European Counterparts

Cancer Institutes in London and Paris

BY A SPECIAL CORRESPONDENT

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"August is far too valuable to use for a holiday" said Professor Tubiana, chairman of the radiotherapy department at the Gustave Roussy Institute. While other Parisians escape to the country to avoid the tourists, he is happy to stay behind to catch up on his own research work after the university term and the end-of-examinations are over; for, in common with clinical professors in Britain, Professor Tubiana finds that shortage of time is a perennial problem.

More than 3,500 patients, many from overseas, come each year for treatment to the clinical, teaching, and research centre situated in a quiet suburb a few miles south of the bustle of Paris itself. Professor Tubiana is responsible for the clinical care of these patients (with his 11 consultant radiation therapist colleagues); he is also in charge of the radiobiology research laboratories, in which work 14 postgraduate full-time research workers, subdivided into small teams each consisting of a senior research worker, junior assistants, and technicians. He serves on three major governmental committees concerned with the general policy of scientific and medical research in France; he is on two university committees and is active in several international organizations; and he tries to find time every week for his own laboratory research.

Working Week

Not surprisingly, Professor Tubiana works a six-day week. He usually arrives at the institute between 9.00 and 9.30 a.m., though on two mornings he gets there at 8.30 a.m. for the staff meeting. This is the occasion when the consultants discuss the management of difficult patients and review overall policy, such as the strategy of treatment of breast cancer. There are two teaching seminars each week, between noon and 2 p.m., on clinical radiobiology and one on nuclear medicine. These are attended by about 20 postgraduate students from the institute; and Professor Tubiana says he tries to give the seminars priority over his other commitments. His major contract with patients is in the three clinics he conducts each week. At each of these he sees up to 20-25 patients, though usually fewer, of all whom present fresh complaints, but all of whom have already been "worked up" by junior staff. Each week Professor Tubiana has three afternoons when he is theoretically able to spend time in his laboratory—but in practice he sometimes finds himself at one or other of the many committees that claim his attention. Of the 14 senior scientists at the laboratory, says Professor Tubiana, he is really deeply involved with the content of the work of perhaps four. The earliest he gets home at night is 8 p.m., and only after reaching home does he find time for undisturbed attention to his research papers and committee documents.

Clinical Ignorance

The main themes of Professor Smithers's approach to his clinical work are assessment and consultation. Accurate records and careful follow-up, documentation, and suitable controlled trials are vital if knowledge is to be advanced, he explained. "One of the few things I find unforgivable," he told me, "is a clinician's ignorance of the results he is getting. I know hospitals where the surgeons have different primary surgical treatments for breast cancer; each is sure he is on the right lines but with no idea of the results he himself is getting. How can a doctor assess the relative worth of a treatment if he does not even know what his own results are?"

Sir David's work begins every morning at 9 a.m. in the diagnostic radiology department, where the previous day's films are discussed with his clinical colleagues and the radiologist. Two mornings a week are spent seeing outpatients, many of the new cases being seen in consultation with the medical consultants. He does two major ward rounds each week, one the formal teaching "grand round" and the other dealing with practical aspects of his own patients' care. He also regularly visits the ward alone for talks with patients and relations. He is greatly helped by the medical social worker; together they

Pressures on Professors

"Maurice Tubiana's life seems very like mine," said Sir David Smithers, professor of radiotherapy at the Royal Marsden Hospital. "It is just not possible for one man to do all the things that are expected of a clinical professor today—or at least it is not possible to do them all well." Like Professor Tubiana, Professor Smithers spends a lot of time on committees. Some are concerned with the running and administration of the hospital and research institute; he is chairman of the Medical Research Council's committee on carcinoma bryonic antigen and its clinical trials committee on lymphomas; while he also regularly gives advice to the Department of Health as chairman of its cancer subcommittee and serves on the Central Health Services Council and the standing Medical Advisory Committee. Unfortunately, said Sir David, he finds that the easiest parts of his work to give up are the things he most likes doing. He felt deprived every time he had to spend a day in committee rather than at the hospital.

Why was he prepared to attend these committees? I asked. Was it a matter of sense of duty? There were many reasons, he replied: the most important was his wish to influence the future of his specialty in medicine. "Anyone who cares about the future and wants to see change must be prepared to work for it," he added. There was perhaps some element of personal gratification in being asked to give advice but he hoped this did not have much influence. Primarily his interest in national committee work had come from his conviction that a national policy is needed for the control and management of cancer. He believes that real advances can be achieved through regional oncology centres, each covering three to four million people, described in the recent report of his committee which has been accepted by the Department. Particularly in the fields of prevention and screening, said Sir David, carefully prepared population studies are essential if one is to avoid the confusion that had arisen through inadequate assessment in the application of techniques such as cervical cytology.
have become familiar with the problems faced by the families when a patient is away from home and by the patient when he returns, and they can as a result deal better with such difficult problems as terminal care and bereavement. "It makes no sense for social workers in units such as this to be replaced by distant staff from multiple local social service departments," he said. "Patients come here from all over the country and a hospital social worker's experience in this field cannot be replaced by staff from dozens of local authorities with no special knowledge of the medical problems."

