THE NHS COMPANY INC.? THE SOCIAL CONSEQUENCE OF THE PROFESSIONAL DOMINANCE IN THE NATIONAL HEALTH SERVICE

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The technology and organization of medicine has long outgrown its sociology with the result that physicians and medical care institutions have tended to become divorced from the actual needs and demands of most patients. The artificial maintenance of social polarization between patient and doctor and the preservation of an obsolete professional ideology have facilitated the development of trends in care better suited to those that control health care than those that use it. In recent years, the hegemony of the medical profession has been challenged by corporate and state interests as a more rational condominium has been sought for the pursuance of health care policy. However, there has been little or no attempt at an assessment of the actual health needs of the population. Implicit in the principles behind the inception of a National Health Service lay the promise that the history of health care would be determined by those it served. But failure to initiate an educational system representative and appreciative of the patients' milieu and to bring the control of health policy under the decisive influence of those who both work in and receive health care actually perpetuates and extends regional, sectional, and class distortions in the patterns and delivery of care.

It is not mere chance that medical care has been more concerned historically with the needs of members of the profession than with the needs of patients. It has been doctors, drawn almost exclusively from the higher social classes, who have traditionally dominated the ideology and organization of medicine. The medical schools have long turned out "artistes" (1) rather than technicians, and "doctors" rather than sociomedical scientists. The process of medical education itself provides an essential preliminary to the maintenance of this professional hegemony. The selection of medical school applicants is guided by socioeconomic criteria rather than academic ability. Matriculation brings isolation from any but professional contacts. A language and dress are cultivated which lend a reassuring confirmation of identity to the initiated and the prospective doctor is furnished with an identity which takes its inspiration from the milieu of the profession. This is not a fact to be passed over lightly.

THE BIAS IN MEDICAL EDUCATION

Far from decreasing in recent years, the social gap between patient and doctor has actually widened. Earlier work by Kelsall (2) in this field has been confirmed by more recent studies. Selection through the channels of the professional/public school[1] network has become more stringent. In 1961, 68.9 per cent of final year medical

[1] British "public" schools are to varying degrees supported by private fees.

doi: 10.2190/QAK3-AC3P-CHJF-763Y
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Table 1

Distribution by social class of successful and unsuccessful applicants to medical school[a]

	Social Class	
	1 and 2	3, 4, and 5
	%	%
Average of medical students entering in 1961 and 1965	72.7	27.3
Unsuccessful applicants	66.4	30.1
General population	18.3	81.7

[a] Adapted from data in reference 4.

students were drawn from the Registrar General's social classes 1 and 2, while only 31.1 per cent were drawn from combined classes 3, 4, and 5 (3); these proportions are in an almost inverse ratio to those extant in the general population, where social classes 1 and 2 make up only 18.3 per cent of the total while classes 3, 4, and 5 make up 81.7 per cent. In the succeeding 5 years, 1962-1966, the balance in intake altered. Of first-year medical students entering in 1966, the proportion drawn from classes 1 and 2 had risen to 75.7 per cent, while social classes 3, 4, and 5 had fallen to 24.2 per cent of the intake (3). In comparing successful with unsuccessful applicants, Table 1 shows that proportionately fewer applicants from social classes 3, 4, and 5 are accepted and more rejected, than applicants from social classes 1 and 2. A study of rejected applicants (4) revealed that this anomalous distribution was due in part to preentry selection factors, though the study failed to account for the entire distribution. The medical schools cannot be exonerated from a distinct bias in the selection process. Women particularly have been conspicuously underrepresented.

The pursuance of a selectional policy which not only perpetuates but extends such differentials is unjustifiable. The argument that there were academic standards for such a policy is without foundation, those from lower class backgrounds having a consistently superior academic performance at medical school in contrast to their colleagues from the upper social classes (3). Other explanations must be sought. For example, the nature of the school at which precollege education was taken features prominently in the differential policy of selection: 78.3 per cent of those applying for entry to medical school from a state-financed school were rejected, while only 20.5 per cent of those applying from the various forms of privately financed schools were similarly treated (5). On academic grounds, a policy which rejects four out of five applicants from state schools is brought into question for a study of rejected applicants from state schools shows them to be as well, if not better qualified than their rejected private colleagues (5). In addition, patrilineal and family descent continues to characterize entry into the professional ranks: 21 per cent of medical students in Britain have a medical father (3) and statistics from the U.S. show that as many as 68

per cent of medical students have close relatives practicing medicine, a higher figure than that in any comparable profession (6). Certainly it is not unknown for medical schools in Britain to ask their graduates to notify in advance of prospective entrants to whom they are related (7).

