medical staff; but every effort should be made to preserve continuity in treatment (pp. 40 and 85). For other patients the problem is difficult of solution, though—subject to the maximum provision of skilled care for the patient—the utilisation of the private doctor in smaller hospitals is to be welcomed.

There still remains the case of municipal and county official hospitals. For fever hospitals the practice of allowing private practitioners to attend their own patients while in the hospital has fallen into almost complete desuetude. For most sanatoria for tuberculosis the same remark applies; and inasmuch as the medical staff of official general hospitals in large towns consists of whole-time officers, often with additional consultant surgeons and physicians paid by annual salary or per visit, there is little possibility of the private practitioner attending his own patient in the hospital.

Other points of the policy of the British Medical Association may be briefly enumerated. The Association is of opinion that the normal method of admission of patients to the hospital should be on the recommendation of a medical practitioner. Subject to provision for emergencies and for urgent or acute cases of illness discovered in the out-patient or casualty department of the hospital, this opinion is sound. The Association also regards it as undesirable for a hospital to undertake the indefinite risk implied in insurance. In fact, hospitals accepting money from contributory schemes safeguard themselves on this point; and were it otherwise they would be following the example of insurance doctors in accepting a sum which varies with the incidence of sickness among the insured persons from whom they have received capitation fees.

Hospital Social Services

There has been some development in Britain, and much more in the United States, of a system of hospital social

service, which holds promise of the organisation of a much neglected branch of preventive medicine. This work has developed out of that of the Hospital Almoner, who investigates the financial circumstances of patients applying for treatment. In the first instance the almoner's object was to prevent patients who should contribute from receiving gratuitous treatment, and to assess, after inquiry into family circumstances, the scale of charges. Her work has now become a means of co-ordinating social and medical help, thus enhancing the value of treatment. Through her it becomes possible to supply the doctor with social information respecting his patient, which may throw valuable light on the patient's personality and environment and thus increase the effectiveness of prescribed treatment. The almoner is doing the work of a health visitor and the doctor is thus enabled to judge whether a patient can safely be sent home, and whether supplementary treatment can be obtained at home. This is a valuable programme, hitherto only utilised in a small minority of hospital cases. It may be widened in scope and made immensely more widely useful, not the least of its advantages being the information given to the private doctor from the hospital as to the time of discharge of his patient from the hospital. This work has not been systematically linked up with that of the health visitors of a municipality, though communications sometimes pass between the health visitor and the almoner. Social preventive work is always most effective when it is closely related to social care for the sick, and it is clear that collaboration between health visitors and hospital almoners presents a most promising field of work. The keynote of the work is that sickness is seldom an isolated phenomenon; that it may be only a symptom; and that equally important with medical physical care is psychological care, as regards worry and neglect, together with action to combat overwork, malnutrition, and unsatisfactory housing.

Hospital almoners have done much to prevent out-patient departments of hospitals from remaining "schools

of pauperism". Almoners have helped to reduce abuse and misuse of these departments, especially by insurance patients coming without reference from their doctors, and they have helped in directing patients to means for obtaining necessary surgical appliances and convalescent treatment.

For this work highly trained and certificated officers are now being appointed. According to a recent report of the Institute of Hospital Almoners, the almoners at some thirty-five hospitals and clinics in London, and about the same number outside London, have been trained by this Institute. Their work is becoming that of a trained profession; and already a tendency towards specialisation, as in psychiatric social work, is seen.

It has been suggested that the hospital social service should be separate from the almoner's work. If the latter's work were invidious and financially inquisitive, and implied a non-sympathetic attitude to the patient, this separation of functions would be desirable. But, in fact, this is not so; and hospital almoners are already giving valuable social help to patients.

But the social work of hospitals needs a large extension. A large proportion of hospital patients should be followed to their homes, by municipal or county public health nurses (health visitors) who are in direct touch with the hospital almoner for this work. This would enable many of the factors, domestic or social, which protract convalescence, or even prevent complete recovery, to be satisfactorily tackled.

Schemes of Organisation of Hospital Provision

In Great Britain no clear-cut decision as to the future of voluntary and official hospitals is possible. Nor is it desirable. In organising more efficient hospital provision one cannot start anew, but present provision must, in large measure, be utilised and extended as necessary; and each hospital unit must gradually be made to fit into a general scheme, so far as is practicable. In short, THE IDEAL SCHEME OF HOSPITAL SERVICES IN ANY COUNTRY IS ONE IN WHICH THE PROVISION,

WHETHER OF BEDS, OF STAFF, OR OF DIFFERENTIATED EXPERT SERVICES, OF EVERY HOSPITAL IS BROUGHT INTO CO-OPERATIVE RELATION. This principle necessitates the formation of hospital areas of wide extent in each section of a country, with closely interrelated units. In England it will sometimes be necessary to constitute areas wider than counties, and it will be imperative that the geographical areas shall be closely interrelated in their work. This is necessitated by THE NEED FOR PROVIDING FOR THE EVER-INCREASING MOBILITY OF THE POPULATION. If the cost of hospital provision in each hospital area is partially de-localised or nationalised, the difficulty will be met. It is already met in Britain in the national gratuitous treatment of venereal diseases.

Schemes have been advanced in recent years which have a general resemblance to each other. None of these, as it appears to me, visualises fully the necessity of starting from the point of present hospital provision; nor do they appear to appreciate that partial or entire support from State or local funds derived from taxation necessarily implies a corresponding amount of official supervision and control. Nor do they satisfactorily deal with the difficulty involved in the existing dual system of voluntary and official hospitals.

The materialisation of a co-ordinated scheme of hospital provision for a large area can be secured in one of two ways: by agreement between all the bodies concerned, or by handing them all over to public authorities. In Volume III of *International Studies* I have given Aberdeen as a successful illustration of the first of these methods. The old public assistance hospitals and the voluntary hospitals of Aberdeen have been brought into co-operation, the University of Aberdeen thus securing both types of hospital beds for medical teaching. Some combination of medical staffing of these voluntary and official hospitals has been arranged, and thus more complete hospital provision has been made for a large area.

The Times of May 30, 1928, gave an outline of a hospital

scheme for the provinces, contributed by the members of three provincial hospital staffs. In this contribution the continuance of the voluntary system was urged "at all costs as against a general State service". It was suggested that a provincial body should be set up similar to King Edward's Hospital Fund. This Fund, it may be here explained, has a large endowment, and receives large annual contributions for the voluntary hospitals of Greater London. These sums are distributed at the will of the Council of the Fund, the special circumstances of each hospital being taken into account. Because of its annual contributions the Fund is able to insist on uniform hospital accounts and statistics, and can bring some pressure to bear to prevent inco-ordination of hospitals. A similar body is recommended for the provinces. If such a body could secure vast contributions, it could undoubtedly effect some co-ordination of provincial hospital provision. The scheme as set out in the proposal now quoted would comprise:—

1. A primary hospital, with general and specialist departments.
2. Convalescent hospitals.
3. Co-operating hospitals.
4. Cottage hospitals and convalescent homes.

Remembering the multiplicity of hospitals in a large area, the existence of official as well as voluntary hospitals, and the probable unwillingness of some hospital committees and their staffs to be relegated to the minor categories, the difficulties of such a scheme for a large geographical area, in the absence of statutory authority, will be appreciated. If statutory power were given, implying the right to call on local rates and on taxes, it is doubtful whether after the lapse of a few years many voluntary hospitals would remain.

The Labour Party, in 1922, formulated a policy for a complete hospital service, representing what they would regard as ideal. This would consist of a complete chain of units from the local or cottage hospital to the national hospitals in university centres.

This in substance is identical with the object of the scheme put forward by the Consultative Committee on Medical Service to the Ministry of Health in 1920. This Committee, whose chairman was Lord Dawson of Penn, stated in outline a scheme which sets out the chief national necessities of a satisfactory medical service. There can be no hesitation in agreeing with its general statement that the organisation of medicine has become insufficient, and that with increasing complexity of knowledge, the needed services have become "less within the power of the individual to provide. . . . As complexity and cost of treatment increase, the number of people who can afford to pay for a full range of services diminishes".

The scheme outlined in this report would consist of:—

1. A domiciliary service in each district, associated with a PRIMARY HEALTH CENTRE conducted by the several practitioners of the district, with an efficient nursing service and with the aid of visiting consultants and specialists. The health centre would have a number of beds, and patients would be attended in them by their own doctors. This centre would serve also for consultations between practitioners and with consultants.

2. A group of primary health centres would be based on a SECONDARY HEALTH CENTRE in a town, to which would be referred difficult cases. Patients received here would pass from the care of their own doctors into that mainly of consultants and specialists.

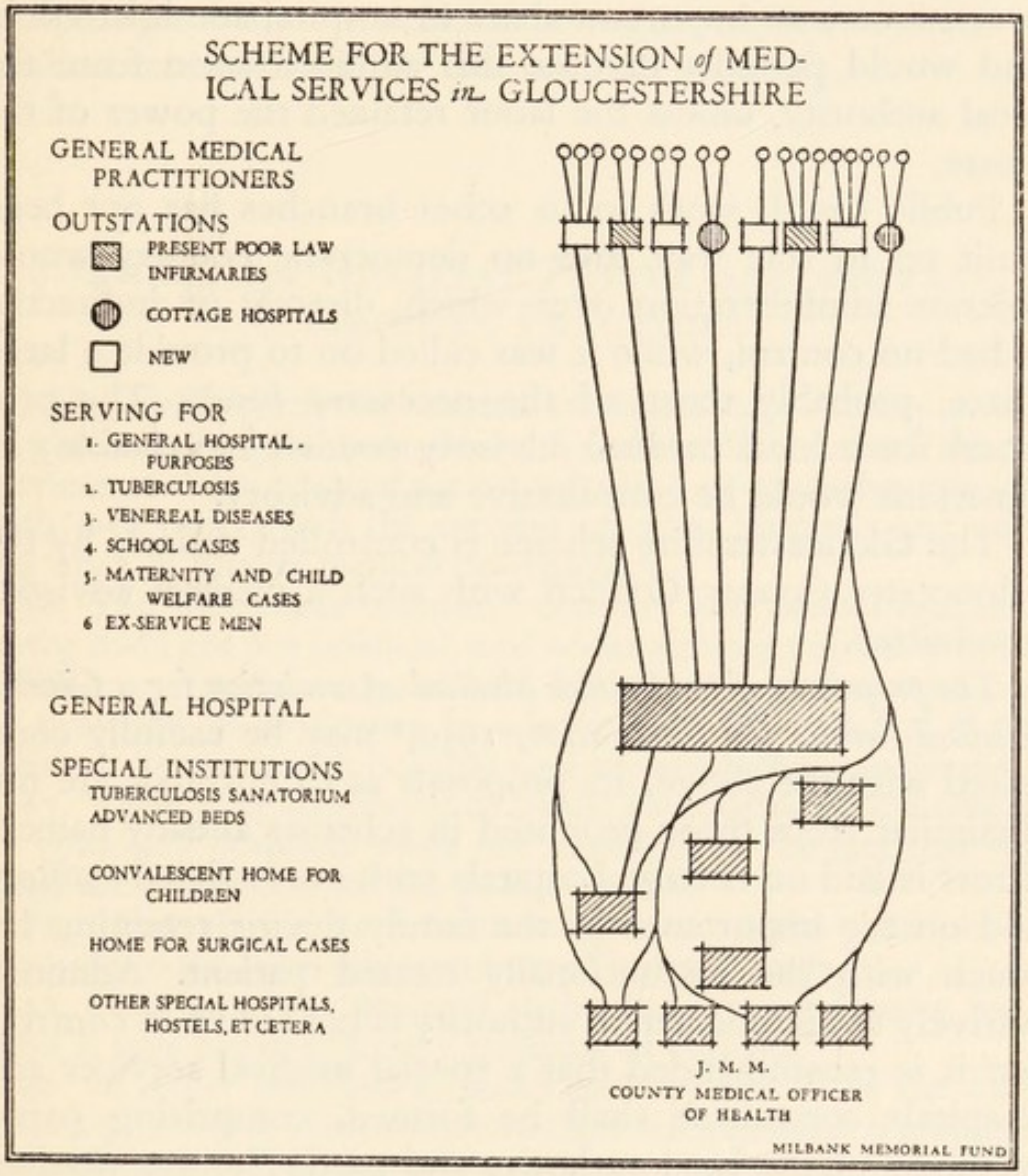
3. Secondary health centres should be brought into relation with a TEACHING HOSPITAL having a medical school, for cases needing special skill. The two last-named groups may sometimes be merged. The various domiciliary and health centre services are distantly linked up with a higher consultation centre or teaching hospital. This, if completely organised, would give a medical service meeting all needs.

The scheme outlined above emphasises clearly the view that consultation is team-work, in which—especially in chronic illnesses—pooling of information and perhaps review of diagnosis or treatment, are secured.

The chief defect in this scheme is its neglect of existent public medical services, which must necessarily be incor-

porated and form a chief element in any more general medical service.

The diagram (reproduced from Volume III of *International Studies*, p. 301) shows a somewhat similar scheme, which is already in partial operation in Gloucestershire, a



full description of which is given in the volume referred to above.

The two schemes differ administratively in that the Scheme of the Consultative Committee contemplates a separate *ad hoc* Health Authority for its administration, three-fifths of whose members would also be members of the official

public health authority, and two-fifths, it is suggested, should be persons having "special knowledge" which "would be of value in health questions", a majority of them medical representatives elected by the local medical council, a special body proposed under the scheme. This method of government, which is suggested tentatively, would give medical practitioners an important share in hospital administration, and would partially divorce this administration from the local authority, unless the latter retained the power of the purse.

Public health work in its other branches has not been built up in this way, and no democratic country would tolerate administration over which, directly or indirectly, it had no control, while it was called on to provide a large share, probably most, of the necessary funds. The proposal for a local medical advisory council is valuable; its functions would be consultative and advisory.

The Gloucestershire scheme is controlled entirely by the Gloucester County Council with such a medical advisory committee.

The proposals of the British Medical Association for a General Medical Service for the Nation, 1930,[1] may be usefully compared with the above. Its proposals as to hospitals are not dissimilar from those proposed in schemes already named. Stress is laid on cottage hospitals with unrestricted staffing, and on the importance of the family doctor retaining his touch with the institutionally treated patient. Administratively the public health authority is held to be in control; but it is recommended that a special medical services and hospitals committee shall be formed, comprising partly members of the local authority and partly "representatives of those bodies of persons who are rendering service under the scheme". I see no prospect of this being accepted, and regard it as undesirable; though every opportunity should be given, through a medical advisory committee or otherwise, to ascertain general medical opinion, in supplemen-

[1] To be obtained, price 6d., from the office of the British Medical Association, London.

tation of that of the official medical staff of the authority. Expert aid should also be called in as needed.

It will be noted that in the scheme of the British Medical Association the supremacy of the public authority supplying the needed funds is accepted. This implies a great advance in realisation of the essentials of representative government. Hospital provision in relation to a general State system of medical service is further discussed on page 263.

Summary on Hospital Policy and Private Medical Practice

35. The ideal scheme of hospital services in any country is one in which the hospital beds, the staff, and the differentiated expert services of every hospital are brought into co-operative relation with each other, with the services of other hospitals and with the work of private medical practitioners.

36. The differences between voluntary and official hospitals in the main are not essential, and under either a voluntary or an official organisation a good and adequate hospital service can be provided, if its finance be adequately supported and if the relations between each hospital unit are satisfactorily adjusted.

37. There is no likelihood of public authorities adding official to voluntary hospitals when not impelled by the fact that the latter are inadequate for the public needs.

38. There should be a frank acceptance of the principle of payment to the honorary members of hospital staffs.

39. Hospitals have changed their character, and some payment is now required from a majority of patients.

40. In larger hospitals a closed staff appears to be the only system practicable; but, subject to rigid safeguards, it is administratively practicable for private doctors to attend their own patients in small hospitals.

41. There should be a universal system of consultation between the private doctor and the medical officer of the hospital before his admission and after his discharge.

CHAPTER VII

INSURANCE FOR MEDICAL TREATMENT[1]

In the preceding chapters it has been possible to formulate certain conclusions: that no single unit in the community shall be allowed to suffer the lack of medical care; that this care calls for co-operation between general practitioners of medicine and consultants; that it is an important though subsidiary part of public health work to ensure that the treatment of sickness is not belated or inadequate; that at present there is widespread inadequacy and discontinuity in the medico-hygienic provision for the community; that domiciliary care of the sick, while it is invaluable and irreplaceable, sometimes fails to give completely the service needed; that hospital treatment is needed for a large proportion of the sick and injured; that voluntary provision of hospital treatment is everywhere being supplemented or superseded by official hospital provision; and that direct family payments are often unequal to the task of providing the needed medical aid.

The general conclusions already reached bring us to the discussion of the MEANS FOR PROVIDING MEDICAL AID BY GROUP ACTION; and this problem needs to be discussed in its dual form of domiciliary and institutional medical care.

In its essence one of two courses is necessitated. Either the PROVISION must be made BY THE STATE or by local governing bodies by means of taxation, the individual contributions to which in the shape of tax will vary with the financial position of the taxpayer; or the PROVISION must be BY INSURANCE on a provident basis, periodical payments being made by the insured, while they are well, for the contingent benefit of medical treatment when they are ill; or the two methods of provision may exist side by

[1] This chapter should be read along with Chapter V of Volume III of *International Studies*.

side. It is recognised that, whichever procedure is adopted, a section of the population, until poverty disappears from the community, will need to have gratuitous treatment; and in most communities gratuitous treatment, more or less, is already being given. (See Chapter IV.)

These alternatives may be regarded as ultimately identical. Taxation for the prevention or treatment of disease in a well organised country is more equable in its incidence according to means than any existing system of payment for medical care in any system of sickness insurance; and in fact throughout Europe it has been found necessary to supplement insurance by State provision. Taxation is enforced in civilised countries for the provision of conveniences and necessities, some in daily demand, others only contingently required, by some people never required: for example, hospital treatment for infectious diseases, diagnosis of pathological material, use of a public ambulance, fire brigades and appliances, protection against criminals, sanitary provisions, etcetera. Elementary and to some extent higher education are now provided from general public funds for the entire population, though a minority do not utilise the official provision. In view of University grants, etc., no medical practitioner in Great Britain can claim that he personally or through his guardians has paid entirely for his professional training; and similar conditions apply in other countries.

Taxation, then, may be regarded as a universal form of insurance, intended to secure the provision of general or contingent needs for each member of the community, and to adjust the cost of this provision according to means.

In existing systems of insurance against sickness or unemployment or for pensions for old age and for widows and children, more limited sections of the community are benefited; and in providing these, or some of these benefits, the procedure varies in different countries. The State imposes a responsible duty to insure, and arranges the machinery for collecting and protecting the funds which are contributed for this purpose by employers and the

insured employees; or, as in Great Britain, the State provides the machinery and, in addition, a large fraction of the insurance funds.

What is the justification for this use of national funds for a section of the population? It is in part a form of taxation, the benefits of which accrue only to a portion of those taxed. It is relatively easy to justify compulsory sickness insurance when the insured alone contribute and receive benefits, though compulsion in a matter of strictly personal or family concern is contrary to individualistic sentiment. Nor is it difficult on economic grounds to justify compulsory contributions from employers for sickness insurance of the employed. The organised government of the entire community can also, I think, rightly argue that its contribution to the insurance fund thus formed is justified by the communal importance of the prevention of destitution and dependence. The amount of communal contribution varies greatly in different countries. In some it amounts to little more than a share in the expense of administration; in Britain and in some other countries the State's contribution forms a considerable fraction of the total cost of insurance. If insurance for medical care be extended to include the greater part of the total population, the distinction between taxation and insurance to that extent disappears.

THE ARDENT DESIRE FOR SECURITY is the underlying motive for the various forms of social insurance. Security is a primary desire in human life; and the value of life in a community consists largely in the removal of fear and insecurity, the creative impulses of mankind being thus allowed scope for action. Sickness insurance is a well-tried device to buy security in the sense of provision during sickness. It obviously has two defects. It may slacken the zeal for preventive measures against the contingency for which insurance is provided; and it may be an effective "dope" to that spirit of adventure which is indispensable for the development of virile and moral humanity.

It is always true that PREVENTION IS MORE IMPORTANT THAN PROVISION. In so far, then, as provision for sickness

slackens personal or communal efforts for its prevention, or diverts funds which necessarily are limited, from prevention to provision, it is to be strongly deprecated.

Security may not merely retard preventive effort, including the correction of unsatisfactory personal habits. It may encourage a static instead of a dynamic mental attitude; it may restrict the scope of operation of that spirit of adventure in man which is a main condition of mental and moral progress. This is a danger in all forms of security. The element of venture and daring is needed for fullness of manhood; and to the extent to which social insurance limits its scope, other outlets for adventure are called for, including those of the spirit as well as of the physical side of man.

That insurance is required for a large section of the population is undoubted. The considerations stated above and later in this chapter show the underlying risks of insurance; these can be obviated in its working, given the active co-operation of the insured.

Economic conditions demand social insurance. A large proportion of the total population find it difficult to meet current expenditure, and can only make provision for a "rainy day" on a basis of mutual insurance. This is especially true of sickness and unemployment. These two hazards cause a vast amount of social misery; and will continue to do so unless in prosperous days each family contributes steadily to a fund for days of sickness and unemployment, and, it may be added, for old age and dependence.

In the anxious mind of the weekly wage-earner sickness and unemployment loom largest among these risks. I may quote on this point a paragraph from page 148 of my *Health Problems in Organised Society* (P. S. King & Son, London, 1927):—

> The haunting fear of disabling sickness or of being "out of work" at any time on a week's notice is a condition of affairs the malignity of which others than those concerned find it hard to realise; but that it is felt keenly by a large proportion of manual workers is beyond doubt. It is a demon which can only

be exorcised by some system of insurance against the casualties of life.

Both these risks theoretically are controllable, in part at least, without insurance against them; and TO THE EXTENT THAT IT IS PRACTICABLE, PREVENTION OF AN EVIL IS INFINITELY PREFERABLE TO MERE INSURANCE AGAINST LOSS. Public health measures already have largely decreased the burden of sickness on the community (but see p. 119), and voluntary and official provision of treatment has greatly aided.

It is possible for communal organisation to reduce the peaks of unemployment; but this involves international co-operation, and both for unemployment and for sickness there will remain for generations to come a void which insurance must fill, if misery not otherwise preventable is to be avoided.

Unemployment Insurance

Insurance against unemployment is not free from drawbacks, including risks to integrity of character, which throw light on the parallel case of sickness insurance. In Great Britain unemployment insurance is provided for the majority of wage-earners (omitting agricultural workers and domestic servants), out of funds to which employer and employee contribute nearly equal amounts. [The State pays about two-ninths of the cost of benefits and of administration for the three chief forms of social insurance in the aggregate (health, unemployment, and pensions).] In present circumstances the contributions for unemployment have not accumulated for enough years to make the fund financially sound, and in *post-bellum* years the British Government has supplemented insurance funds by large sums which in fact constitute official relief of destitution. This further aid has meant a duplicated organisation for relieving the poor, detached from that of the public assistance authority; and with it some abuse of the funds. The amount of this abuse has been exaggerated, but never-

theless it is serious. The worst feature of the position is the lessened desire on the part of many to endeavour to obtain work. Occasionally this has gone so far as to lead to efforts to secure dismissal, with a view to obtaining unemployment pay. This fact gives colour to a summary of the position in the words that "the dole has been one of the greatest blessings bestowed on willing workers, and it has been one of the grandest opportunities ever afforded to dishonest shirkers".

Its evils are incidental and not essential objections to unemployment insurance on improved lines. There is need to make the benefits proportional to the number of insurance payments, to limit payments according to the actuarial position of the general fund, and to separate completely from the insurance system the support of the unemployed whose share in insurance has been exhausted. Subject to these provisos unemployment insurance forms an important buttress against anarchy and a valuable means for minimising the anxiety which may haunt a wage-earner's life, even when yet employed.

Is Compulsory Insurance Advisable?

Compulsion in many forms is indispensable in communal life; and its adoption or non-adoption is decided in the main by expediency, and not on principle. Many extremely valuable reforms would be impracticable without compulsion. Although "the foundation of authority is laid in the free consent of the people", prohibitions are inevitable in social life; without them there would be anarchy. Certain forms of compulsion are accepted almost universally; as, for instance, laws which give protection against crime and violence; the taxation of the well-to-do to protect the destitute against the extremity of want; the inhibition of evil conditions of industrial work; protection against communicable disease; and the compulsions which —in the interest of those concerned and of the public— limit freedom in the relation of landlord and tenant, of vendor and purchaser, of employer and employed, and

even of parent and child. The parent is compelled to have his child educated; and taxpayers must pay for the education of other people's children. Neglect of the medical care of a child is a punishable offence in Great Britain. In short, in modern life LIBERATION from unfair conditions has become the social desideratum more than LIBERTY; unless the last word be read in the sense of the words: "Where the Spirit of the Lord is there is liberty".

These general considerations throw light on the equity of compulsory insurance against some of the chief contingencies of life, and go far to justify the coercion of a small minority by a large majority of the community. For no system of national insurance can be enacted unless it is endorsed by a majority vote of the elected representatives of the total adult population; nor can it be worked successfully unless it continues to have the approval of most of those concerned. Such a system represents compulsion only for an unwilling minority, many of whom in the absence of compulsion would eventually need to be supported by State aid or voluntary charity. No member of a complex community can justly claim the right to be improvident. Compulsion is justified in that it protects the weakest, financially and morally; and insurance, compulsory or not, is necessary because it provides a degree of protection which no single worker can ensure for himself by individual action. Furthermore, insurance is forced on the individual not only for the benefit of the insured, but for the protection of the economic welfare of the community. Communal aid in insurance is given to the insured person, not as to an individual receiving charity, but to him as a member of a social community.

THE ALTERNATIVE TO COMPULSION

Denmark alone among European countries has made a success of a voluntary system of sickness insurance. In 1928 more than 65 per cent. of the total population of this country over 15 years of age were members of State-recognised sickness clubs. But although in Denmark

membership in these clubs is optional, there are indirect penalties attaching to failure to belong to a club. If a man receives public assistance he loses his right to vote, he cannot marry without the consent of the authorities, and if he has received relief during the three preceding years he forfeits his claim to an old-age pension. He must also repay relief given him when he becomes able to do so. The Government contributes largely to the expense of this voluntary insurance. Furthermore, there is a separate system of compulsory insurance against invalidity, the expense of which is shared between the insured person, his employer, and the State. A further legislative proposal is pending to limit old-age pensions to members of sickness insurance societies.

In Sweden also sickness insurance is on voluntary lines; but although the State gives some aid, the Swedish is less successful than the Danish scheme.

It is convenient here to summarise some of the features of other national systems of sickness insurance.

European Schemes of Sickness Insurance[1]

The Danish and Swedish systems of voluntary sickness insurance have already been mentioned.

Norway.—There is a compulsory system in Norway for those with an income below 5,200 kr. a year (about £292 or $1,460). When this income is exceeded, the person affected loses all rights, including his past subscriptions (see Volume I of *International Studies*, p. 118). The money benefit during sickness is 60 per cent. of wages. The doctor must treat not only the insured, but also his dependents. Drugs are not an insurable benefit. (Maternity benefits for this and other countries are summarised on p. 160.) The insured person has a free choice of doctor, whose payment is according to service rendered, on an official scale. Only one insurance society is allowed in each district. The State pays $\frac{2}{10}$, the commune $\frac{1}{10}$, the employer $\frac{1}{10}$, and the insured person $\frac{6}{10}$ of the expense of sickness insurance.

Germany.—Medical attendance is commonly given to the dependents of the insured, as well as to the insured. These two

[1] Fuller details for each European country are given in Volumes I and II of *International Studies*.

together form about 60 per cent. of the total population. Sick benefit, as in Great Britain, lasts for 26 weeks. It is not a fixed sum as in Britain, but about half the worker's wage. Medical attendance includes hospital treatment and the service of specialists. Doctors are paid according to various methods, but free choice of doctors is usual. In Berlin payment, as in Britain, is *per capita*. There are many polyclinics for consultation and expert services. The sick funds pay for hospital treatment in municipal hospitals, but not the full cost.

AUSTRIA.—In Austria sickness insurance is compulsory in two classes, one for manual workers and one for other salaried employees. Each insurance society must be localised or occupational. Sickness insurance is in force for 66 per cent. of the total population. Free medical treatment is given, including hospital treatment in the third class. For manual workers the domiciliary doctors are districted and salaried; in other classes the insured person can choose his own doctor, the insurance society paying a standard sum per consultation and visit, which may need to be supplemented by the insured person.

BELGIUM.—There is a voluntary system of sickness insurance in Belgium, which it is now proposed shall become compulsory for three-fourths of the total population. There are various types of insurance societies, and a wage limit is not imposed. The Government aids these societies by subsidies. Medical treatment and the cost of drugs are included in the benefits, but the insured person is expected to pay one-fourth of the cost of doctor and of drugs. Institutional treatment and specialist treatment in polyclinics are organised by federations of insurance societies. The insured can choose his own doctor, who may be paid *per capita* or according to work done. Each federation of societies has a supervisory doctor. The patient can choose his own hospital, when hospital treatment is needed, and he pays about half the cost.

FRANCE.—In France there is only the beginning of compulsory sickness insurance. Full particulars are given in Volume II of *International Studies*. Full medical benefit is to be given, and medical fees will be payable on an agreed scale according to amount of work done. French doctors have secured the concession that fees for medical attendance shall be paid directly to them by the insured. Each doctor can charge an additional sum beyond the agreed scale, if he wishes to do so. Every person (at present the upper limitation of income is 18,000 francs) who is compulsorily insured must be insured in the department in which he lives. The sickness benefit is half the wages.

ITALY.—This country has organised a beginning of compulsory sickness insurance, which at present is limited to tuberculosis.

JUGO-SLAVIA.—All voluntary schemes of sickness insurance have been superseded and replaced by a single national scheme. Only a small proportion of the population is insured, as relatively few are employed workers. No choice of doctors is allowed beyond those on a selected list. Polyclinics with special departments supplement domiciliary treatment, and in large measure take its place.

HUNGARY.—All persons earning wages must be insured for sickness. The insured person is medically attended by the doctor allotted to his district, the entire medical arrangements for the country being organised from the Central Insurance Institute in Budapest. There are branch institutes throughout the country at which specialist and general treatment is given to the insured. Institutional work is very highly developed, and to a large extent supersedes domiciliary work.

POLAND.—In the part of this country formerly German, the German method of medical attendance is followed. In other parts domiciliary treatment is unsatisfactory, and there is great over-use of the polyclinics to which all insured patients have unrestricted access.

CZECHO-SLOVAKIA.—Most of the population is insured for sickness. There are many insurance societies. As a rule there is no free choice of doctors. The general method of payment of doctors is on a *per capita* basis.

In what follows as to sickness insurance I shall quote chiefly the German and British systems, which are the most extensive extant, and in which both the advantages of and the drawbacks to sickness insurance can be most fully studied.

INSURANCE *v.* PREVENTION

A few preliminary observations may be made as to the possibility of reducing the need for sickness insurance and of decreasing its burden when in operation by increased activity in public health measures. This point was raised by the British Medical Association in its evidence before the Royal Commission on National Health Insurance in 1926 (Stationery Office, Cmd. 2596, p. 12). In this evi-

dence it was suggested that in certain other directions—among which were enumerated proper housing, town planning in its wider aspects, smoke abatement, a pure milk supply, and aid to medical research—expenditure equivalent to the vast sums now spent in Britain in State aid to sickness insurance might probably produce greater benefit to the national health. This opinion is of value as showing appreciation by the general medical profession of public health measures and desire for their extension. Its full discussion would require more space than can be given here; but some observations are called for.

The need for promoting further measures directed to the removal of external enemies to health is evident; the progress already made justifies and calls for increased activity. The insurance doctor might and should, however, be a chief agent in securing this increased activity. Sickness would rapidly decline if he regarded himself as not merely available when illness occurs, but as actively concerned in the manner of life of the insured, including the recognition of bad industrial conditions and unsatisfactory housing or use of housing, as well as wrong habits concerning food and drink. This may legitimately be regarded as coming within his work as medical adviser—for doctor means teacher—of the insured. PROPHYLAXIS as well as clinical care should be—alas! that it so seldom is—an essential and even a PREPONDERANT part of the insurance doctor's work. All this implies that so far from sanitary reform and medical insurance (properly organised and utilised by every doctor) being alternatives, each of them is a highly important complement of the other. The British Medical Association in another part of its evidence from which I have already quoted state that "the evidence as to the incidence of sickness benefit does point to the fact that the Scheme itself has almost certainly reduced national sickness". This statement is difficult to reconcile with the evidence as to great increase in demands for sickness benefit (quoted in Volume III of *International Studies*, p. 126, and on p. 125 of this volume); but I am prepared to regard

its truth as possible. Early and prompt medical treatment does not increase illness; it must almost certainly reduce its real duration, though certified illness has hitherto moved in the opposite direction. Clinical treatment should, furthermore, be associated with advice which would reduce the risk of recurrent illness. That potentialities in these directions are only very partially realised is, I think, undeniable.

The general conclusion, then, is that extended public health efforts and a more satisfactory use of medical insurance are both indicated. From the humanitarian standpoint medical attendance of the sick has a first call on the community if private help is not forthcoming; and sickness insurance can be made an efficient means to this end. When a case of typhus fever is discovered, the first indication is to secure humane and skilled treatment; prompt and thorough action to trace its source and prevent its spread occurs simultaneously. Corresponding action applies in non-communicable diseases.

A minority comment on the Report of the Royal Commission on National Health Insurance, 1926, includes a valuable discussion (p. 294) by Sir A. Duncan and Professor Alexander Gray, Professor of Political Economy in the University of Aberdeen, as to whether money spent on health services (including public health and sickness insurance) will yield dividends in improved health and efficiency, and with these an improvement in the financial condition of the country. This appears to be almost self-evident; but the above-named regard the argument as specious. They quote the British Medical Association statement that "the alleviation or cure of morbid conditions when once they have arisen" is relatively a minor part in the campaign for public health. And they remind us, further, that medical skill by prolonging life "must tend towards an increase in the actual volume of illness". The survival of a greater proportion of older people, of course, implies that the larger number of survivors at these ages will experience the greater incidence of sickness which is

natural as age advances,[1] but it still leaves it probable that there is less sickness than formerly at any given age. All this emphasises the importance of insisting on a full development of the prophylactic work of the medical practitioner in his daily work.

Statistical Investigation of Sickness Records

Not only in his individual capacity should the doctor be a medical officer of health within the range of his practice; but through him the medical officer of health of each county and county borough should be in a position to investigate the total incidence of sickness in his area, according to age and sex, occupation, and the geographical distribution of sickness. This mine of valuable possibilities is at present almost entirely unworked. It may appear incredible, but in Britain THERE IS NO PROVISION FOR THE REGULAR COMPILATION OF THE DATA indicated above AS TO THE INCIDENCE OF THE COMMON SICKNESSES OF THE INSURED; and important facts remain neglected, which could help in detecting industrial and social sources of excessive illness in a given locality, and in determining appropriate preventive measures. These measures would go far beyond personal prophylaxis.

