CABINET

NATIONAL HEALTH SERVICE: ATTITUDE OF THE MEDICAL PROFESSION

MEMORANDUM BY THE MINISTER OF HEALTH

IN view of the current publicity given to the attitude of the doctors to the forthcoming National Health Service, my colleagues may like a report from me as to the present position.

First, the facts. The doctors have been taken into consultation on every issue arising on the new service, by my predecessors under the previous Government and by myself, since 1943. There have been discussions with various groups of the doctors' representatives which total, according to my records, about fifty meetings. Many have been taken by officers of my Department, some by myself and my predecessors. In 1947 alone there were twenty-three discussions.

All of this culminated in a two-day meeting of their Negotiating Committee with me in December last.

Then the B.M.A. circulated to all doctors a detailed statement of their case. I similarly circulated my detailed answer. These two documents are appended in case any of my colleagues wish to study them. After this the B.M.A. held a meeting of some 300 spokesmen from different parts of the country and passed a resolution in the following terms:

"The elected representatives of the medical profession in Great Britain and Northern Ireland, meeting in London this eighth day of January, 1948, solemnly declare that in their considered opinion the National Health Service Act, 1946, in its present form is so grossly at variance with the essential principles of our profession that it should be rejected absolutely by all practitioners."

The B.M.A. now propose (at the end of this month) to hold a "plebiscite" of all practitioners which, it is understood, is to take the form of a paper to be signed by each voting doctor, to contain the resolution above, and to ask him whether he approves of the Act and whether he is ready to abide by the decision of the majority vote.

In preparation for this "plebiscite" an intensive campaign is being conducted to persuade doctors to reject the Act. Branch meetings of the B.M.A. are being held all over the country at which officially sponsored speakers urge the doctors to reject the Act. Press and publicity campaigns are in full swing, even including the use of the film news-reel. All is being organised by Dr. Hill, the secretary of the B.M.A.

The attack is upon almost every main feature of the Act—the abolition of the sale of practices, the right of the Government (through a specially constituted medical body) to say that a particular area does not justify an increase of public expenditure because it has enough doctors already, the introduction into remuneration of a £300 fixed payment element (the rest being on the familiar capitation basis), the appeal to the Minister where a special Tribunal has said that a doctor is not fit to continue in the service (they want to appeal to the High Court).
So much for the facts. From all the evidence—the speeches of their spokesmen and, above all, Dr. Hill—it is quite clear that this is, on the part of the B.M.A., an attempt not merely to seek detailed improvements of the Act but completely to sabotage it and prevent its ever coming into operation. For example, in his news-reel address, Dr. Hill says: "The doctor should be your servant, not the State's servant. You should choose him, or change him." (which, of course, the Act already allows). He goes on: "As a salaried officer of the State" (which he is not). ... Then he makes this statement: "The real issue is not whether you want a better health service (everyone wants that) but whether you want your doctor to be your doctor or the State's doctor. There is something personal in medicine, something in the doctor-patient relationship, something private and confidential which is essential to good medicine. Break into that, make the doctor not your doctor but the State's doctor; no longer your friend, your advocate, and you will have done some damage to medicine that it will be impossible to repair. Doctors believe that their freedom as a profession and as individuals is your freedom, and that is what they are fighting for."

This scarcely needs comment. Dr. Hill knows very well that the personal relationship, freedom of choice and freedom to change, is maintained in the new Act. If what he declares to be their aim were to be accepted beyond that, nothing but private practice would remain. But Dr. Hill is the accepted Conservative candidate for Luton, and it would be a feather in his cap to try to enter Parliament as the Conservative who stopped a major social measure of this Government.

As to the Press reception? It mainly follows the usual lines of political persuasion, inevitably—and is certainly not all favourable to the doctors' attitude. But one can pick out of it a few points genuinely made by, on the whole, reasonable critics. I will deal with these next.

There is one point on which I have always agreed that we are on uncertain ground. I will not bother my colleagues with legal details, but—in brief—it is not certain that the Act sufficiently protects doctors under existing financial partnership obligations to each other. I am asked to clarify the position in an amending Bill, and should like to do so. But the difficulty is that neither side can say for certain what should be put in such a Bill. Their legal advice and mine differ and we do not know which is right. So far, I have assured doctors that, as soon as a Court decides we are wrong and in what way we are wrong, I will seek the appropriate amendment. But I think that rather more assurance is justifiable. I am proposing now to announce that, in view of the uncertainty, I shall appoint a small committee of, say, five independent and well-known lawyers to examine the Act and to advise me in what way (if any) it fails to protect the rights of partners under existing partnership agreements and how its defects (if any) could best be rectified at law. I should then undertake, on the receipt of their report, to introduce any amending legislation on this point which seemed appropriate. I believe this would help considerably in showing good faith and calming the legitimate doubts of some doctors.

Another point often genuinely put forward is that, where the special Tribunal rules that a doctor is not fit to continue in the service, appeal should lie to the High Court and not the Minister. This, I am sure, is simply a misconception of the proper constitutional position. It is proper for a Court to say whether "dismissal" is wrongful at law, but not—if it is lawful—to say that it is wrong on merits. The more genuine critics on this are simply confusing the two things. To accept the second would lead to impossible consequences in other fields of employment—apart from obliging a Minister to continue to be answerable for the negligences of a doctor whom the Courts would not allow him to disown.

Thirdly, there is criticism in unbiased circles that I do not abandon the £300 "fixed" element in remuneration. The doctors say it is the thin end of the wedge and could lead to a full-time salaried service later. But a full-time salaried service later would be exactly as possible with the £300 now as with it. Moreover, a full-time salaried service has been possible under National Health Insurance for 36 years and does not seem to have worried them before! In my view the £300 fixed element, on top of which the rest of payment is by capitation according to the number of patients, has great advantages for the beginner—giving him an assured living while he collects patients—and, for the other doctors, is a convenient peg on which to hang additional fixed payments (such as "inducements" to go to unpopular or sparsely populated areas).
promise of having a "fixed" payment only for beginners or other groups and involve administrative difficulty in applying varying rates of capitation.

As to my own action? I have so far taken the view, certainly until the plebiscite, that I will not be drawn into an exchange of propaganda which would make the doctor's position in the new scheme seem to be governed merely by political doctrine and in which I should be at an inevitable disadvantage with petitioners who need not be, and are not, scrupulous about the truth of their facts. Acting, I believe, could prevent the doctors—as an organisation—from voting against the Act this month. That does not mean that they will not, as individuals, take part in it. If we keep firmly to our "appointed day" those who do not take part will (a) lose their present panel income, (b) lose their right to share in the £66,000,000 compensation for capital values when they later come, (c) lose all right to have any private patient in any pay-bed in any hospital. They could only succeed if they were to push us off our appointed day and delay the whole service.

Meanwhile, I propose to build up accumulating evidence in the Press and elsewhere that the Act goes on, that I am setting up the machinery piece by piece so that they are not affecting the progress of the preparations. I propose to deliver, in due course, a guide to the new service to all households, to publish a little booklet on it, to run films on it and generally go on with the explanatory work which is most likely to create public demand and thus affect the doctors' position more and more if he sabotages it.

It is the period between their vote and the appointed day which will be difficult for the B.M.A. in continuing to keep up the resistance. It is that period which I shall use to make clearer and clearer that, for the decent doctor, there is a square deal and for the public an essential service. I do not believe that the B.M.A. can ultimately face being the only obstacle to the public using that service. Above all, we must adhere to the appointed day—unless we want it to be known that a sectional group have succeeded, in their own words, in "rejecting" an Act of the present Parliament.

A. B.

Ministry of Health, S.W. 1,
19th January, 1948.
The Council of the British Medical Association sends to every member of the medical profession two documents:

1. The Negotiating Committee's Statement to the Minister of Health.
2. The Minister of Health's reply.

Members of the profession are asked to study these documents, which contain all the information at present available. The Association will shortly proceed by plebiscite and the Minister's letter of Jan. 6 to the Hospital and Specialist Services, General Practice, Public Health Services, Mental Health Services, Ophthalmic Services, and Superannuation were accordingly established, and 31 meetings have taken place between them and the Minister's representatives. These sub-committee discussions have now been completed.

3. In this memorandum the more important representations made by the various sub-committees to the Minister's representatives are gathered together for presentation to the Minister personally, with the request that he should now reply to the points made and the arguments adduced in their favour. The discussions have been comprehensive and, as the possibility that they may lead to further action is not excluded; and that after the conclusion of the negotiations a second plebiscite be taken on the issue of the Ministry, who replied in the following terms:


It will be Hill, Jan. 31, 1947. to thank you for your letter of Jan. 29 and for sending a copy of the resolution passed by the Special Representa

THE PROFESSION'S AIM

The medical profession itself has provided the impetus towards the establishment of a comprehensive medical service. From time to time since 1920 the profession has made statements of policy and published concrete proposals, all with the object of arousing public discussion and stimulating governmental action to this end. Differences as have arisen between the Government and the profession relate not to the objective itself, but to the means proposed to achieve it. In particular, the medical profession is opposed to any form of service which leads directly or indirectly to the profession as a whole becoming full-time salaried servants of the State or local authorities.
II. The medical profession should remain free to exercise the art and science of medicine according to its traditions, standards, and knowledge, the individual doctor retaining full responsibility for the care of the patient, freedom of judgment, action, speech, and publication, without interference in his professional work.

