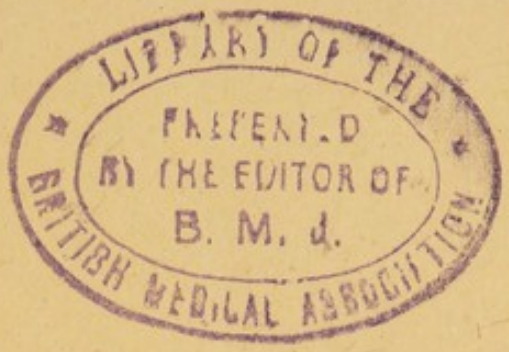
Physician, heal thyself : study of needs and means / by G. Scott Williamson.

wellcome collection

Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
https://wellcomecollection.org


LIBRARY OF THE
PRESENTED
BY THE EDITOR OF
B. M. J.
BRITISH MEDICAL ASSOCIATION

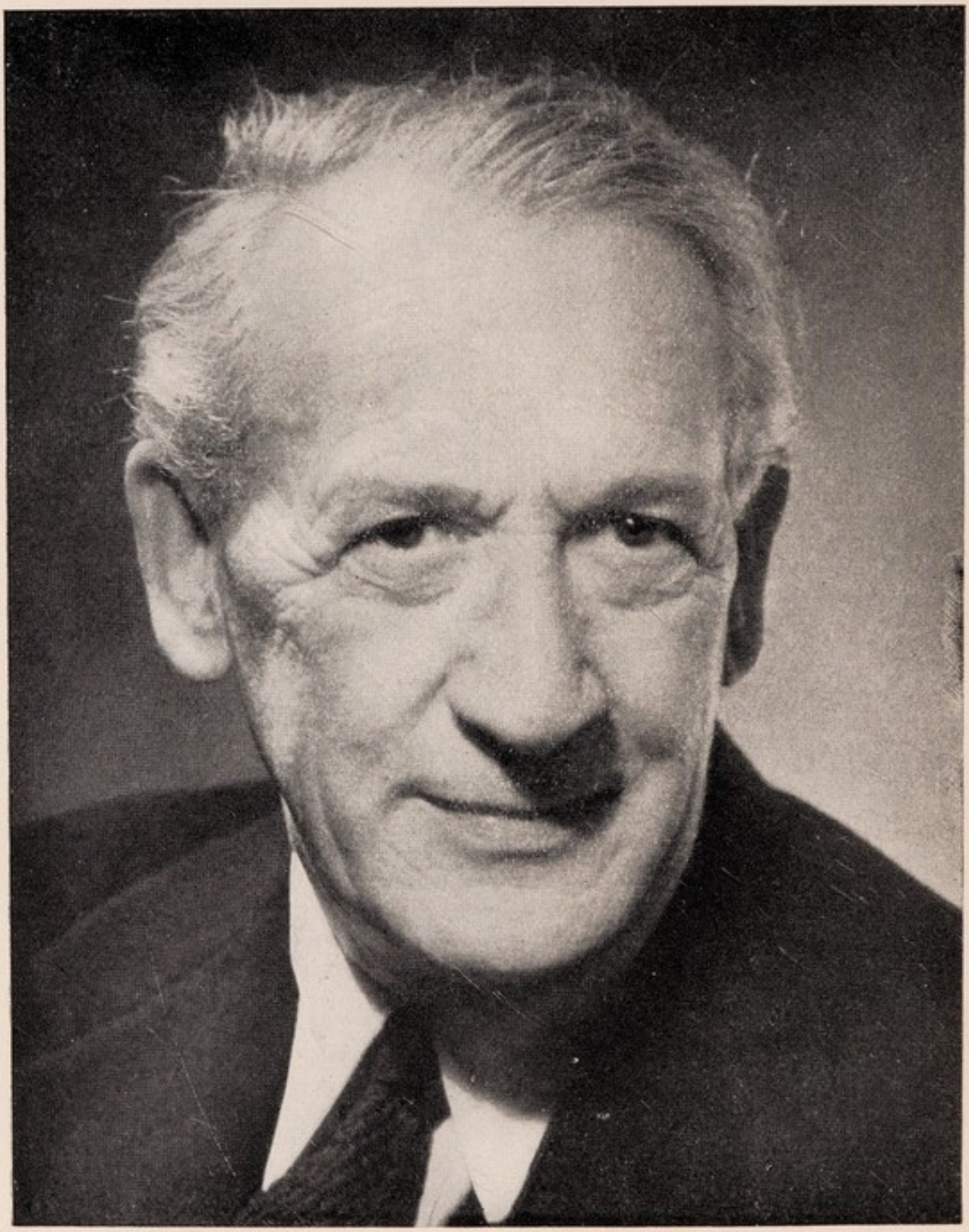
PHYSICIAN, HEAL THYSELF

by the same author

★

THE CASE FOR ACTION (jointly)

BIOLOGISTS IN SEARCH OF MATERIAL (jointly)



THE AUTHOR

PHYSICIAN, HEAL THYSELF

A Study of Needs and Means

by

G. SCOTT WILLIAMSON
M.C., M.D. (EDIN.)

FABER AND FABER LIMITED
24 Russell Square
London
1945

TO

DOROTHY WINKWORTH

AND TO THOSE PATIENTS AT PECKHAM

WHOSE STORY THIS IS

First published in Mcmxlv
by Faber and Faber Limited
24 Russell Square London W.C.1
Printed in Great Britain by
Latimer Trend & Co Ltd Plymouth

This book is produced in complete conformity
with the authorized economy standards

FOREWORD

The Government have spoken on the medical services of the nation with one voice but through many loud speakers. The people have invested their interests in central authority; authority claims, in the absence of the people preoccupied with war, to speak with the voice of the 'people'—but it is the stentorian voice of Monopoly.

The medical profession has spoken with many voices, but alas also in many tongues; so the doctors have withdrawn to their Tower of Babel to collogue together and find out what they mean.

Here speaks the 'patient', who, lost midst the great 'mass' of the people, speaks for himself—the still small voice of the 'individual'.

November 1944

CONTENTS

CONTENTS

Chapter One

PRELUDE TO PLANNING

Necessity is the mother of invention. But we must realize that invention is no virgin birth—that old superstition is dead. Necessity must find the father of her invention.

The idea that necessity—the mother—is a loose-living promiscuous female is not supported by fact. Necessity waits—like a virgin—the emergence of the *means* before her necessities press upon her consciousness. In other words, inventions are all legitimate children of the 'means' and the 'needs'—children of a true parenthood and a true home.

The female wants a mate; but any mere male will not do. So she waits and waits until there emerges 'the' mate among males. 'The' mate is what she *needs*—like the newborn infant who 'wants' food but 'needs' its *own* mother's milk. 'Wants' are indiscriminate and non-specific, while 'needs' are highly discriminate and specific. The key must fit the lock and the lock the key.

The patient is the key, the doctor the lock of any new medical service.

WHAT IS 'A PATIENT'?

Patients are the material the doctor works with. What then is a patient, in fact?

A patient is a sick person who decides that he cannot carry on any longer by himself; that is to say, a sick person who has become helpless, unable to help himself. You must remember that all sick persons are not patients; in our survey in the Pioneer Health Centre,[1] only 50 per cent of sick persons were

[1] See *Biologists in Search of Material*, Interim Report by the Staff of the Pioneer Health Centre (Faber & Faber, 1938), p. 80; also, *The Peckham Experiment*, Pearce and Crocker (Allen & Unwin, 1943), pp. 97–100.

patients.[1] The doctor knows only about 'patients', for he very seldom sees sick persons before they have decided to become patients.[2]

Who, then, treats the sick person before he becomes a 'patient'? The sick person himself, secretly; the newspapers through advertised (once called 'secret') remedies; the person's friends, his fellow sufferers and other well-meaning people by good advice. Anybody in fact but the doctor, who is always the last to be called in. So disease in its early stages very rarely reaches the doctor.[3] To take a particular example; the average duration of sickness among forty cases in one hospital ward was seven years. So the average patient had a seven-year-old sickness, and the older the sickness the harder it is to treat. The sick person, by delaying action, makes the task of the 'patient' and of the doctor very difficult.

A patient then is a sick person who can no longer help himself and who unwillingly is driven to go to a doctor.

THE MEDICAL CONTRACT

The doctor has to deal with patients, and they are the helpless sick. Because the helpless sick are, as it were, prisoners arrested by their disease, helpless in the hands of the circumstances of natural law, the doctor must protect them. Thus the medical craft and art must be a profession; that is to say an *ethical corporation*—like that of the lawyers who have to deal with prisoners helpless in the hands of the civil law. Disease is the police minion of the natural law through which the diseased

[1] Excluding accidents, infectious diseases and other acute disorders.

[2] The medical services never have catered for all the sick, only for 'patients'. But, the medical services can never be 100 per cent efficient until all the sick are *willing* to be treated as early as possible. There are only two ways of getting people to do things. The first is to *educate* them; the alternative is to *force* them—by physical fear or mental fear. The characteristic of a democracy is that people are educated.

[3] Except the diseases that are acute and cannot become chronic.

person loses his freedom. The patient's helplessness and innocence must be protected by the ethic of a profession. The ethic of the medical profession is there to protect the helplessness and innocence of the patient—not the pocket of the doctor nor the vested interests of his practice—his medical trade union should and does do that. Medical ethics are for the patient's benefit—a clause in the patient's Habeas Corpus Act.

When, therefore, the administrators disregard or seek to overrule the ethic of the medical profession, they are preparing to take advantage of the helplessness of the patient. They are undermining one of the pillars of freedom.[1] The doctor therefore must remain a sworn independent member of an ethical corporation—not become a licensee of the Treasury administrator. A strong medical ethic alone can ensure the patient all he needs to protect his helplessness.

MEDICAL ETHICS

The average person never bothers to learn about ethics and never seeks to know what they are. He thinks that they are something to do with morals or with social habits. What then, in fact, is the essence of the medical ethic?

The medical ethic is the *personal contract* between the doctor and the patient. In this contract a doctor binds himself to use all his medical skill, knowledge and equipment solely for the benefit of the patient.

The patient does not bind himself to the doctor, but the doctor binds himself to the patient. Thus, the ethical contract will not allow any doctor to turn away any sick person who seeks his help. While the civil law *cannot* force a doctor to attend a sick person, the doctor's ethical contract compels him to do so. Fee or no fee. The fee is no part of the ethical contract. Any fee is in the nature of a gift—no good doctor sues for his fees. A general practitioner's 'bad debts' would shock any business man, but the public know very little about that.

[1] The lawyers are being treated in the same way by 'Orders in Council'.

The idea that a State medical service can be a substitute for the ethical contract is nonsense. Any State medical service must cancel every doctor's ethical contract with the patient.

Under the ethical contract, the doctor belongs to the patient; he is counsel for the defence. Under a State contract, the doctor belongs to the State; is counsel for the prosecution. There is then a vast difference between being a 'servant of the patient' and the 'servant of the State'.

Not even a doctor can serve two masters. You may think that a doctor can be forced to serve two masters by sending round State inspectors or policemen, so that the shadow of the inspector would always stand between the patient and the doctor. It will not work; you cannot make a good craftsman through the fear of the inspector—nobody can serve two masters.

The doctor must be free from all contracts except that with his patient—in which case the doctor can still protect his helpless patient against the administrator, the employer, the industrialist, the insurance company, and even the civil law of the land; for all these can, will and do take advantage of the patient's helplessness (*vide* the Workmen's Compensation Act). If all doctors were State doctors, who would the patient find to protect him? Justice is only possible if the ethic of the doctor and the ethic of the lawyer are maintained.

I would even go as far as to say that any doctor using his medical skill for any other purpose than the patient's, is acting unethically. The doctor is licensed by the law solely for the treatment of the sick—hence all compensation and industrial questions should be settled as all medical questions are settled, by the patient's doctor in consultation with his colleagues acting under the ethical code. No jury or judge can ever settle a medical question, because all medical questions must be settled for the benefit and good of the patient.

Why then, does the State want to rob the patient of his doctor and to make all doctors State servants? *To protect the Treasury.* Who says so? The Minister of Health, on behalf of the Government, said that the Government desired *control of the medical*

profession 'in order to keep a firm hand on the issue of certificates'![1]

Is there any need to protect the Treasury? There is not the slightest need *under an insurance scheme*, because *all* risks can be calculated for in the premium. So it appears in fact that a State medical service is merely a cheap medical service, giving the patient the *barest* minimum instead of the *essential* maximum of benefit.[2]

The truth is that the administrator, who should be merely the collector of premiums, also wants to be the spender of the money. Money is power; but only if you can *spend* it. An attempt, outlined in the White Paper, is being made to make a corner in doctors.

Any reform of the medical services demands the strengthening of the ethic of the profession. The doctor must be exclusively the patient's doctor.

That is the first question the public must decide. The patient's own doctor or the State's doctor? Which do you want?

THE DOCTOR

What about the doctors themselves? There are many kinds of doctors, and some of them do not belong to the patient. But so far as the sick patient is concerned, there are, in fact, only two kinds of doctors. First the 'doctor proper', or general practitioner, and second, the 'specialist'.

To become a patient, every sick person must first go to the key man, the general practitioner. The general practitioner may or may not use a specialist. The specialist always comes into contact with the patient through the general practitioner.

The inner intention and effect of the White Paper is to employ specialists and to set up more specialisms; using the doctor proper *only* for finding and directing 'cases' to the specialist.

[1] Mr. Ernest Brown, March 1943, quoted in letter to *The Times*, 21st June 1944.

[2] See *National Health Insurance*, Hermann Levy (Cambridge University Press, 1944).

This is natural because the White Paper is built up on advice given by specialists. The public is satisfied with this because, misled by the press, it thinks as does the Government that the specialist is the best sort of doctor. People do not know why they think so, nor how they have been misled.

What are the facts?

The specialist deals, not with 'patients', but with 'cases' of disease—a case of heart disease, a brain case, a lung case, a kidney case, a nerve case, etc. So patients are broken up into dozens of diseased anatomical bits and pieces, called 'cases' for the purpose of specialism. The general practitioner deals with a 'patient', that is to say with both the *person* and his *disease*.

Now it is the general practitioner who must decide *for the patient* which specialism his disease or one of its symptoms needs. Nobody else has the knowledge to do that. No specialist, for example, could be trusted to select and sort out his own 'cases' from among the welter of different kinds of patients. That indeed is one of the reasons why the specialists themselves will not allow a patient to go direct to the hospitals, of which they are in charge. Patients must go through a doctor, a general practitioner. The specialist knows his limitations, and he depends entirely on the general practitioner to feed him with his cases. The specialist is here obeying his own clause in the ethic of medicine—for the specialist is *the doctor's* servant.

Now before trying to base a medical service on specialism, as in the White Paper, there are other facts about specialism that the public must know. The facts are these:

There are two kinds of specialists: (1) the legitimate specialist and (2) the illegitimate specialist.

(1) LEGITIMATE SPECIALISMS

The legitimate specialist, what is he? First, there are very few legitimate specialisms. For example, major surgery in all its branches (including dental surgery); mental diseases, pathology and pharmacology or therapeutics.

The legitimate specialists are those who must have *extra*

special post-graduate training in doing something that is beyond the natural skill of the individual general practitioner. The specialist's delicate work needs constant practice and special aptitude. A legitimate specialism is a whole-time occupation.

The legitimate specialist is like a violinist (or other instrumentalist) who chooses his instrument and restricts his special skill to violin parts. He does not try to master all the instruments; he is *exclusive*. Any specialist forms only *one* of an orchestra of specialists.

The *conductor of the orchestra* is the general practitioner, and he must know *all the principles of music* however many instruments are playing in the orchestra. The conductor need not be a *master* of any one instrument—he may play on any one, but not as a master.

As the players in an orchestra are chosen, so all specialisms and all specialists should be authorized and chosen *by the general practitioners as a body*. Specialists must be special men doing a special job for and on behalf of the patient under the doctor's sanction. Unscrupulous specialists are the greatest danger to the helpless innocence of the patient—another reason why no patient should ever go direct to the specialist. Indeed a reputable specialist will not accept a sick person directly. The specialist, then, must never boss the medical show, as is the intention of the White Paper, which makes the general practitioner a mere subordinate.

Obviously, all legitimate specialism must be taught *after* the doctor knows all about medicine. As it is at present, a medical student may begin to specialize even before qualification, without ever having been in general practice, so he may never learn any more than is necessary for treating a small special group of cases. Thus he learns to know a great deal about a very little corner of medical knowledge; beginning like this as a specialist, and being *without wide experience*, he is not an expert—obviously an absurd situation. All who would be specialists should spend *at least three years* in the general practice of medicine, after which they should be obliged to work for a licensed post-

graduate qualification. This applies of course only to legitimate specialism.

(2) ILLEGITIMATE SPECIALISMS

What about the illegitimate specialists? That is a very different story.

The illegitimate specialists and specialisms have arisen entirely through the *monopoly of tools and equipment*. How has this come about?

Few individual general practitioners can afford a complete X-ray outfit and the necessary technicians to run it. Buy one, and you become a bastard specialist, because you have a corner in that market. Few doctors can afford a complete clinical laboratory and the necessary technicians; buy one and you become a bastard specialist because you have a corner in that market. Again, nursing is an *essential* part of medical equipment; all doctors need a skilled nursing service. Or again, beds are needed by all doctors; by 'beds' we mean hospital beds in a ward, *with all its essential technicians*, such as house physicians, pharmacists, nurses and other attendants. You cannot achieve modern diagnosis or give modern treatment except with the help of an assistant junior doctor, a nurse, etc. Monopolize the house physician, the nurses and the beds, and you become a bastard specialist, because you have got a corner in that market.

Thus we see that illegitimate specialism is sheer monopoly, and should not be tolerated in the interests of medical efficiency —which are identical with the interests of the patient. Illegitimate specialism is of course not confined to medicine. Industrial profiteering too is based on the monopoly of tools. All modern tools are too big and too expensive for each craftsman to have his own tools. It is the same with the doctor's tools and equipment.

Remember, *every* doctor when a medical student was trained to use all these tools: X-ray, laboratory, beds, nurses, etc. But no *one* doctor can from his own private practice fill beds with patients and fully occupy the time of a resident medical staff,

of nurses and technicians. The most any one doctor can do is to occupy the tools and equipment for, say, forty minutes each day. But, twelve doctors could make use of the tools and equipment for eight hours a day. It thus needs a number of doctors to keep the necessary machinery of diagnosis and treatment running.

Here, then, is the very crux of the situation. It is that 80 per cent of the doctors—fully qualified, highly trained craftsmen—are at present deprived of the use of the tools of their profession. Give the doctor—the general practitioner—his tools and the illegitimate specialisms will disappear *automatically*.

Of course, by making the patient pay extra in time (in the case of the working man), or in money (in case of the rich man), the doctor can buy the results he needs from the bastard specialist—buying a pig in a poke. But that is good neither for the doctor nor for the patient, for it is second-hand knowledge the doctor buys and, like second-hand clothes, seldom fits; it is in fact not knowledge but information.

'Give us the tools,' said Churchill. Let Churchill's Government then give the doctors their tools to win the war against disease. The White Paper does not do so—it legalizes and consolidates monopoly.

This being so, the patients and the public must help the doctors to break the monopoly.

But, unfortunately, the patients and the public will have to *force the doctors* to break the monopoly. That sounds rather curious, does it not? Not only will the public have to force the illegitimate specialist to renounce his stranglehold on the tools, but they will have to force the general practitioner to use the tools. Why?

When speaking to general practitioners about this point, they answer in one of two ways. The older men among them have been without tools so long that they are afraid to be forced to use them, for they have forgotten how. The young men on the other hand seldom wanted to become general practitioners, because they were not trained to be general practitioners, but

trained as specialists, treating 'special cases'. Their teachers were specialists so naturally they all want to be specialists themselves, and they do become specialists *if they have the money*. The others, those without money, *are forced into general practice*, but even then they do not give up hope of one day becoming specialists until after they have been in general practice for at least five years. So the young doctors are not anxious to break the monopoly either.

Hence the public must break it for them—by giving all doctors all the necessary tools for efficient diagnosis and treatment.

THE DOCTOR'S TRAINING

There is yet another fact which must be taken into account.

What is the effect on the patient's doctor of the bastard specialist's monopoly of the tools of medicine? It is very serious from the patient's point of view.

It happens this way. All the tools are at present the monopoly of the specialist—both legitimate and illegitimate. Hence the budding general practitioner is trained exclusively by specialists in hospitals that treat only 'special cases'. Some thirty years ago, the great teaching hospitals were still carrying out their original charter—treating the sick poor. They had only a limited number of beds for 'special cases'. In those days, the hospitals were staffed and the students were taught by *super general practitioners*—'consultants' they were called. Now, the hospitals, originally chartered for the poor, treat only 'special cases' and the staff are *all* specialists dealing with these special cases.

But the fact is that 'special cases', which alone now reach the hospitals, represent no more than 20 per cent of all the patients a general practitioner sees. So it follows that no medical student is ever trained in the medical schools to do the work of the general practitioner who has to diagnose and treat 100 per cent of the patients who seek his help. The student never sees and is never taught how to treat 80 per cent of the general practitioner's patients. So, *only after he is licensed to practise does he begin to learn the most important and greater part of his job.*

He has to teach himself, either by rule of thumb, by trial and error, or by becoming the sweated assistant of an overworked practitioner, too busy to teach him. It takes five to ten years' further experience before a newly licensed doctor is properly experienced to look after 100 per cent of his patients. The reason for this is that *medical education has become the specialists' monopoly.*

All that the specialists who now monopolize medical education are able to do, is to train the medical student to pick out and sort out 'special cases'—i.e. cases that need specialist's treatment. The specialist, in fact, teaches the student *to feed the monopoly.*

When, therefore, a doctor gets his licence to practice, he is only, at most, one-quarter qualified to deal with the sick.

But even that is not the worst aspect of the monopoly. The medical student has been trained in how to make use of *all the modern instruments of diagnosis and treatment.* He is moreover cautioned never to 'guess', i.e. never to make a diagnosis without these aids. Yet, when he goes into general practice he has to learn to diagnose and treat his patients without his tools—all that is left to him is a stethoscope and a prescription book!

Now this is no fault of the medical student nor of the doctor. It is the fault of a monopoly that has grown up unnoticed by slow and gradual stages (just as it has in industry, for industry does the same thing with its craftsmen).

To put this right, medical education must be given back into the hands of highly experienced general practitioners—who are the *only* doctors who see and know all types of patients and all stages of all diseases. This will follow naturally if patients and public break the monopoly of the illegitimate specialisms.

Illegitimate specialism must be swept away. The public must see that every practising doctor has access to all the tools and instruments he has been trained to use and which he has a licence to use. At present a poor doctor cannot afford the tools, and 90 per cent of the doctors are poor because they work among the poor; hence the doctor is what is wrongly called

'making the best of a bad job'. You cannot make the best of anything that is bad—all you can do with the 'bad' is to stop it getting 'worse'. And that is what 90 per cent of the doctors are doing, with great care and skill. The White Paper takes no heed of these facts, because the Government have not any intention of breaking any monopoly.

The public must see, first that every general practitioner has the use of his full equipment and tools, and second, that he has had adequate training in the use of these tools on all types of cases. These tools and that training must not be used merely on the 20 per cent of special cases selected from among the 100 per cent of patients the general practitioner is called upon to treat.

MEDICAL SKILL

So much for the facts about the doctor's *material*, his *tools* and his *training*. Now let us get to the facts about the doctor's *skill*.

There are two sides to the doctor's skill—the right and left hands, as it were. They are (i) diagnosis, and (ii) treatment. If you can imagine disease as a fiddle, the doctor has to finger the strings for 'diagnosis' and bow the strings for 'treatment'.

(i) *Diagnosis*. Who is the first person to see the patient? The general practitioner. Thus, first and foremost, the success of all medical care hangs upon the general practitioner's skill in diagnosis. A wrong diagnosis by the general practitioner *always* means wrong treatment—even if it is the specialist who gives the treatment. That is another reason why the general practitioner is the king-pin of the medical services.

The doctor cannot work without his tools, which dig out the facts; but, to make a *diagnosis* out of the assembled facts, he also needs great experience. We have seen that in the present circumstances—which the White Paper will perpetuate—all the experience he has when he qualifies is theoretical experience in the diagnosis of the relatively few patients who are 'special cases' selected for treatment in the hospitals.

