Portraits from Memory

10—Dr Thomas K Buchan (1885-1958)

JAMES HOWIE

In the village of Laurencekirk, Kincardineshire, where I was brought up, we were fortunate in having Dr Buchan as our general practitioner. He was a firm but very kind man. He was also a well educated doctor. After graduating in Edinburgh on 19 October 1907 he took four years of postgraduate work with a view to becoming a surgeon. He would certainly have been well able to become one if he had not decided to get married and go into general practice. This was a real bonus for Laurencekirk.

When I enrolled as a medical student at Aberdeen University in October 1925 he sent for me.

"Welcome to our profession," he said. "You are one of us from today." I was warmed and uplifted; and my parents never received a doctor's bill from that day. "Come and see me at every vacation," said Dr Buchan. "You will tell me what's new in the medical school; and I will show you what it is to run a general practice." Two older students in our village urged me to take the offer seriously, which I did. It had been to their great advantage they assured me. "Whatever subject we could have failed on our way, we couldn't have failed the finals." So it was with me also.

Realities of practice

In my clinical undergraduate years, and with a developing interest in bacteriology, I suggested to Dr Buchan that he could make more use of the help available from the laboratory in diagnosing his PUOs (pyrexias of undetermined origin).

"I don't really need it" said Dr Buchan. "Most PUOs remain undiagnosed; but most also settle in under five days whatever you do. If they last longer, perhaps a Widal test would be sensible, but only if the patient had been abroad. There's no typhoid in Laurencekirk." I saw the logic of this; but I asked what he told the relatives while waiting for the pyrexia to settle or the cause of it to become evident.

"That's easy," he said. "Tell them 'Your relative has a chill.' Prescribe a mild diaphoretic medicine. The patient will feel more comfortable. Usually the pyrexia will subside and your medicine will get the credit. If it doesn't settle, probably it will prove to be bronchitis, pneumonia, pyelitis, hepatitis, or enteritis. You then explain that the chill has settled on the lungs, kidneys, liver, or stomach, as the case may be. Alter the treatment if required; and all's well." It was a simple lesson in one of the realities of practice.

Dr Buchan's consulting hours were quite short. He listened hard and attentively, never interrupting, obeying Osler's advice to listen well and let the patient tell you the diagnosis. If necessary, the patient was given a visit at home and a careful, full examination next

This is one of a series of short articles by Sir James Howie. The complete collection will be published as a book.

day. "You don't really know your patient till you've seen him in his own home" was his dictum. This was true; and his referrals to the consultants in Aberdeen were few and were treated with serious respect.

Learning the language

Just after the time I qualified Dr Buchan was puzzled by the different outcomes of two cases of cerebral tumour, both operated on by Mr Norman Dott in Edinburgh. One patient progressed well and was obviously cured. The other soon showed signs of recurrence and rather quickly progressed to death. Both had been diagnosed as astrocytoma. Why the difference?

Four years later I was able to call on Dr Buchan with a probable answer to the puzzle. At that time (1934) I was doing a year in pathology at Aberdeen, having returned from Glasgow, where I was under Sir Robert Muir's influence. The Aberdeen year was my introduction to post mortems and morbid anatomy. The new professor of surgery at Aberdeen, James Learmonth, was not satisfied with the terse reports on cerebral tumours produced by the wise, benevolent "Daddy" Duncan, the clinical pathologist. These ran: "fibrous glioma, nil malignant" or "very complex cellular glioma, probably malignant." The professor of pathology, Theodore Shennan, sent me to London to The National Hospital, Queen Square, to study the pathology of cerebral tumours under Professor J G Greenfield.

"Greenfield!" exclaimed Dr Buchan, "that must be the son of old Greenfield who taught me clinical medicine. He had wards at the Edinburgh Royal Infirmary although he was professor of pathology. His clinics were masterly expositions linking the patient's symptoms, signs, and diagnosis with the underlying pathology. We were fascinated. Then—bang! The one o'clock gun would sound, shaking Greenfield back into the hard reality of time. 'Just a word on treatment,' he would say; and by three or maybe five minutes past one o'clock we would be out in Lauriston Place, aware that there was no real treatment—only palliatives."

Off I went in April 1934 for a week in London with Greenfield in Queen Square. I stayed at the Regent Palace Hotel. I was a bachelor then on £400 a year—real wealth—and so I could afford the above average cost: 7/6 a night for bed and breakfast, equal to today's 37½ new pence. "Young" Greenfield took my mission seriously and I had no idle moment, seeing post mortems, biopsies, tumours, slides, and reports by experts. By the end of the week I knew the Bailey and Cushing language about the pathology of brain tumours, which was what Learmonth wished to be used in pathology reports.

