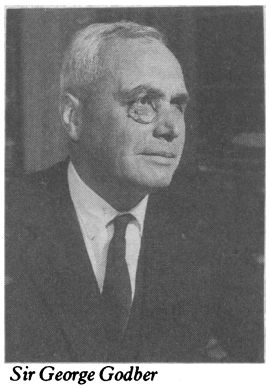

Sir George Godber

tary, and club members. Over the 22 years they included care of the aged, adolescence, school health services, child health, occupational health, hospital services, general practice, costs of the NHS, future of mental hospitals, collection and use of data in the NHS, social aspects of obstetrics, and medical care in other countries. Government reports were analysed and debated, as were hospital plans, perinatal mortality surveys, medical education, and empathy with and care of patients. There were never any publications from the club, but the private discussions must have initiated many by individual members.

Looking back and forward

The club died in 1974 because there was no young generation of leaders ready to take up the baton. Times have changed; there is now more sophistication and specialisation and less time for social medicine involving informal, interdisciplinary exchanges and discussions.

But what lessons can be drawn? The chief one is that the best continuing education and learning is through the stimulus of the regular meeting of like minds who are prepared to let their thoughts run free and wide. It may be an old fashioned way of learning but it is still one of the best and most cost effective.

Another lesson is that there is a time and a place for specific initiatives. The Keppel Club was right and relevant for its times and its members. It ceased partly because most of its original members had reached the stage when they had no longer the time, energy, or need for it. Surely with the radical changes now taking place in the NHS the time has come for a new generation to set up new Keppel Clubs?

I should like to thank Margot Jefferys for advice and comments and Tom Arie for his contribution.

BASIC MEDICINE

Seeing for themselves

M J Kelly

Why do 5% of candidates fail the final MB, and why do about half of these fail it so badly? After all, they had mostly AAA or ABB grades at A level. My attendance at examiners' meetings over the past seven years in Bristol, Leicester, and Cambridge strongly suggests that although marginal failures can result from many factors (unlucky on the day, a couple of bad errors, mind too occupied with matters non-medical), the bad failures uniformly seem to attract the comment, "Don't think he/she *really wants* to become a doctor!"

Sometimes such men or women are sent to our surgical firm for "remedial teaching" to "get them through the finals next time." So I have talked with them—and found myself in quite a dilemma regarding whether it is in their best interests that I should be attempting this conjuring trick (on their behalf) or not.

I believe that this is what happens: the teacher sees a bright, but uncommitted, science sixth former and encourages his or her application to medical school on the grounds that the child is not overtly hostile, medicine is a very secure career, socially it is highly acceptable, and acceptance will add kudos to the school, the child, and the teacher. Armed with good A levels (say AAB) and supported by a suitably glowing testimonial from the head teacher (which, with the alteration of but a word or two, might equally well have supported an application to law school, an engineering course, or a merchant bank) the child is accepted to become a doctor, perhaps without interview.

On arrival at medical school students start by dissecting cadavers preserved in formalin and are required to master an excess of biochemical trivia learned by rote. Most accept this cultural shock stoically: if doubts do surface the students are frequently reassured that although the preclinical course may seem dull, "The hospital will be completely different—and wonderful!"

Because they are AAB people, they pass the examination (which is very like an A level) and arrive on the wards, where they feel just as out of place. Should they complain now, they will be told that it is "Too soon to tell!" Thus, one way and another, it may be only by the start of their final year, when they really can perceive the shape of the way that lies ahead, that they pluck up the courage to tell someone that they cannot imagine what they are doing here at medical school, and that they don't want to qualify, or to be a doctor.

By now the argument runs: "Well, this may be so, but it seems a pity to throw away five or six years of endeavour: at least go on and take your medical degree." So some do; but it is then no use having it unless you have completed the year as a house officer to permit full registration. Thus, only when they are 23 or 24 years old will we all admit that these students should have changed course long ago. Other students find it impossible to settle down to study in order to achieve the MB passport to a career they no longer wish to embrace.