Diagnosis is a 'little science' but a very 'great art'. Why? Be-

cause every patient with the *same disease* does not have the *same symptoms*, *signs* and *sufferings*. Not only do diseases differ among themselves, but each disease differs with each individual patient. It is therefore the study of the *patient* that guides the doctor in diagnosing the *disease*. Herein lies the general practitioner's great art—about which the specialist can know little or nothing, for the general practitioner has made the primary diagnosis before the patient can become a 'case' for the specialist. So great then is the experience needed in the art of medicine that every doctor must not only have seen all types of patient as a student, but must act as assistant to a set of general practitioners already skilled in their art, before proceeding to practise on his own. *Post-graduate training in general practice is essential to every doctor.*

It cannot be too emphatically stated that not only the patient, but even the specialist is entirely dependent on the general practitioner's art in diagnosis.

(ii) *Treatment*. The second medical skill of the doctor is skill in treatment. There are two main kinds of treatment: (*a*) curative treatment, and (*b*) palliative treatment.

(*a*) *Curative treatment*. The public should know that there are as yet very very few curable diseases and very few curative treatments. The general idea that a perfect medical service would cure all, is utter nonsense. The public are being deceived by the press; the press advertise, they do not educate. A rough estimate of my own experience would indicate that only 10 per cent to 12 per cent of all the patients going to a general practitioner or specialist have so-called curable diseases.

Thus it is the second form of treatment which applies to about 80 per cent of all patients.

(*b*) *Palliative treatment*. The second form of treatment is palliative treatment in which the skill of the general practitioner is great. In this form of treatment the doctor treats the symptoms, because he cannot treat the underlying disorder. All he can do is to stop the disease getting worse.

Is this palliative treatment any use to the patient? It is. First, because it prevents the disease getting worse and in so doing gives Nature the better chance of dealing with the underlying disorder. It is characteristic of Nature to get rid of disorder and disease if she can. Man can help or hinder Nature; he has a choice.

Secondly, palliative treatment generally enables the patient to carry on with his social, industrial or leisure life. And that is in fact *all* that any patient ever asks of the medical services. That is what he, the patient, wants and pays for; to get back to work, to home and social life—to cease being a 'patient'. So he will learn to put up with his sickness as long as he is not helpless. That is the fact, despite all the statements to the contrary by industrialists and administrators, who make a bugbear of malingering.

There are then two kinds of medical treatment: curative treatment which is rare; and palliative treatment which is the rule. Both depend on the skill of the doctor, but the degree of that skill in turn depends upon the doctor having the tools needed for the treatment.

The doctor's tools are of two kinds: his diagnostic tools, and his treatment, or therapeutic tools; and to do his job he needs the full range of both.

But what in fact happens? As each new remedy is discovered by the research workers, it is monopolized as far as possible by the bastard specialist—quite innocently on his part, for he is part of the vicious circle of monopoly. The reason for this is that almost without exception, a remedy for a disease is a highly dangerous drug or procedure. The remedy, therefore, needs to be given with the greatest care and under the constant supervision of a house-physician or nurse, with all the laboratory and technical facilities to observe the effect—*vide* insulin for diabetes (which is a palliative and not a curative remedy).

The bastard specialist has the monopoly of these tools of treatment (therapeutic tools). Hence every doctor in general

practice is being deprived by the monopoly of proper practice and experience in the use of the newer remedies, just as he is deprived of the newer, finer and more critical tools of diagnosis.

What is to be done? There is no alternative. Clearly we must break the monopoly of training and of tools. But it is not sufficient to do that; we must so break the monopoly that no other monopoly can arise, we must *democratize* the medical services.

We must give the general practitioner the tools and leave him free to use them. Only so can we win the war against disease; for then we shall have mobilized the whole medical strength on a major assault.

And so we come to the question: How is the public to break the monopoly? How can the whole strength of the medical service be mobilized in the war against disease? Where do we begin? By patching up the old medical service, as the White Paper tells us the Government is going to do? Or by creating a new medical service?

There is no evolution without birth, so if the future is to be a new era, we must create a new medical service.[1]

[1] Since all doctors are biologists, you would have thought that evolution by birth of a new era would have been their method of choice. But we have seen that the doctor is not master in his own house.

Chapter Two

THE PLAN

Having laid our foundations on the broad basis of fact, we can now proceed to build—The Patient's Charter.

Since all doctors must be licensed to practise, let us follow that up and determine that:

(*a*) *All licensed doctors must practise on licensed premises.*

(*b*) *No premises can be licensed unless they are fully and completely equipped with the tools and services necessary for efficient diagnosis and treatment.*

These licensed premises will be of two kinds: Local Clinical Centres and District Hospitals.

THE LOCAL CLINICAL CENTRE

Every Clinical Centre needs:

(1) Private consulting rooms; one for *each* general practitioner on the staff.

(2) A ward of beds with the necessary two or more resident medical officers, nurses, technicians and other attendants.

(3) A comprehensive transport and telephone service.

(4) A pharmacy and pharmacist's assistants.

(5) A full range clinical laboratory with technicians.

(6) A full range physical laboratory, X-ray, etc., with technicians.

(7) A full registry with staff.

(8) Special examination rooms.

(9) A casualty and emergency department, with suitable minor operating theatre.

(10) A consultation theatre.

Every Clinical Centre must be staffed by general practitioners.

The number of doctors is determined by the equipment—which for efficiency of service must be kept working at full pitch—perhaps ten or twelve doctors. If ten or twelve is technically an economic number, there still could be less or more doctors in certain difficult districts. But even if a district is so sparsely populated as to need only one doctor, that doctor must have *his full equipment* of tools and services and a full Clinical Centre. It must be noted however that if *transport is fully provided and organized*, such districts will be quite exceptional. Transport—aeroplane and motor—can cover 50—100 miles' radius in these modern days. Hence *no* modification of the essential equipment of tools and services need ever be permitted.

The standard Clinical Centre will then need a staff of ten or twelve doctors, all of whom are general practitioners.

These Clinical Centres are not for *group* medical practice. In group practice, all the doctors in a group *share* the patients. That may be convenient for the doctor, but it is bad for the patient, because in group-practice one member of the group may diagnose and another treat the case, and we have seen that that is bad for treatment, and bad for the patient—it is pseudo-specialism.

At the Clinical Centre *each doctor* is an individual practitioner personally responsible for the patient. The patient then knows who is responsible for whatever is done—nobody can pass the buck from hand to hand under the table.

These doctors continue to practise as 'private' doctors; they share, only, a common economic equipment and service. They can only gain their complete professional *freedom* to work, i.e. the freedom that comes with being properly equipped, by sharing a common equipment of tools and services. (That is Liberal Socialism or Social Liberalism.)

Nothing less than *all* doctors adequately equipped with tools and services can give *all* patients efficient and economic medical services for primary diagnosis and treatment. Having adequately equipped these Clinical Centres for primary diagnosis and treatment, they are now capable of diagnosing every disease and

of treating all patients except those with physical and mental diseases needing tools and equipment and technicians on a scale so large as to serve, not ten or twelve doctors, but fifty to a hundred doctors—and that would constitute a hospital.

The Clinical Centres are then not hospitals. Their beds—in the nature of 'observation beds'—and services are not for more lengthy occupation than from one to fifty-six hours, after which a patient is referred either to hospital, or back to his home for treatment, or to work for treatment.

No provision is made in the Clinical Centre for large-scale waiting-rooms, and that is explained in the next section. Each doctor will be provided with his own private consulting room with a suitable dressing-room annexe for the use of his own private patients. These private consulting rooms will communicate easily and directly with the special examination rooms, the various laboratories and the registry, so as to give easy access for patient and doctor to the technicians in each of the various departments. The casualty and emergency department will have its own suitable provision for cases of that order, who are however admitted and treated under the supervision of their own doctor.

TRANSPORT SERVICES

The transport and telephone services merit special comment. The proper scientific organization of the first-line defence stations—these Clinical Centres—has now become a possibility because of the rapid development of transport facilities. This war has made us familiar—many of us too familiar—with the medical transport services, by aeroplane, motor-car, train and ship. In civil life, medical transport services are a no less essential part of medical equipment. They are in fact a fundamentally important part of the equipment of each Clinical Centre.

Why is this necessary? Because *all patients must go to the* Clinical Centre.

The reason for this is simple. The doctor must make a *complete and critical* examination when he first sees the patient, and

for this, as we have seen, he needs all the modern tools and instruments. The instruments cannot be taken to the patient; therefore the patient must be taken to the centre where the instruments are assembled.

This necessity, despite all false sentiment, must be accepted by both patient and doctor for efficiency's sake. The transport service is *not* for the doctor's convenience, but for the patient's benefit. Home diagnosis can never be anything else than a rough guess—an expedient of emergency. Hence, there must be a specially organized medical *transport* and *telephone* service.

Disease, as we have seen, is Nature's policeman, the minion of natural law. So the telephone service must be free, and the alarm-call word 'doctor'—just like 'fire' and 'police'—and connection must be instantaneous.

All visits, emergency excepted, to the Clinical Centre must be organized and arranged by appointment. An efficiently organized appointment system precludes the necessity for public waiting-rooms. The patient's time is every bit as important, more so to the patient, than is the doctor's time. Indeed, the doctor is there to save the patient's time. There is however no need to waste the time of either. No waiting-room for the crowd or the masses is needed; no patient who has keyed himself up, at last, to go to the doctor must be kept waiting. Hence the need for a *free* telephone service for appointments, to facilitate economy of valuable and expensive time for doctor and patient.

The transport service must also be free; not only free of charge but free to come instantly. No waiting can be condoned. Why?

After many neglected warnings, sooner or later Nature's policeman, disease, arrests the patient. Either it handcuffs the patient and he goes by himself to the doctor, or the patient is manacled feet and hands and has to be carried to the doctor. In either case he must ride free; by public conveyance—aeroplane, train, tram or bus—if he is only manacled; by *special ambulance vehicles* if he has to be carried, for the patient being helpless

must be helped at every step to get to the Clinical Centre as early and as easily as possible.

The ambulance transport service will be in charge of one of the *resident medical officers* at the Clinical Centre. Every patient who does not transport himself must be seen by the medical officer and be 'prepared' for transport. All transport servants must be trained. They are not servants of the State removing *social waste and garbage*, but the patient's servants transporting his most valuable possession—*his person.*

The transport service serves other purposes. We have seen that it is impossible to make and confirm a diagnosis in the home, because the tools and equipment necessary for diagnosis cannot be taken to the home. Treatment, however, is not in the same category; some forms of treatment can be carried out in the home and *even in the factory*. But that treatment, wherever it is done, must be administered efficiently and meticulously in exactly the same way as in the centre and the hospital; that is to say by the doctor *and his team of junior medical officers, nurses and technicians*. The transport service makes this possible.

But the transport services should be used for treatment only with the greatest care and skill, for neither a doctor nor his team of medical officers, nurses and technicians can be in continual and immediate attendance in the home, or in the factory.

That does not mean that the doctor can ever leave the supervision and nursing of any patient to the patient himself, to an unskilled and harassed wife or mother, or—in the case of women patients—to the erstwhile kindly convenience of a neighbour or relative. That merely defeats the purpose of the doctor. Indeed it should be laid down as a rule that no patient shall be deprived of the constant service of a skilled doctor and his team of medical officer, nurse and attendants. Under the present medical system, only if the patient is in hospital, does a competent trained person carry out *all prescribed treatment*. The new transport service makes this possible in *all* circumstances.

Therefore, for purposes of treatment, patients are to be carefully divided into two categories.

First, those with diseases that should be treated while the patient is still capable of sustaining his position in the social pattern—still able to work and play. Eighty per cent of all diseases pass through this phase. These are the diseases that do not prostrate the patient—knock him off his feet. Such patients can be called 'ambulatory patients'.

An ambulatory patient is fighting two battles, so he needs more, not less help and assistance than do the others. He is battling against disease, but he is also fighting to keep his place in both his industrial and social existence. Only the patient's doctor knows that.

And another thing the doctor knows is that the 'morale' of the patient is lost when he has to stop work and play—and only the doctor knows what an important part this 'morale' plays in the *treatment of disease.*

When I say, 'Only the doctor knows', I mean that only the patient's doctor, his local general practitioner, can fully appreciate these facts. The industrialist's doctor, the State's doctor and all the other doctors are not in a position to know.

Now you know why the patient's doctor hates the Panel certification. No patient's doctor would ever willingly condemn the patient to stop working—if he could help it—because it adds 'unemployment' to the patient's sufferings.

So you see that the patient's doctor will strive to keep the patient at work as long as work is *doing the patient good.* Only the patient's doctor knows how to use what is left of the industrial and social capacity of the patient as part of the treatment of disease. That is one of the great arts in medicine that only the artist—the general practitioner—knows anything about.

The doctor, the patient's own doctor, must therefore have at his disposal the means of treating the patient *while at work.* A properly organized transport service would make this possible.

Think of the absurdity and cruelty of the present situation. All diagnosis and all treatment of the patient *who is working* has to be made in the patient's leisure hours. These leisure hours—so-called—are already far too short and are needed to recover

from fatigue; they are too short because they do not allow for relaxation without which rest cannot take place. What then happens? *All* patients who are working have to visit the doctor in the two hours of the evening surgery. Accurate diagnosis, as we have seen, is quite impossible in these conditions, and so *treatment also is inefficient.*

That is entirely due to the conditions in which the doctor is compelled to carry on his profession—due to monopoly. The patient's doctor is making what is called the best of a bad job. All that anyone can do with a bad job is to stop it getting worse too quickly, and that is what the doctor does, with great skill and care, and with that the innocent patient is too apt to be satisfied. Indeed, so skilled has the patient's doctor become at stopping the bad from getting worse too quickly, that *he also*, the doctor, is too often satisfied, and so comes to resent any and every new method or any suggestion that things need to be radically changed.

There is a vast difference between stopping a bad job getting worse and making the best of a good job. To make the best of a good job for the ambulatory patient, the patient's doctor, properly equipped to do all that is necessary, must have free access to the patient suffering from diseases in which he thinks it will do the patient good to be at work while being treated.

It is of course in the interest of industry to keep the patient at work.

Very well then, let us so arrange it that treatment can be carried out in the factory by the patient's own doctor, through his team of junior medical officers, his technicians and equipment. The new transport system makes this possible.

Some enlightened industrialists have already arranged facilities for treatment in their works. The only new factor, therefore, that we propose is that the *staff of the local Clinical Centre*, not *the industrialists' doctor*, should run the treatment centres within industry. That would unify and indeed make the medical services comprehensive, instead of becoming more and more frag-

mented into special departments—for the industrial doctor is yet another 'specialist'.

Moreover, it must not be forgotten that the medical man in industry is there to protect the industry, not to protect the patient. Industrial doctors arose out of the Workmen's Compensation Act. The medical man in industry is engaged and paid to look after the interests of his employer—his contract is with the employer, not with the patient.[1] The industrialist naturally enough uses his doctor to protect his interests, if need be against the helpless patient. In this situation, circumstances may arise in which the poor helpless and innocent patient may find that he has himself to carry the onus of proving negligence against the employer.

A properly organized transport service makes it easy for the doctor of the Local Clinical Centre, while maintaining his proper ethical relation to his patient, to supervise treatment in the factory through his team of junior medical officers, nurses and technicians. There must be no more treatment of the patient by the patient: 'Here, take these drops and do so-and-so three times a day—and come back when they are finished!'

Access by the doctor and his team of assistants to the patient while at work is then necessary for the patient's sake—though incidentally the employer also will benefit. By this means the patient's doctor can help the patient to win both his battles, to wit, the battle against his disease and the battle against unemployment through sickness. If you ask any patient which is worst, to suffer disease or to suffer unemployment, the answer is *always* 'unemployment'—and this fear is a severe handicap to efficient and early medical treatment. It is also the answer to those who believe that the majority of patients must be regarded and treated as potential malingerers.

So much for the ambulatory patient whose doctor thinks it will do him good to go on working.

[1] Indeed, I would go so far as to say that the medical man in industry should not have a 'licence', since he has abrogated his ethical contract by contracting with industry.

The Prostrate Patient. Now we come to the prostrate patient, who cannot work without doing harm to himself. It is not only physical prostration but also social prostration that we refer to. This patient can be treated either at home, or at the hospital.

If the patient's doctor is properly equipped, then home treatment ceases to be something inevitable that is forced upon the doctor. He can now choose. Home treatment thus becomes something that the doctor will be able *deliberately* to prescribe when it is the best treatment for the patient. Best for the patient —not best merely because he is impecunious, nor best for a sentimental mother, father or other person.

There are diseases that are best treated at home. These, however, are few. They are diseases that are not contagious nor infective—i.e. causing other diseases to other members of the household.

But, when the patient's doctor does think home treatment is the best treatment, that treatment must never be left to the patient and his friends. With an efficient transport service it can be carried out by the doctor through his team of medical officers, nurses and technicians.

The transport service thus puts the doctor at liberty to use:

'Work' as a prescription *when it does the patient good.*

'Home' as a prescription *when it does the patient good.*

'Hospital' as a prescription *when it does the patient good.*

There is, however, an important consideration which the patient's doctor must never lose sight of. A sick person in his home, affects and infects that home. So the prostrate sick person is generally better removed for treatment, as if he were an infective case.

One of the most distressing and most wasteful diseases of the home is the physical and psychological orientation *of a whole family* round the pains and suffering of a sick person. *The whole family becomes diseased,* i.e. the disease becomes endemic. The old idea that the sick person was the cross that had to be borne is an exploded myth belonging to the past when there was no thought or possibility of providing adequate and efficient treat-

ment for sickness. It was the way of, and the reward for making the best of a bad job—and, we have already seen, you cannot make the best or even the better of anything that is bad, you can only stop it getting worse. Home treatment, therefore, may, and usually does, mean that neither the patient nor his family are in fact receiving efficient medical treatment.

Furthermore, half the sufferings of the sick person himself arise from his sense of being a burden to, and of being dependent on his family; his dependence on those *who are not servants* as are doctors, nurses, etc., whose profession it is to service the sick. All the so-called 'heroic sacrifices' made by a family make matters worse for all. When the hospital was a 'poor house', last resort of the hopeless and the destitute, there was reason for making such sacrifices. To-day, they are forms of mutilation that in themselves need medical attention.

Under our scheme then, the doctor will be free to prescribe what is best for the patient and for his family. Hospital treatment may be duly prescribed. If it is, here again an efficient transport system makes all the difference, for it will bring the hospital nearer to the home.

Now the patients who are being treated in hospital are of two kinds: (1) those who can *come out and visit* their homes, relations and friends; and (2) those whose families, relations and friends *must visit them.* Either of these is something that the patient's doctor may wish and will be able to prescribe for the good of the patient. The doctor must be able to make use of the transport system to carry the patient to his friends, or vice versa, to carry the friends to the patient, as part of the treatment of the disease.

This of course is only possible if our new hospitals are controlled *by the patient's doctor* in the interest of and for the benefit of the patient, so that hospital routine will no longer turn on the specialist and on the nurse but on the patient and on the patient's doctor.

Not less important, an efficient transport service saves the doctor's time. As things are at present, one-half to one-third of

the doctor's time is spent in a motor-car driving about the streets. Take all patients to the centre, and you save this wasted time. Thus, in one stroke, you add a half to a third to the number of doctors on the active list. There need then be no shortage of doctors—and you can introduce the patient's new medical service at once.

Special emphasis must now be given to what is perhaps the most important aspect of using an organized transport service to give the patient's doctor and his team easy and rapid access to the patient even while working. It is the one and only way to educate and encourage the sick person *to take his disease to the doctor early*.

What we have defined as 'ambulatory diseases' include the early stages of 80 per cent of all diseases—early stages which at present even the patient's doctor rarely, and then only accidentally sees. 'Ambulatory diseases' include also the 'minor maladies'—to which doctors now give little or no scientific attention, being already too occupied with the end stages of major maladies. For we must never forget that the most urgent call upon the doctor is to postpone death—and the more urgently death threatens, the more urgent is the claim upon the doctor. Under the present system, then, most minor maladies escape scientific attention. There would be no place for quack remedies,[1] herbalists, chiropodists, arch supports at the bargain counter, etc., if the doctors were in a position to pay due attention to minor maladies.

Minor maladies are those diseases which the patient thinks it not worth while to take to the doctor. There are hosts of them, and all of them have the makings of major maladies. In fact, except for the acute fevers and for injuries, all major diseases begin as minor maladies. Important and serious then as are minor maladies it is a remarkable fact that the only method that has yet been found of dealing with those 'sick' *who will not*

[1] £20,000,000 per annum was spent in this country on self-prescribed remedies before the war.

go to the doctor, is the Pioneer Health Centre method of periodic health overhaul of the family. Sending the patient with a minor malady to his doctor's crowded surgery was found to be of no use at the Pioneer Health Centre; and of course sending him to the hospital was worse, for the specialist there is not interested in, and knows nothing at all of minor maladies. Indeed, so completely inadequate is the present medical system that in the Pioneer Health Centre we had to open up a special research department to deal with these patients.

The 'ideal' of any patient's doctor is that *every disease and every disorder* shall be detected at its onset, that is to say, at the earliest moment that the trained doctor could diagnose it. And further, that it should be treated immediately—so early, in fact, that neither diagnosis nor treatment will interfere with the social and industrial life of the patient, thus making him socially sick as well as physically sick.

The first step to the realization of that ideal is to equip the patient's doctor with all that he needs for modern scientific diagnosis and treatment; that is to say, a Local Clinical Centre, and with access to his patient while it is still good for the patient to continue his work. That is the beginning.

And when once that is working, the next step is to establish *health* centres of the Peckham type, where the trained health doctor can detect disorders in their earliest stages, before the individual himself is or can be aware of anything wrong, and long—possibly years—before he decides to become 'a patient'; for, by the Peckham method *disorders* can be dealt with long before they become *diseases*.[1]

Let us proceed then step by step. The first step is to equip the patient's doctor with a clinical centre in which there must be all he needs to do his job.

CONSULTATIONS

There is yet one other new but essential feature of a Clinical

[1] See definition of 'disease' and 'disorder' in *Biologists in Search of Material*, p. 78.

Centre. It must have a consultation service and a consultation theatre. How does this benefit the patient? In two ways.

First, every patient's doctor who meets a difficult problem and feels the need for a second opinion in either diagnosis or treatment, must refer the patient to 'consultations'—held daily or weekly, at times to suit the convenience of the patient. At the consultation, the *general practitioners* of the centre will attend, so that the patient's doctor may ask help from his colleagues. These consultations will be presided over by one of the consultant staff of the District Hospital (with which we will deal later). In this way, the patient will have the advantage of the whole experience of the doctors of the district for the solution of his problem.

Secondly, by this method the doctor no longer will have to rely on his own *limited* experience; he will be learning all the time from the widest possible experience in his locality. Not only the one patient, but all his patients will benefit.

Ah! The doctors might say: 'This might mean that the group of doctors were acting as cover for the incompetence and inefficiency of any one of its members.' Yes, that could be so. But the doctors alone would suffer from their colleague's inefficiency —not the patient. At present, it is the patient alone who suffers as the result of the personal incompetence of any doctor.

This provision for consultations means that medical education becomes a continuous life-long process. In these days of specialism, it is usual to think that education depends upon the teacher; that is not so, it depends far more on a continuity of interest, sustained by the natural method of 'talking shop'.

Here at last we get rid of the intolerable isolation which bears so heavily upon the doctor, and we further create a continuous and mutual interest among all the doctors of the district. This in turn will have its effect upon the patients, both as patients and as citizens.

THE REGISTRATION DEPARTMENT

This is an entirely new departure as an integral part of the

organized medical services. It should really be called the 'intelligence department', because here we find the records of all the diseases diagnosed, their location in the area and the occupations with which they are associated. This information will help the doctor to trace the causes of disease that lie in the environment. It is, in fact, the work the *epidemiologist* and *endemiologist* should now be doing, instead of which he is merely concerned in compiling statistical returns of death and disease which he generally publishes under the curious title of 'Vital Statistics'. And even then, such statistical analyses lose much of their point, for they are only made long after the events have occurred.

Under the new management, the records of disease in the locality and the district will be analysed by the epidemiologist and endemologist daily, so that all the doctors of the district can be kept in constant and immediate touch with any infectious or contagious disease from the moment of its first appearance in the area, and thus be in a position to act in a *preventative* capacity.