III. The citizen should be free to choose or change his or her family doctor; to choose, in consultation with his family doctor, the hospital at which he should be treated, and free to decide whether he avails himself of the public service or obtains the medical service he needs independently.

IV. Doctors should, like other workers, be free to choose the form, place, and type of work they prefer without governmental or other direction.

V. Every registered medical practitioner should be entitled as a right to participate in the public service.

VI. The hospital service should be planned over natural hospital areas centred on universities in order that these centres of education and research influence the whole service.

VII. There should be adequate representation of the medical profession on all administrative bodies associated with the new service in order that doctors may make their contribution to the efficiency of the service.

6. In this memorandum the Committee considers that the two features of Part IV of the Act which have aroused the gravest misgivings of the medical profession are the abolition of the custom of buying and selling general practices and the establishment of a machinery of “negative direction” over the movements of general practitioners. In its published comment on these features of the Act, issued by the Negotiating Committee in November, 1946, the following statement appeared:

The Act provides for the abolition of the custom of buying and selling general practices and for the establishment of a machinery of negative direction over the movement of general practitioners, while the profession maintains that the ownership of goodwill is essential to the continued freedom of the general practitioner. This abolition is regarded as a first and substantial step to a State salaried service, while the system of “negative direction” which is proposed is an unjustifiable and unnecessary interference with the freedom of the doctor. Any necessary improvement in the distribution of doctors can be achieved on the existing basis of general practice.

The abolition of the custom of buying and selling practices creates more problems than it solves.

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Distribution

8. The question of distribution of the profession is taken first because it is upon the need for better distribution that the Minister based his arguments for the abolition of the ownership of goodwill in public general practice.

Problems of distribution can be met in a satisfactory way by dealing with any cases of under-doctored as they actually exist or occur. No areas will remain under-doctored because of inability to purchase medical service, for, as a result of the Act, there will be available a medical payment in respect of every member of the community. The medical payment will be the same in respect of every patient, wherever he lives and whatever his status. Doctor-distribution in relation to population-distribution will follow naturally upon a 100% service. When stability has been reached any remaining deficiency in medical manpower in particular localities can be effectively remedied by adjusting the
Ejjcal Practices Committee could make yet another offer to a layman. It is difficult to see how the notice there will need to be inquiry into the circum-
stances of the particular area, in order to determine whether an area is held to be under-doctored or over-doctored. The present arrangement, which has worked satisfactorily over many years, gives discretion to an insurance practitioner to accept any person on his list whether or not the person lives within the area ordinarily covered by the doctor's practice.

Ownership of Goodwill

14. In the discussions which have taken place between the Minister's representatives and the Committee, the Committee's original statement that "the abolition of the custom of buying and selling practices creates more problems than it solves " has been abundantly justified. Some examples of the problems created are given below.

Existing Partnership Agreements

15. Practically every existing partnership is governed by an agreement. In general, these agreements provide that in certain circumstances—e.g., the retirement, death, or sickness of one partner, the other partner, or partners, shall have an option, and often an obligation, to purchase the share of the partner retiring or dying.

16. So far as these partnership agreements are concerned the interpretation which the Ministry places on Section 35 of the Act on the advice of its legal advisers is:

"(a) Existing partnerships between doctors are not determined on the appointed day, nor is there any reason for partners to determine existing agreements. The position is the same whether all or any of the partners in a partnership join the new service.

"(b) Clauses relating to the sale and purchase between partners of shares in the goodwill of the practice or the option to purchase such shares contained in a partnership agreement entered into before the appointed day will be unaffected by Part IV of the Act coming into operation on the appointed day and will remain operative. An obligation in such an agreement by a partner who joins the new service to buy or sell to another partner a share in the practice, or the right of such a partner to exercise an option to buy or sell a share, either on a fixed day or the happening of an event after the appointed day, will continue as a right or liability of the partner concerned. No such sale would constitute an offence under Section 35 (2) of the Act.

"(c) A doctor who is a member of a partnership and who joins the new service will lose the right to sell his existing share in the partnership, except to an existing partner in pursuance of the partnership agreement. While the various rights (as in the form of options or obligations) to buy a further share in the partnership, which exist under the typical partnership agreement, will continue, he will not be able to sell those rights. All these matters will have to be taken into consideration in fixing as between partners their respective shares of the compensation attributable to the partnership practice, and provision for this will be made in the Regulations under Section 36 (3)."

17. This official interpretation means that all partnership agreements in existence on the appointed day retain their full validity. Is the Ministry interpretation right? This was the question the Negotiating Committee submitted to an eminent Chancery Counsel, who found himself able to express an opinion, to use his own words, only "after long suspense of judgment and fluctuations of view." His first conclusion was that on balance (he regarded it as a "fifty-fifty" affair) the Ministry interpretation should prevail. His opinions have been conveyed to the Ministry. What follows in paragraphs 18-27 is on the assumption that the Ministry interpretation of Sections 35 and 36 is right.

18. Acceptance of the Ministry's interpretation, however, gives rise to two main difficulties:

(a) It is impossible to determine, in advance of the various contingencies which may arise under the usual partnership deed, the amount of compensation "payable to any medical practitioner." Even if it be assumed that the amount of compensation due to a
partnership can be calculated; it is impossible to calculate the shares of the individual partners. (b) It is impossible to determine at the appointed day for what interest due on the compensation monies should be paid.

19. It is necessary to examine some implications of the Section, on the Ministry's interpretation. Where practitioners A and B are bound by a partnership deed which contains the usual mutual options or obligations to buy the share of a retiring or deceased partner, the compensation due to each partner cannot be determined until it is known who dies or retires first. It is impossible to assess in advance the cash value of the various options and liabilities. The amount of compensation due to a practice can be estimated, but, in the case of a partnership, the division of the amount of compensation is impossible until certain events have in fact happened. In the meantime it will not be known what proportions to divide the compensation in which the Government has promised to pay between the appointed day and the liquidation of the compensation sum.

20. It has been suggested that this difficulty could be overcome where both (or all) members of a partnership enter the new service:

(a) by regarding the partnership as one practice for the purpose of calculating compensation, and

(b) by arranging, when subsequent transfers of shares are made between the partners, for the compensation to "follow the share."

Thus where a continuing partner A is required to buy the share of his retiring partner B (in, say, five years' time) the compensation apportioned to B's share will be transferred to A. Having received A's purchase money, B would have suffered no loss by reason of being unable to sell his share in the practice and would not, therefore, be entitled to compensation under the Act. A, who cannot resell, has suffered the whole of the loss sustained by the partnership and would receive the whole of the compensation. A, whom the interest is paid into the practice to help him in B's place, will lose nothing because he will pay nothing on entering the practice.

21. There are at least two objections:

(a) Though compensation may "follow" a share of the practice when it is sold, such compensation may or may not be equal to the sum paid by the purchaser for which he cannot subsequently sell. A practitioner buys something at one price, but its value, when he comes to be paid the compensation due, may be a lower or a higher price, probably a lower price.

(b) The Act requires that interest should be paid annually from the appointed day until the time when the compensation sum is paid. Under Section 36 (a) (d) the interest is to be paid "on the compensation payable to any medical practitioner," that is, to the practitioner entitled to the compensation. If interest were apportioned and paid on the basis of the partnership shares as they exist on the appointed day, a partner who, in, say, five years' time fulfils an obligation to buy an additional share in the partnership would lose the interest paid over those five years on the compensation due in respect of that share of the partnership. On the other hand, the seller would have received during those five years to interest on a compensation sum to which he is not entitled, in so far as the Act has not prejudiced his right to sell

and, in fact, has not precluded him from selling. He will have received interest on a compensation which is going to be paid, not to himself, but to man who has bought him out. In brief, the Act has bought something which the Act precludes from selling but has lost some of the interest the fee. The Committee will have to consider which is going to be shown in the report of that prohibition. The seller has received three on a capital sum to which he is not entitled.

22. The Ministry contends that the position is same whether all or any of the partners join the service. This is inaccurate. For example:

(i) Consider the case of practitioners A and B in partnership, with B under an obligation to purchase A's share in A's death or retirement. Assume that A enters the service but B does not. The medical profession has been promised that its members will be free to enter or not to enter the service. B, exercising this right, decides not to enter the service. In due course A's share and B is required to chase his share. B, having no alternative, purchases the share, only to find that he cannot enjoy the income in the whole general practice which he has purchased by entering the service. But on entering the service he lost the right to dispose of both his own share and the share has just purchased from A. He sacrifices these rights in compensation, for there can be no compensation to a practitioner who joins the service after the appointed day. The Committee do not believe that Parliament contemplated that the Act would have this effect of expatriation. It is not be that the practitioner desiring to remain outside the service will have to accept compensation for his share in the service. This would be breach of the promise given during the Second Reading of the Bill that the profession is free to enter or not to enter the service.

The Bill places no obligation on any medical practitioner. He may stay outside the service altogether if wishes to do so.—(Hansard, May 1, 1946, Col. 220.)

The Committee asks the Minister whether he proposes to leave the position where it is.