While disproportionate social weighting is a persistent feature throughout higher education, selection along class lines for entry to medical school is unequalled in any other sector. In 1961, undergraduates from social classes 1 and 2 made up 59 per cent of the total university population (8), while those in medical school constituted 73 per cent of the students (3). Incontrovertibly there are wider social forces at work than the medical school selection panels. However, these panels would appear to be playing an active role in the maintenance of social gradients between the profession and the majority of its clientele. If the Royal College of Surgeons is to be believed, this forms part of a systematic policy. In presenting evidence to the Royal Commission on Doctors and Dentists Remuneration in 1958 (9), the College stated:

> . . . there has always been a nucleus in medical schools of students from cultured homes. . . . This nucleus has been responsible for the continued high social prestige of the profession as a whole and for the maintainance of medicine as a learned profession. Medicine would lose immeasurably if the proportion of such students in the future were to be reduced in favour of the precocious children who qualify for subsidies from the Local Authorities and State purely on examination results.

Moreover, the importance of such medical school admission policies cannot be overestimated. Once accepted into the medical school, the prospective doctor effectively enters the professional world and views himself accordingly. In the United States, one-third of first-year students considered themselves primarily doctors (6), a conception which at such an early stage in the educational process must stem rather from the assumption of a professional identity than from any accumulation of professional knowledge. Further, the comparative isolation of the medical student for a period of some 6 years fosters a social dependence on and identity with the dominant professional ideology. The prospective doctor is isolated from the broader educational experience in the mainstream of the student world, and, in the pathologic environment of the teaching hospital, he is isolated even from the patient. Indeed, the profession has actively sought to maintain this isolation. The recommendations of the Royal Commission on Medical Education (3) for closer integration of the medical schools with the mainstream of academic life in the universities were opposed by many teaching hospitals (10).

PROFESSIONAL SELF-PRESERVATION

In addition to the selection of a group of prospective physicians who, in their social and educational origins, are totally unrepresentative of those to whom their skills are to be directed, the medical student is further removed from an appreciation of and identity with the patient and his social milieu by the process of professional socialization. In the words of Hill (11), the

> "aim and object of medical education is to educate a student to become a member of the profession of medicine rather than a mere scientist or technologist."

While the doctor may utilize skills not generally used in the academic world of the

"mere scientist," there is no evidence that such professional socialization is required or even salutary. Indeed the view that the formation of a prime identity should conform with the ideology of the dominant professional institutions is certainly contrary to the view of Virchow (12), who considered that the prime identity should be with the patient in that the physician is the advocate of the poor. The medical historian Sigerist (13) would consider the question in a broader context of the physician as the advocate of the working class. Medical care certainly needs social organizations. That it also requires the prevailing professional ideology is equivocal. Surely the socialization process deserves reevaluation.

Froelich and Bishop, in an article entitled "A method for guiding professional socialisation in medical education" (14), have described how medical students might be furnished with the values and ideals of their intended profession. I doing so they outline part of the process which implicitly occurs in the course of a student's education:

> It is through anticipatory socialisation that the medical student begins to learn the behaviour, expectation, values and norms that will ease his movement into the professional role. He must also learn the scientific skills with which to successfully practice medicine. But the acquisition of knowledge and technical skills without professional socialisation leaves the student with an incomplete education. . . . Situation simulation combines role playing with recording and review in such a manner that the student behaviour, attitudes and values become conscious. . . . By repeated role playing exercises and reviews with self observation, the student can mould his behaviour toward that which he, his peers and his instructors consider to be the professional ideal.