Dangers of the scheme

There was much heart searching after one lad went out like a light while talking to me and landed with a tremendous crash on the theatre floor, sustaining moderate concussion. We discovered that his parents were abroad for the week; so, skull *x* rays were taken and he was admitted overnight, while many telephone calls were made. I personally felt terribly guilty, with visions of a trip to the neurosurgeons, burr holes, and the rest. However, he was fine by the next morning, and I received great support from colleagues, especially the district medical officer and the unit general manager; they pointed out that everything possible had been done to avoid this happening. The school authorities were also used to this sort of thing and took it in their stride, with the boy's form master coming to visit him in hospital that evening. A full recovery followed—and the boy wants to be a surgeon.

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I believe that one of the most crucial stages in this sequence, perhaps the most important of all, is the original decision to apply to medical school. At present, the UCCA form needs to be completed and submitted in the September of the second year in the sixth form. With it go the head teacher's A level predictions; interviews either do or do not happen in December; and on this basis provisional places are allocated in January, to be confirmed or renegotiated when the actual A level results come out in the summer. Thus the decision to apply to medical school has to evolve during the first year in the sixth form.

Work experience for sixth formers

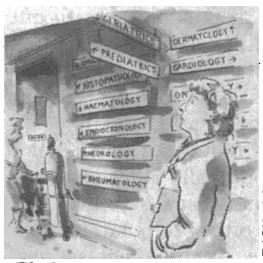
I resolved to see what I could do to influence such applicants in my own area. I wrote to 16 secondary schools in Loughborough and north Leicester offering a single day's work experience to pairs of youngsters in the first year of sixth form who were considering applying to medical school the following autumn. Considerable interest was shown, so I put forward my plan to the various authorities. Far from encountering any opposition, I received enthusiastic support from them all, including the Leicester division of surgery, the district medical officer, the unit general managers of Loughborough and Leicester, the directors of nursing, and the relevant ward sisters.

To display "surgery" the day includes some operating, a ward round, contact with the junior medical staff and medical students, and some endoscopy. A car journey between hospitals gives me a chance for an informal talk, and an outpatient clinic is avoided because of its potential for the youngsters meeting patients whom they know socially. Pairs of children are preferable on the grounds of mutual moral support.

We meet at 8 30 am on the surgical ward at Loughborough General Hospital (a general practitioner unit where I do two sessions per week). Together with the senior house officer, who is "fresh" from our take night in Leicester, we do a quick preoperative ward round (they come behind the curtains) and then go up to the operating theatre. The youngsters change and come in to watch me teaching the senior house officer basic surgery (varicose veins, hernias, piles). At noon we finish. There is a rapid postoperative circuit of the ward, and into the car. It takes about 30 minutes to drive to Leicester, during which I can have a detailed structured talk with both candidates. Back at the main hospital, we have a snack lunch in the canteen, and then do a post-take ward round with the senior house officer and house surgeon. Then to endoscopy, where they can see it "on video" till 3 pm, when I ease them out and off to spend the last two hours with the preregistration house surgeon. The youngsters finish at 5 pm (although the house surgeon doesn't and neither, for that matter, do I!).

Since the scheme's inception two years ago we have had over 100 sixth formers pass through. They have been polite, courteous, and thoughtful, with only a couple of exceptions. I have resisted the temptation either to make notes on them, or to communicate with their teachers afterwards, reasoning that once such a liaison became "known" in the neighbourhood, the children would cease to "open out" to me.

Predictably, there is a happy minority, perhaps 20%, who have already done their homework, know what is what, and have merely come to confirm what is obviously the right decision for them. Likewise, there are 10% who shouldn't have come at all: whether by inclination or by lack of academic attainment in their recent GCSE results, and they will discover this for themselves quite easily as the day progresses. That leaves 70% who seem to have only the haziest idea of what the lifestyle of a qualified doctor might be. These are the ones I am trying to reach—and of these it is the brightest that concern me most. The weaker brethren will have to fight for their place at interview and are likely thereby to be carefully sifted, whereas those with AAA grades are at risk of sailing into medical school "on the nod" without having their decision rigorously discussed, let alone tested.



