Papers and Originals

British Medical Association

ONE HUNDRED AND THIRTY-SIXTH ANNUAL MEETING, HELD IN CONJUNCTION WITH THE
AUSTRALIAN MEDICAL ASSOCIATION, SYDNEY, 1968

President's Address

British Medicine in Australia

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Brit. med. J., 1968, 3, 393-395

Contemplation of the roll of those who have preceded me in office serves to remind me of my presumption in accepting this appointment, and especially the responsibility that devolves on me now for the delivery of this discourse.

In his Presidential Address, Dr. Roddick, professor of surgery at McGill University, said: "A question which is nowadays agitating the minds of those especially interested in medical education is the kind of groundwork which is likely to bear the most direct relation to the future studies of the medical student." This on the occasion of the 65th Annual Meeting, held at Montreal in 1897, the first meeting of the British Medical Association to be held outside the British Isles.

What constitutes adequate medical education at all levels—undergraduate, postgraduate, or continuing—now "agitates" the whole profession, as is evidenced by the holding of international conferences, and the production by national bodies of innumerable reports. Unfortunately, action to compass the findings and recommendations therein is tardy, though the need for action is urgent.

The needs of the present being always pressing, and adequate finance so difficult to secure, the opportunity of planning and providing for the future rarely presents, and progress follows rather than anticipates requirements.

This is not altogether surprising, for the necessary emphasis on the various facets of health services changes with the stage reached in national development and with changing conditions of the economy and in the social structure. In addition, to test planners still further, are changes in medical practice and a superabundance of scientific knowledge which becomes ever more difficult to evaluate and to digest.

To define future trends in medical practice and to predict the future needs of the community offer a formidable challenge to even the most farseeing, a challenge which must be met if educational standards are to be aligned to match the requirements of total health care.

These matters will be considered more fully and with more authority in the Second Plenary Session of Congress—"How Many Doctors?"

Confederation

In another passage of his address Dr. Roddick says: "Let us give our Australian brethren a hint: if the confederation of your provinces be in contemplation see to it that all matters of professional education are left in the hands of the Central Government, at least so far as qualification for registration is concerned."

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It is interesting to read in a brief résumé of the history of the Canadian Medical Association that in 1912 "Forty years of effort, headed by the Past-President, Sir Thomas Roddick, result in the passing of the Canadian Medical Act to provide a standard basis for medical registration." It seems apparent that, by comparison, enough time has not yet passed for our efforts to overcome the outmoded and parochial concepts of "State Rights" that stand in the way of achieving national uniformity, and the responsibilities, so wisely urged on us so long ago.

Osler, in his address at the same meeting, also referred to the fact that Australia fell short of the progress made in other parts of "Greater Britain" in the satisfactory regulation of practice.

He made another observation in similar vein when he alluded to the "question of ethics, to which one really does not care to refer, were it not absolutely forced upon the attention in reading the journals. In the large Australian cities differences and dissensions seem lamentably common."

We were certainly contemplating federation at that time, and we were indulging in much "washing of dirty linen in public," mainly owing to the methods used in elections to hospital staff posts. The strictures that were then well merited have in the main been corrected, though occasionally a tendency to use the public press to advance a domestic grievance still appears.

I have already quoted from Osler's Address in Medicine which was entitled "British Medicine in Greater Britain," and should like to read another passage. He says: "In certain aspects the Australasian settlements present the most interesting problems of Greater Britain. More homogeneous, thoroughly British, isolated, distant, they must work out their destiny . . . The traditions are more uniform, and, of whatever character, have filtered through British channels. . . . What the maturity will show cannot be predicted, but the vigorous infancy is full of 'crescent promise.'" He goes on to suggest that "At the end of the twentieth century ardent old world students may come to this side (America), 'as o'er a brook,' seeking inspiration from great masters—or the current may turn towards the schools of the great nations of the south."

The "brook" has often been crossed since that time. Now the presence here of so many physicians from that "old world," together with others from younger nations, seeking perhaps some inspiration, as well as providing it for us, does suggest that there exists a south-running current.

Australian Medicine

The theme of Congress is "A Review of Australian Medicine as at 1968." The scientific sessions during the week, together

with the opportunities afforded for discussions, and for the inspection of our facilities, will enable those who take part to evaluate how far the "crescent promise of our vigorous infancy" has been fulfilled. Opportunities also exist to assess our system of practice, as embodied in the National Health Service.

Most people's conception of a national health service is not one embracing all the activities which combine to protect the health of the population, but is rather that part of the whole which ministers to personal health. It is this aspect that attracts the most publicity, stimulates the greatest controversy, involves ideologies and emotions, and increasingly interests politicians.

