explaining what is going on in terms of diagnosis and treatment? He or she assesses the patient and the "other," attempting to identify their physical and psychological needs; when possible the adviser tries to help them solve their problems and to facilitate personal growth, which means steering and encouraging the couple to acknowledge what is happening to them and to come to terms with it. The adviser should be able to refer patients for specialist care when necessary (psychiatric treatment for depression, for example). But the adviser is also the patient's advocate and can help him or her to have the courage to ask the clinician for a review of treatment options and possible outcomes—and perhaps decide to call an end to active treatment.

Provision of cancer care services will be expensive, even if paid for in part by local fund raising and charitable sources. I

hope that the big cancer relief charities will put some of their knowledge—and their money—into the movement supporting the growth of these services. If such units are to be successful, however, they will need to be seen and to function as part of the mainstream NHS care of patients with cancer. That will require national guidelines on structure, staffing, and financing as well as on the work that the units do. It will require that the treatments and interventions offered to patients are validated and provided by trained staff. Most important, it will require that the treatment, advice, and support given to patients are monitored and assessed. When treatment is in any way controversial rigorous medical audit is the key to convincing the doubters.

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Chasms in communication

Still occur too often

Each month, in a postbag of some 270 letters and 400 papers, the *BMJ* receives at least one article that provides food for thoughts of an uncomfortable kind. Written by a patient or a relative of a patient, these letters and personal papers have a common thread: how a particular medical problem was mishandled by the profession. The nub of the complaint is usually less about the failure to make the right diagnosis or to prevent avoidable complications than about a perceived failure of the doctors concerned to communicate adequately and show that they cared.

Not surprisingly, these articles tend to relate to sticky clinical problems: the patient with persistent symptoms but in the early stages of disease with repeatedly negative test results, for example. One woman with advanced neurological disease sent a letter last month expressing her "distress and isolation...and the painful, humiliating experience" of having her early neurological symptoms and signs dismissed (as psychogenic). Chronic incurable disease is another problem that seems to trigger letters expressing anger and disillusionment about doctors' interest tailing off once the disease is diagnosed. In a recent personal view a neurologist spoke of incurable disease as "an area between rehabilitation and terminal care which places the highest demands on doctors' skills." He went on to state that "students must not be biased against palliative treatment such as physiotherapy, occupational therapy, counselling, and supportive psychotherapy."¹

Teaching communication

In its recommendations on basic medical education the General Medical Council states that medical students should be taught to "communicate clearly, sensitively, and effectively with patients and their relatives and with fellow professionals."² How individual medical schools choose to do this is up to them, but over the past few years formal teaching of communication skills has assumed increasing importance in the undergraduate curriculum. Some approaches are particularly imaginative; Guy's Hospital employs actors to play the part of patients and their relatives in a week long advanced communication course. Students are recorded on videotape as they take histories, counsel patients, break bad news, and so on, and the video is then used in group

discussions. Teaching along similar lines is also part of general practitioners' vocational training.

Outside the teaching circuits awareness that patients are consumers to whom the health service should be more responsive has spawned much political rhetoric and numerous reports.^{3,4} Equally numerous papers have been published on what patients want from their doctors, especially about the style and length of the general practitioner's consultation.^{5,6}

But brave new communication initiatives and paper stockpiles of theoretical knowledge on how to increase patient satisfaction are hard to translate into the realities of patient care. This is especially so of care in hospital, where enthusiasm for improving communication skills and responding to patient preference seems muted. In a paper delivered at an Office of Health Economics symposium two years ago Professor Sir David Weatherall spoke of the problems posed by the rapid turnover of patients in hospitals in which the corporate spirit was dwindling. He cited a study showing that 30-50% of inpatients experienced a loss of personal identity and suffered as a result of poor communication.⁷ How much worse might a similar assessment be now? And is the standard of pastoral care appreciably better in general practice? Anecdotal reports suggest that the new general practice contract has left doctors with less time than ever to communicate with their patients.