These records will include not only diseases, but accidents and injuries arising in factories, on roads, etc., so that the incidence in any one place will be information shared by all doctors. This will enable the doctors to see that the proper preventative measures, industrial or otherwise, are taken. This is part of the responsibility of the patient's doctor, for he is there to protect as well as to treat the patient.

Thus in the registration department, the technical assistants of the endemiologist and epidemiologist will keep the live records of the incidence and distribution, treatment and duration of all diseases, so that the patient's doctor can deal not only with the patient, but also with *the patient's environment*, through the specialists in endemiology and epidemiology. In addition to this, the recording office will undertake the normal routine work, providing secretaries and recording clerks to the general practitioner staff, and supervising the appointment list of each general practitioner.

OTHER FEATURES

Special Examination Rooms include rooms housing special pieces of equipment for the examination and treatment of special parts of the body as, for example, the eye, the ear, the chest; and also one or more dental operating rooms, where the dental specialist will attend for dentistry.

The other departments of the clinical centre are all of them technical. They will be in charge of trained technical assistants (not doctors or dentists as is the case in many of the more modern hospitals to-day). These will include such technicians as pharmaceutical chemists, analytical chemists and physicists, X-ray and other types of electrical technician, a dental mechanic, an optical mechanic, artificial limb mechanic, etc.

It will be appreciated that the Local Clinical Centres are elaborate organizations—but they should not be housed in permanent buildings or architectural memorials and monuments to commemorate either the mayor, the architect or the builder. Experience in this war has taught us how to accommodate the medical services in buildings that permit of rapid change.

Nothing is growing so fast as medical technology; it is in its early adolescence, and nothing is more ridiculous than a gawky boy in a suit of clothes that are four or five sizes too small for him, and nothing more painful than boots that do not grow with the boy. Thus all accommodation must be of a semi-permanent kind. The Forces on demobilization will provide any amount of building material suitable for these centres. There need be no waiting to put them into operation. Nor should it be forgotten that a transport service allows a very wide range for siting these Local Clinical Centres.

The war against disorder and disease can only be won by mobilizing and equipping the whole medical profession—50,000 strong. A modern army does not fight with bows and arrows, nor by skirmishing in back alleys. The medical war is as elaborate an affair as the present war, and like the war it is a

total war affecting 80 per cent of the populace. The Local Clinical Centres are the front line organizations.

Now we can turn and look at the next line of attack—for we must never settle down comfortably entrenched for a defensive action as in the past.

THE DISTRICT HOSPITAL

The future hospital must primarily be an extension of the general practitioner's equipment, providing beds and wards, nurses and technicians for the treatment of the prostrate patient —not only for those needing specialist treatment, but for all those who are laid low and are prostrate, whatever kind of treatment they need.

All treatment of disease is essentially experimental. This does not mean that the doctor is guessing at treatment or experimenting on his patient. It means that every sign and symptom of disease can be modified by the individual patient, and similarly that every patient can have his *own* reaction to every *remedy*. For example, if you wish to poison a germ living in the patient's body, you must know both the dose that will poison that particular germ and the dose that will saturate but not poison that particular patient—and these two doses are not the same in every case. So you see that nearly all drugs of that kind are 'kill or cure'—the doctor must not cure the disease and kill the patient—which does sometimes happen. Nearly all modern remedies are like the germ poisons: they are very very critical remedies capable of doing as much harm as good to the patient. Hence, *all treatment* is in fact experimental.[1]

Every patient's doctor must therefore have at his command all the essential skill and labour needed to control and direct these experiments. The doctor must have his team of technicians (including legitimate specialists) under his direction and control, if the patient is to get the maximum benefit of medical science.

[1] There may be rare exceptions among the so-called 'specific' remedies.

That is what the clinical centres and hospitals are for; a doctor without his clinical centre and hospital is guessing—he is using the statistical methods of *the average and the normal.* Average and normal patients do not exist. Statistics can serve to determine the dose you put in the bottle, but not the dose you put in the patient. *Every patient is a law unto himself.*

Nor can you separate the disease from the patient—and only the general practitioner knows the patient. That is the main reason why the general practitioner must control and direct *all treatment,* even that relegated into the hands of the legitimate specialist. As we have already seen, the general practitioner alone, as part of his art is concerned with both the patient and the disease.

Thus not only the Clinical Centres, but the District Hospital beds also must be under the control of the general practitioner. Nothing must be permitted to come between the patient and his doctor. Where the patient goes, there *his* doctor must go.

All hospitals must be general and inclusive hospitals—with special departments for special purposes. These District Hospitals will then house the beds for the treatment of all diseases —medical, surgical, mental, and all the various forms of infectious disease. Even mental cases must be accessible to the general practitioner. Indeed it is a profound mistake to separate any disease and any treatment from general therapy; the asylum is every bit as much a hospital as is the fever hospital—even though therapeutic 'restraint' needs the King's Commission in Lunacy to authorize imprisonment.

The hospitals are then to be used *by the general practitioner staff of the clinical centres.* They are to be considered as part of the general equipment of the general practitioner. They will serve a district group of clinical centres. Thus all the general practitioners of a district will find a meeting place in their own District Hospital, just as all local general practitioners find a common meeting place in their own Clinical Centre. The hospital and the clinical centre are really a mere recognition of the fact that the tools and equipment can be so big that they must

serve, not an individual but a group of craftsmen if they are to be economically efficient.

All hospitals then are to be general hospitals, with *departments* for their specialisms—e.g. for surgical, mental, epidemic and endemic disorders. The reason is that the patients must be under their own doctors from the beginning to the end of any diagnosis and treatment. It is part of the doctor's ethical contract to protect the helpless patient—even against the specialist member of his own profession. The doctor cannot share or shelve his responsibility, even in a hospital.

Let me give you some examples. 'Appendicitis' was once a fashionable disease. . . . Yes, it does seem strange that diagnosis can be subject to the vagaries of fashion, but it is a fact. When appendicitis was fashionable, it used to be a standing music-hall joke—hiding the truth under a laugh—that the patient had a warning tattooed on his body—'my appendix has been removed three times!'

More recently, say twenty years ago, very few children reached adolescence with their tonsils intact. That was in keeping with the prevailing theories taught by the specialist in hospital. Only the general practitioner saw the *results* of that operation—and the results were not good. So out of this experience, the general practitioner stopped sending patients to the specialist for tonsil operations, as a general rule. Again, gastric ulcer, a chronic and desperate disease, was treated fifteen years ago by the specialist by cutting out the ulcer or ulcer-bearing area from the stomach. The general practitioner by experience learned the results of that procedure—and he stopped sending such cases to the specialist. The operation is now comparatively rare. *Only the general practitioner* can fully assess the success of any treatment. The specialist is trying to dodge that fact by setting up 'follow-up departments' to assess the results of his work; that is a very poor substitute for the general practitioner. The specialist need only ask the general practitioner, for the general practitioner is the person who will be in a position to determine whether the treatment has been good or bad

—and if bad he will cease sending cases to that specialism. The patient's doctor, the general practitioner, is the only competent and *independent* judge of the ultimate value of the specialist's handicraft.

The hospitals are there for the patient, not for the benefit of the specialist. It is more necessary now than ever before to have this bulwark—the general practitioner—to protect the helplessness and innocence of the patient, because a mass of information, accurate and inaccurate, is handed out by the press, and this the suffering sick seize upon in desperation. *The Citadel* was a popular novel dealing with that aspect of specialism; it was based on more than a mere grain of truth. Direct access to the specialist is a potential danger to the patient—not because the specialist is a rogue, but because he can only treat the disorder; he knows neither the patient, nor his environment.

We do not decry the specialist's zeal—but his discretion. You cannot temper red hot zeal; it has to be annealed by the general practitioner—the patient's doctor. When your doctor needs a second opinion he may refer to the specialist. In doing so, your doctor only thinks that *two heads* are better than one, not that the second opinion is to be preferred because, being specialist, it must be better than the first opinion.

All hospitals then must be general hospitals for the use of the general practitioner in the diagnosis and treatment of the patient. A sick person is the doctor's 'patient' and the specialist's 'case'. If you remember the fact that a general practitioner knows all about the patient, while the specialist knows all about the disorder, you will see that from the patient's point of view both the general practitioner and, when he is needed, the specialist, must *together* look after the diseased patient. It needs both 'art' and 'craft' to treat the diseased patient. There are of course a few specialists, very rare nowadays, who are not only craftsmen but artists, but they are the exception that proves the rule. The rule is that a specialist is only a specially trained craftsman who has a talent for a special craft. The general practitioner is the conductor—the artist—who should direct

and control the orchestra of craftsmen who specialize in this, that or the other instrument.

I have emphasized these facts again, because the hospitals are now the great seat of the monopoly by the specialists, including the bastard specialist who is entrenched behind the hospital bastion. Until the public have breached the walls of the citadel, they will not have won for the patient medical efficiency in every branch of medicine. The battle of the patient has to be won and it is most unfortunate that neither the medical specialists nor the general practitioners have so far helped the public to this end.

Very well then, under a proper medical service the patient goes to the hospital and takes with him his own doctor, to give him his treatment and to watch over any craftsman that he may call in to do any job.[1] Since the doctor has no time to waste running hither and thither from one specialist hospital to another, the specialists must conveniently work in the different departments of a general hospital. The doctor's *time* as well as his skill belongs to the patient; it must not be wasted.

So the patient is now in his own hospital. As hospitals are at present, they are run for the convenience of the specialist—so that a patient with a pain in his joints may find himself next to another whose disease is noisy and revolting, because all the beds in that ward belong to that specialist. The specialist has what are called his *own* beds, and his *own* wards and his *own* cases.

In our new hospitals, the beds and wards must belong to the patient—as if he were in his *own home*. In this new kind of hospital run by the patient's own doctor, the patient's susceptibilities will be of paramount importance. The patient's companions in distress should not distress him further. If he could sleep all night, he would be in a ward with others who also could sleep all night. He would not be wakened up at dawn to

[1] Do not forget that the doctor will select the specialist not only for his craftsmanship, but also because the specialist is *acceptable to the patient*.

suffer for nursing deficiencies; for the nurses, like the doctor, would be the patient's nurses, paid by him—rather than he the nurses' patient. Possession is nine points of the law, they say; very well, the patient must possess the doctor, the specialist, the nurse, and the hospital. In this new hospital, when he began to get better he would not lie next to another patient who was in the last stages of getting worse. And so on. In fact, once again *the patient of the doctor* and not *the case of the specialist* would occupy the beds.

The specialist has still to learn that pain and discomfort are something the patient prefers to *bear in private*; that keeping a brave face in public is an exhausting process, to suffer in public is ignominious—even more so, indeed, if the sufferer is a sick person. The doctor, of course, knows this, that is why he is called a *private* practitioner. A public doctor is an abomination; he will hold his sick parade in the public square like an army doctor or, like too many specialists in the existing hospital wards, discuss the patient's private suffering in public. They know nothing of the privacy of suffering.

The doctor is not part of a State cleansing department removing *social refuse* to the local public cleansing station, or State hospital. The doctor is the patient's doctor, with the patient as his only consideration; and the hospital must be the patient's hospital, providing something as near as can be to the privacy of the patient's own home. Once these conditions are achieved, the patient's objection to going to hospital will disappear, because he will go there with his own private doctor, into his own hospital.

Thus we have secured for the patient: (1) his own doctor; (2) his own nursing and technical team; (3) his own local clinical centre; and (4) his own hospital. They do not belong to the State, nor to the specialist, but to the patient.

Now we have to take precautions to see that the patient keeps control of his own property. To do that, we stick to medical tradition, and once again place the hospital in charge of consultants, who are super general practitioners chosen from

among the general practitioners of the district as master general practitioners—doctors at the top of their profession.

How to choose the Master General Practitioners. The first requisite is that these master general practitioners, or consultants, must have *succeeded in general practice.* That is to say, many patients must first have chosen the future consultant as their doctor. That of course means unlimited free choice of doctor. Under our clinical centre scheme there is free choice from at least twelve doctors, and since no patient need be compelled to choose one particular centre, if others are near, the choice becomes real and very wide.

To-day, most so-called consultants and all teachers of medicine are men who have fought shy of general practice, its discipline, its rigour, and its training. In future, our consultants and teachers of medicine must be super general practitioners, who have been chosen from amongst those who have succeeded in, not retreated from, general practice. That is where we get to, when we choose the patient as the measuring stick and guide to medical practice. The tool then is adapted to the material—not the material to the tool.

What happens at the present time to a successful general practitioner? As his practice grows, it begins to grow too big for him. What does he do? He begins at once *to restrict the scope of his skill and genius.* He makes his fees high, so that fewer patients can choose him. Not, mind you, because he is a snob, or greedy, but because there is no other way of doing it. And generally it does not work well, so he has to get an assistant with a view to partnership. This even further restricts the scope of his skill and genius, for his assistants are not like house physicians in a hospital—obeying orders—but are quasi-partners, sharing the daily work.

In either case, the successful general practitioner is restricting his general effectiveness as a skilled practitioner. Such a man should do the very opposite and expand his effectiveness and efficiency over larger numbers of patients. He should in fact

become a consulting general practitioner and teacher of clinical medicine, whereby his skill would be available for greater numbers and would be applied where it was most needed, namely to the problems and difficulties of the patient's doctor.

Thus the first qualification for promotion to consulting rank must be that the patient's doctor has made a success of general practice. The patients have determined that by their choice of him as their doctor.

While the patients are the supreme judges of how a doctor deals with his patients—the *art* of medicine—only his fellow practitioners can be the judges of his skill in diagnosis and treatment—the *science* of medicine. These two essential qualifications do not necessarily grow up in strict proportion. So while the first choice must rest with the patient, the second or confirmatory choice must rest with the successful practitioner's colleagues on the staff of the clinical centres of the district. The proposed routine of 'consultations' among the staff of the clinical centres on problem cases, will ensure that any *genius* among the group will disclose itself. So the local general practitioners will be in a position to judge the scientific skill and capacity of their colleague of whom the patients have made a success. His fellow practitioners, who are also his protagonists in practice, should promote him to consulting rank at the hospital, as their chosen guide, philosopher and friend as well as teacher. Thus he will become a master general practitioner.

At present, the consultant and teacher is appointed by his fellow consultants, who have a monopoly of the teaching hospitals. By the above method we effectively democratize medical tradition. Now the consultant and teacher is chosen (1) by the patients who have made him a success in general practice, and (2) by his fellow practitioners because he exhibits a genius and skill above the ordinary. His genius is put to the widest possible use for the benefit of all patients in the district who need more than normal skill to solve their problems.

In our new type of hospital, consultants have a purely executive capacity. They see that the prescriptions and treatment of the

patient's doctor are properly carried out by the technicians and specialists of the hospital. The consultant represents the fact that the hospital is the property of the patient and of the patient's doctor.

In this way the patient can keep the purely professional direction and control of his own hospital in the hands of his own doctor, and can ensure that his own doctor is in constant contact with all progress and experience in medical art and science. Furthermore, the light of genius is not hidden under a bushel and used merely to illuminate the parlour of the rich, but is given scope to shed its light on the man in the street and the woman in the home.

The Teaching of the Medical Art. It is but right that the consultant whom the general practitioner has nominated as a master practitioner, should also become the teacher of the student. So all district hospitals must be teaching hospitals. That further redounds to the benefit of the patient, for there is nothing like youth to force the teacher to keep up to date—provided always that the student is as free to choose his teacher as the patient is to choose his doctor.

Since man invented books, the master practitioner in every profession and craft has almost ceased to be the teacher. The teacher has become a specialist, a man who can read and memorize and make profit out of other people's experience—which in effect is the practice of fantasy. All modern education is of this 'fantastic' nature. It is increasingly true even in medicine—which is one of the most highly technical and practical of all the arts and sciences. Of course the teacher calls it 'theory'—but true theory is something quite other than 'inexperience'.

The master is a practical man who is there to see that the work is done to the best of the ability of his disciples; he is there to incorporate his 'genius' in the 'idiom' of his time and place, spreading his genius as leaven through the lump, or as a catalyst. Outbreeding is the true function of genius; inbreeding is atavism and degeneracy—which follows when consultants appoint con-

sultants and teachers appoint teachers. The master is a man attuned to the idiom; that is why the patient must be the *first* selector of the consultant and teacher, and his local colleagues the electors of their master—and the master washes his disciples' feet, to fit them for their journey.

Each District Hospital must be a Teaching Hospital. Since teaching requires that the staff must keep themselves up to date, then for the patients' sake each district hospital must be a teaching hospital. No doctor should be allowed to learn *only* from his own limited experience. This can be avoided by making every district hospital a teaching hospital, where each doctor can gain knowledge from all the clinical material of the district. *That is the democratization of medical knowledge and experience.*

Furthermore, if the consultant staff of the hospital are teachers, they must collate experience from all over the world, thus concurrently keeping the local doctors up to date.

So each hospital must have a staff of teachers. Who are they to be? They must be the super general practitioners, since the hospitals are there for the benefit of the patient, and only incidentally for the benefit of medical science. Indeed, it is the needs of the patient that should wholly determine the course of medical science.

Thus we avoid the old dangers: if a teacher becomes a specialist in teaching, he will sacrifice everything for the benefit of teaching—in most cases *even* his pupils. A patient is looked on by a teacher as a good 'case' for demonstration and teaching purposes; and so the student gets a wrong impression of the patient and of his own relation to the patient from the very start. Both the patient and the pupil doctor are sacrificed and lost sight of by the teaching specialist.

As we have said before, and cannot too often repeat, the only doctor who puts the patient first and foremost is the general practitioner. Hence clinical teachers must all be experienced general practitioners. The teacher, therefore, will be a super

general practitioner of consulting rank; not a clever laboratory scientist, not a clever teacher or other theoretical or purely technical genius, but an artist in medicine who knows as much, if not more, about the patient than he does about the diseases the patient suffers from. The science and study of suffering is called pathology, and that is the study *of the patient* as well as of the causes of his suffering.

So we now see that all District Hospitals must have a staff of super general practitioners who will teach the students all about the patient and will act as consultant advisers and administrators for the general practitioners of the district. They will in fact act as executive medical officers, seeing that the orders and prescriptions of each general practitioner are carried out by the technical staff of the hospital. They must be whole-time officers, and will, in rota, attend in their consulting capacity at the Local Clinical Centres as well as in the District Hospital.

These appointments will be the highest professional positions —the acme of medical practice.

Every District Hospital shall have:

(1) General wards for the treatment—by the patient's doctor —of the prostrate patient, whatsoever the disease.

(2) Special departments for the application of treatment needing the *specialized* skill of the specialist.

(3) Scientific departments for the continual study of the causes and consequences of disease.

(4) A teaching school for clinical medicine.

(5) A teaching school for the auxiliary medical services.

The professional direction of the hospital shall be under the care of the consultant staff of master general practitioners who will act for the general practitioners of the district.

A number of registrars will assist the consultants in their executive duties.

Ward duties will be carried out by junior resident medical officers under the *immediate* supervision and direction of the consultant staff. The consultants must arrange among them-

selves a day and night resident rota to effect this continuous supervision.

These junior medical officers will be graduate students from the university who must spend from six to twelve months as resident medical officers *before they are licensed and put on the medical register*. To turn doctors loose on the public with no experience of responsibility at all, as is done at present, must not continue. These medical officers will be there to carry out the instructions and prescriptions of the patient's doctor, but they will be guided, assisted and directed by the consultant staff.

RELIEF POOLS FOR SICK ABSENTEES

There remains one other new piece of organization that the patient's doctor needs if he is to be at liberty to do the best for the patient.

If treatment of disease means 'unemployment' of the patient, then *the cure is infinitely worse than the disease, and the doctor's hands are tied.* He is not at liberty to prescribe the best for the patient.

Thus the very first therapeutic measure the patient's doctor needs is a means of relieving the consequences of social sickness or unemployment while he is trying to deal with the physical disability of the patient. *A relief pool for sick absentees is a medical necessity.*

We have seen that the patient's doctor must be absolutely free to prescribe for the patient any treatment that may be necessary. But, before he can prescribe 'home treatment' to a wife, for instance, he must have available 'domestic relief workers'. A wife burns one hand, for example; there are many things she can still do at home, but there are many things she must not do with that hand. The patient's doctor must be able to prescribe a 'domestic relief worker' whom the wife chooses herself from a pool of domestic relief workers.

Or again, before the patient's doctor can prescribe hospital treatment for a wife, he must be in a position to arrange for the care of the family. The wise doctor will not prescribe 'another

woman' to take charge of a wife's own home and family—a home is too personal for that, that won't ease the wife's mind. So the doctor must have available a 'family hostel' where father and children as a group can lodge and be looked after by 'domestic relief workers' in an impersonal way.

Such 'local family hostels' would be ideal schools of domestic training for girls—for prospective brides and for brides. They must be part of a Liberal Socialist educational scheme, and the educational grants should cover their cost.[1] From these schools, the domestic apprentices would go out to any home where the wife needed them while undergoing home treatment. These trainees would be infinitely more acceptable than any form of 'professional' domestic help—as many doctors have discovered when they have had experience of professional helps. Thus the 'domestic relief worker' is an essential part of the social equipment needed by the patient's doctor. He must have a pool made available for any wife, before he can freely prescribe home or hospital treatment, whichever is in the best interests of the patient, and at no cost to the patient.

So much for the wife; now for the industrial worker. Here again, the patient's doctor must be free to prescribe home or hospital treatment whichever is in the best interests of the patient. If the patient loses his earnings or his employment through going to hospital, that makes it utterly impossible for the doctor to prescribe freely.

No patient should ever lose either his earnings or his employment when the doctor prescribes the appropriate treatment—home or hospital. So the patient's earnings must remain what they were, and his own niche in his chosen industry or other employment must be kept for him. Therefore the patient's doc-

[1] Since this is essential to medicine, let me say that domestic incompetence is the commonest cause of disease; every doctor would like to see every bride produce a 'Certificate of Domestic Competence' before marriage, from the 'Domestic Craft Union'. Domestic economy is a craft and profession worthy of every educational facility that can be devised.

tor in the Liberal Socialist medical service must have available a pool of industrial relief workers who shall deputize for the patient during his absence owing to sickness. We are dealing here exclusively with *unemployment due to disease of the worker*, a worker's problem; we are not dealing with the question of a *diseased industry causing unemployment*, which is an industrial problem. They are not the same disease, either as to cause or to effect—as Beveridge and the other monopolists seem to think. That fact alone condemns the Beveridge scheme as a thoroughly unscientific muddle-headed Monopoly Socialism—which always blames the 'individual' and makes the 'individual' pay the penalty—preserving the group at the expense of the individual.

Monopoly Socialism deliberately confuses the issue. When dealing with any disease, the first thing to do is to find out the 'cause', and then deal with that cause. Unemployment is a name for *two different diseases*. The one is caused by the 'sick worker'; the other is caused by the 'sick industry'. When the causes are different, the treatment is different.

At the moment, we are only concerned with unemployment due to a 'sick worker'. You will see at once that that demands an organized pool of temporary substitutes; it cannot be left to the haphazard irrational methods of competitive industrial labour supply.

How would Liberal Socialism solve the problem of unemployment due to a 'sick worker'? How can we relieve the worker of all the 'consequences' and penalties of being 'sick'? The solution is as simple as it is natural.

Who is the natural substitute for the master craftsman? It is *the journeyman apprentice*.

When the apprentice was personally attached to the master, that was easy and natural; the master left his journeyman and apprentices to carry on. To-day all apprenticeship is lost; there is no 'master' to teach the beginner, he is left to learn his job as best he can. That has occurred as the result of the new 'tools'. Tools everywhere, not only in the medical art and craft, are now too complicated to belong to one man. Tools to-day are group

tools. That has made it easy for monopolists to monopolize the tools of craft and skill—to make the worker pay through the nose for hiring the tools—and the worker has paid for the tools a hundred times over in rent and hire. Had there been a hire-purchase system, the worker would have owned his group tools long ago. But that is not our immediate concern.

Group tools mean 'group apprentices' and 'group journeymen'.

Who is the group? That should be obvious. The group is the craft or the trade union.

Now let us get it very clear: (1) that there is no such thing as an 'unskilled worker'; (2) that there are however large bodies of 'untrained workers'; and (3) that no person, male or female, can be allowed to grow up untrained or unskilled, because that interferes directly with their liberty—their freedom to move in an industrial civilization.