The complex process of professional socialization, then, is essentially one of building an identity with the profession, a process antithetical to the formation of relationships in terms defined by the patient. "Indeed," wrote one author, "the process of learning to be a physician can be conceived as largely the learning of blending seeming or actual incompatibles into stable patterns of professional behaviour" (6). The needs of patients are therefore likely to become subordinated to the professional ethic and definitions, and patients become the means to a professional end rather than an end in themselves. Medical education in short is deficient in that it furnishes the prospective doctor with a common, if confused, ideology which is divorced from the social experience of most patients. Given a conflict of interests, the profession is the professional's prime concern.

Historically, the concern of the dominant professional grouping has always been the preservation of its own position. This was exemplified by the bitter early battles between apothecaries and surgeons for the basic rights of medical practice (15), and in more recent times by the pressures exerted against new forms of health organization by, for example, the American Medical Association which saw them as a threat to professional hegemony (16-18). Professional codes of practice similarly allow only those forms of activity which benefit the profession as a whole. Advertising by individual practitioners is forbidden while advertising for private health insurance schemes is permitted, the benefits accruing to the professional body, or at least to that dominant sector practicing private medicine. The conflict between the professional resolution to maintain a particular style of care and the actual health needs of the population has manifested itself in almost every major health reform in the United Kingdom. The first public health act of 1848 was vigorously opposed by the professional institutions of the day and the Earl of Shaftsbury, listing those who had

pursued a policy of vested opposition, named "... the College of Physicians and all its dependencies, because of our singular success in dealing with cholera when we maintained and proved that many a Poor Law Medical Officer knew more than all the flash and fashionable doctors in London" (19). A similar situation prevailed in 1911 when the medical profession found itself in solitary opposition to the National Health Insurance Act, and again in 1948 when the British Medical Association, basing its opposition to the National Health Service primarily on considerations of status and remuneration, stated "... that in their considered opinion, the National Health Act of 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" (20). Need we wonder that the hegemony of the medical profession is so staunchly defended? The problem arises in appraising the degree to which these socioeconomic, psychologic, and political forces enhance or detract from the basic right of all persons to adequate health care.

HEALTH AND SOCIOECONOMICS

The discrepancy between the socioeconomic origins, education, and ideology of patient and doctor and the active maintenance of this polarization by the professional institutions has in fact produced patterns of care which reflect less the needs of the patient than the aspirations of the profession. This social gap combined with the professionalization process, has militated against those who do not share the origins and motivation of the profession both in the relationship between the patient and the doctor and in the relationship between the patient and the medical care system.

The Patient and the Doctor

It can readily be established that the doctor identifies most with the middle classes and in particular the professional classes. The practitioner seeks to relate to those sections of the population in which he finds the greatest reflection of his own interest. For example, middle-class localities have significantly higher doctor-patient ratios than localities in which there is a preponderance of working-class patients (who may, for the purposes of this paper, be equated with the Registrar General's social classes 3, 4, and 5). Middle-class patients can also expect to be visited more often by their general practitioner than working-class patients while in the hospital (21). Conversely, the patient also tends to seek help from those with whom he has the closest social links. One study found that upper-middle-class patients were less likely to consult a nurse for advice than working-class patients (22), who were twice as likely to say that their main source of information was the nurse (23). The relationship between the patient and medical staff thus tends to vary inversely with the latter's position in the medical hierarchy and the former's social class (24).

At the time when neither doctor nor patient possessed much in the way of medical knowledge, there were few alternatives to resignation and blind faith on the part of the patient and mystification on the part of the doctor who was to maintain his position. As the knowledge of doctors increases and the multifactorial nature of disease begins to be more fully appreciated, mystification and blind faith become not just unnecessary, but actually counterproductive and irrational. Mutuality is required if the wider interaction of sociomedical factors is to be assessed. But an educational process which seeks to establish the authority of the doctor by virtue of his membership in the

profession rather than on the basis of his knowledge militates against such mutuality. Not only is the doctor reluctant to offer knowledge for fear of jeopardizing his professional authority (25), but he also finds it difficult to relate the knowledge he is prepared to offer to those patients with whom identification poses a problem[2].

