training experience than her general house jobs. When the midwives got into trouble she set off on her bicycle with emergency bag and lamp—many of the houses had no electricity—and applied the forceps or whatever was necessary. Both of them commonly had to act as anaesthetist and obstetrician in a routine that sounds deceptively simple. Don two pairs of gloves, go to the head end and give a light chloroform anaesthetic, rush to the other to do a forceps delivery. Most breeches were delivered vaginally in those days.

Innovations preceded the NHS

In Oxford we were in a unique position though, for in 1938, £2m was given to create the Nuffield department of obstetrics, together with the corresponding departments of medicine, surgery, and anaesthetics. Before taking up my post as first assistant to the new department I spent three months in Vienna studying under Professor Fraenkel. At this time, in marked contrast to England and America, colposcopy was a routine procedure in the teaching hospitals in Vienna, Leipzig, and Berlin, and indeed in much of Europe, and after the war we imported a colposcope and started a colposcopy service.

Gradually we took over the gynaecology from the general surgeons and built up our department. We also took over responsibility for the maternity home and built up outpatient clinics in all the outlying hospitals in the Oxford region, with a back up consultancy service for general practitioner obstetricians working in cottage hospitals as well. I was on call all the time, and it was rare to have an unbroken night. But such was the spirit in the hospital that no one resented the hours they put in.

One of the innovations with the most impact was the weekly departmental meetings we started to discuss difficult cases and clinical, research, and training policies. Registrars from as far afield as London, Bristol, and Birmingham came for, amazingly enough, at this time such meetings were actively discouraged because they were "not conducive to good departmental discipline." We also, in 1938 on the advice of Professor Chassar Moir, set up a flying squad for it was not uncommon for women with serious obstetric complications to be dead on arrival by the time the ambulance had reached hospital from villages 30-40 miles away.

Gynaecological practice was obviously different in those days. There were few screening tests. We could not measure hormone concentrations, for example, and most operations were carried out without recourse to intravenous fluids or blood transfusion. There was no organised transfusion service so when necessary the obstetric team would cross match the blood of relatives or friends, or blood lost intraperitoneally after a ruptured ectopic pregnancy, for example, was collected perioperatively by the surgeon, filtered through sterile gauze to remove clots, and then used in an autologous transfusion.

Infection was a major hazard and it was not uncommon to admit a young woman with gas gangrene septicaemia a few hours after a criminal abortion and see her die. I well remember one such girl who was moribund on admission and when we asked the pathologist to do blood tests he refused. "Its a waste of time," he said, "you know as well as I do that she has only got a few hours to live." Undeterred, we established that her septicaemia was due to combined staphylococcal, *Escherichia coli*, and clostridial infection. We then approached Professor Florey and his team who were doing clinical trials with penicillin and they gave us one million units, which was sufficient to cure the clostridial and staphylococcal infection. But the resistant *E coli* gave rise to further complications so we asked Sir Hugh Cairns, who had been issued with a limited supply of streptomycin to assess its effect in the treatment of tuberculous meningitis, if he could spare us some streptomycin. He was sympathetic but unable to help, so in the end one of the residents literally stole what we needed, and she survived. It was wonderful.

Creeping administration

With the inception of the NHS general practitioners had to cease undertaking obstetric care in NHS hospitals. This edict made little difference in our region because the transition had already begun. What we did notice, however, was the increase in administrative staff (with no discernible benefit) and the regular directives coming from the Department of Health and Social Security. At one stage we were forbidden from doing vasectomies on the NHS; not that I took any notice.

There were positive aspects, though: the salary, for one, and the improved coordination among general practitioners, consultant specialists, and the nursing staff. In addition, the DHSS set up a national maternal mortality survey, which was and continues to be invaluable as a means of identifying the cause of death and avoidable factors where clinical mismanagement is implicated.

It is sad to hear of the disillusionment of some current obstetricians (take the one who wrote a personal view in the *BMJ* earlier this year, for example) and worrying to hear that early retirement seems to have been adopted as Mecca by others. The specialty is demanding but it is an exciting and rewarding one for those who are prepared to accept the challenge.

Personal views of the NHS—warts and all

One hundred years ago it would have been impossible to imagine an institution attempting to provide free health care for all on an equal basis. Now doctors, patients, and politicians complain when the NHS falls short of this ideal.

