Portraits from Memory

5—Professor George M Wishart (1895-1958)

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Wishart was a man of genuine self effacing modesty whose integrity guaranteed that his work as an administrator made an outstandingly effective contribution to Glasgow University's declared policy of linking academic medicine to the work of the National Health Service (NHS). This was the policy of the principal, Sir Hector

Hetherington, who never failed to insist that its implementation would have been impossible without Wishart's devoted and loyal acceptance of the difficult task of bringing the faculty of medicine into effective cooperation with the regional hospital board of the new NHS.

In the mid-1940s Wishart saw that "physiological chemistry" must now become a discipline, in its own right, of biochemistry. In 1947 he faced the reality that new young biochemists would be required

to bring into the department methods and training that he could not confidently provide; and he proposed that he should make way for a suitable biochemist and himself continue to serve the university in a different role. Hetherington not only accepted and welcomed this generous and unusual offer but devised exactly how Wishart could effectively help the NHS, due to begin the following year, to upgrade the periphery with the help of the university teaching hospitals—a policy that had to ensure that academic medicine continued to flourish even though the university teaching hospitals became part of the regional hospital board's ordinary administrative structure and did not, as in England, rely on having independent boards of governors.

Model management

Hetherington, a master of administration, worked out exactly the right arrangement. Wishart retained his professorial status by becoming professor of applied physiology, without a department, and was director of postgraduate medical education, with an appropriate salary and a good staff. He was not to become, as some had proposed, a permanent dean of the faculty; but there was no reason why he should not be elected dean, with annual re-election, for as long and as often as the faculty desired. He was also to be the principal representative of the university on the regional hospital board, and he could so remain for as long as the board and the university agreed that he should. A vital principle, strongly insisted

on by Wishart, was accepted by the regional hospital board and the university—namely, that the terms and conditions of service for academic medical staff working for both board and university must be identical in all matters with those of doctors employed full time in the NHS. Thanks to the personalities of those making the arrangement it worked smoothly and happily until Wishart's death in 1958, when he was succeeded by Professor Charles Fleming under an identical arrangement and with equally good results. But the foundation was laid by Wishart.

In other places more complex arrangements spawned masses of committees and mountains of paper without the same warm and trusting cooperation. Hetherington and Wishart met often and informally with the chairman of the regional hospital board, Sir Alexander Macgregor, a former medical officer of health of Glasgow, and with the board's principal medical officer, Dr Alex Bowman, brother of a former professor of moral philosophy in the university and biographer of Macewan, the famous surgeon. Any difficulties that arose for either side were examined at the frequent informal meetings of these four men, and the best answers were found and applied. This worked so well that it was not until 1960 that a formal medical education committee was set up with some 40 members. During my time—1951-63—it never met. There was no need for it to do so.

Academics were often frustrated by the bureaucracy, and board officials were similarly infuriated by the lack of reality sometimes displayed by professors and their staff. But nobody got into the bad habit of "blowing his top," knowing that he could count on Wishart and his colleagues to straighten out apparently hopeless tangles and have good proposals endorsed by the "gang of four"—surely a model worthy of study by those who seek to make management acceptable to professionals. Each year the faculty of medicine re-elected Wishart as dean. At the appropriate meeting he reminded the faculty members that they must now elect one of their number as dean. It need not be him again unless the faculty so wished. His salary came from his being director of postgraduate medical education and his place in the university from his being professor of applied physiology, which did not yet exist as a visible department. He explained that he and his clerk would now leave the meeting under the chairmanship of the senior professor. He asked only that the name of the next dean be conveyed to him at once so that he might have adequate time to brief his successor on the agenda for the next meeting. So saying, Wishart would gather his papers and, with his clerk, move towards the door. I never saw him reach it, his re-election having taken only a matter of seconds. Wishart was liked and trusted as a fair minded man of intelligence, insight, and agreeable manners.

Glasgow's miles livelier

His real contribution to the academic life of the faculty was no mere chance. He thought hard about it and worked diligently to uphold and increase quality and reputation. On returning from a meeting in London, Hetherington one morning called Wishart and

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related to him a pleasing though unexpected communication that had been made to him at breakfast in the Athenaeum Club. Two distinguished members of the British Postgraduate Medical School had told him that the staff of that distinguished body had been classifying the departments of the medical schools of the United Kingdom into one of two categories: alive or dead. They told Hetherington that to their surprise the University of Glasgow's medical school had been judged to have more alive departments than any other school. How did he explain that, they asked Hetherington, who replied, "Am I not the principal thereof?" "But what," continued Hetherington to Wishart, "would be the real explanation?" He told Wishart to look diligently for possible explanations lest in the reforming zeal then prevalent the university medical school might unthinkingly eliminate some advantage that endowed it with a high proportion of alive departments. Wishart examined the matter carefully and thoughtfully and asked the members of the faculty to take the examination seriously and discuss it fully. The judgment of the British Postgraduate Medical School might indeed be correct. If so, wherein was the Glasgow set up unlike that of other medical schools?