Obstacles to Efficient Working of Sickness Insurance

At this point we may indicate some of the obstacles to urgently needed reform in sickness insurance administration.

They arise very largely from the imperfections and overlapping in the organisation of insurance work. As seen in my account of sickness insurance in European countries, the arrangements may be made by the central government,

[1] Recently published figures of experience in Scotland show a higher proportion of sickness claims among younger than among the older insured. The needed correction for total duration of sickness cannot at present be applied, owing to absence of the necessary data. Furthermore, we must remember the possible difference between amount of sickness and the amount of sickness certified to obtain a financial benefit.

every insured person being allocated to his own local division; or insurance societies may function, no local overlapping of their work being permitted. In Germany and in Britain, the two chief examples of sickness insurance, there is no such local limitation of the choice of insurance society, and serious difficulties have resulted from this freedom. Financial arrangements in Great Britain are in the hands of about 1,000 approved societies, the members of a society varying from a few scores to over two millions. The members of a given society may be scattered all over the country; and this involves serious difficulties in utilising insurance sickness statistics for medical and public health investigations. The absence of classification of the insured according to locality and occupation furthermore precludes any possibility of arranging for varying rates of contribution according to the incidence of sickness. Thus a valuable impetus to investigation of the causes of excessive sickness is lost. As stated by me in Volume III of *International Studies*—

> it would conduce immensely to the efficiency of the British scheme if a national society could be formed with local branches in each county and county borough; much of the present inordinate book-keeping would be avoided, the number of paid officials could be reduced, and it would become possible to utilise the national and local experience of sickness as a means of detection of excessive sickness, with a view to remedial measures.

The vested interests of the friendly societies (in which are 46·5 per cent. of the insured), of trades unions (9·9 per cent.), of employers' provident funds (0·8 per cent.), and, above all, of industrial and collecting societies which represent 24·8 per cent. of the insured, are enormous; and it will be difficult to secure radical reconstitution. Short of the most satisfactory reform, it would be possible to insist on receiving from the societies concerned exact sickness records for each county and county borough area, classified according to age, sex, locality, and occupation. These records would have a high value in enabling the

conscientious medical officer of health to study the incidence of sickness in his area, and to base etiological inquiries on this study.

A SYSTEM OF SICKNESS INSURANCE WHICH FAILS TO PROVIDE ACCURATE AND COMPLETE RECORDS OF THE INCIDENCE OF SICKNESS AMONG THE INSURED, STATED IN RELATION TO THE NUMBER AND CIRCUMSTANCES OF THE PERSONS INSURED, FAILS TO SECURE THE BEST INTERESTS OF THE INSURED, AS WELL AS OF THE POPULATION OF WHICH THEY FORM PART.[1]

Medical Certification

The value of such a system of records varies with the degree of accuracy of the medical certificates on which it is based. This is true both as regards the total duration of sickness of all kinds, and as regards individual causes of sickness.

Certification of Character of Illness

This often is necessarily somewhat vague when an insured person first comes to a doctor and receives a certificate of unfitness for work. Such terms as Catarrh, Chill, Influenza, are common, in which diagnosis is incomplete and merely tentative. Even when illness is more prolonged, and when, for instance, a certificate of Anæmia, Bronchial Catarrh, Dyspepsia, Rheumatism, Lumbago, Gastric Catarrh, etc., is given by the doctor the certificate may continue to express merely a symptomatic diagnosis. This may be inevitable. A vague statement may embody more truth than a rash guess which simulates exact knowledge of the patient's condition. Much leniency should be accorded to an indefinite certificate, if it is clear that the

[1] The Annual Report of the Department of Health for Scotland, 1930 (Stationery Office, Cmd. 3860), issued since the above paragraph was written, describes machinery recently inaugurated in Scotland for securing the records stipulated above as being necessary in the interest of public health. To each doctor is allotted a permanent reference number, and thus for each insurance area it is possible to stamp medical certificates as they are received and to localise sickness indicated by them. As these certificates give the age, occupation, and marital condition, and as all final certificates include the doctor's ultimate diagnosis, much valuable information may be expected from these arrangements.

patient is in fact incapacitated for work, and that his case is being watched and investigated by his doctor. This unfortunately is not always so; bottles of medicine may be given, a hasty interview accorded, and the patient may continue to receive his weekly money allowance on the strength of a renewed medical certificate, without adequate investigation. This investigation demands time, and in some instances also a medical consultation; and an indefinite minority of certificates on which money benefits are accorded may not represent the result of the application of accurate medical skill, but merely the first impressions of a busy doctor, seeing an excessive number of patients during his short consulting hours. If on signing the patient off the sick list, the doctor gives his final diagnosis, based on a review of the whole case, and uninfluenced by a desire for consistency, more accurate statistics of the diseases prevalent among the insured can be attained. Whether in present circumstances of insurance practice this can be generally secured is dubious. A more equal distribution of the insured among doctors is required, and a freer use of consultation facilities is called for, before the ideal becomes practicable.

Certificates of Duration of Illness

Even while doubt exists as to a large proportion of the diagnoses entered by doctors on their certificates, these give valuable information as to the number of days of certified sickness causing incapacity to work. If geographical and occupational studies of the incidence of total sickness were to be undertaken on a more general scale than the small attempts hitherto made, a great impetus would be imparted to local and occupational investigations of sickness, and in this way sickness insurance would become a true handmaid of preventive medicine and public health.

Excessive Medical Certification

In some instances there is (*a*) a too facile certification that an insured patient is unfit for work, and (*b*) a too

great willingness to continue to give weekly medical certificates of unfitness when requested by the patient. Both (*a*) and (*b*) are stumbling-blocks to the finances of insurance.

Does such over-certification exist to more than an inevitable extent? There is almost unanimous opinion that it does, but there are acute differences of opinion as to the share it bears in producing the steadily increasing incidence of certified sickness among the insured, both in Britain and Germany. The British Medical Association contends that the number of legitimate claims have increased; while the Ministry of Health has endorsed the view that medical laxity in certification is a chief cause of the increased claims for benefit. This problem is rather fully discussed in Chapter V, Volume III, of *International Studies*. Here I indicate the chief outstanding points.

The medical certification of incapacity for work is the pivot on which the whole of sickness insurance revolves. Each medical certificate of unfitness for work is a cheque drawn on the funds of the sickness society to which the insured person belongs. There is relatively little friction between insurance societies and doctors concerning the initial certificate, but much concerning the weekly medical certificates for continuance of sickness benefit. The existence of laxity in certification in a proportion of total cases is accepted; but medical opinion usually maintains that its amount has been exaggerated. The relation of the insured doctor to his patient, who can change his doctor if displeased with him, does not conduce to absolute accuracy in restricting certification. It is even contended by some that accurate medical certification is incompatible with the conditions of private medical practice, but, whether the doctor is an official or a private practitioner, in doubtful instances he must give his verdict or certificate in favour of the patient.

In recent years a great increase in certified sickness has occurred, and this has meant much heart-searching. An actuarial investigation showed that comparing 1921 with 1927 the average claims of men for sickness benefit had

risen by 41 per cent., of unmarried women by 60 per cent., and of married women by 106 per cent.; while for the more permanent disablement benefit the corresponding percentage increases had been 85, 100, and 159. This increase is shown by official investigation to have been in the number of persons claiming sickness benefit, not in the duration of claims; and it has occurred among the younger insured persons, not the older.

Many factors must have aided in producing this increased certification of sickness. Lax medical certification doubtless occurs in a considerable minority of cases; but the rapid increase in certification stultifies the opinion that doctors as a class suddenly have ceased to exercise moderate care.

In the case of married women, the difficulty of distinguishing between desirability of work for a pregnant woman and unfitness for work is patent. Advanced pregnancy may not be an adequate reason for a medical certificate; but the complication of varicose veins may bring the patient over the borderland between a physiological and a pathological condition. It is, indeed, doubtful whether the continued inclusion of employed married women in the national sickness insurance scheme is wise. A separate and more adequate provision for maternity would be preferable.

Fitness for work is a relative term. A doctor would not regard a miner with lumbago as fit for work, though he might hesitate in the case of a clerk. There can be no fixed standard applicable to all workers. Lowered vitality from unemployment and consequent malnutrition have borne a part in leading to increased certification, and, as stated on p. 128, Volume III, of *International Studies*, "lowered morale of workers is often quoted 'many of these having become certificate hunters in search of easy money' ". Increased and often exaggerated appreciation of the value of rest in aiding recovery and convalescence has also borne a share in the result. And there is also in some instances the habit of "cultivation of sickness", most difficult for the doctor to combat (see also p. 144).

In Great Britain a staff of nearly 100 regional medical officers are employed by the Government, who work on a territorial basis. These examine insured patients referred to them by insurance societies or medical practitioners; and their employment has often led to a more prompt return to work of chronic cases. Their increased use would doubtless be valuable; and doubtless a routine will gradually evolve in this direction. As soon as monetary conditions allow also of the use of specialist and consultant facilities for the insured sick, further improvement in accuracy of certification can be anticipated.

International Experience of Certification

In Denmark no considerable over-certification by doctors has been noted. In Denmark's invalidity insurance scheme most elaborate precautions are taken to ensure exact knowledge of the invalid's state, including in many cases placing the patient in hospital for independent observation. Vigorous efforts are also made to restore the invalid's health, as by baths and exercises for rheumatism. The arrangements in Norway are similar.

In Germany the employment of specialists as well as general practitioners, and the fact that hospital treatment is also available for the insured, should lead to fewer complaints from insurance societies of over-certification; but these complaints are heard. In Hamburg and in other large centres the amount of certification from each doctor in proportion to his practice is regularly checked, and an interview with the medical referee follows heavy certification in the practice of a doctor.

Austrian insurance gives expert consultations and hospital treatment for a month when required. Some societies have appointed non-medical controllers who make unexpected domiciliary visits. Insurance societies for non-manual workers allow members to choose their own doctor, and pay his fees up to a certain standard amount. When a complaint is made of over-treatment and over-certification, doctors state that they may be made "the whipping-boy between the two parties".

Belgium's experience in recent years is one of a considerable increase of sickness claims; but this is ascribed to propaganda and educational work on the part of the Socialist National Union, which is thought to have led to persons seeking medical aid more readily than formerly.

Over-certification of sickness could be diminished or even prevented if the dossier of every insured person were made to include a record of the financial sickness benefit already given him, and if he were given a financial motive to keep his "going on the club" down to a minimum. This might be done by giving some special benefit dependent on the insured person's previous claims being below the average. Or a bonus might be given, or weekly payments might be reduced, or a fund might accrue increasing the insured person's old-age pension when he reaches the age of sixty-five. These suggestions apply only to monetary benefits. Medical benefit is a separate matter; and no curtailment of it is suggested.

Degree of Completeness of Medical Treatment in Insurance Systems

There are the following differences in various countries:—

1. The treatment provided may be solely domiciliary and at the office of the doctor, and be limited to medical work which an average practitioner can reasonably be expected to provide. This limited service may be provided for the entire family of the insured person or only for him.

2. This individual medical service is often supplemented by—

(*a*) consultations when needed given chiefly at special institutions called polyclinics or ambulatories; and by

(*b*) hospital treatment when needed.

These various provisions may be unlimited, or (especially hospital treatment) may be limited in time.

The Netherlands.—Usually hospital provision is insured, either through the sick funds or independently. Co-operative hospital provision is steadily increasing.

Denmark.—Voluntary societies for sickness insurance in Denmark not only pay for domiciliary treatment of the insured and of his family, but also contribute towards the expense of hospital treatment. Insurance societies pay the hospital charges for seven-tenths of the total population; but these charges are much below the cost of hospital treatment.

Sweden.—Voluntary societies in Sweden are similar to those

of Denmark. There is a very high development of hospital treatment provided by the State and municipalities to which insurance societies contribute for hospital treatment of their members.

NORWAY.—The insurance doctor is required to attend also the family of the insured. About 15 per cent. of the total medical insurance funds are devoted to hospital treatment. The scale of payment for insurance patients for hospital treatment is the same as for other patients.

GERMANY.—Medical benefit to dependents is included with the medical benefit given to the insured by most sickness funds in Germany. It includes the services of specialists as well as of general practitioners. Hospital treatment is given to the insured and sometimes also to dependents out of insurance funds. Some funds have hospitals of their own as well as polyclinics. The payment made to hospital authorities is inadequate to cover the cost of maintaining and treating the insured.

AUSTRIA.—Austrian arrangements resemble those of Germany. Medical treatment may or may not be given by the insurance society to the whole family of the insured. Hospital treatment of the insured is very extensive.

BELGIUM.—Some societies in Belgium include medical benefit for the family of the insured, others do not.

HUNGARY.—Medical benefit in Hungary includes treatment for the entire family. A vast amount of treatment is carried on at polyclinics.

POLAND.—The remarks made under Hungary apply to Poland. Hospital treatment is inadequate.

BRITISH SICKNESS INSURANCE

The British system of sickness insurance, like Continental systems, is not applicable to the entire population. As in most other countries, the margin of people left uninsured, above the fixed income limit, often have as great difficulty in providing medical and other benefits in sickness as the insured. This is a difficulty in all countries. But the British system differs from Continental systems in the following important respects:—

1. The weekly payments made are "flat rates" equal for all workers of the same sex, whatever their wages. The money benefits during disabling illness are also equal in amount for all the insured of the same sex, and do not form,

as in other countries, a percentage of the wages of the sick person. In Britain the weekly benefit of each incapacitated male worker is 15s. for a period of 26 weeks; if disablement continues, 7s. 6d. a week is paid for an indefinite period. In Germany and most other countries the limit is also 26 weeks, during which time the allowance is 50 per cent. of basic wages in Germany, 60 per cent. in Norway and Poland, 75 per cent. in Hungary, and varies from 66·6 to 80 per cent. in Austria.

Evidently the flat rates of contributions and of benefit require ingenuity for their defence; these rates mean that societies with favourable experience have surpluses from which partial special benefits can be paid (some hospital treatment, a convalescent home, dental treatment, spectacles, etc.), while in other societies these extra benefits are fewer or non-existent.

As stated in the Report of the Royal Commission on National Health Insurance, 1926, page 100: "In the free formation of societies a considerable process of segregation took place, so that there are few societies which can be regarded as being in any way microcosms of the insured population as a whole". This segregation of "members of varying health experience and health prospects" means that additional benefits both in cash and kind go to those "who having the best health experience require these things least", while the system withholds them from those "whose needs have been shown to be sorest".

But the present system of separate societies is not without defenders. It has been claimed that it favours effort for efficiency on the part of the approved societies, and conduces to economic administration; also that it gives liberty of action to groups of people who, for occupational or other reasons, wish to combine separately from others outside the group. It would be a great public gain, in my view, if at least in each county area—if not for the nation as a whole—financial benefits were pooled, and special benefits beyond the minimum weekly benefits were distributed on a wide basis subject to regulations which would

ensure a high standard and economy of administration. The continuance of a flat rate of contributions and of benefits would then be more fully justified.

Limitation of Benefits

The British system differs from others in the following additional respects:—

2. Only non-institutional treatment of the insured is provided for the insured; but a few societies contribute to the cost of hospital treatment for some of their members.

3. No medical benefit accrues to the wife and family of the insured. (On maternity benefit, see p. 160.)

4. The domiciliary and surgery treatment given by each insurance doctor is limited, as follows. It comprises all proper and necessary services other than those involving the application of special skill and experience of a degree or kind which general practitioners as a class cannot reasonably be expected to possess (see Volume III of *International Studies*, p. 119). Beyond this the insured person medically is dependent on agencies outside the Insurance Act.

Thus the British medical benefit is much more restricted than that given under other European insurance schemes. It is confined in the main to the work of a general practitioner; and the work of this practitioner is only required to come up to an average standard which may be below the individual practitioner's professional capacity, as shown in his treatment of a private patient coming under his care. This position does not favour the best work of the doctor. Furthermore, he has no certain access to a consultant or specialist in cases in which he knows one is needed, though the insurance rules require that he shall send his patient to a hospital or otherwise recommend his patient for further treatment when he considers this necessary. The insurance society usually does not make even partial financial provision for this; and the patient must therefore fall back on municipal or voluntary aid, or supplement

his insurance by contributing independently to a hospital contributory scheme (p. 95).

Notwithstanding these admitted defects of the British system a vast amount of good work is being done by insurance doctors; and within the range which their medical work covers, the conditions of employment of doctors work more satisfactorily in Britain than in most European countries.

Conditions of Work of Insurance Doctors

The relatively satisfactory position of insurance doctors in Britain arises from the fact that they are not employed directly by sickness funds or insurance societies. The National Insurance Act makes it obligatory to admit any qualified practitioner who desires this on the local list which must be kept of available doctors. No doctor can be excluded from the list, or dismissed from it, except for proved professional misconduct. Patients may make their choice from this list, and may change doctors with but little difficulty. The amount of the *per capita* payment of doctors for every patient who enrols himself on a doctor's list is not determined by the insurance society from whose funds the doctor's remuneration comes. It is settled by national agreement between the Ministry of Health and the associated medical practitioners. From the first the associated doctors strenuously opposed the intended direct financial relation between the doctor and the insurance society. The past experience of doctors in the days when there was only voluntary sickness insurance made their association insistent on this; for medical insurance work then was ill-paid, and doctors were often tyrannised over by the secretaries of insurance societies. The national arrangement of terms has been advantageous financially to insurance practitioners, and the standard of medical attendance is higher than in the pre-compulsory period.

It is generally agreed, however, that THE INCOMPLETENESS OF THE MEDICAL CARE GIVEN IN THE BRITISH INSURANCE SYSTEM IS NOT IN THE INTEREST OF THE INSURED. IT REDUCES

THE VALUE OF THE TREATMENT GIVEN, WHILE ALSO HINDERING THE DEVELOPMENT OF PREVENTIVE MEDICINE IN INSURANCE PRACTICE.

The British Medical Association in 1922 stated the following reasons for regarding with favour the continuance of medical benefit even in its imperfect scope. Real medical attention was now being given to whole classes of persons who formerly did not get it; in densely populated areas practitioners were more numerous; the treatment given in the medical benefit was superior to that formerly given in the best of the old clubs; illness was now coming more promptly under skilled observation; a bias had been given towards preventive work; and the medical profession showed an increased recognition of their collective responsibility towards the community in respect of all health matters. (See also Volume III of *International Studies*, p. 134.)

These considerations the British Medical Association regards as "justifying the profession in uniting to ensure the continuance and improvement of an insurance system".

Extension of Medical Benefit

In 1930 the Association, through its representative body, adopted a further resolution to the following effect:—

> The time is now ripe for the medical profession to ask for the inclusion under the National Health Insurance service of the dependents of insured persons, provided that such an extended service include adequate safeguards respecting remuneration and conditions of service.

This extension would mean that the dependents of insured persons would come within the scope of compulsory insurance, and in that event 80 to 90 per cent. of the total population of Great Britain would be brought within the scope of the insurance scheme. Unless the medical care given under the National Insurance Act were made less incomplete than it now is, the extension of insurance to the whole family of the insured person would be very

undesirable. Assuming the national funds required for family insurance to be forthcoming, and the ability of insured families to pay the higher weekly premiums to be established, which of two courses would be preferable:—

1. To extend the present limited medical benefit to embrace the entire family; or
2. To devote available funds to making the present service for the insured reasonably complete, leaving compulsory family insurance to follow later?

I think that extension of medical benefit in its restricted form is to be deprecated, and that further funds as soon as available should be utilised to make the medical benefit for the insured satisfactory and complete.

The pronouncement of the British Medical Association that "medical benefits of the National Health Insurance Acts should be extended so as to include the dependents of all persons insured thereunder" is brought up to date in the tentative "Proposals for a General Medical Service for the Nation" approved by the Council of that Association in April 1930. This scheme sets forth the following general provisoes:—

1. That a satisfactory system of medical service must be directed to the prevention of disease no less than to the relief of individual sufferers.
2. That a medical service of the community must be based on the provision for every individual of a general practitioner or family doctor.
3. That a consultant service and all necessary specialist and auxiliary forms of diagnosis and treatment should be available for the individual patient, normally through the agency of the family doctor. This includes hospital treatment when needed.

It is after stating these general provisoes that the British Medical Association proposes the extension of the medical benefits of the present National Insurance Act to the dependents of all insured persons. In doing so, it will be observed that the Association emphasises the need for extended and more complete services, and recommends

that these services shall also be based on "a contributory insurance system".

The same problem was fully discussed in the Report of the Royal Commission on National Health Insurance, 1926 (Stationery Office, Cmd. 2596). This report stated the view that medical benefit cannot continue indefinitely to be limited only to a general practitioner service. The report continued: "It cannot seriously be claimed that this is a satisfactory state of affairs. . . . The insurance medical service stops short just where the need is greatest"; and the Commission propose the following additional services as within the reach of the insurance funds; they describe them as—

Expert Out-Patient Services

They comprise:—

1. Expert medical advice and treatment for patients who can travel to meet a specialist.
2. Expert advice for persons who are unable to travel.
3. Laboratory services.

These services would include ophthalmic diagnosis and treatment.

The adoption of this proposal would vastly improve the insurance medical service. As has been seen in Chapter VI, page 95, there is also rapid growth throughout Great Britain of a system of voluntary insurance or semi-insurance for hospital treatment. Expert consultation services and hospital provision would secure a fairly complete medical service.

Objections to Existing Sickness Insurance Schemes

It is noteworthy that the British Medical Association has recommended continuance of sickness insurance and of its medical benefit, improved as stated in the preceding paragraphs, and extended to include the entire families of the insured and others in similar financial circumstances, thus bringing over 80 per cent. of the total population within the range of a contract system of medical attendance.

The consequences of this on private medical practice are discussed in Chapter XIII. Meanwhile it is an outstanding fact that A MAJORITY OF THE MEDICAL PROFESSION IN GREAT BRITAIN represented by the British Medical Association ENDORSE A CONTINUANCE AND EXTENSION OF INSURANCE FOR MEDICAL TREATMENT ON A CONTRACT BASIS. This is especially noteworthy when we recall that the basis in the British system on which medical payments are made is not one of payment for each individual "medical act", but one which makes the doctor share the risks of work, which will vary greatly according as sickness and injuries among the insured vary from season to season and from year to year.

This system, although in Britain it has greatly improved the financial position of the average medical practitioner and is officially endorsed by his professional Association, does not meet with universal medical approval. It would be easy to fill many pages of this volume by critical quotations.

The medical secretaries of the National Medical Union, a body with a small membership, recently stated a view held by many, that "the panel system places a premium on hurried and imperfect work . . . and that it destroys the proper personal relationship between doctor and patient".

That there is much hurried medical work in sickness insurance and in general medical practice apart from insurance is certain. It can only be surmised whether this blot on medical work is more extensive in insurance work than it still is in "cheap" medical work outside insurance.

That the personal relationship between the insurance doctor and his patient is not so good as that between a private doctor and his patient is also often affirmed, and this is true in many instances. The patient may become suspicious that he is not getting the same medical care as if he were a private patient, and that he is being provided with inferior drugs. He may even ask to be treated as a private patient, and may offer to pay specially for this.

Or he goes to another doctor, or to the out-patient department of a hospital, because he distrusts the "panel doctor". When the latter gives scanty and hurried attention, and fails to make a thorough examination, the patient is justified in his suspicions and desertion. But although there is too often hurried medical work, the proportion of doctors whose work is really and scandalously bad, I am confident, is small.

The Medical Attitude in European Countries

In European countries, judging by current literature and by my careful personal inquiries in the countries of which particulars are given in Volumes I to III of *International Studies*, the medical profession is less friendly to medical insurance, as it is practised, than are British practitioners.

But the position in these countries is not entirely parallel with that in Britain. In some of them a large part of the population would be medically neglected almost completely were it not for the enforcement of sickness insurance. State medical relief has not proved adequate or satisfactory. The impoverishment in Poland, Hungary, and Jugo-Slavia implies scanty medical care except in towns, and the medical profession in these countries agree that although the insurance conditions under which they work are unsatisfactory, the position for them and for their patients would be still more unsatisfactory without sickness insurance. In Scandinavia the insurance position, largely voluntary, is much more satisfactory, and insurance societies and the State are in active partnership to secure first-class medical care.

The German medical profession especially has unsatisfactory experience of medical insurance. And yet Germany is the country in which the largest volume of skilled medical aid is being rendered under its insurance system. The attitude of the medical profession in Germany appeared to me to be one largely of seething dissatisfaction with their "bondage" under the various insurance societies which they serve. The reasons for this are set out in

Chapter V, Volume I of *International Studies*. The essential difficulty is associated with and largely due to the directness of the financial relationship between the doctors and the insurance societies, with no "buffer" or arbitrator. It is in this particular, among others, that the insurance doctor in Britain is placed very advantageously. Nevertheless, sickness insurance is popular with the insured in Germany, many to whom compulsory insurance does not apply joining voluntary insurance societies; and in Germany's present impoverished condition, as in the rest of Europe, absence of insurance would mean more or less medical neglect.

Reforms in administration of medical benefit are evidently needed in Germany, and especially release from the direct financial pressure of wealthy insurance clubs with heavy political influence. But given these reforms and the reforms already indicated for Britain, one must conclude that in all European countries sickness insurance and its medical benefit are beneficent, and that drastic reform and not abolition is needed. In fact, abolition of sickness insurance whether in the British Isles or on the continent of Europe is a practical impossibility. It has taken deep root, with a prospect of indefinite life; but the conditions of service can be greatly improved, and its trend towards softness of moral fibre and personal irresponsibility can gradually be eliminated or greatly reduced.

Further Defects of Insurance for Medical Treatment

I have already mentioned the undeveloped preventive possibilities of medical insurance. It is in this direction that the great hope for the future lies. The full development of this hope is contingent on the family and not the individual being the unit in insurance as it is in private medical practice, but the hope can be partially realised even when only one member of a family is medically insured. In some industrial life insurance societies, especially in the United States, successful action has been taken on preventive lines.

An insured person can come for a gratuitous medical overhauling, and receive advice as to his future manner of life based on an accurate knowledge of his physical and mental condition, and on ascertained details as to the circumstances of his domestic, social, and working life. The adoption of similar action in insurance for medical treatment would go far to remove the distrust with which "panel doctors" are sometimes regarded by their patients. It would then be appreciated that the doctor is vitally interested in health as well as in sickness; the wish to change doctors would decrease, and with it most of the present excessive certificates which embody the erroneous assumption that sickness is necessarily disabling would cease to be given.

SYSTEMATIC MEDICAL EXAMINATION OF THE INSURED IS NECESSARY IF MEDICAL INSURANCE IS TO HAVE ITS MAXIMUM INFLUENCE IN PRESERVING HEALTH. At the least AN INSURANCE DOCTOR SHOULD REGARD IT AS ESSENTIAL TO HAVE KNOWLEDGE, BASED ON A DETAILED EXAMINATION OF HIS PATIENT'S PHYSIOLOGICAL SYSTEMS AND OF HIS CIRCUMSTANCES AS BEARING ON HEALTH. Such an examination is made when a life insurance policy is taken out and a record of facts is kept. Similar examinations are made, partially at least, in school medical inspection, and each scholar's dossier remains available if he changes his school. A complete examination cannot be regarded as less necessary when a person comes under the care of an insurance doctor. If this condition of sound medical work were met insurance practice of a large number of practitioners would be lifted out of its present quagmire of dangerous superficiality. Incidentally the confidential relationship brought about by such examinations would help greatly to reduce the present extravagant prescription of unnecessary drugs.

Excessive Resort to Doctors

One claim rightly made for insurance for medical benefit is that the patient is not inhibited from receiving prompt medical aid for minor ills, which if neglected might become serious. There is another side to this gain. There is much

excessive resort to doctors for minor complaints, which would become unnecessary were the insured better instructed concerning hygienic living. Visits to the doctor for slight illness would be useful if they did not mean, as often happens, a hurried interview, and the prescription of a bottle of medicine, without which the hasty consultation would leave the patient dissatisfied. It is one of the chief drawbacks to the insurance system as it now works, that it has helped to perpetuate the drug-swallowing habits of the people. This habit could have been reduced to proper limits long ago had the interviews of the patient with the doctor included as a general practice a satisfactory examination of the patient followed by full explanation of what needed to be done. In contract practice this increased resort of the insured to the doctor for minor ailments can be made to aid fuller development of preventive medicine, if the doctor already knows his patient medically or now seizes the opportunity to overhaul him and to study his personal habits and *milieu*, and then instills advice as to future hygienic conduct of life. Is it beyond hope to anticipate the realisation of this ideal?

Treatment Limited to Minor Complaints?

As matters now stand the British insurance medical benefit is open to the accusation that it provides for the insured what he least needs, treatment mainly for minor complaints, but does not supply some of the major medical needs of the insured. In 1913 Sir William Collins, M.D., put this point as follows:—

> if an illness is trivial or an injury slight, it is deemed to be an affair of the panel doctor and the State; whereas if the injury is severe or the disease serious or grave, it is not the affair of the State but of a voluntary charity.

Many serious illnesses are treated at the patient's home by the insurance doctor; but domiciliary treatment is the part of the total treatment of patients which could most easily be provided apart from insurance, while the sickness insurance provision in Britain does not secure expert and

institutional treatment. In foreign insurance systems a more complete range of medical treatment is provided for the insured.

Reforms Needed to make Medical Insurance Satisfactory

Some of these reforms have already been indicated.

1. Preventive medicine needs to be developed in individual medical care.

2. Each insured person should have a medical dossier of his physical condition and social and industrial environment, carefully filled up by the doctor chosen by him, and confidentially handed on by him to the doctor chosen by the patient, when a change of doctor occurs. This dossier should be confirmed or modified by the new medical attendant, and kept intact.

3. The analysis of records of sickness among the insured collected on the lines indicated on page 122 should be undertaken by the medical officer of health in each administrative area.

4. The treatment provided for each insured person should include specialist and institutional treatment when medically indicated.

5. When the preceding reforms have been secured, it is desirable that the family be brought within the scope of medical insurance, at first experimentally and on voluntary lines. As the members of the family not industrially employed would usually not be eligible for monetary benefits, the risks associated with certification of unfitness for work would not arise. But excessive prescription of drugs would probably be increased beyond what would result from the increased numbers brought within insurance; and more effective action, educational and disciplinary, would be necessary to keep the administration of drugs down to the limits of actual need. Insurance doctors have assured me that the proposed extension of medical benefit to dependents would mean inordinate increase of unnecessary resort to doctors, and have urged that a special charge to the patient of say sixpence would be desirable for each first consultation. I am aware of the theoretical objections to any such charge; but I do not think the charge would seriously inhibit resort to the doctor when this is desirable. It will be noted that I assume that it will be obligatory on the doctor to be cognizant of the medical status of every person on his list, of which he will possess a record.

Excessive Administration of Drugs

Some action is already being taken in Britain to discover the incidence of drug administration as related to the extent of each doctor's practice. In England a statement is prepared quarterly and sent to the doctor concerned of the cost per patient and cost per prescription of the patients on his list. If TERRITORIAL DISTRIBUTION OF SICKNESS INSURANCE SOCIETIES were enforced this and other necessary details of supervision could be rendered more effective.

There is much to be said also for making the patient pay a portion of the charge for drugs prescribed. In some countries this is already done. Often the drugs prescribed are unnecessary; they have been given by the "doctor in a hurry", who thus satisfies his patient, while evading his moral responsibility to give his patient a thorough examination. I do not doubt the occasional utility of a bottle of medicine as a *placebo*, through which the patient's confidence is secured, and hope of recovery is inspired. But the doctor of the future to an increasing extent will attain this end without unnecessary drug administration.

Exclusion of Medical Benefit from Sickness Insurance

At present there is only one country in which medical treatment of the insured is outside the sickness insurance scheme, namely, the Irish Free State (see Volume III of *International Studies*, p. 536). The same held true until recently for Northern Ireland; but this part of Ireland has recently followed the example of other countries in supplying medical attendance as well as monetary benefits in sickness insurance. In Ireland there is a dispensary system of medical attendance at the cost of public funds, through which a large portion, in many areas one-half, of the total population receive domiciliary and to some extent institutional medical treatment. Medical certification of the insured is arranged in the Irish Free State on economical lines under this system, and it is contended with

justice that to start a domiciliary insurance service in addition to the old-established dispensary service would imply much duplication of work and expenditure.

In European countries sickness certificates are given by the insurance doctor. He is checked in various ways to avoid over-certification, but often with little success. This over-certification has been already discussed. To a minor extent it is unavoidable. Medical science does not permit of an immediate diagnosis in every case of illness; nor is it always possible to decide by objective signs—apart from expressions of opinion and statement of symptoms by the insured—whether the patient should or should not continue to be certified as still unfit for work. The difficulty as to medical certification will remain whether it continues to be part of an insurance doctor's work or is placed outside insurance. The suggested plan of employing an insurance doctor and a separate official doctor need not be discussed. It would be excessively costly if adopted for more than a limited number of "referee" cases. If a State service of full-time doctors were employed to treat the insured, it would be possible to ensure more rigid medical certification, and the State medical officers would not be influenced, as some insurance doctors sometimes now are, by fear that righteous rigidity in certification would lead to their losing a patient. A reputation of rigidity may mean also that few insured persons will join the panel of the conscientious doctor. But no such State service is contemplated. It is doubtful if it is desirable for domiciliary medical work.

When the British Insurance Act came into operation there was a special sanatorium benefit, providing for satisfactory treatment of insured persons suffering from tuberculosis. For reasons set out on page 209 this subsequently ceased to be a benefit under the National Insurance Act. Thus it is conceivable that similar action might be taken for sickness in general. The British Medical Association has considered this problem, and has published a tentative scheme (see p. 133) for a "General Medical Service for the

Nation", which would bring dependents of the present insured and all legally necessitous persons within the terms of the contract insurance terms arranged under the present Act, with financial modifications. The scheme also proposes that specialist services be included in medical benefit, and that the present insurance committees be replaced by statutory committees of the county and county borough councils. This would enable a close liaison to be effected between municipal hospitals, clinics, and health centres and the chiefly domiciliary work of the insurance doctor. The capitation fee for the destitute would be paid by the local health authority.

This scheme is preferable from the standpoint of public health to that of the National Insurance Act. When that Act was passed in 1911, the medical profession, through the British Medical Association, strongly objected to being placed in direct relationship with insurance societies, and with almost equal emphasis they declined similar relationship with the local health authorities. This led to the creation of separate local insurance committees to administer the medical benefit. Their work has steadily declined and atrophied, having been taken over largely by the central government, and their abolition was proposed by the Royal Commission on Insurance in 1926. The proposal that medical arrangements for insurance patients be supervised by local authorities, if and when effected, will make possible much unification of control and of work between the insurance service, hospital and consultant services, and the special tuberculosis, venereal disease, and maternity and child welfare medical work of these authorities.