Working in the NHS, however, means coping with numerous petty imperfections. Staff spend long hours dealing with problems of life and death and, as a result, are often tolerant of minor, yet potentially soluble, problems. Equipment is poorly maintained, stocks are badly monitored, patients are told to report to outpatient departments too early. Nobody is in charge, nobody makes a fuss, and everybody gets by. Many blame the "monolithic" NHS, saying that these problems would not arise in a private system. They would not happen in the present system if it was better managed.

It is disturbing that after 40 years enormous inequalities in health remain. In a health service paid for by taxation the potential for improving public health and tackling inequalities is too great to be sacrificed because we still have a few unsolved problems. In the next 40 years I want governments to recognise that Britain can afford to have a decent health service. I want more doctors to become managers, and I want all doctors to take an interest in how money is spent and the kind of service that it provides.—JOHN PETRIE, *Medical student, Edinburgh.*

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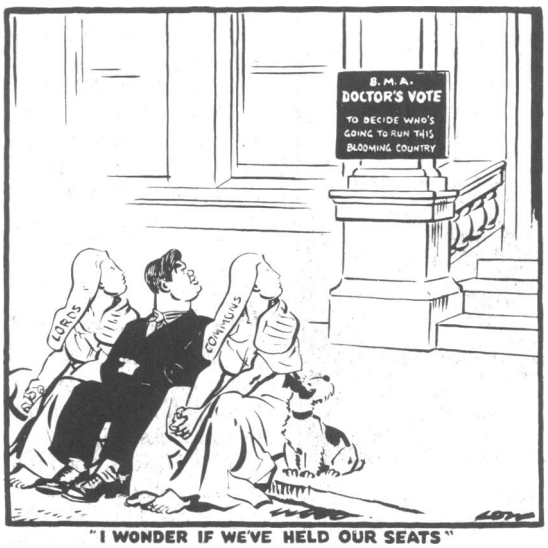

EVENING STANDARD 29 APRIL 1948

"I WONDER IF WE'VE HELD OUR SEATS"

Introduce "optional extras"

A birthday party is not an occasion to find fault with the celebrant. The inception of the NHS was a bold and perceptive measure, and its success astounded many. The steady improvement in "high dependency" units, new surgical techniques, and advances in therapeutics, however, have led to speculation and gloomy prognostications about its future. There are those who think that the time has come to label the service "not for active resuscitation."

The continuation of a service that provides medical care of equal quality to all, regardless of status or income, will depend on two factors. Firstly, the introduction of "optional extras" which would be chargeable. (These should relate to things like accommodation and food and not to medical care or the right to bed and board on an open ward.) Secondly, those who work for the NHS need to develop the qualities of wisdom and humanity. They must recognise the difference between that which is "treatable" and that which it is humane to treat. (This applies especially to frail and demented elderly patients and people with highly malignant tumours.) Tender loving care is often the response of a compassionate doctor rather than merely a failure to "pull out all the stops."—CHRISTIANE HARRIS, *house officer, North London.*

Corrupt, inefficient, mismanaged

While I like the concept of the NHS, I dislike its corruption, inefficiency, and mismanagement. Corruption is a strong word for systems like merit awards, given by anonymous people to sometimes inadequate consultants, for consultants who take their salary and do not do their work, and for the sales activities of drug companies which inflate the NHS drug bill.

Inefficiency is inbred and self propagating. A private patient with haematuria can have his consultation, cytology, urinary tract imaging, tumour resection, and histopathology report all within 48 hours. In the NHS that would be laughable. In 1987 over 90 of my NHS patients had check cystoscopies cancelled because there were no beds or theatre space.

In Harley Street three histopathologists process over 15 000 specimens annually, and reports are ready within 48 hours. In one teaching hospital 8000 specimens are processed by over twice the number of histopathologists, yet reports take at least twice the time to arrive.

Sadly, mismanagement is the doctors' fault. Without their resistance a hospital would appoint a management consultant as its chief executive, pay him £200 000 each year, and sack him after two years if he failed to deliver the goods. One kidney transplant unit dealt directly with a chief executive and completed a feasibility study, made structural changes, introduced 24 hour laboratory and radiological facilities, and performed its first transplant in less than one month.—GRANT WILLIAMS, *consultant urologist, London.*

Excellent training but no prospects

Training in the NHS is regarded highly all over the world, but after the initial pride at successfully completing it I found myself stuck at the bottleneck. Six months on and not even an interview. I scanned more journals and lifted my self imposed geographical restrictions. I even had my revised curriculum vitae laser printed! I was impressed, but "they" were not. I contemplated emigrating, but the thought of further examinations is too much.

