Papers and Originals

British Medical Association

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President's Address

One Profession, One Purpose

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Our beloved Queen, in her most recent Christmas message, spoke of concern for others—in fact this matter of being concerned ran through all that broadcast, in which she paid so many tributes to womankind, generous, but how true. She particularly praised them for their sagacity, tenacity, and loyalty, attributes which we would all wish to possess.

About this time I attended my first B.M.A. Council Meeting. What struck me most was the evident concern of all those present for the plight of two of the smaller groups of our profession. With a long agenda there was no hurry; the most careful consideration was given to the problems besetting these colleagues, in some ways less fortunate than others and standing in need of help.

My attendance at all subsequent Council Meetings has convinced me that that first impression of their concern for minority groups was no mere chance. Since then there has been anxiety and concern for the present position and future of senior hospital medical officers and senior administrative medical officers, Service doctors, and whole-time teachers. On the last occasion there was a prolonged and most sympathetic hearing of the special case of public health doctors. It was the main preoccupation of the meeting, and I have been most impressed. Impressed, too, with the support given to the more junior doctors, who have now achieved substantial representation on important committees, and are playing an active part in negotiations at a time when their needs are great and urgent.

For many months I had been casting about for a subject for this special audience—not too technical and not too inflammatory. At one time I was almost tempted to repeat that memorable address at Oxford four years ago—as brief as it was memorable. Then, as you remember, Sir George Pickering said that he had "felt like a Sunday preacher seeking for a text," which he found in the mottoes of Winchester and New Colleges—"Manners Makyth Man." His captive audience will remember the account he gave of William Wickham, and the theme which followed—"The ethos of medicine is of no less significance than the science" and "that this must not be squandered." "It was manners that makyth man—that character and conduct mattered at least as much as learning," though, of course, we must have both. He spoke of arrogance, selfishness, and alcohol as examples of bad manners and the cause of much injury and grief, particularly in regard to road accidents. This was evidence of lack of concern for others.

So it was that I came to my text or title—based upon concern for each other and concern with the service we give—"One profession, One purpose."

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Unity

We hear a great deal about the importance of the unity of peoples, of countries, of the Churches. This oneness is surely imperative for our great profession, and never was it more needed than now. Each of us must have real concern for the whole profession, every branch, every group, however small. It has gladdened the heart to have seen this spirit in operation in your Council and on your Committees. We might with advantage remind ourselves of our own good fortune, of all the help we have received because others have been concerned about us. Maybe it was a parent, a schoolmaster, a particular friend in the profession, or a wife whose concern for us and for others has meant for her a life of selflessness, perhaps taken too much for granted. It may even have been the British Medical Association.

Sir Ian Fraser, in his Belfast address, deplored "this disintegration from which the consultant side of the profession must be saved," referring particularly to divisions into teachers, clinicians, and research workers. After all, the so-called clinicians must be responsible for a great deal of the teaching, and who better able to do so? The clinicians should encourage the researcher and the laboratory man, dependent as they are on their special labours. They should not only receive their meed of praise, but we must see to it that they are properly paid and efficiently equipped. But of greater importance is the development of closer bonds of unity between the family doctor and all the rest of the profession.

William Stokes, Regius Professor of Physic at Dublin, and President of the B.M.A. 1867–8, in his valedictory address at Oxford, said: "So far we have been an united body, working for the benefit of science in the world, with independent local action and a representative on the central executive. How long this strength-giving union may last no man can predict, nor on the other hand can any man say to what amount of influence for good this association may attain.

"But it is plain that its durability and usefulness will depend on its being made the instrument for public good rather than the machinery to advance the immediate worldly interests of the profession."

I could mention many examples showing how in recent months concern for others in our profession has led to active steps being taken and not just pious hopes expressed.

The changes proposed in the composition of the Central Consultants Committee of the special Negotiating Committee of fifteen, which will replace the present one of nine members, were all designed to give the younger men an important say in our deliberations, and not only as regards terms and conditions of service. The committee on training at the Royal College of Surgeons will now from time to time invite repre-

sentatives of those younger men in training to listen in, as it were, and express their own views on any plans envisaged for their future education and examinations. We look for happy co-operation, not a grudging acceptance of regulations laid down. After all, the younger men are not so young. Anyone attending the last Junior Doctors Forum in Manchester or that special meeting in Newcastle would have satisfied themselves that many are mature, thinking people, capable of adding strength to our discussions, and bargaining with the administration. By integrating these younger men and women into our councils we are at once strengthening and unifying our Association.