It should be added that the British Medical Association in its scheme considers it fundamental that "as regards the control of the purely professional side of the service . . . as much responsibility as possible should be placed on the organised medical profession"; and that they "should be freely consulted from the outset on all professional matters" by the local authorities controlling the service.

The details of this interesting scheme need not at present

be further described or made the subject of comment. But the scheme shows how far the general medical profession in Britain has travelled in the realisation of the need for State and municipal organisation of medicine, for no scheme can become practicable without a large measure of State and municipal subsidisation. This advance is quite consistent with the continuance of some choice of doctor by the patient. It is consistent also with a part-time service of doctors in ordinary and expert medical practice, and with freedom of doctors from interference in their medical work. But this proposed vast extension of insurance for medical treatment will almost certainly mean that a high proportion of the doctors employed in insurance work will be occupied in this work almost exclusively; and no special foresight is needed to realise that the scheme as it develops may readily progress more and more towards a State service in which the number of full-time medical officers will greatly increase.[1]

A further review of insurance medical service in relation to private medical practice will be given in Chapter XIV. But some remarks must, in conclusion, be made as to the

Influence of Sickness Insurance on Morale

In a full consideration of the merits of sickness insurance one has to bear in mind not only its obvious merits. Insurance doubtless reduces the financial anxiety of the insured and his family, and it secures prompt and continued medical attendance in illness by the chosen practitioner. This is a social as well as a personal gain. In the paragraph on over-certification some not infrequent abuses of sickness insurance are mentioned, to which the practitioner may unwittingly or wittingly lend his aid. The cultivation of the habit of illness when a holiday is desired, or when regular work cannot be obtained in the labour

[1] In the year 1930, 73,000 doctors in England and Wales were engaged in insurance practice, i.e. 52 per cent. of all total registered doctors, including those who are retired or in consultant practice, as well as general practitioners. The average payments to each insurance doctor in that year were £463 (about $2,300).

market, is known too well. Indeed, it is from financial motives that the abuses of sickness insurance arise almost exclusively, and still more those of unemployment insurance.

For the conscientious insurance doctor it is a great boon to be able to give satisfactory treatment to the persons on his panel, without regard to a future doctor's bill. The too complaisant doctor may incur serious moral damage by hasty consultations with his patients and by giving equally hasty and unjudicial medical certificates of inability to work. That is the doctor's side; for the insured there are similar moral risks. As Dr. Alfred Cox, the secretary of the British Medical Association, has put it in a paper contributed at a Congress of the Royal Sanitary Institute on June 27, 1930:—

> All agree that there is little or no malingering . . . but rather a feeling that work is a thing not lightly to be persevered with when one is not feeling "quite up to the mark". If this is so, if this is one of the major reasons for the ominous increase in sickness benefit claims, we may be paying too highly for the undoubted advantages of sickness insurance and other forms of social assistance.

In another sentence of the same paper Dr. Cox states:—

> My correspondents nearly all agree that the insurance system, combined with other forms of social assistance . . . has had a bad effect on the morale of the industrial classes. They think that the undoubtedly greater tendency to claim aid or benefits—including that of lying off work for a time without too great a financial sacrifice—is due to a new but now general way of regarding public funds as inexhaustible.

This statement emphasises an aspect of sickness insurance of great importance. Its significance and truth are not confined to sickness insurance in any single country. But this sinister attitude towards social insurances on the part of many concerned can be obviated; nor does its existence furnish a valid argument for abandoning insurance, or for refusing to inaugurate insurance systems wherever on general grounds these are deemed to be desirable. This common attitude does, however, necessitate improvement

and rigid reform in the administration and organisation of existing social schemes. And perhaps even more important than these reforms, it calls for a parallel and equally vigorous movement on the part of all who can influence the moral outlook of the individual. This is even more important than improvement in the environmental factors of health.

There is need for EDUCATIONAL WORK AMONG THE INSURED which will lead them to realise that insurance funds are not a bottomless reservoir out of which benefits can be dipped; but that the capacity of the reservoir depends all the time on a realisation of the fundamental principle of mutual insurance, which is one of mutual altruism with mutual benefit when really needed.

The development of the insurance conscience can be aided, and is already aided in some countries, by secondary financial motives. Administration should favour incentives to action in the right direction. In some countries the patient has to pay a portion of the cost of medical attendance and drugs. It is easy to assume that this would lead to neglect of medical treatment. I doubt this inference; and if the restriction were limited to drugs it would almost necessarily lead to insurance doctors giving more hygienic advice than is now given.

The German Reichstag has issued an order (1931) one condition of which is that every insured person wishing to consult a doctor has to pay sixpence for a voucher allowing him to do so, and has to pay the same amount for every prescription made up by a druggist. The first half of this order is open to some objection in the particular form in which it has been enacted.

But more important and more urgent than possible medical restrictions is the necessity of giving the insured a direct personal interest in keeping his sickness benefit, i.e. his money allowance during absence from work, down to a minimum level (p. 127). By this means thrift can be made an important element in insurance. I am not much concerned with the exact machinery. There would be needed a complete dossier of each insured person's life-history as an insured person. There would be needed also knowledge

of the average rate of sickness of male and female insured respectively in each age group, and a periodical, possibly annual or quinquennial, comparison of individual with general experience. It would thus be possible in favourable cases to add a bonus to the credit of the insured, which would be withdrawable at the end of a stated period or which would be convertible into an old-age pension additional to the pension now accruing in Britain and elsewhere at the age of sixty-five. (For an account of an Alsatian scheme on somewhat similar lines, see an article by Dr. Sprecklin in *British Medical Journal, Supplement*, January 25, 1930.)

Hitherto compulsory sickness insurance has differed from commercial and mutual life insurance schemes in that favourable experience does not earn a bonus or a reduction of premiums. The plan suggested above would remove this anomaly. It would introduce a practice which is accepted not only in life insurance, but also in other insurance schemes, such as those against accident, fire, or motor-car liabilities.

This is one suggestion of possible action encouraging the insured to cultivate health and avoid incapacitating sickness; but many schemes could be devised, all of which would favour the same object.

It will be convenient to make further remarks on sickness insurance and its medical benefit in Chapters XIII to XV, in which the relation of the private medical practitioner to other forms of medical aid and guidance which are partially or wholly subsidised out of communal funds is discussed. Such medical aid is commonly described as "State Medicine", and the name is sometimes received in medical circles with a shudder. It may be convenient to state at this point that any existing schemes of this kind and any likely developments are completely compatible with the continuance of private medical practice, in which, as in most sickness insurance systems, the patient can choose his own doctor and the doctor can accept or decline to accept patients.

Summary on Insurance for Medical Treatment

42. There is need for group action in private and in institutional medical practice.

43. Underlying insurance against unemployment and sickness is the anxiety to secure relative security in life.

44. Prevention is always more important than provision. To the furthest practicable extent, prevention of an evil is infinitely preferable to mere insurance against loss.

45. In the complexities of modern life liberation from conditions inimical to health or to the recovery of health has become a social desideratum more than liberty in the sense of freedom from compulsion.

46. A system of sickness insurance which does not provide accurate and complete records of the incidence of sickness among the insured fails to secure the best interests of the insured, as well as of the population of which they form part.

47. The incompleteness of the medical care given in the British insurance system is not in the interest of the insured. It reduces the value of the treatment given, and it hinders the development of preventive medicine in insurance practice.

48. Complete occasional medical examination of the insured is necessary if medical insurance is to have its maximum influence in preserving health.

49. At the least, an insurance doctor should regard it as essential to have knowledge, based on detailed examination of the physiological systems of his patient, of his fundamental conditions of health.

50. Territorial distribution of administration of sickness insurance is indispensable for efficient and economical medical and lay administration.

51. Definite measures need to be taken to minimise the danger of lowered morale among some insurance doctors and the insured.

PART II

CHAPTER VIII

THE MEDICAL CARE OF MOTHERHOOD

Preliminary Considerations

Whatever view be taken as to the best arrangements possible for promoting the health and welfare of the mother and her child, there is great satisfaction in the thought that with complete unanimity the premier place is accorded in nearly every civilised country to public health and social activities which will safeguard the mother and her child from every avoidable risk, and which will, furthermore, enhance existing standards of life and health, so that the total quantity of happy and useful family life in our midst may be increased. The attainment of this ideal necessitates the cultivation of every potentiality of the individual, physical, mental, and moral; and if in this and the next chapter it is the first of these three elements in health which is almost exclusively discussed, this is only because it is in this part of health work that the main problems of difficulty in adjusting the work of private and public practitioners of medicine have appeared.

The premier position accorded to maternity and child welfare work is the more significant, because it represents a partial escape from the pathological to the physiological side of public health problems. The escape, of course, is only partial. The older measures of public health are as necessary as they ever were in the control of endemic and epidemic diseases; and uncontaminated food and water and satisfactory housing are more important for the infant and toddler than for any other section of humanity. But our increasing knowledge of nutrition and general hygiene and the more general realisation that the formation of right habits and attitudes in infancy and childhood is a chief factor of satisfactory future character, and there-

fore of health, has opened up avenues for improving mankind, the value of which it would be difficult to exaggerate.

The story of public health is one of encirclement of the individual by circumvallate trenches, if a simile of warfare may be utilised. The first circle consisted of communal protections against importations of infection, against dangerous water supplies and accumulations of organic filth, and against unwholesome foods. A second encirclement consisted of domestic sanitation in its various branches, including provisions to protect against infection. The third is formed by the application of our increasing knowledge as to the influence of air-movement, of sunlight, of dust and noise, and other physical agencies on health. A fourth consists in the formation of right personal habits, not only as related to the physical factors of health, but also as to food, exercise, fatigue, and the avoidance of intemperance in any direction. There is included in it the cultivation of the power of inhibition of instinct when tending to anti-social conduct, and the general training of character. The success in the formation of this penultimate protection and fortification of the entire man is dependent in the final issue on the integrity of the citadel, which consists of the individual's own motives and ideals and outlook.

Even in intra-uterine life there is a constant exposure to an environment which at this stage is the maternal blood circulation, the health of the fœtus depending on the nutrition of the mother and on her freedom from toxic poisons and from infections. In the suckling period the infant remains in a position of facultative parasitism, both physiologically and psychologically. Its well-being depends in large measure on the mother's milk. And both at this period of infancy and, later, the infant's environment of feeding, of cleanliness, of warmth and protection, of exercise, of fresh air and sunshine, dependent as they are on the care and the financial circumstances of the mother, form an illustration of the impossibility of separating between what is called personal hygiene and the parts of

hygiene with which public health in past decades has chiefly concerned itself.

Although birth is a physiological event, it is associated with risks to the health and life of the mother and of the infant. Infections may attack the fœtus *in utero* and the mother before and during parturition, or in the subsequent fortnight; and the mother and the infant may be seriously or even fatally injured during parturition. It is not surprising, therefore, that in the past the efforts of medical science and of charitable bodies and public authorities have been directed mainly to the treatment of sick infants and of complications of pregnancy and parturition. These efforts continue to be needed and extended; while, happily, it is now more fully realised that these complications and dangers can be anticipated and sometimes prevented. Some examples of wide-range preventive measures may be cited.

Wide-Range Preventive Medicine in Relation to Maternity

1. One of these is embodied in the aphorism which I may quote from my *Health Problems in Organised Society* (P. S. King, 1927):—

> A sure method of decreasing childbed mortality is to make cod-liver oil a regular item in the dietary of the future mother during the first year of her life.

The administration of cod-liver oil, especially if associated with a practical appreciation of the value of exposure to sunlight and fresh air, is the best means of preventing rickets and the contraction of the pelvis, which, when adult female life is reached, is a serious danger to the mother and to the safe birth of her infant. This is part of the general policy which may be summarised in the statement that SAFE MATERNITY DEPENDS LARGELY ON THE REARING AND MAINTENANCE OF A HEALTHY POPULATION.

2. Even when adult female disease has not been prevented, a satisfactory medical service for all would mean that such conditions as serious heart disease, renal disease,

active tuberculosis or syphilis would lead to the adoption of advice as to the avoidance of pregnancy, until, at least in the case of syphilis, cure of the disease has been ensured. The fact that FOR A MINORITY OF WOMEN PREGNANCY AND PARTURITION CAN ONLY BE UNDERTAKEN AT A RISK WHICH SHOULD NOT BE INCURRED is too little remembered.

3. A third much-needed advance in preventive medicine as applied to maternity consists in inducing all married women to realise the serious dangers of abortion, especially when volitionally induced. With the increased adoption of contraceptive methods, there has probably also been increased resort to abortion, often produced by unskilled persons, when contraceptive methods have failed, as they do in a considerable proportion of total experience. As Dr. J. S. Fairbairn has put it (*Proceedings of the Royal Society of Medicine*, February 1931):—

> Births are restricted and spaced, and when failure to do so occurs they do not think a demand for the removal of the unwelcome guest is unreasonable, though any qualms on the doctor's part may be so regarded.

For convenience, Dr. Fairbairn's further wise remarks bearing on the general problem may be quoted at this point, as they have an important relevance to excessive puerperal morbidity:—

> With these spaced and less frequent pregnancies there is also a more insistent call for adventitious aids to an easy delivery and more and more the services of the medical attendant have been diverted from their true purpose of securing natural function and removal of the causes of its disorder to relieving pain and shortening the duration of labour.

The results of abortion not improbably form a considerable factor in the failure of the mortality from puerperal sepsis to decline; and to some extent this factor explains the relatively high puerperal death-rate in some countries (p. 156).

These illustrations show that the need for and the possibilities of application of preventive medicine to child-

bearing, including the antenatal period, are wider than might at first appear. If recent results in experimental animals showing that septic infection may be decreased by a dietary including abundant vitamin A are confirmed in human experience, this truth will be further extended.

It will be convenient to discuss first the statistics of puerperal mortality and morbidity; then to set out the practice of medicine and preventive medicine as related to the mother (the infant being considered in Chapter IX); to comment on the education of doctors and midwives; and finally to state the necessary conditions of a satisfactory maternity service.

Much information on all these points is given in Volumes I to III of *International Studies*; and I would especially refer the reader to the discussion of English practice in Chapters VII–IX of Volume III of these *Studies*. Here I shall chiefly limit myself to outstanding problems concerning private medical practice in its relation to the practice of midwives, and to the maternity work undertaken by unofficial bodies and by public health authorities.

Puerperal Mortality and Morbidity

In national registration statistics this includes the complications and accidents of pregnancy as well as of parturition; thus maternal deaths from early abortion, or from sepsis occurring several weeks after parturition, but directly due to it, are included in the statement of puerperal mortality.

1. In discussing puerperal mortality in The Netherlands (Volume I of *International Studies*, p. 43) I have questioned whether the records for different countries are completely comparable, even though ostensibly the international rules for allotting certified causes of death have been followed. It would especially appear that American figures may be somewhat overstated, in consequence of a more liberal allocation of deaths due to intercurrent febrile disease occurring during the puerperal period to the heading "puerperal sepsis". It is impracticable to state definitely

to what extent this or some other divergence in practice may have occurred in the United States and in other countries when comparisons are made with English figures.

2. The next point is that the frequency of addiction to purposeful abortion by instrumental means varies greatly in different countries, and in urban and rural experience in the same country. It is common in Berlin and Stockholm, for instance; and it is probably much commoner in some sections of the United States than in Britain. Abortions mean increase of puerperal sepsis, for the incidence of sepsis is greater in abortions than in births at term.[1]

3. Puerperal mortality is usually greater for illegitimate births than for legitimate, and a community with high illegitimacy will thus compare unfavourably with one in which there is little illegitimacy. An entirely satisfactory comparison would give separately the experience of married and unmarried.

4. Some of the excess of puerperal mortality among unmarried mothers is due to the fact that a larger proportion of them are primiparæ. First-births are much more dangerous than subsequent births.

Puerperal mortality in most countries is stated in proportion to the number of live-births. Theoretically it should be stated in terms of the aggregate number of live-births, still-births, and abortions; but the last two are not accurately known in any country. Registration of still-births (not of abortions) is usual, but is carried out to an uncertain and varying extent. The present method of stating the puerperal death-rate, although imperfect, probably gives a nearer approximation to the truth than other methods.

It would be of great advantage if registration figures permitted of a statement of (*a*) puerperal deaths in first child-bearing in terms of first-births, and (*b*) a similar statement for subsequent births and deaths.

[1] In the midwifery district experience (2,000 cases) of a large metropolitan hospital (London) cases of septic infection in instrumental delivery were tenfold those of normal delivery (p. 48, *Report of Departmental Committee on Maternal Mortality*, 1930). In instrumental abortion the proportion of sepsis is probably still higher.

The general conclusion from consideration of the factors enumerated above—especially changes in accuracy of certification, smaller families, and probable increase in abortions instrumentally induced, often by unskilled persons—is that some amount of improvement in puerperal mortality, when comparable conditions as regards care in parturition are contrasted, is concealed by not allowing for the factors of change, independent of obstetric care.

International Position as to Puerperal Mortality

Subject to the above general consideration, we can next review the relative position of European countries. The differences are remarkable.

In The Netherlands total puerperal mortality from all causes (per 1,000 live-births) is only 2·69 (years 1924–27) and only 3·61 in Amsterdam, its largest city. In Scotland it is 6·3 (years 1921–27), as compared with 4·0 in England, a difference not explicable, I think, entirely by difference in the practice of allotting deaths in the two countries.[1] Denmark (2·48 to 3·17 in the years 1925–29), Sweden (2·5), and Norway (3·2 to 2·4 in 1923–27) stand out in marked contrast to 6·3 in Scotland for total puerperal mortality, and still more to Berlin, in which, in 1928, the death-rate per 1,000 births from puerperal sepsis alone was 6·4. In Austria the death-rate from sepsis alone in 1927 was 2·07 and 3·91 in Vienna. The total puerperal mortality in Belgium was 5·72 in 1927.

Mortality figures reveal only a part of the suffering due to complicated childbirth and to abortions and miscarriages.

Subsequent disablements, partial or entire, are more numerous than those directly caused by parturition. It is likely that the later deaths caused remotely by unfavourable childbirth are double those now attributed to the puerperal condition; and Professor Blair Bell (*Lancet*, May 30, 1931)

[1] In the *Annual Report of the Department of Health for Scotland*, 1930, p. 40, is this statement:—

"Owing to the different methods of classification in operation, the statistics of maternal deaths in Scotland are not directly comparable with those for England and Wales, and still less with those for foreign countries."

states that while 3,000 women in England and Wales die annually as the direct results of maternity, "at least 60,000 parous women, also, are crippled annually, many gravely, others less though seriously injured enough to cause ill-health and disablement. . . . Trauma and injury . . . often associated . . . comprise about 75 per cent. of all causes of disablement".

The great differences shown in the national figures given above, in my judgment, are only partially explicable by differences in certification and in allocation of causes of death. There remain great divergencies in mortality from childbirth, for explanation of which we must look chiefly to divergencies in the management of parturient women. It can scarcely be argued, furthermore, that differences in physique or in roominess of pelvis will explain fully the unfavourable experience of Scotland and of Belgium and the favourable experience of the Scandinavian countries and of The Netherlands. Part of it may be thus explained. Pelvic contractions are stated, for instance, to be rare in Sweden. The people live a more completely outdoor rural life than the majority of the population in Scotland, and the children—from whom the future mothers are derived—consume many times more milk than the children in Great Britain.

The greater puerperal mortality in large towns throws light on the problem. The puerperal death-rate in Vienna is nearly double that of Austria, and that of Stockholm is nearly double that of Sweden as a whole; that of Berlin is deplorably high. In Norway the rural death-rate is much lower than that in towns. Although there may be some defective certification in country districts, we can reasonably associate these differences in the main with the frequency of purposeful abortion in the towns.

As bearing on this point recent figures from Hamburg may be quoted (*Lancet*, p. 492, February 28, 1931), giving some of the answers to a questionnaire addressed to medical practitioners by the Hamburg Medical Chamber.

The following examples may be given: Should abortion be

legal if the condition of the family requires it, although the medical indication is doubtful? (Yes, 691; No, 178.) Is abortion desirable if there are more than four children already living? (Yes, 418; No, 437); if the mother has become pregnant after too short an interval? (Yes, 497; No, 360).

Should it be allowed only if the husband agrees? (Yes, 511; No, 266; Yes, with reservations, 101.)

It would appear that in many cities illegitimacy and the sepsis associated with abortion more than counterbalance the greater availability in them of skilled attendance and hospital provision.

International Provision of Midwifery

Arrangements under Insurance Acts are considered in the next paragraph.

In Great Britain over 61 per cent. of births are attended by midwives. The destitute can secure attendance by the district medical officer, but this is seldom utilised. A large number of births occur in public assistance hospitals, and an increasing number in maternity hospitals (voluntary or maintained by public authorities) and in homes of private charities and public authorities.

As set out in Chapter VII, Volume III, of *International Studies*, many official provisions are made by public health authorities in Britain for improving the prospect of safe child-bearing. These include—

antenatal clinics and consultations;
guarantee of payment for the doctor called in by a midwife in difficult cases;
provision of hospital beds for women for whom this is medically indicated, or whose home circumstances are unfavourable;
provision of consultants for private doctors' patients when there is puerperal pyrexia, or when special difficulties occur in or after parturition;
hospital provision for puerperal fever and other sequelæ of parturition;
occasional hospital treatment of mother when breast feeding fails;
convalescent homes for mothers after parturition; the provision of home-helps.

They also include—

some subsidisation of the training of midwives;
the subsidisation of midwives in some scattered districts, where otherwise they could not earn a living;
a system of inspection and supervision of midwives, and of arrangements for post-graduate courses.

Payments for some of these services may be required from patients according to means.

Sickness Insurance and Maternity

All countries in which sickness insurance systems exist make some provision for care of maternity.

The provisions in Great Britain under the National Insurance Act are stated on page 164, Volume III of *International Studies*. There is a money grant of £2 (nearly $10 at par) to each wife of an insured person, double this amount if she also is industrially employed and insured. No medical or nursing services are supplied, the mother being left to make her own provision. For this the money grant is scarcely adequate. These insurance arrangements are additional to the provision made by public health authorities as set out above.

In Denmark some insurance societies make a daily money allowance for ten days after confinement, and may pay for a consultant doctor when needed. Nearly all confinements are attended by midwives.

In Norway insured women receive a lying-in benefit, which includes, in addition to money payments, free attendance by a midwife who is paid on a specified scale. Hospital treatment may be substituted for a midwife.

The German Reich gives large subsidies for help in maternity (p. 142, Volume I of *International Studies*). The statutory insurance benefits include provision of a midwife and of medical treatment when needed, and certain cash benefits (p. 144, Volume I of *International Studies*). Commonly each Sick Fund provides treatment and maintenance in a maternity home, or attendance by a nurse, in partial or entire substitution for the maternity cash benefit.

Maternity benefit is granted not only to the wife, but also to other members of an insured person's family.

In Austria free obstetric help is given to the wife of an insured person. There are special insurance maternity homes as well as municipal homes.

Under the new Insurance Act of France a wage-earning insured woman will be entitled to both medical and financial benefits, and most of these benefits accrue also to the wife of an insured man (Volume II of *International Studies*, p. 95).

In Hungary similar benefits are given, including complete medical attendance. In Poland maternity assistance without money benefits is given to the wives of the insured.

Review of Provisions for Maternity

The above curtailed review can be supplemented by reference to Volumes I to III of *International Studies*. In all European countries skilled help in childbirth is given gratuitously, usually both domiciliary and institutional, for the very poor, apart from sickness insurance.

In most European countries aid for the poor has been supplemented and expanded in two directions, (*a*) through insurance organisations, and (*b*) by the activities of central and local public health authorities. The supplementation thus effected in these countries, including Britain, has been irregular and unequal in its distribution and completeness. It is irregular even in those countries in which insurance organisations provide midwives, with doctors in reserve for insured women and sometimes for the wives of insured men, and even when some Sick Funds, as in Germany, have special maternity hospitals of their own. Commonly the insurance funds do not pay a sum which completely covers the cost of care of their members in the maternity hospital, a portion of the cost coming usually out of municipal or national taxes.

Circumstances as to institutional provision for parturition vary greatly; but in Scandinavian countries in particular, hospital provision is largely at the expense of the taxpayer,

though charges are made according to means. Often hospital treatment is given in lieu of a midwife paid from insurance funds.

In Britain there is no medical or obstetric provision for an insured woman or the wife of an insured man, as such, beyond the money benefit already stated. But public health authorities in towns—not in rural districts generally—have provided on a considerable scale maternity homes and hospitals, into which insured and non-insured alike are admitted, payment being assessed according to means. Similar conditions apply to the lying-in wards of public assistance hospitals, and to many obstetric beds provided in large towns in voluntary hospitals for maternity patients. In addition, there is in Britain a large amount of supplementary maternity aid by lying-in charities, at official clinics, and in the homes of patients, especially in towns where there are medical schools.

Official public health provisions, as already noted on page 159, include antenatal consultations, supervision and sometimes provision of midwives, and the provision of obstetric consultants in different cases (p. 171).

There has thus grown up in various countries a vast system of obstetric aid, including pre- and postnatal aid, some paid for out of insurance funds, some out of communal funds. A fusion of different agencies on a common basis is obviously needed, if the maximum good is to be attained.

The majority of lying-in women throughout Europe are attended by midwives, doctors being the obstetricians in a minority only of the total normal births, and in a majority of cases in which serious complications arise. In the Scandinavian countries nearly all maternity cases are cared for by midwives and in lying-in hospitals, and this is true for a majority of births in other countries, including England, but not Scotland. In each of these countries a high proportion of births occur in institutions. In Stockholm this proportion is over 90 per cent., and it is 30 per cent. for the whole of Sweden.

In Prussia some 90 per cent. of all births are attended by midwives. In Berlin three-fifths, and in Hamburg three-fourths, of the total births occur in hospitals. Austria is served chiefly by midwives, and in Vienna three-fourths of the total births occur in maternity homes or hospitals.

In urban France there is a large amount of gratuitous care in maternity. In Paris between 60 and 70 per cent. of total births are thus cared for, nearly three times as many being confined in hospitals as in their homes. Throughout France there is stated to be one midwife to 3,285 of population, and these and handy-women attend most of the births in France.

The conditions in other countries need not be particularised here. Reference may be made to Volumes I to III of *International Studies*.

Obstetric help being available in all countries from midwives or doctors, or from both, how are we to explain the varying experience of puerperal mortality and morbidity to which the figures on page 157 point?

Causes of Excessive Puerperal Complications

No dogmatic statements can be made on the strength of mortality figures alone; for it is even possible that obstetric care is more efficient in a town in which, let us say, illegitimacy and intentional abortions are frequent, than in a rural district with a lower puerperal mortality, but in which illegitimacy is less frequent and unprovoked abortions are unknown. But the problem cannot thus be evaded. There is another approach to it, by investigation of the management of the parturient mother in different countries. If at the same time one can also ascertain the experience of practising obstetricians in these countries, and if we know even approximately the proportion of primiparæ to multiparæ, we may reach some practical conclusions. The facts justify certain conclusions; but before stating these I must interpolate remarks on the teaching of obstetrics.

The Training of Doctors and Midwives in Obstetrics

The care of maternity, as we have seen, is divided between midwives and medical obstetricians. In some countries, as in most of the United States, midwives have no legal status, and are usually regarded as unqualified and objectionable practitioners. In most American States also few, if any, arrangements are made for the training of midwives; nor are they barred from practice without training.

In all European countries some provision is made for training midwives, and in many of them women who have not been trained are prohibited from practice. In Britain all midwives to qualify for practice must now undergo a year's training, except fully-trained nurses, for whom half the period is remitted; and all midwives must pass a qualifying examination. The training is still unsatisfactory, and will need to be prolonged (p. 180).

In The Netherlands and in the Scandinavian countries, midwives receive very complete training and are carefully selected. In some of these countries (see Volumes I and II of *International Studies*) the number of candidates for training in midwifery is strictly limited to the calculated needs of the country.

The number of midwives in The Netherlands is strictly limited in accordance with needs; 60 per cent. of all births are attended by midwives. The Government encourages the employment of midwives. It prescribes fees, and insists on the provision of a midwife for each district, who can charge a fee except for the poor. For further details see pages 31 to 40, Volume I of *International Studies*.

The duration of training of midwives may be three years (Netherlands), or two years (Denmark and Sweden), or one year (Norway and Britain, except for trained nurses in Britain, who may be trained in six months), or eighteen months (Austria), or from twelve to eighteen months (most of the German States). In Belgium and France untrained women in large numbers still act as midwives. In

Britain some untrained women, who were practising before the Midwives Act was enacted, are still in practice. It should be noted also that before 1916 only a three months' course of training was required of certified midwives, and that the training required was only extended to twelve months in 1926, while it remains six months for previously fully-qualified nurses. Thus of the midwives in Britain a large proportion remain who have not been satisfactorily trained. This fact makes the relatively satisfactory results of the work of midwives the more striking (p. 170).

Even more important than its duration is the selection of candidates and the quality of their training. In this respect the Scandinavian countries again excel. There is careful selection of candidates, who are much more numerous than the vacancies, and the course of training is practical and thorough. In Britain the course of training is not altogether satisfactory. Dr. Ethel Cassie has stated that, "in the majority of instances, the training of midwives is treated as a cheap method of staffing maternity wards" (*Journal, Royal Sanitary Institute*, February 1931). The subject is complicated in Britain by the fact that the majority of candidates for the certificate of the Central Midwives Board do not intend to practise as such, but obtain the certificate in order to obtain a post as a health visitor. Drastic reforms in the training of midwives are needed in most countries.

The training of doctors in midwifery has hitherto been unsatisfactory in many countries. The excellent training of midwives in The Netherlands is described on page 36 *et seq.* of Volume I of *International Studies*, and that of medical students in Stockholm on page 88 of the same volume. Each medical student resides in and is on duty for four months in the State Lying-in Hospital.

At St. Thomas's Hospital, London, very complete training has been organised, assuming that the number of confinements available for each student is ample. There are doubtless similar arrangements elsewhere outside my

knowledge, though the position in Britain, speaking nationally, is relatively unsatisfactory.

The following account is taken from an official description of the St. Thomas's Hospital Scheme:—

Since 1910 each student has devoted a term of three months to the whole-time study of Midwifery and the Diseases of Women, but the work has now been arranged so as to include Pædiatrics and the term of service in the combined subjects has been increased to six months. The change has been made in order to allow of the clinical teaching of these subjects being conducted in chronological order, and presented as a scheme of preventive medicine, starting with the care of the pregnant mother, with a view to the maintenance of her health throughout reproductive life, and leading up to that of the young child of school age. The practice of obstetrics, gynæcology, and pædiatrics is thus learnt in a new atmosphere. A view of medicine is presented as applied to the problem of reproduction and the care of the rising generation as well as to the individual patient, and with prevention of disease as its primary objective. In this way a much more correct perspective of the relative importance of the different parts of the work is obtained than was formerly the case when maternity cases, gynæcological and pædiatric practice were attended as isolated events in the curriculum.

The teaching of the care of women and children is given from the physiological side as well as the pathological, and the student is instructed in normal and healthy subjects with the view of maintaining health and learning to discover the early signs of disordered function.

He begins with the pregnant woman in the Antenatal Clinic and learns the diagnosis and treatment of the diseases and disorders of pregnancy and how to avoid preventable difficulties in labour. The more serious of these cases admitted for further investigation and treatment afford him opportunities for more detailed observation. He also attends the Infant Welfare Clinics, under Dr. Jewesbury, where instruction in the management and feeding of the child is given, and thus obtains a view of the whole system of prevention in his term. The actual birth he is taught to look on not as the sole or even chief object of his study, but merely as a stage, though a critical one, calling for special care in the life-history of mother and infant. During this first month he is drilled in the Maternity Ward (600 deliveries per annum), in the examination and management of the woman during labour and lying-in, and in the care and feeding of the

new-born infant, and learns the work with all the resources of the hospital in his hand; then for a month he goes out in the district to apply these methods to the very different conditions he finds in the patient's own home. Throughout this service he is in close touch with the Social Workers of the Almoners' Department, and thus acquires some acquaintance with the relationship of his professional duties to human society and the great social problems which he will soon discover to be pressing round him.

The next two months of his term are devoted to the study of the Diseases of Women in Out-patient and In-patient Departments, where the results of the injuries and infections of childbed which his previous training was designed to teach him to avoid are seen, together with other ailments of the female reproductive tract.

In his final two months he returns to the Infant Welfare Clinics, and attends both the Out-patient and In-patient Departments for Diseases of Children, where again he sees the effects of failure of prevention of disease—this time on the growing child—and continues his gynæcological practice by attendance in the Out-patient Department for Women.

That there is great need for reform in the usual midwifery training of medical students in Britain is indicated by the interim conclusions (December 1930) of the General Medical Council, after consideration of the interim report of the Departmental Committee on Maternal Morbidity and Mortality, 1930. They favour the proposal to concentrate the teaching of obstetrics, gynæcology, and closely related subjects into a continuous period of six months. They also approve the proposal to increase the duration of residential study in a maternity hospital or ward to two months whenever practicable.

If the general medical practitioner is to practise midwifery successfully, it is imperative that he should personally, when a student, conduct a much larger number of confinements than those provided under the present regulations of the General Medical Council. This is the minimum requirement if general medical practitioners are to retain as much of their obstetric practice as they still possess. More is needed if the average practitioner is to be fully competent to deal with many of the complications for

which his aid is asked by midwives. If training in this direction is given adequately, it would justify reducing elaborate requirements in subjects which the general practitioner will never have to deal with.

Causes of Excessive Puerperal Complications (*Contd.*)

In the light of this necessarily incomplete review of the present training of both midwives and doctors in obstetric work in many countries, we can now examine available statistics as to the special experiences respectively of high and low puerperal mortality. There are preliminary doubts in attempting this task, in addition to the more general doubts enumerated on pages 154 to 157.

The more favourable experience of midwives in Britain is the more remarkable in view of their somewhat imperfect training. Is this more favourable experience in certain classes, especially among those attended by midwives, due to the greater success of these female non-medical practitioners in obstetrics, or have their patients been weeded out by one or more preliminary processes of favourable selection?

Several points bear on this difficulty. The facts given below are quoted from British experience:—

1. Statistics of the experience of midwives do not include the 10 per cent. of total deaths in the puerperal state which are officially certified as due to abortion and other accidents of pregnancy. They do, however, include cases attended by midwives in which medical aid is obtained by them.

2. Women suffering from inter-current disease or who in previous confinements have had difficulty, or women who when antenatally examined are regarded as needing special treatment in parturition, are likely to engage a doctor or arrange for hospital treatment in childbirth.