Therefore the onus for training workers lies with the craft and trades groups. The group of master craftsmen cannot leave that training to the tool owners. The chief characteristic of the modern tool owner is that he does not know how to use the tools.

So we find the solution to our problem by going back to the tradition of the people (or Liberal Socialism); to the principle of apprenticeship brought up to date. The craft and trade unions, like the medical profession which is a craft union, must take on the burden and privilege of educating and sustaining the supply of skilled and trained workers by a definite apprenticeship and journeymanship.

So the craft and trade unions must be 'ethical corporations' and 'educational institutions', and every factory and every workshop must be a training school and educational institute for the use of the craft and trade unions—just as we have seen that every hospital must be a training school and educational institute for the medical craft.

You may say that means a revolution. It does not. It means that we shall have got rid of the effect of the revolution in industry; we shall have gone back to the point where natural

evolution stopped and artificial substitution began. By changing from individual to group apprenticeship we can pick up the dropped stitch in the tradition of the people.

So every industry and every employment becomes a training school. Industry must no longer exploit youth in dead-end jobs. Because a good boy is also a good office boy he must not be condemned to be a clerk for life; for the office is only one tiny corner of the industry, and the boy must be allowed to explore the whole range of the industry before he finds a place for his talent. So Liberal Socialism or Social Liberalism thrusts on trade and craft unions the responsibility for technical education on a half-time basis leaving the other half for general education up to nineteen years of age. This must apply to all trades, crafts and professions, and thus will lead to *education for 'all'* up to the age of maturity. Technical education then becomes a responsibility, or ethic, of the trade, craft or professional unions. That is the next stage in the evolution of the trade and craft unions, away from monopoly to Liberal Socialism. They have to meet the demand and supply of industry not only in *quantity* but also in *quality*.

This pool of apprentices and journeymen is of course no solution to unemployment due to a sick, diseased or disordered industry; it is the means to meet only the sick worker's needs. The trainees in this pool will represent every stage of progress from cabin boy to captain journeyman in a craft, and provide our pool of deputies for craftsmen and others who are sick.

That then is the principle on which the pool of craft and skill is created and maintained. Once the principle is apparent the details follow naturally. With them we are not concerned in this thesis. What concerns us here is that the apprentices and journeymen become the pool of skilled labour, from which the doctor can draw the substitutes to deputize for the sick craftsman.[1]

[1] I have not dealt with the whole problem, for there is a lesser pool of deputies—the 'pensioners'—who should be used as teachers of the apprentices and who should be a fixed *local* pool—journeymen are very mobile.

So, when the patient's doctor prescribes home or hospital treatment, the doctor notifies the trade union who send a deputy to keep the job open for the patient. Thus *the patient's earnings are still paid* and *his job is secured for him.* The deputy is giving his time in exchange for experience of a responsible job. There is no further charge on industry.[1] In that way you can get rid of the detrimental effect of absentee unemployment added to physical disorder and disease, and make it possible for the patient's doctor to do the best for the patient.

Above all, you break the vicious circle which involves the family and dependants in the patient's disorder and disease—and this is no small factor in the totality of disease.

To retain your earnings and position when sick is no new idea; it is in fact what happens in the higher ranks of industry, the Civil Service, the R.A.F., the Royal Navy, the Army and with municipal workers—*in fact throughout the bureaucracy.*

So, by meeting the fundamental needs of the patient in a rational Liberal Socialist manner, the great bugbear of 'protecting the Treasury' seems to disappear by the mere method of using a Liberal technical educational system to sustain the supply of technicians to meet the need occasioned by the natural wastage from sickness.

Thus the patient is not punished socially as well as physically by his disease. Every encouragement is thereby given to the patient to take his disease to his doctor at first—instead of at last.

MALINGERING

But, says Monopoly Socialism, that will encourage and foster malingering! If that were so, then the Civil Service, the police, the whole of bureaucracy must be a hotbed of absenteeism. But it is not. It is just as hard to persuade a Civil Servant to go sick—even though his job and his pay are secure—as it is to persuade a worker. It is just as hard to persuade the city magnate to go sick, as it is the Civil Servant or the worker.

The richest patient is as loath to suffer 'absentee unemploy-

[1] This is a charge on Education.

ment'—or social sickness—as the very poorest. The one factor that keeps the physically sick away from the doctor is the utter dread and fear of social sickness or unemployment. Every patient's doctor—indeed, every doctor worthy of the name—detests the prescription: 'Stop working'; 'Take a month's holiday'. Even a rich man will go from one Harley Street specialist to another until he finds one who will say: 'You may go on working if you are careful'. A panel doctor wastes more time persuading the patient to 'lay off' than he ever does in persuading the patient to go back to work.

When we are well, we all think that we ourselves would be very sensible and stop work the moment we were sick—a stitch in time saves nine. But when we are faced with the fact of sickness, ninety-nine out of a hundred of us find a million excuses to go on working—when we know we should be under the doctor. The mind of a sick man is not the same as the mind of a well man. The sick mind limps like the sick body; literally, it will face the threat of physical death rather than face social sickness, or 'unemployment'.

That is deeply ingrained in 'nature'. Every mother will tell you that the most difficult task in treating a sick child, is to keep it 'unemployed'—and that is nine-tenths of a nurse's duty. 'Be "patient" '—a very good word illustrating the impatient revolt against unemployment by any sick person.

The medical ministry of Monopoly Socialism have explained to the medical profession that the White Paper is designed to protect the Treasury against sickness claims and that therefore the doctors must be the servants of the State—must be medical policemen as well as counsel for the public prosecutor.

According to Monopoly Socialism every patient is a malingerer—seeking to exploit the State and get money for nothing. 'Certification' for medical benefit has driven a wedge deep into the relationship of patient and doctor and will ultimately split off the doctor from his patient. The State doctor will be compelled to treat every patient as though he were suffering from malingering.

What then in fact is malingering? The prevailing idea that every patient is, *ipso facto*, a potential malingerer, indicates *the 'state of mind' of the official*—not the state of mind of the patient.

The only person who knows about malingering is the doctor. The fact is that malingering is a *symptom* of a disease—it afflicts no more than one in a thousand patients. And like any other disease, it needs treatment—not punishment.

Before you can treat the disease, you must make a correct diagnosis. Malingering is due to *primary* social and occupational incapacity—the square peg in the round hole. There are *two types* of social incompetence—*primary* and *secondary*—and they must never be confused, since the cause is quite different in each case.

The ordinary worker rarely suffers from the primary disease, because his social and occupational incompetence is almost invariably due to physical sickness. He suffers from the secondary type. If he is socially and occupationally incompetent, he immediately gets the sack, and drifts down the scale of craftsmen to become a 'casual' labourer—wherein the hole is so big that almost any shaped peg will do. There is then little opportunity for the ordinary worker to develop malingering, and among the workers, malingering is so rare that it is easy to carry the risk under an insurance scheme.

Now for the primary disease. Where malingering does develop is in those situations where the sufferer can 'cover up' his occupational incompetence. It is thus not the physical incompetence due to sickness but *primary* social and occupational incompetence that causes malingering—the man who does not know his job but clings to it with disastrous results to industry and other occupations. The real malingerer is the death watch beetle of industry and other occupations. Malingering is thus more prone to affect the higher than the lower ranks.

That such parasites should think that all men want to be parasites on industry is only to be expected, for theirs is the 'state of mind' that sees in every patient a malingerer.

It would be as well for everybody to have a clear idea as to *why men work*.

In the existing ordering of society there are two reasons why a man works. The first is a natural or ethological reason. The individual wants to work *because he can*—so as to exercise his faculties, capabilities and competence. If a person knows *how* and *what* to do, it is an irresistible urge to do it—money or no money.

The second reason is an artificial or pathological reason. Either a man has not been educated to know *how* to do what he can do, so that he is a mere 'engine' without any 'machine' attached, a pure source of horse power (casual labour and many repetitive jobs for example); or industry has closed the door to the laboratory or workshop the man wants to work in. Both these circumstances lead directly to the frustration of his faculties, capabilities and competence, so that there is no other incentive besides the threat of starvation to cause him to work.

As we have already shown in Peckham, the pathological reasons are found in the environment, not in the individual. If society is so ordered that all persons can cultivate their faculties, capabilities and competence, these persons will *create* work. As with everything that grows naturally, abundance of work will prevail. There is in fact no other solution of the problem, only the natural one of cultivating the individual's faculties, capabilities and competence.

Unless these 'reasons' for work are kept very firmly in mind, the whole problem of employment will remain in a state of confusion. No amount of 'mass organization' or Monopoly Socialism can attack the root of the problem. The root of the problem lies in *our attitude to the individual*—to his personal faculties, capabilities and competence.

Mass action can only serve as a method of 'treating' palliatively (for you cannot cure frustration) the diseases due to frustration of the faculty for work. That means the use of first one then the other nauseous nostrum or medicament; the Dole—or 'money' as an artificial substitute for 'work'—when men are hungry for the work they can do.

RELIEF POOLS FOR SICK ABSENTEES

It is a biological axiom that no competent worker is ever work shy. Hence we must cultivate competence through social and occupational education: industrial competence through group apprenticeship to our craft unions, social competence through the Peckham method of family education. There is no short-term cure for the 'industrial sickness' that causes unemployment; it will take two or three decades of Liberal Socialism before we breed it out of our national heritage.

Chapter Three

THE POLICY

MANAGEMENT OF THE MEDICAL SERVICES

From the point of view of management, the medical services fall naturally into two distinct organizations. First, the organized patient's doctor, and his consultant, specialist and scientific colleagues. Secondly, the organized local clinical centres and district hospitals with their staff of medical officers, nurses, technicians, etc.

In this section we will deal only with the Clinical Centres and District Hospitals. How are these Local Clinical Centres and District Hospitals to be managed and run? By the State, or by the State's servant, the Local Authority? No! No!! No!!! But by a well tried and successful method which is a British invention and tradition, brought up to date.

The clinical centres and the hospitals must be run by a *Lay Committee of Subscribers* in the same way as British voluntary hospitals—the best in the world—have been managed and developed.

THE SUBSCRIBERS

Who are these new 'subscribers'? They are the local people who will be served by the local clinical centres and district hospitals. Their subscriptions will be collected through their national sickness insurance contributions.

Who will collect the subscriptions? The Treasury.

The Treasury is no more than an insurance agent who knocks at your door every week. Never lose sight of that fact; the Treasury is a mere collector of subscriptions. There is not the slightest reason why the Treasury, or agent, should *spend* those subscriptions because it collects them. You would not let the

bank spend your savings, would you? Then why let the Treasury or Parliament or anybody else do so? They are YOUR SAVINGS.

The people must do the spending themselves; they must spend their own savings. (That again is Liberal Socialism or Social Liberalism.) The people must not leave the affairs of their estate to be run by an agent—for the Treasury, and Parliament itself, are merely the agents or delegates of the people. An absentee landlord is a curse to any estate, but an absentee landlord who gives his agent a blank cheque is a fool and soon becomes a nonentity and a bankrupt. That method of doing things has already ruined the British landed aristocracy—do not let it ruin the inheritance of the British people.

The Treasury and Parliament are merely the agents of the people; among other things they will collect and distribute the people's savings for sickness.

A Lay Committee of the local populace should spend the money. By this method we put power in the hands of the people, so that they are free to buy what they need. That means decentralization of Government, taking the power out of the hands of the bureaucracy and Whitehall, and once again reducing Parliament to a delegation—not a plenipotentative assembly giving orders.

That is Liberal Socialism or Social Liberalism—for money is not power, it is *spending that is power*. The people must spend their own money and retain the power in their own hands.

COLLECTION OF SUBSCRIPTIONS

How will the people's agent collect the subscriptions? From the national earnings—for there is no other source of wealth than *earnings*.

There is a tradition among the people to put something away for a rainy day—each family tries by saving to insure itself against the cost of sickness. *So each subscriber will contribute according to his means*. The agent of the people should collect whatever the worker can afford out of his earnings. That is the traditional and the Liberal Socialist method.

The Government's White Paper method—the Monopoly Socialist method—is to force every individual to contribute according to his *needs*—monopoly takes advantage of the fact that the more you need a thing the more you are prepared to pay for it. That is what the 'flat rate' subscription means. It sweats the poor. If you earn £1 a week you will pay 3s. 10d. per week, if you earn £52,000 a year, or £1,000 a week, you pay 3s. 10d. per week; 3s. 10d. is the price of a cigar to the rich, 3s. 10d. is the price of the 'third child' to the poor. That is Monopoly Socialism.

It could be called C.B.B. Socialism, that is Capital or Big Business Socialism (or Churchill Beveridge Bevin Socialism). The people ought to remember that Churchill, Beveridge, Bevin & Co. are *war expedients*, like 'conscription'. They will defile the peace with capital or big business methods of which the flat rate insurance is a typical example. Remember that war is war and peace is peace and never the twain *can* meet. War means 'capital or big business' methods just as surely as 'capital or big business' means war; that is why C.B.B. & Co. did not conscript capital or big business, but did conscript or monopolize labour—and that completed the monopoly—war *is* Monopoly Socialism. The tradition of Monopoly Socialism is to make you pay according to the urgency of your *needs*.

Now let us look at the traditional method of the people—which is also the Liberal Socialist or Social Liberal method. Each subscriber subscribes whatever he can afford—that is, according to his *means*.

What then are your means?[1]

Every worker is dependent on what he earns. Let us say that a worker earns £3 a week. One worker with that income may be working for himself only; i.e. he has one life dependent on his earnings. Another worker with the same income may be working for his family—let us say that he has three lives de-

[1] 'Means' sounds ugly, it reminds one of the 'Means Test', which was a test of the meanness of monopoly, who make you pay according to your needs, but give you benefit according to your means.

pendent on his earnings. To arrive at the respective means of each, you divide the earnings by the dependants.

So the 'means' of the worker earning £3 per week with only himself as a dependant=£3 per week, that is his means. The worker earning £3 with three dependants, divides the £3 by three, and his means is £1 per week.

What you have done, in fact, is to divide the *earnings* by the *needs* to find the *means*. A very simple piece of arithmetic.

Ah! some calculating statistician will say, but a little child has not the same physical and material value as an adult, you must divide up the 'homes' and 'family'. Well! that is not possible. The 'home and its family' is like an egg, you cannot divide it up and 'keep it alive'. The Liberal Socialist plan, following the tradition of the people, only talks about and considers the *needs of life*—that is why we divide earnings by *one life* or by *four lives*, etc., as the case may be; because it is a fact that there is no such thing as a quarter life or a half life. There are no fractions in *biological* arithmetic or economy, only 'wholes'; one life is as valuable as any other life. Each is unique—that is one of Nature's immutable laws. So, the corollary to that law is also immutable—you divide the earnings by the lives dependent on the earnings and that equals the *means*.

Having defined 'means', the next step is easy. You will subscribe at so much in the £1 of your means—1d., 2d., 3d., 6d. or 1s. in the £1.

Thus (1) if you earn £3 and have one life dependent upon you, then £3 divided by one—£3 at, say, 6d.=1s. 6d.; or (2) if you earn £3 and have three lives dependent upon your earnings, then £3 divided by three=£1 at, say, 6d.=6d.

That is how your weekly subscriptions to the savings fund would be calculated.[1]

In that way you make suitable provision for all lives dependent on you and no matter how rich or how poor you are, you save according to your means. That is in strict accord with the

[1] However you pay, the medical services will cost the nation the same amount.

tradition of the people, and the tradition is not dead, it is alive to-day in every home and family. It is a principle of Liberal Socialism or Social Liberalism.

Every worker then should subscribe according to his means in saving against a rainy day. There would be nothing more to say if *the worker got all the money his work produces.*[1]

But the worker does not get, i.e. have the spending of, all the money his work produces.

A new White Paper, published by the C.B.B. Monopoly, very carefully states that the money the worker produces, very mysteriously or supernaturally, '*divides itself*' [*sic*] into three parts: (1) the employer's costs—3s. 1d.; (2) the Treasury charges[2]—3s. 1d.; and (3) the worker's earnings, 3s. 1d. plus 9d.=3s. 10d. So the greater part of the money—two-thirds at least—produced by the worker is monopolized by C.B.B. (the mysterious deviser is monopoly).

Perhaps the social insecurity of the worker is due to the fact that the employer and the financier, or Treasury, monopolize the greater part of the money produced by the worker. You see, it is not as if the employer and the financier were not paid their own wages, like any other worker. They are, indeed the directors' fees are first and permanent charges on wages costs. So the employers' costs and the financiers' charges are not their wages—not a bit of it—they are unearned income, as it is called.[3] So it is obvious that all 'unearned income' represents the savings of the workers 'as a group'.

It is also obvious that 'unearned income' is not the same as the pension of the 'incapacitated worker', the 'worker's widow', the 'worker's orphans', or the 'worker's dependants'—because all 'pension income' must be part of the 'worker's wages'. Ap-

[1] Monopoly economists will tell you work produces goods—not money—that is eye-wash! 'Goods' are what the worker *elects* to spend his money on, not what the industrialist selects to make.

[2] The Treasury being a branch of the Capital or Big Banks.

[3] Meaning that the recipient did not work to produce it—somebody else did.

parently monopoly recognizes the fact, for that is what the 9d. is (3s. 1d. plus 9d. is the worker's share). The worker would seem to get only one-third of the money produced by his work.

Now we are told in a White Paper by C.B.B. & Co. that every worker should be able to *exist* on his 'earned income'—which means that nobody is dependent for his existence on 'unearned income'. Unearned income then has not got to be divided by any life, so it must subscribe to the limit.

So the 'unearned income' represents at least *twice* the earned income, hence if each share of 'earned income' subscribes at the rate of *6d.* in the £1 then unearned income must be at least twice as much on *each share*, let us say 1s. in the £1. Now all this is on monopoly's own showing, so we must leave it at that for the moment, until in fact we have solved the mystery—which is why monopoly should 'spend' two-thirds of the money the worker produces by working. The proportions of worker's earnings to worker's savings may be correct—that is to say, the worker may need to save two-thirds of the money he produces, in order to keep the machinery of industry operating. May be? but that is not the point. The real point is: why does the worker not spend his own savings, instead of leaving it to the mystifying monopoly. The answer is that spending is 'power', and power is the watchword of monopoly.

Well, then, we now see how under Liberal Socialism subscribers' subscriptions are made up. On earned income, the worker subscribes *according to his 'means'*, say 6d. in the £1. On 'unearned income' he subscribes at least twice as much; say 1s. in the £1, on all dividends, bonuses, rents, and on all capital appreciation (i.e. unspent savings).

So the patient (and the people) must instruct his agent, the Treasury, to collect his subscriptions to the Clinical Centre and Hospital Service at so much in the £1 on his earned income and so much more on his unearned income. In every case it is a personal contribution. So that you pay your subscription according to your *means*.

DISTRIBUTION OF SUBSCRIPTIONS

What about the distribution of the subscriptions by the collector—the people's agents, the Treasury and Parliament? That is a different matter.

Distribution must be according to the *needs* of each person —irrespective of age or of anything else.

Now 'needs' have not the slightest relation to 'means'; they do not run parallel. For example, the child has great 'needs' and few 'means'.

Why must distribution be on this basis? Because we are distributing a skilled medical service, from which each, every and all persons must, for efficiency's sake, get the maximum benefit. In and for sickness, everybody must get the best, wherever they live and whatever their means—not according to whether they are rich or poor, or live in a rich or a poor district. This is essential for everybody's good. *Sickness in the midst of a nation is a threat to all its people.* Like a family—in the tradition of the people—we swim or sink together; that is a principle of Liberal Socialism.

It is a scientific fact that the social security of an individual earning £50,000 a year depends absolutely and directly on the social security of the individuals earning £100 a year.[1] Rich and poor sink and swim together. Thus nothing but the best is any good either to the poor or to the rich. Consequently, the rich may not contract out of *any* public service. Since in the past they have been more familiar than the poor with 'the best that money can buy', they must use the same service as the poor, so that it will be brought up to the standards of the best. So, under Liberal Socialism the rich cannot have a separate medical service or pay higher fees so as to 'monopolize the best'. As we have seen, under this Liberal Socialist scheme no doctor may

[1] 'Ah!' says he with £50,000 a year, 'the fellow with £100 depends on "us".' That does not follow; there are such things as 'irreversible processes' in the natural order—for example the coagulation of the blood or the setting of concrete. Or, putting it colloquially, the strength of a chain depends absolutely on its weakest link.

practise except *in licensed premises* which are the property of the local populace—rich and poor use the same clinical centres and hospitals, each rich and each poor individual having his *own* chosen doctor. A doctor under this scheme is no richer for servicing the rich and no poorer for servicing the poor.

There is then a very important key corollary to this principle of Liberal Socialism: '*anything but the best is bad*'. That is the family principle: mother and father know that nothing but the best is good enough for their children—the family swims or sinks together. Thus when anything has to be *socialized*, it *can* only be of the best quality—so that whether you need little or much in quantity, the quality is the same. It is quality we pay for under Social Liberalism. The slogan is 'All for the best and the best for all'.

The principle is: while you *subscribe* according to your *means*, you *spend* according to your *needs*.

It is not always easy to determine what your needs may be, but that can be done for the medical services; there is in this case no difficulty. You can calculate exactly how much it will cost to maintain the tools, equipment and assistance needed by your doctor to diagnose and treat you efficiently. There is any amount of data available to make this calculation.

The Lay Committee of subscribers which does the spending, is to get the funds for managing, running and paying for the Local Clinical Centres and the District Hospitals, from the people's collecting agent, the Treasury. The Lay Committee now provides and owns the tools and employs the technicians needed by the medical services. The Lay Committee does *not pay the doctor*; it only maintains the tools, services and equipment needed by the doctor.

Collections from means and *distribution according to needs* makes the efficiency of the medical service national as well as local. Efficiency thus no longer depends on whether the area in which you live and work is wealthy or poor—it does not depend on local rates and local wages. In this way, every locality is free

from the penalties of either wealth or poverty—and both have their pains and penalties. (That again is Liberal Socialism or Social Liberalism.)

THE LAY COMMITTEE OF THE CLINICAL CENTRE

The Lay Committee of the Clinical Centre is elected by, and from among, the subscribers within the locality served by any Clinical Centre. It is an 'ad hoc' committee; i.e. elected for its own purpose; it is not a sub-committee of any local authority and no local authority or other authority has any representatives thereon—nor is co-option permissible.

The Lay Committee must be autonomous and local because on it depends the functional unit of medical efficiency—the Clinical Centre.

The locality itself must be defined and determined by the needs of medical efficiency, and by nothing else. Such a 'locality' may be geographically narrow or wide, square or round, crowded or thinly populated—it can never be determined by any pre-existing parish, municipal, county or other boundary.

The 'spending unit', or local committee, is there to fulfil the needs of medical efficiency, and for that alone. Hence it should not have to wait on municipal authority or on anything else to get on with the job of modernizing the medical services.

There is another principle here. Every social service has its own unit of functional efficiency. Thus the medical service may cover a different area from, for example, the educational service, the transport service, or the food service. Each social service has its own 'autonomous localization' and its own autonomous local governing democracy—determined by its own unit of functional efficiency.

Thus the 'social efficiency' of any service comes to depend on the local functional units. Government is in this way decentralized and rests in the hands of local autonomous bodies. In the case of the medical services, it is in the hands of the Lay Committees of the Clinical Centres.

This is a machine age—we are told. If it is, then like good

engineers we must clearly and emphatically distinguish between the 'engine' and the 'machine'. The 'engine' produces the energy or 'work'; and the 'machine' produces the 'goods'. The engine is always running; the machine produces according to the needs. You can let in or take out the clutch between the engine and the machine. In a modern set-up, the cable or grid collects and distributes the energy of the engine, energy which circulates freely at uniform pressure in every nook and cranny of the machine shop. But each machine *taps* this energy as it needs it, to produce the 'goods'.

In this new system of administration, the 'national' authority is the grid which merely collects and distributes energy, but makes nothing. It *only* collects and distributes; it does not govern production but is at most the stabilizer or unifier. As we have seen already, each 'earner' is joined up to the collecting circuit, and the 'grid' picks up from every individual his volume, or contribution of energy or earnings. This energy is then automatically stabilized at one unified voltage before it enters the distributing circuit. Thus only the stabilizer and unifier is centralized. That is the modern engine—and that is what the role of Whitehall and the bureaucracy should be.