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Before I left, Greenfield sat down with me for an hour and checked that I knew the language. But then he added: "Of course, no matter what you call these tumours, assess their prognosis as you would that of any connective tissue tumour anywhere in the body. Is it well organised, fibrous, with mature blood vessels and cells well formed and uniform? If so it's simple. But if it has immature blood vessels, multiform cells of many different sizes and shapes and complex active nuclei, and is loosely organised, it's malignant. Never mind its name." I realised that he was very close to Daddy Duncan.

What's in a name?

The final enlightenment came, as so often, from Robert Muir (portrait No 2). On my way back from London to Aberdeen I called on my friends in Glasgow. Muir wanted to see me. Somehow he

knew that I had been in London learning about brain tumours from Greenfield. Muir gave me four microscopic sections to examine and name. "Write down your diagnosis," he ordered. I remember them still: astrocytoma, ependymoma, spongioblastoma, and angioma. Muir consulted a postcard.

"Well, you've given them the same names as Kernohan gave them. He's from the Mayo Clinic where they stick to the Bailey and Cushing language. These four sections, however, are from different parts of the same tumour—so you see what you're up against if your biopsy is from only one area of an extensive growth. Bailey and Cushing's nomenclature presupposes that all brain tumours arise only from the growth of embryonic rests, and they do not." Dott, as I was told, used the Bailey and Cushing nomenclature.

I bore the news back to Dr Buchan as the probable explanation of the different outcomes of his two cases.

"Tomorrow," he said, "let's go to Edzell for a game of golf."

For Debate . . .

Testing for HIV without permission

RAANAN GILLON

Sir Richard Doll wishes to carry out anonymous screening for the prevalence of the acquired immune deficiency syndrome (AIDS) on blood samples taken in hospitals for other purposes. Apparently ethics committees have been reluctant to sanction such testing. In a letter to the *BMJ* he says: "How it can be unethical is incomprehensible, as it can do no possible harm to anyone and could do much good."^{1,2}

The proposal is simple enough: after blood samples have been tested for the reasons they were taken they would be made unidentifiable except for the donor's age, sex, and residential district and would then be tested for antibody to human immunodeficiency virus (HIV). Samples for testing "might for example be obtained from antenatal clinics or casualty departments."

The case in favour of doing prevalence studies is straightforward and uncontroversial: HIV positivity occurs far earlier than AIDS, and by testing for HIV prevalence the earliest measurements of spread within the population may be obtained. Such information is likely to be beneficial in combating AIDS and its spread.

Few people can object to the desire to obtain information about the prevalence of HIV. But medicomoral problems arise in relation to two aspects of the proposed method. Firstly, such testing would be carried out without the patient's permission. Secondly, results would be anonymous so that patients could not be told that they did or did not have HIV antibodies even if they wished to know.

In analysing these issues perhaps the first thing to note is that the proposed prevalence testing falls into the realm of non-therapeutic medical research—that is, research that is done without any direct intent to benefit the subjects of that research but with the hope of

benefiting others medically. The World Medical Association's Declaration of Helsinki on the principles that should underline medical research on human subjects, which was last endorsed in 1983, makes it explicit that "the subjects should be volunteers"—either healthy persons or patients for whom the experimental design is not related to their illness.³ Moreover, in any research on human beings each potential subject must be "adequately informed" and "should be informed that he or she is at liberty to abstain from participation in the study." And for good measure the declaration states (in effect twice) that "in research on man the interests of science and society should never take precedence over considerations related to the well being of the subject."

Absolute moral principles are always questionable, and the last is no exception. Sufficient benefit, or the avoidance of sufficient harm, may I think (but do not argue here) in rare cases justify the overriding of normally strong moral obligations when these unavoidably conflict with such benefit or avoidance of harm. But the principle of consent is an extremely important one and should be upheld unless there are powerful moral arguments against obtaining such consent. In the case proposed I see no such powerful arguments and am not at all clear why adequate consent should be unobtainable. Given the importance of consent, if it is obtainable then it is surely important to obtain it rather than do the research without it.

As I understand them the main objections are that (i) it would be too cumbersome to obtain consent; (ii) if any patients withheld consent the prevalence studies would be made less accurate; (iii) testing blood samples anonymously and without consent is already an accepted part of hospital medical practice; (iv) consent for such tests is not legally necessary; (v) consent for such tests is implied in the consent given by the patient in agreeing to have blood taken; (vi) the requirement for consent can be ignored in trivial or minor procedures, including such testing of blood samples obtained for other purposes; and (vii) there is no need because "it could do no possible harm to anyone."

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