PAUL COX

The basic career decision is: medical school, or not?

We have had very few problems with the sixth formers on the wards. I usually introduce them to the patients as "work study students who are considering starting medical school" and the senior house officer as "the junior doctor who is going to do your operation with me supervising." When, as occasionally happens, a patient objects (more usually to the latter part of the proferred package) they withdraw. In theatre the sixth formers mostly manage well. All are warned about the symptoms of incipient fainting. Some come in and out several times during the morning; the nurses are very supportive. The female applicants greatly value the chance to talk with our female consultant anaesthetist, and many are rather taken aback to discover her trenchant views supporting equality, but not special treatment, for women.

The youngsters seem to like the endoscopy session; certainly seeing it on the video screen comes across as "high tech." They also value their two hours with the house officer, who is the member of our team nearest their age and best able to remember (dimly!) their perspective.

It is plain, however, that the central part of their day is the half hour discussion during the car journey. I have discovered that the car provides a particularly good ambience for low key, heart to heart discussions: it is almost totally unconfrontational, eye contact is impossible, and I can always manufacture a distraction to gloss over any awkward moments.

Emphasis on career grades

Not surprisingly, most of the youngsters are greatly exercised over the choice of medical school, the minutiae of the various courses, the difficulty of getting in, and then the difficulty of getting out again (finals). I see my task as trying to get them to raise their eyes beyond these foothills of a medical career to the wide open spaces that lie beyond. I tell them that almost all the undergraduate medical courses are the same (and not by accident either, since the General Medical Council and the universities go to a great deal of trouble with visitations and external examiners to make sure that this is so); thus I cannot tell whether house officers were trained at Oxford, Leicester, Bristol, or London.

Since most of us spend four or five years as medical students, three to 12 in junior posts, and then 30 to 40 in the career grade of consultant or general practitioner, what really matters is what the students think of these two lifestyles. Much of the answer to whether they want to be a doctor at all should depend on their evaluation of the situation of the hospital consultant and the general practitioner. Thus, they should not worry unduly about the details of medical school curricula or junior hospital life but concentrate on the career grades: hence their day out with me.

The youngsters need to see how hard we all work. Coming from a school environment, children find this difficult to evaluate since life in the adult world in many occupations is a far cry from their well regulated day that has lessons during fixed hours, with long meal breaks, generous allowances for sports and pastimes, and all weekends "off" except for self imposed schedules of work or play. But they do have to decide whether they wish to work as hard, and as continually, as we do—for the rest of their lives. On occasion, I have left children slowly eating their lunch,

done a complete post-take ward round, and returned to pick them up as they finished a leisurely cup of coffee. The difference is that I know that if I forgo that ward round and later discover that something is amiss I will have to spend the whole evening there sorting it out, instead of doing whatever I had planned for what we consultants laughingly call "off duty."

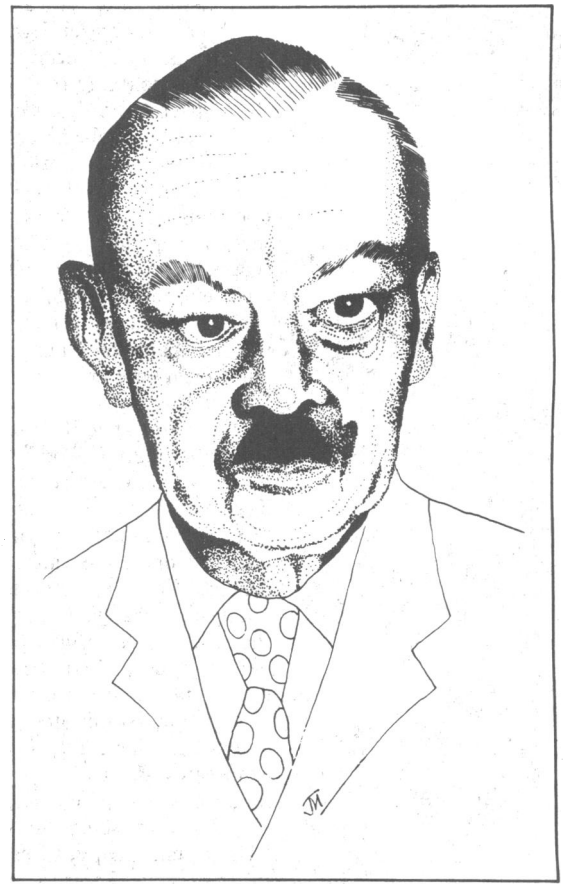
The candidates also need to see some of the professional satisfaction and the heartache that each day brings. I also suggest to them that, to make their decision to apply to medical school, they should spend one or two days with a hospital consultant, such as myself, perhaps a week with their general practitioner, and a fortnight on the "executive side" actually doing something with the sick, such as working in an old folks' home or a handicapped children's home. If, after all of this, they still feel comfortable with this environment, are not revolted, and are not physically or mentally overtired then they have the potential to go into medicine, qualify, and find a fulfilling niche.