(ii) Another situation arises if B retires or dies first and A is required to purchase B's share. Having done so, is precluded from disposing of that share because he is member of the service. Having joined the service on the appointed day he is entitled to compensation in respect of his own share of the practice, but he has sold his share to B, which he cannot sell and for which there is no compensation. The Minister's representatives have stated that they would advise him to give compensation to a partner in partnership, not merely in respect of the share which he has bought but also in respect of his share. The compensation due in respect of that share will be calculated on the assumption that the practitioner would leave the position where it is. But even if the Minister's advisers are correct there eleon a global element in the whole of £66,000,000, or the "appropriate proportion thereof, for this compensation, for the amount will, under the Act, be calculated in proportion to the number of practitioners who actually join the service on the appointed day. Compensation in respect of a practictioner who in, say, five years' time fulfils an obligation to buy an additional share in the partnership would lose the interest paid over those five years on the compensation due in respect of that share of the partnership. On the other hand, the seller who has received during those five years to interest on a compensation sum to which he is not entitled, in so far as the Act has not prejudiced his right to sell

23. There is a further complication of a technical character. £66,000,000, or some proportion of it is the whole of the global sum to be distributed. The Act requires that the amount will, under the Act, be calculated in proportion to the number of practitioners who actually join the service on the appointed day. The amount will be paid out in compensation the sum of £66,000,000, or the amount will be paid out in compensation the sum of £66,000,000, and, in fact, has not precluded him from selling. He will have received interest on a compensation which is going to be paid, not to himself, but to man who has bought him out. In brief, the Act has bought something which the Act precludes from selling but has lost some of the interest the fee. The Committee will have to consider which is going to be shown in the report of that prohibition. The seller has received three on a capital sum to which he is not entitled.

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fact enter the service. For an amount of money remain undistributed would be in conflict with section (2) of the Act. For example, if practitioner A, having been paid in full, loses his claim on compensation fund. The amount which, on the appointed day, was set aside for his compensation can never go to him or to anyone else—and interest on the amount will have been improperly paid. It is possible to calculate in advance what the size of this will be. Accordingly, it is impossible finally to calculate the amount to be allocated to any individual practitioner in compensation until the death or retirement of the last practitioner in partnership who joins the service. Being unable to calculate the amounts of compensation, the Government is unable to calculate appropriate amounts of interest which it is required to pay to individual practitioners.

Furthermore, if every principal entered the service, of his own free will or because of this pressure of circumstances, it is also impossible to estimate his compensation to which he is entitled. It will be impossible to give effect to this promise, because, as the law now stands, it is impossible accurately to estimate at the appointed day the amounts of compensation due either to individual practitioners or to individual practitioners in an action at law. Setting aside the existing agreements, with all their options and liabilities, financial and other, remain legally valid unless a principal entering the service on the appointed day can demonstrate that he has suffered a loss in respect of a debt incurred in the purchase price, he will receive immediate payment of compensation to which he is entitled. It will be impossible to give effect to this promise because, if already added, it is impossible accurately to estimate the last of the Act that interest should be paid annually to individual practitioners.

The Negotiating Committee has been promised wherever a principal entered the service on the appointed day, the amounts of compensation due either to individual practitioners or to individual practitioners in an action at law. Setting aside the existing agreements, with all their options and liabilities, financial and other, remain legally valid unless a principal entering the service on the appointed day can demonstrate that he has suffered a loss in respect of a debt incurred in the purchase price, he will receive immediate payment of compensation to which he is entitled. It will be impossible to give effect to this promise because, if already added, it is impossible accurately to estimate the last of the Act that interest should be paid annually to individual practitioners.

To sum up, the consequences of the Ministry of Health interpretation of Sections 35 and 36 of the Act in their present form include:

(i) Existing agreements, with all their options and liabilities, financial and other, remain legally valid despite the fact that they were designed to meet entirely different circumstances.

(ii) As a result, an individual practitioner may be required to pay out a sum of money to purchase a share, of compensation value of which is less than the amount he has paid.

(iii) As it is impossible to estimate in terms of money the various rights, obligations, and options in typical partnership agreements, it is also impossible to estimate the amount of compensation due either to individual practitioners or to individual practitioners in an action at law. Setting aside the existing agreements, with all their options and liabilities, financial and other, remain legally valid unless a principal entering the service on the appointed day can demonstrate that he has suffered a loss in respect of a debt incurred in the purchase price, he will receive immediate payment of compensation to which he is entitled. It will be impossible to give effect to this promise because, if already added, it is impossible accurately to estimate the last of the Act that interest should be paid annually to individual practitioners.

(iv) In fulfilling his contractual obligations under a partnership deed a practitioner may be required to buy a partner's public practice which he cannot sell and in respect of which no compensation is payable from the monies provided under the Act.

It appears likely that the assumption hitherto made that it will be possible to estimate the shares of individual practitioners (as distinct from individual practitioners) is unfounded, for the Act requires, in theory, that the whole of the £5,000,000, or the appropriate proportion thereof, shall be paid out and, in practice, there will be an undistributable residue. The Government cannot keep its promise in regard to the relief of hardship, and at the same time put into operation the Act in its present form.

(iii) In the Committee's view, Sections 35 and 36 of the Act in their present form are unworkable. The official interpretation is doubtful because of the ambiguity of the phraseology used, and, even if it is accepted, unfairness amounting in some cases to expropriation will result.

27. The preceding paragraphs have been written on the assumption that the Ministry's interpretation of Section 35 in relation to pre-existing partnership deeds is correct. The doubts expressed on this point by Chancery Counsel of the highest eminence have already been mentioned. Counsel has used these words: "I still have very grave doubts as to the true construction of Section 35 which, unless made clear, will in my opinion reflect no credit on its authors." Because of the obvious doubts in the mind of Counsel, a further legal opinion was sought jointly from Sir Cyril Radcliffe, K.C., and Mr. J. H. Stamp. After the fullest consideration, they have both reached the conclusion that the Ministry's interpretation of Sections 35 and 36 is wrong. Their reasoned opinion will be conveyed to the Ministry as soon as it is received.

It is submitted that a grave injustice would be done if this situation is allowed to remain. An authoritative opinion can only be given by the House of Lords, and while it is recognized that this is true of any legislation, the essential feature in this case is that it is known now that ambiguity exists, giving rise to the situation that no medical practitioner, even after consulting his solicitor and counsel, can be certain of his position. Moreover, the question can only be brought before the House of Lords at the expense of some individual medical practitioners in an action at law. Setting aside the arguments which have been raised earlier in this memorandum as to the inequity flowing from the Ministry's interpretation, it is strongly urged that in any case the Act should be amended to remove the ambiguities.

Indeed, individual members of the medical profession have a right to know before the appointed day how the Act will affect them. It is unjust to leave a demonstrably ambiguous Act unamended and their own financial position uncertain until a case has been fought out in the Courts. Doctors who do not join the service by the appointed day will not qualify for compensation. For this reason alone they need to have the position precisely defined at least six months before the appointed day.

They must know beyond any reasonable doubt whether existing partnership agreements remain in force or not. The Ministry says they do and the highest legal opinion available says they do not. Where do partners stand? Are all existing agreements rendered null and void, with all the consequences which flow from such an extraordinary position?

The Act has nothing to say about the validity, after the appointed day, of existing partnership agreements. If learned Counsel are right, a practitioner who, being bound by an existing agreement to buy or sell a share, carries out his obligation, will be liable to fine or imprisonment, or both. Such a situation is intolerable.

*This opinion is being published in the British Medical Journal.*
Partnerships after the Appointed Day

28. In partnerships formed after the appointed day between practitioners involving a practice in the public service it will be illegal for the partners to distribute the emoluments of the practice except in the proportion in which they are earned. In the terminology of the Act there is deemed to have been a sale of goodwill "where in pursuance of any partnership agreement between medical practitioners services are performed by any partner for a consideration substantially less than those services might reasonably have been expected to be worth having regard to the circumstances at the time when the agreement was made."

Even if the argument be admitted—and it is based no more than a Ministry interpretation of the Act—that the "worth" of a partner could be assessed not only on services rendered but also on his seniority and experience, it is impossible to assess what the experience of the senior partner "might reasonably have been expected to have been worth." It is equally difficult to assess the anticipated value of the services of a junior partner at the time when the agreement is made. In any case, the respective "values" of junior and senior partners may change materially over the years. The general effect will be to discourage senior partners from taking junior partners. It illustrates that the Act seeks to destroy the indestructible, for whatever legislation may be passed between medical practitioners services are performed by any partner for a consideration substantially less than those services might reasonably have been expected to be worth having regard to the circumstances at the time when the agreement was made." It is ironical that an Act which purports to encourage the development of group practice should in its operation have precisely the opposite effect—that of discouraging practitioners from entering into partnership one with another, whether inside or outside health centres.

29. It is a curious and presumably unforeseen anomaly arising from the Ministry interpretation that, should practitioners after the appointed day but before their entry into the service enter into a partnership deed involving buying or selling, that deed will still be binding on the participating practitioners.