The NHS provides no feedback so there is little hope of rectifying problems for future applications. The pyramidal system of training, with its inevitable casualties, is far from ideal. I would like to see the introduction of a parallel system so that progression to consultancy could be smooth and unhindered for all trainees. This would provide care of the highest quality to those in need and give a just reward to doctors successfully negotiating the examination hurdles.—S V PATEL, *locum registrar in psychiatry.*

Poor career structures for clerical staff

The value of the NHS is that patients are treated according to their medical condition rather than their financial status. Well qualified, committed employees are needed to maintain the high standard of service which the NHS offers.

As secretary to a consultant in a large district general hospital I found little to attract people to work in the NHS. Many are leaving, including myself, and the standard of new recruits is poor. As able school leavers turn to industry for better prospects and colleges reduce their entry requirements the decline continues. This is largely the result of lack of financial rewards,

LEE, EVENING NEWS 20 JANUARY 1948

"Proper mad, 'e is. Off to complain about 'em. Nationalizing 'is rheumatics without asking 'im about it"

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EVENING STANDARD 14 DECEMBER 1944

poor career structures, unsatisfactory recognition of worth, and little investment in new technological equipment.

I had worked previously in general practice, where I had set up a computer based cervical screening system. I was, therefore, surprised by the lack of modern equipment in the hospital sector. I found little scope to develop my career or become really involved.

A good secretary is vital to a consultant and his team, but she is rarely credited as such. I only hope that the importance of this job is recognised before it is too late.—SUSAN JEAVONS, *medical secretary, Birmingham.*

Fast access, free care, high quality

Against the simplistic objective of 40 years ago—access to free medical care for all—the NHS must be judged a success. Society now expects everyone to have fast access to free medical care of a high quality. The three major constraints are resources, managerial efficiency, and medical performance. While the first two must still be tackled, changes are imminent in the third, where reliance on the moral imperative and financial incentives is being augmented by two further stimulations of medical performance.

Competition has great potential for breaking the "conspiracy against the laity" and eroding medical collective bargaining. It will be accompanied by a punitive approach involving the definition and policing of a contract related to quality. The only valid professional response will be to acknowledge that health care is primarily for patients not doctors and that audit should be integral to any professional career. Only by offering demonstrable quality will we maintain our position in the delivery of health care.

Tiberius said "At 40 every man is a fool or his own physician."[1] Let us hope that NHS doctors can be their own physicians, and soon.—MIKE PRINGLE, *general practitioner, Newark.*

1 Plutarch. *Treatise on the preservation of health.*

More sinned against than sinning

The NHS stands for high quality medical care with social justice, a combination that has inspired loyalty from staff and affection from customers in fairly equal measure. As to its faults, it is more sinned against than sinning. Britain spends a lower fraction of its national income on health care than most other industrial countries. This must be partly responsible for our slowness to spread expensive but fruitful procedures like kidney transplants and cardiac surgery and possibly also for our relative decline (despite absolute improvement) in the league tables of infant mortality and life expectancy.

These are not, however, reasons for departing from the principle of a comprehensive state health service. The expansion of private hospitals and medical insurance in the 1980s may be unobjectionable (being associated, among other things, with increased international trade in medical facilities), but the further the process goes the more pressing will be the need to ensure that price does not become the dominant means of rationing. When major skill or other bottlenecks are identified the authorities must respond by expanding resources and not merely by inventing tougher performance indicators or larger savings.—PETER M OPPENHEIMER, *fellow in economics, Christ Church, Oxford.*

We are not a poor country

I think that the NHS is a marvellous thing. My mother was bedridden with arthritis and the doctor came once a month. She had a bill every quarter. I do not pay for anything.

Last May I was very sick one morning and was taken to hospital. I had an operation that day. I was lucky; some people have to wait months, even when they are very ill. Afterwards my arthritis flared up and I was taken back to hospital. Now I go to the day hospital twice a week. They need the beds in hospital, and as soon as you can get around they like you to go home. At the day hospital I have my blood pressure checked, blood tests, and a proper heart test on a machine. I get physiotherapy, and I have my lunch. It costs me nothing.

The worst thing about the NHS is the way they keep putting up the prescription charges. I know that tablets are very expensive, but for people who depend on them they should be free.

You keep hearing about wards closing yet people are still on waiting lists. We are not a poor country—we are quite well off. In the next 40 years I would like to see more money spent on the NHS.—CATHERINE GOODHEAD, (aged 74,) Birmingham.

General practice—no longer a cottage industry

The NHS has reduced social class inequalities, transformed general practice from a cottage industry, and facilitated educational advancement. An even deployment of consultants has brought medical knowledge close to hand regardless of income.