Fairly soon Wishart and the faculty came forth with a clear answer. Two factors were important. Firstly, with the upgrading by the regional hospital board of the traditionally non-teaching hospitals in Glasgow there were now many more clinics well qualified for teaching and anxious to be given recognition by the university. Secondly, only about 200 new medical students could be accepted each year because of the relatively limited accommodation in the departments of anatomy, physiology, and biochemistry. So it was easy to have clinics with small numbers of students, five or six being common numbers; and it was possible to continue the policy of allowing the students free choice of clinic. As the two main university teaching hospitals, the Royal Infirmary and the Western Infirmary, each had a full quota of paraclinical and clinical academic

departments the student had a real freedom of choice. He was not a captive of any one hospital and he could have some of his classes at one teaching hospital and the rest at the other. By exercising free choice in this way the students stimulated competition between the academic departments and the available clinics. The dean therefore had objective information about where the students thought the best teaching was to be had. The students' opinions were not by any means infallible, but the exercise of their freedom of choice kept all departments and clinics aware that they were in a competitive world and that their place in it could not be taken for granted.

Some distinguished teachers disliked the pressure thus put on them by students not yet mature enough, as they asserted, to form accurate judgments. But Wishart resisted successfully all attempts to do away with the students' very real freedom of choice. I recall having to reconsider my own teaching programme in the light of the decision of the rival establishment to issue printed lecture notes. I am sure that certain improvements that were not easy to make but that proved popular would not have been made without the challenge of the printed lecture notes. One consequence of these was to draw off to the rival department the more easy going students and to leave the more ambitious to what I think was a more exacting but more stimulating programme. As all students sat the same examination the distribution of distinctions and failures provided at least some guide to the results of different teaching methods and encouraged their not being left unchanged for too long. If it had not been for Wishart's careful analysis of the school's set up and his persistent defence of its essential features it is quite likely that something important could have been lost.

In 1958 he died after a brief illness. He was deeply mourned; but his work lived on. Surely it offers a model that deserves careful examination in the repeated outbursts of reforming zeal that seem to do so little to promote the essential cooperation between academic medicine and the NHS.

What action, if any, should a general practitioner take over an articulate, middle class woman whose three children aged 2 to 13 have had no immunisations because they have been done homoeopathically?

The children's lack of protection is worrying. Older children can suffer severely from these preventable infectious diseases. They also contribute to the low level of herd immunity that is preventing the control of pertussis and the elimination of measles. What to say to the parents? Firstly, it is perhaps important to know how they came to their decision. The family may well be informed homoeopaths. On the other hand, they may have turned to homoeopathic medicine in panic when confronted with conflicting advice over contraindications and the dangers from immunisations. In these cases parents usually welcome a sympathetic informed discussion starting with an understanding by the doctor that decisions over immunisation may not be easy for parents. A recent discussion of the dangers from pertussis and measles and the real and mythical contraindications to immunisation may be helpful.¹ All doctors doing immunisation counselling should also have the DHSS guide for definitive advice.²

Often parents fail to understand the real dangers from pertussis and measles. After recent epidemics this is less true for the former but many still consider measles a trivial disease. A convincing personal witness of its rare tragic consequences is Roald Dahl's account of his daughter's death. This is available in letter form suitable for showing to the public.* Parents who are not regular homoeopaths rarely realise that the homoeopathic pertussis preparation comes from the sputum of a person with the disease. Neither do they seem to appreciate that homoeopathic logic requires continuing doses. They may also need to know that in contrast to the vaccine the only trial of the homoeopathic preparation failed to show any protection. If counselling is successful—the usual contraindications notwithstanding—children beyond their third birthday should receive an accelerated schedule of three doses of triple and polio at monthly intervals. Measles immunisation is given

simultaneously with the first dose. The school entry booster should be given a year later for the older children.—DAVID HULL, professor, and ANGUS NICOLL, lecturer in child health, Nottingham.

1 Nicoll, A. Contraindications to measles and whooping cough vaccination: reality and mythology. *The Practitioner* 1986;230:593-7.

2 Department of Health and Social Security. *Immunisation against infectious disease*. London: HMSO, 1984. (All general practitioners are supplied with these. Those not possessing a copy should contact: DHSS, Hayward Stores, No 2 Site, Manchester Road, Hayward, Lancashire.)

A schizophrenic woman in her 30s is not well controlled by neuroleptic drugs but she obtains rapid relief of the symptoms of fear and aggression from the use of diazepam. Is long term treatment with this drug advisable?

The treatment of unstable schizophrenia requires a delicate balance between the level of control possible and the price all psychotic patients have to pay with the presence of some side effects. It is important to recognise the maximum therapeutic benefit from drugs and not to exceed the dose required. Not infrequently a dose reduction, but not a dose withdrawal, is an important management strategy. The presence of fear and aggression in schizophrenia, as with many affective symptoms, has no agreed aetiology. This is probably because the causes vary and are often multiple, but one important cause is likely to be a continuing activity of the psychotic process, and treatment should be directed at the "process" rather than individual symptoms. The social and environmental setting of the patient requires careful evaluation to exclude any form of stress. Increased time spent in day hospitals or day centres with their wide range of activities is always worth while. Clinical psychologists may be able to offer specific interventions in the family scene or to use techniques to reduce target symptoms. The presence of a fluctuating or labile mood state may indicate the need for a therapeutic trial of lithium in combination with a neuroleptic. The risks from the long term use of diazepam almost certainly outweigh the benefits, particularly when a moderate to high dose is required. The use of diazepam in such schizophrenic patients has been only poorly researched but almost certainly the indications for its long term use are likely to be rare.—D A W JOHNSON, consultant psychiatrist, Manchester.

*Available from: Health Education Centre, Sandwell Health Authority, 8 Grange Road, West Bromwich, West Midlands B70 8PD. General practitioners requesting limited numbers should send an A4 size stamped addressed envelope. Cost to health authorities £49 per 1000.