30. It is highly desirable that newly qualified practitioners seeking to enter the field of general practice should, for a period, act as assistants to practitioners whose names are on the lists of Executive Councils, so as to gain the necessary experience. A practitioner who employs an assistant at remuneration "substantially less than his services might reasonably have been expected to be worth having regard to the circumstances at the time when the remuneration was fixed"

and who subsequently admits the assistant to partnership commits an offence. The effect of this will be to discourage practitioners from admitting assistants to partnerships and to encourage them to employ assistants for short terms without the prospect or possibility of partnership. Add to this the diminished incentive to become an assistant because by application one may succeed in acquiring an independent practice and it appears the prospect of there being sufficient assistants will become remote. The effect will be that more and more practices will be left with no one in charge when a principal dies or retires.

The Doctors House

32. The widow of a practitioner who has worked in the service is precluded from selling the house to another practitioner with the knowledge that it will be used for practice purposes, if the purchase price is "substantially in excess" of the price which might reasonably have been expected if the premises had not previously been used for practice purposes.

The effect of this may be, firstly, to penalize the widow by leading her to accept a price which is less than the real value of her property; secondly, to run the risk of prosecution by putting up the house for auction or, thirdly, to lead her to sell to a third party who will offer it at a higher price to the incoming practitioner.

Many premises have been adapted structurally professional use and in these cases it will be impossible to assess the price "which might reasonably have been expected if the premises had not previously been used for practice purposes."

33. It may be argued that the system of registration of agreements with the Medical Practices Committee will protect the profession and the public from the danger referred to in the foregoing paragraphs, although it is difficult to see how the widow could be afforded protection. But nothing is now known, or can yet be known, by the Ministry or the profession, of the attitude which may be adopted by any Medical Practice Committee. Such a committee will have no alternative but to interpret the sections of the Act as passed by Parliament. However much it may desire to do nothing to endanger partnerships and assistantships or to endanger practitioners, it cannot act except in conformity with the definitions set out in the Statute.

Remuneration

34. The Committee asks that the Minister will no make clear his attitude on the subject of remuneration. The subject is not dealt with in the Act. The Committee is aware of the Minister's acceptance of the principle of the majority recommendations of the Special Committee. It would now be grateful for the Minister to say how he views on the translation of those recommendations into terms of actual remuneration. It is the Committee's view that, except where special circumstances justify it, the remuneration of general practitioners should be by capitation payment in proportion to the number of persons on a doctor's list, and that this principle, which it regards as fundamental, should be embodied in the Act. It is opposed to the payment generally of a salary basic or other, considering that in ordinary circumstances the general practitioner should be paid by capitation fee. The time has now come for a clear and detailed statement on the whole subject. The Minister will recall the statement of the Lord Chancellor in the House of Lords on Oct. 28, 1946, replying to an argument that the terms and conditions of service should be made known to the profession well before the appointed day, and says the Minister agrees that we ought to aim at a period of six months so that the doctor can have ample time to make up their minds as to whether they are going to come in or not."

Right of Appeal to the Courts

35. The view is widely held in the medical profession that there should be a right of appeal by the practitioners affected to the Courts of Law from any decision of the tribunal to remove a practitioner's name from the lists of any or all Executive Councils or, alternatively, that there should be a right of appeal from any adverse decision of the Minister on this point. In the Health Service Bill for Northern Ireland a practitioner aggrieved
The local executive council is not required to consult the local medical committee in all appropriate matters coming before it but only "on such occasions and to such extent as may be prescribed." This limitation is regarded as unsatisfactory.

Scope and Conditions of Service

40. (a) In general, and subject to what is recommended below, the definition of the scope of the general practitioner service should follow the lines of the existing definition of the obligations under the National Health Insurance Act.

Anaesthetics

(b) The administration of anaesthetics in midwifery and dental cases should be excluded from the practitioner's obligations.

(c) The administration of other anaesthetics for patients on the list of the practitioner concerned should be within the terms of service only if:

(1) the operation is of a kind which is usually performed by, and is in fact performed by, a general medical practitioner, and

(2) the administration of the anaesthetic or the other assistance rendered does not involve a degree of special skill or experience not possessed by general practitioners as a class.

Emergency Attendances

(d) The following procedure should govern emergency attendances:

A. Public Service Patients on Practitioners' Lists:

(i) That a public service practitioner should be under an obligation to make deputizing arrangements to the satisfaction of the Executive Council and the Local Medical Committee.

(ii) That in an emergency the public service practitioner could properly be under an obligation to attend a public service patient not on his list, where the patient has tried unsuccessfully to obtain the services of his own doctor or his deputy; or where the doctor is satisfied that such is the grave nature of the emergency that the calling in of the nearest available doctor is justified.

B. Patients not on Practitioners' Lists:

Where emergency treatment is rendered to a patient whose name is not on the list of any practitioner in the service:

(i) the patient may if he so desires and if he is resident in the area of the doctor’s practice ask to have his name included in the list of the practitioner rendering the treatment. Where the patient does not reside in the area of the practice he may express a desire to be treated as a public service patient. In the circumstances here indicated no fee should be payable by the patient for the emergency treatment.

(ii) the patient may if he so desires elect to be treated as a private patient.

C. Practitioner’s Fee for Attendance in Emergencies:

Where a public service practitioner attends in an emergency he should be entitled, on making application, to a fee from the service for his attendance.

Practitioners’ Lists

(e) (i) A practitioner entering the service should retain his present National Health Insurance list.
(ii) the objective should be a maximum of 4,000 public patients per practitioner.

Certification

(f) The requirement is imposed by Section 33 (2) (d) of the Act to issue certificates “for the purposes of any enactment,” which includes the purposes of regulations made under any enactment. The Committee’s view is that the practitioner’s obligation should be limited to certificates under the National Health Service and the National Insurance Acts, 1946. Although it welcomes the establishment of a committee to examine the whole position of certification, the burden of certification is bound to be oppressive while Section 33 (2) (d) of the Act remains in its present form.

Health Centres

(g) (i) The Central Health Services Council should appoint a Standing Advisory Committee on Health Centres; the establishment of these Centres should proceed experimentally and under central control.

(ii) No practitioner should be compelled to undertake service at a Health Centre.

(iii) The Medical Committee of the Centre, including its chairman, should have an appropriate status in relation to (a) the administrative arrangements of the Centre, and (b) the making of appointments of persons (e.g., nurses) employed at the Centre. In general, the responsibility for the arrangements at the Centre so far as these relate to general medical services should rest with the Medical Committee.

Assistants

(h) (i) It is highly desirable that newly qualified practitioners seeking to enter the field of general practice should, for a period, act as assistants to practitioners whose names are on the lists of Executive Councils so as to gain the necessary experience.

(ii) There should be no legal requirement to prohibit a newly qualified practitioner from having his name included, for the purposes of independent practice, on such lists.

(iii) It should be permissible for an agreement to be required by a principal from an assistant which would prohibit him, on leaving the practice of the principal from having his name entered on the local list in petition with the practitioner for whom he has worked.

Collective Responsibility

41. On and after the appointed day a proportion of the population will sign on doctors’ lists. Of this proportion, a proportion, varying in different areas, will sign on doctors’ lists when the need arises to consult a doctor. A third group will consist of persons who do not intend to use the service and adhere to their intentions.

Thus an obligation will exist to attend two of the three groups described above, those who have in fact signed on doctors’ lists and those who will at future date. Indeed, as any member of the community can at any time call a doctor, and at the outset of consultation request to be accepted as a public patient, there does exist a responsibility relating to the whole community. In any case, it is clear that to first two groups that responsibility will exist from the beginning.

With this in mind, collective responsibility for the great majority of the community will exist, and it is essential that this should find expression in a central fund, made up of the total number of persons estimated to be at risk multiplied by the agreed capitalisation. The two things necessarily go together—collective responsibility and a central fund.

There should be established a central practitioners fund equal to the capitalisation fee agreed upon multiplied by a number equal to a high percentage of the population, this percentage being less but only slightly less than 100. The allocation of the central practitioners fund would be the responsibility of a Distribution Committee analogous to the one now in existence for purposes of National Health Insurance.

HOSPITAL AND SPECIALIST SERVICES

Transfer of Hospitals

42. In its present form the Act makes possible a state monopoly of hospitals. To the Minister are transferred on the appointed day all voluntary and council hospitals, the definition of voluntary hospital covering any institution for the reception and treatment of persons suffering from illness of any kind, including associated clinics, dispensaries, and out-patient departments, such institutions not being carried on for profit. So wide a definition may cover not only institutions generally regarded as voluntary and public hospitals but a number of institutions hitherto regarded as, and sometimes called, nursing homes. There is no assurance either that such private accommodation as is taken over will continue to be used for that purpose, or that private accommodation will be retained or developed according to the public demand for such accommodation. Quite apart from this automatic transfer the Minister is given power to acquire by compulsory purchase any institution not so taken over, even though it may be conducted privately on a profit-making or dividend-paying basis.

The Committee asks that the position of private homes should be clarified by excluding such institutions, whether carried on for profit or not, from definitions of hospital and clinic set out in Section 10, and 79 of the Act.

43. State ownership of nursing homes is not essential to the efficiency of the service. It would deprive the profession of facilities for independent practice. The continuance of independent practice is necessary to the maintenance of a high standard of medical service. If this is to be ensured, a Minister should neither take over automatically existing nursing homes, nor have power to acquire either those nursing homes which are in existence or those which may be set up in the future.