3. There are differences in patients as well as in their obstetric attendants. Does not the fact that a midwife is engaged by the expectant mother indicate a trust in nature's processes and a satisfactory freedom from morbid fears, favouring calamity, which may be lacking when a doctor is engaged?

On this point Dr. J. S. Fairbairn, Chairman of the Central Midwives Board, may be quoted in evidence. He emphasises—

> the rapidly accelerating change in the attitude of mind of the whole community towards childbearing and all that it involves (see also p. 154).

and he instances the recent agitation for wholesale anæsthesia (see also p. 49 in Volume III of *International Studies*), and stresses the consideration that while relief of the pangs of labour is one of the obstetrician's duties, this must be—

> with the proviso that it must not interfere with our primary object of normal function, and that we (the medical obstetricians) must be left to decide when and how it shall be given. . . .My argument is that all our right hand has gained by better obstetric knowledge and technique is now being squandered by our left hand using this skill on occasions tenfold and more than is justifiable for strictly medical reasons (*Proc. Royal Society of Medicine*, February 1931, p. 403).

I have already mentioned the changed social attitude to childbearing as bearing on probable increase of instrumental abortion and the demand for early release from the pains of childbirth. The mind of the social observer is brought up against the additional consideration that in Dr. Fairbairn's words "the class of attendant may not have the importance that would naturally be assigned to it, and that possibly the type of patient dealt with has a much greater weight than has hitherto been laid on it".

Bearing these and similar points in mind, the comparative statistical facts are striking. In Scandinavian countries and in The Netherlands, in which confinements are attended almost always by midwives, the registered puerperal mortality is little more than half that in most other countries and the difference may exceed this.

Differences of certification and registration, of healthiness of mothers, and of fortitude in regarding childbirth as primarily physiological, may and probably do explain part of the discrepancy; but it must in reason be held that the skill of the midwives in these countries, their surgical

cleanliness, and their abstinence, in the absence of real need, from obstetric interference, have been largely responsible for the result.

British experience points in the same direction (see pp. 170–180, Volume III of *International Studies*), although midwives in Britain are less satisfactorily trained and not so carefully selected as in the countries named above. This is shown more clearly when the separate experience of fully-trained midwives is examined. Making all reasonable allowances for the factors mentioned above, the experience of the East End Maternity Hospital, London, in which the puerperal death-rate is only one-half and among its patients attended at home is less than one-fourth of that in London as a whole, testifies to the exceptional obstetric care (by midwives with doctors in occasional consultation) which these patients receive. This is so, even after reasonable arithmetical allowance has been made for the less inclusive statistics of this institution (Volume III of *International Studies*, p. 172).

The experience of British Maternity Hospitals and of nursing associations and the home maternity services attached to medical and midwives' schools confirms this conclusion (p. 170, Volume III of *International Studies*).

From a careful study of all available data in international experience I have no hesitation in concluding that in present experience there is EXCEPTIONAL SAFETY IN CHILDBIRTH THE CARE OF WHICH IS UNDERTAKEN BY TRAINED MIDWIVES, who have skilled medical help available when complications render this necessary.

The safety associated with midwives' attendance on parturient women is seen even in Great Britain, in which the training of midwives and the circumstances of their work, including their remuneration, must still be regarded as far from satisfactory. This relative safety is even more a national characteristic in the Scandinavian countries and in The Netherlands, in which carefully trained midwives are almost exclusively responsible for the care of maternity.

Thus the international practice in virtue of which mid-

wives care for the vast majority of normal confinements in Europe is associated with an exceptionally favourable maternal experience, and may be made still more so as the conditions of obstetric work improve.

In the preceding paragraphs I have avoided detailing the various causes of excessive maternal mortality. Such a discussion would not necessitate a conclusion divergent from the one stated above.

But if midwives continue to undertake to the present extent the ordinary obstetric care of women, skilled surgical help will continue to be needed in a certain proportion of cases. This will be so even though midwives in future are more fully trained, and are allowed to give help in emergencies, pending the arrival of a doctor.

Consultant Medical Obstetricians

The regulations made by the Central Midwives Board confer the right and impose the duty on a midwife to call in a doctor whenever one of a long list of complications occurs in a patient in her practice. (These are enumerated on pp. 151–153, Volume III of *International Studies*.) The patient can make her own choice of doctor, any doctor in the district being eligible. The local authority is responsible for payment of the doctor's fee (according to a schedule given on page 150, *op. cit.*), but can recover this or part of it from the patient or her husband if able to pay. Thus every patient attended by a midwife in Britain has a doctor in reserve. The existence of this provision has increased the demands made by midwives for medical aid in confinements. Some illustrations are given in the Local Studies in Volume III of *International Studies*. The following are further instances.

The percentage of medical calls by midwives to every 100 confinements attended by them—

in Essex was 11·5 in 1919, and 25·3 in 1929;
in Somerset was 20·4 in 1919, and 28·2 in 1929;
in Warwickshire was 15·0 in 1919, and 29·0 in 1929;
in Worcestershire was 11·0 in 1919, and 38·0 in 1929.

(See contribution by Dr. W. G. Savage, *Medical Officer*, May 3, 1930.)

In a few areas expectant mothers have contributed to an insurance scheme entitling them to medical aid if this is needed by the midwife attending them. This method has been followed by an exceptional increase in medical calls, and it has been found desirable to limit the insurance to cases seen antenatally by a doctor. If the increase in number of medical calls means real need for medical help, it is to be encouraged. If, however, it implies lack of courage on the part of the mother, and a desire on her part to have hurried relief beyond partial anæsthesia, medical attendance may do more harm than good. This is so especially if there is premature intervention in a normal process. Thus while access to a doctor whenever necessary should be safeguarded, means should be devised for keeping these calls within legitimate limits. With a more fully-trained and competent service of midwives these difficulties will decrease.

More serious in its implications than possible inordinate calls by midwives for medical aid is the regulation controlling the midwife's work, which implies that the parturient woman—often, perhaps generally, influenced by the midwife—can choose any doctor in the district to help her. There is no guarantee that the doctor thus sent for has special skill in obstetric cases. He may never have attended or seen more than the twenty cases which are now required to be seen, perhaps in a very partial sense, by every medical student. There is inconsistency in the present position, even though many of the contingencies in which a doctor must be sent for do not necessitate exceptional skill. As stated in a recent official circular of the Ministry of Health:

> Under the Local Government (Qualifications of Medical Officers and Health Visitors) Regulations, 1930, the medical officer of an antenatal centre is required to have had special experience of practical midwifery and antenatal work.

The same principle is recognised for major obstetric complications (see Memo. 156 M.C.W. of the Ministry of

Health, December 1930). In this the local authority are recommended

> to satisfy themselves that a consultant is available for any doctor who needs assistance in difficulties or complications arising during pregnancy, or at or after confinement. It will generally be found desirable to engage for this purpose the consultant at the maternity hospital or antenatal centre serving the area.

It is recognised also in connection with the duty of each practitioner to report to the medical officer of health each patient who during the puerperal period has a temperature of 100·4° F. for 24 hours or recurring within that period. In many sanitary areas already one or more local physicians having special experience have been selected, often by the general practitioners themselves at the suggestion of the local authority, to act as consultants to doctors attending these cases. In each instance the consultant's fee is paid or guaranteed by the local authority.

This is as it should be. But such special experience is more critically important in many of the ordinary emergencies of complicated parturition than in the diagnosis of the significance of a temperature of 100·4° F. or in the work of an antenatal centre; for the former may involve immediately the life of the patient; and one must regard it as a continuing defect of the British maternity service that the medical aid sent for in all the emergencies—major and minor are not always distinguishable in the practice of a midwife—is not certainly that of a doctor "who has had special experience of practical midwifery".

The principle behind the illustrations given from British obstetric practice is clear. If the confinement involves assistance beyond the competence of an adequately trained midwife, the doctor giving this assistance should himself be competent for the task. Some doctors are not competent at the present time, through inadequate training or inexperience or otherwise. There must therefore be provided for midwives a service of doctors who are specially competent. The appreciation of this need has been used as an argument for medical attendance in all midwifery cases.

I have advanced the point in argument in European countries in which midwives attend most confinements, and have been impressed by the light weight attached to it. Notwithstanding this it appears to me that medical skill in complicated midwifery must be promoted by large experience of normal confinements.

In Paris I was assured that medical consultant obstetricians at the patients' homes were not needed, because of the abundant hospital provision for complicated midwifery, which is made on an extensive scale in Paris and in large cities in all countries. Behind this provision, however, I fear that there remain complicated cases in which domiciliary medical aid is lacking or is unskilled.

But in England it is unlikely that doctors will in future attend a larger proportion of confinements than they now do unless efficiency and economy both call for this; and it is doubtful if future developments of medical practice will justify such an extended training of medical students in midwifery as will prepare them all to be obstetric consultants. Thus future developments in England are likely to waver between increasing specialisation of the practice of midwifery by medical obstetricians in every area acting in conjunction with midwives, and more complete training of all doctors for the same work; and the result will be determined probably by financial considerations.

Antenatal Medical Work

Definite provision for this work appears to be more developed in Britain than in other countries. It is work which until recent years has everywhere been much neglected in medical practice. For it and for the medical care of infants and of school children, it must be remembered that throughout Europe medical care of the wives and children of the insured population is included in medical benefit, whereas in Britain dependents are omitted. Hence, in part, the greater need of special antenatal work and of school clinics in Britain, apart from private medical practice. Some particulars of antenatal centres are given in Volume III

of *International Studies*. A chief object of these centres is to diagnose any contraction of pelvis or maternal disease which calls for special medical care; though general hygienic advice to the mother forms an important part of their work. These centres are utilised also for the examination of patients referred by private practitioners who desire the advice of an obstetric consultant. The Ministry of Health, in their already quoted memorandum 156/M.C.W., remark that sometimes women who have engaged midwives for their confinement may be unable, or may be reluctant, to attend an antenatal centre, and it is suggested that in such instances the local authority may pay a private doctor who undertakes the necessary medical examination. No separate mention is made in this suggestion that the private doctor thus employed shall have the special experience recommended by the Ministry for the medical officers of antenatal centres (p. 172); and the recommendation apart from this is of doubtful value.

The present position of antenatal centres is not altogether satisfactory. Midwives may sometimes suspect that they will lose their patients if they send them to a doctor or to the centre. Happily the practice is increasing of partially compensating the midwife when the doctor at the centre discovers that the patient referred to him should be treated in a hospital. Thus in Birmingham the midwife is paid 10s. if her patient is sent into a hospital. Similarly, the private doctor desiring expert advice as to his prospective maternity patient, who cannot afford a private consultation fee, must be assured, as he can be, that reference to an antenatal clinic does not imperil his future personal charge of the case except with his concurrence. That some conditions in pregnancy call for special professional skill is undoubted.

Dr. S. J. Cameron, Obstetric Surgeon to the Royal Maternity Hospital, Glasgow (*Journal, Royal Sanitary Institute*, September 1931), emphasises this point:—

> Prior to confinement patients should be attended by a practitioner with an extensive knowledge of obstetrics or by an obstetrician,

and, save for the administration of an anæsthetic during labour, the services of a skilful nurse fulfil the requirements of a normal case.

In a later sentence he states:—

the importance of training in abdominal palpation for students and nurses cannot be over-emphasised.

I am tempted to quote here another sentence from his contribution, with which I concur:—

The founding of several small maternity hospitals throughout a city or county would be wasteful expenditure.

There is need for experience and skill on the part of medical practitioners who undertake antenatal examinations and supervision; but, except in special consultation cases, this may well stop short of the experience of a consultant obstetrician. If private practitioners make a study of antenatal complications and risks, they will in the future render official antenatal centres unnecessary, except for cases of exceptional difficulty; and for these cases they should, with certainty of not endangering their private work, be able to consult an expert at a maternity hospital or antenatal centre, as they now can consult the official tuberculosis medical officer of a local authority.

But even then the position of antenatal clinics would remain rather anomalous. They are not merely consultation centres for doctors requiring an expert opinion concerning their poorer patients. The majority of confinements are attended by midwives, and for their patients increased utilisation of antenatal consultations should not be difficult. The difficulty arises when it is found that medical care is needed, and decision is called for as to whether a given patient should be transferred to a private doctor or to a maternity hospital. This point is mentioned further on (page 175).

Maternity Hospitals and Homes

Women arrange for their confinement in an institution to an increasing extent year by year. In all such institutions

some payment is exacted, except for the very poor. The payment is usually inadequate to cover all expenses, the balance being contributed by charitable people or coming out of public funds. At these hospitals and homes midwives undertake the routine attendance in confinement.

In large voluntary lying-in hospitals, and in the lying-in wards of public assistance hospitals and of general voluntary hospitals attached to teaching schools, there is also a regular visiting and resident staff of doctors; and a doctor sending a patient to such a hospital loses touch with his patient, and loses any fees that might have been obtained for treatment at home. On this see page 180, Volume III of *International Studies*.

In the smaller municipal maternity homes which are now found in many English towns medical care may or may not be supplied by the medical practitioners of the district. On this there is some diversity of action. Sometimes a patient who has engaged her own doctor can independently arrange to have his services in the maternity home, subject to his adhering to accepted precautionary measures. The hospital has a matron who is a midwife, and there may be additional midwives on the staff. In some hospitals a rota of doctors is arranged for patients who have not engaged their own doctor, one of whom is called in if emergencies requiring medical skill arise. In other hospitals a few doctors are chosen who have special obstetric experience, or a single doctor is appointed to act in emergencies who may be a full-time medical officer on the staff of the local authority.

Midwives or Doctors?

A general question obtrudes itself throughout this chapter: Which is more desirable IN THE LYING-IN WOMAN'S INTEREST, whose welfare is the paramount consideration: attendance by a midwife or by a doctor?

We have seen that in international experience many more maternity cases are actually attended by midwives than by doctors. Is it desirable to diminish this number and

increase the number attended by doctors? Judged by actual experience the answer must be negative; but this answer cannot be regarded as final. A doctor's training in antisepsis and asepsis is more prolonged and has as its background a more scientific training than that of a midwife; and he, furthermore, has the general medical skill and ability to deal with unexpected complications which the midwife cannot have. Evidently at present these possibilities are far from being fully realised; for otherwise we cannot explain the general superiority of experience in the charities attached to maternity hospitals over private medical obstetric practice, and the superior experience in private obstetric practice of midwives over that of doctors. Are we, then, to decide the merits of future midwifery practice on present experience, or should an attempt be made to counter the current which runs towards leaving normal obstetric practice of midwifery to midwives, specialist obstetric physicians (see p. 171) being retained for obstetric emergencies in every area? Or is it desirable to train and to induce every medical practitioner to raise the standard and quality of his work so that the expert obstetrician will be required only very exceptionally?

The last point may be taken first. The regular attendance of a doctor in childbirth would remove the difficulty felt in permitting midwives to produce partial and intermittent anæsthesia by means of chloroform. But, on the other hand, a more fully-trained midwife may become competent to employ partial anæsthesia safely (see p. 49, Volume III of *International Studies*).

The regular employment of a doctor in childbirth would furthermore ensure that most general practitioners would become fairly competent to meet the ordinary emergencies, for which a midwife in Britain is required to send for medical aid. A chief danger of universal medical attendance in parturition is the liability of the doctor to intervene prematurely in normal labour, often at the patient's or husband's urgent request. It is held on high authority that hurried interference in parturition by forceps, and their unskilful use,

are responsible for much excessive sepsis in patients medically attended. This statement is not inconsistent with the opposite possibility that unduly delayed assistance by forceps or otherwise in very protracted labour may also be responsible for injury of tissues and resultant sepsis.

The Report of the British Departmental Committee on Maternal Mortality, 1930, states that 39·1 per cent. of a total 616 deaths from puerperal sepsis investigated in their inquiry were cases of instrumental, operative, or breach delivery. Of 2,000 cases investigated at St. Bartholomew's Hospital district, London, septic infection in cases of instrumental delivery was tenfold those of normal delivery. In the enormous experience of the East End Maternity Hospital forceps were applied in 3·2 per cent. of the cases. The deliveries are chiefly by midwives. According to some authorities interference with delivery is justifiable in 7 per cent. of deliveries; in some districts the forceps rate reaches 20 per cent.!

Can the occasional "doctor in a hurry" be inhibited from his unhygienic desire to bring about too early delivery? In more frequent cases can he be given the moral courage to resist the importunity of his patient for undesirable intervention? Can patients themselves be trained to greater fortitude, or cannot we arrange for more general provision of partial anæsthesia?

If these conditions could be satisfactorily met, there would be no hesitation in concluding that medical attendance even in normal parturition, i.e. in parturition in which no complications are expected, presents advantages over attendance by a midwife, given equal experience on the part of the compared doctor and midwife. An economically weak point in his attendance is that he cannot, like the midwife, in part play the part of nurse as well as of accoucheur.

The attendance of a doctor at the confinement, furthermore, unifies the care of the patient before, during, and after parturition, and removes the difficulties associated with separate responsibility for antenatal and postnatal diagnosis of complications.

But in existing circumstances the midwife can claim the right to retain what she holds and even to extend her area of work. Her results compare favourably with those of medical accoucheurs, even when the statistics of complicated cases are included in which she has called in a doctor. She is less expensive than the doctor. She is nurse as well as accoucheuse. She is less open to the patient's natural plea for hurried interference, even when allowance is made for the excessive proportion, a third or fourth of her total cases, in which she sends for medical aid.

It does not follow from this relatively favourable review of the work of midwives that their present practice in Britain is altogether satisfactory. The training of midwives needs to be more complete, and their position improved financially.

Their work, when they are retained by a patient, ought to include some antenatal supervision of every patient, including fortnightly examination of urine from the twenty-sixth week of pregnancy onwards, in addition to the antenatal work noted on page 174. Every midwife should be able to diagnose the fœtal presentation before parturition, and to recognise pelvic deformity; and she should be required to record her observations on these points, on the form set out in the recommendations of the Central Midwives Board (pp. 160–161, Volume III of *International Studies*).

Given the general fulfilment of these conditions, normal midwifery will probably fall increasingly into the hands of midwives, for whom a skilled medical obstetrical consultant or consultants, who may or may not be general practitioners, are made available in every area both for prenatal and midwifery work. The alternative, as already indicated, is for the medical profession to organise a service utilising doctors of experience to a larger extent than now, and at a cost which is not too great.

A National Maternity Service

The present position of midwifery in Britain being unsatisfactory, although practised with less unfavourable

results than in some other countries, various schemes of reforms have been proposed. Without giving full details it is useful to note the chief points in two of these schemes, one issued by the British Medical Association and approved by its representative body in 1929 (published at the office of the British Medical Association), and a second quasi-official scheme contained in the Interim Report of a Departmental Committee on Maternal Mortality and Morbidity, 1930 (H.M. Stationery Office). Both schemes are tentative, that of the British Medical Association being published as "a contribution to the improvement of the present unsatisfactory position of the puerperal morbidity and mortality rates in this country."

In this scheme the following chief proposals are made:—

1. Every pregnant woman is to choose a doctor and a midwife and to be examined at least once by the doctor chosen by her, not later than the 36th week of pregnancy, and on further occasions if he thinks this necessary, and it is to be the duty of the midwife chosen by the patient for her confinement to persuade her to this effect.

2. Every woman is to be encouraged to have at least one postnatal medical examination.

3. A doctor should be made available whenever his attendance is requested by the midwife. (This already is an accomplished fact.)

4. A further consultant shall be available for certain serious conditions.

The scheme of the Departmental Committee agrees in many respects with that of the British Medical Association in the above respects. Its proposals are summarised as follows:—

1. The provision in every case of the services of a qualified midwife to act as midwife or as maternity nurse.

2. The provision of a doctor to carry out antenatal and postnatal examination in every case, and to attend during pregnancy, labour, and the puerperium, as may prove necessary, all cases showing any abnormality.

3. The provision of a consultant, when desired by the doctor in attendance, during pregnancy, labour, and the puerperium.

4. The provision of hospital beds for such cases as need institutional care.

5. The provision of certain ancillary services (e.g. transport, sterilised equipment, laboratory facilities).

The two schemes are interesting in that each of them assumes that a midwife suffices for normal confinements. Both of them agree in points which must have general approval, and they agree that some of the needed antenatal work is medical. Thus the midwife is confirmed in her present position, and the doctor is reserved for antenatal and postnatal work and for emergencies in confinement. This acceptance of the midwife is the special feature of the two reports, and it is significant for the future. Neither scheme appears to safeguard the patient and the midwife against calling in an inexperienced or unskilled medical practitioner when emergencies arise.

In the preceding pages I have endeavoured to set out the conflicting considerations in this social problem with fairness and impartiality. The future course of events may follow the lines indicated in the two reports. This is by no means certain. The cost of these proposals may be beyond their merits. It will be incumbent on the medical profession to show that they can organise a midwifery service which will not be too costly, and which will be as efficient as a service of midwives supported by skilled medical obstetricians. The only escape of medical practitioners from an extension of the existing predominant service of midwives —more highly trained than at present, with whom will be associated consultant medical obstetricians—appears to me to lie:—

(*a*) In the development of improved training of the average doctor in midwifery; (*b*) in his devotion of longer time to his cases, and his more general adoption of aseptic precautions, and of every art of skilled midwifery; and (*c*) in his moral courage to resist the too frequent importunity of the parturient mother or of the midwife to hurried and unnecessary intervention with normal confinement. This, of course, does not mean abstinence from such an amount of anæsthetisation as may be indicated, when operative intervention is contra-indicated.

It will not escape notice that moral courage is required both by patient and doctor, alike in midwifery and in the certification of unfitness for work in sickness insurance. In both instances the character of the patient and of the doctor is involved in the course of action to be followed; but in one instance the relief of pain is involved, and in the other monetary considerations prevail.

Summary on the Medical Care of Motherhood

52. Safe maternity depends largely on the rearing and maintenance of a healthy population.

53. For a minority of women, pregnancy and parturition can only be experienced at a risk which should not be incurred.

54. Considerable doubt attaches to official statistics of puerperal mortality, especially when these are employed for international comparisons.

55. Provisions for aiding the parturient mother on an insurance basis are fairly general in Europe; and public authorities make additional provision.

56. There are great variations in the standard of training for midwifery work in different European countries, both for doctors and for midwives.

57. General experience points to the conclusion that there is a relatively high standard of safety in childbirth the care of which is undertaken by trained midwives.

58. When midwives require medical assistance in their work there is still great need for ensuring that the medical practitioner called in is a competent obstetrician.

59. There is rapid growth in the use of antenatal consultations; but their co-ordination to attendance in and after parturition is still unsatisfactory.

CHAPTER IX

THE MEDICAL CARE OF CHILDHOOD AND YOUTH

THE subject of this chapter, considered with that of Chapter VIII, may be said to embrace the entire problem of social life; for it is concerned with the integrity of the family, on the maintenance of which depends the continuance of Christian civilisation. The family results from the union of man and wife and finds its greatest happiness in the nursing and tending of the children of the union. The success of the family depends in the first instance on the health and character of the parents; and the multitude of arrangements for promoting child welfare, which voluntary agencies and official organisations have devised, can never derogate from this primary predominant parental responsibility and influence. In most families the parents thus chiefly responsible for moulding the health and character of their children attain a substantial measure of success in their parental work; and we should refrain from exaggerating the influence of organised intervention from without in securing the physical and moral well-being of children.

But although family life is usually successful, this success may be made fuller, and, in the minority of families characterised by failure, the physical as well as the intellectual and moral defects which occur can be greatly reduced by auxiliary counsel and care contributed by voluntary agencies and public health authorities. The communal aim, then, is to reduce the social and economic difficulties impeding successful family life, to give the hygienic guidance which is lacking, to aid in the recovery of health when it is temporarily lost, and to guide towards increased fitness those who are well. In this work more is needed than is within the range of the special work of child welfare organisations. Let me indicate some items before passing on to the main subject of this chapter.

Better housing conditions and school hygiene are most important; so also are measures calculated to postpone or prevent infectious diseases, especially diphtheria, measles, and whooping cough; and the provision of open spaces, of toddlers' playgrounds, of open-air classrooms, backed by the more general teaching of hygiene as related to everyday life, are all needed to ensure the success of the special measures described in the following pages.

In this special work for children THE SEARCHING OUT OF MINOR DEPARTURES FROM THE NORMAL AND THE RESULTANT APPLICATION OF PROMPT REMEDIAL MEASURES—at least more prompt than would otherwise be forthcoming—CONSTITUTES THE SALIENT FEATURE OF INFANT AND CHILD WELFARE WORK AND OF SCHOOL MEDICAL INSPECTION. It substitutes relatively early diagnosis in child welfare centres and in school medical inspection, for the belated and perhaps never realised maternal recognition that "something is wrong".

But although failure to search out defect and disorder in the young constitutes the outstanding and important distinction between the ordinary practice of medicine as it exists in all countries and the medical work for infants, toddlers, and school children now undertaken by public health authorities, this important *differentia* is not alone in giving to public medicine for the young its premier place; for, as pointed out on page 151, the public medicine which concerns itself with the medical care of children has achieved even greater distinction in having partially escaped from the pathological into the physiological—which includes the psychological—field of work.

PUBLIC MEDICINE FOR THE YOUNG HAS INCREASINGLY BECOME A PROBLEM OF ASSESSMENT OF PSYCHO-PHYSICAL FITNESS, a point which Sir Leslie Mackenzie has specially urged. The two problems, that of assessment of fitness and that of prompt diagnosis of departures from the normal, can, however, never be separately considered. They overlap in the history of every child; and in infancy the balance between health and disorder is so delicate that the medical

officer of an infant welfare centre, concerned chiefly with hygienic counsel, cannot easily refrain from giving corrective treatment for some of the disorders which so readily and so unexpectedly arise.

In this chapter we are concerned with the part which public authorities and voluntary agencies take in the application of preventive and curative medicine to the needs of children, and with the relation between this work and that of private medical practitioners.

Influence of Child Welfare Work

Happily there is no difference of opinion as to the value of the child welfare work now being done by public health and education authorities.

Readers wishing to study the evidence in further detail may consult Chapters XXIX–XXX of my *Elements of Vital Statistics in their Bearing on Public Health Problems*, 1923, and Chapter X of my *Public Health and Insurance : American Addresses*, 1920. Here I am justified in assuming that work like that now undertaken by child welfare organisations and in school medical inspection must in the public interest continue to be extended. Whether it may partially be transferred to private family practitioners is discussed later (p. 192).

The facts as to public medical work for children in Great Britain are given in Chapters IX–X of Volume I, of *International Studies*, and in the local studies in that volume; and some general considerations arising chiefly out of British experience will be reviewed later in this chapter.

In no other part of Europe has there been such widespread and universal organisation of special work for the infant and pre-school child as in Britain; and with the possible exception of some parts of Germany, Britain also occupies a premier position in the magnitude and universal distribution of its curative medical work for school children.

The circumstances of both child welfare work and of

medical work for school children in European countries have been profoundly modified by their systems of sickness insurance, which, as seen in Chapter VII, page 127, commonly include medical care of the families of insured persons. The inclusion of medical care for wives and children of insured men in Continental sickness insurance schemes has reduced the need for the special municipal activities for these which are needed in Britain. But in some foreign cities there is admirable work in infant consultations and in school clinics similar to the work in Britain. This work, however, has not been systematically developed throughout each country as it has in Britain. Further particulars are given in Volumes I–III of *International Studies* to which reference may be made.

For the reason just stated, my observations on child welfare work will be based chiefly on British practice.

Home Visits by Nurses

Child welfare work is based on visitation of the home and the giving of counsel bearing on the health and welfare of the infant by a trained health visitor (public health nurse); and it may be said that OTHER ACTIVITIES OF CHILD WELFARE WORK, IN THE MAIN, ARE SECONDARY TO THIS SYSTEM OF HOME VISITATION.

To secure the maximum amount of visitation, and the giving of the early advice which is supremely important, the Notification of Births Act was passed in 1909 and became universally obligatory in 1915. This Act made it the duty of the parent to notify within thirty-six hours of its occurrence the birth to the medical officer of health of the district or county. By this means it was hoped, for instance, that bad advice as to substitution of artificial for natural feeding might be avoided. When we remember that of all deaths under one year of age one-fifth occur before the live-born infant has survived a week, and that one-third occur in the first four weeks of extra-uterine life, the desirability of preventing some of this large share of total infant mortality is evident.

INFANT MORTALITY IN THE FIRST MONTH OF LIFE

In practice visits to mothers are seldom made by health visitors during the first ten days after parturition. During these days the mother is under the care of a doctor or a midwife, and visits by an external nurse would need to be almost miraculously tactful to avoid friction. The health visitor's work usually begins on or after the tenth day; and more and more medical officers of health are endeavouring to secure from midwives the initiation of satisfactory infant hygiene; and the training of midwives is increasingly facilitating this.

The importance of these first ten days in the infant's life cannot be exaggerated.

There is a common superstition that the excessive mortality at this period is inevitable, and that it remains fairly uniform in all communities, and in all sections of a community. This is far from being true. In England and Wales the average rate of infant mortality in the first week after birth in 1927 was 9·4 per cent. lower, and that in the whole of the first month after birth was 9·7 per cent. lower than in 1906–10. If particular districts are compared the differences shown are even greater than in this instance of improvement in time. Much can be done to reduce infant mortality in the first week and month after birth; but action against this relatively neglected unnecessary part of infant mortality will depend on the efficiency of the hygienic work of the doctor and the midwife.

Much of the mortality in the first month after birth is due to accidents and complications during parturition, some of which might have been avoided. For some of it congenital syphilis is responsible, and this implies failure, perhaps neglect, to secure the needed antenatal diagnosis and care. Antenatal medical work and improved midwifery are the chief means of preventing excessive infant mortality soon after live-birth.

HOME VISITATION OF INFANTS (*Contd.*)

On an average several visits are made by a health visitor to every infant during its first year of life. In a Midland

town whose report is before me, 19 home visits were made by health visitors for each birth. These included visits made up to five years of age, and visits for minor infectious diseases as well as for hygienic advice apart from sickness. Each visitor on an average made 68 visits in a week. The health visitor has duties also in helping at infant welfare centres.

These visits have become an important part of the total health work of the public health authority. They are almost universally welcomed, and the tactful and intelligent health visitor becomes the friend of the mother, and her adviser in many minor social as well as hygienic difficulties.

Special training is required for this work (see p. 290, Volume III of *International Studies*). The health visitor should be an educated woman, and is required also to be a trained nurse, and to have had special training in a children's hospital or at an infant consultation centre. The certificate of the Central Midwives Board enabling her to practise as a midwife is also required; but this is not indispensable, unless she is expected to supervise the practice of midwives in her district, work which is preferably undertaken by a woman doctor.

In carrying out her work a health visitor necessarily acts almost independently. She has a general not a specific mission; whereas the duty of a tuberculosis nurse or a nurse visiting infectious cases in the main is to carry out definite medical instructions. Hence the health visitor must be a woman of tact and good judgment, who will antagonise neither the mother nor the family doctor if there is one.

On page 189 of Volume III of *International Studies* I have discussed this point more fully. Instances of friction and counsel divergent from that of the family doctor are surprisingly infrequent, and in the main the health visitor is a valuable auxiliary to the family doctor. As stated in the passage referred to above:—

> in a high proportion of the total families visited, the mother would lack the needed advice as to the management of her infant but for the health visitor's visits. Even fairly well-to-do

families are very apt to neglect to seek medical advice, unless there is actual illness which appears to be serious; the health visitor's advice not only prevents much illness, but also accelerates the seeking of medical advice when needed.

As HEALTH VISITING now functions, it DOES NOT ENCROACH ON MEDICAL PRACTICE, AS THIS HAS EXISTED IN THE PAST, BUT INCREASES THE DEMAND FOR IT, BY CONDUCING TO EARLY MEDICAL ATTENDANCE IN ILLNESS, and by creating a demand for hygienic medical guidance.

In a later chapter will be discussed the important point as to whether, and in what circumstances, this important work, so far as it is medico-hygienic, might be undertaken by private medical practitioners. It may be said at once that much of it must remain in the hands of nurses, as being too detailed and pernicketty for doctors to undertake and carry out successfully, in any circumstances that can at present be visualised.

Next in importance to the home visits by health visitors comes attendance at

INFANT CONSULTATIONS or Infant Welfare Centres. The work done at these centres is chiefly hygienic. Little medical treatment is undertaken, and no responsibility is undertaken for continued medical care. The chief exceptions to this rule are the occasional giving of a "grey powder" for infants whose mothers would be unable to consult a private doctor; and the much more general distribution of cod liver oil at cost price for children for whom this is prescribed by the medical officer of the centre.

The magnitude of the work at the 2,522 centres in England may be gathered from an example taken from a large Midland town in England. This town in 1930 had—

17,417 live-births,
103,944 total attendances at centres of children under one,
129,225 total attendances at centres of children aged 1–5.

Of the children born during the year 65 per cent. attended the centres. In rural districts fewer consultations are held, and a larger proportion of the total work is done in the homes of the people.

The work in these centres is largely work which might properly be undertaken by private medical practitioners, subject to the important limitation already indicated under health visiting. This limitation is in part financial; in part it arises from the fact that doctors are still regarded as only concerned with the care of the sick. The two reasons overlap. Even were doctors willing to weigh and examine infants weekly or monthly in the absence of any indication of illness, their time is too valuable to be thus employed, and for poorer mothers there must be some system of selection of children to be referred to them. Even then there would be, as there is now, occasional experience of a busy practitioner pooh-poohing the mother or nurse who thinks a doctor's skill is needed for minor complaints. This is not surprising in view of the conditions of medical practice, especially in industrial areas. The consulting "surgery" hours of doctors in such areas are necessarily limited, and during them there may be twenty to thirty insured patients waiting for an interview followed by a medical certificate. The circumstances are inappropriate for a chiefly hygienic interview with a solicitous mother; and unless there is actual illness an intelligent health visitor can usually give the guidance which is needed, subject to occasional or periodical medical overhaul of the infant.

Leaders in the medical profession have not hesitated to animadvert on the deficiencies of the training of medical students in the care of infancy, and on the lack of acquaintance of practising doctors with the borderlands between health and disorder.

But this position happily is improving, and the chief reason which for many years to come will necessitate the continuance and probable extension of existing child welfare centres is that of finance. Most mothers and even the mothers of the middle and professional classes cannot afford to pay the fees necessitated by taking their infants to a doctor for the frequent medico-hygienic supervision and advice which are desirable.

Whether under other conditions of financial arrangement

of medical practice this difficulty is likely to diminish will be subsequently discussed (p. 254).

Meanwhile it is often urged that private medical practitioners should be employed as medical officers of child welfare centres. This has been a difficult problem in several countries. In Hamburg private practitioners are employed, but only at centres which are remote from the district in which their private practice is carried on. In some areas in France and in other countries it is stated that the employment of private medical practitioners for this work has caused no difficulty with other doctors. In many places, as, for instance (p. 307, Volume III of *International Studies*), in Gloucestershire, a six-monthly rota of local practitioners is employed. In other areas there has arisen difficulty, owing to private practitioners preferring an urgent call in their private practice to the fixed engagement at the centre. This contingency cannot, I think, be avoided, and the advice of a Special Committee of the British Medical Association, that practitioners must regard themselves as bound to give their public engagements priority, is scarcely consistent with the frequent demands of general practice. English experience has settled down in most areas to the employment of full-time (chiefly women) medical officers for infant welfare centres (see p. 193, Volume III of *International Studies*).