The central authority is then merely a stabilizer and unifier—not a controller or director of production. The 'engine' is quite separate from the 'machine'. The 'machine' is *plugged in locally* when it is needed to produce 'goods'. The 'machine' which produces the 'goods' is local; only the 'engine' is national.

Furthermore, ask the engineer and he will tell you that technical efficiency depends on using the *smallest possible engine* to work the largest possible 'machine' in producing the 'goods'. The 'goods' in this case are to meet the needs of the local people.

Government, then, to keep up with modern methods, must be put in the hands of autonomous localities. The central bureau ceases to be an authority and becomes merely the agent. Bureaucracy and egotistic authority which can stop the circulation of energy or work, must go.

As we have seen, each social service has its own fundamental

unit of efficiency—its own autonomy. In the case of the Medical Services, it is the local committee of the 'subscribers' to the Local Clinical Centre.

CONSTITUTION OF THE COMMITTEE

Each committee should be composed of an equal number of men and women *parents*.

Why parents? Because all social services are purely domestic; they are not public, they are private. They are not the *equal concern* of individual men and women, but the *mutual concern* of parenthood (of husband and wife). A sickness service is a parental duty, and neglect of parental duty is an offence against natural law (as well as against civil law)—a punishable offence. If parents are to be responsible for the family, then parents must control and direct the services the family needs.

In other words, the committee is not an outlet for the ambitions or enthusiasms of the individual—male or female—but the expression of *parental anxiety, wisdom and responsibility*.

This natural force—parental responsibility[1]—is one of the very greatest forces of Nature and of *natural* human beings. That force has not been harnessed for public purposes. Ninety per cent of it is running to waste; indeed, it is even being treated as a contamination and deliberately being run into the social sewers. Put that 'waste' through the turbines of local government, and the full force of social evolution will become at once apparent—for the biological unit, the unit of living, is not the individual but *the family in its home*, that is to say, parenthood.

It will be said, as usual, that the people will be apathetic and (also as usual) that candidates will not be forthcoming. In this case, that will not be so. The people will know all about this

[1] The cosmic energy which activates this force, is love. That obviously is not one of the forces the physicist and engineer know about. It will take a long time to get used to the idea that parenthood is a dynamo that drives the motor—'home'—which creates 'life' and transforms existence into living. Hence a biological engineer creates homes—instead of building factories.

medical service, for it must be noted that there will always be *grateful patients* anxious to see the good work of which they have had experience furthered, and *ungrateful patients* anxious to see the bad work from which they may have suffered, eliminated. That is why voluntary hospitals have been good and progressive.

Furthermore, it is up to the doctors to educate and lead their patients to take an active interest in the medical services. The doctors will want to keep up the efficiency of the services and to keep their tools up to date; to do this they must make the people know the needs of their own locality.

Candidates for a committee are then chosen from parents—an equal number of married men and women residing in the area. The Lay Committee is elected annually, two-thirds of its members serving for one year only, and one-third for two years to ensure continuity of policy. At the end of each year, the members of the committee elect the one-third of their own number who are to serve for a further year, by alternative ballot vote. From this one-third, a chairman, a secretary and a treasurer are chosen by the old committee, to serve for the following year only.

The Lay Committee is the basic unit of administration and government; they own, administer and manage the technical working of the clinical centre. Their purpose is to see that their doctors have all the tools, equipment and technicians needed for efficient diagnosis and treatment.

In order to be in a position to do this, the Lay Committee is assisted and advised by two Boards:

(1) *The Medical Board* consisting of all the general practitioners serving the clinical centre.

(2) *The Auxiliary Medical Board* consisting of the heads of each technical department; e.g. the nursing staff, the pharmacy, the clinical laboratory, the physical (i.e. X-ray, etc.) department, the transport ambulance department and the registration department.

Two or more members from each Board attend in an advisory

capacity all Lay Committee Meetings. They are not appointed for a term of office, but chosen *ad hoc* for each meeting, varying with the items on the agenda of the meeting.

Apart from that, these medical and technical Boards will deal with all their own professional matters, and can meet in common session to deal with any joint professional matters.

All appointments to the staff of the clinical centres are to be made by the Lay Committee from the recommendations of the Medical Board. In the case of technicians, the Auxiliary Board first recommend to the Medical Board, and they recommend to the Lay Committee. The Lay Committee make the appointments from the list submitted by the Medical Board, if that list is satisfactory.

The Lay Committee has three executive officers: the senior resident medical officer; the technical steward and accountant; and the domestic steward and accountant.

These three officers shall move round from each clinical centre to other centres within the district. The senior resident medical officer moves every year, and the stewards every two years. In circulating, they collect and distribute varied experience; furthermore, the committee cannot then leave things in the hands of any *permanent* official.

These executive officers of the local clinical centres are on the promotion list from which are chosen candidates to fill any vacancies in clinical centres or district hospitals. For example, from the list of senior resident medical officers of the clinical centres of a district are chosen:

(1) The doctors to fill any vacancies on the general practitioner medical staff of any clinical centre.

(2) The doctors to fill any vacancies on the junior 'specialist' staff of the hospital.

When appointed, these journeymen—whether destined to be general practitioners or specialists—will act as part-time paid clinical registrars to the general hospital of the district, while they build up their practice, or learn their speciality.

Thus the only port of entry into either general practice or

specialism will be through *experience with patients*, gained when acting as assistant to a group, or to groups of general practitioners; the young doctor acting first as junior resident medical officer and then as senior executive medical officer to the clinical centres of the district.

Thus we ensure that particular or 'specific' skill develops from 'general ability'; that development—like a chicken from the egg—is from the *general* to the *particular*.

Thus the history of a medical student, just graduated, is: first, still unlicenced, to serve as junior resident medical in hospital; then, licensed, as junior resident medical officer in a clinical centre; then as senior resident medical officer of a clinical centre; then either as general practitioner and registrar, or as specialist and registrar learning his speciality.

It is the same with the stewards. They are chosen from executive officers of the auxiliary services of the locality, and they in turn are promoted to district positions.

HOSPITAL ADMINISTRATION

Each hospital is to be a District Hospital; that means no more than that each hospital serves its own group of Local Clinical Centres. The district has no relation or reference to geography, industry, transport, local authority or any other factor; the district is based on the units of medical efficiency—which are the local clinical centres. Under this scheme the clinical centres are not subsidiary *sorting* and *collecting* stations for the hospitals; the hospitals are an extension of the clinical centres, an outlying part of their equipment designed to enable the patient's own doctor to carry out every and any necessary treatment.

Hence the District Hospital service must be controlled, administered and paid for—*at so much per bed*—by a sub-committee of the local Lay Committees of the group of Local Clinical Centres. The members of this hospital sub-committee are *mere delegates* commissioned by the Lay Committees of the Clinical Centres; they are not plenipotentiaries—cocks of the hospital walk.

CONSTITUTION OF THE HOSPITAL SUB-COMMITTEE

The delegates to the Hospital Sub-Committee, equal numbers of men and women, are to be elected annually from among the members of the Lay Committees of the various Clinical Centres, from among those members who are serving their second year, and they will serve as delegates to the hospital sub-committee for the coming year. They will also attend all meetings of their local Lay Committees, but will have no vote in the decisions of the Lay Committees of their Clinical Centres.

So constituted, the hospital sub-committees shall at the end of each year elect (as usual, by alternative vote and ballot) one-third of their members—equal numbers of men and women—to serve a second year *only*. From that one-third, the chairman, the secretary and the treasurer for the ensuing year will be chosen. Delegates serving this second year are not *ipso facto* members of the Lay Committee who originally elected them. Thus we secure continuity of policy, without creating a vested interest in hospital management.

The hospital sub-committee shall be assisted and advised by:

(1) A Medical Board.
(2) A Hospital Staff Board.
(3) An Auxiliary Medical Board.

(1) *The Medical Board* is composed of two or more elected members from the Medical Boards of each clinical centre. These are elected for one year, and one-third of the members are chosen to serve a further year—and from these members a chairman and secretary are elected for the ensuing year. Two or more members of this Board will attend each meeting of the hospital sub-committee. They will be chosen *ad hoc* to meet the needs of the agenda of that meeting.

(2) *The Hospital Staff Board* is composed of all the specialists in charge of departments, and they proceed in the same way as the Medical Board.

(3) *The Auxiliary Medical Board* is composed of the heads of the various technical and domestic departments of the hospital, and will proceed in the same way as the other Boards.

Each Board will have the right to place any proposition on the agenda of the sub-committee. Each Board will manage its own professional affairs and will be concerned in recommending candidates to fill vacancies on the staff, though all appointments must rest with the Hospital Sub-Committee.

By this constitution, each hospital sub-committee shall arrive at its administrative and controlling decisions. It shall execute these decisions through three executive officers:

(1) *The Principal Executive Medical Officer.* He shall be chosen from among the recommendations laid before the sub-committee by the consultant general practitioners from among their own number. The principal executive medical officer shall, as it were, be captain of the ship, dealing with all medical professional administrative duties: admission to, disposition within and discharge from the hospital; and with responsibility for seeing that the prescriptions and instructions of the general practitioner are carried out properly by the house physician, the surgeon, the nurses and technicians.

He shall be assisted in this matter by his colleagues of the consultant staff and by the part-time clinical registrars.

The dean of the medical school, also chosen from the consultant staff, shall act as his deputy assistant.

(2) *The Principal Executive Domestic Officer*, who will be appointed by the Sub-Committee on the recommendation of the Auxiliary Medical Board from among the executive domestic officers of the Local Clinical Centres. The dean of the school of medical domestic training shall act as deputy assistant.

(3) *The Principal Technical Executive Officer*, who will be appointed by the sub-committee from among the executive technical officers of the clinical centres and recommended by the Auxiliary Medical Board. The dean of the school of medical technical training shall act as deputy assistant.

These last two officers shall act jointly as joint secretary and treasurer of the hospital sub-committee and carry out the ordinance and discipline of the sub-committee through their respective groups.

The appointments of the principal executive officers must be confirmed at the end of their first year of office by the appropriate Boards. These three principal executive officers shall move round every two to three years from one district to another district, in the same way as the executive officers of the clinical centres move round from one locality to another locality.

In this way we can secure a constant flow of varied experience and generally raise the standard of efficiency, achieve a uniform maximum through all districts, and avoid parochialism. And, above all, we can avoid the danger of any permanency of officialdom taking over the direction and control of any district or locality by playing upon the innocence of the lay members.

Chapter Four

THE POLICY (contd.)

PAYING THE DOCTOR

Paying the doctor has always been a matter of deep concern to the patient—and we are here only concerned with the efficiency of the medical services from the point of view of the patient.

In our scheme, the local lay committee has already paid for and made available to the doctor, for his free use, all the essential accommodation, material, equipment, tools and technical assistance that his craft needs; and, by the reorganization of *medical education* for the student apprentice, the newly qualified journeyman apprentice and the doctor have been secured the maximum skill, and experience of patients and of equipment.

But, without 'willing service', the best-equipped workshop and the highest standard of skill cannot produce efficiency. We have still to secure the 'willing service' of the doctor.

The basis for 'willing service' by the doctors is laid down by medical tradition which is as old as the profession itself—that the patient pays his own doctor, but that *patients are only expected to pay according to their means.*

It is obvious that this must be so, for no doctor worthy of the name would strive to return the patient to social life and then proceed to cripple the patient socially by demanding more from him than the patient could afford. So, obviously, the patient pays according to his means. The doctor has to be the sort of man who can accept the widow's mite in the spirit in which it is offered. He works on an ethical code; anything that assails that ethical code renders medical practice inefficient.

Wherever society was healthy, it naturally grew up on a vertical basis, so that all classes were to be found in any one social zone, or community. In these circumstances, every doctor had

all classes in his list of patients—the poor and the rich had the same doctor. To-day society is disorganized, so that the people are very very closely segregated and isolated in horizontal wage levels. Now we have doctors for the poor, doctors for the lowest, the lower, the middle, the upper and the rich classes. Doctors are labelled 'panel' (probably worth 9d.), 'shilling', 'half-crown', 'five shilling', 'ten shilling' and 'guinea' doctors. So that now, the doctors are as poor or as rich as their patients; they too have suffered, like the people, as the result of this disease of society—social segregation and isolation. Now, once a 'shilling doctor' always a 'shilling doctor'. Whereas once upon a time the medical profession was a field permitting of social advancement, it is so no longer; and, however much we may be inclined to sneer at social ambition, it was an incentive that helped to attract the best type of individual into medicine. This social isolation of the doctor, increased since the Panel Act, has led to the development of the lock-up surgery for the poor of the large towns—with the result that the doctor to the poor knows less and less about the social life of his patients, so that in fact a deliberate exploitation of the sick poor has arisen out of the Panel Act. A lock-up surgery is as bad as an absentee landlord.

Medical tradition paid a doctor according to the patient's means, so that (in a properly organized society) it was said that the rich paid for the poor—but that is nonsense. The fact was that the doctor to a mixed society was working on an insurance basis; he was spreading risks over his whole practice, the equalization of pay for equal services. But nowadays when the rich have a rich doctor and the poor have a poor doctor, the poor doctor is carrying *all the risk* of the whole profession. For the patient, this inevitably means that the poor doctor has to have the *extreme maximum* number of patients, while the rich doctor needs only the *minimum* of patients to make a living wage—and this difference between the two is the measure of medical inefficiency and failure. Equalization of pay for equal service no longer prevails, except in a few mixed practices, generally in country districts.

So, guided by medical traditions, let us determine that: (1) the patient must pay his own doctor; (2) the patient must pay according to his means; and (3) the equalization of pay for equal services must return.

We must see that the doctor's earnings are solely and wholly determined by the nature of the services rendered. Whether he goes to the slums of Jarrow or the paradise of Bournemouth, his pay must be determined by willing service—because each doctor's earning capacity must depend solely on his capacity to meet the patient's needs.

Ah! The doctor might say: I do not want to go to Jarrow. If you make me, that is compulsion. The patient will say: No; here are the new facts. The doctor is a trained craftsman, his material is the patient. A patient is a sick man who has *no social* value because of his helplessness—as a patient, he is neither rich nor poor, he is merely a patient. *As a trained craftsman*, a doctor will go wherever he can find the tools and equipment to allow him to practise his craft and to exercise his skill —that is his profession. No craftsman would call that 'compulsion', since no one is compelled to be a doctor.

The patient needs a doctor who is first and foremost a professional craftsman, enthusiastic in practising his craft wherever there is material to practise on. At present it is easier for a doctor to exercise his craft and skill in Bournemouth among the rich, than in Jarrow among the poor. He, the doctor, can *do more* for his patients in Bournemouth, and it is that, rather than easy money, that attracts good doctors to rich areas—for there the doctor can order X-ray, laboratory examination, massage, nursing care in the home, nursing homes, etc., can make use, in fact, of *all* the equipment for diagnosis and treatment that his craft demands, every item being paid for by the well-to-do patient. Furthermore, *he keeps the patient*; he does not lose the patient to the specialist at the hospital or clinic, and that is the greatest source of satisfaction to the upper middle-class doctor. Also, he has few if any certificates to sign, even his panel patients are members of his patient's family households. As a

matter of fact, the *net* income of Bournemouth doctors is not so very different from the *net* income of the doctors in Jarrow. The difference is in the number of patients needed to produce the income, and in the absence of tools, equipment, nurses, etc., in Jarrow.

Now the new Lay Committee we have constituted has made it possible for a doctor to exercise his craft everywhere and anywhere. We have now to see that pay, as well as craftsmanship and service, is equalized. So we proceed to standardize the fees, paid for work done in circumstances of standard opportunity of exercising skill and craft.

But let me say at once, so as to avoid any misunderstanding, that a standardized fee does not mean standardized earnings. We are not repeating the error of the craft trade union, in which standardized wages and fees means standardized earnings, irrespective of the 'services rendered'. It is proposed that the patient pays his own doctor for all services rendered at a standard rate —in fact, it is piece-work pay. We are merely going to do on a national scale what the doctor in a mixed practice did on his own. He gave everybody the same service, charged everybody according to their means, and so equalized the fee for services rendered within his own practice. Now we wish to do the same within the practice of the whole profession.

How is this to be done? Once again, the patient instructs his agent, the Treasury:

(1) To collect so much in the pound from all earnings; that is according to the means of the people.

(2) To give the *total sum* to the medical trades union, to be distributed according to the patient's needs. The money is still the patient's money to be spent by the patient.

(3) The patient pays his own doctor as the services are rendered, by drawing a cheque on the medical bank.

In fact, this money, the savings for sickness of the people, is a credit given to the medical profession as a whole. The patients are using the medical trades union as a bank.[1]

[1] The bank can use the 'credit' as other banks and insurance com-

Remember, you are no longer a panel patient, but a patient with a cheque-book. When you are a patient, this is what happens:

(*a*) Your own doctor presents his bill in accordance with medical tradition—for the contract is and was between the patient and his own doctor.

(*b*) The patient merely puts his signature to the bill, if he approves of the bill; if, in fact, he is satisfied—just like any other free consumer of goods and services. If he is not satisfied, either he does not sign the bill, or he signs under protest and can change his doctor. The doctor is like every other supplier; he must seek and get the approval of his customer, not only for the goods (which in this case are the best), but also for the services, which must be *equally* good.

So you see, once you take the patient's point of view, then both the patient and the doctor are sustained in their mutual personal relationship. The patient's and the *doctor's morale* is sustained, and that is absolutely fundamental to efficient medical service.

You have thereby liberalized the personal relationship of doctor and patient (Liberal Socialism or Social Liberalism).

This is exactly what the patient would like; and, as we have seen, it is what the doctors have been doing naturally under their ethical code.

(*c*) The patient then having paid his doctor by merely endorsing the doctor's bill, the bill so endorsed becomes a cheque which the doctor presents to the medical bank of his trades union.

(*d*) The patient's agent—the Treasury—having collected the money already, and paid it over—*en bloc*—to the medical trades union, in advance:

(*e*) The medical bank meets the cheque at a calculated rate for the piece-work detailed in the bill and approved by the patient.

panies do—it can invest it. In this way, the bank can make enough to pay costs of distribution, pensions for doctors and sick pay for doctors.

It is all so very simple that, at once, somebody will say that there must be a snag somewhere. Is there a snag? There is. Oh! no! it is not what the patient's agent will point out to him . . . that his boss, the patient, is giving a blank cheque to a lot of rogues and rascals called doctors. Oh, no! the patient trusts his doctor—even if his agent trusts nobody. That is not the snag.

The real snag is that, as things are, the patient is like an absentee landlord who knows nothing at all about the management—or mismanagement—of his estate by his agents and his delegates—by bureaucracy and by Parliament. That is the real snag. The patient has lost the power to spend his own money. The agent doles it out for the 'absentee landlord' as though the patient's estate were bankrupt. The agent cannot possibly assess the value of services rendered, because the agent has not received the services—only the patient can know how much they are worth. So, like any good agent in the absence of his master and employer, the agent must *contest every claim* made on the estate. The result is that the agent browbeats every employee of the absentee landlord—so that the doctor is like the worker under the Workmen's Compensation Act in which the poverty-stricken claimant has to fight the wealthy insurance agent for every penny he may get. Do you, as a patient, think that is the way to treat your doctor? Do you think you are encouraging your doctor to give of his best, by allowing such offhand scurvy treatment? Your agent acts like a receiver in bankruptcy—'Take it or leave it,' he says; 'that is all the bankrupt can pay.' That is not the way the patient himself would behave—but it is what his agent does.

Do you approve of this sort of thing? Of course you do not. Well, neither does your doctor. He does not trust your agent, who is bound to *exploit* the doctor in favour of the funds, or Treasury. Your agent is bound to do this because he is afraid you will come home one day and personally look into the management of your own estate, and the agent is an honest man and therefore spends the *absolute minimum* on keeping

things going, and feels he must account for every penny piece he has spent.

The patient should get the maximum and the best; but if the patient leaves it to the agent, the patient will only get from the doctor the very minimum benefit from the medical services, for the doctor will play the tune that the agent pays for. In fact, the patient will have to put up with the agent's doctor, that is to say, a doctor paid *to protect the Treasury* as in the White Paper; and because no decent doctor would *voluntarily work* for the agent, the agent will get Parliament to compel all doctors to work for the agent, and so the patient will lose his *own* doctor. The exception to this, of course, will be the rich who in any case will not make claims on the Treasury, but will pay their own doctors' bills—*vide* the White Paper. So it is to be the agent's doctor for everybody but the rich; the agent's doctor and not your own doctor. The patient will have to put up with a conscripted 'compulsory service' rather than have a 'willing service'.

The choice rests with the people. Are they going to *take what they want and need*, or are they going to *accept what they are given?*

Now that you, the patient and the people, have the facts before you, what are you going to choose? For, remember, the doctor only wishes you to pay him according to your means (but not according to the meanness of your agents). The quarrel then is not between the patient and the doctor, but between the doctor and a *third party*—the agent of the people's Treasury. The doctor does not fear the goodwill of the patient—but he very rightly fears the bad-will of the agent. The patient must himself pay his own doctor since the medical ethical contract is between the patient and his own doctor—there can never be a third party to that contract.

The patient then makes up his mind to spend his own money. How much will it be?

The patient should know what payment the doctors are asking from the new medical service. All that the doctors ask is that

they shall not be the poorer for their 'willing service'. They are 'willing' to undertake all the extra work to get the service going in the first place, for what they are earning now.

How can the patient see that the doctors do not suffer financial loss as the result of the new organization of the medical services? That also is very simple.

What the patient needs and wants to know is: how rich or how poor are the doctors now, as a profession? The patient's agent, the Treasury, can answer that question categorically, with figures. The Treasury has a record of the net and gross income of every doctor. All the patient has to do is to instruct his agent —the Treasury—through his delegates—Parliament—to add together all the net incomes and all the gross incomes of all medical practitioners on the register. No exceptions are to be made, for we are out to get a 'comprehensive service'.

From what I know of the patient, he will say to his agent: No! you must not choose the year when doctors earned *the least*—which would be the agent's first reaction. Or again: 'No! you must not average the last ten years, that is taking the mean' —and meanness is no part of the patient's attitude, however restricted his means. 'No!' the patient will say to his agent, 'take the *best year* for the doctors over the last twenty years— because that year may indicate the year when we, the patients, *needed* our doctors most.'

Having got the total net and total gross incomes, the patient now knows what the medical service (only the service) costs— approximately; the actual cost lies somewhere between the net and gross income.

So the patient adopts these figures and instructs his agent— the Treasury—to meet the medical trade union and negotiate, where exactly between the net and the gross income the real cost lies; and then instructs his agent to add to it the necessary 'cost of living bonus'.

That will tell the Treasury how much to collect per pound out of the people's earnings, and pay into the medical trades union bank, to be held for and on behalf of the patients of the nation

for the ensuing year—so that the bank gets the credit use of that sum.

The doctors do not wish to exploit this occasion to enrich themselves; they only ask that they be not the losers by the changes needed to make the medical services of the nation efficient.

As for the patient, I do not think that even your agent will dare to say to you: 'I can get a cheaper doctor than that'—for nothing but the best will do for the patient.

But what the agent will say is: 'Look here! I can use the credit you are giving to the medical trades union—I'll pay your doctor for you.' That again is merely a method of cheapening the service; but it is also a method of giving your agent power over your doctor, power that he can exercise by saying *secretly* to your doctor: 'Look here, doctor, is it not time the patient was back at work? He cannot really afford to be sick.'

The agent hates to lose the power of spending. So the patient and the people must make up its mind to spend all its own money—for it is the patient and the people that alone knows the worth and value of either the goods or service that it needs from the doctor.

That, then, is how the patient pays his doctor.

POSTSCRIPT

Perhaps we ought to deal, now, with the agent's fears, that when your doctor is given a blank cheque to draw on your savings, he will tend to try and get money for nothing—will cheat, in fact. For all agents, since the money that they handle is *not their own*, look on every claim or bill as a 'try on'—they contest every claim.

You might say: 'Now that we have given the profession as a whole the money, how they pay themselves is no concern of the patient.' But it is. Why?

Well, patients differ as to the service needed, not only on account of their particular diseases, but also *as patients*—part of their symptomology belongs to the patient and part to the

disease. So one patient needs more service than another. Doctors, too, have each their own personality, and differ in the amount of service they feel compelled to give to the patient.

Now, just because there is bound to be here and there a rogue among the doctors, who might over-service the patient so as to get easy money, we must not allow this to deprive the nine hundred and ninety-nine other doctors of their personal attitude to the patient, nor the patient of the service he feels he needs. The management of the patient as well as the management of the disease is what makes the difference between a doctor and a specialist—the management of the patient is the art of medicine, and that is what the patient is paying for—and it is the patient we are concerned about.