44. It is the two situations—the automatic take-over and the power to acquire—regarded together, which arouse the fear that a Minister, present or future, will establish a monopoly in hospitals by compulsory purchase, or threatening so to do, any private or voluntary hospital, home, dispensary, or clinic establishing private patient lists.
The Committee believes on grounds of public interest that a Minister should not be so enabled and authorized to establish a monopoly, but rather that the accommodation should be provided to enable private establishments to be carried on outside the service, whether on a profit or non-profit basis.

Under Section 6 (3) of the Act the Minister is enjoined to "disclaim" or to subject to the right of the governing body of a hospital to give a notice on the Minister stating that they wish the hospital to be taken over. The Committee asks for an early announcement to be made of the hospital to be taken over. In the Committee's view the same principle should be extended to patients who pay the full cost of private treatment referred to in Section 5 of the Act.

Where the professional services of a radiologist or pathologist are required for a patient occupying a private ward, the radiologist or pathologist should receive a fee for his services in the same way as any other specialist.

Method of Reference of Patients to Specialists

51. The Committee accepts the general principle that the National Health Service should provide a full specialist service. In its view there should not be referred on the patient the right to consult a particular specialist. It considers that:

(a) Patients should be referred to specialists only at the request of a general practitioner;
(b) It is desirable that a written communication from the general practitioner should accompany the patient;
(c) Facilities for diagnosis should be made directly available to general practitioners, whether in hospital or elsewhere.

Appointment of Specialists

52. Appointments in non-teaching hospitals at levels below that of the professional staffs of teaching hospitals should be made by Regional Hospital Boards on the advice of Advisory Appointments Committees. In the Committee's view appointments to the junior staff up to and including the registrar level should be made by hospital management committees with formal approval by the regional board. There should be an early announcement of the precise constitution of advisory appointments committees. The Committee stresses the need for a close liaison between teaching and non-teaching hospitals and considers that, so far as the appointment of specialists is concerned, there should be representation on the advisory appointments committee both of the hospital management committee and the university concerned, with provision for the attendance as observers of external assessors. The Committee recognizes that, though it is desirable, it might be impracticable to have a common advisory appointments committee selecting candidates for both teaching and non-teaching hospitals.

General Terms of Service

53. The Committee recognizes that any decision on specialist remuneration must await the report of the Spens Committee. In regard to the mode of remuneration, it recommends:

(a) that for hospital work remuneration should be on an annual payment basis generally related to status, responsibility, and estimated total time spent in the service, and possibly also to length of service;
(b) that for domiciliary work remuneration should be on the item-of-service basis and that specialists should be free to determine whether or not they will
undertake an obligation for domiciliary work under the service.

Appointments for domiciliary visits should be made by the hospital concerned on the application of a general practitioner. Each hospital should keep a list of specialists undertaking domiciliary work, including days and hours at which they will be available. Except in emergency patients should be permitted to consult the specialist of their choice, to his availability.

Boards of Governors of Teaching Hospitals; Hospital Management Committees—Chairman

54. The Committee considers that, after the appointments, boards of governors of teaching hospitals and hospital management committees should be permitted to appoint their own chairman.

LOCAL HEALTH AUTHORITY SERVICES

Statutory Health Committees

55. The Act requires each local health authority to appoint a health committee and that a majority of the members shall be members of the authority. The Committee's view is that local health authorities should be required to co-opt to the health committee medical practitioners representative of the local profession. In a circular to the authorities the Minister, while not accepting the view that these authorities should be required to co-opt medical representatives, has emphasized the importance of the inclusion on health committees of proper representation of the profession.

The Committee has collected information on the extent to which these powers of co-option have been exercised from 42 of the 62 county councils and 57 of the 83 county borough councils. Of the 99 authorities in respect of which information is available 94 have co-opted a total of 138 members of the profession, and five authorities have decided not to co-opt medical practitioners.

Remuneration

56. The Committee attaches importance to the principle that the remuneration and conditions of service of all medical officers employed by local authorities (including those which are not local authorities within the meaning of the Act) should be negotiated at the same time and through the machinery.

Decentralization of Local Health Authority Services

57. In county areas the Minister has advised authorities that the best method of organizing the administration of the services enumerated in Part II of the Act is by the subdivision of the county into health areas, with a subcommittee of the county committee exercising delegated functions for each area. Such local subdivisions will be based on the health considerations of the locality rather than on areas already determined for the purposes of the administration under the Education Act, 1944.

Where such schemes of delegation result in district medical officers of health losing the majority of their present work there should be adequate compensation for loss or partial loss of office. In the Committee's view it ought to be made possible for medical officers to claim and receive compensation in lieu of accepting new posts offered by a county merely with a view to finding them work without salary.

MENTAL HEALTH SERVICES

Division of Responsibility

58. The Committee is anxious about the division of responsibility for the mental health services between regional hospital boards and local health authorities, and wishes to stress the importance of securing a close liaison between specialist psychiatrists working in these two fields. There should be available to local health authorities the services of a practitioner of specialist standing in psychiatry and mental deficiency. Local health authorities might be grouped to employ such an adviser and encouraged to make 'Joint Users' appointments in consultation with regional or teaching-hospital boards.

Regional Psychiatrists

59. The Committee attaches considerable importance to the appointment of regional psychiatrist. It estimates that the remuneration attaching to these appointments should be of an order sufficient to attract psychiatrists of highest ability.

SUPERANNUATION

60. The Committee regards as unsatisfactory the omission from the Superannuation Scheme of:

(a) Provision for "added years" to compensate for the long period of training before medical qualification and the relatively late age of entry to the service.

(b) Some form of immediate cover (whether by "added years" or the reckoning of non-contributing service) against permanent incapacity or death in the early years of service. This applies particularly to practitioners who are 55 years of age or more on the appointed day.

61. So far as the profession is concerned, proposals for widows' pensions are inadequate. The minimum of one-third is too low, especially in view of the substantial reductions that may be made in the case of widows where the widow is younger than her husband.

62. Consideration should be given to the desirability of extending the Scheme:

(a) To include provision for the transfer of annuity rights for medical officers who transfer from the local government service to the university service;

(b) To include superannuation facilities for taries and dispensers of practitioners who are on service.
PRESENTATION OF THE PROFESSION ON ADMINISTRATIVE BODIES

The Minister, during the second reading debate in the House of Commons, expressed the view:

"I believe that democracy exists in the active participation in administration and policy. Therefore I believe that it is a wise thing to give the doctors full participation in the administration of their own profession."

POWERS OF THE MINISTER

The Act involves an excessive concentration of power in the hands of the Minister. He will appoint central health committees and other bodies. The Minister nominates 85 members of the profession for the 14 Regional Boards, an average of six per region. Only 27 of these nominees were appointed by the Minister. In five Regions only one of the six nominees was appointed; in five Regions the six were appointed, and in the remaining four three of the six were appointed by the Minister. The Royal College of Surgeons nominated a total of 31 practitioners, of whom seven were appointed by the Minister, including one who was also a B.M.A. nominee.

At the time of this report the membership of the Central Health Services Council has not been announced. So far as local health authority services are concerned, the extent to which county and county borough councils have exercised their powers of co-option to health committees has already been discussed under paragraph 55.

The Committee desires to remind the Minister of his statement during the second reading debate:

"I believe that democracy exists in the active participation in administration and policy. Therefore I believe that it is a wise thing to give the doctors full participation in the administration of their own profession."

MAIN POINTS OF THE NEGOTIATING COMMITTEE'S CASE

In many respects the Act as it now stands is unacceptable to the medical profession. The main points which need to be modified, in most cases by amendment of the Act, are:

1. DISTRIBUTION

Doctors should be free to determine without pressure, direct or indirect, whether or not to enter the public service. If they decide to enter the service they should be free to choose their area of practice.

2. BUYING AND SELLING OF PRACTICES

It is in the best interests of the public and the profession that general practitioners should retain the ownership of the goodwill of their practices. This ownership provides an important incentive, encourages good and efficient work, provides a basis for co-operation between practitioners and a bond between doctors and their patients. Although in this document emphasis is laid on the unworkability of the Act in this regard the issue of ownership of goodwill is regarded by the medical profession as fundamental to its freedom.

3. REMUNERATION

Remuneration of general practitioners should be by annual payments in proportion to the number of persons on a doctor's list, except where special circumstances justify some other method of payment, and the Act should be so amended to provide for this, as in the Northern Ireland Bill. The Minister has accepted in principle the majority recommendations of the Spens Committee and the profession asks for his views on the translation of those recommendations into terms of annual remuneration.

The remuneration of specialists for hospital work should be on the basis of annual payments and for domiciliary work should be on the item-of-service basis.

4. RIGHT OF APPEAL TO COURTS

There should be a right of appeal to the High Court against a decision to remove a practitioner's name from the list(s) of any or all executive councils.

5. MIDWIFERY

It is inconsistent, unnecessary, and undesirable that the Minister should seek to impose upon practitioners undertaking midwifery in England and Wales a qualification which is not imposed by the Medical Acts or upon practitioners undertaking midwifery in Scotland and Northern Ireland.

6. ADMINISTRATIVE BODIES

Executive and other councils and committees set up under the Act should elect their own chairmen.