The National Health Service will not make people healthier. But it is a part of our national way of life. It must be made to work. And, as regards the saving of expense, it is my personal view that we are not doing all we could and should to preserve this Service, for it must be preserved. The astronomical expense could be cut. We may not be able to tackle the administrative costs, but we should do whatever we can; for a little here, with a little there, can add up to a considerable sum. It is so easy to be complacent or to feel that our little efforts are of small account. In any case, inevitably we must need more and more to meet all kinds of new expenditure as science advances and many new and expensive procedures are developed. Kidney transplants are now almost commonplace, and other organ transplantations are in the offing. Haemodialysis presents ethical and moral problems, but certainly the cost is going to be great.

The Cost of Life

The recent symposium at the Royal Society of Medicine (under the able chairmanship of Lord Cohen) served to emphasize the price we must pay for these refinements of treatment. Yet we *must* concern ourselves with the tetraplegic, the mongol, the hydrocephalic, the spina bifida, and the serious head injury in particular. To listen to these papers made one realize something of the future developments and demands. The horizons of medicine are limitless and none can foretell how far we may be able to go. But there can be only one standard of treatment. We cannot choose a treatment for one and give something less to another. We may not play God —we must accept the risks involved and constantly try to improve our results.

As doctors we should never too readily give a certificate of unfitness or for minor ailments. Men and women taken out of industry and kept out of work are paid for doing nothing. Demoralizing for them, it is bad for the country. Convalescence, be it from medical disease or surgical operation, is often so protracted that it has itself to be recovered from. Between us, doctor and consultant together, we must try harder to get patients back to work just as soon as is reasonable. In many conditions the early return to useful activity makes the best possible contribution to full mental and physical recovery.

Governments, at their wit's end to find more and more money, might more readily be persuaded to look again at the Health Service if it was seen that all of us were contributing something in one way or another to eliminate wastage. Many have given much thought to methods of collecting money from other sources, but some such measures suggested might provide a relatively small return for a big outlay in money and manpower. It is said that, unlike other activities, we have no end-product for sale or for export. Surely we have the best of all—positive health. Our great trade unions know this and are alive to the fact that illness and absenteeism account for more loss in working days than all the strikes put together. One cannot at this moment refrain from saying a word against overemployment if only because of its bad effect on real health of mind and body of those insufficiently employed. Standing about on the shop floor is much worse for them than a certain degree of overwork.

Use of Hospital Beds

Another contribution concerns the more careful use of hospital beds, for there is no doubt that bed-stay in various parts of the country varies between wide limits. We should save every single day that is reasonably possible, having regard to the home conditions of the patients about to be discharged. Serving on a regional board I saw something of the work of the geriatrician. Some of them contrived to save the use of hospital beds in a remarkable way—a real contribution, saving money and personnel to be deployed to meet other demands.

Sir George Godber said in Londonderry that the fullest possible use should be made of outpatient departments. With complete collaboration between the family doctor and the consultant, Farquharson, of Edinburgh, has shown what can be done in this respect with regard to operations for hernia, and we are all well aware of Fegan's admirable work in Dublin, where he has re-emphasized and improved the injection treatment of cases of varicose veins as outpatients.

I am glad that for my first fifteen years as a consultant I served in a voluntary hospital, and, brought up in that old school, I have never felt it was right to have a waiting-list for outpatients, or at most a very short one. Though I am prepared to admit that in some specialties it would be difficult to follow this practice, I would just like to say that by using the help of a senior registrar, a senior house-officer, and a house-surgeon we ran an outpatient service with no waiting-list. Sometimes we were in a little trouble with the establishment, overstaying our allotted time, but the service we give to patients in need is all-important. We were saving money, too, because patients waiting for a consultation were only too often put off work in the meantime. The cost of drugs was constantly under review by a watchful subcommittee who found that at the Bristol Royal Infirmary there were wide variations in the use of drugs without noticeable difference in results. I was proud that I was about the cheapest consultant available. Obviously there must be special allowances made for research.