The accusation that these centres seriously encroach on private medical practice has frequently been made. In the main this suspicion is unfounded in respect of medical practice carried on as it has almost always been until the immediate past; the centres are confined chiefly to medico-hygienic work, which in their absence would be neglected, to the public detriment. It is work which before the days of child welfare work was being universally neglected. An almost entirely new sphere of medico-hygienic work has been created. The evidence that the centres have been beneficent in their working is supported by their increasing popularity; and there has been a considerable call for similar centres for middle-class people, who would pay for the service rendered. This is a movement likely to

grow. It can be worked, so as to safeguard the position of the family doctor (p. 194, Volume III of *International Studies*), on a scale of charges which, while they would be inadequate in private practice, suffice under the conditions of nursing and medical care at a centre. It is a most promising field of work in that grouping of medical work by private practitioners which is urged on pages 238 and 274.

To sum up: both health visiting and infant welfare centres have become embodied in public hygienic practice in many European countries, especially in Great Britain. Of their value to the community there can be no doubt; and that they will continue to function, perhaps to an increasing extent, is indubitable. The only possibility of their partial displacement and replacement appears to be through the family doctor reorganising his family work on an insurance basis of annual payment, and becoming—what he should be—the skilled hygienic as well as medical adviser of the families who employ him. Even then, unless the private doctor employs a nurse, he must undertake much work which a nurse would more appropriately carry out. He can best undertake such work when acting in co-operation with a group of doctors as suggested above.

The Pre-School Child

With complete working of hygienic private medical practice, of health visiting, and of infant welfare centres, the number of children who pass into the second year of life in a damaged physical condition will be markedly decreased. But beyond the impaired health which has escaped observation and treatment in infancy, further defects and ailments develop in the next three years of life, with the result that when children enter an elementary school at the age of five, sometimes earlier, a vast amount of impaired health and actual disease is found.[1] The machinery

[1] Thus at the Inspection Clinics in Birmingham, of 884 children, aged 1½ to 2 years, examined in 1930, 64 per cent. had rickets, 10 per cent. had enlarged tonsils, nearly 14 per cent. had otorrhœa, over 10 per cent. had squint, nearly 19 per cent. had eczema. Of course, a relatively larger proportion of children with defects would be brought for examination than of healthy children (Dr. E. Cassie, *Public Health*, July 1931).

of school medical inspection does not always detect these defects promptly at the beginning of school life, and a preponderant part of the activities of school medical officers and school nurses is swallowed up in detecting and treating or arranging for the treatment of scholars already seriously damaged.

In Britain, owing to past separation of public health and school medical work, there has been duality of public medical arrangements for the care of the pre-school and the school child; but now increasingly preventive and curative measures for both are being arranged together by extension of child welfare services upward until they join hands with the school medical services. Health visitors now visit young children over as well as under a year old; and in many areas visits to children aged 1–5 are already more numerous than those to infants. These children are invited to attend a child welfare centre, from which if there is a definite morbid condition they are referred to the family doctor; or if this, because of poverty or from some other reason, cannot be arranged, remedial measures are arranged at the centre itself or at a hospital. School clinics are increasingly being made available for this purpose. Experience of children brought to pre-school inspection centres shows that most of them are suffering from conditions, either requiring specialist care, as, for instance, correction of squints or orthopædic defects, dental treatment, removal of tonsils and adenoids, or requiring some form of institutional treatment. In many cases attendance at a centre for special remedial exercises is required.

School Medical Work

In most countries some medical inspection of school children is undertaken; but to a markedly less extent in the countries in which sickness insurance includes medical care of the whole of the family of the insured person.

In some Continental countries there is excellent school medical work in large towns, little in rural districts. Often school dental work is done on a considerable scale. This

is so in Stockholm, where half the scholars receive dental treatment. In Oslo over 69 per cent. of the boys and 62 per cent. of the girls leaving school present themselves for a voluntary examination at which parents are advised as to a choice of occupation. In Germany the completeness of the school medical service varies greatly in different States. It may be rudimentary in rural districts, and be very detailed in large towns. As a rule little or no treatment is given by the school medical service in Germany, except for dental defects. Sometimes the school doctors are part-time officers and sometimes engaged entirely in official work. Most of the treatment is given at polyclinics, which may belong to insurance societies. Some large insurance societies contribute towards the social help given by municipalities for school children; and some independently provide convalescent homes and hospital beds for children, as well as ophthalmic surgeons, and arrangements for adenoids, etc. In some instances they even provide school meals for necessitous children.

In Austria school medical work is confined chiefly to its large towns. As in Germany, the school doctors do not usually treat defects found on inspection, this being undertaken by hospitals or by the insurance society to which the parent belongs.

In Switzerland conditions vary from canton to canton. In the canton of Vaud every parent of a child attending primary or infant schools is required to insure him for the receipt of medical care during school life. The annual charge for one child is 12 francs (1 franc equals 9·6 pence or, say, 19 cents). A reduced rate is charged where more than one child in a family attends school. The parent selects his own doctor in a given area. If an operation is needed, this is done at a hospital at the expense of the cantonal caisse (insurance society). No dental treatment is given; and as many conditions call for specialist treatment the arrangement cannot be regarded as altogether satisfactory.

In Belgium and France school medical work is very incompletely organised. In Milan (Italy) I found some

admirable school medical work, including specialist work in school polyclinics. In Zagreb (Jugo-Slavia) there was also very complete school medical work, every scholar being eligible for gratuitous treatment at the school polyclinic without social distinction. In this town a system of insurance for medical treatment of scholars is in preparation. In Hungary there are school doctors in high schools, and commonly also in elementary schools, though few pupils are treated except for dental defects.

School Medical Treatment

In Great Britain, as can be seen in detail by reference to Volume III of *International Studies*, medical inspection of scholars and treatment of those children found to need it are relatively complete. Education committees of local authorities are now required to provide or to arrange for the treatment, as well as to make medical inspection, of the children attending elementary schools. They must charge the parent of each child treated "such an amount as is determined by the local education authority". These assessments are made in a generous spirit, and in no case are they allowed to inhibit ready access to treatment. Particulars of the low charges made, which are often waived, are to be found in the local chapters of Volume III of *International Studies*.

Each year over a third of the children attending schools are medically examined, and school nurses attend to minor external ailments, especially skin conditions, on a scale much greater than that of medical treatment. The chief forms of medical treatment provided are for—

defective vision and squint,
enlarged tonsils and adenoids,
uncleanliness and verminous conditions,
certain skin diseases and sores,
dental disease,
orthopædic conditions.

It will be seen that the above items include chiefly conditions which are not ordinarily included in the scope of a general practitioner's work.

If there is a family doctor, he is given an opportunity to treat; but a major part of the treatment under the above headings is carried through in the school clinics or in other clinics for which the education authority pays, and with the help of school nurses. As in the case of child welfare centres, it is literally true that most of the medical work undertaken for school children is work which otherwise would not be done; it is work which in the past has been seriously neglected.

The value of school medical inspection and the treatment following on it in improving national health is not open to doubt. The service is concerned primarily in discovering and arranging for the treatment of existing diseases; and it is thus largely clinical and palliative, and is largely cut off from its possibilities as a chief agent of preventive medicine. This is seen very markedly in school dental work. Most of it is concerned with the extraction of bad teeth, and preventive dentistry in most areas is still practised only on a relatively small scale. Valuable as it is, school medical work is chiefly concerned in filling up gaps in medical aid otherwise lacking; and even thus it does less than will be practicable when public medical work for infants, for toddlers, and for school children becomes a unified organisation in every public health area. The school medical service is valuable, furthermore, in promoting general school hygiene, physical training, etc. Reference may be made here to the fact already noted that in countries in which the dependents of the insured are included in medical insurance the scope of work in school clinics is reduced; and under the proposed conditions set out on page 140 this would be true also in Britain. That they will no longer be needed as part of more general clinics is highly improbable.

School Medicine and Private Medical Practice

Difficult medical problems have arisen in the relation between private practitioners and the school medical service, and between the latter and voluntary hospitals.

THE OUTSTANDING FACT IS THAT A VAST AMOUNT OF IGNORED AND NEGLECTED DISEASE AND DEFECTS HAS BEEN DISCOVERED BY SCHOOL MEDICAL INSPECTORS. Had it not been for this work much of this would have remained undetected and untreated, with serious results in adult inefficiency in life. This is, for instance, seen in the detection of rheumatic cardiac disease, and in the institution of special school convalescent homes for these. It is equally obvious in the good effects which follow the treatment of tonsils, adenoids, and otorrhœa, in the prevention of chronic deafness or even artificial stupidity, and in the clearing out of dental and other septic foci.

The treatment of orthopædic cases in schools is rapidly increasing, and thus children with disabling and disfiguring deformities or with tuberculous joint diseases have been prepared for useful life.

Any general statement of school medical work which left out of account THE INVALUABLE WORK OF SCHOOL NURSES would be incomplete. They see school children much oftener than school doctors, they follow up defects found by the latter, and their independent work in treating such minor conditions as impetigo, eczema, sore fingers, and pediculosis, not only increases average school attendance, but also does much to prevent glandular enlargements or more serious disease.

The question arises, how much of this work would or could be done by private practitioners apart from the school? There is no doubt that little of it would be done. Financial considerations and the *vis inertiæ* of parents render this the inevitable answer. This applies especially to dental treatment, which is perhaps the most successful part of school medical work.

A LARGE SHARE OF SCHOOL MEDICAL TREATMENT, especially that for such conditions as defects of eye refractions, adenoids, and diseased teeth, IS SPECIALIST IN CHARACTER, and would in most circumstances not be undertaken by the general practitioner. And on the whole it is safe to assert that ON BALANCE THE PRACTITIONER HAS MANY MORE

PATIENTS REFERRED TO HIM AS THE RESULT OF SCHOOL MEDICAL INSPECTION THAN HE LOSES BY THE WORK OF SCHOOL CLINICS.

The views of the British Medical Association on school medicine, as practised in Britain, are given on page 208, Volume III of *International Studies*, and an interesting example of the occasional struggles out of which the present position has emerged is seen in the experience of Brighton (p. 367, *op. cit.*).

For details of town and country experience of school medical services in Great Britain I must refer the reader to the local chapters in the same volume.

In nearly every area school medical inspectors are full-time officers, either engaged solely in school medical inspection and in school clinics, or dividing their time between these and the work of child welfare centres. There is much to be said in favour of this combination, though hitherto it has been exceptional.

The use of private practitioners as school medical inspectors, even when safeguarded by their employment for schools remote from their private practice, has often proved unsatisfactory. There is difficulty in securing a uniform standard of inspection, and there is the not infrequent clashing of private and public medical work. In time it should not be impracticable to secure the requisite standard of work from part-time medical officers of school clinics; and doubtless they would increasingly learn to consider the children seen by them from the preventive standpoint; but there remains the official difficulty of the greater complexity in the official machinery when part-time are employed in lieu of whole-time medical officers. If medical insurance be extended to the families of insured persons, the position of part-time medical officers of official clinics will resemble that of part-time medical officers of health, and it will frequently become possible to utilise them in the work of official clinics, as well as for other medical work in the public health department. Even then the need for specially skilled officers (e.g. in tuberculosis,

in maternity and child welfare work, venereal diseases, and in aural and ophthalmic surgery) will remain.

Given the ideal of private medical work (p. 229) in which every doctor in the range of his own practice faithfully watches the hygienic interests of every family entrusted to him, medical inspection of school children on behalf of education authorities would become less general in its scope, and school clinics or more general polyclinics would then be reserved more completely for specialist cases (refractions, adenoids, ringworm, orthopædics, etc.). But I have not found any community exemplifying this ideal even in the countries in which treatment of dependents and their children is included in the medical benefit of insured persons.

School Medical Work and Voluntary Hospitals

The relation between the school medical service and voluntary hospitals in Britain has gradually become more settled. In the earlier days of school medical inspection voluntary hospitals were almost swamped by children brought for the treatment of adenoids, eye refraction defects, otorrhœa, etc. (*a*) Now the treatment of such conditions is sometimes undertaken by these hospitals on payment according to an agreed scale. (*b*) Their treatment may also be managed—as in some parts of London—by specialist clinics conducted by a group of local practitioners paid by the education authority for each session; or (*c*) there are special school clinics. In all these varieties of provision some payment from parents is usually required. This is always much below the cost of treatment, and it is usually nominal in amount. For children of the poor payment is waived. Scales of payments in different areas are set out in Volume III of *International Studies*.

From the preceding sketch—which should be supplemented by reading the details given, especially in Volume III of *International Studies*—it will be clear that there has gradually evolved an increasingly efficient system of medico-hygienic supervision and care of the infant from

birth until adolescence or until the period of compulsory school attendance ceases.

THIS SYSTEM IN A CONSIDERABLE MEASURE HAS ALREADY SUCCEEDED IN ANTICIPATING AND PREVENTING DISEASE; and when it has not succeeded to this extent, IT HAS SEARCHED OUT DISEASE AT A RELATIVELY EARLY STAGE, not waiting for the belated resort to a doctor by the overworked and too often impecunious mother. The success in attaining these ends has been greatest in infancy, much less hitherto in the next four years of childhood; and the efforts of school medicine have consequently been disproportionately concentrated on the treatment of defects and diseases which might have been prevented. Notwithstanding this, school medicine, and the collateral work of general school hygiene, including remedial exercises and the valuable work of the playground in organised play and in mental and moral discipline, have accomplished marvels in raising the standard of health in the general community. In the future this purely hygienic work will occupy a much greater portion of the educational timetable. The work is for the teacher as much as for the doctor, for it includes the psychological and ethical problems of juvenile development.

It rests with the practising medical profession, if they wish to do so, to arrange combined action in medical practice, especially in group combinations of private practices, for undertaking much of the beneficent work now being done by these public agencies. If this can be done by co-operative and insurance efforts to any considerable extent, and with an equivalent efficiency, public authorities will doubtless welcome the transfer. There will, even when this is done, remain a large number of families in every community who for financial or other reasons will not or cannot use the group services here suggested, and for whom the present official arrangements must continue. And there will remain the need for the specialist work now undertaken by public health authorities for school children.

The essential point is that the welfare of the largest number of children must determine the issue, and the one thing which cannot be tolerated is that between public and private effort any hiatus in the care of large groups of children shall be permitted.

Summary on the Medical Care of Childhood and Youth

60. The searching out of minor departures from the normal and the resultant application of prompt remedial measures constitute a salient feature of infant and child welfare work and of school medical inspection.

61. Furthermore, public medicine for the young has increasingly become a problem of assessment of psycho-physical fitness.

62. Other activities of child welfare work, in the main, are secondary to the system of home visitation of mothers and their infants by competent health visitors.

63. The excessive mortality in the first week and month after birth is not inevitable, and in British experience it is, in fact, declining.

64. Home visitation by health visitors does not encroach on medical practice in existent conditions, but favours early private medical attendance in sickness.

65. For child welfare centres the same claim can be made.

66. There is a happy trend towards the unification of public medical work for the infant, pre-school child, and school child.

67. Medical examination of scholars almost necessarily involves some treatment of certain special diseases discovered in the course of this inspection.

68. A vast amount of ignored and neglected disease and defects has been discovered by school medical officers.

69. The work of school nurses in the detection and treatment of minor cutaneous ailments and in bringing more serious cases for medical treatment is invaluable.

70. On balance the medical practitioner has many more patients referred to him as the result of school medical inspection than he loses by the work of school clinics.

CHAPTER X

THE PREVENTION AND TREATMENT OF TUBERCULOSIS

Public health authorities throughout the civilised world have concerned themselves with attempts to reduce the prevalence of acute infectious diseases, and during the last half-century also with measures for controlling two diseases or groups of diseases having a more protracted course, namely, tuberculosis and venereal diseases. In the control of these diseases treatment of patients suffering from them has always formed an important part. Thus problems of private and public medical work and of their relative spheres are involved and will now be considered. We shall then be prepared for a final discussion of the general problem of medical care, public and private (p. 259).

The Prevention of Chronic Infections

In both tuberculosis and venereal diseases the main object of all public expenditure of money is to apply every iota of our knowledge of preventive measures, and thus reduce the strain on the public purse necessitated by dispensaries, clinics, hospitals and sanatoria, and the service of staffs associated with these.

The same principle should, of course, govern action in regard to such crippling diseases as poliomyelitis, and the hydra-headed diseases chaotically grouped under the name of rheumatism. But in the last-named group of diseases our knowledge is insufficient to enable us to treat them with complete success or to prevent their onset; and we are obliged to limit ourselves to such measures as are possible for alleviating suffering and deformity, including the treatment of acute rheumatism in children, thus reducing subsequent cardiac disability. We also attempt to remove local septic foci.

The Moral Side of Hygiene

In tuberculosis and venereal diseases immense reduction if not entire extermination is within reach, if co-operation of every patient and of each member of the community is secured for measures to this end, and if this co-operation is on an adequate scale. This being so there is an unfailing incentive to greater and better directed effort than has hitherto been made.

The chief obstacle to the annihilation of venereal disease is the sexual appetite, one of the strongest motives in unregulated human life. It is beyond the scope of this chapter to detail the educational work needed to assist the needed control over irregular passion; or to stress, as it should be stressed, the moral training in childhood and youth, which will enable passion-impelled adolescent and adult to control impulse and preserve the socially imperative bonds of monogamous union.

There is, of course, the lower path of pursuit of wandering passion, safeguarded to some extent by mechanical or chemical inhibitions of venereal infection. The advocacy and practice of these methods strikes at the basis of civilised family life; and their half-hearted recommendation condones unnecessary breaches of ethical conduct, and thus lowers the standard of social life. True hygiene can never be the companion of what is socially undesirable and of practices which do not lead to the ethical as well as the physical improvement of mankind.

In tuberculosis no such directly urgent moral problems come like lions across the path. But moral conduct is involved also in the problem of prevention of tuberculosis, and this needs to be realised if we are to have a more rapid reduction of tuberculosis than is now occurring, relatively satisfactory though this is. Finance as well as ethics call for this advance in moral hygiene as related to tuberculosis; and the private medical practitioner can be, and I think should be, a chief agent in its cultivation and growth.

Let me illustrate. In many countries, and particularly in Great Britain, the doctor is under the obligation to report to the medical officer of health each case of tuberculosis, pulmonary or non-pulmonary, among his patients as soon as ascertained, thus enabling the many measures of prevention to be brought into action: these include advice as to bedroom accommodation, as to coughing and sputum disposal, as to the provision of a garden shelter, as to institutional treatment, and perhaps as to additional food from charitable sources. But in a not inconsiderable proportion of total cases of chronic cough or wasting the doctor has failed to examine his patient thoroughly or has not availed himself of the gratuitous provision for examination of the patient's sputum, or when he is in doubt has not utilised the services of the consultant medical officer, who is also gratuitously available in nearly all countries. Does this not involve an ethical as well as a medical problem?

Or the patient himself has received careful instruction as to the need for separate sleeping arrangements, as to caution in the disposal of his sputum, and as to covering his mouth when coughing; but he is either callous or unbelieving or careless, and he neglects these precautions. Here also is an ethical problem. In the treatment and control of tuberculosis and of venereal diseases we cannot afford to neglect the ethical element in prevention, a contention which might be illustrated in much further detail were it necessary.

Prevention of Tuberculosis in Various Countries

In European countries a large share of anti-tuberculosis work is done by insurance societies. I include treatment of cases of tuberculosis; all scientific efforts at treatment imply a corresponding diminution of risk of infection for others. Voluntary associations formed to organise direct efforts against tuberculosis do much work; and in many countries their work is more extensive than that of official organisations.

In The Netherlands all three forms of effort are seen. The State gives subventions to tuberculosis institutions; and a special diploma is given to nurses who have qualified as tuberculosis visitors (Volume I of *International Studies*, p. 29).

Cases of tuberculosis are not notifiable in The Netherlands. In Denmark respiratory tuberculosis is notifiable, and there are special regulations limiting the occupation of patients with open tuberculosis (op. cit., p. 67). The State provides most of the funds for treating cases of tuberculosis, and a third of the cost of dispensary work and of hygienic supervision. Great stress is laid on hygienic instruction of the patient during institutional treatment, and still more on the necessity for institutional treatment in the terminal stages of the disease (op. cit., p. 68).

Somewhat similar conditions apply in Sweden. In Germany the position as to compulsory reporting of cases of tuberculosis varies in different states. Similar discrepancies exist as to the relative amount of municipal and insurance work against tuberculosis; but in the aggregate the amount done is very great. There are triple arrangements which need unification. For the non-insured provision is inadequate; and for the insured there has been an unfortunate tendency to transfer the burden of needed help from sickness to invalidity funds (op. cit., p. 152). Now health visitors are being employed by sickness funds to help in discovering cases and to arrange for earlier examinations in tuberculosis centres.

Austria has arrangements which resemble those in Germany but are less complete.

In Belgium most of the anti-tuberculosis work is done by two national associations, subsidised by the State.

France has done work on a relatively small scale, beyond the work with which Calmette's name is associated, though during and since the Great War activities have multiplied. The obstructionist attitude of a large part of the medical profession, influenced in part by the fetish of *le secret médical*, is largely responsible for this (Volume II of *International Studies*, p. 75).

For Italy we may note the recent national enactment of compulsory insurance for tuberculosis (Volume II, p. 139) already mentioned on page 117, which will secure treatment for all employed persons if they become tuberculous.

British arrangements for the prevention and treatment of tuberculosis, with local illustrations, have been described in Volume III of *International Studies*, and we need now only allude to some of the outstanding difficulties experi-

enced in Great Britain in securing more complete control of this disease.

Delayed Recognition and Notification (reporting)

Delay often occurs, though it is slowly decreasing, on the part of patients to apply for treatment and of some private practitioners to recognise the existence of tuberculosis when treating their patients. In a recent inquiry as to 2,500 patients by Dr. J. A. Wilson, of Glasgow, it was found that 55 per cent. were in an advanced stage of the disease when notified, 35 per cent. in an intermediate stage, and only 10 per cent. were early cases.

This experience can be matched and even more serious delay in reporting can be found in other communities. Delay is oftenest due to neglect of the patient to seek medical advice. Tuberculosis in adolescents may be neglected until the case is hopeless. In older patients with tuberculosis a chronic cough due to tuberculosis may be neglected by the patient for months or years, and may then be treated for months by a doctor who gives a cough mixture without making a chest examination or sending sputum for examination. When this delay is due to the patient's procrastination in seeking medical advice, the responsibility is non-medical and educational work is indicated. But, in addition, there often occurs SERIOUS DELAY IN RECOGNISING THE EXISTENCE OF TUBERCULOSIS IN PATIENTS WHO ARE UNDER MEDICAL CARE.

The dispensary organisation renders this delay unnecessary; and the universal facilities for free examination of sputum help to the same end. Happily the tuberculosis medical officer who is available for consultation at the tuberculosis dispensary or at the patient's home in every county and town area throughout Britain—nearly always a whole-time medical officer of the local authority—is being more frequently used by medical practitioners for diagnostic purposes, and the resources of free radiography in diagnosis are also available through him. For dispensary services no charge is made, and in a high proportion of

cases treated in sanatoria and hospitals, treatment is also gratuitous.

In well-organised areas in which the tuberculosis officer has won his way into the confidence of private practitioners 80 or even 90 per cent. of all cases of tuberculosis pass through his hands; and his help is bespoken especially for help in diagnosis. In Lancashire, in 1929, 86 per cent. of new cases were sent by private practitioners to the tuberculosis officers for an opinion as to diagnosis before they were reported.

Next in importance to early diagnosis and reporting by the practitioner of cases of tuberculosis which are clinically recognisable is THE EXAMINATION OF CONTACTS with cases thus notified. The possibility of thus detecting early cases of tuberculosis which would otherwise have been overlooked is one of the reasons why cases of non-pulmonary as well as of pulmonary tuberculosis are required in Britain to be notified to the medical officer of health. Thus a case of tuberculosis meningitis or of joint tuberculosis may possibly have been caused by bovine infection; but its origin may be connected with a parent with "winter cough", who is intermittently discharging tubercle bacilli.

This domestic overhaul gives the further opportunity of arranging for precautions which, if the patient is treated at home, will minimise the risk of infection, special attention being paid to risk for the youngest members of the family.

In Britain the private practitioner is invited to make this examination of contacts or to permit the tuberculosis officer to undertake it.

INSTITUTIONAL TREATMENT

The satisfactory and economical use of institutions for the treatment of tuberculosis is a difficult problem, in which medical practitioner and tuberculosis officer should consult each other. It cannot be fully discussed here; but bearing in mind the general proposition that prevention is more important than treatment, I would draw attention to the

aphorism on page 78, which emphasises the importance of submitting every patient over a short period in a sanatorium to the hygienic education and training in the methods of life he must hereafter pursue. In my own experience as a local medical officer of health I secured that nearly every known case in the town should be thus treated; and given a limited number of beds I am confident that in the interest of the public health this is a more profitable method than the attempt by prolonged treatment of six to twelve months to attempt to cure a smaller number of patients. The short stay in a sanatorium is usually associated with rapid improvement in weight and relative freedom from cough; and the patient goes home imbued with the right ideals. Even with limited home accommodation it is astonishing what often can be done in the way of continued open-air treatment.

I need not stress the importance of protracted institutional treatment of acute and advanced cases of tuberculosis. It is a fundamental part of policy in the prevention of tuberculosis, and has been most extensively used in the countries which have experienced the largest decline in and now have the lowest death-rate from tuberculosis.

General Medical Practice and Tuberculosis

The relation between private practitioners and official tuberculosis officers in Britain has steadily improved. There is still some slackness in reporting cases; but the provision of sanatorium and hospital beds by public authorities and the official facilities for expert consultations, including radiography, have led to increasing cordiality between the two. A tactful and skilful tuberculosis officer has relatively little difficulty in becoming a general tuberculosis consultant within the area of his work.

This position is facilitated by the conditions of medical benefit under the National Insurance Act. About a third of the total British population is insured, and for them domiciliary attendance for tuberculosis as for other diseases is assured. The institutional treatment of tuberculosis was originally one of the benefits received by insured persons;

but the absurdity of differentiating between insured and non-insured persons for a communicable disease like tuberculosis soon became evident, and the burden of institutional treatment of tuberculosis for the entire community was thrown on public health authorities, aided by large grants from the central government. That is the present position. The tuberculosis officer examines patients recommended for sanatorium treatment by their private doctor and decides as to their admission. A large part of this work is done at the official tuberculosis dispensary, which in the main is consultative in character.

The remuneration of doctors undertaking the domiciliary treatment of insured persons is merged with general medical attendance on a *per capita* basis. They have no financial motive for delaying the sending of patients either to a dispensary or a sanatorium, and friction under this heading is rare. The domiciliary treatment of insured tuberculous patients is left in the hands of the insurance doctor, who is required to make periodical returns to the tuberculosis officer as to his tuberculous patients. This part of tuberculosis work is not always satisfactorily carried out.

The visiting tuberculosis nurse does much to improve the domestic hygiene of home-treated cases of tuberculosis, and to educate those families, for whom this is especially important, in hygienic methods of living.

Summary on the Prevention and Treatment of Tuberculosis

71. Public authorities everywhere are concerning themselves with treatment as a means of curtailing and often of preventing tuberculosis.

72. In the prevention of tuberculosis, and still more of venereal diseases, problems of conduct are involved in securing more rapid and more complete success.

73. There is still delay in recognising the existence of tuberculosis in many patients who are under medical care, and an even greater delay on the part of tuberculous patients in seeking medical advice.

74. A chief object of public organisations against tuberculosis is to furnish the consultant services which enable prompt diagnosis to be made.

75. Every patient should receive for a short period hygienic education and training in a sanatorium.

76. The protracted institutional treatment of acute and advanced tuberculosis, when home conditions are unfavourable, is a major need in successful efforts for the diminution of tuberculosis.

CHAPTER XI

THE PREVENTION AND TREATMENT OF VENEREAL DISEASES

EVEN before the Great War public opinion was being roused to effort which would reduce the terrible toll on life and health which venereal diseases inflict on the community. It is highly probable that their maleficent effect in the aggregate is greater even than that of tuberculosis.

In European countries older attempts on the part of public authorities were directed to the disinfection of prostitutes and to their segregation while contagious. These attempts at control have never had more than a very partial and localised success (see Volume III of *International Studies*, p. 229) for many reasons, among which may be mentioned the number of loose women who could not be identified as prostitutes, and the still larger number of men who were left uncontrolled to spread these diseases. The large share which gonorrhœal ophthalmia bears in causing blindness in children, the terrible chronic invalidism caused by gonorrhœal complications in innocent married women, the terrible rôle which the syphilitic virus plays in producing early arterial degeneration, insanity, and premature old age, and the fact that syphilis is a chief cause of still-births and a frequent cause of infant mortality after birth, as well as the many other injuries to health and life owing to the same origin, all indicate the momentous importance of the present more successful action now being taken against venereal diseases.

The details of the British Scheme are given in Volume III of *International Studies*, and a few particulars of these will be discussed later in this chapter. The following paragraph gives a few of the salient features of measures taken in other countries to control venereal diseases.

International Measures

In The Netherlands there is State subvention of the treatment of these diseases on a small scale, and there are free clinics in some towns.

Denmark has a remarkable record of early action against venereal diseases (Volume I of *International Studies*, p. 19). From 1788 onward, in one diocese of Denmark free treatment was required to be given to every patient suffering from venereal disease, whether rich or poor, and in 1790 this became general for the whole country. The treatment is undertaken by official district medical officers.

In 1918 Sweden adopted a system of free medical treatment for all. Certain obligations in conduct, as in Denmark, were imposed on patients in return for treatment—a thoroughly sound provision.

In the three Scandinavian countries, Welander Homes have been open for the free treatment over several years of children with congenital syphilis.

Germany, like some other countries, has an enactment making it obligatory on all persons suffering from venereal diseases to secure treatment, and doctors are made responsible for hygienic instruction of their patients (Volume I of *International Studies*, p. 153). There are many consultation centres supported by municipalities and insurance societies; as a rule, at municipal centres no treatment of patients is undertaken; but they are referred to hospitals or to the insurance or other doctor. There has been no general adoption of a system of gratuitous treatment such as exists in Britain and in Denmark. In Berlin and a few other centres some treatment of venereal diseases is in part undertaken by the municipalities; but this is chiefly carried out by sickness insurance and invalidity insurance societies. Attempts are being made to secure the unification of these services (see Volume I of *International Studies*, p. 155).

In Austria venereal disease clinics, free for all, have been opened in all its nine provinces. Some insurance societies have special clinics for these diseases. Special benefits are given in Vienna to pregnant women not members of an insurance society who up to the fourth month of pregnancy attend a special clinic for a Wassermann test and are found to be syphilitic and destitute.

Belgium has undertaken active anti-venereal work, which differs considerably in detail from that of England. The expense of medicaments is borne entirely by the Government, that of clinics by local authorities. There is free access to these clinics. Special stress is laid on the co-operation of private practitioners.

Each doctor supplied with drugs at the expense of the State is expected to make a full return as to the treatment of his patient.

In France much medical anti-venereal work is being done at dispensaries and hospitals, partially subsidised by the Government. Most urban centres have such dispensaries. Arrangements are sometimes made for the treatment of patients by private doctors at the public expense under regulations. Some payment is asked for from the patients, but this does not appear to be pressed. Many clinics for congenital syphilis exist, and in maternity hospitals in Paris valuable antenatal work is being done.

In Italy since 1926 free anti-venereal dispensaries have been provided for the entire population. These dispensaries are obligatory in all towns with over 30,000 inhabitants. The cost is borne jointly by the communes and the State.

In Hungary and Poland some partial State efforts are made. In Poland the medical practitioners have strongly objected to gratuitous treatment in special dispensaries. They do not themselves receive a gratuitous supply of drugs for their patients.

The treatment given in insurance polyclinics in Poland is often unsatisfactory.

In Czecho-Slovakia the resort to anti-venereal dispensaries is small; only indigent patients are treated gratuitously.

In Great Britain the expense of the treatment of venereal diseases at venereal clinics is borne jointly by the State and by the local authorities. These clinics are found in every considerable town; and special allowances can be made to patients who cannot otherwise afford to travel from a rural district to the clinic. No residential restriction is made as to the clinic a patient may attend; this was arranged as an additional motive to favour coming for treatment. No charge is made for any patient. If a patient is sent by a private doctor, he is sent back with a note giving the result of the consultation.

Most clinics are attached to general hospitals, so as to avoid the fear of publicity in treatment. In some towns special *ad hoc* clinics have been started, and have been very successful (see Chapter XIII, Volume III of *International Studies*).

The medical profession have cordially accepted the principle of the gratuitous medical treatment at a clinic supported

from public funds of all applicants who have a venereal disease. A large proportion seen at these clinics are found to have non-venereal disease and are referred elsewhere. The circumstances under which the present national system of gratuitous treatment came about are set out in the volume cited above.

My inquiries in various local centres in Britain have shown that there is a general recognition of the fact that the satisfactory treatment of venereal disease is a specialist problem, and that continued treatment on the elaborate lines required is best conducted at special clinics. Most practitioners welcome the opportunity to be relieved from these patients.

Medical practitioners desiring it, who are able to show they are familiar with their administration, are supplied gratuitously with arseno-benzol preparations for their private patients.

From the preceding review it will be evident that throughout Europe there is a general attempt to diminish the ravages of venereal diseases by their prompt and efficient treatment.

IN SOME COUNTRIES efforts in this direction are only partial; in some only the poor are treated gratuitously; in others THE PRINCIPLE OF GRATUITOUS TREATMENT OF ALL APPLICANTS AT THE PUBLIC EXPENSE IS FULLY ACTED UPON. This is so in Britain, Denmark, and Sweden; partially so in Belgium.

This method of attacking venereal diseases, and especially syphilis, is inspired by the urgent need to sterilise the virus in each patient by the therapeutic action of arseno-benzol compounds. Prompt treatment minimises infection and curtails its duration. In some countries there remains controversy as to the extent to which State funds should be used in the treatment of venereal disease. The immediate disinfection of the patient by treatment is regarded by some as the extent to which the State should go; while more wisely, in the countries named above, it is considered that although immediate disinfection is the urgent need,

there are later possibilities of development of latent infection; and that a satisfactory programme of public effort for the control of syphilis must, therefore, include more protracted treatment, so that infection in future married life may be inhibited and congenital syphilis avoided. Very valuable results have been obtained in the treatment of syphilis in pregnant women. Even when this treatment is only begun in the later months of pregnancy, it is marvellously successful in securing the birth of an infant free from syphilis.

