years, increasing intensity of treatment and more accurate diagnosis have meant that clinical judgment remains just as important, but the emphasis has changed towards the understanding and exploitation of new diagnostic and therapeutic methods. Advances in understanding the process of cancer development have been astonishing, and have come from the technical virtuosity of modern molecular biology. The conceptual framework has been transformed and with it the possibilities of new treatments that are now emerging.

The constant development of new approaches is engrossing. In cancer medicine how far should new pathological classification and precision change practice? Who will benefit from new treatments and who might be harmed by them? How will an early diagnosis through screening change the advice you give to the patient in front of you? The rapid increase in knowledge necessitates continued learning through specialist publications, meetings, and congresses. Like everyone else, I had to abandon the breadth of the generalist to become specialised in a much narrower area of medicine. I regretted this, and I still do. You become technically expert in the area you know about, but you risk losing the balance and judgment that a wider interest brings.

This leads me to the last main source of inspiration and that is medical science. My academic work has had two components. The first has been therapeutic research, especially in lung cancer and sarcoma, largely based on large scale randomised therapeutic trials. The trials have brought together investigators in different countries, statisticians, clinicians, nursing specialists, and pharmacists. They have raised issues in medical ethics, data interpretation, and monitoring and have greatly improved the standard of what can be considered to be reliable evidence. The results of some of these trials have changed clinical practice and improved management. The second component has been laboratory work. Here I have had the benefit of working with exceptionally able scientists. As an academic clinician I don't expect to be working at the bench for many years or much of the time. Of course, you need to understand the techniques and their limitations. The partnership comes in the direction and focus of the work and its relevance to cancer. Knowledgeable clinical scientists have much to contribute in this respect. Conversely, knowledge of the limitations of the laboratory science prevents naive or over-optimistic interpretation of new findings in clinical research—a recurring problem in cancer management. It's a great career. Given the chance I'd start all over again.

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Living conditions

David Loxterkamp

Do you see him sitting there? He broods over us from the examination table, his body language singing its silent demands. Eyes riveted down, I fumble through a formidable chart. My eye catches a spinal scan mangled by surgical artifact, an allergy list to every drug except schedule II analgesics, and half hearted reports from half hearted visits to a dozen different specialists. Must we bother with the examination? Both of us know the nature of the contest. Would I mind refilling a prescription that my partner already conceded? Could I complete disability papers that will provide support for his wretched living conditions? He winces. I posture. We are doomed.

Yet in the vagaries of our impasse lie what lured me to medicine. Let the patients with sore throats and urinary tract infections and those with metabolic syndrome taking 15 prescription drugs and on standing orders have their measurable outcomes, their chronic care plans. I stalk a more elusive prey—crumbs of happiness displayed for me, a view from the verge of change. Tell me of these, brother. You can trust me with their insignificance.

Lay of the land

I live in a small town on the coast of Maine. It takes no more than 35 minutes to jog the periphery of my community, two minutes to bicycle from hospital to home, 30 seconds to round the well trod hallways of my office. None of us here is going any place, anyway. Here I have settled in, made a home, learnt to limit the burdens that agitate my sleep, and attend to what matters for those who matter to me.

In 22 years of patient care I have made my own bed. I have established or accepted the conditions for my success. They are not what I grouse about at medical staff meetings or boast about among friends. No, clinical guidelines and insurance forms are merely the crust over meatier matters. Patients are people, which is something more than a meal ticket or an obstacle to "having a good day." They are neighbours, team mates, and fellow parishioners. Their misfortunes ripple through the organism of our community. Through a hundred handshakes and self limited illnesses they have earned the audacity to say, "You are more than my doctor; you are my friend." It is their call.

The conditions that shape my professional life are geographical, where every street corner and public market holds a flash card for a moment of mistaken judgment, clinical oversight, or verbal blunder. As with most doctors in primary care, my need for approval and gratitude has impaired my ability to say no or to concede the battle lost to disease. Conditions are also economic, forcing me to see more patients on a given day than I can do justice. It is the pace I negotiated for the salary I feel I deserve. I am conditioned by human nature, which makes it easier to report a positive biopsy

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What is the medical equivalent of shunning sled dogs and native guides?

result or to confront a patient's abusive behaviour than to thank my assistant or remind my wife how much I love her. And there is the rule of silence that veils my mistakes for fear that they will lead to a lawsuit, or loss of patient confidence, or breach of confidentiality.