The old adage "Doctors make the worst patients" indicates that mutuality entails a degree of reciprocal critique. This conclusion is supported by the work of Freidson (22) and Cartwright (21), who showed that middle-class and, in particular, professional patients tended to be better served, but more critical of doctors than working-class patients. Mystification is most likely to be substituted for mutuality in those cases where the social divorce between patient and doctor is greatest. In further support of the negative impact of professional socialization on the clinical relationship, a study in the United States (26) of 800 mothers attending a children's clinic revealed that almost 20 per cent of these mothers felt they had not received a clear statement of what was wrong with their child, and almost half the group were still wondering what had caused the illness when they left the clinic. Three hundred of the mothers considered themselves in some way responsible for the illness and yet in less than 5 per cent of cases did the physician engage in personal conversation not directly related to the technical task in hand. In fact the value of the communication which did take place is questionable, for in more than half the cases examined the physician had used medical jargon. More importantly, 25 per cent of the mothers felt they had not had the opportunity or encouragement to express their greatest concern, and less than half the total group finally carried out the doctor's medical advice.

The failure in communication and care resulting from such mystification is by no means solely dependent upon a mechanical relationship between the social class of the patient and that of the doctor, in that it occurs to a lesser or greater degree across the class spectrum. However, the importance of relative social positions can be gauged to some degree by the extent to which diagnostic criteria and treatment may find their source in cultural assumptions rather than in medical science (27). It is axiomatic that the distinction between the "good" and "bad" patient owes little to scientific criteria. A patient is not "bad" because he presents a difficult surgical problem; rather, the "bad" patient is one who does not correspond to the doctor's definition of what the relationship between them should be. More detailed studies would also indicate that social values and origins tend to play a significant role in the outcome of the care process. Sudnow (28) found that the doctor's social relationship with the patient affected his methods of treatment, the intensity of efforts made to save the lives of the dying being related to the moral characteristics and social status of the patient. Further, Hollingshead and Redlich, in their work *Social Class and Mental Illness* (29), found that social class position actually correlated more highly with acceptance or rejection for treatment, with the choice of specific treatment offered, and with the duration of hospitalization than did the clinical diagnosis. Similar results were reported in the follow-up study 10 years later (30).

Thus, patients are required to conform to the expectation of the doctor. Where this fails to occur, the needs and interests of patients become subordinated to the attempts of the doctor to preserve the relationship between them as he defines it (25). If the most important thing a doctor prescribes is himself (31), then the resulting conflict

[2] For a further discussion on the effect of social divorce in other professions, see M. H. Kuhn, The interview and the professional role, in *Human Behaviour and Social Processes*, edited by A. M. Rose, Routledge and Kegan Paul, London, 1971.

and rejection can only bode ill for those who do not share his social schemata. Hollingshead and Duff (24) found such conflicts frequently in their study on the interaction between patient and doctor in the public and private wards of an American hospital. The private patients, drawn predominantly from the upper social classes, received "committed" care from a single physician; in these cases, relatives were kept well informed and the patient tended to be satisfied with the facilities and care. By contrast, patients on the public wards received a lack of continuity in care, being served by a floating pool of doctors. The patient was "...confused about his symptoms and fearful about the illness. He frequently delayed reporting his symptoms because he feared not only the illness, but the physician he saw." It was on the public wards that the widest educational and social gap existed between patient and doctor. Patients viewed themselves as uneducated and incapable of understanding the explanations given them. The doctors found it difficult to identify with their patients, rarely took account of social factors, and tended to make poor diagnoses and keep the patients ill-informed. To the doctor these patients could offer nothing, not even money.

The Patient and the Medical Care System

A similarly deleterious effect on patient care may be observed when the social and professional values of the doctor are translated from the doctor-patient relationship to the wider sphere of health organization and its control. The issue as posed so far has considered to what extent the social gap between doctor and patient has militated against the latter on an individual basis. But this argument is essentially marginal to the question of the extent to which the social and professional divorce of doctors and their institutions affects whether or not a patient receives care at all.