The treatment of gonorrhœa involves greater difficulties than that of syphilis; and the prevention of infection of innocent persons, even when there has been full treatment of the patient, cannot always be guaranteed.

Additional items in public preventive work against syphilis may be briefly mentioned. In some districts in Britain midwives are paid a small fee for sending fœtuses for examination for spirochœtes. This renders it possible to treat both parents for syphilis after investigation. The usual procedure would be for the medical officer of health or of the clinic to interview the parents, and if there is a family doctor to consult with him. For the very poor, direct action can be taken to advise treatment at a hospital or clinic. In one or two towns each practitioner sending a specimen of blood for a Wassermann examination has been paid 2s. 6d. (about 60 cents) for his trouble. Such examinations are always made gratuitously by the Public Health Authority. There is still a neglected field, that of systematic investigation of mothers who have had stillbirths. For this work a better co-operation between private doctors and public health officers is needed.

Summary on the Prevention and Treatment of Venereal Diseases

77. Older efforts to control venereal diseases by police methods alone have largely failed and are now replaced or supplemented by treatment to curtail and terminate infection, and by general educational measures.

78. In some countries completely gratuitous treatment of venereal diseases is provided for all applicants at the cost of the local authority and the Government. In other countries partial provision in this direction is made.

PART III

CHAPTER XII

GENERAL MEDICAL PRACTICE AND PREVENTIVE MEDICINE

In Chapters I and II the general problems involved in the relations between private and public medical work have already been partially considered; and in each of the subsequent nine chapters these problems have been the recurring topic. It is in fact the theme both of this volume and of the three volumes of *International Studies* in which I have set out the facts on which the conclusions stated in this volume are mainly based.

The difficulty in adjusting satisfactorily the relation between the private and the public practice of medicine has been greatly increased and in part created by the growth of scientific knowledge; and in so far as medical practitioners have shared in producing the advances in medical science of the past few decades, they may be said to have contributed to the daily increasing difficulty in adjusting to the best advantage their work with that of consultants, of medical institutions, and of public health authorities.

The complexity of medical work has been vastly enhanced by the discoveries made in the present generation in bacteriology and general pathology, in physics and chemistry and in physiology and biochemistry; while its scope has been widened by the work of social workers intent on securing that the economic and social circumstances of the patient shall be made part of medical diagnosis and treatment.

Illustrations of the difficulties which arise are to be found throughout this volume. They occur in the practice of every family doctor, and he, acting in the interest of his patient, is the first to demand the help which can be given by experts. He finds that he is no longer always the sole master in his private medical work. A certain proportion of his patients must be treated in hospital to secure what

cannot be supplied at home; concerning others there must be consultation with the ophthalmic surgeon, the ear and throat specialist, the urologist, the obstetrician or gynæcologist, the pediatrician, the dermatologist, or some other consultant. The need for consultative work in tuberculosis and venereal disease need not be stressed as far as Britain and some other countries are concerned, as a complete official organisation for this purpose is in being.

The necessary contacts of the general medical practitioner with the public health authority now bulk almost as largely as those with voluntary hospitals and with the consultative facilities which in the strict sense are not official. Official services include not only the two special services named above, and the work of public authorities for maternity and childhood, but also diagnostic facilities for infectious diseases, arrangements for the isolation in hospital of infectious patients, for the treatment of poorer patients in municipal hospitals, and for nursing.

We can rejoice that medicine now can offer almost immeasurably more for the sick than was possible a generation ago; and that this provision is not being withheld from the poorest in the community. That is the distinguishing feature of the medicine of to-day. WE ARE NO LONGER CONTENT THAT ANY SINGLE PATIENT SHALL HAVE LESS IN ESSENTIALS THAN THE RICH CAN OBTAIN, FOR PREVENTION OF SICKNESS, FOR ITS PROMPT CURE, OR FOR ALLEVIATION OF SUFFERING. The methods of obtaining this threefold object have already been partially stated, and are further discussed in the following chapters.

SPECIALISM

The increased necessity for utilisation of specialised knowledge is an accepted fact. But in the necessity for the specialist in a minority of medical cases there lurk certain dangers. It is possible to forget the patient while studying intensively his special ailment. The general view as well as specialised skill is needed. The occasional myopia

of the specialist is as detrimental to the patient as the occasional hypermetropia or misty vision of the family practitioner.

For the majority of cases the well-trained and conscientious general practitioner suffices; and his synthetic judgment even in the exceptional cases in which he does not suffice is needed to balance the more complete analysis of the specialist. It is only by this "exchange of insights" that the patient's welfare can be completely conserved. Like the laboratory, specialism is a good servant, but a bad master; and in the successful treatment of difficult cases, as well as in the great mass of straightforward illnesses, the private practitioner will continue to be the most important element in the practice of medicine, subject to two conditions: (*a*) that he has familiarised himself with every phase of his patient's physiological condition by accurate examination as well as by observation and questioning; and (*b*) that he secures the special medical aid which is indicated when doubt legitimately arises affecting the patient's welfare.

The IDEAL for the general and the special practitioner alike IS NOT ONE OF ISOLATED INDEPENDENCE, BUT OF CO-OPERATIVE INTER-DEPENDENCE IN GIVING MEDICAL AID.

Dr. Richard Cabot has expressed this thought well in setting out, in the wider field of man's whole nature, the relative work of the minister of religion, the physician, the teacher, and the social worker:—

> Division of labour in this field, as in many others, is never an unmixed blessing and may easily become a curse unless energy and intelligence are devoted to the ways and means of attaining a close co-operation and interchange of ideas, methods, and plans among the divided labourers.

This mention of the relation between the medical practitioner and educational, social, and religious workers cannot be expanded here; but evidently the most successful family doctor is the one who realises the importance of the collateral factors indicated in the above quotation, which

affect the patient's health, including his social and occupational life and his mind and character as a whole. This family doctor occupies an impregnable position.

In acting thus he approaches not only to the ideal in which the private practitioner is a medical officer of health within the scope of his own practice, but he also occupies a valuable field of sympathetic personal activity, which commonly is inaccessible to the public official. At this point we may conveniently consider the

Relation of the General Practitioner to Preventive Medicine

The object of the general practitioner, like that of the medical officer of health, should always be to make himself unnecessary. In so doing, each of these two physicians of the community finds that his work steadily expands, while its character as steadily changes, veering from the problems of established illness to those of minor ailments and to the maintenance and improvement of health in its widest sense.

The first desideratum for the doctor who wishes to enter into the work of the New Medicine is A FULLER ACQUAINTANCE WITH THE NORMAL and a more complete knowledge of means for its maintenance. To adopt an illustration from sanitary practice: the application of ingenuity is giving us furnaces and fireplaces which will consume smoke; these are needed, but a better way is to develop arrangements which will ensure that no smoke is produced. The same principle applies to the practice of medicine. Much of the needed preventive work must always rest with the Public Health Department; the community in this respect is the expanded family; but more intimate and personal preventive work is ready for the private practitioner who is trained for it.

In undertaking this work, he is helping to increase as well as to maintain the fitness of the community; and this fitness is a much larger part of the working capital of the community than its land and the cattle on it, or its manu-

factures and machinery. Without this personal fitness all else lapses and loses its purpose. If fitness includes character-health as well as body-health, fitness while it is working capital is much more; it is the ultimate purpose of civilisation.

Action which will help to prevent sickness and to increase fitness is proceeding with increasing momentum, and the future of private medical practitioners depends on their reaction to it. The scope for such work is very great, for at present over 2 per cent. of the working population may be ill at any one time from disabling illness, and the prevention of a large part of this illness is an appropriate part of the family doctor's work.

The intervention of lay social workers who are interested in health problems has hastened the realisation of the preventive ideal of medical work, and has caused some disturbance of private medical work. Medical care is not only a concern of the family and of the private doctor. It is always an obligation of the community, and the only means by which private practitioners can meet the all-round communal institution of additional agencies to safeguard and improve health is by providing the same aid themselves, or by taking part in the working of these agencies. Dr. Charles V. Chapin, of Providence, R.I., in a recent letter to the author, has expressed his opinion in these words:—

> I have always believed that the correlation of preventive and curative medicine is the great problem of the immediate future;

and this effort at correlation and co-ordination must necessarily determine a large share of future private medical practice. Wisely guided it does not necessitate clashing between private and public medicine, but it gives scope for co-operation on a vast scale.

A formidable difficulty in realising the ideal is the ordinary method of remuneration of private medical practitioners, which is left for consideration in Chapter XIV.

"Rush" Medicine

Perhaps the greatest obstacle to realisation of the ideal, next to unsatisfactory conditions of remuneration, is the irksome urge of apparent necessity experienced by private practitioners who are engaged in a large insurance practice or in practice among the dependents of the insured and others of limited means. These doctors have limited hours of consultation; their surgeries are often crowded with waiting patients, and it is difficult to avoid giving a hasty interview and a bottle of medicine, without having made the diagnosis or attempted diagnosis which follows a satisfactory interview with the patient. THE GREATEST EVIL IN MEDICAL PRACTICE, ESPECIALLY AMONG WAGE-EARNERS, IS TREATMENT WITHOUT DIAGNOSIS. It would be possible to fill many pages with illustrations of this point; but this is unnecessary, as the facts are well-known. (But see, for example, p. 104, Volume III of *International Studies*.)

The remedy is more difficult. Its application is needed especially in medical practice in industrial areas; in rural districts and in residential neighbourhoods patients more generally receive the time-consuming care they need. There is no cut-and-dried remedy. Indeed the solution lies within the sphere of morals as well as of medicine. If two doctors joined together in the same surgery in consultation hours, and shared the work of physical examinations; if several doctors arranged together to have the same surgery and the same surgery hours and employed a nurse to help them in minor work and in preparing their patients for examination, much improvement would be secured. This is the intention of the Primary Health Centres adumbrated on page 104; but the rivalries of private medical practice conducted by single practitioners make such joint medical work extremely difficult.

Without accurate diagnosis, without consultation with another doctor in cases of difficulty, satisfactory treatment, much less preventive measures, are impracticable. Necessarily

time is an element in diagnosis, and the ideal set out above cannot always be attained at the first interview with a patient.

Two preliminary points bear on the relation between preventive and clinical medicine.

Familiarity with the Normal

Medical practitioners have few opportunities in their work of getting into close touch with the normal person, and especially with the normal child. Their medical training in the past has proceeded throughout on the assumption that their work is solely with the sick. This means unnecessary difficulty in recognising functional departures from the normal, especially when these are not accompanied by symptoms uncomfortable to the subject.

To secure his full usefulness the doctor should be the family adviser of the well and not only of the sick, and for this purpose, it may and, I think, will be necessary to change the present arrangements for remuneration in family practice. I do not ignore that fussy medical care may stimulate over-anxiety as to one's health, and that many persons may become more concerned with "keeping fit" than with using their fitness for its rightful purpose of adding to the community's wealth (weal-th) in its widest sense. But if this tendency is counteracted and fitness be regarded as a means of usefulness, medical advice, for instance as to undue leanness or obesity, as to diet and exercise, as to habit or habits of mind, or as to conditions of work and recreation, will be most valuable.

Periodical Medical Examinations

Stress has already been laid (p. 138) on the necessity, if medical practice is to be honest and scientific, of every doctor knowing the exact condition of each of his patient's physiological systems. This does not imply such an overhaul in each casual illness; but the doctor must in fairness to his patient possess this knowledge. As Sir James Mackenzie has put it, it would—

be ridiculous to put a man with a cut finger through such a process (a thorough examination) and expect him to pay for it, as it would be to expect an automobile owner to have the entire machine overhauled each time he has a puncture.

But these illustrations of the discretion needed in applying a rule cannot be used in defence of the medical practitioner who—when responsible, as, for instance, for an insured person on his panel—does not make himself thoroughly conversant with his patient's physiological competence in every respect, and with his habits and occupation as bearing on his patient's health. If this contention be challenged, then there is need for an immediate change in the contract of service of insurance doctors. Such a change on the merits ought to be unnecessary, for prophylaxis is an indispensable part of treatment.

Periodical medical (including dental) examinations are valuable, when widely carried out without faddism and in such a way as not to encourage chronic introspection on the part of the person examined. But this will not lead us to forget that the acute infectious diseases, including acute rheumatism in childhood and youth and syphilis in early adult life, are more serious causes of adult inefficiency and premature breakdown than current errors in the manner of life of men and women between forty and sixty. The chief exceptions to this statement are excesses in eating and persistent indulgence in alcoholic drinks, especially during working hours.

I have contended that the general practitioner should be familiar with normal as well as with morbid humanity; and that he should have exact knowledge of the physiological condition of his patients and of their social and occupational circumstances. His duty should also include the systematic revision of the facts in the dossier which he keeps as to each patient.

To enable the practitioner to fulfil these conditions of maximum usefulness it is highly desirable that he should act as such for all the members of the same family.

The Family Doctor

This ideal of a family doctor is too rarely realised except in rural districts and in the families of the well-to-do. It is, indeed, doubtful if the ideal of the family doctor who is fully acquainted with the lives of the families attended by him was ever more than an unrealised ideal for the majority of the population. The immense contract medical service under sickness insurance in Britain has improved the prospect of the insurance doctor also treating the wife and dependents in the same household; though under the hurried conditions of much of his work, the potential benefits of the relationship are too seldom fulfilled. In foreign countries in which the medical benefit of sickness insurance is extended to the entire family, the doctor is more certain to become the family doctor. When this is practicable the doctor greatly increases his power for good work. Without his aid, for instance, how difficult it is to secure examination of contacts in tuberculosis, or to undertake the necessary tests for ascertaining the cause of repeated miscarriages at the seventh month of pregnancy. The doctor's advice, when based on knowledge of the sanitary circumstances of the home, on the economic position of the family, and on the occupation of all wage-earners in the family, can be made much more useful than is otherwise possible.

But although this is so in theory, practice, alas! rarely comes up to the possibilities. The present methods of payment for medical attendance tend to perpetuate present defects. The paymaster in the family naturally postpones sending for or visiting the doctor as long as he or she can; and the doctor who is not pachydermatous realises that the minimum of visits presumably consistent with necessity are to be made. Other reasons for the present defects of medical practice exist, among these being the inadequate realisation by parents and even by many family doctors that the latter should be employed to detect early disease or to prevent its occurrence.

It will, therefore, be understood why a wide field—too seldom able to be occupied by most family doctors—has been cultivated by voluntary and official workers in preventive medicine, and work has been carried out by them which has had a marked influence on the public health in many countries. The resumption of much of it by the family doctor, under conditions of family employment which will not inhibit competent scientific medical work in each family, is within the reach of a well-organised system of private medical practice, in which each doctor is co-operatively related to other doctors in his neighbourhood.

The Ideals of the British Medical Association

That the ideal adumbrated at the end of the preceding paragraph can eventually be realised is further evidenced by the fact that in the proposals of the British Medical Association, 1930, for a General Medical Service for the Nation (see also page 106) it is set out as

> a fundamental principle . . . that a satisfactory system of medical service must be directed to the prevention of disease, no less than to the relief of individual sufferers;

and for this purpose it is maintained that it

> can best be secured by associating every general practitioner with the general health service, and emphasising on every possible occasion that there is no real line of demarcation between the preventive and curative branches of professional work.

This is a welcome declaration from the main body of General Medical Practitioners in Britain. It emphasises the thesis running through each chapter of this book that clinical work more and more is becoming work in preventive medicine, when it is based on accurate pathology, and still more on physiology.

When this is fully realised, the fear of the general practitioner that his fate is merely to act as a "clearing house" for the hospital or for consultants will disappear, and he will take his right place at the centre of all the co-ordinated

medical work that may be needed in the treatment of complicated sickness.

In bringing about this ideal, periodical medical examinations will become general in the families under the care of each doctor, insurance patients especially will be overhauled and their exact condition recorded, much health work will be done for the children, and somehow or other the nurse and the health visitor will be made systematically available in supplementing the more general directions of the family doctor. The difficulties in bringing about the ideal here indicated are very great, especially for the families of wage-earners. Many medical practitioners are not ready to undertake the necessary work, and many others unfortunately detest keeping even the most rudimentary record for each member of the family, without which much of the health gain attainable will be lost. Financial difficulties also loom very large in the way of realisation of the ideal, especially when we remember that it implies that the panel list of many insurance doctors will need to be severely pruned. And meanwhile, pending this approach to a medical millennium, the daily work necessary to further the aims of preventive medicine must be carried on by all the present public health and other agencies concerned with this work; and this work can only be relaxed in so far as it is certain that it will not be neglected by the private practitioner. At present, wide gaps exist not only in the special territory of the private practitioner, but also in the territory partially occupied by health authorities; but eventually no gap of neglect between what the private practitioner can do and the total medico-hygienic work undertaken on behalf of the community will be tolerated.

Summary on General Medical Practice and Preventive Medicine

79. The community is no longer content that any single patient shall have less in essentials than what the rich obtain, for prevention, for prompt care, or for the alleviation of suffering.

80. There is frequent need for exchange of insights between the general and the special practitioner of medicine.

81. The ideal for both is not isolated independence, but co-operative interdependence in medical care.

82. The medical practitioner should have a fuller acquaintance with the normal.

83. The greatest evil in medical practice, especially among wage-earners, is treatment without diagnosis.

84. The medical practitioner should not continue to be responsible for the medical care of any person unless he has made accurate inquest into all his physiological systems, and has knowledge of his social and industrial circumstances.

85. The ideal is that there should be a medical adviser for each complete family. The future rôle for medical practitioners is to become searchers out of disease, as well as physicians for its treatment when it occurs in an obvious serious form.

CHAPTER XIII

GENERAL MEDICAL PRACTICE AND STATE[1] MEDICAL SERVICES

MUCH has been written in the preceding pages and in medical journals concerning encroachments on the work of the private medical practitioners by hospitals and by public health authorities. Some of the considerations involved in the latter source of "encroachment" have been discussed in preceding chapters. I have specially emphasised the fact that the greater part of the medical work undertaken by public health and education authorities had previously been neglected by parents and that private practitioners had seldom undertaken it. Much of it also requires specialist aid. In short, THE DISPUTED TERRITORY IN THE MAIN HAD NEVER BEEN OCCUPIED. It was opened up by public authorities, and the total amount of medical work coming to the medical profession (including private practitioners) has been greatly increased by this continuing exploration.

We may now further review the different branches of medical work carried out at the expense of public health (including education) authorities from this particular angle, using Britain as our illustration, unless otherwise stated.

The largest encroachment on private practice by public authorities is in the mental hospital provision made by them. As this is universally regarded as necessary, it need not be further discussed.

A. TREATMENT AS PART OF DIRECT PUBLIC HEALTH WORK

Next in magnitude to the provision of Mental Hospitals by public health authorities is that for the INSTITUTIONAL TREATMENT OF INFECTIOUS DISEASES. In most countries this provision is made to some extent. In Britain most cases of the acute infectious diseases, except the so-called minor infec-

[1] The word "State" is used in the sense defined on page 23.

tious diseases of childhood, are treated in fever hospitals. This is true especially for scarlet fever and diphtheria. Separate hospitals are provided for smallpox.

Specialism has been carried too far in institutional provision for infectious diseases; and in Britain in future there will be reduction in the number of separate institutions, now that official hospitals of all kinds have come under a single public authority. This reduction is quite compatible with the prevention of cross-infection.

With very few exceptions, PATIENTS ARE TREATED IN PUBLIC HOSPITALS FOR INFECTIOUS DISEASES WITHOUT PERSONAL CHARGE, and in this respect it may be said that MEDICINE HAS BECOME ENTIRELY SOCIALISED.

Allied to this is the almost complete SOCIALISATION IN BRITAIN OF MEANS FOR SECURING IMMUNISATION AGAINST CERTAIN SPECIFIC INFECTIONS. The two diseases concerned are smallpox and diphtheria.

Vaccination against smallpox has been organised in England since 1840, a single local medical practitioner being appointed in every area as public vaccinator to give gratuitous primary vaccination, without any social restriction, to all parents desiring it for their children, or revaccination after a lapse of years. The parents preferring to employ and pay their own family doctor for this purpose can do so; but the Government vaccine lymph unfortunately is not supplied for this private vaccination.

Vaccination of all infants is still legally compulsory; but in practice it has almost ceased to be so, and there is widespread neglect of this precaution against smallpox. The problem of compulsory vaccination in Britain is profoundly modified by the present almost exclusive prevalence of an extremely mild strain of smallpox; and attempts at compulsion have been rendered more difficult because of the occasional though rare sequence of vaccinal encephalitis.

No reasonable doubt exists as to the protective influence of vaccination against smallpox; and we have here THE OLDEST INSTANCE OF THE COMPLETE SOCIALISATION OF MEDICAL PROVISION.

In Denmark vaccination has been compulsory since 1810. It is a condition of admission to school at the age of seven.

In Norway there is a similar social compulsion to be vaccinated; school attendance, religious confirmation, and marriage by the parish minister being forbidden unless the subject has been vaccinated.

In the rural districts of Norway specially trained midwives do most of the vaccination against smallpox.

In Italy (Genoa) vaccination at the age of eight is undertaken by the school medical inspectors.

IMMUNISATION AGAINST DIPHTHERIA is undertaken gratuitously but only to a relatively small extent by public health authorities in Britain and on the continent of Europe. There has been slow and cautious advance, not the strikingly great advance seen in the United States. The diphtheria immunisation of children residing in institutions has made considerable progress.

In both smallpox and diphtheria more complete success would, in my view, be secured if private medical practitioners were authorised to undertake immunisations for the public health authority, by whom they would be paid on a defined scale. It would, of course, be necessary to insist on exact certification in each case of the methods and results of procedure, so as to obtain assurance of quality of work. The present official vaccination against smallpox in England is made the subject of inspection by medical inspectors of the Ministry of Health, whose verdict determines part of the remuneration of the public vaccinator in the form of a bonus. Under the suggested procedure similar inspection would be impracticable, except when extreme suspicion arose.

THE TREATMENT OF TUBERCULOSIS is the next great illustration of partially socialised medicine. In most parts of Britain payments for treatment in residential institutions are imposed on only a small scale. It is recognised that tuberculosis commonly means a heavy financial strain on the family or actual poverty, and that enforcement of payments for residential treatment may reduce the nutrition of the patient's family to a dangerous extent. The parents of

a child with tuberculous joint disease may be asked to pay a small sum weekly towards the cost of maintenance in a special institution. In practice the great majority of cases of tuberculosis are treated free. No payment is taken from patients seen in tuberculosis dispensaries, whether attending independently or sent for consultation by a private practitioner.

Under the sickness insurance system in Britain domiciliary treatment of all insured consumptives is partially subsidised, like that of other diseases, by the State. The general position as regards tuberculosis is more fully stated on pages 205 and 209. There is now little friction between private practitioners and public health authorities in regard to cases of this disease. It cannot be said that everywhere there is complete co-operation; but private practitioners increasingly are utilising the consultative facilities organised by local authorities, and also utilising for their patients the chiefly gratuitous institutional treatment provided by these authorities.

The most complete instance of socialisation of treatment of disease as a public health project consists in

THE TREATMENT OF VENEREAL DISEASES at the public expense. In several countries it amounts to complete gratuitous treatment of all applicants, irrespective of social or financial status. In these countries and certainly in Britain, this provision of treatment by the State has been welcomed by those concerned, and has met with the general approval of private medical practitioners. It is a remarkable triumph of collectivism over the financial interest of private medical practitioners. (See, for example, p. 33, Volume II, and p. 231, Volume III of *International Studies*.)

The almost complete unanimity of medical opinion as to the State treatment of venereal diseases does not exist in regard to the CHILD WELFARE AND SCHOOL MEDICAL WORK of public authorities. It is unnecessary to rediscuss these two services, but reference may be made to Chapter IX and to page 229 in Chapter XII. New ground has been broken in these two services. It had been previously neglected, partly from

motives of finance, even more so because of the defective acquaintance of parents, and to some extent of medical practitioners, with the beginnings and sources of disease. This ground is being increasingly cultivated by public authorities in many countries, although these authorities usually desire economy in their work, and are not likely to refrain from wishing private practitioners to undertake more of it. On the other hand, municipalities are rightly proud of their maternity and child welfare work; and there is at present a strong current, at any rate an undercurrent, towards its extension. It must be remembered, furthermore, that a very large part of school medical work is specialist in character (e.g. refractions, dental work, operations, orthopædics), and that a very large part of infant welfare work is undertaken by public health nurses, though it is done under medical guidance. It is unlikely that this will revert entirely to private practice. The work undertaken by nurses was practically never done by private doctors.

ANTENATAL CONSULTATIONS also are chiefly new developments of obstetric work, competent to reduce materially the complications of midwifery. Much of this work should be undertaken by a doctor, preferably the doctor who will afterwards attend the mother in childbirth if any complication arises. Many mothers intend to employ only a midwife in their confinement; and the question is discussed on page 174, as to how far she can be trusted to undertake supervision of her future patient, and in such cases what doctor shall be entrusted with the necessary medical antenatal work.

This review confirms the statement already made that the system of payment for "work done" is a stumbling-block in the establishment of a system of wider medical work under the family doctor, which would consist largely of the application of preventive medicine in the family circle.

Although it may be considered desirable that various forms of medical work now undertaken by public health

authorities should be undertaken by private practitioners on the initiative of the head of each family, the idea must be deprecated that private medical practitioners have a vested interest apart from the interest which is created and maintained by the parents' desire. Public authorities and private medical practitioners alike can only act when action is desired or permitted by the patients or their parents while the patients are children. The only exception to this statement is that of cases in which it can be shown that "constructive cruelty" is being inflicted on a child by lack of treatment. Then a public authority can intervene.

I have suggested that public medical services for infants and children are likely to extend and not to decrease. But whether this will be so or not will depend in large measure on the future organisation of private medical practice. Extensions of group practice and changes in methods of payment for medical work would lead to much additional child welfare work being undertaken in private medical practice.

Present imperfections and incompleteness of private medical work have their counterpart in public medical services, and in both of them the danger of stereotyped medical practice is always present. A private practitioner may remain intellectually stagnant after leaving his medical school; and for like reasons and under governmental influences, local or central, official medical work may similarly become "standardised" at a level which is unsatisfactory. Public failure to realise its importance is an even more important reason for stagnation of health work.

In social work, and especially in medicine, standardised work may easily become stereotyped work, and this may eventually mean sterilisation and inability to grow and develop in the light of advancing research.

Medical Practice in Groups

The frequent assertion that the day of the general practitioner is over will prove largely true if he fails to keep himself in touch with the work of hospitals, of specialists,

and of public health authorities. Furthermore, if family practice is to survive and recover some of its lost ground, A TEAM OF DOCTORS ON THE MEDICAL SIDE MUST BE THE COUNTERPART OF THE FAMILY ON THE PATIENTS' SIDE.

This point has already been emphasised. Its importance is gradually being realised, and team-work in private practice will doubtless increase, and if satisfactorily organised will reduce the present demand for public clinics. By its means the weakest member of the team can be levelled up. His forgetfulness or neglect to use every available means of diagnosis will emerge; and jointly two members of a medical team can in many cases do much better work than either of them in isolation. In remote rural districts such team-work may be impracticable, and one realises the marvellously good work which continues to be done by many isolated medical practitioners. They are now being assisted by publicly provided agencies, and the locomotive facilities of to-day render the task of these practitioners less onerous than it has been.

B. Medical Treatment at the Public Expense

Public health authorities throughout Europe are responsible for the medical treatment of the necessitous section of the population. In Chapter IV the arrangements for this purpose are briefly summarised, and they are more fully set out in Volumes I–III of *International Studies*. In nearly all European countries there is AN ALMOST COMPLETE INSTALLATION OF TREATMENT OF ALL FORMS OF DISEASE AND OF CARE OF MATERNITY AT THE EXPENSE OF THE COMMUNITY FOR THE NECESSITOUS PORTION OF THE POPULATION. In Ireland the proportion of the total population thus provided for may roughly be estimated at one-half; in Scandinavian countries, and still more in Eastern Europe, the proportion may be still larger.

In some instances charges are made according to means; but in all of these countries the main cost of the medical service for the poor devolves upon the local and national

taxpayer. The treatment available in each country is both domiciliary and institutional; its quality varies between wide limits. It is always best when the necessitous and the non-necessitous (the latter paying, in part at least, for their treatment) are treated together in the same institution.

The need for a free medical service for the very poor has been accepted in all countries. This service has usually been given in parsimonious fashion, and, unhappily, hitherto has had in it little of a preventive character, and relatively little of a restorative character if we include social with medical needs.

The British Royal Commission on the Poor Law when reporting in 1909 made majority and minority recommendations, both of which emphasise the point now under discussion. Thus the Majority Report wrote of the need for

> a genuine attempt . . . to transform into a living and helpful organisation the existing medley of independent and often harmful agencies for dealing with the sick people.

Similarly in the Minority Report it is stated—

> We agree in ascribing the defects of the present arrangements to the lack of a unified service based on public health principles.

The above statements are not inconsistent with the more recent development of contributory systems of medical treatment. Although theoretically much can be said in favour of fairly general gratuitous medical treatment parallel with present systems of gratuitous elementary education, the balance of argument and advantage in medicine is definitely on the side of personal or familial contributions when they can be made. Average humanity has not yet learnt to use communal privileges with due regard to communal economy in the absence of a personal motive for carefulness.

Medical Treatment on an Insurance Basis

In my *Public Health and Insurance* (Johns Hopkins Press, 1920) I expressed the view that the introduction of sick

ness insurance diverted attention from the more urgent problem of reformed and complete medical (including preventive) care for the very poor. I may quote from this source:—

> The inauguration of the Sickness Insurance Act meant an enormous increase in the direct relationship of the medical profession to the State. A great stride in the socialisation of medicine was taken. But it was done ill-advisedly; it continued a false and low ideal of isolated general medical practice . . .; and it diverted the energy and money which were urgently needed for the immense good obtainable by reform of the poor law and public health administration, and extension of their medical services.

In the chapter from which the above extract is taken I went on to state that had the alternative course indicated above been followed, it would have been practicable to advance to a nearly completely unified medical service for those needing help when ill. I was careful to indicate that—

> with the principle of contributory insurance to secure monetary support during illness there can be no quarrel; but in the interest of national efficiency complete medical provision, preventive and curative, must be made by the State, irrespective of insurance, for all in need of it; and the medical practitioners employed in the necessary certification of such insurance work as is continued must, if the insurance is to be satisfactory, be employed under conditions which will render them independent of the favour of the insured, and will enable them to utilise their knowledge of each patient's case for the needed preventive measures, whether these be concerned with the sanitation of home or factory or work-place, or with personal habits.

The above extract embodies my views as to the future possibilities of utilising the medical work of sickness insurance in the interest of preventive medicine. Further particulars on this important subject are given in Chapter VII.

Ad hoc Provisions

But whether medical care be gratuitous or on an insurance basis it must be available without stint for all needing it. My contention quoted above emphasised the necessity

in social improvements of building on and extending from what already exists, and of not multiplying machinery whenever a new or added need arises. In Britain, and to some extent in other countries, this creation of new and independent machinery whenever a new need emerges has been the bane of satisfactory and economic progress; and the Insurance Act as administered is the great example of this evil. Now, happily, the trend is back to intelligent co-operation and combination in the administration of all public medical services.

A Royal Commission has reported in favour of the abolition of independent insurance committees; the Local Government Act of 1929 unifies hospital administration for the destitute and for others, so far as it is provided by local authorities; there is a strong movement to make the special municipal clinics fit more closely into a general system of medical treatment; and gradually the work of voluntary hospitals will—through hospital contributory schemes or otherwise—doubtless be brought into close collaboration with municipal and insurance medical work.

The problem of medical attendance on insured persons is further considered in Chapter XIV.

The problems for the private practitioner involved in hospital services have been already discussed (pp. 97 and 106).

Summary on General Medical Practice and State Medical Services

86. The so-called encroachments by public health and educational authorities on private medical practice consist chiefly of "territory never previously occupied".

87. The treatment of acute infectious diseases in official hospitals has become almost completely socialised, in the sense that it is done at the public expense.

88. Immunisation against smallpox by vaccination is the oldest instance of the complete socialisation of medical provision.

89. Immunisation against diphtheria is increasingly being practised at the public expense.

90. The treatment of tuberculosis partially and of venereal diseases totally at the public expense is commonly practised.

91. In antenatal consultations, at infant welfare centres, and in school medical work there have been vast developments of socialised medicine, especially in the last two.

92. If family medical practice is to continue and succeed, it will be necessary that a team of doctors on the medical side shall be the counterpart of the family on the patients' side.

93. Medical treatment for the necessitous is provided with varying completeness in all European countries.

94. Medical treatment on the basis of previous insurance is fairly general in Europe, and its finance is always directly or indirectly assisted from State funds.

95. *Ad hoc* provisions for a special medical need are to be deprecated, when not intimately related to general medicine.

CHAPTER XIV

FURTHER CONSIDERATIONS ON PRIVATE MEDICAL PRACTICE

I PROPOSE to consider in this chapter some of the features of existing arrangements of private medical practice, in which medical practitioners of their choice are employed on their own initiative by persons and families, and possible alternatives to these arrangements.

THE CASH NEXUS

(1) Those who, like the writer, have had experience of private medical practice will be familiar with the difficulties involved in its cash nexus. These difficulties are not serious in medical practice among the wealthy; but among wage-earners and among those families in English-speaking countries whose income is less than, say, £800 (about $4,000 at par) the payment of medical fees for a considerable illness is serious and often very embarrassing. It is embarrassing also for the doctor, who desires conscientiously to keep down the cost of his attendance on the family, and who may consequently not give as prolonged or as frequent attendance as is desirable.

To many medical practitioners this position is most obnoxious, and they would welcome escape from it if this could be attained without loss of the intimate relationship which the family medical adviser secures and rightly prizes in private medical work, and which is a valuable factor in the welfare of the community. This would be safeguarded if medical insurance were to be extended to the dependents of those insured at present in Britain, and if in private medical practice a system of insurance for medical care were adopted generally on voluntary lines. Such a practice would strip medical practice of one of its main impediments to full utility. Extension of insurance for medical treatment on voluntary lines would be especially valuable

for those having incomes between £250 and £800 to £1,000. It should not be on a flat-rate basis, but, in accordance with long-established practice, should vary with the income of the insuring family.

The method here indicated has been widely adopted for many years in Denmark, the family doctor being paid an annual sum which does not vary with the amount of medical care required in any year. The Danish Medical Association has fixed the minimum rate for this service by the family doctor for a family in town at 50 kroner (18 kroner = about $5 or £1 at par), the rate increasing with the family's means. For this payment the doctor attends the whole family and advises in all questions of health.

I am informed by Dr. Frandsen, the medical head of the public service in Denmark, that the above arrangement has been most commonly made between doctors and the so-called middle and upper classes. It has been partially displaced during the last 10–20 years, because a large part of the middle classes have been admitted to the State recognised insurance societies, and to some extent because many of them wish to be free to choose their doctor according to the nature of their "illness".