7. PUBLIC HOSPITALS

It is undesirable that a Minister should be empowered to establish a monopoly in hospitals. Private nursing homes, whether carried on for profit or not, should be excluded from the definitions of hospital and clinic set out in Sections 9, 10, and 79 of the Act.

8. HOSPITAL ACCOMMODATION FOR PRIVATE PATIENTS

The Minister's discretion should be replaced by an obligation to permit specialists in the service to attend their patients in private hospital accommodation. In at least a proportion of such private accommodation...
arrangements between the specialist and the patient should not be subject to control by regulation.

9. FACILITIES FOR DIAGNOSIS

Facilities for diagnosis, including radiological and pathological services, should be made directly available to general practitioners, whether in hospital or elsewhere.

10. STATUTORY HEALTH COMMITTEES

Local health authorities should be required to co-opt to Health Committees medical practitioners representative of the local profession.

11. PUBLIC HEALTH SERVICE

The remuneration and conditions of service of all medical officers employed by local authorities (including those which are not local health authorities) should be negotiated at the same time and through the same machinery.

12. REPRESENTATION OF THE PROFESSION ON ADMINISTRATIVE BODIES

There should be adequate representation of the medical profession on administrative bodies concerned with Parts II and IV of the Service, such representation being arranged by the Minister in agreement with, as well as after consultation with, the appropriate medical organizations.

November 7, 1947.

POSTSCRIPT

66. The Act as it stands is full of legal perplexities and anomalies which could only be resolved, if at all, after long litigation and widespread uncertainty among the profession and the public. Many of the provisions are fraught with the risk of grave hardship to patients and with serious injustice to doctors and dependants. Even with the utmost good will on the part of the medical profession the wording of the Act places so obscure that to bring it into force as it is will create chaotic conditions. The Committee offers views as the mature conclusion of many months of detailed study of the Act carried out in company with officials of the Ministry.

When the reply from the Minister is conveyed to the Negotiating Committee it is proposed to circulate to the profession both the Committee's memorandum and the Minister's reply.

The next step will be for the profession as a whole to be advised by a plebiscite and meeting, to decide its attitude. As the Minister so plainly put it in his letter of Jan. 6, to the Presidents of the Royal Colleges:

"Every doctor will have to decide for himself the proper time comes whether or not he should take part in the new Service, and the profession as a whole will be free to determine their views on the Service as they know what it is to be."

In the light of the Minister's reply the profession proceed to determine its views on the Service.

THE NATIONAL HEALTH SERVICE AND THE
MEDICAL PROFESSION

ERAL COMMENTS OF THE MINISTER, ADDRESSED TO THE INDIVIDUAL DOCTOR

Minister's memorandum on the Negotiating Com-
statement about the National Health Ser-
The Secretary of State for Scotland associates
with the memorandum, which may therefore be
applicable (with the necessary changes) to the
Scotland, so far as conditions in that country
same as in England and Wales.
memorandum deals only with the points raised
Committee. But, for the individual doctor,
other—simpler—matters on which he wants to
ecessarily to do in his own way
if he participates in the
health service, how does it affect him personally?
ny major step to better social services (in
doctors, above all, are interested) has provoked
mis-statements or misunderstandings than the
Health Service Act. The Minister would like
this opportunity, in preface to his main memo-
and do so.

WHAT DOES TAKING PART MEAN?
Any doctor, like any other member of the public,
participate in the new scheme or not—or partly do
partly not—just as he thinks fit. There is no
reason whatever.

Any doctor participating can also retain private
tics. This and other professional services for fees
or remuneration, other public or private medical
may go on. The only limitation is that no fees
be charged to patients whom he has accepted on
within the scheme.

"Service" is perhaps a misnomer—if it is thought
organised corps, like the medical branches of
flying services. Nor is there any hierarchy of
vision or interference with a doctor's pro-
nal judgment and clinical practice. He undertakes
after patients and is left to do so in his own way
the best of his clinical ability. He is not "under
red"

He is not "employed." He enters into an arrange-
with a Local Executive Council (half professional,
dentists and chemists) which takes the place of
Insurance Committee and, in essence, his con-
to look after the patient whose care he undertakes
to be paid for it from public funds, in these cases,
by private fee. He is certainly not a civil

HOW WILL THE DOCTOR BE PAID?

What is this payment from public funds? It is
t in detail in paragraphs 26 and 27 of the main
memorandum attached. But examples of it can be
given here.

A doctor takes on 4,000 potential patients under the
scheme, his gross income from this source would
be £300. If his number is 3,000 potential patients, the
income is nearly £2,600. In addition he may have
fees from other patients, other public or private
paid appointments, additional fees for undertaking
maternity work, mileage allowances, allowances for
training assistants, and other extras.

(6) Also there will be a fund of over £400,000 a year
available for discretionary payments as "inducements"
to assist practice in difficult and unpopular areas.

(7) The aim will be to set 4,000 as the maximum num-
ber of patients for a doctor under the scheme, but there
is no rigidity in this.

(8) All of this assumes that no less than 95% of the
population use the new service. If the figure is less, the
payment per patient is proportionately higher. But, in
two years' time, that position will be reviewed. It is the
essence of a successful national service that both doctors
and the Government co-operate in getting the nation as
a whole to benefit by it.

COMPENSATION AND SUPERANNUATION

(9) Doctors who participate in the scheme on the
appointed day will establish their claim to their share of
the £66,000,000 which the Government has set aside as
compensation for their being unable in future to sell
public practices. The sum of £66,000,000 represents an
amount agreed with the profession's representatives. The
Minister is prepared to take the profession's own advice
as to how this is to be most equitably distributed.

Normally, it will be payable when capital values would
otherwise be realised—on retirement or death—with
interest in the meantime. But, if there is hardship, like
some undue debt burden on the practice, it can be paid
at once. If a doctor wants, later on, to stop practice
for any reason he can draw his compensation at once
and do so.

(10) In addition, a superannuation scheme is to be
started; the doctor contributing 6% of the payment he
receives in the new service (less a percentage for "practice
expenses") and the Government 8%; the benefits to
include a pension and a lump sum on retirement
(including retirement on incapacity) a death benefit and
a widow's pension.

(11) The profession's representatives think that
partnership agreements will be prejudiced by the new
arrangements. The Minister is advised otherwise, as
will be seen (see paragraphs 14 to 22 of the main mem-
randum). But, if the Minister finds, on any judicial
decision, that he is wrong, he undertakes to introduce
legislation to restore his original intentions, as indicated
in the main memorandum.

NO DIRECTION OF DOCTORS

(12) All existing doctors can participate in the new
scheme where they are practising now. After the scheme
is operating a doctor wishing to participate—and draw
public remuneration—will need to get consent from a
mainly medical body to be set up. Private practice is,
of course, unaffected. Consent in respect of public
practice will only be refused in those few areas where
there is clearly no need for additional "public practice." (This
is dealt with more fully in paragraphs 6 to 13 of the
main memorandum attached.) No doctor can be directed
anywhere.

(13) Under the old National Health Insurance Scheme
a doctor can be debarred by the Minister from con-
tinuing to participate. In future he can only be so
debarred by a special and statutory tribunal—a lawyer (appointed by the Lord Chancellor) someone representing the Executive Councils, and a doctor. If they do debar him, he can still be retained by a successful appeal to the Minister. If they decide he should remain, the Minister has no power to intervene. The advantage lies only with the doctor.

(14) Although a doctor may not get consent to report a confidential (14) opening a surgery for practice with the scheme in a particular area (on the grounds that it is not needed) he can accept patients from any area he wishes as long as he is prepared to visit them as necessary.

(15) As and when Health Centres are set up, no doctor will be compelled to practise in them. Their object will be to provide premises and equipment, usually costly for the doctor to provide for himself, and to enable him the better to treat his patients. In Health Centres the personal relationship (of "my doctor") will be retained. There is no question of setting up "institutions" where the patient has to see the doctor "on duty." They will be a substitute for the doctor's home surgery, publicly serviced and equipped. Group practice, like present partnerships, will be encouraged in them.

ASSISTANTS

(16) Assistants, paid by the doctor, will permit—as before—of enlarged lists of potential patients. In addition there will be a system of grants to doctors for the training of young assistants—still to be worked out in detail in consultation with the profession.

DOCTORS IN THE RUNNING OF THE SERVICE

(17) Doctors are, for the first time, brought on a substantial scale into every main field of administration of the new scheme—Regional Hospital Boards, Boards of Governors of Teaching Hospitals and Executive Councils. It is a new experiment in bringing the profession itself into the direct administration. In addition it is to be a Central Health Services Council, majority of doctors (to advise the Minister on the scheme) and a special Statutory Advisory Committee. Each can advise without being asked and the Minister has to publish the report (save only where the public interest prohibits).

GENERAL

It is the very essence of a doctor's relationship with his patients that it should be personal and confidential. The scheme in no way interferes with that. The profession is not to be asked to extend the scheme in any way it can be, or interfere with the greatest health service in the world. There is no reason whatever why the personal relationship of doctor and patient—and the professional independence of the doctor—should be affected.