The history of health care has always been more concerned with doctors and their representative institutions than with patients. The two crucial years for socialized medicine in Britain, 1911 and 1948, saw a clash of interests between the profession and the potential patients, though in each case political judgment overruled the conflicting interests. However, in 1948 the almost exclusive dominance of the medical profession was to some extent eroded, for implicit in the principles which gave birth to the National Health Service lay the promise that the history of health care would be determined by those whom it was intended to serve. The mediating effect of such a service has been a major factor in reducing the distortions in care which beset many other health care systems, though it must be admitted that these others make no claim of providing a comprehensive service. The possibilities foreseen in 1948 have yet to be fully realized. The medical profession has maintained its position as one of the most decisive influences in the control of health care. This hegemony was found to be so extensive that the Guillebaud Committee (32) recommended in 1956 that medical representation on the Regional Hospital Boards (RHBs), which control regional policy and resources, and representation on the Hospital Management Committees (HMCs), which perform a similar function for individual hospitals, should be reduced to no more than 25 per cent, since lay representation could not make itself felt against greater odds. However, a more recent study was made in 1964 (33) of the composition of a sample of 4 of the total 15 Regional Hospital Boards. This study showed that 46 per cent of the members had a medical background. Of these, 69 per cent had been or were university professors, deans, or top consultants, while 21 per cent had been or

were medical officers or superintendents in charge of hospitals. In all, only two general practitioners were represented on the four Boards.

The binding ethic for diverse interests within health care is stated to be one of commitment to the patient. Yet the values and aspirations and prestige of the controlling interests do not necessarily favor or correspond to this goal. Titmuss (34) has suggested that as the technology of medicine becomes more complex, hospitals ". . .may tend to be increasingly run in the interests of those working in and for the hospital rather than in the interests of patients." The real possibilities for health care become greater with the continuing advances in medical science and in the social structures through which these may be brought into operation. The degree to which there is a failure to translate scientific theory into caring reality is finally a failure on the part of the controlling interests in the social structure. For those not represented on decision-making bodies, which would include the vast majority of patients, the irrational in medicine becomes increasingly accentuated and less justifiable as time goes on. When all remedies were equally ineffective this was perhaps not so important. But this is not always so today.

Distortions in Care Patterns

There is ample documentation to show that distortions in patterns of care—whether occurring by region, section of the service, or social class—are associated with the dominant professional groupings. Indeed, the hegemony of the hospital sector has become less justifiable as the main problems of health care shift from acute hospital-based medicine to chronic and preventive care units based in the community. Despite this shift, the proportion of total NHS spending on hospitals has steadily increased, while that passing to the general medical services has decreased (35). Discrepancies in care also exist from sector to sector within the hospital service, correlating closely with the status and prestige of the institution. For example, Morris (36) showed that there were significant differences in morbidity and mortality patterns in teaching and non-teaching hospitals. This might have been expected for conditions requiring specialized expertise and equipment. However, the conditions under study were common surgical emergencies. The study also found that the non-teaching hospitals had a heavier load of patients who tended to be older, sicker, and from the lower social classes than the teaching hospitals, which had an undue preponderance of middle-class patients. It was not the relative skills of the surgeons which were in question, but merely whether or not the patient received an operation at all. The limitations for operative procedures were directly associated with the lack of manpower and resources available to the non-teaching hospitals (37). Moreover, the regional and class distribution of morbidity and mortality is well documented (38, 39). While social factors outside the sphere of health care are largely responsible for such distributions, failure of the Health Service to match the greatest need with the greatest care (40) must represent one of the most anomalous aspects of a system purportedly providing comprehensive care. There can be little doubt that regional and sectional variations in the allocation of resources are largely dependent upon differences in the status, prestige, and power of the profession and associated interests in the areas under consideration. Governors on the Boards of teaching hospitals carry considerably more weight than the management committees of the non-teaching hospitals, while the regional distribution of resources (Fig. 1) correlates more closely with the status of