Among OTHER DIFFICULTIES IN PRIVATE MEDICAL PRACTICE, as now conducted, the following, of which some have already been indicated, may be further considered.

(2) The necessity of replacing single-handed by group practice has already been urged as a practical means of securing the continuance of general medical practice. Except in rural districts, there is no serious difficulty in this reform; and it is—too slowly—taking place.

(3) The competition in towns between private practitioners is apt to lead to reduction of remuneration to an extent which almost necessitates shoddy medical work. In medical insurance work similar competition exists, which unfortunately is not determined mainly by professional merits. Patients have little skill in assessing medical skill; and their choice of doctor may depend on the cut of his coat, on his social qualities, and sometimes, alas! on his plausibility in explaining phenomena which he has not accurately analysed. These elements necessarily reduce the value of "free choice of doctor" in medical insurance work; though it remains true that the mere exercise of choice

tends to establish the confidence which undoubtedly helps a doctor in the treatment of his patient.

Shoddy medical work—work of a hurried character, in which treatment without accurate diagnosis is given—means crowded surgeries and hasty visits to enable the doctor to earn an adequate income. This evil is prevalent both in medical insurance work and in medical practice among the families of wage-earners which is not governed by a contract of service.

(4) Although calls for medical treatment increase, the ability to pay for this does not increase to the necessary extent. Doctors lose much of their earnings in "bad debts". The cost of medical attendance is causing some even among the middle classes to resort to free clinics. In some European countries, as we have seen, voluntary sickness societies are increasing which cater for the treatment of persons above the compulsory insurance level.

(5) Closely allied with the last difficulty is that experienced by the doctor of giving enough time to each patient to ensure accurate diagnosis. Time as well as skill is needed; and the conditions of much private and insurance medical practice make it difficult to give the necessary time and skill. THE DOCTOR FREQUENTLY UNDERTAKES FAR TOO MUCH WORK IN A LIMITED TIME TO BE ABLE TO DO IT WELL. It is extremely difficult to avoid hurried medical work. In present circumstances it is often only by undertaking more medical work than can be accomplished with complete satisfaction to himself that the doctor can earn an attractive income, and in these instances medical practice tends to become commercialised.

(6) A further great difficulty in private medical practice, not excluding insurance practice as conducted in Britain, is that the practitioner commonly is unable independently to supply specialised medical skill; and that he has no definite and authorised access to consultant and hospital facilities when these are needed. This is less true in most European countries than in Britain.

On the other hand, private medical practice as ordinarily

organised has the great psychological advantage that it embodies a deliberate responsible policy on the part of the head of the family; and one cannot deprive him or her of this responsibility without running the risk of favouring thereby a parasitic habit of life.

The ultimate and, I think, decisive defence of the family doctor consists in the continuity of his relation to the family. At his best he cannot be replaced. The ideal is only attained for a minority of the total families of the community, and is seldom attained for working-class families in towns. But when it can be secured it has a high social value. The best type of family practitioner, who, happily, can be found in any considerable community, is the family's guide, philosopher, and friend. Even though he may neglect to keep a single note of his cases, he is, nevertheless, the registrar of the medical history of each member of the family; and he is the guardian of that medical continuity which has a definite value. If he deserves the characterisation indicated above, he never presumes on his own omniscience. He is ready to consult when necessary with experts, but he then maintains his place as the liaison officer, and he takes a judicial view of each case as a whole and of the patient concerned in the case, and thus can prevent the lop-sided action which might otherwise be taken.

Modifications of Private Medical Practice

Many modifications of private medical practice have been suggested, and these must next be considered. In all of them the question of finance is involved.

(1) There is the proposal to extend present sickness insurance schemes in Britain to the extent generally prevalent in the rest of Europe, bringing entire families within the range of the medical benefit. This would still leave out families with an income higher than the present maximum limit of insurance, many of whom experience much difficulty in affording satisfactory medical service.

(2) The last-named proposal may be made to include consultative services and hospital treatment, or may leave

these to be independently provided. This additional provision is already made in part at least in insurance schemes in European countries. If these additional services are not included there will be needed extension of voluntary contributory hospital and allied services, and the continuance and probable extension of general and special municipal services.

(3) A complete medical service may be provided at the expense of the State, both domiciliary and institutional. Most doctors then would become salaried civil servants. Such a service would bring medical care, like elementary education, among the services which are paid for out of rates and taxes, available to all alike without social or monetary distinctions. Nor is the distance between this proposal and present conditions so great as may at first sight appear. At the present time a considerable proportion of the entire medical profession hold official or other public medical posts, many of them on a whole-time basis, e.g. medical officers to large businesses or to life insurance or accident insurance societies. Including medical officers in official services for treatment of the poor, at home or in hospitals, and in the various departments of public health administration, the proportion is still higher. If we, furthermore—as is justifiable—regard medical insurance work in national schemes as partially in the same category, then it can be said that the vast majority of the medical profession throughout Europe are already engaged in one or more branches of State medicine, i.e. of medicine which is supported or assisted from taxes or local rates.

Whatever system of medical service is adopted, the question of—

METHODS OF REMUNERATION arises. What are the relative advantages of payment according to amount of actual service (the number of "medical acts") rendered; or payment by salary; or payment *per capita* according to the number of persons in an insurance organisation who are allotted to a particular doctor, this amount being paid whether there is much or little illness needing treatment?

Remuneration in Private Practice

The objection which the fastidious doctor feels to "sending in a bill" for services rendered has already been emphasised. It is the most uncongenial and even disagreeable incident in medical practice.

Medical fees are varied according to the financial status of the patient, and in practice this adjustment according to means implies that well-to-do patients pay partially for the treatment of poorer patients. This was so before sickness insurance became compulsory for a third of the population in Britain. It is less so now, though well-to-do people still assist through taxation in the medical treatment of poorer patients.

The alternative to fees according to amount of medical work done is—

Contract Medical Work

This may be arranged, as already indicated, on a *per capita* or family basis, a fixed sum being paid annually for each person or family which enters into a contract with the doctor. Payment by salary by a public authority or by a hospital or an insurance society is another form of contract practice.

A Salaried Medical Service

The project of a salaried official service for the entire population, or for such portion of it as might be willing to be cared for medically in this way, has attracted many minds. It has been praised by some doctors who have been in similar service in the army or navy as well as by doctors in whole-time civilian posts. It can be argued for it that it avoids entirely the hateful presentation of accounts for services rendered, and that in any well-organised official service the doctor has a fixed and known salary, generally also a pension on retirement, that each year he has a definite leave of absence, and that arrangements are usually made for post-graduate work or for undertaking definite research.

In Britain, and to some extent in most other countries, there is an analogous provision of elementary education for all at the expense of the State, the teachers in charge of the service being salaried and pensionable.

It is frequently argued that whole-time salaried appointments are destructive of personal initiative and inhibitory to continued effort. This incidentally is a grave and undeserved reflection on present whole-time officers in the medical and in the scholastic professions. The reflection is deserved in individual instances, and these instances in the aggregate may bulk somewhat largely, but in my judgment they form but a small proportion of the total. In these instances security of tenure of office, relative or absolute, such as that, for instance, of civilian (including county and municipal) officials in Britain, reduces effort and short of this may and sometimes does stereotype and render static present methods of work.

But it cannot be said that intellectual stagnation and moral lethargy, when they occur in officials, are their special possession. With these occasional accompaniments of a too sure livelihood may be compared the medical work of an occasional medical practitioner in a poor district, his hurried interviews with patients, his too frequent treatment of many patients without diagnosis, the pile of weekly medical journals which one can see unopened on his table, and the inability to attend the meetings of medical societies, still less to cultivate post-graduate work.

It may be agreed that absolute certainty of a livelihood can have a paralysing effect on men with wrong ideals of life; and that there is therefore indicated the need for greater mobility and interchange of official posts, and for variations in salary which should not be accorded entirely by automatic rules, but depend in part at least on quality of service impartially adjudged. This adjudication is, of course, very difficult, and the cure may be more in the direction of increased mobility or mitigated security in office than of variation of salaries.

In institutional medical work there is an increasing trend

towards whole-time medical appointments with fairly certain tenure of office. This is a general practice in hospital medical work in many European countries. It is becoming so in Britain in the public assistance hospitals of local authorities, there being additional consultant physicians and surgeons when cases calling for their aid occur. The latter are paid by salary (part-time) or by fee for each visit. In the voluntary hospitals in Britain, the chief members of the staff are usually unpaid, and engage also in private practice, sometimes solely in consultation with other practitioners, sometimes also independently. I have already expressed my view that the staff, at least the junior staff, of voluntary hospitals should be salaried (p. 92). This would enable hospital committees to insist more successfully on prompt attendance of doctors and thus would avoid much of the present waste of patients' time in out-patients' departments. As these patients commonly make some payment, this ought ere long to be financially possible.

Admirable work is being done in hospitals both by part-time and by whole-time medical officers, and no case can be made against medical work in hospitals by whole-time medical officers, given opportunities for exchange in professional experience.

Although whole-time medical appointments are likely to increase in number, it is unnecessary to consider, at least for ordinary civilian life in Britain, the contingency of a State medical service for the population staffed by whole-time officials. The balance of advantage as well as of national predilection is, and is likely to continue to be, against this; and it may be regarded as both rigid and undesirable.

But although the idea of a whole-time State medical service for the entire population cannot be entertained, a State service composed largely of part-time medical officers is already actively in existence throughout Europe.

Not only is there a State domiciliary medical service for the destitute in all countries, and a large amount of

gratuitous institutional provision for them and for persons of limited means, but there are also the special public health medical services already described; and there is, last of all and greatest of all, measured by numbers within its scope, the insurance medical service of various countries. The service against which polemical discussion is often so heated already exists; and throughout most European countries, including Britain, the totality of State medical service as defined below is greater than the totality of private medical service, in which each family is responsible for its own medical arrangements. I include medical benefit under sickness insurance in the category of State medical service, though this inclusion is strongly contested by some. By State medical service I mean medical attendance undertaken on the basis of an agreement of doctors with a public authority or hospital committee or insurance organisation. This inclusion of hospitals and insurance organisations in my definition is justified by the fact that both of these are partially subsidised out of taxation, or, in the case of voluntary hospitals, out of general charitable contributions.

Contract Insurance Medical Service

The proportion of the total population coming within a State medical service thus defined varies in different countries. In Britain over a third of the population are insured, and about 42 per cent. of all registered medical practitioners are engaged in insurance medical work. If the insurance service were extended to the dependents of the insured and persons of corresponding financial position, as has been proposed by the British Medical Association, four-fifths of the total population would be included. In some European countries a considerable majority of the total population are already being treated under sickness insurance schemes. In France, and occasionally in other countries, the doctor is paid for each "medical act" according to a scale authorised by the insurance organisation, but he may charge his patient an additional fee or refuse to attend him.

Payment of insurance doctors may be made in other

ways. Exceptionally a salaried doctor is employed. Oftener a capitation fee is agreed for every insured person who is on a doctor's "panel", and the doctor receives this amount annually, whatever the extent of medical attendance may be. In half the cases on his list it may be *nil*, while it is heavy for a minority of the insured.

The general problem of good medical service under a State insurance contract has already been debated (Chapter VII). We have seen that in Britain the majority of the medical profession now favour it and advocate its retention and extension. In Europe generally it has become so firmly established as to render its displacement impracticable. With insurance medical work as controlled in Germany there is much medical dissatisfaction, and in some other European countries there are obvious abuses. The complete subordination of medical activities to lay administration in individual insurance societies is fraught with difficulties and implies much friction. In Britain the settlement of capitation fee by collective bargaining between the medical profession and the Government has avoided this difficulty.

On the whole there can be little doubt that the insured receive ampler medical care than they would have had if uninsured. In recalling the defects of medical attendance on the insured it is necessary to remember the perhaps even lower standard and scantier amplitude of medical work for non-insured persons in a corresponding social position.

Behind the whole problem of medical care is the general economic problem of the people. More complete medical care is required and the margin of income available for this is lacking, unless the standard of life, including many unnecessary luxuries, be simplified in other respects. This is the fact behind the growth of municipal medical services, and of contributory hospital schemes, and behind the general trend towards co-operative methods of medical treatment, which, while efficient according to modern standards, are more economical than individual effort can command. Many persons above the sickness insurance

income limit would welcome medical attendance on an insurance basis; and probably medical practice of the future will more and more be organised on insurance lines (p. 114).

The economic pinch is felt particularly when expert and institutional treatment is needed by families whose total annual income may be double or treble the maximum income of insured persons. (See also p. 245.) The same difficulty arises in the relative absence of institutional medical benefit under the British Insurance Act. If this be given in the future for insured persons, it is almost equally required for the non-insured just above the insurance level, to whom a severe operation, for instance, is a crippling burden.

These conditions must eventually issue in the more general provision of medical services for non-insured as well as for the insured. Hospital contributory schemes on voluntary lines point the way to a partial solution of this problem; but they will need to be modified and developed, contributions being graduated according to family income. They will need to be made actuarially sound for those who can afford to pay on the basis of average cost per hospital patient. Behind these contributions, taking the total experience, further funds must be forthcoming from charitable gifts or from general taxation.

Summary on Further Considerations on Private Medical Practice

96. In private medical work the practice of paying in accordance with number of consultations and visits is a handicap to satisfactory medical care, whether hygienic or clinical.

97. The same consideration makes it difficult to resort to specialists in doubtful and complicated cases, except when provisions to this end are made by voluntary hospitals and public authorities.

98. The general practitioner frequently undertakes far too much work in a limited time to be able to do it well.

99. For the above reasons modifications of private medical practice are needed for all except the rich. These may take the form of insurance associated with contract medical work. A complete State service of medical officials has also been proposed.

100. The cessation of remuneration for each "medical act" in arrangements for medical care would greatly assist in securing adequate medical care for the community.

The trend of events in the majority of European countries is in the direction indicated in the last sentence.

CHAPTER XV

PROPOSALS FOR THE CO-ORDINATION AND COMPLETION OF MEDICAL SERVICES

A STUDY of preceding chapters and of the methods of medical practice in different countries which have been outlined in these chapters, and more fully in Volumes I–III of *International Studies*, shows that these methods are deficient in orderly and economical adjustment of means to secure the maximum benefit to the community. It is not strange, therefore, that the medical and the public health world should teem with proposals for reform and extension. These proposals should not be allowed to disguise the fact that in all countries a large part of the medical services now in being are already nationalised, in the sense that they are provided otherwise than by the self-controlled effort of each person or family. What is needed in the main is the regularisation and partial extension of what already exists in inchoate forms.

A general remark is called for against most of these proposals of reform; they lack vitality; for as a rule they have not grown naturally out of existent conditions and provisions, and are not devised to be organically related to these. An initially imperfect and lop-sided scheme which has developed naturally and is normally related may be, and probably will prove to be, superior to a scheme which makes a more consistent or more complete show on paper. NO SCHEME OF MEDICAL DEVELOPMENT INVOLVING THE EXPENDITURE OF PUBLIC MONEY WHETHER OUT OF RATES AND TAXES OR DERIVED FROM CHARITABLE FUNDS IS LIKELY TO DO THE MAXIMUM GOOD WHICH IS NOT EVOLVED FROM WHAT IS ALREADY AT WORK. This is true on the financial side. It is true in large measure on the medical side. Further remarks on this point are made on page 102.

This proposition may not be universally accepted; but

it accords with experience and with sense; and I propose to regard it as a postulate throughout this chapter.

In stating this postulate, I have assumed also that STATE OR LOCAL GOVERNMENT AID IS NECESSARY IN ANY SCHEMES FOR THE CO-ORDINATION AND COMPLETION OF PRESENT MEDICAL SERVICES. This necessity is proved by existent large public expenditure in all countries on the treatment of sickness, and by a survey of present needs and possibilities.

PRESENT PUBLIC EXPENDITURE ON MEDICAL TREATMENT

In each country, certainly in Britain, the sum spent by public authorities on the treatment of sickness amounts to many millions sterling coming directly out of rates and taxes. In addition, there is the vast additional amount received for voluntary hospitals from private contributions and bequests (see, for instance, pp. 64 and 78, Volume III, *International Studies*). Lastly, there is the expenditure on the medical benefit in sickness insurance, about two-fifths of which comes out of public funds. In England, in 1928, the total cost of medical benefit, including drugs for 13,900,000 persons, was over £8,500,000. The total expenditure on sickness insurance that year was £29,254,710, and the total Government grants for all the purposes of sickness insurance amounted to £5,261,552.

All this expenditure would need to be continued and much increased if a more complete service were inaugurated. Some of the additional cost would be paid by the patients themselves; and the voluntary hospital contributory schemes already described (p. 95) illustrate the possibilities in this direction. But even with these conditions the needed codification and extension of medical services would require large increase in present public grants, so it may be said truly that finance governs future possibilities.

FAMILY SCHEMES OF TREATMENT

There is no serious difficulty—except that of finance—in groups of doctors forming independent schemes for medical

treatment on a co-operative basis, and a number of such schemes exist. Similar arrangements between individual families and a doctor have already been noted (p. 249). In many medical practices, e.g. in mining districts, dependents of the insured are treated on the basis of a *per capita* or per family insurance charge.

These schemes, however, fall short of needs in that they provide only medical care by general practitioners, reinforced to some extent by co-operative action among these. In themselves such schemes are good, if the doctors are strong enough to avoid the imposition by their employers of terms of remuneration which tend to inhibit good service. Past experience in Britain shows how often this direct relation between the doctors and the co-operative society (for such it is) which employs them has yielded this disastrous result.

There are instances to the contrary. In Chapter XVIII, Volume III of *International Studies* I have described the experience of Swindon. This is a town of some 65,000 people in the Midlands of England, the majority of whose male adults are employed in the Great Western Railway works. Almost the whole of these workers and their families are joined in a single voluntary society, assisted by the Great Western Railway in their supply of central buildings for clinics and a hospital. A fixed fee is paid weekly, which entitles the workers to the benefits under the National Insurance Act, and gives, in addition, consultative facilities for each family at a central institution, considerable hospital and dental treatment, as well as domiciliary medical attendance for the entire family when needed. There is no choice of doctor for this domiciliary work, but there is for consultations at the centre. Swindon thus presents an instance of almost complete family medical attendance, satisfactory in the skill available, and going far beyond medical insurance arrangements in the national scheme. Similar schemes are to be found in other countries. Evidently, then, British compulsory insurance for medical attendance can be extended on a mutual basis to meet

nearly all needs. It will be noted, however, that to secure economical working, there is no complete choice of private doctor in the Swindon scheme. This is a town of fairly uniform social status and its population is employed at a single centre; both factors must assist in securing the success of the scheme. Swindon is the nearest approach in England to a medical service which meets the needs of the great majority of an urban population of a fairly uniform social composition. But even in Swindon the additional municipal facilities for maternity and child welfare and for the treatment of tuberculosis and venereal disease are needed, as is also the institutional and domiciliary medical care provided for the very poor by the public assistance committee of the health authority.

It can safely be concluded that arrangements for complete medical treatment of a wage-earning industrial community must be aided from rates and taxes to enable them to be complete, unless an exceptional amount of charitable money is available, and is uniformly available, to fill up the gaps certain to be left in a privately organised scheme for medical treatment for wage-earners. This becomes more evident when we recall the need for the special skill provided in large hospitals.

The truth of the postulate stated on page 57 is equally indisputable. The problem of medical care can no longer be solved completely by direct family payments. It has become a problem of arranging for insurance payments guaranteeing medical care when ill, supplemented when really necessary by national or local taxation. There is no other way, except that of a complete medical service supported entirely by taxation.

Advantages of an Organised Medical Service

If a completely organised national medical service for all needs were developed on the partially provident or insurance lines indicated above, it would present the following advantages, assuming that the system incorporated safeguards against undue competition to secure

patients between local medical practitioners. Unless this fear is in large measure eliminated, the use of a common consultation or health centre by all the practitioners in a district is likely to prove impracticable. Even assuming this competition to continue, most of the advantages set out below would accrue from a combined medical service organised on the lines suggested in the following paragraphs.

(1) The general medical practitioner should be satisfactorily related to consultants and hospitals and have within reach the pathological facilities often required for diagnosis or for satisfactory treatment.

(2) The general practitioner should be paid on a family basis, in which the anti-hygienic influence of payment per visit has been eliminated and precise arrangements should be made for him to give family advice on the preventive lines indicated on pages 118 and 185, as well as for obtaining additional help in difficult cases of illness when he required it.

(3) If each general medical practitioner acted in collaboration with the group of practitioners in his own district, it would be possible to organise common surgery hours at a primary consultation or health centre (see p. 226). This centre would have appliances and facilities, including a nurse, which the doctor's private consultation room usually lacks, and there would be the daily possibility of conference with medical confrères. A great need in an ordinary doctor's surgery is a nurse to assist in preparing patients for examination and in bandaging, etc.

A large part of a doctor's time in industrial and insurance work is occupied in writing certificates and in making records. Secretarial help which could be made available at a health centre would save this valuable time for strictly medical work.

(4) A necessary development which would fall into place in a completely organised service is a staff of PAID CONSULTANT PHYSICIANS AND SURGEONS, general and special, FOR DOMICILIARY SERVICE, whom the medical practitioner could send for to meet him in the home of the patient, when the

removal of the latter is not indicated or is too dangerous to be attempted, or when the practitioner is uncertain as to the right procedure. On page 104 of Volume III of *International Studies* I gave illustrations of serious failures in diagnosis on the part of inexperienced or careless private practitioners, patients being admitted to a public assistance hospital at a stage when they were in an almost hopeless condition. On the other hand, many patients are unnecessarily sent into hospitals. Much public money is thus wasted, especially in regard to cases of infectious disease. A large number of further cases are ill-diagnosed and badly treated by a limited number of general practitioners. These cases are exceptional, but in the aggregate they form an evil of serious magnitude. Reasons other than ignorance or carelessness may lead to occasional bad treatment in private medical practice. A case may be essentially difficult or of dubious nature; or it may merely be that the doctor finds it awkward to send his patient to hospital without reflecting on his own skill. For all these cases a staff of officially paid consultants available for the general practitioners in each district would render valuable public service.

The home consultant service would include general consulting physicians and surgeons and specialists. It would also comprise consultants in accident cases involving claims for compensation; and the expert services of the medical officers of all official clinics (tuberculosis, venereal disease, maternity and child welfare) would of course be available. If this comprehensive service were provided on an insurance basis, with partial or complete exemptions from payment for the poor, and if hospital treatment were made adequate in all communities and economically used, the community would secure a complete medical service without serious change in the present relationship between the family doctor and his patient. It will be recalled that in obstetric work the need for domiciliary skilled consultations is especially great; and that for acute infectious diseases the medical officer of health usually holds himself in readiness for consultation with private medical practitioners.

(5) A completely organised medical service would imply a greatly improved relationship between the private medical practitioner and the various consultation and treatment clinics of public health authorities, and would gradually abate the present partial isolation of these individual services.

The chief official clinics concerned are:—

(*a*) Infant and child welfare centres.
(*b*) School clinics.
(*c*) Tuberculosis clinics.
(*d*) Venereal disease clinics.

Recently a few official DIAGNOSIS CENTRES FOR CANCER have been initiated in England, and they would come into the same category. The intention of these centres is to give an opportunity for persons suffering from suspicious symptoms to obtain advice which may reassure them or may lead to their being referred to the doctor of their choice if they can afford to employ one, or to a hospital. It is too early to write definitely as to their prospects of effective work.

THE CESSATION OF THE ISOLATION OF CARE OF ANY ONE DISEASE FROM THAT OF OTHER DISEASES IS DESIRABLE, while retaining the special skill of the expert in the treatment of the one disease. An effort in this direction is illustrated by the SOCIAL HYGIENE DISPENSARIES organised in some parts of France (see pp. 69, 106, and 113 of Volume II of *International Studies*). These are polyvalent dispensaries, at which infant consultations are held, as well as tuberculosis and venereal disease clinics, sometimes also clinics for the early diagnosis of cancer. They represent a step away from the segregation of clinical work for special diseases. In Britain, as seen in the local examples in Volume III of *International Studies*, health centres (not usually so-called) exist in some areas in which school clinics and infant consultations are held at different hours. Subject to suitable precautions, there is no reason why the same centre should not more often be used for tuberculosis medical work. Some economy in nursing staff as well as increased opportunities of intercommunication may be thus secured

between the doctors and nurses of these three official departments of medical work.

(6) A completely organised medical service would facilitate interchange of patients and of consultations between the official services enumerated above and the staff of voluntary hospitals. Such inter-consultations would not constitute the only advantages accruing from this collaboration; for the private medical practitioner or the group of medical practitioners in a local centre would be able equally to arrange for consultations with the staff of the larger hospitals, and for hospital treatment when needed. Where there is a cottage or district hospital staffed by local general practitioners, similar privileges will become available for the patients of the cottage hospital.

I am assuming the continuance of large voluntary hospitals, with and without schools attached to them for the training of doctors, midwives, and nurses; and there is no need to assume otherwise, if the hospital contributory schemes already existent become general and are organised on a basis which will graduate family payments for possible future hospital treatment on a basis of income. But there will also be needed some partial subsidisation from official funds.

(7) There remains another supremely important link in the chain of a completely organised medical service, that of the public assistance hospitals of local authorities. In Britain these have rapidly developed and in populous centres are worthy to rank with the best of voluntary hospitals. They present certain advantages over the latter: for public assistance hospitals are so distributed in every county and town area as to provide a hospital available for those needing it. No patient needing hospital treatment can be refused, and chronic as well as acute cases calling for hospitalisation must be treated. Some public assistance hospitals are inferior in quality; but rapid improvement is occurring. These hospitals are now available for the non-necessitous on payment, which is graduated according to means.

Some of them already have out-patient departments; and this indicates the possibility of their future development towards combining a number of clinics on the same site, including often the present special clinics of public health authorities. Either by means of the staff of these public assistance hospitals or otherwise, paid consultants for seeing patients at home in consultation with the private doctor will, I hope, ere long be organised (p. 260).

Comparison with Existing Conditions

The enumeration just made of the desiderata of a good general medical service in which private and public and quasi-public medical facilities would be efficiently related, shows existing arrangements in most countries in an unfavourable light. The defects of British arrangements have already been pointed out. Some of them are in process of rectification. In Denmark, and to some extent in Norway and Sweden, there is a less complicated medical system, and the general medical service for the poorer people, and especially the very complete hospital arrangements and midwifery service, in these countries call for imitation in many respects.

In Germany, while much high-class work is being done, there is even more confusion between various services than in Britain. Hospitals are official and are partly supported out of taxes and partly by insurance funds; the midwifery service outside hospitals is sometimes unsatisfactory; and there is much inco-ordination between the medical provisions of sickness and invalidity funds; while insurance funds are doing much work which is identical (especially in child welfare, tuberculosis, and venereal diseases) with that partly organised and supported out of taxes.

In Central and Eastern Europe there are overgrown polyclinics, including special treatment centres for the insured, very unsatisfactorily related to the domiciliary treatment given by insurance doctors. The list might be extended, but reference may preferably be made to

Volumes I–III of *International Studies*. Evidently, then, there is a widespread lack of co-ordination and co-operation between different agencies concerned in the treatment of disease. There are two chief reasons for this almost universal disorder, which are instructive for communities still looking ahead as to right avenues of advance.

(1) There is the already indicated apparently incurable tendency of the social reformer when promoting advance in some new branch of hygiene or medicine to create new machinery for the purpose (see also p. 241). The outstanding instance of this is the medical attendance in sickness insurance. Its admitted inadequacy in Britain might have been obviated, in large measure, if medical benefit had been kept outside the range of insurance, or if the previous medical provisions under the State had been remodelled, removed entirely from poor-law control, and arranged for the entire population below the upper limit of income for sickness insurance. Had this been done, the hospital provision in public assistance hospitals would at once have become available for the insured, as also the special public health clinics enumerated on page 262. This unification in the main still remains to be effected (see also p. 259). This *ad hoc* VICE, as it may not improperly be named, arises in part from the human motive of desire to "run one's own show", and in part from monetary and other considerations. It is easier to secure isolated advance at one point than to organise measures which, while assisting advance, will fit in with the general situation.

(2) Voluntary medical and health agencies in the past have been especially responsible for the initiation of *ad hoc* reforms. A particular need arises, this appeals to a group of voluntary workers, and subscriptions are readily obtained. When the new movement becomes organised some paid workers are employed; and then the continuance of the *ad hoc* work is strengthened, not only by the loyalty of the voluntary zealots, but also by the interests of the paid officials. There is a good side to the *ad hoc* vice, whether the special agency be voluntary or official. It enlists eager

unpaid workers, and spreads the gospel of social amelioration. This is good; but it ought to be practicable to be intelligent as well as emotional; and when it becomes clear—and ere long this happens—that there is overlapping and uneconomical working in medical arrangements, such changes as will ensure the maximum of effective work with the minimum expenditure of energy, financial or human, should follow without loss of moral impulsion.

Reference should be made at this point to pages 101 to 107 in Chapter VI, on which are given some particulars of schemes proposed for co-ordinated hospital and private medical work.

Summary on Proposals for the Co-ordination and Completion of Medical Services

101. Schemes of altered and extended medical services which are practicable and have a prospect of continuity are those evolved from what is already in being.

102. Financial aid from State or local governing bodies is inevitable in any scheme for the co-ordination and completion of present medical services. Thus national or local taxation must supplement provident or insurance organisations on the part of those who are made eligible to receive treatment under the scheme.

103. Payment of the general medical practitioner on a family basis, independent of the fluctuations in the amount of medical attendance required, will make such a scheme practicable on his side, and can be utilised to advance rapidly the interests of preventive medicine.

104. The local formation of health centres or joint consultation clinics, for general practitioners and consultants, non-official and official, should form an essential part of such a scheme.

105. There is also great need of a service of consultant physicians and surgeons, general and special, and of obstetricians of consultant rank, officially paid in part, available for general practitioners among the poorer sections of the population.

106. While maintaining the skilled services of special clinics, it is desirable that their relative isolation from other special and general clinics should cease under the proposed scheme.

107. The scheme should include the co-operation of the voluntary hospitals of an area.

CHAPTER XVI

OBSTACLES TO PROGRESS IN MEDICINE

FROM the preceding review of medical work in various countries, and particularly in Britain, it is clear that phenomenal advance has been made in medical science, and in its application to the benefit of mankind; also that medical science has been utilised in different communities to a variable extent. It is clear, furthermore, that in every country there still persists a great gap between the amount of scientific knowledge fully available for the treatment and prevention of sickness and the extent to which this knowledge is applied to these ends. The joint responsibility for the failure to secure the full realisation of the improved health which is within the reach of the public is attributable to the ignorance of the majority of the general public, the parsimony and indifference and still more the conservatism of public authorities responsible for enlightening the public and for adopting appropriate measures, and the absence of cohesion between various branches of the medical profession and its ancillary services.

Two points need to be recalled in this connection.

FIRST: Although much invaluable preventive knowledge fails to be utilised, there remains much disease the means of preventing which is still unknown. It is possible, for instance, to treat cancer by prompt action, to cure appendicitis by operation, and to remove adenoids which, if neglected, will produce deafness and artificial stupidity; but our knowledge of the means for preventing these and many other diseases is rudimentary and unsatisfactory. A large part of medical practice is still unscientific, and necessarily will remain so until our knowledge of healthy and morbid physiology and psychology becomes less incomplete. But even in the large region in which medical practice remains empirical, the medical practitioner of experience and

judgment is able to render important service to his patient; and it is particularly in this wide area of medical practice, though not exclusively in it, that the older-fashioned general practitioner of medicine remains supremely useful. This fact emphasises the importance of the further point, that

SECOND: No system of medical practice which does not ensure the continuance of the work of the general medical practitioner can be regarded as compatible with the greatest good of the people. This point, which has been made in previous chapters (see, for instances, pp. 197 and 229), need not be further stressed here. But I make the point in this connection in order that such criticisms as follow may not be read as reflecting on more than the minority of general practitioners who from time to time have been responsible for inferior medical work and for non-co-operation in public health and allied measures which favour the progress of preventive medicine.

It is the aim of every medical practitioner who realises the responsibilities of his calling to prevent illness, to curtail its duration when it already exists, and to give such counsel as will prevent its recurrence. In disease which must end in death his object is to alleviate suffering and to aid in giving mental and physical comfort to the patient and his family.

Why in every community do some of these possibilities of medical utility to a greater or less extent fail to be realised in practice? The responsibility for relative failure must rest with public authorities and their officers who are responsible for medical and hygienic work, with voluntary medico-hygienic charities whose work is inefficient or unrelated to similar work by others, with educational authorities who fail to take the steps needed to raise the general standard of hygienic intelligence, and with individual medical practitioners who do not pull their weight in clinical or preventive work. The last-named neglect is not special to private medical practitioners. It is seen in public health officers and other medical officers engaged

in official work; and this manifestation of human frailty cannot be entirely eliminated, though it can be steadily reduced.

I am not concerned with apportioning responsibility for the existence and continuance of these various obstacles to medical progress; and I have already indicated that obstacles due to our present limited knowledge cannot be removed until medical science is further advanced.

Many of the above-indicated obstacles have already been described in previous chapters. Here I am attempting to give a shorter and more general conspectus, the statement of which, even though it involves some degree of repetition, may be of help to the more general reader.

These obstacles to medical progress occur in individuals, and in the organised medical activities of each community.

Individual Obstacles

Obstacles arising out of the non-existence of the science needed for progress need not detain us further. It is with the vast amount of failure on the part of the public, of their elected representatives, and of some medical practitioners to utilise existent science that we are concerned. This failure arises from many factors, some of which may now be mentioned.

The medical profession, like the rest of the community, comprises those with a conservative and those with a progressive mentality. It is largely because a large proportion of medical practitioners believe in the old ways, and their minds are not open to the rapid advance of medical skill, that specialist aid has been sought for by patients beyond its necessary scope, and that clinics in various branches of hygiene and medicine have multiplied and extended beyond what would otherwise have been needed.

The history of medicine and current experience of the practice of medicine in all countries alike serve to illustrate the slowness with which advances in medicine are applied; with the result that one sees illustrated in a single genera-

tion, or even at the same time in the same town or village, the practice of obsolete and inefficient medicine alongside of the practice of scientific medicine, which continues to retain all the good elements of the highest type of general practice of an earlier generation.

The story of Childbed Fever illustrates the slowness with which new conceptions and discoveries receive general assent. Oliver Wendell Holmes wrote in 1843 his first essay on "The Contagiousness of Puerperal Fever" from patient to patient. His views were traversed, and his fuller monograph on the same subject published in 1855 was regarded by a distinguished medical contemporary as consisting of "jejune vapourings."