Emigration

A further aspect of the Health Service is the vexed question of emigration, for beyond certain limits this burden may be too heavy to bear. For many years now medical students have received free or greatly assisted education and training by funds ultimately raised from the taxpayer. The Minister was surely right when he pointed out that there was a moral obligation to give something in return to the country. In Egypt there is an enforced period of service wherever there is need, and the scheme works well. There is no doubt that certain countries, badly needing doctors in all but their larger towns, are proudly exporting far too many of their own well-trained young men and women.

The loan method is not a new idea, but the soaring costs of higher education may force the introduction of this alternative in the place of direct public grants. The loans would have to be repaid over a period of years after qualification, when students have started work. Professor Vaizey put the case clearly before an audience at Sussex University as recently as last month.

Now that continuing education in our hospitals is receiving more attention, house-officers are not just regarded as hard-working pairs of hands. Their interests, their futures, are being cared for by special lectures and demonstrations, so that they are more prepared for whatever step they next propose to take. This was one of the things, among many, that we learned

from our friends across the Atlantic, and until recently the absence of such concern was one of the causes of emigration and the loss of promising young men from our country.

And thinking of continuing medical education, I feel I must speak for the cottage hospital, which, properly used, is still a means of continuing medical education, both of visiting consultants and of the local family doctors who bring their cases for discussion. Both learn; the consultant learns again to appreciate the doctor's difficulties, and, though expensive in consultant time and labour, this should be shouldered in the interest of service given on the spot, with the saving of patient's time travelling to and fro, perhaps many miles each way. The local community hospital is still a valuable and viable entry. It is up to us, particularly the consultants, to use these lively useful hospitals wisely and well. They will then never disappear.

Purpose

Nothing is better calculated to preserve the unity of our profession than a purpose, a creed, almost a religion if you like. Purposes may be partly or wholly evil; but powerful, even fanatical movements have often solely depended on a unifying sense of purpose.

When we come to reflect on our service to our patients may I refer you again to the Oxford address: "Yet they get stupefied with drugs or afflicted with unnecessary surgery." I would add—tormented by innumerable, tiresome, and often unnecessary investigations, which can be painful, even frankly dangerous, quite apart from the cost to the service in manpower and bed usage, with the inevitable delay imposed on others.

Clinical Diagnosis

To my mind this is largely due to a gradual loss of the science and art of clinical diagnosis. Here is the root cause of the abuse of all these ancillary investigations. Consultants must accept their fair share of blame. With so many laboratory facilities and all manner of superb radiological aids at hand they too readily resort to these and more elaborate methods before they have tried to get as near to the truth as possible without them. Thus the taking of infinite pains with the history, and exquisitely careful and complete examination of the patient, is so seldom seen that when it is it is a cause for special notice instead of being the rule and sheet anchor of diagnostic procedure. I am sure we should reaffirm our faith in clinical diagnosis, teach it more carefully, recognize that it takes a long time to learn, requiring as it does a great deal of experience, quite apart from a vast amount of knowledge, correctly to interpret the story and the physical findings. By emphasizing the importance of these time-honoured methods we are encouraging our family doctors in their work, for of necessity they will always have to rely largely on their powers of clinical diagnosis, even though many of them may have access to pathological and radiological services. The first suspicions of disease must always be their responsibility and concern, even if selective investigations are found necessary either to support a clinical suspicion or to provide a more complete or more precise assessment of the case.

Yet the teaching of diagnosis is not enough. The clinical teacher must all the time be doing his best to explain the scientific method in addition to his efforts to train powers of observation and thought. In his fine Harveian address in 1963 Dr. Rae Gilchrist used again the words of Bacon: ". . . the desire to seek, the patience to doubt, the fondness to meditate, the slowness to assert, the readiness to reconsider, the carefulness to dispose and set in order; . . . and to hate every kind of imposture." And he went on to say that "One result is that sound judgement can often dispense with multiple diagnostic tests and the battery of biochemical analysis which masquerade as the scientific approach in current hospital practice. The limitations of the scientist tend to be revealed when discrimination, judgement, and wisdom are in short supply."