A scheme of this magnitude is bound to need amending, as it is found wanting. But its very conception, it is something of incalculable social and economic value. The profession will be the first to want—as they have before—something of this kind. For his part, the Minister concerned mainly to get this great national service launched, and to plan on wider, better lines, so that the profession directly co-operating in the management of the new service. He asks the profession to help in making it a success, and he is confident that the profession will join with him, as constructively and often properly critical partners, in getting it under way.

THE MEMORANDUM OF THE MINISTER

on the STATEMENT OF THE NEGOTIATING COMMITTEE'S VIEWS

1. The Minister has studied the statement of the Negotiating Committee's views. He has also discussed the main points in meetings with their representatives on 2nd and 3rd December, 1947, and the subject matter of the statement has been discussed in greater detail earlier with his officers.

2. The Minister now sets out his own views, following on the discussions, and in doing so follows the subject headings as the statement—for ease of reference.

PRELIMINARY

3. The Minister agrees with the account given of the events leading up to his discussions with the Negotiating Committee. He has never excluded—and does not now exclude—the possibility of amending legislation being found desirable. Indeed, in his experience, it would be most unusual if points for amendment were not discovered sooner or later in any measure of the scope of the National Health Service Act. He expects this to be no exception. But the discussions have not convinced him of any sufficient reason to go to Parliament and ask it to alter its intentions as to the new service before that service has been tested in actual operation and found to need amendment. If, when the time comes, it is so found, the Minister will not only be willing to but will himself be the first to wish to seek—its cation and improvement by Parliament.

4. Meanwhile, within the framework of the scheme in its administration, there is clearly room for adjustments which result from discussion and from the purpose of discussion. These are dealt with by point, in the rest of this paper. The Minister will certainly be prepared to give effect to them and he assumes that the profession, for its own sake, will whole-heartedly help him in making the health service the success which both they and he desire it to be.

THE PROFESSION'S AIM

5. The Minister has again examined the seven general principles set out in the Committee's statement, and does not believe that anything in the proposed National Health Service is really in conflict with them.
Under the decision of Parliament to assure all people the liberty to benefit from a full medical service, the Committee approve in their statement—the placing of responsibility somewhere for the reasonable distribution and availability of service. A public duty cannot be undertaken by any reasonable means of fulfilling it. Public cannot be attracted to practice in areas where the interest does not warrant it. Even so, the Actrapy avoids any power of "direction" of doctors (as it is mentioned by the Negotiating Committee's stated principle). All existing doctors can take the new arrangements where their practice lies, disturbance. After that, and for the future, reserved to the new health service the right only in what areas it has no need for additional partici­pations— for its own purposes. This has to do with, and does not affect, private practice. As it is the Minister who will normally decide this, mainly medical body (the Medical Practices Com ­mittee) specially set up for the purpose and not subject to the Executive Council, the Executive position which no other profession or occupation can have the option of two or more claimants for one practitioner whose share is bought by his partner does not need for new public practice or replacement— there will be few, for many years to come, until the new of doctors available has increased. Apart from need for new public practice or replacement—the Minister will unhesitatingly seek from Parliament such adjustment. If and when the Minister considers that provision by regulations on all the legal advice which he has obtained) and also what the Minister believes to be the effect of the Act. If there are varying opinions as to the validity of this interpretation, the Minister has no power to decide such problem are set out in paragraphs 17 to 22 below, and ownership of Goodwill: Existing Partnership Agreements 14. The interpretation of the Act set out in paragraph 16 of the Committee's memorandum correctly sets out what the Minister believes to be the effect of the Act (on all the legal advice which he has obtained) and also what he understands Parliament to have intended in the Act. If there are varying opinions as to the validity of this interpretation, the Minister has no power to decide upon their merits; that is for the Courts. If, in the event, this interpretation is proved to be wrong, the Minister will unhesitatingly seek from Parliament such correction of the Act as will be designed to restore it. He gives that assurance without question. All of this is normal and familiar constitutional procedure. The Minister, with Parliament's endorsement, does what he is advised to be right in achieving his intentions. If and when that is proved to be wrong he asks Parliament to adjust it. 15. The interpretation referred to means that the Act does not make it illegal to carry out, as between partners, existing partnership agreements. Existing powers or obligations between partners to buy or sell shares of the partnership practice will remain in force and can be fulfilled. Careful provision is necessary to secure that the right proportion of compensation goes eventually to the practitioner who actually suffers the loss and that a practitioner whose share is bought by his partner does not get both the purchase money and the compensation. The methods by which it is proposed to deal with the problem are set out in paragraphs 17 to 22 below, and the Minister considers that provision by regulations on these lines will dispose of all the major difficulties, which it is his firm intention to do.
16. But suppose that his advice is wrong. It is always within the power of any partners, if they still feel that in exceptional cases some anomaly is left which is not and cannot be covered by any general provision, to vary by agreement the terms of the partnership and so to remove the anomaly. 17. Where all partners participate in the new service, the Minister proposes to provide by regulation that: (1) compensation will be assessed in respect of the value of the partnership practice as a whole at the appointed day; (2) partners in the same practice shall be apportioned compensation for the practice shall be apportioned between them—and interest will then follow the agreed apportionment; (3) failing agreement between the partners, compensation will be assessed on the basis of the shares which they hold at the appointed day. Whenever the Minister is later notified that a sale of shares has taken place in accordance with the provisions of the Agreement, the assessment of compensation will then be correspondingly adjusted and interest will follow the change; (4) in cases of hardship early payments on account of compensation will be made, subject to arrangements for securing that if the recipient’s share of the partnership is afterwards bought by his partners (and he therefore suffers no loss entitling him to compensation) the compensation will be repaid.

18. The Negotiating Committee consider that such arrangements would still leave two anomalies: (1) the price which a partner has to pay for the purchase of a further share under his agreement (which he could not re-sell) might be more than the compensation; (2) a partner will not necessarily receive interest on the full amount of the compensation which ultimately becomes due to him. 19. The former situation will arise if the value of the practice increases as a result of the new health service (involving also an increase in the income from the practice). It might also arise in individual cases without any change in the income of the practice. The basis on which the purchase price is to be fixed varies from one agreement to another, and it is of no more importance for the price to have to be paid, instead of greater than the amount of the assessed compensation. Partners who anticipate difficulty from this can, if they think it necessary, agree among themselves that the price to be paid for shares bought under the agreement should be the same as, or not exceed, the compensation assessed in respect of those shares.

20. The suggestion that the payment of interest in the manner of purpose is not a fair basis of his value to the partnership. Compensation is provided under the Act to meet the loss which will be non-payment of compensation for which there is provision in that aggregate. For the time being it is proposed to proceed on the assumption that the excess on paragraph 21 (e) be balanced by the saving on paragraph 21 (e), but the precise cannot be known for many years, and probably will be hardly be exact and will need later adjustment. The Com also contend that the total amount provided for compen will be insufficient if every practitioner in general practice part in the new service before there is any payment. The Min the Service Committee will provide an appropriate in the global sum. All these points are matters for suc legislation as experience may require.

Partnerships after the Appointed Day
23. The main object of new partnerships, entered into at an appointed day, will be greater convenience and better fa for carrying on practice. The remuneration of each part will be assessed on the basis of his value to the practice and in making this assessment account can be taken not of his earnings but also of his knowledge, experience and staff. There seems to be no reason whatever why this basis of part should be disturbed. It is, however, desirable, in the absence of more tangible evidence, that the selling of shares should be regarded as the essence of a partn in medical practice. If there is any doubt whether a pro division of earnings is in accordance with the Act the M Practices Committee can be asked for their opinion. T think the proposal is in order they will then issue a cert which will be a complete defence if the transaction shoul be questioned.

Assistants
24. An offence will only be committed if an assistance so obviously less than he is worth as to amount to an act of goodwill, and this is obviously not what the profession will think. The effect of paragraph 21 (e) will be to enable the Negotiating Committee to state the price at which the sell of a certificate from the Medical Practices Committee being so, the Minister cannot think that the difficulties ant by the Negotiating Committee are likely to arise. He en agreement to the desirability of an initial period of assist and he has suggested to the Committee a scheme of gra experienced practitioners willing to train assistants, who hopes will benefit both principals and assistants alike.

The Doctor’s House
25. Some of the difficulties anticipated by the Committe will be met by enabling the Executive Council to buy the ho the incoming doctor. For the rest, the Minister is advised is there is no reason of committing an offence if the house is to the State. The house will be retained by the State and the body certificate from the Medical Practices Committee will complete protection. The Medical Practices Committee devised as a professional body so as to ensure that it does not under-stand and pay can regard the proper interests in the profess before it, and it will have a wide m of discretion.