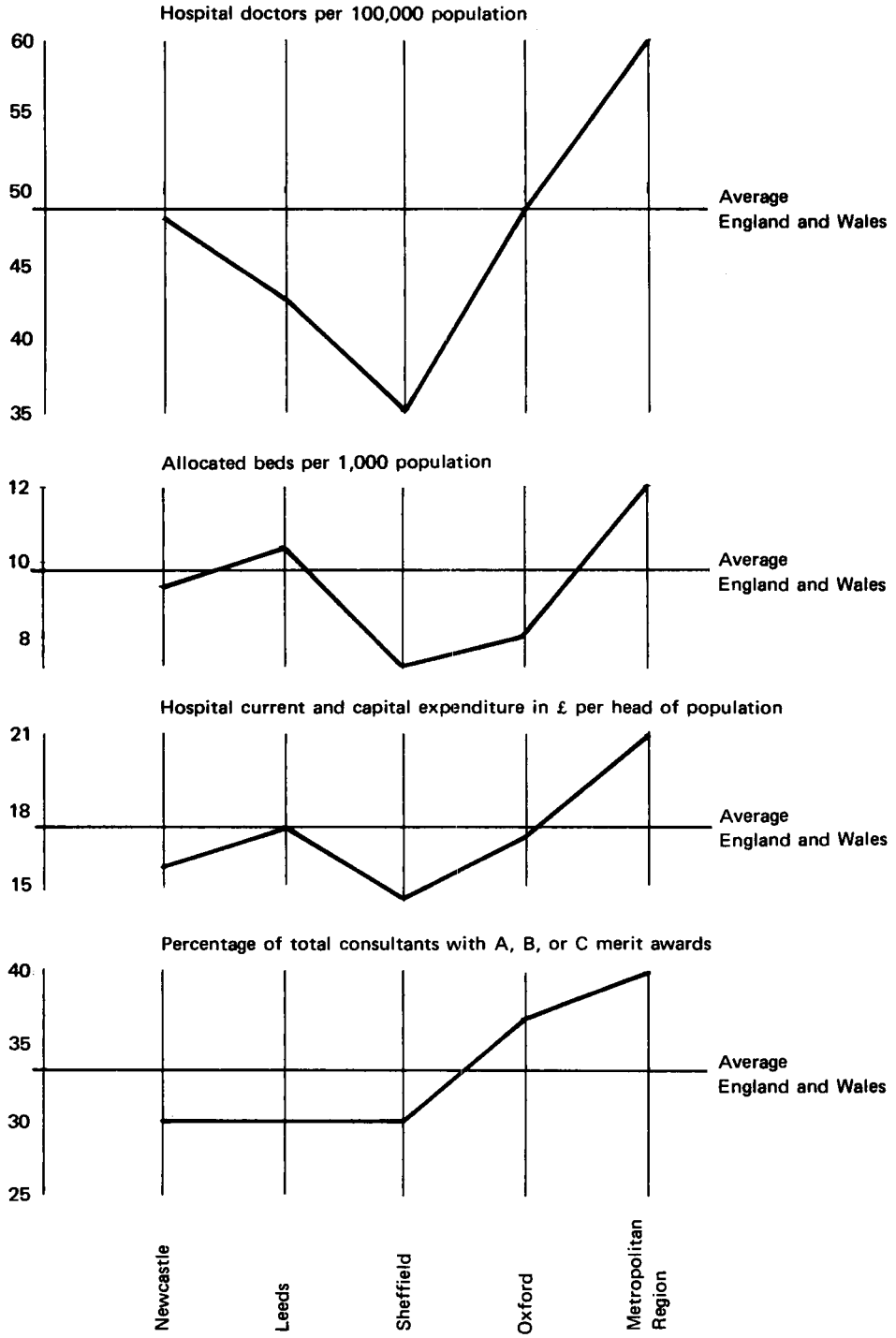

Figure 1. Regional distribution of resources and merit awards. Compiled from reference 9 and *Do We Spend Enough on Health Care*? Kings Fund Hospital Center, London, 1971.

consultants in those areas as judged by the distribution of merit awards[3] than with morbidity, mortality, and corresponding health needs (40).

Health Policy and the Policy Makers

The hegemony of doctors has not given way to a more rational balance of power between patients, health workers, and the profession. Rather, the forces of "progress" have sought a suitable condominium between the profession and local corporate and political interests in the control of health care. Of the 15 chairmen of the RHBs in 1964 (33), 11 were either directors, partners, or chairmen in one or more of 50 different companies. Of the membership of the four Boards studied in detail, the largest single occupational group represented, apart from the medical profession, was that of company director. Of a total of 108 members on the four Boards, there was only 1 industrial worker. Hospital Management Committees reflected a similar disproportion of membership: 21 per cent of RHB members also sat as HMC chairmen, 4 of the total 360 chairmen being lord lieutenants, 20 deputy lieutenants, 146 justices of the peace, 12 peers or baronets, 5 wives, widows or offspring of peers, 1 retired ambassador, 1 ex-lord mayor, and 8 retired admirals or generals. Of a sample of 92 of the HMCs, one quarter of the chairmen were company directors and not a single one as far as was known was a wage earner. .