We must never forget a mistake—we must ponder over it, learn from it; and I mean mistakes of omission as well as those of commission.

In all our efforts toward the education of future consultants or family doctors we must see to it that they are firmly determined to practise the art and science of clinical diagnosis, and encourage this rather than direct their attention to all the tests which are possible and which on occasion may be necessary. This is particularly true for those of us who frequent other less-advanced countries, who need encouragement, and who must not be exasperated by extolling investigations which in the main are beyond their present resources.

Clinical Judgement

But clinical diagnosis of a high order requires a special capacity for judgement, the ability to set aside the unimportant, the irrelevant, and seize upon the important facets of the problem case. In the Usher Hall in Edinburgh, where many medical conferences are held, there is a dome-shaped ceiling—very high up, unhappily not so well seen by the audience, but there for all speakers to read, if they care to look, are the well-known words: "Wisdom is the principal thing, therefore get wisdom, and with all thy getting get understanding."

This kind of wisdom and judgement is attained to only by long years of application, and, with some, never at all. But it is something beyond price and, for those who acquire it, the hallmark of a great doctor, whatever branch of medicine he adorns.

Of course there are limits beyond which clinical diagnosis cannot go, but even then many possibilities should have been ruled out and consequently investigation reduced to a prudent minimum. It is necessary, too, to remember that results from investigations may mislead, giving rise to a false sense of security. It is well to be particularly sceptical when such results conflict with a considered clinical assessment, or even a well-based clinical impression.

It happens that in three of my own special fields of interest—the thyroid, the biliary tract, and the large bowel—the painstaking history coupled with a most careful and complete physical examination more often than not will enable the physician or surgeon to make a confident diagnosis, or at least be able to decide on the wisdom of an exploration without any recourse to special tests.

I must not weary you with example after example to illustrate my point. Suffice it to say that the acute abdomen, the injured abdomen, as well as those many cases where the abdomen can be wrongly incriminated—the actual cause of symptoms being derived from an extra-abdominal cause—these all almost entirely depend for their successful management on sound and maybe rapid clinical judgement, based on clinical diagnosis or reasoned clinical suspicion.

All this of course takes time, but the more the family doctor can do the fewer should be his calls on the hospital service. The doctor will need adequate time to do this efficiently, but if he is not burdened with too many patients he will give the kind of service which will automatically cut down hospital work and outpatient waiting-lists. If, added to this, the consultants relied a little more on clinical diagnosis and a little less on multitudinous tests much labour and expense would be saved. I am sure it is our bounden duty in this and every possible way to have regard to the expense of this National Health Service of ours.

All too often the surgeon or physician is thanked and praised for his promptitude and skill; but maybe it is the family doctor who should get the praise and gratitude, for it was he whose suspicion was first aroused, and the consultant called in may have a relatively easy problem on his hands. A timely operation or a prompt removal to an intensive care unit has been entirely due to his informed mind, his wise judgement. Let us give, and make a point of giving, praise when and where praise is due . . . . One profession—one purpose.

Iatrogenics

Concern for our patients' good must inevitably lead to the study of iatrogenics—that is, the study of disease and disability inflicted or created by doctors.

Our Gold Medallist today in 1965 said: "No remedial agent or measure is without its hazard. Yet to be overcautious may result in lack of performance." The same caution should be observed if risk of iatrogenic disease is to be avoided when using certain methods of investigation.

Hippocrates, 460–335 B.C., said: "First do no harm."

Bonaparte, 1820, said: "I do not want two diseases, one nature-made, one doctor-made."

Osler, 1894: "But know also that man has an inborn craving for medicine . . . which distinguished him from his fellow animal creatures. It is really one of the most serious difficulties with which we have to contend."

As Sir Stanford Cade, the chairman of our symposium of this afternoon, wrote: "The review of the hazard to which the patient is exposed, never deliberately . . . is a melancholy clinical exercise, but is nevertheless salutary." In the ninth Crookshank lecture Sir Stanford was directing his remarks to some of the iatrogenic diseases which may follow irradiation; most of these are the results of scarring or fibrosis, and well-nigh any tissue may suffer. These effects may be avoided by changes in technique, in timing, in fractionation of dosage, or by using other therapeutic measures—perhaps combined with irradiation.

