Doctors on the Box

SIR,—The more I see of doctors on television the greater is my conviction that it might be better for their patients, for the practice of medicine, and for the profession’s image if they stayed away from it. If they don’t I am very much afraid that the views of the prejudiced, the oddball, and the plain ignorant—and medicine has no more than its share of these—are likely to have the greatest impact on the public, because, being attractively unorthodox and vociferous when they achieve publicity, these will always be better entertained than those, for example, who in the television programme on 2 February Professor Barnard Faces His Critics spoke sober common sense, though too often alas with articulate monotony. I am therefore firmly on the side of Mr. W. J. Dempster, who is reported to have refused an invitation to appear on the programme. He, to his credit, prefers to discuss complexities of graft rejection with Professor C. N. Barnard in medical circles rather than in front of millions.

Personally, I found the programme great entertainment, but that is all it was. There was the splendid spectacle of the two South African doctors making rings round their detractors, and the sense that they were winning over a good many doubters with their eloquence. There was the painful sight of some doctors behaving in a way that critics of the medical profession might expect them to behave. There were platitudes to groan at, and a little, and the excitement of wondering whether dear old so-and-so, whom one had spotted in the crowd, was going to have the guts to say something and, if so, whether he would score a hit or a miss.

Altogether, great stuff. Surely television is primarily entertainment, but what was the intention here? I am sure that it can also be of great educational value—but largely incidentally—and for the enlightenment of the general public on medical matters I believe that a good method has yet to be devised. The straight talks on the radio without visual distraction have always seemed better. The programme there were two particular occasions when I felt that opportunities to inform the public were being lost.

Firstly, someone should have immediately disillusioned the unusually naive journalist who later said that Professor Barnard had been able to predict long ago one of his patients would have lived without the operation. Though not a very good example, perhaps, here was the second of the public’s two extreme errors about doctors: that they are all fools or that they are god-like or both. I am least endowed with the gift of prophecy. Secondly, there was the wheeling in of the poor, anonymous patient in his chair. Did anyone really believe that the press couldn’t find out who he was if they wanted to? Someone should have pointed out that though a pathetic invalid he was at least still alive six years after the onset of his illness, and that it was extremely unlikely that he would have been if he had at that time had a cardiac transplant performed, even in the light of knowledge that has been acquired since then. The programme did not need such an undiluted appeal to the emotions.

With the arrival on the scene of this sort of circus, have not the time come when the General Medical Council ought clearly and unequivocally to state its views on this aspect of advertising? Does it approve of a situation where some doctors allow themselves to be named while others still feel constrained, presumably by the Council’s rules, to observe anonymity? Is it more ethical for a full-time clinician to be identified by the general public when this might attract funds to his department than for a man who is in private practice for his own personal gain? Some sincerely desire a more permissive attitude so that money might be more easily attracted to medical research, as it is in some other countries. But advertising and competition for money in medicine are, it seems to me, apt to lead to the same abuses whatever their motivation—incomplete objectivity, premature conclusions, over-publication, petty one-upmanship at meetings, and ultimately frank ballyhoo. All these and others are harmful to the proper performance of good medicine and medical research.—I am, etc.,

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SIR,—I was one of the doctors in the T.V. show “Professor Barnard Faces His Critics” on B.B.C. 1 on 2 February. Like many others I made no vocal contribution, not because I disagreed with the title of the programme but because the general trend of the discussion allowed little opportunity to introduce the important question of resources and priorities. Professor W. J. H. Butterfield touched on this topic in his opening remarks but they were not retelevised.

As a preliminary I must state that I am impressed by the technical achievements of Professor C. N. Barnard and his team, and also as a pathologist I look forward to the information which is expected on the laboratory aspects. However, I believe that our profession as a whole is failing in directing the attention of the general public to what is best in medicine, for we ought to know that the lay public is not particularly discriminative. One remembers only too well that until a few years ago little money was available for study of cardiovascular disease, yet it headed the causes-of-death list in Western society, especially in the U.S.A. However, the heart attack of the President and the emotional upsurge that followed produced that cornucopia in dollars which challenged even those stars in the public esteem polio and leukaemia.

The gap between the frontiers of medicine and the day-to-day medicine of general clinical practice is daily wideness, and Friday evening’s programme tended to accentuate this gap—especially when staged with the dramatic personal appearance of former patient and patient-to-be. But what were we talking about technically? In fact we were discussing a feat of surgical plumbing which has already been carried out in many animal houses all over the world. Indeed, looked at another way, a hospital environment is unnecessary, for the operations could just as efficiently be performed in a veterinary hospital by a team of vets, supported by a non-medical team of biologists, biochemists, and immunologists.

This technical perfection in a narrow field involving relatively few patients has little to do with the fight against disease in general. On the continent of Africa in which Professor Barnard lives there is more a need to cure more than 20,000 patients, and millions are deprived of even elementary medical care. Considering the expense of heart surgery and the relatively few hundreds who may be tempted to be alleviated of their condition it is surely it is hard to justify the concentration of expertise, money, and medical manpower on such exercises. It would have been salutary and much more worth if while the consciousness of television viewers had been quickened by a programme devoted to the prevention of disease for millions of Africans—a goal which is within our grasp, given the means—but this would not be entertainment.

Our profession must pursue excellence in an academic sense but in the quietude of anonymity far removed from television. But we must have also a sense of proportion so as to concentrate most of our efforts on the training for, and the practice of, medicine in its general or pastoral sense. If this is not appreciated then medicine will be allowed to get on with training its own particular breed of medical scientists and some other authority will step in to train ordinary doctors to look after the welfare of the people, ordinary, if common, diseases.—I am, etc.

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Nursing Services in General Practice

SIR,—The article by Dr. J. Weston-Smith and Mrs. E. M. Mottram (16 December, p. 672) on the use of a nurse practitioner for visiting, and the subsequent correspondence (30 December, p. 803, and 20 January, p. 186), raise some important issues.

If a nurse is asked to diagnose and initiate treatment then she is doing the work of a doctor and should be called a nurse. If she is necessary in a practice for this work, untrained in diagnosis as she is, the demands made by the patients of that practice or the morbidity must be excessive. In that case the evidence of demand for and the proportion of misdiagnosis. The skill of the general practitioner is above all else in distinguishing and diagnosing through history and physical signs the important from the unimportant symptoms. A nurse cannot do this. But a nurse in the practice can do all the routine work which enables a doctor to use his skill to a wider extent in diagnosis, treatment, prognosis, and support. This has little to do with the traditional district nursing service in any case, the latter is for sickness. Nor is it covered by the health visitor.

The practice nurse should have good technical as well as nursing experience. In our practice she runs the inoculation programme, takes the swabs, urines, bloods, etc., both at home and in the surgery, gives them the “written up” and deals with—does E.R.S., takes and mounts the E.C.G. tracings, records the peak flow measurements, sets up pelvic traction for those with prolapsed intravertebral discs at home, visits the elderly and chronic sick (alternating with the doctor), and occasionally follows up from first visits taking blood and other tests as needed. She sometimes transports the ill to the surgery for consultation. She helps arrange admissions to hospital and