Ignaz P. Semmelweiss almost contemporaneously published researches proving that decomposed organic material, as, for instance, from uncleansed hands, produced puerperal sepsis, and he showed how this infection might be prevented. But his views were scouted by most of his contemporaries; and even now there is much puerperal sepsis which might be avoided, as may be seen by reference to Chapter VIII of this volume.

In this instance, prejudice, or the power of tradition, or a lack of appreciation of the risks of sepsis, or unwillingness to obtain the help which might have prevented the traumatisms favouring sepsis, have all been concerned in the continuance of a vast amount of avoidable maternal suffering and mortality. In a minority of cases sepsis was due to unavoidable circumstances; and in the remaining instances this great calamity in family life has been avoidable, but not avoided.

The story of Scurvy is a further illustration of the great delay which so often occurs before knowledge of prevention of disease is utilised. The Dutch knew in the sixteenth century that fresh fruit and vegetables would prevent and cure the scurvy common in long sea voyages.

Dr. James Lind, in 1754, urged that the necessary action should be taken to suppress scurvy in the British Navy, but forty-one years elapsed before this counsel was applied

practically, and a daily ration of lemon juice was required to be taken by all sailors in the navy.[1]

For many years it had been known empirically that small doses of cod liver oil were curative in Rickets. More recent clinical experience and actual experimentation have proved that cod liver oil along with open-air conditions of life and access to sunshine can be depended on to make rickets as rare a disease as chlorosis now is. And yet rickets—although greatly decreasing as the result chiefly of the child welfare movement—is still the indirect cause of heavy child mortality, and through its production of permanent deformity of the pelvic bones is a very serious cause in adult life of maternal damage and death in parturition. Here, once more, knowledge exists, but its application lags. Need this continue if every general practitioner utilised the opportunities he enjoys in his unrivalled access to the homes of the people?

The means of preventing Tuberculosis whether from bovine or human sources of infection are well-known; but this disease, though declining, is still one of the chief causes of premature mortality and of prolonged sickness in the community. The public, a large part of it, do not realise the importance of drinking only pasteurised milk and of the simple precautions needed to ensure that the patient with open tuberculosis shall not infect others, and especially the young in the same family. Many patients neglect to obtain early treatment, and it remains true that some patients still fail to be diagnosed and treated satisfactorily by the practitioners responsible for their care. A more rapid decrease in tuberculosis would occur if every practitioner not only used available facilities for prompt diagnosis and satisfactory treatment, but also impressed on the families regarding him as their adviser the need for medico-hygienic action.

Invaluable work for the prevention of Syphilis by secur-

[1] Fuller particulars of these and similar instances are given in the two volumes quoted on page 30; and Dr. Bernhard J. Stern's *Social Factors of Medical Progress* (Columbia University Press, 1927) gives an admirable review of the subject.

ing its satisfactory treatment is being done in many countries, and as concerns Britain I have borne testimony to the public-spirited manner in which the general medical profession have endorsed the treatment of venereal diseases by special doctors employed by public authorities. But there are large spots even on this bright sun. It is impossible to track out and give the necessary treatment to a large number of cases of undetected syphilis, except with the consent and co-operation of the family practitioner, and this is difficult to obtain under present conditions of medical practice. The family doctor knows, for instance, of the repeated miscarriages which may mean maternal syphilis, and it is not surprising—in view of the financial arrangements of present private practice—that many such cases fail to obtain the needed anti-syphilitic treatment.

It would be easy to multiply examples, but I will give only one more, in which in European practice desirable action still implies courageous initiation on the part of the family practitioner beyond what is often displayed. Vast numbers of children die unnecessarily each year from Diphtheria. If every doctor seeing a sore throat which he suspects may be diphtheria would at once administer diphtheria antitoxin without waiting for confirmatory laboratory diagnosis of the case and its dubious result, a large part of the holocaust of children from diphtheria would vanish! This fact is well-known. It is almost too obvious to call for repeated statement; and yet the needed promptitude of action is lacking on the part of a lamentably large number of medical practitioners. When will this unnecessary delay —an inertia which is against light and knowledge—cease? Only courage, a full appreciation of the essential need for a contingent diagnosis and for prompt action and an absence of moral inertia, are needed to end the present serious loss of life, when this is caused by medical procrastination.

Greater courage and somewhat fuller knowledge are needed to secure the adoption of prophylaxis against diphtheria by the administration of toxoid-antitoxin. But here,

as in the case of vaccination against smallpox, is a field in which the private practitioner can become a valuable auxiliary in public health work (see p. 234). In the State of New York I have seen the remarkable success attending the work of specific prophylaxis against diphtheria. This success is in part due to steady and persistent appeal to parents through the microphone and by other means. The family doctor has been almost pestered into action; and public health officers have then willingly given a supply of serum with instructions to the family doctor to enable him to protect the children whose medical care is entrusted to him.

In some of the above illustrations there has been failure to utilise valuable preventive knowledge which one would expect to be known by all. For much of this failure the public must be held primarily responsible; but some doctors cannot avoid a measure of responsibility; there has been failure in the stress of daily work to maintain openness of mind enabling one to consider daily responsibility from the viewpoint of preventive medicine.

The conservative mentality to which I have already referred governs the majority of mankind. It represents the summation of personal experiences and the additional weight of the large mass of mental conservatism in the community. The doctor's mental development, like that of the mass of mankind, may stop short when he leaves school and college; and his thoughts and outlook may remain static, like those of many of his contemporaries. Happily in the medical profession this human characteristic is becoming less common; but its existence explains in large measure the special consultative centres and clinics of public authorities, and the undue and excessive resort to specialists and to hospitals for illnesses which are well within the capacity of the family doctor, aided by an occasional consultation with an expert confrère, at a clinic or otherwise.

One cannot reasonably expect a uniformly high standard of general medical skill in all practitioners. Available knowledge does not sink into the minds and influence the work

of all alike, and we may be glad that what may be called the latent period or period of incubation of better medical treatment is happily becoming shorter than in the past.

At the same time there is great public need for better education of medical students, for increase in use of post-graduate instruction, and for the steady pressure of medical and public opinion to bring backward and careless doctors up to the high level of their colleagues. Above all, there is supreme need for the introduction of the teaching and the practice of preventive medicine into the teaching and practice of every branch of medicine and surgery, and especially into that of obstetrics. This desideratum is only limited by the limitations of our knowledge of causation and prevention. If this ideal cannot be attained except by jettisoning some details in anatomical and other knowledge demanded from medical students in specialist departments of medical practice, the sacrifice is well worth while.

But individual obstacles to medical reform do not exist alone. There are equally great—

Obstacles in Medical Organisation

The general public necessarily takes a hand in the collective supply of medical aid, for they furnish a part or the whole of the funds to carry it out. We have seen that general medical practice may be made more efficient when carried out by co-operative groups. Financial reasons render the application of Group Medicine, unless aided by public funds, difficult or impossible except for the well-to-do, especially if Group Medicine includes the paid collaboration of experts in special branches of medicine and hospital treatment. Even in the United States, in which this form of medical practice has been largely developed, it cannot be made to pay its way for the masses of the people; certainly not if hospital treatment is included within the work of the group.

The Limitations of Group Medicine

Let me interpolate at this point remarks supplementary to those made in previous pages as to the relatively limited

scope of group medicine and of special expert medical aid.

The public mind is too much obsessed with the wide necessity of specialist medical aid; so much so that the scope of general practice has become seriously and unnecessarily restricted. In some parts of New York State, for instance, it is difficult to secure the services of a doctor for the ordinary complaints of children. Doctors migrate into towns and attempt specialist practice, leaving families unable to obtain more general medical help for the common ailments which constitute the bulk of medical work. Some years ago this problem was investigated by the late Dr. Hermann Biggs, the Commissioner of Health for the State, and legislation was proposed for the provision at the public expense of travelling expert clinics available for consultation with local doctors. Had such clinics been generally inaugurated, they would have greatly helped in retaining practitioners in remote rural districts.

With increasing education in the preventive side of medicine it will be practicable to widen the utility of the general practitioner as well as to reduce excessive trend to consultants. The general practitioner will, furthermore, be ready to undertake in the course of his daily work much of the work now carried on at child welfare centres. But to this end it appears indispensable that the remuneration of the private practitioner must be arranged on new lines (p. 259).

Group practice on co-operative lines for the majority of the community is only practicable if fees on a low scale are accepted; and there will remain the need for assistance through hospitals and special clinics. The burden on the community can be reduced by adopting a system of insurance of families for hospital and special services; and where no such system now exists, insurance for hospital treatment and for consultative services should come first, as being the part of medical attendance which the wage-earner finds himself most incompetent to obtain except from charity.

Objections to Special Clinics

Further comments may be made on objections which some general practitioners continue to urge against special clinics and consultation centres, especially those organised by public health and education authorities. These objections are usually raised by a small minority of medical practitioners who have assumed control of divisional county or State medical societies, while the majority of the medical profession disapprove of their obstructive agitation, but stand aside and are too busy to intervene in "medical politics". In some parts of the United States visited by me medical politics were regarded by the majority of medical practitioners with the contumely which attaches, alas! to "politics" and to "politicians" in the minds of a large part of the total population. Could these non-politicians be brought to regard the practice of politics as an essential part of their social religion, public health and other departments of public administration would become almost immeasurably more efficient, the word "politician", whether the work involved is medical or lay, would lose its sinister connotation, and medical, especially its public health problems, would cease to be misrepresented by a small organised minority of doctors.

Meanwhile, public opinion when educated favours advance in all branches of medico-hygienic work; and the justification of, and the necessity for, the educational activities of non-medical social organisations to promote this work need only be continued and extended to ensure ere long the affiliation and active support of the great body of medical practitioners.

The history of the medico-hygienic activities of the general medical profession in Britain augurs well for the future of like work in the United States. This history is one of steady emergence from a relatively narrow "trades-union" point of view to a statesmanlike position, in which endeavour is made to place first the welfare of patients and the public, and to utilise every medical practitioner

as a unit in maintaining and advancing the common health.

I have already mentioned VENEREAL DISEASE CLINICS as an exceptional instance of public action for the treatment of disease adopted in several countries almost without friction with private practitioners, and as having received in some countries the cordial endorsement of the organised medical profession.

TUBERCULOSIS CLINICS have not been so universally welcomed by medical practitioners, and the consultation facilities provided by them are still inadequately utilised by many practitioners to the detriment of their patients. Reference may be made also to page 209 on this subject.

CHILD WELFARE CENTRES have been widely resented in different countries, and attempts to cramp their usefulness have been frequently made. Similar objections have occasionally been made to the home visits to mothers made by health visitors (public health nurses). This subject has already been rather fully discussed (see p. 190, and various chapters in Volumes I–III of *International Studies*). Public authorities and voluntary agencies cannot abandon their work or reduce its amount in present circumstances. On the contrary, in many districts and countries its extension is needed. When medical practitioners increasingly adopt the method of remuneration suggested on page 249, when they set themselves actively to engage in the hygienic supervision of the families entrusting themselves to their care, it may be possible to reduce the scope of public work having the same object. Under present conditions of private medical practice among the vast majority of the weekly wage-earning population, such decreased public activity would constitute a public calamity. The proposed extension of medical benefit in Britain to the dependents of insured persons would theoretically make it practicable partially to supersede child welfare centres except in one important particular stated in the next paragraph; for it would imply a fixed annual payment per family instead of payment according to number of actual medical consultations and

visits. But under national sickness insurance on a similar financial basis this hygienic extension of medical practice has remained substantially undeveloped in all countries in which I have conducted inquiries. Would the same hold good under the suggested system that all families should pay an annual fixed sum for complete medical attendance? It would almost certainly be so, in the absence of much further enlightenment of mothers on health matters, and unless practitioners generally devoted more time to training in the hygienic side of medicine, and unless specific regulations were made as to some of the hygienic work proposed to be done.

In the last paragraph I have referred to an item which is lacking in the outfit of the private practitioner, which for the poorer population must continue to be supplied by public authorities, both for the pre-school child and the scholar.

Doctors cannot undertake the detailed hygienic counsel and guidance which mothers often need in the management of their children; nor can doctors advantageously be asked to treat the vast number of minor complaints which occur. Those familiar with school clinics and child welfare centres will remember the minute instruction needed as to the preparation of foods, as to feeding bottles, storage of food, baths and bathing, exposure to fresh air and sunshine, and as to the treatment of sore fingers, septic sores, eczema of the head, and many other minor ailments which would occupy a doctor's time inordinately, but which when neglected may seriously affect a child's health.

Unless doctors in group practice are prepared to employ nurses, not only in their surgeries, but in frequent visits to industrial families, the beneficent work of health visitors and school nurses will need to continue and to be increased.

SCHOOL MEDICAL INSPECTION in some American visits I have found to be strongly resented by private medical practitioners. If "the children of their patients" are to be medically examined, then these doctors contend that they must be employed to undertake it. This impracticable and

unreasonable attitude still persists to some extent; but in most countries there is frank acceptance of the value of medical inspections by special school medical officers; and there is even an increasing appreciation of the fact that the discovery of ailments in scholars has led to increased medical work for the family doctor.

This "feeding" of the private practitioner with work is an actual fact, although much more of the medical work found necessary in school medical inspection is work which in the past has not been undertaken by most general practitioners, for it needs specialist skill. This applies especially to the correction of eye defects and to the satisfactory treatment of diseased tonsils and adenoids and of deformities in children. There is, therefore, need everywhere for school clinics or for arrangements for the treatment of many school children at hospitals, the school authority paying for hospital treatment at an arranged capitation rate, part of which may be paid by the parent. The medical treatment now undertaken at pre-school and school-clinics excites much less opposition than in the past. Medical practitioners, certainly in Britain, now realise that it is in the public interest that pre-school and school children should be inspected medically, and that so long as, failing this provision, a large number of children would remain untreated, official provisions for the treatment of infants, children, and youths must continue.

Those desiring to trace the evolution of medical opinion in Britain from its "trades-union" attitude on public medical work for children to its present liberal and statesmanlike position may advantageously consult pp. 207–210 in this volume, and especially pp. 367–376 of Volume III of *International Studies*.

The illustrations there given show clearly the rapid growth in public and medical opinion and action, and are especially instructive in relation to those places in the United States in which school medicine is still in the infantile or even embryonic stage.

THE CARE OF MATERNITY provides perhaps the most

striking illustration in British experience of opposition by a part of the medical profession to needed reforms. For centuries the care of women in childbirth has been shared between doctors and women who were neighbours or others who had acquired some rough skill from experience of many similar occurrences. From the middle of the nineteenth century a number of doctors, especially those engaged as obstetric specialists, agitated in favour of better training for women who attended confinements for gain, and for prohibition of the practice of untrained women. For years this movement was successfully opposed by a majority of the medical profession. Much of this opposition undoubtedly arose from fear that midwives, if trained and regularised, might supersede medical men as obstetricians. Their Demetrian motive was identical with that which influenced the silversmiths of Ephesus to call a town meeting of protest on the occasion of the visit of the Apostle Paul. Others—possibly a majority of the opponents—were convinced that mothers' lives and health would be endangered were they confided to the care of even trained women in their hour of need. But the movement spread; and the humanitarian motive which ensured its ultimate success was identical with the motive which must ensure the extension of many forms of medical treatment at the public expense, if in the absence of such provision illness goes untreated or maltreated. The handy-women and untrained midwives whom it was proposed to supersede were responsible for much avoidable suffering, and the training of midwives and the gradual supersession of untrained women was the practical way out of this evil state.

From 1902 onward midwives have been required to be trained before they can practise, and untrained midwives practising before that year are only permitted to continue to practise on sufferance. The process thus initiated has proceeded further than this. The majority of confinements are now attended by trained midwives, and the British Medical Association, representing the vast majority of medical practitioners in Britain, has recommended the

adoption of a National Scheme which is based on the assumption that a midwife suffices for normal accouchements, subject to the condition that antenatal, and when necessary intranatal and postnatal, medical care is available.

The story of midwifery in Britain, and the even more general employment of midwives in European countries, have important bearings on future obstetric work in the United States, in many parts of which—outside hospitals in which a high proportion of the total births occur—the organisation and control of midwifery practice at the present day is similar to that of Britain in the nineteenth century.

I have dealt in the preceding pages with some of the obstacles, medical and communal, to progress in medicine, especially to progress in preventive medicine.

Other obstacles have been indicated in earlier chapters. It is scarcely necessary to emphasise once more the importance of training of every boy and girl in the elements of health in such a way that self-conscious concern with the state of one's own health will not be fostered.

I have repeatedly emphasised the valuable health education which is incidentally given when there is domestic sickness. Doctors and nurses have invaluable opportunities which come to no others of instilling lessons in health. The work of midwives, health visitors, and school nurses similarly is of inestimable value. The doctor and the nurse might become almost immeasurably more influential in the prevention of disease were the change to be made in their financial relation which has already several times been indicated.

There remain certain moral bases of health which, though implied in much that has already been written, have not hitherto been specially stressed. Those are of such fundamental importance as to justify a short separate chapter for their consideration.

CHAPTER XVII

MEDICINE AND CHARACTER

In several chapters in this volume the close relationship between physical health and morale has been the subject of comment. It is difficult to generalise on this aspect of hygiene; but as the success of efforts at medical care, especially of social and medical care which is undertaken collectively for individual benefit, is so closely dependent on the character and conduct of the individual, some observations are made here on the problem.

The religious aspect of the problem is always in the background; and without discussing this aspect it may at least be said that unless the two Great Commandments of the Gospel, including more directly the second, are kept, much of the strenuous effort in the world to improve personal and communal health will remain futile.

In many particulars there has been a vast advance in altruism. Humanitarian motives have overcome narrow economics in successive departments of life, and especially in the industrial. Mining and factory reform, the control of hours of work of women and children, the contribution in many communities to old age pensions and to unemployment and sickness insurance, are a few among many illustrations of the altered outlook of man on his fellow-man. It is possible to sneer at these changes as manifestations of sentimentalism; they are in reality valuable efforts to fulfil the Second Commandment. The course of modern events, furthermore, shows the practical worldly wisdom of the policy embodied in them, notwithstanding the serious defects in some of these schemes. In their absence what more likely than unrelieved self-seeking, violent class struggles unregulated by social contracts, and possibly social revolution.

Some of the reforms indicated above, especially those of social insurance, though blessings, have not been un-

mixed blessings; and in times of world-wide economic distress it is not unnaturally urged that they lead to Niagara.

But this is not necessarily or probably true; and it is therefore well to realise that retrogression to the full-blooded barbarism of the older economics is impossible. That present social provisions do not necessarily spell ruin will soon be seen. Meanwhile, we can appreciate the importance of gradualness in social improvements. The growth of sympathy has been greater than that of intellect and science, and of the ethical standard of the community. There is therefore great need for that reconciliation of motives and action, of character and conduct which will ensure the common good.

I have no fear of the ultimate result. The solution of the struggle between individual interest and communal welfare will come—as the growth of communal concern for individual welfare has come—by the creation and growth of the individual conscience, to an extent which will prevent the communal reason from being swamped by unreasoning sympathy. In Gerard Heard's words (*The Ascent of Humanity*, Cape, 1929), the reform needed is the change of man from a physique dominating a psyche to a psyche dominating a physique.

The community as a whole has escaped from the callousness which enables us "to bear with complacency the misfortunes of others"; and we need now, while pursuing a steady policy of social, including medical, helpfulness to promote by our example and influence the elimination of greed and the fostering of that love to our fellows which makes unselfishness in social insurance easy.

The bearing of morals on sickness insurance has been discussed in Chapter VII. Insurance is the most prominent case in which morals trench on social work. Let me emphasise at this point that elements other than character are also concerned in excessive certification of unfitness for work. Industrial stress and anxiety must tend to lowered health; and apart altogether from malingering, unemployment increases the necessity of a workman having recourse to

his sickness benefit. Were the general conditions of employment improved, a large part of the sickness resulting from mental anxiety, hastened as it often is by a defective dietary, would be avoided.

A further factor is stressed by many observers. The health propaganda of recent years has led to increased resort to doctors for advice; and in a proportion of such cases there has been increased certification of unfitness. This ought to have been more than counterbalanced by reduced necessity to claim sickness benefit; but so far from this being so, claims for monetary benefit have greatly increased. Health propaganda has not been confined to the post-bellum period, and it is easy to attach too great importance to it as bearing on increased claims for sickness benefit since the Great War.

But there is excessive certification; and whether the instances of abuse are relatively few or many, abuse undoubtedly exists to an extent which may not unnaturally make any community hesitate to adopt social insurance as a State policy, or to widen the range of its operation. This need not be so. Abuse often arises from thoughtlessness or carelessness and is scarcely intentional. It is associated with a failure of patient or doctor to visualise the serious financial consequence of abuse of sickness benefit, and its unfairness to the great majority of doctors and of the insured who "play the game" as all honourable men and women should play it.

Certification which states that an insured person is unfit for work when he could work without detriment involves a moral degradation of the insured person and of his doctor alike; character has been undermined and may be shattered. There are, of course, many border-line cases in which the doctor's position is delicate and difficult; and the difficulty is increased by the patient's ability (in British practice) to change his doctor if the latter is not complaisant.

The giving of medical benefit alone does not involve the same difficulty. It is true that some patients become obsessed with the desire for medical care. Patients are

found who wander for months from one out-patient department to another. In European polyclinics unrestricted access to consultative services for the insured has increased this evil. But resort to the doctor for treatment is only exceptionally abused, and this abuse can, if necessary, be rectified by making the cost of medicaments and of doctor fall fractionally on the insured (p. 146). It is in the medical certification of incapacity to work that the problem of moral fortitude is involved. This necessary pre-condition of receipt of monetary benefits is a standing temptation to laxity; and it is eloquent testimony to the morale of the great majority of insurance doctors that they do not yield to it.

Certain precautionary measures are possible to assist the growth of conscientiousness on the part of those insured who exploit the sickness benefit unworthily, and of the doctors who connive with them in doing so. It will be possible, as already indicated (p. 147), to enlist the insured person's interest by making him profit eventually by refraining from obtaining unnecessary benefits. It is impossible to avoid entirely abuse of insurance; but to cut the Gordian knot by refusing to continue insurance means the abandonment of a valuable social provision for the many because of the callous or careless few who abuse its provisions.

It has been suggested that medical benefit should be excluded from the Sickness Insurance Act, each person making his own medical arrangements. But medical certification would still continue to be necessary; and it is doubtful whether over-certification could be thus reduced. It might be avoided by having whole-time insurance doctors to treat the insured and all others who are below a stated income limit; but this policy would introduce many possibilities of friction, and resort to it should not be necessary. To adopt this plan, furthermore, is to follow the—sometimes necessary—plan of altering circumstances and not trusting to moral improvement. Only clamant and widespread abuses will necessitate this course. By judicious

administration, by bringing public opinion more fully to play on the problem, by direct efforts at moral improvement, and by reducing the opportunities for temptation, we can divert the stream of abuse of insurance benefits and divert it from partial bankruptcy to the attainment of the ideal. It will, I am confident, in time be possible for the beneficiaries of national systems of insurance to revert to the mutual helpfulness, to the laudable pride in refraining from claiming money benefits, and to the will to get well and to keep well, which is a potent factor in the maintenance and recovery of health. These were largely characteristic of the Friendly Societies who had voluntary systems of sickness insurance before systems of national scope were compulsorily instituted. It may be that in making this statement I have overstated the mutual altruism of members of former voluntary Friendly Societies; but in so far as the statement is true it illustrates the value of group-opinion and of the ideals of brotherly love on which in the final issue avoidance of abuse of sickness insurance must depend for its success.

Although sickness insurance is the chief illustration of the importance of character in regard to administrative provision for disease, it is not the only instance in which character is as important in disease prevention and treatment as all the agents for prevention or the entire *materia medica* for treatment. I have already illustrated this in regard to tuberculosis and the venereal diseases (p. 204).

I have also emphasised the moral duty of every doctor who makes himself responsible for the medical care of a person or a family fully to acquaint himself by physical examination and by adequate investigation with everything which will make his medical care really efficient.

On page 67 it is deplored that hitherto gifts from the communal funds for the domiciliary support of the necessitous have seldom been utilised as levers for the social reform of the recipients. In Britain, for instance, weekly money allowances are often given almost unconditionally in the guise of destitution allowances. With better social organi-

sation and regulations, it would be practicable to make the continuance of these allowances conditional on the maintenance of a minimum standard of conduct, in respect of cleanliness and of sobriety.

To elaborate in further detail the points emphasised in this chapter would take us too far from the main subject of this volume; but other illustrations will doubtless occur to the reader. In conclusion I would merely emphasise my conviction that the future success of medicine and hygiene depends very largely on the aspects of medical work discussed in this chapter and on action based on their full appreciation.

CHAPTER XVIII

CONCLUSIONS

At the end of most of the chapters in this book I have set out a summarised statement of the chief propositions advanced in the chapter. The propositions stated in successive chapters occasionally overlap in the orderly development of the whole subject.

In this final chapter I propose to state summarily my main conclusions.

It is universally agreed that the health of each individual is an all-important condition of successful life, and that it is a communal as well as an individual concern.

This applies to medical care as well as to communal and personal hygiene.

The advance of the science and art of medicine has made it impossible for doctors acting individually to meet a large share of the medical needs of the community. Single private practitioners can, however, undertake most of the medical attendance needed, and, if their training and practice in this direction are cultivated, can undertake the hygienic supervision and care of families. This is the great need for the future.

New developments in medicine call for close co-operation between general medical practitioners and consultants who are specially skilled in one or other department of medical practice.

It is by hygienic guidance before illness occurs, and by action which will prevent the diagnosis of illness being belated or its treatment neglected, that the full possibilities of medicine in respect of health can be secured.

In promoting these ends the entire community is concerned; and extending research is showing that in many directions the scope of preventive and curative medicine can be widened.

At present the efficiency of medical aid is reduced by

inadequacy in its provision and by discontinuity in the work of the different doctors undertaking it.

Inadequacy occurs particularly in cases in which the single doctor should have co-operative aid; and discontinuity and resultant partial lack of success frequently arise through imperfect co-operation between hospitals, clinics, public health authorities, and the private doctor, or between any two of these.

Voluntary agencies, especially voluntary hospitals, in the past have furnished a large part of the medical aid given in most countries, beyond what the individual doctor can supply. In every country voluntary effort tends to be superseded by official, including insurance, provision of medico-hygienic services.

Official services are maintained by taxation of the entire community, or by insurance payments generally compulsory by a large part of the community, often by both taxation and insurance. The use of public funds for medical aid necessarily carries with it a large measure of control by the elected representatives of the taxpayers.

The maintenance of health is worth all expenditure incurred in its maintenance or renewal under efficient administrative conditions.

For a large share of the population the individual cost of sickness is overwhelmingly great. This is so even so far as the best domiciliary medical care is concerned; much more so when hospital treatment is required. Thus the problem of medical care has ceased to be one which can be solved for all by direct family payments at the time when the need for it arises.

It has become a generally accepted principle that no person or family shall be allowed to die or suffer serious harm through lack of shelter or food or medical care. In civilised countries this principle is, at least partially, the basis of provision for medical care of the necessitous. In view of the intimate relationship between the treatment and prevention of disease, it is satisfactory that in Europe both prevention and treatment, so far as they

are dealt with officially, in the main come under a single authority.

It is essential that medical aid should be given whenever otherwise medical care would be lacking; but financial aid for the necessitous may properly be made conditional to some extent on such reform of the recipients as a study of each case shows to be desirable or necessary.

Hospitals are a chief form of medical aid, whether voluntary or official. Provided originally for the necessitous, they have ceased to be thus limited in use; and, more and more, admission to a hospital for treatment is being determined on medical need alone. The rapid increase of official hospitals is due chiefly to the inability of voluntary hospitals to meet the increasing demands for hospital treatment. These increasing demands are the natural result of advance and specialisation of medical and surgical skill.

Hospital provision needs to be organised so as to bring the provision, whether of beds, or staff, or of differentiated expert services of every hospital into co-operative relation. For this purpose major and minor hospitals and clinics should be satisfactorily related to each other and to the needs of private medical practice.

Hospitals are provided by charity or by the officially elected representatives of the people, acting for the whole country or for a division of it. Some provision is also made officially for the domiciliary treatment of the necessitous. These arrangements in no country have been found to provide complete medical aid in all respects, and insurance systems have been organised supplementing, and in some measure replacing, official and private medical charity. In every national system of insurance for medical attendance in Europe, financial as well as medical aid is given during sickness; and in most countries the insurance is made obligatory on those coming within the income limit to which insurance applies.

These two facts of compulsion and of the dependence of monetary benefits on medical certification—especially the latter—have given rise to trouble.

The principle of provident provision for sickness, including medical care, is thoroughly sound. A combination of individuals can thus secure for themselves and their associates when sick satisfactory medical and financial aid to an extent which would be impossible by individual effort.

A chief initial danger in sickness insurance is that it is apt to divert attention from preventive measures. To the extent that it is practicable, prevention of an evil is infinitely preferable to mere compensation or support when the evil comes. But inasmuch as much sickness is not preventible, insurance has an important and indispensable place in medicine; and with improved administration, sickness insurance can become a valuable instrument of preventive medicine. Compulsion is indispensable for a minority of the persons who should insure against sickness.

If medical records are kept, sickness insurance can give valuable socio-epidemiological guidance in greatly needed public health investigations.

The medical services given in most national sickness insurance systems are incomplete, especially so in Britain. This fact hinders the development of preventive medicine in insurance practice.

No arrangement for the medical care of an insured person can be regarded as satisfactory, unless the doctor responsible for it knows the circumstances of his patient bearing on health and has made a complete examination of his physiological systems.

Suggestions have been made for eliminating the provision of medical aid from sickness insurance. Medical certification of illness would then still continue to be needed when incapacitation for work called for it; and the frequent complaints of over-certification would not be likely to be reduced by adopting this suggestion.

The problem of certification of sickness is one largely of morale. Educational work among the insured will help them to realise the mutual character of insurance. It will probably also be necessary to give the insured a direct personal interest in keeping his financial sick benefit to

a minimum level (see p. 146). Behind and beyond the two lines of action suggested at this point is the ethical problem which is the subject of Chapter XVII.

Hospital provision in nearly all countries is paid for largely out of charitable funds or from taxation, or both; and insurance payments for this purpose only meet a part of the cost of hospital treatment.

In recent years public health authorities have provided not only much hospital treatment, but also certain specialised medical services. The most important of these are four in number, or five if we separate the school medical service from the service for the mother and her infant and the pre-school child. These special services have, especially in Britain, been much more actively objected to by private medical practitioners than the larger-scaled work of general and special hospitals.

Of these services first mention must be made of the pathological and other facilities provided to aid practitioners in the diagnosis of certain diseases, especially of diphtheria, enteric fever, syphilis and gonorrhœa, and tuberculosis. In the same category come the provision of X-ray facilities for diagnosis.

Next to these come the official provisions for medical care of motherhood and childhood, which form a partial escape from the pathological to the physiological side of medicine. These provisions occupy a very important place in the medicine of to-day and of the future.

The prevention of puerperal mortality and morbidity requires that the doctors and midwives responsible for obstetrics should be better trained and have ample experience. Whether this is to be secured by differentiation of obstetric work or otherwise, these fundamental requirements must be fulfilled. In European experience the care of parturient women by trained midwives has been associated with a high standard of safety in childbirth. This is subject to the availability of aid by an expert medical obstetrician when needed.

The official procedures for the medical care of childhood

and youth have two characteristics which differentiate them from private medical practice as ordinarily conducted. In the first place there is undertaken a searching out of minor departures from the normal and the application of remedial measures; and secondly, counsel is given and action is taken to increase psycho-physical fitness, and thus raise an additional obstacle to the onset of illness, whether physical or extra-physical.

The infant consultations conducted by special medical officers do work, chiefly hygienic, which for the vast majority of infants would be otherwise neglected.

In school medical inspection similarly, a vast amount of ignored and neglected disease is discovered, and arrangements made for its treatment. The treatment officially undertaken for school children is chiefly specialist in character, and would ordinarily not be undertaken by private general practitioners. School medical work brings an increased amount of medical work to the private practitioner.

The work of public authorities in the prevention of tuberculosis is seriously impeded by delay in recognising the existence of tuberculosis both in patients under medical care and still more in those who neglect to obtain this care. In most countries provision is made for skilled examination at tuberculosis centres, of suspected cases of tuberculosis, and of contacts with them; and for consultations with private practitioners as to diagnosis; and for institutional treatment.

An outstanding feature of recent public medicine in Europe is the extent to which the official gratuitous provision of treatment of venereal diseases has spread. In several countries the principle of gratuitous treatment of all applicants at the public expense is fully acted on. In Britain this is done with the cordial consent of the medical profession as a whole.

The developments in medical practice, private and public, already considered, raise important problems as to the relation of the private practitioner to public health authorities, to hospitals, and to insurance organisations.

Behind these problems is the demand of the communal conscience that no patient shall have less in essentials than the rich can obtain for prevention of sickness, for its prompt cure, or for alleviation of suffering.

In securing this the ideal relationship between general practitioners of medicine and special practitioners (including hospitals) is not one of isolated independence, but of co-operative interdependence in giving medical care.

A chief desideratum for the private doctor is a fuller acquaintance with the normal in human life and a more complete training in the means for its maintenance. To give an analogy: smoke abatement is valuable, but it is even more fundamentally important that smoke should not be produced.

In medical practice among wage-earners the greatest evil is treatment without diagnosis. The value of periodical medical examinations is too little recognised. The well-equipped doctor will have little difficulty in preventing these examinations from fostering fussiness and morbid self-inspection.

A medical adviser for each family is very valuable when he can fulfil the condition indicated in the preceding sentences.

Treatment not of the character of family practice has rapidly increased. The treatment of infectious diseases and measures for immunisation have been largely socialised. In the treatment of tuberculosis and of venereal diseases the same phenomenon is seen. In the medical care of maternity and of childhood and youth the same tendencies are seen. If family practice is to survive and recover some of its lost ground a team of doctors on the medical side must be the counterpart of the family on the patient's side.

In most countries there is a fairly complete installation of medical treatment and care of maternity at the communal expense for the necessitous.

Insurance medical work also has greatly changed the character of family medical practice.

In private medical practice payment according to the

number of consultations and visits is a handicap to satisfactory medical care, whether hygienic or clinical.

The same consideration causes difficulty in resort to specialists and to hospitals and clinics, when desirable, unless these are provided gratuitously for the patient at the expense of the taxpayer or of a charitable donor.

In the co-ordination and completion of existing medical services expenditure of public money is unlikely to fulfil its object to the utmost, unless it is evolved from what is already at work. This applies in particular to hospitals and clinics, and to the due adjustment of work between official and voluntary institutions.

A great need for the poorer population in every district is the provision of a staff of consultant physicians, surgeons, and obstetricians for domiciliary service, paid for in part at least out of public funds.

With adequate extensions of medical services, the isolation of clinics for any one disease or period of life from other clinics should cease. There should also be provided health centres at which general practitioners may see their own patients, and consult when necessary with specialists or with their brother practitioners.

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