It is in the "national" approach to personal medical care that differences most manifest themselves, each nation developing its own pattern from its own philosophy, to suit its own conditions. Whatever system is adopted, however, there are certain conditions which must be met if the system is to be successful and to continue in efficient operation. It must satisfy the people it serves, and who finance it, for it will fail if standards of medical care and of hospital service are not maintained at a high level, and are not readily available to all, and it will surely fall into disfavour if the cost is too high.

It cannot continue to operate successfully unless those who provide the service are given conditions which are attractive in all respects. With unfavourable conditions, as you well know, there is inevitably a drift of practitioners to more favourable areas, with consequent shortages and further dissatisfaction, to the detriment of patient care.

National Programme of Personal Health

A national programme of personal health service is judged more by the satisfaction it gives to those concerned than by the measure of improvement effected in the total health of the population.

This is understandable, for the majority of people are not so much interested in the high standards of medicine as such, but rather in how these modern scientific wonders can be deployed to their advantage, how they can be made available to the individual, and how the costs are to be met.

In all countries there is a growing demand for medical attention, a mounting appetite for drugs, both of which are stimulated rather than repressed by greater understanding and increasing affluence. There has also grown up in modern society a belief in the inalienable right of all citizens to medical treatment "without cost."

The easy assumption of any "right" without acceptance of corresponding responsibilities is a concept which, if followed, will assuredly lead on to a disregard of the "rights" of others, with inevitable deterioration in national harmony and national services.

Unfortunately it is money, both in total amount and in the manner of its procurement, and in the method of its disbursement, that activates a health service and determines in very large measure the success of its operations.

Ideologies and politics play major roles in deciding these factors, and hence the form a system will take. As a consequence the pattern will be shaped by emotionalism as often as by well-reasoned conclusions.

Despite this, and indeed because of it, medical associations must accept a large measure of responsibility for shaping the pattern of national health care in their own countries, for it is their members who, by personal contact with the sick, best know their requirements. It is their members who provide the service, and it is they who are best equipped to raise standards, and to advise, who are organized to lead in the best interests of the whole community.

Divergent Systems

The systems of private practice in Britain and Australia first diverged with the introduction of health insurance plans to Australia. In their early formative years these made no great impact, the divergence becoming appreciable only with the abandonment, by Friendly Societies, of the capitation system of reimbursement in favour of that of a fee for service.

Subsequently the Commonwealth Government accepted this system as the basis of the National Health Service, and by subsidies encouraged people to insure. This set our courses on paths now poles apart.

We in Australia believe that each individual should accept the responsibility for providing for his personal medical care. We believe that patients should have a completely free choice of personal physician, of consultants, of diagnostic facilities, and of public or private hospital accommodation. We further believe that the intervention by a third party between doctor and patient undermines their essential personal relationship, with adverse effects on the quality of service. We adhere firmly to the opinion that the present form of service in Australia, whatever its known imperfections, provides the best and soundest basis for the construction and operation of the most efficient plan of national health care.

Might I now venture a reference to the present position in Britain. This I should wish to do for two reasons, the first being to bring to the notice of Australians the interim report of the Advisory Planning Panel on the Health Service. In so doing I should like to congratulate the Association on being so fortunate as to have such an admirable report prepared for it. I am certain that the other aspects to be dealt with by the committee will be equally competently treated.

It is known to us that there is increasing dissatisfaction with the operation of the present system, and that, fearing a breakdown in the medical services, the Association instructed the Council "to use whatever method it chooses to prepare an alternative Health Service."

I should like to quote to you some paragraphs of the summary of this interim report, enough to excite a study thereof.

155. This interim report leaves no doubt that the present system of financing health services in Britain must be reconsidered.

158. On the evidence so far considered by the Panel, no advantage appears to be derived from perpetuation of the existing financial structure. It inhibits full expansion of the potential derived from the rising standard of living in the community by compelling those who wish to provide for themselves something more than the basic social welfare provision to pay twice.

159. The fundamental issue in deciding the most appropriate method of financing comprehensive medical care for an entire community is whether or not taxation should play the predominant role.

163. While the current system attempts to achieve the maximum possible equalization of benefits, it seems, on the evidence presently available to us, that a greater proportion of finance by insurance would promote increased flexibility and could also provide equal opportunity for all to secure higher standards of medical care than is at present possible.

By the time you hear this the report will have been received and decisions taken.

Hint to British Brethren

Like my Canadian precursor in office, I should like to "give a hint" to my British brethren, that whatsoever be decided as to the basic method of financing the National Health Service there will be strong support for an alternative voluntary health insurance plan, for which there already exists a rapidly growing demand in the United Kingdom, likewise that every effort be made to secure Government encouragement for this by taxation rebates on contributions, and, if possible, subsidy of benefits related to taxation payments to the N.H.S.

We in Australia, after 15 years of running repairs and alterations, have a vehicle in need of a major overhaul. Like you in Britain, our difficulties are basically those of finance, how best to obtain and apply this to provide all members of the community with complete cover.