Lessons

As you can see, I have survived. This is not true of my patients, the ancient and unfortunate and quickly forgotten. Or my father, a general practitioner whose heart attack snuffed a promising career. Or the certainty of my convictions, the invincibility of faith, the spotlessness of a reputation. I have survived by adapting to conditions and learning from the mistakes of others, which by abstraction and distance seem more manageable than my own.

Early on I was given John Berger's and Jean Mohr's book entitled *A Fortunate Man*. It is a classic depiction of general practice and the doctor who mastered it. The doctor, John Sassall, laboured a generation ago in the countryside of western England where he tended to every aspect of his patients' lives. They depended utterly on his skill, observations, and insights, in part owing to their backwardness and in part because of his unusual talent and devotion. We are told that the dependence was reciprocal: during bouts of depression, he relied on the minimal needs and tolerance of his patients.

The irony of Berger's tale is that Sassall later committed suicide. It may be that depression overwhelmed him. But his relative isolation, arrogance, and failure to seek or accept collegial support weighed heavily. The conditions that seemed so suitable to his early labours would later cost him his life.

The author Annie Dillard offers us a cautionary tale about the failure to adapt to harsh conditions. In *Teaching a Stone to Talk* she describes Robert Scott's fated 1910 expedition to the Antarctic. Scott perished in a blizzard after becoming the second person to reach the South Pole, just a month behind his rival, Roald Amundson. But the tragedy lay in the explorer's unsuited sentimentalism.

Instead of storing supplemental coal, his ships carried a library of 1200 volumes, hand organs, cut glass wine goblets, and sterling silver flatware. Scott never brought himself to use dogs, let alone feed them to each other or eat them. (He struggled with English ponies, for which he carried hay.) Notes Dillard, "He felt that eating dogs was inhumane; he also felt that when men reach a Pole unaided, their journey was a fine conception and the conquest is more nobly and splendidly won. It is this loftiness of sentiment, this purity, this dignity and self-control, which makes Scott's farewell letters—found under his body—such moving documents. Less moving are documents from successful polar expeditions. Their leaders relied on native technology, which, as every book about the Inuits puts it, was adapted to harsh conditions … There is no such thing as a solitary polar explorer, fine as the conception is."

What is the medical equivalent of shunning sled dogs and native guides? What sterling flatware, what fine traditions must we unload before it is too late? Solo practice is one, especially the kind carried out in large groups, where doctors perform in parallel play, in thoughtless and busied shift work without ever so much as rippling the surface of the collegial unconscious. For another: the glib use of the term "complications" to cover human error. "System failures" happen to particular doctors and patients, and their emotional liability, when ignored, often spawns needless lawsuits, paralysing doubt, and self reproach.

"Continuity of care" once trumped the desire for a private life. Doctors were meant to mind their patients not their families. To cope with the excessive demands of the profession we accepted monetary bribes and misused chemicals. Had we been more comfortable at home we might have noticed that the world of medicine was no less chaotic and messy. But we pressed on for greater control, analysis, and order, and so lost track of what patients, through their illness, were trying to tell us.

When asked how to humanise medicine, William Carlos Williams, the great American physician-poet, replied, "I can only come up with my shame, as I remember it, and its sources; and I can only say: let's have some heart-to-heart stories to tell each other." In recent years there has been a resurgence in the sharing of medical stories, such as I offer to you now. Doctors' diaries and personal narratives flood the bookshops; narrative medicine has become a legitimate field of study among academic clinicians and humanists. We talk, we write, and we listen to better situate and see ourselves in the examination room, in sympathy with what Anaïs Nin, the French born American author, once said: "We don't see things as they are. We see things as we are." By carefully listening to patients' stories and placing them in context, we find common ground, affection, and a source of forgiveness. "I postpone death," Nin also observed, "by living, by suffering, by error, by risking, by losing."

Limits

I, too, toss in the intensive care unit on cool mitred sheets, pondering our fate. My patient, who paid for the bed, presented the night before with chest pressure, soaking sweats, and a piercing pain through his jaw. "No, I cannot stay, not without insurance, not under the circumstances," he insisted. "The benefit performance, the one I have been planning for weeks, is three days off and there's too much to do."

Thus he pleaded his case to the empty emergency room in its waking hours. That he still smoked cigarettes drew no pity. That his eldest daughter was now in college, as was mine, that he preferred to douse his occupational stress with a pint of beer, like me, that we both recently turned 53 gave me sudden pause.

"Can I leave?" he pleaded, having already thought better of the request.