Patients' vulnerability

Irrespective of the problems that now face the NHS and those who work in it, however, there can be little justification for cavalier treatment of patients or their relatives.⁸ Even the briefest spell on the other side of the desk or in a hospital bed gives blinding insight into patients' vulnerability and of their need to be listened to, treated with respect, and given full, unhurried, jargon free explanations.^{9,10} Simple gestures of kindness and encouragement go a long way—as does the occasional admission of fallibility. One of the more poignant personal views we published concluded as follows. "I am disappointed that the consultant did not write back as he promised. He never discussed what went wrong with my mother either. I suppose that he was afraid of litigation. But if he had admitted his mistake we would feel less bitter about the whole agonising episode. I still feel let down. I wish he'd said sorry."¹¹

One final chastening thought: most of the articles and letters that the *BMJ* receives are written by doctors or relatives of doctors. How much worse do we sometimes handle those who are less well informed and articulate?

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Archives of contemporary medicine and science

Are important if we want historians to assess our times

No period of human history has seen so many advances in science and technology that have revolutionised medicine as the twentieth century. In the words of Sir Henry Dale in 1950, "Our successors . . . are likely to recognise the first half of the twentieth century as the period in which civilisation first began to feel, for good or ill, the full impact of progress in the natural sciences."¹ Since then the pace of scientific advance has quickened further, the new sciences of molecular and cell biology affecting both the principles and practice of medicine, to say nothing, for example, of the immunological revolution. It will be for historians to assess and analyse the ways in which medicine and its allied sciences have developed during this century, yet they can do so only if they have access to the source material. Are we paying enough attention to archives, or is our society discarding its history?

Until recently there has been little professional interest in the history of recent medical science. The Wellcome Trust, however, has now launched a new initiative to promote the historical study of twentieth century medical sciences. For historians, professional or amateur, the most important sources are contemporary records. These may include published work and the records of public bodies such as the Medical Research Council. But they also include the valuable information contained in correspondence, diaries, and—particularly—the original laboratory notebooks of individual scientists. Oral history and the recollections of individuals, as well as film, audio, and even machine readable material, all provide important subsidiary evidence. If the remarkable history of twentieth century medical science is to be pursued effectively, such archives and records must be professionally preserved.

Some of these archives are and will continue to be housed in well known repositories such as the Public Record Office. But few working papers of scientists seem to have survived. Scientists themselves, or more often their executors, commonly fail to appreciate the historical value of apparently routine or mundane material. Records emanating from government funded and research institutions are not always deemed to be public records, and even when scientific information is preserved it may be buried in administrative archives. Some academic bodies do, however, hold records of importance. For example, Sheffield University holds the papers of Sir Hans Krebs, and University College those of J Z Young, Karl Pearson, and Lionel Penrose. The personal papers of Sir Henry Dale and Lord Florey are housed at the Royal Society, and royal colleges and other institutions may preserve similar collections, including biographical information relating to their members or fellows, as well as their own archives. This apparently random disposition is often

explained by the different acquisition policies of the various repositories.

Introducing order

An attempt to introduce some order and positive action to preserve papers of twentieth century scientists was the creation in 1973 of a Contemporary Scientific Archives Centre, set up in Oxford with the help of a grant from the Royal Society. Renamed the National Cataloguing Unit for Archives of Contemporary Scientists it is now based at the University of Bath. It does not retain archives but locates and catalogues papers of distinguished contemporary British scientists and engineers and advises on the placement of their collections in appropriate repositories.

The Wellcome Trust established the Contemporary Medical Archives Centre in 1979 as a component of the Wellcome Institute for the History of Medicine. The centre's collections include archives of organisations such as the Lister Institute and the Strangeways Laboratories, records of professional associations—for example, the British Pharmacological Society—and the personal papers of many medical scientists.

For the future, we hope that those in possession of papers will dispose of them to an established repository, where the material will be correctly stored, listed, and made available. It is not enough simply to hand over scientific collections to other individuals or small organisations. This may lead to confusion and will not always ensure adequate housing, access for historians, and, ultimately, the long term preservation of the material. While the records, archives, and personal papers of twentieth century literary and political figures are treasured, those of scientists, medical or otherwise, are undervalued and often neglected. If the history of twentieth century medical science is to be studied effectively its source materials must be preserved.

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