I am enormously grateful to my junior medical staff; our ward, theatre, and endoscopy staff; and our administrators for their enthusiastic and continuing support for this project.

In defence of eponyms

V Wright

Academics commonly deride eponyms as vehemently as they insist on unpronounceable generic names for drugs instead of euphoneous trade names on the basis of cost. The aetiology of the use of eponyms is multifactorial, and not all the reasons for their use are despicable. Let me enter the lists in their defence by providing reasons for their use.



Hans Reiter (1881-1916)

Hiding distressing aspects of a disease

Mongolism may have been a vivid description of the patient suffering from Down's syndrome, but how much more humane is the eponym. It also avoids suggestions of racial prejudice. Likewise, Hurler's syndrome is preferable to gargoylism.

In emphasising the term Hansen's disease for leprosy[1] the late Dr Stanley Brown minimised the use of "leper" with all its destructive and ostracising associations. When, in 1981, the British Medical Association invited me to lecture at their annual conference in San Diego on aspects of rehabilitation, it selected the catchy title, "Disability: the new leprosy." Imagine my dismay on returning to Leeds to read the description of my visit in the local newspaper under the headline "Leeds professor says disabled people are lepers." No self respecting editor would have used the precious front page to exclaim, "Leeds professor says disabled have Hansen's disease."

An eponym can, moreover, give dignity to a sufferer. Who would wish to be called an "india rubber man" when he can proudly announce to his friends he has Ehlers-Danlos syndrome? One of my senior registrars commented that she had been glad, in younger years, that she had Perthe's disease, rather than "avascular necrosis of the hip occurring in small (stunted) children of low social class."

Crediting the origin of a new understanding

This is the usual reason for using an eponym, and is entirely appropriate. The pleasantly sounding von Willebrand deserves to have his name attached to the usually mild bleeding disorder, the fundamental lesion of which is an insufficiency of or a defect in his factor—a protein that promotes platelet adhesion. An eponym is preferable also to an acronym such as SARA (sexually acquired reactive arthritis), which attaches a girl's name to a disease that affects mainly men.[2]

Directing attention to the original article

The authors first describing syndromes often did so in beautiful prose. They lived in an age when journal space was not at a premium, and they could expand their observations in marvellously descriptive phrases. The discussion by George Frederic Still (while a medical registrar at Great Ormond Street Hospital) of the spectrum of conditions that comprise juvenile chronic arthritis is masterly.[3] Several years elapsed before rheumatologists woke up to the fact that these children did not have juvenile rheumatoid arthritis but a cluster of diseases, as Still had indicated. The descriptions of Felty and of Whipple—both from the Johns Hopkins Hospital, Baltimore—of their respective syndromes cannot be bettered.[4,5]

As investigators have often found, knowledge of a few patients well described originally is usually little extended by vast surveys in later years. Moreover, the original author's insights were often profound. Reiter's syndrome is defined as the triad of non-specific urethritis, conjunctivitis, and arthritis. Hans Reiter himself described the case of a cavalry officer serving

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