It has become apparent that our ideas on the basic philosophy of national health care are again approximating, and that our paths, at present as antipodean as our countries, are converging.

Both our countries can gain much from each other in their efforts to provide, on a national scale, readily available medical care of the highest standard. This we shall both achieve if all concerned approach the task with open minds, actuated by the highest motives, basing their decisions on facts and diligently pursuing one common purpose.

What would have been the reaction of those distinguished gentlemen who attended that 65th Annual Meeting if they could perchance be with us this week? Roddick would no

doubt have exhorted us to continue our efforts to achieve a national registration board. Lister would have experienced great satisfaction in the progress of surgery. Osler would doubtlessly have regarded our progress in the control of medical practice with "equanimity."

All three would assuredly survey the advances of science and technology with amazement, and we trust they would approve the progress made towards maturity, and promised in our "vigorous infancy," of "British Medicine in Australia."

When the time arrives for your return to your homes we hope that you will take with you many happy memories of your stay in this land of Australia, new friendships, and an enhanced knowledge and appreciation of our country, its people, and their way of life.

We, for our part, shall long cherish this occasion and treasure the wisdom you bring with you, as well as the great personal pleasure we have in this meeting with you.

Tertiary Hyperparathyroidism

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Brit. med. J., 1968, 3, 395-399

Summary: In our first 200 cases of primary hyperparathyroidism confirmed by operation 12 were also shown to have a long history either of a malabsorption syndrome or of chronic renal-glomerular failure. We consider that they first went through a phase of secondary hyperparathyroidism, during which one or more of the glands became autonomous adenomata. This then produced the biochemical changes of "primary" hyperparathyroidism, necessitating excision of the adenoma. This condition is best described as "tertiary" hyperparathyroidism. The transition from secondary to tertiary hyperparathyroidism occurred in four of the 12 patients while under our observation. We think the same process can be traced retrospectively in the other eight cases. The concept of tertiary hyperparathyroidism may help to explain the high incidence of other diseases in association with primary hyperparathyroidism.

The behaviour of the parathyroid glands provides a valuable model for the investigation of tumour formation in man. All states occurred in our patients with primary hyperparathyroidism, from normal through hyperplasia to adenoma formation and finally to parathyroid carcinoma.

Introduction

In 1956 Davies, Dent, and Willcox described the case of a patient with steatorrhoea and osteomalacia (their Case 2). She appeared to have suffered from lifelong coeliac disease, but her plasma calcium level was persistently raised even before treatment with vitamin D, and there was only a partial response of the osteomalacia when vitamin D treatment was given. After two parathyroid adenomata were later removed at operation the patient was cured of her hypercalcaemia and then responded normally to vitamin D. Davies *et al.* concluded: "In some cases of steatorrhoea a parathyroid hyperplasia occurs which is reversible with vitamin D treatment. In other cases, however, presumably of longer duration, one or more adenomata will develop."

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Dent (1962) presented further evidence that autonomous hyperparathyroidism with adenoma formation may have developed from a background of secondary parathyroid hyperplasia both in malabsorption syndromes and in chronic renal-glomerular failure. Other reports followed. The Case Records of the Massachusetts General Hospital (1963) reported the case of a patient with a long history of progressive chronic pyelonephritis who gradually developed hypercalcaemia. At operation a parathyroid adenoma was removed and this patient was considered to be the first case of secondary hyperparathyroidism developing under biochemical observation into primary hyperparathyroidism in the way that Davies *et al.* (1956) had postulated retrospectively in their patient. During the discussion of the case Dr. Walter St. Goar suggested the use of the term "tertiary" hyperparathyroidism to describe such cases in which autonomous parathyroid adenomata causing hypercalcaemia apparently developed from a background of reactive (or secondary) parathyroid hyperplasia. Though the term is not ideal we think it is the best available.

Other cases of supposed tertiary hyperparathyroidism have since been described by McPhaul *et al.* (1964), Golden *et al.* (1965), and Ludwig *et al.* (1967). In addition Glanville and Bloom (1965) described one of our patients with adult-presenting "vitamin D resistant" osteomalacia who developed hypercalcaemia under observation and from whom we then removed a parathyroid adenoma. Among our first 200 patients with hyperparathyroidism confirmed at operation there are 12 probable cases of tertiary hyperparathyroidism and two possible cases. Only three of these 14 cases arose on the basis of longstanding renal failure, a situation presenting particular difficulties in retrospective diagnosis, and in interpretation of plasma electrolyte levels.

Case Material

The 12 probable cases of tertiary hyperparathyroidism are listed in Table I. Five of these have been reported elsewhere (as shown in the Table), three as such and two others in papers dealing with other clinical aspects of hyperparathyroidism. Short case reports of the remaining seven are included in this