Remuneration
26. The Minister proposes the following arrange in order to translate the general recommendations of the Spens Committee (which has already accepted the occurance of remuneration for general practitioners (the Spens Committee on Specialists not having reported):—

(1) A central fund as contemplated in paragraph (1) of the Negotiating Committee’s statement (cor with the assumption by the profession of c responsibility for all who wish to use the new ser will be established—equal to a capitalisation fee multiplied by 95% of the civilian population. (2) This 95% of the population, by which this is multiplied before being put into the fund, is recomme at the end of seven years, having added to the aggregate cum gives of practitioners who are found to be using the new service at that date. (3) There will be a first charge on that fund for (a) allowances for mileage (which may be separate sub-fund), fees for temporary rest emergencies and anaesthetics, on the general followed in the National Health Insurance Scheme. (b) a sum sufficient to distribute to every part in the service, on an Executive Council, a fixed annual payment of £300 a year—to to conditions to ensure that some minimum number of patients is accepted by doctors within a reasonable period of time. (4) The remainder of the fund will be dist
The gross income (exclusive of receipts from private practice, obstetric service, mileage, etc.) would then be—

1,000 public patients  
£300 + £ 850 = £1,150

2,000 do.  
£300 + £1,700 = £2,000

3,000 do.  
£300 + £2,550 = £2,850

4,000 do.  
£300 + £3,400 = £3,700

If 90% of the population were on doctors' lists the rate would be—  
18s. 0d. (approx.)

The gross income (exclusive of receipts from private practice, obstetric service, mileage, etc.) would then be—

1,000 public patients  
£300 + £ 900 = £1,200

2,000 do.  
£300 + £1,800 = £2,100

3,000 do.  
£300 + £2,700 = £3,000

4,000 do.  
£300 + £3,600 = £3,900

Right of Appeal to the Courts

28. Parliament have accepted the view, embodied in the Act, that as the ultimate responsibility for the service is placed by Parliament on the Minister, it must be left to him to decide in the last resort whether it is possible for him to retain in the public service in any particular area, or even at all, a practitioner whose retention, in the Tribunal's view, "would be prejudicial to the efficiency of the Service." Any other situation would be impossible. If the Minister is to be answerable to Parliament for the success of the service, he cannot be put in a position where he has to answer for a doctor whom he is forced to retain. The Minister thinks that it would help him to consult an Advisory Committee of the type which has hitherto advised on similar cases arising under the Insurance Scheme and provision will be made for this in regulations.

29. Nor would such a situation apply to any other profession or vocation. Of course, there is fully retained the doctors' ordinary legal rights to go to the Courts on the grounds of unlawful action by the Minister or others. Nor are the rights of the General Medical Council in any way prejudiced.

Midwifery

30. There is no suggestion, of course, that any qualified medical practitioner should be in any way debarred from practising midwifery. The new health service is concerned with arrangements for maternity only within the service. There have been some discussions on this with general practitioners, midwives and others, and the Minister is advised that the best arrangements to secure that the standard of attention for the expectant mothers is uniformly good throughout the new service should be as follows. The hospital and specialist service will provide for specialist obstetrics and for confinements in hospitals. Otherwise all general practitioners in a local health authority's area will be asked to say whether or not they wish to practise midwifery and to answer calls by midwives for medical aid under the Midwives Act, as applied to the new service by the new Act. Any who wish to do so will be asked the extent and nature of their obstetric practice during the preceding three years. Their particulars will be put before a local professional committee (including general practitioners, a local obstetrician and the medical officer of health). This committee will decide on the list of local practitioners suitable for answering calls from midwives and at the same time taking part in the maternity services provided by the new Act. Others, not included in the list, will need further obstetrical experience first, and the list will be periodically reviewed.

31. Every woman will be entitled under the Act, for all ordinary purposes, to the medical advice and treatment of a general practitioner, by their mutual agreement. She will no doubt consult him in pregnancy, and, for her confinement, he will tell her how to obtain the
where circumstances make it possible—to the proportion of the available private beds to be about any prescribed maximum charge. He will show this can best and most fairly be done.

should be clear that there is a complete difference between the comfort of the patient in accommodation provided under this Act and elsewhere (as referred to in the Registrar's statement). The former is taking advantage of the latter. and is paying only for the additional amenity of a room or small ward. The latter has elected not to use the public service, but to seek his hospital accommodation outside it.

Section 4 the only charge payable by the patient will be the cost of the separate accommodation, and nothing in debate to the recovery of medical fees was to refer to this, but to deal with the position where the private pay block may exist and where any accommodation for pure private patients may therefore be set aside in blocks, or small wards; but this would be done under Section 4 and not under Section 4.

The extent to which purely private pay-bed accommodation available and treatment of private patients in it allowed must clearly depend on the size of the demand on these services, or on the size of the demand for pure private pay-bed accommodation within prescribed limits under the Act.

Reference of Patients to Specialists

The Minister accepts in the main the proposals made by the Committee. It is contemplated that the patient will normally consult his family doctor, who will refer him on a written statement. Exceptionally, the patient may seek specialist treatment directly for a venereal diseases clinic. With regard to the Department of Health facilities, it will be an objective of the service that specialist advice through his family doctor, who will refer him on a written statement.

LOCAL HEALTH AUTHORITY SERVICES

Remuneration

As to grouping, the Circular says:—

"Two or more Authorities may agree arrangements for the joint user of an officer having special qualifications or experience in mental health work to act as medical adviser to their mental health service sub-committees."

Regional Psychiatrists

Regional Psychiatric Services

61. Memoranda already issued to Regional Hospital Boards indicate the Minister's view that the Boards should appoint a responsible local government bodies, ought not to be on the co-optation of non-elected members on health Committees. The Minister has no powers of appointment in the matter and would not wish to see them.

The Minister fully recognizes the importance of the points raised in this paragraph, and his views have been conveyed both to the Regional Health Committees, and to the Minister in each case.

Mental Health Services

Meeting them by providing that a doctor will become superannuable as soon as he enters a hospital post, which—it is hoped to secure—will include the last year of his training after qualification but before registration. For the average doctor,
this will happen at about the age of 23 or 24. From then onwards his service will build up in the scheme through his various employments in hospitals, clinics, and practitioner service. He will be able to retire at 60, though if he stays on till 63 or 64 (when he has done his forty years' service), he will get a larger pension.

In comparison with, for example, the local government scheme now, he will be much better off because at present his service does not begin to count until he has taken up a local government appointment which may be after a period of practitioner service and certainly after his training hospital work and he cannot retire until he has done forty years' service or reached the age of 65.

Immediate cover against incapacity or death

61. Other public service schemes require a period of qualification before benefits are payable. In the proposed scheme it is five years for death gratuity and a gratuity on incapacity and ten years for pension on retirement on age or incapacity. The scheme requires no medical examination and it cannot take on a quite unknown liability in respect of people who may be unsound lives, without some preliminary period of service.

62. As to elderly doctors who come in at the beginning, they will get compensation for the loss of their right to sell their practices; and this represents what they would normally have expected to get, quite apart from the further benefits provided by the new scheme.

The suggestion that the proposed widow's pension is inadequate

65. The widow's pension is one-third of the pension which the doctor would have got had he retired on account of incapacity at the time he died. Any increase on this would have meant diminution of pension other otherwise granted on a large number of medical practitioners. Moreover, this widow's pension will be in addition to the new national insurance arrangements which after 5th July will apply to everyone. It should be remembered that this is major public service scheme which has included a widow at all.

66. As to the reductions to be made where the wife is younger than the husband, no reduction at all is made where the wife is under 42 or in any case where the wife is not more than 5 years younger. The more advanced the age of the man the more will be the pension which he has earned and therefore the greater the amount from which the widow's pension is derived. Reduction at all is made where the difference in age between the wife and widow has to look after children of school age.

Provision for Transfer of Superannuation Rights

67. The local government scheme for this purpose can be altered in Regulations made under the National Health Act. The Committee fully agreed, however, that it is a desirable one that the earliest opportunity will be taken to import it into local government law.

Provision for Secretaries and Dispensers of Practice in the Service

68. Any such arrangement as the Committee suggested must have to apply to all such people. It would raise considerable difficulties because there must be a substantial amount of time service and temporary employment among these employees. To such persons a superannuation scheme has disadvantage only because it requires a substantial contribution which may not want to be paid from their remuneration. Moreover, in future they will all be subject to the National Insurance Scheme.

Representation of the Professions on Administrative Bodies

The whole administrative structure of the new health service represents the profession as never before. On the Regional Hospital Boards, Boards of Governors of Teaching Hospitals, Management Committees, Executive Councils, strong representation is assured. The Medical Practices Committee is almost wholly medical. The Tribunal has one medical member out of three. A Standing Medical Advisory Committee is proposed and POWERS OF THE MINISTER nominations—and professional people (doctors, dentists, and pharmacists) have been given one half of the bursaries, compared with the much smaller representation on the present Insurance Committees. The Central Health Services Council and the Standing Advisory Committee have an absolute right to advise, were asked or not, and the Minister has an obligation to publish their report and their views, save only when public interest might be at stake. The Act, if so will be found to represent a degree of decentralisation and a degree of professional administration which is probably unequalled in any other field in which there is a Minister remains completely answerable to the for its good or ill administration.

General

Parliament are never infallible; legislation is a constantly changing and re-shaping process. There will be amending Acts, with doubt, and the scheme will so be bettered and reformed as experience is gained. But first it has to be begun, if there is a scheme that the Minister is confident that the mass and a medical profession like the other great professions and women working in the medical field now, or about to join him in beginning it and—as the lessons of trial as come—in constantly improving it.

72. To be ready by the appointed day, much preparatory work has to be done and it must be done as fast as possible. This will be a difficult but better done, and the whole service better administered, if the entative of the medical profession continue to take part in the preparatory organisation (without commitment), and the hopes that they will do so while the views of individual to the profession are being ascertained.

December, 1947.