Positive Health and Leisure

I have spoken of positive health. We all know that this will not come from the National Health Service, which is far more a national disease service. Positive glowing health is much more than a rather negative disease-free state.

At the Saturday evening meeting the subject was "Religion and Health." Speakers set out to show that a state of real health of mind and body may best be reached and kept when we have come to terms with the problems of life and death. The service at the cathedral was an act of unified worship and prayer for the "Hallowing of Medicine," the like of which we have not seen before.

Sir Ian Fraser's last paragraphs were about leisure, the need, and the way to spend it. The maintenance of full health usually requires some form of recreation. Your Thursday afternoon will be taken up by a symposium on this very subject. Well-known experts will be speaking on some of the many ways of pursuing other interests than our work, for, however much we are devoted to that work, we need these outside interests if we are indefinitely to maintain a full service in our profession. We may not yet have a professor of leisure, but universities nowadays provide means and incentives for the enjoyment of leisure, and you will have noticed that in this regard our university is not lagging behind.

The session on vocational practice will indicate that special sense of satisfaction which is derived from devotion to, and a real sense of vocation in, our work, which we intend to *enjoy* not only for our own sakes but for the sake of those who seek our help.

The doctor will always have to be something more than the latest computer. Science will always have its limitations. The doctor must bring to his job the highest ethical standards, the deepest sense of personal responsibility, and a readily felt warm humanity. You will remember the result of a British Medical Association inquiry of some fourteen hundred schoolmasters regarding what qualities they thought important in the boy intending to practise medicine. In a formidable list emphasis was laid on loyalties, perseverance, poise, conscientiousness, resourcefulness, sympathy, patience, compassion, gentleness, and imagination. Some of these are the more intangible things to which Sir George Pickering referred and was so concerned lest we lost these precious assets in our search for science and truth.

To quote again from William Stokes (1867). "When medicine is in a position to command respect be sure that it will be proportionately increased, and its status elevated." And for many decades that respect and regard was ours, sometimes almost automatically. We held an enviable position in society. Now in 1967 how do we stand? Certainly there is no automatic respect or regard today; these must be merited, but they can be won, and kept.

The Written Word

It is customary to publish this address, and there is no escape from tradition. I had many great teachers who taught me to *do* things well, but there is comfort from Keats, who said, "I am convinced that fine writing is, *next* to fine doing, the top thing in the world."

However, it is a duty to publish critical accounts of experiences which may be of far greater value than we may think at the time. As Byron once said: "A small drop of ink, falling like dew upon a thought, produces that which makes thousands, perhaps millions, think." "Written words are dangerous," said Richards, so it behoves us to go into print with caution. What little I have written has never satisfied me. Yet three years ago when, without warning, I visited a surgeon in Colombo he told me that by a strange coincidence only a few days previously he, with his surgical team, had referred to something I had written in 1952, and, as the result, they had proceeded successfully to remove an advanced malignancy of the colon.

You will notice that I have quoted extensively from the works of others—only a few crumbs are my own. It is said that to copy from one book is cheating, to copy from two or more books is research.

At Londonderry someone said that coffee was essential to family practice—referring to the quite splendid medical centres springing up all over the country, where all can meet, family doctors, consultants, and others. There they can chat, learn to know each other, and learn to be concerned for each other. The "happy ship" was mentioned—perhaps a bit wistfully. Surely we should be just that.

Conclusion

In summary, then, free from any threat of disintegration and speaking with one voice, our great and noble profession, unified not only by loyalties and concern for each other but by its one great unifying purpose, will give a service which will still be the envy of every country in the world—the pattern which others will seek to follow.

Perhaps, even unwittingly, as we are more and more concerned for others we shall in fact be following more nearly the pattern of that incomparable life of concern for others. You will remember how our Lord answered the question—

"*When* saw we Thee sick and came unto Thee . . . ?"

"Inasmuch as ye have done it unto one of the least of these my brethren, ye have done it unto Me."