It may well be that such unpaid and time-consuming work is a worthy contribution to health care. Yet of a total of over 40 million persons receiving health care in Great Britain, these decision makers can hardly be said to be representative. While one hesitates to question their judgment, they might reasonably be asked to declare their interests. That a title such as Dowager Viscountess should confer not only social graces, but a working knowledge of health care organization and the needs of most patients, is an assumption too often made by the titled few for the ungraced many.

THE HEALTH CARE INDUSTRY: THE CORPORATE RATIONALE REAPPRAISED

The political necessity of carrying out the demands of a postwar generation, coupled with a period of relative economic growth, gave rise to the National Health Service in 1948. But the path between political necessity and economic possibility has narrowed since that time. The economy has been seeing harder times since 1950 (41), and economic rationalization has become a priority for successive governments (42, 43). The cost of a comprehensive health service is an expense to be balanced against decreasing economic returns. In an attempt to cut down on expenditures, health charges have been introduced for prescriptions and dental and ophthalmic treatment; "hotel" charges have been proposed for beds in hospitals (44); and the rate of increase in capital spending has decreased. While the medical profession has been instrumental in shaping the existing medical structures, the state and private corporations involved in the NHS are now forcing a shift in the balance of power.

[3]Merit awards are discretionary awards to consultants ranging from £1,296 to 7,350 in addition to their National Health Service salary. Criteria for assessments are secret, as is the identity of the recipient.

The private health insurance schemes are the most obvious expression of corporate involvement in health care. The complexity and cost of modern medical care is as much beyond the capabilities and facilities of the single practitioner, as it is beyond the economic means of the majority of patients. With increasing technical advance, the system of private medical practice based upon a simple fee for service paid by individual patient to individual medical entrepreneur possessing both the skills and facilities for practice becomes obsolete. It was essentially superseded in 1948 when a more rational balance for the pursuit of private medicine was struck between the state and profession, whereby the state supplied the facilities while the doctor continued to sell the skills. The last decade has seen a third mode of remuneration as senior medical professionals serving as part-time NHS consultants, while performing private medical work, negotiate increasingly with private health insurance schemes. The growth of these corporations has been provided with a powerful incentive in the form of tax relief on group membership for enrolling companies. In the last 5 years, the largest of the insurance schemes, devised by the British United Provident Association, has doubled its membership, to about 2 million. This growth has fostered a similar rise in the number of part-time consultants, from 2463 in 1949 to 4297 in 1970 (35). In the latter year, part-timers constituted over half of the total number of consultants. Patients now covered by insurance schemes constitute almost 4 per cent of the total population (adequately covering social class 1, which constitutes 2.8 per cent of the populace). At the present rate of growth, an estimated 10-15 per cent of the population will be covered by such schemes within 10 years. Control of these corporations rests once again with corporate and professional interests, several leading figures from the professional medical institutions being represented on their Boards of Directors (45). The present Secretary of State for Health and Social Services (46) would view such corporations as contributing to the sum of health care and has lent his active support in an attempt to remove the financial burden of some welfare sectors while acting as a "stimulus to enterprise."

For those that rule, it has long been realized that a sick population is not merely a menace to the rich; it is also wasteful (13). The former no longer poses the problem it once did and with the evolution of modern industrial society, the primary consideration of the state in regard to health care has been the maintenance of a healthy working population. This was exemplified by the National Health Insurance Act of 1911, which provided a measure of medical care free at the time of use to working males, while wives, children, and the unemployed remained in the vagaries of the private sector. In the Beveridge Report of 1942 (47), which preceded the inception of the National Health Service, it was stated,

> The primary interest of the Ministry of Health is not the details of the National Health Service or its financial arrangements; it is in founding a Health Service which will diminish disease by cure and prevention and will ensure careful certification needed to control payments of benefits at the rates proposed in this report.