"You are free to go. A hospital is no prison," I replied. "But my advice is to put first things first."

And so he stayed, and we listed his condition as "serious." Today it was downgraded to "guarded," and we shipped him for a cardiac catheterisation, during which a dislodged plaque triggered the fatal complication.

Time is not unlimited. Will we take stock of conditions and adapt? This is what nature and our patients keep asking us. Adaptation is one of life's insistent demands, one that could yet save us from the lofty sentiments and fatal flaws of our expeditionary careers.

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The challenging isle: a walk through Soho

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To learn about the history of health care in England, there is no better place than London. It was in London that most of the key developments in health care took place and it was there that the key battles over healthcare policies were fought, where conflicts were resolved, and where many innovations occurred. Some of the important buildings in the history of health care have been destroyed, but many still remain.

Walking London's Medical History aims to inspire and educate through a series of seven walks in central London.[1] These walks help to tell the story of how health services developed from medieval times to the present day. The walks also help to preserve our legacy by informing us of the original function of healthcare buildings as increasingly they are being converted into hotels, offices, residences, and shops. Finally, the walks help to increase our understanding of the challenges to improving health care in the 21st century. To give you a flavour of the walks, let us consider the one through Soho.

At the heart of London lies an island, a foreign land in a sea of Englishness. Since its development in the 17th century, Soho has always been different from the districts surrounding it. The region has challenged and threatened the rest of London while at the same time enticed and nourished it. The reasons are bound up with its origins.

Soho, a brief history

Until the 1660s the Soho area was hunting country. Development close to London was forbidden for fear of contagious diseases spreading to within the city walls. When the great fire of 1666 left around 100 000 people homeless, however, this restriction had to be abandoned as refugees flocked west in search of new beginnings. Although Soho was born out of an urgent necessity, it rapidly became fashionable.

Development started in the south in the 1670s with Old Compton Street and Golden Square, spreading north by way of Dean Street and Wardour Street to Soho Square in the 1680s. Property was bought by wealthy city merchants wanting to be closer to the royal palaces of Whitehall, Westminster, and St James. By 1700 up to 80 titled citizens, 27 members of parliament, and many foreign ambassadors and envoys resided in Soho.

Meanwhile the first of a succession of refugees arrived seeking sanctuary, tolerance, and opportunities. After revocation of the Edict of Nantes in 1685 about 15 000 Huguenots fled to avoid religious persecution. By 1711 almost half of the parish of Soho was French. The air of freedom and non-Englishness created by the politicised Huguenots encouraged people from other countries to settle in Soho.

By the mid-1700s the nobility and gentry started to shift further west to Mayfair and beyond. In the 1760s they were partly replaced by Greeks escaping persecution from Turkish occupiers and in the 1790s by more French, this time fleeing from their own revolution. Little wonder the area was still referred to as petty France in the 1840s. Still more foreigners arrived: political refugees from Germany and from Italy after failed revolutions and Russian and Polish Jews escaping the pogroms. By 1900 Soho must have been one of the most cosmopolitan urban areas in the world, for in addition there were people from Switzerland, Belgium, Sweden, Austria, Holland, Spain, Hungary, Denmark, and the Americas. From the 1920s onwards they were joined by Chinese migrants.

New arrivals may have had little wealth but they contributed their food, art, and energy thus creating the vibrant and convivial atmosphere of Soho. This in turn attracted the unorthodox—artists, revolutionaries, writers, and musicians—Marx, Casanova, Canaletto, Marat, Hogarth, Blake, De Quincey, Dryden, Garibaldi, and Mozart, to name but a few. With the artistic and intellectual freedom these people brought came sexual liberalism. Alongside Soho's reputation for international food and dining came the more notorious reputation from 1800 for night clubs, erotic shows, and prostitution, fuelled by a ready supply of impoverished residents desperate for work.

Although the men of the governing classes in their West End homes were happy to enjoy what was on offer in the brothels and molly houses of Soho, they wanted the area contained. In 1816-24, in a rare act of the Crown, 700 properties were swept away to create Regent Street, a boundary between the nobility of Mayfair and the people of Soho.

An unintended but lasting benefit of such overt social engineering is that Soho is the best preserved area of London. Its street pattern has hardly altered in 300 years. Buildings of domestic simplicity on a human scale have survived, with few high rise developments. Soho remains an island, a foreign land entered from Oxford Street to the north, Charing Cross Road to the east, Regent Street to the west, and Leicester Square to