There are, then, *over-anxious* patients, and also *over-anxious* doctors—and anxiety, wherever you meet it, has to be dealt with as a natural phenomenon. It can be dealt with.

First, it is part of the risk the insurance premium is covering —a risk that can be calculated by the actuarial statisticians of the medical bank. Secondly, it can be kept in check by a statistical analysis of the doctors' bills; making proper corrections for these *two variables*, i.e. the patient's anxiety and the doctor's anxiety; and then surcharging any excess over the mean—and all that can be done without pillory of either the doctor or the patient. So an over-anxious doctor, whose anxiety exceeded the mean, would pay for his idiosyncrasy—as he should. Thus the idiosyncrasy of the patient can be covered by the premium—it is a risk; and the idiosyncrasy of the doctor by a statistical check. Thus the patient need not be deprived of the attendance he wants and needs, and no injustice need be done to the funds.

PAYING THE CONSULTANT AND THE SPECIALIST

Again this is a simple matter. The patient follows tradition, and in the medical tradition the general practitioner (the family doctor) both made the arrangement for a second opinion himself and made himself responsible for the fee of the consultant and the specialist.

That is the correct attitude, for both consultant and specialist are acting as the assistants and servants of the doctor—who can reject or accept the advice and opinion offered by the consultant or the specialist in the best interests of the patient. So that the tradition was not merely that the patient's doctor determined what the patient could afford in the way of fees, but that the doctor was free to act on the advice as he thought best for the patient. Nor was this a matter of preventing the consultant or the specialist from 'taking over' the patient, for in those days neither the consultant nor the specialist saw patients directly.

The doctors themselves must therefore negotiate with the consultants and the specialists as to how their pay is to be distributed; that is to say, by salary, by fee, or in some other way.

Thus the payment of the consultant and of the specialist is a matter for the doctors themselves. Nevertheless, it does concern the patient, for the money is drawn out of the credit standing in the patient's name in the medical bank, so the patient should know what he is paying for. So let us be clear about this fact, which is that the consultant and the specialist render only an *indirect service* to the patient—but a *direct service* to the patient's doctor.

A GENERAL SUMMARY

1. The patient is the material on which medical craftsmen work.

2. The tools and equipment of the medical craftsmen are therefore to be adapted to the material (and not vice versa, as now prevails).

3. The master craftsman of the medical craft is the general or expert practitioner. An expert is the conductor of an orchestra —not a 'specialist', like the first violin or the drummer.

4. The medical contract is with the patient—and is strictly personal as between a patient and his own doctor.

5. It is primarily an ethical contract, which binds the doctor, but not the patient.

6. Under that ethical contract the doctor is licensed to practise *by his peers*.

7. The doctor must practise only on licensed premises.

8. The licensed premises are fully equipped and maintained by the patients (actual and potential).

9. The licensed premises are of two kinds: (*a*) the Local Clinical Centres; (*b*) the District Hospitals.

10. The licensed premises are managed, directed and paid for by the local Lay Committees of the Clinical Centres.

11. The local Lay Committees are elected by and from the local 'subscribers' to the scheme.

12. The 'subscribers' are the people.

13. The subscribers *contribute* according to their 'means'.

14. The subscribers *benefit* according to their 'needs'.

15. Means do not govern needs and needs do not govern means—they are totally independent factors.

16. Disbursement of the costs of the licensed premises and their technical staff is by and through the local Lay Committees of the Clinical Centres.

17. Disbursement of the doctors' fees is by the patient himself.

18. The subscriptions are collected by the patients' and people's agent—the Treasury.

19. The Treasury does not spend the money. The patient and the patient's local lay committee do all the spending according to their *needs*.

20. The Treasury merely redistributes the collections at a universal rate equally over all parts of the system.

21. The people do all the spending (as well as all the paying).

22. No patient is penalized for sickness. His earnings remain the same and his job is kept for him.

23. The *apprentices and journeymen* of the workers—as part of their technical education—deputize for all sick absentees.

24. The craft and trade unions become educational corporations for all technical instruction—regulating and maintaining the supply of trained craftsmen and tradesmen.

25. In that way, unemployment due to sickness is no burden on the sick; social sickness is no longer added to physical sickness. That gives the doctor a chance to cure the sick.

26. The scheme is an illustration of Liberal Socialism or Social Liberalism—the absolute antithesis of Monopoly Socialism.[1]

That, then, is the engine and the machinery of a Liberal Social medical service. The people and the patients drive the machine themselves—they are owner-drivers. No bureaucratic chauffeur is permitted.

Hence the onus of managing his own affairs is thrust upon the 'individual'.

But the average car owner is too easily content to be able only to 'drive', without knowing anything about his engine or his machine. The financier, for example, drives industry ignorantly, knowing nothing about the industrial engine or machine; the industrialist too often drives craft and trade and he generally knows nothing about the 'labour' engine or machine. That must not be. The owner-driver must know enough, at least, to maintain and direct the engine and machine as well as to drive. If not, then we shall slip back to *laissez-faire* Liberalism which has led us directly to Monopoly Socialism. Liberal Socialism or Social Liberalism depends on the fact that no man is free who does not know what he is doing—or what is being done in his name.

The onus is on the individual.

The most important function of a democracy is that the people spend their own money. They must not buy pigs in pokes; *they must learn how to spend.* Democracy has grown up

[1] We always speak of 'Liberal Socialism or Social Liberalism' because father would call it 'Liberal Socialism' and mother would call it 'Social Liberalism'. Each has a point of view; they are the two points of view, or two eyes, of natural vision which is binocular. Thus Socialism does not modify Liberalism, and Liberalism does not modify Socialism; the two act together mutually, as a unity.

and should no longer be doled out pocket money for beer and skittles. It has to spend its earnings. That is a tremendous responsibility.

Hence we must go on to enlighten the individual about the scientific basis of the technology of his medical services—to tell him what is being done and how it is being done.

We have evolved a new kind of political vehicle—a people's political car, designed and built for the owner-driver:

Easy to drive—but, alas, not foolproof. Nothing is proof against folly—not even robot automatism, or doodle bugs.

For those who would not be fools, we append a short account of the scientific principles underlying the political technical invention, as a postscript to policy.

Chapter Five

POSTSCRIPT TO POLICY

WHAT ARE CONSULTANTS AND SPECIALISTS?

In the preceding pages we have detailed what the patient is to expect from the medical services. It is easy to appreciate why you pay your own doctor; it is not so easy to appreciate the quality of the work done behind the scenes—but, until you do, you will not know on what you are spending your money. The patient has not only got his own doctor, his own clinical centre and hospital, his own nurse and other technicians; he has also got his own consultants, his own specialists, and his own scientists. He must know who they are and what they do to help his doctor.

THE CONSULTANT

The consultant is, as we have seen, a super general practitioner—obviously a doctor of wider experience than the doctor himself, but in the doctor's own line. We have already seen how the consultant is appointed and what his duties are in the Local Clinical Centres and the District Hospital. Instead of allowing the successful general practitioner to narrow down his field of action and limit it to the richer members of society, we have arranged to democratize success, by making the field of action of the successful doctor as wide and as critical as possible.

These consultant doctors are at the top of the professional tree; they are the fathers of medical practice, as advisors and teachers who are expanding their field of action to deal with all the patients in a district—not only with a group of 'special cases'. They are not, and must not, become specialists. They must be called in, not to see 'special cases', but to 'general consultative sessions' at the clinical centres and hospitals, so that

they are helping with *all* the problems facing the general practitioner. They are experts—men of wide general experience; they are not specialists—or men of narrow limited experience.

In this way, all the doctors at a Clinical Centre benefit from the study of each others' problems. Furthermore, only in this way is the 'patient' not lost sight of in the 'case'—as happens in specialism. Nor does the patient lose his doctor, nor the doctor his patient—and in losing his patient *lose interest in the disease*, as happens under the present arrangements and as will happen to an even greater degree under the White Paper scheme.

Thus, when the patient pays for a consultant, he is getting full and proper value for his money, and is at the same time democratizing the value by spreading participation in the consultation over all the doctors; in other words, he is *preventing the monopoly of experience for the benefit of the rich.* (Liberal Socialism again.)

The patient must be in a position himself to 'call in' the consultant, knowing full well what he is paying for. Many present-day patients will have had the experience of trying to *get past the State doctor*, in the Army, Navy, R.A.F. and industry during the war, to get the satisfaction of a second opinion—nearly an impossible task in any Government service. When the medical services are founded on the patient, and the patient spends his own money, all difficulties disappear—if the patient takes the trouble to know what he is paying for.

THE SPECIALIST

The specialists must be at the beck and call of the patient's doctor. Under our scheme, we have taken steps to break the monopoly and so have got rid of the illegitimate specialist. What are we left with? We are left with only the legitimate specialisms.

Let us then turn to the specialist. He is a highly trained technician, and no patient can hope to know the details of that technique, but he can understand the general principles on which specialism works.

The legitimate specialists are: the surgical specialist dealing with the anatomy of the body; the mental specialist dealing with the anatomy of the mind; the scientific specialist dealing with the basic principles of medicine, to wit, pathology and therapeutics—pathologists with diagnosis and therapists with treatment of every kind.

Before we can consider what any specialist does, we must know *who* the specialist is. You will have read, in fiction, about the person who is a born artist, a born scientist, a born actor, a born nurse or a born engineer. Well, that is 'who' the specialist should be. Either there are very few of these genetic prodigies born, or we take very little care to sort them out, either at birth or later. So we have to make them, artificially, and they are very poor substitutes for those with natural talents.

In the interests of the patient, we must see that the legitimate specialist is a person with a *specially* developed talent or taste for one of the branches of medical technology. That is one problem, for you cannot make silk purses out of sows' ears—and artificial silk is a substitute only for sows' ears, not for silk. Thus it is up to each speciality to see that it only admits men with a 'natural talent' for the work they have to do. That is the specialists' own problem—their pride in their own talents.

But the patient's problem always is, whether these men of special talent are fit persons to exercise their special talent in the medical profession, that is to say, on innocent and helpless patients. That is why we have taken steps to see that all specialists must *first graduate in general practice* through the clinical centres, before they are qualified to *begin* their specialism. It must be from among these graduates that a speciality must seek for its candidates with special talents. From the patient's point of view, this is a fundamental necessity, for both the science and the technology of medicine are concerned with *the suffering of the patient*, not with 'suffering' in the abstract; so if there must be abstract scientists and technicians, they must begin by knowing the subject of their abstraction. They must know the patient before they proceed to deal with the patient's disorders.

There is still a further danger to the patient in specialism; it is that all specialism tends to become more and more specialized, and so becomes further divided or fragmented into smaller and smaller exclusive pieces, so that frequently you meet specialists who are not only ignorant of the patient, but are ignorant of the *general* nature of their own speciality itself. As the parts get smaller and smaller you get a very large ear and foot attached to a microscopic body, a very very large brain, lung, heart or stomach in a microscopic body, so that not only the patient, but the patient's body and mind are entirely lost sight of among these pseudo-specialists. So the patient in his own interest must see to it that a specialist is first and foremost a general in his speciality and not a mere lance-corporal—paid or unpaid—a violinist, and not a street fiddler.

For a long time, the specialist has divided the patient into *a body* and *a mind*, and kept these as far apart as possible. But now, not only the body but the mind also is lying about the special departments in a multiplicity of pieces. The general specialist must not allow this fragmentation of his speciality to occur.

Why is this important? The patient should know that the human body is a 'natural' machine, but that it differs from the 'artificial' machine in that you cannot deal with one part only—you cannot take it to pieces and put it together again. Whoever meddles with one part of the human machine, upsets the *whole machine*. The human 'bioplane' is not like an aeroplane; you cannot take out the engine and send it to one specialist, nor can you separate the machine from the engine and send it to another specialist. Above all, you cannot separate the 'pilot' from either the 'machine' or the 'engine'. In the 'bioplane' which we should use to explore and exploit life, these three are utterly inseparable—'engine', 'machine' and 'pilot'—body, mind and spirit, or soul.

So when the patient's 'bioplane' taxis into the medical drome, he cannot switch off the 'engine' nor bring his 'machine' to rest; nor can the 'pilot' be separated from either his 'machine' or his

'engine'. That does not mean that 'pilot', 'machine' and 'engine' are one and the same thing. Ask your own doctor; he knows, for he finds bad 'engines' in superlative 'machines' with excellent 'pilots'; bad 'machines' with excellent 'engines' and good 'pilots'; bad, stupid or ignorant 'pilots' with excellent 'engines' and 'machines'.

Of course, most of the 'pilots' that land on the medical drome are doped with suffering and pain; many of them are completely 'knocked out'—completely anaesthetized.

How then, you may ask, can they land on the medical drome without crashing? Because the 'bioplane', like most aeroplanes, has an automatic mechanical guide so that, if need be, the 'bioplane' can fly automatically—but *only on a 'fixed course'*. For example, the automatic guide seems to know its course automatically from 'house' to 'work'; so the 'bioplane' can bring its 'natural pilot' to his base even when he is completely doped with anaesthetics—shocked into unconsciousness by suffering.

Yes, indeed, the mechanical automatic guide is very sensitive and delicate; like many of our modern mechanisms it is a bundle of 'live wires', or nerves—but it has no feeling. Feeling belongs to the 'pilot'; the natural 'pilot' is nothing but feeling, a solid mass of feeling. Even when feelings are doped, they can still be very seriously hurt. That is why you need your own doctor; for when a specialist is busy, the 'engine' and the 'machine' are left running on the mechanical automatic guide; so your own doctor must be in charge to look after the living natural 'pilot'—whose body of feelings are likely to get hurt.

What? You thought that your senses and your sensitivity were the same as your feelings and your aesthesia? They are not. The war has made it common knowledge that machines of metal can be most intensely 'sensitive', with extremely delicate antennae sensing the air for sound, light or heat, finding 'direction' and location, spotting this, that or the other thing. No; your senses and your feelings can no longer be confused with one another.

In modern society, your feelings are merely lost or forgotten; nowadays you only use them when you are at home. Your feelings have not grown up; they are either little 'midgets', Tom Thumb dwarfs that you play with in your holidays and spare time, or they are starved wraiths, or frightening ghosts.

I expect some of you are muttering: "But surely all this is beside the point?" It is not; for the specialist is quite content if the 'engine' and the 'machine' can fly from 'house' to 'work' under the sensitive mechanical automatic guide, because the specialist is so used to operating with the patient under deep anaesthesia, that he hardly knows about the unconscious living natural 'pilot' and his feelings.

Apart from that, in his innocence the natural 'pilot', with the very last glimmer of consciousness, did set the mechanical guide to deliver the patient at his own doctor's door in complete faith that his *own* doctor would carry out the ethical contract to do the best for the patient—for the 'pilot', his 'machine' and his 'engine'—soul, mind and body.

"Bah! Slush!" says the specialist. "This is a mechanical age—an age of engines and machines, if you like, though I don't see the need for the distinction. We, the specialists, can pick a body to pieces and splint it together again, or tear a mind to pieces and put it together again—*artificially*. As for the spirit or soul—the 'pilot' as you call him—well, one day, when every 'body' and every 'mind' has its whole course firmly and irrevocably set, the authoritarian millennium, then the 'pilot' will be superfluous; we will be able to keep him anaesthetized, keep his feeling asleep just as long as the 'engine' and the 'machine' last. Yes! It is true we cannot at present kill him; but, who knows, one day we may even be able to kill him off—the 'pilot' is an invention of the devil anyhow. Meantime we can give him a taste of dope, and he will not bother us very much."

So we see that this age is in fact only a mechanical age because it is an anaesthetic age. Even the patient's doctor is deceived by the vainglory of the specialist. The patient's doctor forgets that he is to-day, as he was in the past, a priest in the temple of

a trinity, of body, mind and soul. Let not the doctor be afraid of his feelings getting the better of him—for the better is the road to the best. If your feelings run away with you, it is likely to be an elopement that is creatively prolific. We have, alas, to anaesthetize our patients—need we doctors anaesthetize ourselves?

THE SURGEON—PHYSICAL AND MENTAL

We might then begin by asking—why have we any specialists? That brings us to the doctor's dilemma, which is not the cynic's dilemma that Bernard Shaw portrayed in his play of that name.

The patient's doctor keeps an 'ideal' always before him. That ideal is that any treatment must leave the patient intact and complete—as whole as possible. The patient's doctor hence abominates every form of mutilation and sacrifice, such as is inevitable in the surgery of body or mind. But desperate diseases demand desperate remedies; mutilation and sacrifice can become necessary evils.

The innocent patient in the throes of suffering is un-sane and is quite prepared at the moment to sacrifice anything to get rid of his disease; that is why it is so easy for quackery to flourish. But the patient's doctor is no 'innocent', nor can he be 'ignorant' —that is to say, he cannot ignore the effect of the mutilation and sacrifice involved. The specialist who skilfully applies a desperate remedy, like surgery, generally gets the patient's consent in writing, as though he knew full well that when the patient is 'sane' (i.e. not suffering) the sacrifice and mutilation may be more than the patient can bear, that is to say, that it will become a further cause of suffering. The specialist is absolved, but the patient's doctor is not; he has to deal with the new situation.

Hence, when mutilation and sacrifice are involved, the patient's doctor uses a highly trained specialist, so as to *reduce the mutilation and sacrifice to a minimum*—for it is so very easy for the cure to be worse than the disease.

The truth is of course that mutilation and sacrifice are *irrational remedies* for disease. This fact is now becoming more

obvious. Medicine is using sulphonamides, penicillin, etc., instead of the surgical knife, to deal with diseases due to bacteria once exclusively the surgeon's field; and at least one of the cancerous tumours (another exclusively surgical field) can now be treated rationally, by medicines. So the day is already dawning *when surgery will cease to be a remedy for disease* and will once again become a great plastic art and craft dealing with *injury and wounds*. In a few years, the medical student will wonder at the darkness of the age that produced textbooks of 'surgical diseases', i.e. diseases treated by mutilation and sacrifice.

Meantime, the patient's doctor is compelled to use this irrational remedy; he prescribes it and must see that his prescription is carefully and accurately administered by a specially qualified surgeon.

So much for the special anatomist who deals with the body. The same considerations prevail in dealing with diseases of the mind. Analytical mental treatment could in fact be described as mental surgery; and if the mental surgeon possessed a proper knowledge of the anatomy of the mind and was as meticulous in his technique as the body surgeon, and if he practised the same scrupulous attitude to his speciality, fewer disasters would occur and much mutilation be avoided. But even mental surgery is an irrational procedure for treating mental disease; it too may one day become another plastic art, dealing with injuries and wounds of the mind (as in war). But that can only arise when we know more about the anatomy and physiology of the mind. In any case, mental surgery (so-called psychology) is always a desperate remedy only to be used for desperate diseases, and then only when prescribed by the patient's doctor.

So the patient can appreciate the need to place the surgical specialist and the mental specialist in the position of servants to the patient's doctor. Desperate remedies need skilled direction and critical selection.

THE SCIENTIFIC CONSULTANTS AND SPECIALISTS

Science has two aspects—exploration and application—some-

times called pure science and applied science. We will deal with applied science first.

There are two departments of medical science, but only one medical science. The two departments are the pathological department and the therapeutic department of medical science.

The patient seldom hears of either the pathologist or the therapist except as servants of the coroner—the pathologist as a morbid anatomist doing post-mortem examination, and the therapist as a toxicologist dealing with the essentially poisonous nature of all remedies.

The reason why the patient and the public know nothing more than that about the pathologist and the therapist is that they are the 'boys' who are locked up in the 'back rooms' of the monopolists who now own the hospitals and the teaching schools. The back-room boys are the scientists and inventors who are as completely monopolized in medicine as they are in industry.

The patient may say: "Does that matter? What can the pathologist and the scientific therapist do for the patient, or for the patient's doctor? Why must he be paid by the patient through his doctor?"

The pathologist is studying the *causes and consequences* of disorder and disease—i.e. the applied science of diagnostics.

The therapist is studying the 'treatment' of *causes and consequences* of disorder and disease—i.e. the applied science of therapeutics (chemical and physical).

The medical scientists are studying the causes and consequences of disorder and disease. But, we must not draw too sharp a distinction between 'causes' and 'consequences', because one 'consequence' can be the 'cause' of the next 'consequence', so that, in fact, 'cause' is merely a convenient name for the 'first event' in any train of consequences that we happen to be studying or that we may select for study. The technique of diagnosis, for example, is that of selecting the right train of consequences and tracing it as far back as possible.

The patient himself is of course more immediately concerned

with 'consequences'; the consequences of breaking the natural law. In that respect, he is like the 'criminal' who is solely concerned in escaping the consequences of breaking the civil (i.e. human or artificial) law. The patient's doctor and the lawyer are counsel for defence; they must know every facet of the law —the lawyer the human or artificial law, the patient's doctor the natural law. The scientist is not—as some of them seem to imagine—laying down the law; Nature does that. The scientist is finding out from Nature what is the law. It is then quite obvious that the patient's doctor must never lose touch with the scientists.

But what happens as things are at present? The medical *student* is in constant contact with the medical scientists, and, what is more important, is constantly talking scientific shop with his fellow students. The medical student qualifies, and becomes a doctor. If he is what he calls 'one of the lucky ones'[1] he gets a job in the hospital; he may even be so very lucky as to get a job in a teaching hospital. Here again he is in *constant touch* with the scientist and with the other lucky ones, with whom he does nothing but talk shop—expanding his knowledge and expanding his own experience; also learning from the experience of others. This 'talking shop' is the communion of learning—the community teaches 90 per cent of what we learn, the teacher 10 per cent. Some of these lucky ones are also clever—about 10 per cent of them—and of course these good doctors reap enormous benefit from the scientist and from scientific intercourse. The next step for those that continue to be lucky, is to join the *staff of the hospital*, to go on to be specialists. Once again, they are in constant contact with the scientists and in a community that talks nothing but shop. Thus the *specialist* never loses contact with the source of all medical knowledge—the scientist—and furthermore he is continually speaking the language of the scientists whose vocabulary and ideology are being enlarged nearly every day with every new discovery.

Contrast this with the patient's doctor. More often than not, he is the qualified medical student who has not been lucky

[1] Luck in this connection means either money or social privilege.

enough to get a hospital job. This applies to 80 per cent of all medical students.[1] What then happens to them? Once they have failed to get the first step along the road to specialism—a job in the hospital—the door of the hospital and teaching school is locked, bolted and barred in their faces. They now enter the hospital only on sufferance, and by the sanction of the monopolists. They have entirely lost touch with medical scientists and medical science; they can no longer talk shop, for the patient's doctor is an isolated solitary individual—with no one but his wife with whom to talk shop. Fierce competition now further separates him from his fellow doctors; he cannot share their experience or give them of his own experience, as the specialists do. Hence, he soon forgets the very language of the scientist, and very soon, even reading the scientific periodicals becomes a matter of some difficulty to him. In any case, learning by reading is false or artificial learning, for it is not learning by experience. A reader's 'experience' is in the nature of fantasy—you cannot even learn the *theory* of *practice* by reading or from teachers who are not in practice. (That applies to all education, particularly the education of the innocent.) So the patient's doctor, from the moment he qualifies, is completely cut off from the theory and practice of medical progress. This is one of the most powerful and effective methods of monopoly—the monopoly of progress.[2]

What happens? The patient's doctor now comes to rely on the clever advertisements issued by the drug and instrument houses for all his information about medical scientific progress. He, like the patient, uses the *new remedies* according to the directions on the bottle—knowing little more about the contents of the bottle than the patient does. And, as you see, it is not because he is lazy or indifferent, but because 'monopoly' has excluded him from the scientists and the schools.

[1] Fortunately for the patient, there are 50 per cent of the clever ones among them.

[2] The newspapers substitute fantasy for experience—on fantasy that monopoly wields its authority.

The administrators are fully aware of all this. What do they do to counter it? They tempt the patient's doctor to a few days' post-graduate study *free of charge*, at the one and only post-graduate hospital in the country—and there are 30,000 patients' doctors! That is administrative whitewash; but it goes further than that, for who teaches the post-graduate doctor? The specialist. What does he do? He does all that he is in a position to do; he teaches these practitioners how to feed the latest branch of specialists' monopoly.[1] Thus post-graduate teaching as organized at present is only another means of still further fastening the tentacles of monopoly on medical practice—both diagnostic and therapeutic.