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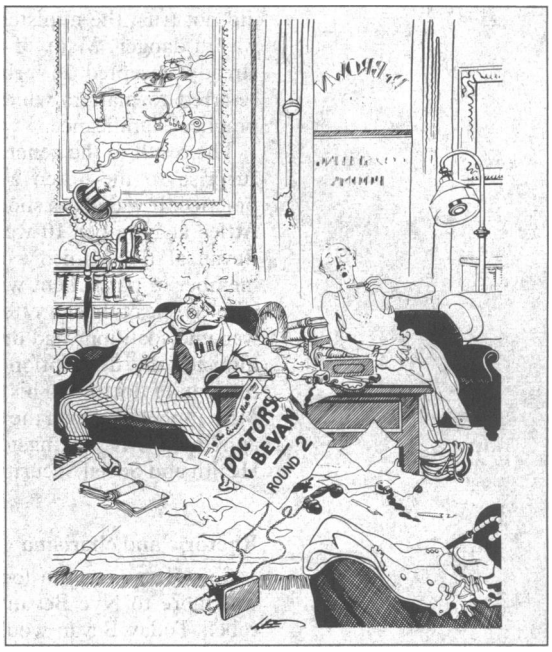
Negative attitudes still sometimes prevent proper team work and a broadening of services in primary care. Poor records systems and shortage of time inhibit the raising of standards and the integration of preventive medicine into general practice. The continued development of computerisation is, therefore, essential.

Patients should be admitted to acute beds only for effective treatment, and general practitioners should care for the present load of chronically sick outpatients. Earlier discharge should encourage the development of more community hospitals. Specialists should liaise better with general practitioners. General practice and the whole primary care service need to be better resourced.

The continuing care and acute sectors of medicine should both be provided for in the NHS and not left to the vagaries of the market place. Services must be responsible to the needs of the consumer. Talbot Rodgers said, "Ideas do have legs and do not stand still." All health care professionals must exchange ideas and work together to shape the NHS of tomorrow.—GEORGE IRWIN, *professor of general practice, Belfast.*



"Hm! You'll have to take things more quietly and on no account get excited."
(Thanks to the Centre for the Study of Cartoons and Caricature, University of Kent at Canterbury for supplying the cartoons)

LEEDS EVENING NEWS 19 FEBRUARY 1948

The act, the minister, and the editors

D Gullick

"'The press is a mighty engine, Sir', said Pott. Mr Pickwick yielded his fullest assent to the proposition."

During the years when the National Health Service began, the *Lancet* and the *British Medical Journal* were both under the editorial direction of remarkable men: (Sir) Theodore Fox and Hugh Clegg. When Clegg died in 1983 the editor of the *BMJ* wrote, "Postwar Britain was fortunate in having two editors of genius for its weekly medical journals; . . . outwardly Clegg and Fox seemed very different . . . nevertheless there were many more similarities than differences: both wrote well . . . both could tackle any topic . . . and politically both bestrode the medical world." I entered general practice in 1945 and lived through the crisis years, and I would endorse those words. Both editors influenced the neonatal years of the NHS, and, even more, the final triennium of its gestation.

"Corkscrew Charlie"—Lord Moran, president of the Royal College of Physicians, London

1911	National Health Insurance Act
1933	*A General Medical Service for the Nation* (revised), BMA
1942	Draft interim report of the Medical Planning Commission, BMA and royal colleges
	Report of an interdepartmental committee—the Beveridge report, HMSO
1945	General election. Labour government in office
1946	NHS Bill introduced. Receives royal assent as the NHS Act in November
	First BMA plebiscite of the profession on whether to negotiate about regulations.
1947	Confidential negotiations. Minister refuses to amend 1946 Act.
1948	January and February: Second BMA plebiscite on whether to accept service under the Act as it stood.
	March: Royal colleges support BMA request for amendment of the Act.
	April: Minister agrees to an amending Act. Third BMA plebiscite.
	July: National Health Service becomes operative.
1949	NHS (Amendment) Act.

1945 Election shock

The major events of those years are shown in the box. The most comprehensive guide to these events is John Pater's *The Making of the National Health Service.*[1] Others are listed in the bibliography.[2-6]

Having reread the story, I believe that all the battle flags—"sale of goodwill," "no geographical direction of doctors," "freedom to publish," "appeal to the courts," etc—were just that: banners hoisted to justify and rally support for the doctors' gut reaction that they

Welwyn, Hertfordshire AL6 0QG
D Gullick, MB

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