Here is posed the classical dilemma of successive governments, concerned on the one hand to keep the population in health and on the other to do so at minimum cost. This latter consideration already creates conflicts when the doctor is required to issue a "sick note" to cover benefits for absence from work for a patient who may have no organic illness.

THE FUTURE OF THE NATIONAL HEALTH SERVICE

With the introduction of the NHS, the social aims of medicine were altered. Health care was no longer a purchasable privilege but a basic right. Yet for the unproductive and the potentially unproductive, the possibilities for the social care, cure, and prevention of conditions intimately related to social factors are slow to be realized. Socialized medicine in its fullest sense contradicts the archetypal professional responsibility of the doctor to his individual patient, an ethic which can be traced to its origins in the private system of medical care with its cash transaction between the doctor and those individuals who could afford to pay for his services. According to Clark Kennedy in his Croonian Lectures for 1950 (48), "We, as doctors, are mainly concerned with the individual man, woman or child, with one individual problem after another. . . ." For governments, the chronically sick, the mentally ill, the old, and those suffering from conditions manifesting themselves in later years have little to offer in the way of economic benefits from the outcome of care, and less to say on the need for it.

Under the terms of *The National Health Service Reorganization* (49), the state will for the third time take precedence over the interests of both the profession and the patient, though again with a fair degree of concession to the former. Trends toward greater economic rationalization, considered above, are to be consolidated in statutory form.

> . . . the other professions, and indeed doctors in medical administration can be suitably organised in managerial hierarchies, and the effective provision of health care will depend to a great extent on the effectiveness of many thousands of managers (50).

The Health Service with an annual turnover of more than £2000 million, employing a diverse work force of over 800,000, and ministering to a population of some 50 million, may well be considered an industry. The value of considering it as a commercial company is questionable. A corporate rationale requires either the production of an economically viable product or the commercial satisfaction of a selected need. The hiring of public facilities to the private health insurance schemes has already begun to profitably satisfy selected health needs. The way has also been paved for the production of an economically viable product by the government's introduction of management techniques into health care. Not only will the logical extrapolation of cost-effectiveness and cost-benefit techniques effect selective distribution of resources to the most economically viable sectors (51), but control of the Health Service is also to reflect this line of reasoning, modelled as it will be on managerial planning evolved for the needs of commercial enterprise in the 1920s (52).

The resulting social divorce between patients and medical personnel will not only be due to social and professional differentials, but also to the latter's "job description." For health workers ". . .regulations may become transformed into absolutes, symbolic rather than utilitarian, and ultimately formalism and trained incapacity may defeat the purposes of the organisation" (53). The corporate rationale for the National Health Service together with the expansion of private health insurance companies and the introduction of means-tested[4] care will restrict health care to an essentially two-class

[4]Means-tested benefits are financial reimbursements or exemptions from certain charges for welfare services (i.e. dental treatment, prescriptions), provided that the individual can prove that his income is below a certain level. In most means-tested schemes, the majority of those entitled to claim do not do so.

service providing on the one hand the basic subsistence care compatible with a healthy working population and political necessity, and on the other, a comprehensive service mediated through private companies for those that can afford to pay for it. A shift in the balance of power away from doctors who would seek to medicalize the world, toward managers who would market it, is being made with no assessment of the health needs that such structures would be serving. The possibilities for the joint control of health care by representative health workers and patients have not even begun to be posed, let alone realized. Of the medical profession, one contributor to the *British Medical Journal* had this to note: "I would rather be tried by a committee of coalminers or railway porters than a posse of professional men. All they care about is their own prestige and personal ambition" (54). Certainly, this is an overgeneralization. It takes no account of the interests of the profession as a body, of the diversity of goals within that body, or of the genuine motivation for equality in the best of care which has always been present for a great many individual practitioners. Yet it does point to the contradiction between the internal motivation of the profession and the external ideal of service which ostensibly provides the doctor with a rationale. It also points to the logic of the need for a decisive influence by the self-interest of those who are served by health care as well as by those who would provide the service.

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Manuscript submitted for publication, February 26, 1973

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