Now, it is bad enough to cut the doctor off from all source of knowledge of practice and progress, but that is not the worst from the patient's point of view.

As we have pointed out, 'special cases' fill the hospitals, and extra-special cases fill the teaching hospitals. But these 'special cases' represent only 20 per cent of all patients that are seen by the patient's doctor. Hence *the whole of medical science* is devoted to the exclusive study of 'special cases' and the scientist's time is monopolized by the study *of the specialist's problems* only. This means that the general practitioner's problems—which are *the patient's problems—are utterly neglected.* Indeed the problems of the patient's doctor never reach and so are not even known to the scientist shut away in the back room of monopoly.

That then is why the monopoly must be broken—purely in the interests of the patient. Only in that way can the whole army of medicine be mobilized in the fight against disease, and the war be carried into the enemy's camp; instead, as we now do, of sitting back and waiting until the enemy makes open attack upon the patient, and then treating the patient *as a very interesting casualty* of Nature's war against disease.

The Liberal Socialist scheme herein outlined overcomes all

[1] My own experience as a teacher to post-graduate students is that they are for the most part young doctors looking for the *back door* into specialism.

these difficulties, for through the clinical centres and the hospitals the patient's doctor is in direct command of the service of both specialist and scientist, and he has every opportunity of 'talking shop'. Thus can socialization liberate experience and knowledge for the free use of all who need it.

But the value of the medical scientist to the patient's doctor is not only a means of keeping him, the doctor, in continuous contact with the forefront of scientific progress. The medical scientist can be of direct service to the patient as one of the doctor's team of assistants.

We have already had to note the duty of the patient's doctor to deal with the patient as a whole—to guard against the modern tendency to deal with the 'engine', the 'machine' and the 'pilot' as isolated entities. There is the same tendency artificially to separate the patient and his environment. Even in science the full significance of relativity theories—which postulate the unity of the part and the whole—has not yet been taken to heart. In biology, the unity of the part with the whole is a fundamental concept that must not be lost sight of.

The patient and his environment are by nature inseparable. When, therefore, we say that the field of pathology, or medical science, falls naturally into the study of the patient and the study of his environment, that means only this: you can begin from the patient and work outwards, or begin from the environment and work inwards, but in either case you are covering exactly the *same field of exploration*. The patient and the environment are naturally inseparable; they can only be separated artificially and theoretically.

There are, only and always, two approaches to the solution of any scientific problem, from within outwards and from without inwards.[1] Now when you are dealing with a patient, you are

[1] In other words, science is binocular; it must use *both* eyes, both approaches to any problem, and use them spontaneously and mutually. Only in that way will the natural perspective of vision, as well as the two optical pictures of sight, appear.

dealing with a biological problem, and the type-problem in biology is the egg.

Working from without inward, you must separate the shell and analyse it, separate the white and analyse it, separate the yolk and analyse it. When you have done that, the very most you can make of the egg, from this approach, is an omelette. Beat your analysates all together, and you cook and eat a reconstructed egg—the war has made us very familiar with this type of egg omelette.

But, working from within outwards, the solution of the problem is to cultivate a chicken. You in fact synthesize the egg. The chicken, or natural synthesis, is the *biological* solution of your problem. The omelette—an artificial reconstruction, not a natural synthesis—is the physical solution of the problem.[1]

We need both methods of approach. The omelette is needed to keep us alive while we solve the problem of the egg, which is the problem of life itself. But if we forget or neglect the biological problem, there will be no eggs even for omelettes.

So you see, the answer to every scientific problem is utterly different according to whether the approach is from *without inwards*—physical science—or from *within outwards*—biological science. The biological approach in science was first applied in the Peckham experiment, which proceeded from *within outwards*. If we were to apply the same principle in medicine, we should begin with the patient and work outwards into the environment.

(1) *Beginning with the Patient.* If we begin with the patient, the cause and consequence of disorder and disease may be due to some factor peculiar to the individual—the patient. All causes and all consequences are modified by the peculiar and specific

[1] This applies to the entities called vitamins. A vitamin held in the synthetic complex of a vegetable is not the same entity as a vitamin built up or reconstructed from a physical analysate—chemically pure. *Physical purity is biological sterility*; such a vitamin is a drug, not a diet.

constitution of the individual. The study of these *inherent personal factors* can be called *idiopathology*.

Let us take tuberculosis as an example. The commonly accredited 'cause' of this state is the tubercle germ. Yet every pathologist knows that 90 per cent of individuals may have had tubercle germs in their bodies, but only a very small percentage have had tuberculosis. In this case, the idiopathologist is the scientist who is studying the *internal* factor, or idiopathic constitution, which causes an individual to succumb to the germ. In any epidemic, there are people who do not take the disease *because of their constitution.*

That is why it is essential that every patient should have his 'own' doctor. In the old days, when we lived in more natural and rational small communities,[1] the doctor to the community had lifelong knowledge of the patient's constitution. Now that we live in segregated herds—like animals in a stockade—the doctor knows nobody individually.[2]

Furthermore, most doctors now know more about the tubercle germ than they do about the 'patient'; for, as we have seen, they have been taught by the specialist and have learnt all about 'germs' and absolutely nothing about 'patients'. The specialist has exclusively studied 'germs' or 'rheumatism' or 'complexes', but never studied the 'patient', the 'individual' who can modify infections, rheumatism or complexes, etc., *out of all recognition.* For each patient *reacts* in his own way to disorder and disease, just as each healthy individual *acts* in his own way to order and ease. (We act idiocratically—but we react idiopathically.)

Your doctor cannot possibly help you, the patient, to fight disorder and disease unless he knows the sort of resistance or reaction you personally can put up. Blind resistance never yet won a battle. But, as we have seen, your doctor has to learn all about the patient after monopoly has excluded him from the hospital and the teaching school and driven him into general

[1] Based on the biological factors, food and shelter, instead of on industry.

[2] In some country districts the doctor still knows his community.

practice—because the idiopathologist has become a germ specialist, and, what is worse, has been monopolized by the other specialists. So the patient must break the monopoly, this time to rescue the scientist from the cellar or back room where he is confined by monopoly. He has been confined so long, that he will take time to recover his faculty for freedom; but the first step is to release him. He must be set free to move among the doctors who know *all* the problems of the patient—not 20 per cent of them only.

(2) *Beginning with the Environment.* So much for the cause and consequences of disorder and disease said to be inherent in the individual, or patient; so much for idiopathology. Now for the second aspect of scientific medicine—the environment.

The pathology of the environment can be called demopathology. Demopathology studies the causes and consequences of disorder and disease due to factors inherent in the environment.

Indeed, the Peckham experiment goes so far as to indicate that *all so-called causes are to be found in the environment.* The individual merely modifies the consequences of these 'causes'.[1]

The patient, in fact, really runs to his doctor for protection and help in his fight against disorder and disease in the environment. What is more, it is never a cowardly retreat—the patient is only driven to his doctor when the wounds inflicted by the enemy are seriously disabling him in his fight. That is the true relationship of doctor and patient—the patient is a guerrilla soldier seeking help from the trained 'general', the practitioner.

The pathologist studying the environment, the demopathologist, should be studying the patient's enemy lurking in the en-

[1] The Peckham experiment also demonstrated for the first time that there was such a thing as social therapeutics—or social medicine. Oxford University have recently established a Chair of Social Therapeutics; this has become necessary because the demopathologists have ceased to be servants of medicine, and become the servants of vested interests. Since the invention of sewage farms and quarantine stations, social therapeutics have been utterly neglected.

vironment. He should in fact become the chief of intelligence to the general who is fighting the battle of the patient.

But what in fact has happened? The demopathologist has come to look upon *the patient as the enemy of the environment*, as we shall see. So the patient's doctor and the official brass-hatted intelligence officer to monopoly, or authority, have come to be in opposite camps!

There are two departments of demopathology, or the pathology of the environment: epidemiology and endemiology.

(a) *Epidemiology*. This covers the causes and consequences of disorder and disease in the general, the national or world-wide environment. The epidemiologist is dealing with disorders and diseases in the mass. That is why epidemiologists deal with disorders and diseases 'statistically'. Which *particular* patient or individual has the disease is of no concern to the statistician—the patient is only a statistical entity or number. For example, in epidemiology, Britain is one of the healthy nations—statistically; but our experience of individual people indicates that 10 per cent of persons monopolize and enjoy 90 per cent of the health, so that *individually* we are far from being a healthy nation. It is the same with the epidemiology of riches. Britain is a wealthy nation among nations—statistically; but among ourselves, i.e. *individually*, 10 per cent of the persons monopolize and enjoy 90 per cent of the wealth. Or in the epidemiology of politics, Britain is a democracy, but only statistically; among ourselves, i.e. *individually*, 10 per cent of the people monopolize and enjoy 90 per cent of the liberty. Statistics prove *everything—in general*; but absolutely *nothing—in particular*.

So you see, epidemopathology is not concerned with the patient as an 'individual', but only as a 'number' in a mass or multiple. Nevertheless instead of getting on with his own job—which would help the doctor to *protect the patient* against epidemic environmental disease—the epidemopathologist has been wasting his time treating the doctor's patients (for he has now himself become the doctor sitting in a clinic immunizing the patient). Why? Because of his concern to *protect the environ-*

ment against the patient? Instead of treating the environment, he thinks it cheaper and finds it easier to *treat the patient*. In other words, the demopathologist regards the patient, the individual, as the cause of all disorder and disease in the environment. That is why the Peckham experiment is a direct challenge to the medical officer of authority—central or local—because Peckham indicates that *all causes* lie in the environment.

Not only does this apply to the so-called *notifiable* diseases—like smallpox, scarlet fever, measles and diphtheria—but to all diseases. Take poverty, or economic malnutrition, for example. The cause is in the environment, the consequence is mostly borne by the patient, the individual. So what does the epidemiologist do? He isolates and segregates the patient in *slums* and '*housing estates*' and then treats him with the dole of poverty (e.g. rate-borne rents and subsidies) so as *to protect the environment* against *the infectious nature of poverty*. The very latest dole is so-called social security, which means that authority and its officers take more and more of your money to spend, and when you are 'poverty stricken' do everything for you—everything, of course, except 'pregnancy', 'labour' and 'birth' which are irretrievably 'individual'.

Again, malnutrition of the body is now officially recognized as epidemic. The epidemiologist does not *treat the environment*, in which the cause of malnutrition lies. He blames the patient and tries to mitigate the consequences by free milk, free meals —he puts 90 per cent of the people on one kind of dietetic dole or another, so as to *protect the environment* against the patient. Instead therefore of being the servant of the doctor, helping to protect the patient, the epidemiologist is the servant of authority, monopolized by vested interests to protect the environment against the patient.

Or again, malnutrition of the mind is epidemic. The epidemiologist has invented a mental dole for the patient. He does not treat the environment, in which the causes of mental malnutrition lie; he blames the patient and tries to mitigate the consequences by an educational dole—free education, administered

'unnaturally', as it were by hypodermic needles into the individual instead of by the natural method—the 'mouth' of the family—but only so as to protect the environment against the innocence of the patient. The one thing that makes the epidemiologist of authority tremble, is family, i.e. unique and 'individual' education. As long as education is statistical, that is to say that 10 per cent of the people enjoy 90 per cent of the education,[1] so long will authority and vested interest be boss. That is why they feed you with an educational dole—teaching and training you to live to work, instead of educating you to *work to live*. The love of life is monopolized by the statistical 10 per cent who work 10 per cent and live 90 per cent of their time.[2]

So, the epidemiologist, instead of being the servant of the doctor helping to protect the patient, has become monopolized by authority to protect the environment against the patient. According to authority and its servant the medical officer, *the 'individual' is the cause of all the trouble.*

(*b*) *Endemiology*. But let us come nearer home and look at the *endemologist* who should be studying the causes and consequences of disorder and disease *in the locality*—the house, the street, the factory, the farm. Obviously, he should be working hand in glove with the patient's doctor, meeting and consulting in the house and in the locality. But as things are at present,

[1] Trades union, or Labour monopoly, is content if their members get a half share of the 10 per cent, at least that is what the Educational White Paper—now law—emphatically legalizes. The 90 per cent of uneducated individual members: well, we must have workers —we can't all be 'officials'. If you fight monopoly with monopoly, and win, you get a share of the monopoly. I believe that is an immutable natural law of pathology.

[2] Again, the World War is epidemic, but to England and still more to America this war is only a 'statistical suffering'. Ten per cent of the people involved—those in occupied countries—carry 90 per cent of the suffering; to them the war is an *individual* matter. If we forget that, when the epidemic burns out, we shall again be merely protecting the mass against the individual, instead of protecting the individual against the mass. The cause of war is in the environment but the individual bears most of the consequences.

when they do meet they find themselves in opposite camps, at war with each other. How has this come about? The endemologist is a renegade doctor, for he also is there to protect the environment against the patient, while the patient's doctor is there to protect the patient against the causes and consequences of disorders and disease in the environment.

For example, the patient's doctor and the endemopathologist know, and have known for fifty years, that a number of cases of tuberculosis are caused by a factor in the environment—the tuberculous cow and farm. What has the endemopathologist done about the environment? Nothing; not because he had not a perfect cure in his hand; he had. No, what he did was to *blame the patient*, accusing him of spreading the disease in the environment by his dirty habits. Next, he accused the patient's doctor of not knowing how to treat the patient; so he took the patient from his own doctor, built T.B. clinics, sanatoria and now elaborate X-ray clinics, etc., and proceeded to treat the patient —leaving the cause, which was in the environment, alone. The epidemiologist cannot even claim the credit for the modern pasteurization of milk—a very very recent invention—for as a scientist he has known all along that the tubercle germ is killed by heat. The fact is that industry and monopoly has pasteurized milk, not to stop the spread of disease; the milk is sterilized by killing not only the T.B. germ but *all* living things in it by heat—so that the milk will not *go bad in the factories of industrial monopoly*. Monopoly pays its medical officers to defend the process by asserting that sterile dead milk is exactly the *same* as fertile live milk. The endemiologist is there to protect the environment against the patient, for it is cheaper and easier to build sanatoria, etc., than to treat the environment to eradicate the cause. For after all, statistically, tuberculosis is of slight importance.

Once you make the endemiologist the servant of the patient's doctor, then only will the causes of disease in the environment be ruthlessly pursued and eradicated, wherever they are found. As it is at present, the patient's doctor can collapse the patient's

lung so that he does not re-infect himself and the environment. But, do you think the patient's doctor is allowed to collapse the focus of infection in the environment? No. The patient's doctor may stop the patient being infectious but he must still send the patient back to be reinfected by the environment.

Authority and monopoly says to the patient's doctor: "You go on treating your patient for the consequences of environmental causes. The patient's environment no longer belongs to him, it belongs to the local and central authority. The 'people' have vested their interests in us, the authority; the environment is our monopoly, it is not the patient's."

The scientific departments of endemio-pathology and epidemo-pathology were originally created to *protect the patient* against the causes and consequences of disorders and diseases of the environment. Endemiology and epidemiology are now exclusively used to *protect the environment*, as a vested interest *against the patient*, by the so-called medical officers of local and central authority. They are not strictly medical officers, for they destroyed their ethical contract when they signed their contract with authority.

Nothing will come right until you break the monopoly and once again allow the patient's doctor the full direction of these medical scientists—the endemiologist and the epidemiologist—to protect the patient against disorder and disease of the environment—for *in the environment lie all the causes of disorder and disease.*

What then are the duties of the endemiologist and the epidemiologist under the new scheme, the Liberal Socialist scheme?

In every clinical centre there should be a registration department, where every diagnosed disease is recorded and a record forwarded daily to be analysed by the demo-pathologist at the hospital for the area, the information at once being conveyed to the patient's doctors to put them wise to any enemy lurking in that locality or area, and to enable the demo-pathologist to point to any imminent attack.

Thus any factory or any industry could at once be spotted as

having a high incidence of infection—as causing disease to its workers—and this would apply to accidents and injuries as well as to disease. The same applies to housing; for it is not only infectious fevers we are interested in, but *all diseases*, and any 'slum'—be it a poverty-stricken or a riches-stricken area—could be detected as a focus of infection in the environment, needing treatment because committing a public nuisance. As things are at present, it takes years of statistical research into past records to get evidence; this is then forwarded to the central authority, and is acted on or not as that authority thinks fit. Central authority says: "The disease is statistically negligible—there is only 1 in 10,000 cases; it is not worth bothering about it; come back when it gets worse, when it rises from 1 per 10,000 to 1 per 1,000—then we will take notice of it." According to authority a nuisance is only a nuisance when *statistically* it interferes with a nation—the individual does not matter. It is cheaper to pay compensation to the few individuals affected, than to treat the cause which is in the environment—in the street, the factory or the farm. When compensation becomes too expensive, and costs more than the cost of treating the patient, then authority will consider the idea of taking action. Meantime, let the patient's doctor go on treating the consequences—in the patient. So the medical officers go on neglecting known causes of disorders and disease in the environment, and they will go on doing so until it is cheaper to treat the environment than the patient.

Or, let us take the example of accidents and injuries in industry, and the Workmen's Compensation Act. Under our proposed new regime, the patient's doctor would at once notify the accident to his endemiologist, who would at once investigate the cause and consequences scientifically (not legally). Why? Because doubt and uncertainty as to the future of the patient ties the hand of the doctor in effectively treating the injury. The patient's doctor is there to protect the helplessness and innocence of the patient—that is in the ethical contract. To do that adequately, he needs the services of the endemiologist. So the claim for compensation would be lodged by the patient's doctor for and

on behalf of his patient with the expert assistance of the endemiologist—who is a *medical* jurist, helping the doctor to treat the patient, instead of being an agent protecting the vested interest of industry.

Until the endemiologist and epidemiologist stop treating the individual patient as the cause of the disorders and diseases, no progress in medicine is possible. These specialists, like all specialists, must be the servants of the patient's doctor. Preventative medicine, as it is called, must *prevent the patient being infected by his environment.*

In the environment lie all the causes of disorder and disease; the patient suffers the consequences. A fearless fight against causes must *first overthrow the power of monopoly.*

Chapter Six

POSTSCRIPT TO POLICY (contd.)

PURE SCIENCE AND MEDICINE

We have now concluded our survey of the purely technological services the patient's doctor must direct and utilize for the protection and treatment of the patient, and for which the patient must pay according to his means and receive according to his needs. But the patient has not finished paying, for he has yet to pay the *pure scientist*.

That will puzzle the patient. "What", he will ask, "has medicine to do with pure science?" Pure science, he imagines, is one of those strange 'luxuries' that monopoly maintains—another vanity, like pure art, that has nothing to do with the people.

Science and art are no mere vanity. It is true that the great power of science (and art) is only fully disclosed by war, but both science and art are as potent for peace. The scientist and the artist, alas, have been used by the confidence trickster to gild the bricks monopoly offers to the public. Science and art are sustained by monopoly—by 'charitable endowment' or 'philanthropy', as monopoly calls it.

The patient and the public cannot know any more about pure science than they know about all the other services of medicine, *because they have not been spending their own money*. When the people vest their interests and create a monopoly—an authority—they do not know what their money is being used for. Indeed, all that concerns the investor is that his *liability* should be limited. What the monopoly or authority is doing with his money does not disturb him as long as profits accrue; he is *apathetic and anàesthetic*. Like the patient on the operating table, he is oblivious to what monopoly or authority is doing to and for him.

Under this new Liberal-Socialist scheme, the patient of the future must spend his own money, and must know what he is buying. The patients and the people will have to pay the pure scientist.

But, hitherto, neither the man in the street nor the woman in the home has met the pure scientist; so the patient must ask "Who is the scientist, and what does he do for me?" The scientist is the only person who can answer this question fully. So *he* must make the people understand what he is trying to do; he must translate the general lines of his approach to his subject into their terms. This is a discipline which democracy demands of the scientist, so that the people may be 'alive' to the world they live in and the future they are moving into. So when the scientist needs money, he must make the people understand in what direction he is moving and what he can and may be able to do for them.

What then is the pure scientist? Let us first look at science and see how it differs from technology, or applied science. The difference is a fundamental one. The pure scientist is an explorer—he explores the unknown.[1] The technologist is an exploiter—he exploits the known;[2] he exploits the discoveries of the explorer scientist.

Speaking casually and loosely, science and its technology should work hand in glove with each other. But no! that gives a false picture, for science and its technology are in fact the right and left hands of a bimanual body of knowledge—related like the two hands of a pianist, each hand playing its own part and each hand knowing full well what the other hand is doing—acting in *mutual synthesis*. That is no mere 'ideal'; it is as it should and could be. Alas, it is not what is.

Science and its technology are not living and working together; monopoly has divorced them. For example, the scientist broadcasts his knowledge; the results and charts of his exploration are given to the world at large—given freely to the

[1] The only unknown is the future.

[2] The only known is the present.

man in the street and the woman in the home.[1] Not so the technologist; he patents, i.e. monopolizes and makes secret, the results and plans of his exploitations. Exploitation has gone to his head, so that the right hand of knowledge no longer knows what the left hand of knowledge is doing.

Or another example. The scientist, because he is a *lover of Nature*, continually proclaims that his discoveries and creations are due to his *willing obedience to the laws of Nature*. The technologist, on the other hand, continually broadcasts that he has *conquered Nature* and that his exploits and inventions are due to the rape of Nature; in fact due to ignoring (even defiantly) the laws of Nature. Exploitation has indeed gone to the technologist's head; he has become a gangster drunk with the ideology of conquest. Ignoring or defying the laws of Nature only multiplies disorder and disease. The conquering technologist knows these laws—for it is the discoveries of the explorer scientist that he is exploiting. Only those 'in the know' can *ignore* the facts, so that 'ignorance' is a disease or vice of those in the know—of the learned. Ignorance is disordered knowledge, it is not no-knowledge—or innocence. So the artificial divorce of science and its technology is a most serious thing.

Knowledge is like wealth. The British, for example, are an educated nation—statistically, or *en masse*. But 90 per cent of the knowledge is monopolized by 10 per cent of the people; thus 'individually' we are an *innocent people*, because 90 per cent of the people share only 10 per cent of the knowledge. Never was so little shared by so many. Now the 10 per cent who monopolize 90 per cent of the knowledge speak of the 90 per cent who share 10 per cent of the knowledge not as the 'innocent' but as the 'ignorant' public. That is part of the guile and cunning of authority and monopoly—to make people ashamed of their natural innocence by calling it 'ignorance'. Who among

[1] That will not last long after all monopolies have been monopolized by one monopoly—the State. Monopoly is forced to ignore whatever does not suit its purpose or plan. A new Dark Age threatens us.

us has not suffered at the hands of the teaching profession the acute shame at our own innocence—ashamed to confess that we did not know. Indeed, it seems to be part of the technique of the so-called educationalist to instil this shame, so as to force us to acquire *other people's experience*, and make that our own.

We have, then, discovered *what* a scientist is: he is an explorer of the unknown. Now we discover *who* the scientist is. The scientist (like the artist) is a person who is utterly unashamed of his innocence; he is exploring the unknown and glories in his innocence. The scientist explores the unknown with reason and will, just as the artist explores the unknown with feeling (or aesthesia) and love.

Thus we make yet a third discovery. It is the fundamental fact that, as the child is father to the man, so it is *innocence* that grows into *wisdom*. Wisdom does not lie behind the dark clouds of ignorance; for the greatest mark of ignorance is that it *ignores* the unknown. It 'ignores' not only some of what it 'knows' but, more important, all that it 'does not know'. It even goes to the length of saying that only through death can we hope to know the unknown—not through living.

It is innocence that can grow into wisdom; so then we have also found the Achilles heel of monopoly. There are 90 per cent of the public in a state of innocence; if we cultivate that innocence it will grow naturally and differentiate into wisdom. Therefore the scientist must no longer loosely and indiscriminately broadcast his discoveries and creations; he must cultivate the common plot of society, the public parks and village greens, and there sow his seed of knowledge in fertile soil. He must go about among the innocent public and take them into his confidence, make his message *personal* and *idiomatic*—as was done family by family in the Peckham experiment. The scientists at Peckham were the first scientists to build their laboratory and workshop on the village green and children's playground. And that is where all scientists must work in the future: not in the isolation of the dark underground back-rooms of monopoly.

There is a slogan—'Let the people sing.' There is a better slogan—'Let the people spend'; in that lies liberty.

The scientist is the natural liberator, liberating the unknown, creating knowledge. He has two alternatives before him: to fight for a place or privilege among the 10 per cent who have monopolized 90 per cent of the knowledge, to join the Board of Directors of monopoly as a guinea-pig; or, alternatively, to come out into the daylight and join his fellow innocents—the public—and find himself 'at home' as an idiocrat among democrats. (The artist, who is the other explorer of the unknown, is in the same position and has the same two alternatives—to become an aristocrat among the monopolists or an idiocrat among the democrats.)

The technologist—whether scientific or artific—is in a more difficult position, because he is an expert in exploitation of the known. Exploitation is, as it were, in his blood and it is so easy to let blood rush to the head and cloud the vision with red.

Nevertheless, the technologist has his own fetish, ideal or god —'efficiency in use'; he never ceases to aim at 100 per cent efficiency or economy. He cannot therefore ever be comfortable and 'at home' in the face of 10 per cent monopoly of 90 per cent possibility. His spiritual home is with the 90 per cent—with the people and with the idiom. So he also can easily become an idiocrat among the democrats. The technologist too is naturally a liberator; using the scientist's new knowledge, he has made the 'people' free of earth, air and sea—yet he wastes his time fighting for a place or privilege among the 10 per cent who monopolize 90 per cent of the earth, air and sea.

But once the people are spending their own money, the scientist and the technologist will have to throw in their lot with the people. They will then constitute an ethical profession, under contract to the individual; like the medical profession, sworn not to take advantage of the innocence of the people; not to lend themselves to monopoly. For it is the people, i.e. the 90 per cent, who suffer from the *laissez-faire* attitude of the scientific

liberators and from the much more serious *fait accompli* attitude of the technological liberators. The scientist and his technician —as members of an ethical profession—must become *the protectors of innocence.*

So we conclude: science is the knowledge of Nature's laws. The scientist is the great agnostic, unashamed of his innocence, who explores the unknown with his reason or will. Science can only explore half the truth, for art is also the knowledge of Nature's laws. The artist also is the great agnostic, unashamed of his innocence, who explores the unknown with 'love' or aesthesia. Knowledge is thus dual or bi-sexual, and from the unity, or parenthood, of art and science is created and born innocence, the infant knowledge which *grows into wisdom.*

Let us turn from the general position of science to the position of science in medicine:

Under the Liberal-Socialist scheme for the medical services, the patient will pay and provide for the medical scientist. Therefore the patient will naturally want to know what he is paying for. First, then, let us find out what 'unknown field of knowledge' the medical scientist is exploring.

The science of medicine is called 'pathology'. Pathology is the science of *the causes and consequences of disorder and disease.* It is therefore the natural philosophy or science of *dying* and of *the dying*—of suffering and of the sufferer, as its name, 'pathos', implies.

Hence the medical scientist and the doctor know no more about *living* than do the man in the street and the woman in the home; their expertness is exclusively confined to a knowledge of the process of 'dying'. The new science of 'living' is called 'ethology'. Ethology and pathology are poles apart.

Medical science knows that the patient with even the most trivial disease has already and reluctantly, temporarily or permanently, turned his back on 'living', on health. He is being forced or dragged along the road called 'dying'—*however far away death may be.* We must never forget that a patient can

spend his whole existence, from the cradle to the grave, in the process of dying.[1] The patient's doctor may make the journey easy, nay sometimes even pleasant; he may make it a very very slow process, but nevertheless it is still a procession along the road called 'dying'. Medical science is only one among many equally important social services that have helped to postpone death seven to ten years. This achievement has been called 'extending the span of *life*'—but it is only accurately called 'postponing the date of *death*'—for that is what it is in fact.

The medical scientist then is *exclusively* concerned with exploring disorder, disease and dying; that is the unknown field of his exploration. What then has he to tell the patient about disorder and dying?

The first discovery of the medical scientist is this—and it might be called the first principle of pathology:

Nature hates dying as fiercely as she loves living, passionately. Nature has an implacable hatred of disorder, disease and dying. So the patient's doctor, as the scientific technician, is there to exploit Nature's hatred of dying, in favour of the patient. To do that, he must learn to work hand in glove with Nature, and *within Nature's laws.*

The science of pathology is then: (1) the study of Nature's *enmity* and *antipathy* to disorder and disease; (2) the study of the strategy, tactics, methods, arms and munitions used by Nature to defeat disorder and disease; and (3) the study of the strategy, tactics, arms and munitions of Nature's enemy—disorder, disease and dying.

We learn then, that it is *Nature* that makes continual war on disorder and disease wherever and whenever they are to be encountered.[2] Thus the fight against disorder and disease and

[1] Just as we can 'live' unto the very last breath.

[2] Nature finds nothing glorious about war; on the contrary, war is hateful, but it is not so despicable as the armed neutrality men mistake for peace but which is 'war-less enmity' (masquerading as *amity*)—sublethal phoney war. Armed neutrality—or apathetic hatred—is trampled under foot and wheel by Nature in her war against disorder and disease.

dying is no little 'private war', or individual fight. Both patient and doctor are enlisted with Nature in this perpetual war.

We must never mistake Nature's enmity and antipathy against disorder and disease for hatred of the land and people wherein the war is fought—that is to say, for hatred of ourselves. We are merely the battleground—and indeed, some of Nature's fiercest battles can leave the battleground unscarred.

The silly story that Nature is at war against man, or that man must conquer Nature, his enemy, is the most stupid of all superstitions. It is just as stupid as to suggest that Nature has decreed a struggle for existence, *in face of the scientific fact* that Nature provides all the means to live in abundant plenty. (Nature does not hoard the harvest in the 'tithe barns'; monopoly, the real enemy of man, does that.)

Or again, just as stupid as the idea that Nature is at war against man, is the suggestion that the biological process of evolution is a survival of the fiercest in a fight between man and his environment. Far from being at war, *man and his environment are inseparably one*—a unity which can be viewed either from 'within outwards', as *man*, or from 'without inwards', as *environment*. Taken apart, either one of these views can only be a half truth, and all half truths are lies. Nature's vision is binocular; so the monocular or half vision is disordered vision.

Nature is wiser, more practised and more learned in her methods than man—as science is continually discovering and demonstrating. So the scientist who studies Nature's method is on Nature's side; and that is the only reason that he has ever succeeded in winning a skirmish here and there in the war against disorder and disease. He knows that there is in fact only one method of fighting the common enemy, and that is by Nature's methods, Nature's laws of war—*the natural laws of enmity and antipathy, or pathology.*

But if you listen to the voice of vanity, you might imagine that these laws of Nature were invented by man for his own comfort and convenience; that Nature's enmity and hatred was some panic-stricken frenzy of disorder and disease, and that

man, the conqueror, was bringing order out of disorder by his supremacy, protecting foolish Nature against herself and demanding due tribute; that in fact *human* nature (as exemplified by the conqueror) is a *very superior* kind of Nature that can sit back and plan the future by coercion, conscription and monopoly.

Before this 'human nature', or 'man in the mass', not only man the individual, but Nature herself is imagined cringing in terror and awe—for, after all, says vanity, it was human nature that invented the tank, the bomb, the aeroplane and anaesthetics, and thus put man *one up* on Nature herself. Or again, it is said, what is the point in learning the law, if not to circumvent the law? Who knows most of civil or artificial laws? Is it not those who seek to take advantage of the innocent by ignoring the law? The artificial substitute, we are told, is far superior to the 'natural'—through artifice and cunning we can so deceive even ourselves.

The scientist then has a serious responsibility for the prodigal technologist—who is exploiting his patrimony in the service of monopoly. The scientist must disclose the secret of science—which is that all knowledge comes from obedience to the laws of Nature. The scientist must assert his pride in that humility which is love—for it is through his love of Nature that he learns the law.

Now is the time for that disclosure, because of two critical developments. One is that science is learning every day more and more of Nature's methods or 'laws', so that man is fast evolving into Nature's *principal agent*—the very spearhead of Nature's army in the fight against all disorder and disease—physical and social.

The other is that we have come to see that Nature is very seriously handicapped in her fight. Nature cannot *conscript* her soldiers, for 'blind obedience' is in itself a disordered obedience.

Only the open-eyed volunteer, the man of will, can join the ranks of Nature's army. 'To will' is 'to know' both what you are doing and how you do it. *How* you do it is as important as

what you do. To conscript is to blind one or both eyes of the recruit. That is why the only and the very first step to freedom is the abolition of all conscription, for that in itself would liberate the will. As long as you are *conscript*, you need to know only one technique—*to do what you are told to do*. Any fool or any rogue can do the telling.

Even in Nature's physique—that is to say, in the physical world—the conscript 'mass' is inert until it is dissociated into its 'atoms'—until the 'atom' is at liberty. That is so with Nature's 'material'; so it is also with Nature's 'personnel'; that is to say, in the biological world. Nature cannot utilize the 'mass'. You may hurl mass against mass—but that is only effective when the mass is fragmented into its active parts, its atoms. Nature in fact first breaks the bonds of conscription. Only then can the individual know what to do, and only in innocence can he learn *how* to do it.

So there is in Nature's economy no conscription—that is a primary and fundamental natural law (even in pathology), for by conscription we cause disorder of both the will and the feeling, or aesthesia. Biological mass is both apathetic and anaesthetic—just as physical mass is inert and passive. That is why monopoly can do as monopoly likes with its conscript army.

Only the knowledge of natural law—which is science and art—can enable us to obey Nature, not blindly but willingly, with both eyes open. Thus the abolition of conscription—*meaning every form of monopoly*—is the basis of all natural freedom. You notice that this provision is strangely absent from the Atlantic Charter, so the Atlantic Charter becomes a half truth about freedom—and all half truths are lies. That particular lie must be a deliberate half truth—for Churchill and Roosevelt grew up in democracies dedicated to freedom; they cannot plead 'innocence' and must be guilty of 'ignorance', unlike Stalin who grew up in other than a democratic atmosphere—he can plead 'innocence'. So the Atlantic Charter is a mere castle in the air, because it is not founded on the abolition of conscription, which is the same as the abolition of monopoly.

'Controlled monopoly' is in fact the slogan of the Atlantic Charter. But there is only one way of controlling monopoly, and that is to get the control into fewer and fewer hands, so that instead of 10 per cent controlling 90 per cent, it becomes 5 per cent then 2 per cent then 1 per cent controlling 99 per cent. That is monopoly socialism; it is a dictatorship of the innocent for the innocent by the ignorant—exactly like the Trades Union Socialist Government—of the Bevin Boys for the Bevin Boys, *but* by 'Bevin'—who is no boy.

But, pleads monopoly (with its tongue in its cheek), what sort of army is it that is made up of volunteers each exercising his own 'will'? Where is the 'obedience'? Who carries out 'orders'? Who leads? The answer to that sophistry is a simple one: it is another question. What sort of 'obedience' is 'blind obedience' and 'unwilling obedience' that needs leading?

Since there are two kinds of obedience, (1) obedience with vision and will, and (2) obedience which is blind and without will, why 'ignore' one in favour of the other? Why use only blind will-less obedience? Is it because we can conceive only of the mechanical and automatic—of a mechanistic inevitability?

Or is it that *we do not know* how to achieve willing obedience? Yet that should not be true, for—as child or as adult—we have all of us been 'in love' and so given willing open-eyed obedience —the obedience of feeling or aesthesia. It is strange that we callously 'ignore' this fact. But even that is only half the truth; for science—physical science—from which we have garnered all the modern fruits of progress, sweet and bitter—though only bitter because they are eaten green before they are ripe—has achieved all its creative discoveries by the scientist's *love* of nature and willing open-eyed obedience to natural laws.

Only when we 'ignore' or defy Nature's laws, do disorder and disease arise. So we see that it is not the aeroplane, the wireless, the split atom, or other great achievements of technology and exploitation, that science has to tell us of; the great lesson of science is that obedience—as ordered and organized

by Nature—*has vision* and *is willing*. Thus art, or aesthesia, and science, or reason, both reach the same irrefutable conclusion, that natural obedience is willing open-eyed obedience—based on love and knowledge.

That is what science has to tell the people. Not man as a 'mass' but man as an 'individuality' is fast becoming Nature's principal agent, the spearhead of Nature's army of volunteers in the fight against disorder and disease. But, Nature wins only through the willing open-eyed obedience of 'individuality'.

But, you might say, has all this anything to do with the re-organization of medicine? It has, for it illustrates the fact that natural laws are consistent and universal and apply to great and to small issues; they even apply to the *willing* patient and the *willing* doctor who are both enlisted in Nature's war against disorder and disease. So, free choice of doctor means a willing patient who wills, not blindly, but with both eyes open, to follow his *own* doctor. The patient's doctor is the professional soldier, the patient is the volunteer recruit in Nature's total war against disorder and disease.

"Bless my soul," says the patient, "in my innocence I fondly imagined that my doctor was only there to anaesthetize my pain and render my 'pathos' apathetic. I have been strangely content to shed half my troubles, my disease, and leave my disorders to look after themselves—to cut the top off a sprouting shoot and leave the root. Dear me, how easily innocence is led astray into ignoring facts that do not *thrust* themselves on us; I can become content with dying if it is comfortable enough—I fondly thought my reward, peace, was beyond the grave."

Nature herself never becomes either apathetic or anaesthetic to disease, disorder and dying. So, neither the patient nor the doctor may slip ignorantly into apathy and anaesthesia—the patient must keep his pathos virile and fertile with hatred and antipathy against disorder and disease. The patient's doctor would like to see the public so aesthetic and so antipathetic to disorder and disease (whether in their own persons, or in their environment) that the first twinge of pain would make them

rush to arms *on Nature's behalf* and deal with disorder and disease with all their native initiative.

The apathy that afflicts the patient puts him out of reach of pathology and far beyond treatment. Apathy, or toleration, defeats the science of medicine, just as surely as anaesthesia defeats the art of medicine. For apathy or toleration implies no resistance; and anaesthesia implies no hatred of disorder and disease. Apathetic and anaesthetic patients are the quislings and collaborators in Nature's total war—they are 'carriers of disorder and disease', infecting the innocent.

Nature's war *is* a total war. That means one thing and one thing only, that it is a guerrilla war, of 'maquis', 'partisans', the battle of the house, the street, the farm, the factory. Who scorched the earth and fought from rabbit holes in Russia? The partisan. No conscript he, waiting to be told what to do. The partisan's hatred and antipathy is idiopathic—personal. Russia's Waterloo was not won on the political fields of Moscow, but on the muck heap of the peasant and in the flower garden of his cottage.

So the battle against disorder and disease turns on the idiopathic enmity and antipathy of the 'person' and the 'individual' to disorder and disease. We are watching the end of organized mob or mass or monopoly rule. In any total war, each battle is won by the person, by the individual, by the family—in a house, in a street, on a farm and in a factory; house by house, street by street, farm by farm, factory by factory. We must no longer be misled by the pomp and bombast of the might of mass.

Monopoly is an army 'in mass' with flags and banners flying. Not so with the individual. Over the soldier's heart do we find the Union Jack? the Stars and Stripes? the Hammer and the Sickle? the Swastika? No! In breast pocket over every soldier's heart we find a picture of wife and child, or mother and sister, and in his head you find a biograph of his 'own home'. That is the real, full and exact scientific measure of nationalism in the individual; the nation is that vague location wherein lies his *home*.

So we discover that the home with its contained nucleus, the family, is the smallest indivisible unit of society, and that to make nations actively mix and commune, you must effect 'dissociation' of the mass into its atomic unit—or 'home'. As in physics, so in biology: mass cannot mix or commune with mass—there is an optimum factor of disassociation for every solution. Labour as a mass is as immiscible as is capital as a mass. Ah! but a worker, is he not a person? Yes, but each person is like an electron which does not exist in a free state, only as an entity within the ambit of the 'biological atom'—the home. *It is the home which is the indivisible limit of disassociation.*

The 'atom', which in biology is *the home*, is the dynamic entity. The 'molecule', which in biology is *the community of homes*, is the static entity of biological energy. In the home you find energy as 'love'; in the community you find energy as 'life'. So that love is the 'eclectivity' that causes the community to 'glow alight and hot' with life.

And that brings us to the second and the most important discovery of all, by which we learn how we can keep our hatred and antipathy to disorder, disease and dying. We have seen that Nature hates dying, as fiercely as Nature loves living passionately. Science now carries us a step farther.

We now know that Nature hates dying so fiercely, *because* Nature loves living so passionately. Science has found the reason behind the power of enmity.

Nature's hatred of and enmity to disorder, dysaesthesia and dying is directly dependent upon and directly proportionate to Nature's love of order, aesthesia and living. The primary and fundamental and only positive factor is Nature's love of living.

Just as there are natural laws underlying Nature's hatred of dying—the laws of enmity, or pathology—so there are natural laws underlying Nature's love of living—the laws of amity, or ethology. It is to a study of those laws that science and art must now turn—to seek the natural law underlying order, aesthesia or ease, and living. Without that knowledge we cannot create peace—for peace is born, not made by any artifice. Peace grows,

like the chicken, out of the egg by hatching in a home or nest.

This is the task facing both art and science. Only the artist can make the factual idea of science into the actual idea of art. Art propagating science—in the universal parenthood.

EPILOGUE

This thesis on the medical services illustrates a new technique *—the government of society by the individual for the individual through the individual.*

That is very different from government of the people as a mass or monopoly, for the people as a mass or monopoly—by monopoly or authority.

The people as a biological mass has not only *grown* but it has *differentiated* into 'individualities'. That which was once an amoeboid mass, and then a polycellular congregation, has now become a colony or society of individual entities—or homes. Democracy is evolving from the 'general' to the particular or 'specific'.

Our socialization is no longer an *intrinsic* function of the people as a mass. It has become a specific *extrinsic* faculty of the individual. As with all other 'faculties', we have to learn 'how' to use it. For example, every infant is born with a complete mechanism of digestion. The infant's digestive ferments, pepsin and trypsin, *in the test tube* (in vitro), can mechanically digest beef steak and onions or fish and chips, but *in the infant* (in vivo) 'will' only digest its 'own' mother's milk. The faculty for digestion has to be learned. The infant has to learn 'how' to use its mechanism—not only its digestive faculty but every faculty, that for seeing, hearing, speaking, thinking, socializing, etc. In the same way as the pilot has to learn 'how' to fly the perfect mechanism for flight—the Spitfire—so the infant has to learn to live the perfect mechanism for living—the bioplane.

The tools that suit the material determine '*what*' *we can do*; there still remains the overriding factor, of '*how*' *we use the tool.* That alone determines the result of our actions.

Democracy has now grown up and differentiated and is no

longer dependent on its parents—the King and Parliament. So the Lincoln statistical 'government of the people, by the people, for the people' no longer applies. It must give place to a *government of society by the individual, for the individual.* That is Liberal Socialism or Social Liberalism.

The old Liberalism died of apathy and anaesthesia, i.e. *laissez-faire.* (There are a few skeletons lying about unburied.)

The new-born Liberalism is 'Liberal Socialism—Social Liberalism'. It is necessary to give it both names, for the male will view it as Liberal Socialism, and the female will view it as Social Liberalism, according to their natural bias, which is sex. To see it whole, both the views of this binocular optic must come together—mutually mutating each other into one vision.

While democracy was yet young like the infant, it possessed only *needs*; it had not the *means*. Necessity has now not only invented or mothered the 'means' but has invented or fathered the 'will' to utilize the 'means'.

Democracy is thus facing an epoch in its evolution. Once a tadpole, it has now shed its gills and tail, evolved lungs, legs and arms and come out of the pond on to the social terrain as a fully formed frog to begin a new cycle of its evolution. So democracy is facing a profound metamorphosis, a new birth.

Just as physiology made no progress until Schwann defined the 'cell' as the individual (or indivisible) unit on which our physiology was based, so also sociology can only look forward to progress when the cellular nature of society is recognized. The 'cell' of society is a 'home' or 'parenthood' in which is embedded a polymorphic nucleus—the family. Each of us is a 'gene' within a family of genes, forming the nucleus of a social cell. The social cell is a *parenthood*—whose protoplasm is the 'home' in which is housed or 'hearthed' its nucleus.

In the political organism I see the natural biological law of growth and differentiation as two processes—Conservatism and Liberalism—two forms or phases of biological energy for ever going on side by side, balancing each other across a fulcrum.

Thus we learn that the politics of socialism—for socialism is the 'means' to satisfy the 'needs' of liberty—depends on the delicate balance of Conservatism and Liberalism—on two-party government.

Capital and Labour are the two powerful Conservative forces —the static and dynamic of the body of Conservatism. They therefore must act together, mutually and mutatively, as one vision—one party. They are the right and left eyes of one party —need they be cross-eyed? Must they each see no further than the tip of the Conservative nose? All that each has to do is to take the distant horizon as the point of focus and they will find the eyes learning to register one 'vision' instead of two utterly different 'optics' of cock-eyed sight. War has given the two eyes, right and left, of Conservatism a horizon. Can they not switch from that dark storm-ridden sight, to another and yet more distant horizon—the sun-drenched horizon of peace, seen with two eyes, but as one vision? Must they turn from war and look down the nose—as cock-eyed politicians? Let them transform their irregular liaison of war, into a regularized marriage of peace.

Only when Labour and Capital have become one, can the second force, Liberal Socialism, operate as a similar unity of two forces—Liberalism and Socialism.

Two-party Government is a biological necessity.

Thus politics should not be a fight between two parties, but a striving to attain an equilibrium between the propagative force of Conservatism and the creative force of Liberalism. At the present moment Labour and Capital are fighting each other to monopolize Socialism. The only possibility of compelling the unity of the two Conservative forces, Labour and Capital, is for Liberal Socialism or Social Liberalism as a party to throw the challenge into the political arena.

But why Socialism? many of you will ask. Is Socialism inevitable? It is! The reason is simple. The *tools* we need to till the social soil are no longer personal tools. Our tools have grown up and developed just as we have grown up and de-

veloped. Our tools can only be handled by a group; they are now group tools—like the tools of the medical profession.

The natural tendency of all group action is to move full swing to Monopoly Socialism. That exaggerated tendency has to be balanced so as to produce an equilibrium between the group and the individual. That is the function of Liberal Socialism as opposed to Monopoly Socialism.

Now the tools are the 'means' to meet our 'needs'. Our 'means' can only be provided by group action—just as parenthood provides the 'means' to meet the infant's 'needs'. The archetype of socialized 'means' is the family in its home.

The means are socialized to meet the needs—which have to be 'personalized'. In other words, the more highly personalized the needs, the more highly socialized the means must be. The socialization of the tools is the only means to the liberty of the individual. That is the essence of Liberal Socialism.

It is therefore the tools we must socialize, not the individuals. Indeed, that is the critical scientific test of any socialistic action: does it liberate the individual? does it meet the personal needs of every individuality?

To return to the metaphor of the aeroplane: Capital is the engine, Labour the machine of the political plane; the pilot is Liberal Socialism. Without the pilot the political plane can only fly on a fixed, planned, predetermined course, in charge of the automatic guide, the bureaucrat.

The political plane is a family bus, not a bomber.

This book is written to provide an example of the use of socialization to meet the needs of the individual. The proposed medical organization uses the means of socialization to meet the needs of both the individual patient and the individual doctor.

A WARNING SIREN

I can imagine the so-called 'individualists' chortling with glee, for does not this deliver the enemy—Socialists, Communists, etc.—into their hands? As a doctor, the author must sound a warning.

EPILOGUE

Individuality (and individualism) also has its 'pathos'; it too can suffer from disorder and disease. The disorder and disease is called 'egotism'. The symptoms of egotism are those of the 'part' that is set 'apart' from the 'whole' and from other 'parts'; a person in a vacuum; and Nature abhors a vacuum. All war, and above all this war, is the clash of forces rushing in to fill the vacuum that Nature will inevitably break. Egotism is diseased individuality.

Individuality, however, has also its 'ethos'; it too can enjoy its order and its ease. That is the free participation of the 'part' with the 'whole' and with the other 'parts' of that whole. That is natural altruism or healthy individuality. The seed of individuality will only spring into growth and development when sown in the cultivated soil of home, and its own home; it is absolutely indigenous to the home and the home is the archetype of Socialism, providing the only means to meet the needs of individuality, that is to say, Liberty.

The author is no artist, so that half the meaning of what he has written can only be discovered by reading between the lines. For that he is sorry.

8k Hyde Park Mansions,
London, N.W.1.
1944