He is much concerned with the treatment and follow-up of patients with testicular tumours, and once a month joins with his urologist colleagues in a follow-up clinic. Thursday is a special teaching day: nuclear medicine is added to the morning, x-ray sessions, and there is a lunch-time treatment-planning meeting with radiographers, and a formal two-hour teaching programme in the afternoon. This combination of a lecture and clinical-pathological conference is often attended by 30 or more doctors—all packed into one small conference room since the hospital still has no lecture theatre. The week also includes another lunch-time teaching session for registrars, a joint follow-up of lymphoma cases, and one of his staff attends the joint meeting of the British and German societies for acute leukaemia being treated in the reverse barrier unit. Wednesday is theoretically kept free for attention to the organization of the department, academic work, and research. Often instead it is taken up with committee work. "I now try to keep Saturday for myself and my family," said Sir David, "but much of Sunday has to be spent in dealing with paper work."

Pull of America

Professor Tubiana finds that his young research workers all want to spend some time in America. Partly, he says, this is a consequence of the pre-eminence and prestige of American biological science; but another important reason is that traveling fellowships are most easily obtained by young men and they find that sponsorship is essential to finance the high travelling and other expenses of a year in America. "Recently I told one of the doctors in my laboratory that he should go either to Israel or to San Francisco to continue his studies," said Sir David, "and he replied, "He would use his fellowship to go to San Francisco since he could go to Israel any time later, on his own." This attitude explains why Britain, Scandinavia, and the rest of Europe seem to be ignored by the younger researchers.

The present generation in France reads widely in other languages, especially English, he found. Perhaps four-fifths of scientific journals read are English language; half of these are American and half European, and half the European journals are from the United Kingdom.

Many of the postgraduates at the Gustave Roussy Institute come from overseas. Some are from French Africa and French Canada, but many more come from the Middle East—Egypt, Tunisia, and the Lebanon. There are also quite a number of students from Central and South America—"Some Spanish students do not study in Spain, they learn English," explained Professor Tubiana. Until two years or so ago, he added, there was little difficulty for doctors in getting postgraduate training in France. This situation is changing, however: for one indirect consequence of the postwar growth in population had been an enormous increase in the intake of medical students in the "sixties into French universities. Until 1968 the output of medical graduates had been less than 3,000 a year (roughly comparable to the United Kingdom). This had increased to 5,000 within the last few years and by 1976 the annual output was expected to rise to 6,500. "France has been under-doctored for too long" observed Professor Tubiana. He agreed, however, that academic careers would necessarily become more competitive in the future. Already things were less easy than before for young doctors with academic ambitions. From 1945 to 1958 there had been little difficulty, and he himself had graduated as a Ph.D. in physics in 1946 and as M.D. in 1950, yet he had been appointed a consultant in 1956 and a full professor in 1962. Nowadays, however, from M.D. to consultant took on average 10 years and the time to a full professorship was anything from 20 to 30 years. Nevertheless, the position was still satisfactory in that all new graduates could get postgraduate training and positions easily enough—in contrast to the situation in Germany, where many had been unemployed for months at a time.

Staff Shortages

Postgraduate students come to the Marsden, too, from all over the world, said Sir David, but the greatest numbers are from the U.S.A.—there are seldom fewer than two American postgraduates in the Surrey branch of the hospital. Students also come from the Commonwealth, the Middle East, and the Indian subcontinent, though less than formerly. There seems no difficulty in attracting good medical staff to the hospital; but there is a serious shortage of nurses, radiographers, and technicians. Some of the nurses come from agencies, because it is difficult to attract girls to a hospital set in the quiet of Surrey despite an excellent social club—"even the Londoners who love "swinging Chelsea" is, for this purpose, in a better situation.

Radiographers are also seriously below strength. The hospital itself trains girls, but in some years there have not been enough suitable applicants to replace the natural loss from marriage and changing jobs. Radiography has to compete with other attractive careers for young women, explained Sir David: there is less of the old fear of the effects of radiation but the rates of pay are still too low. His department has no reserve capacity to cope with holidays, let alone illness, and staff often have to work extra hours; despite the enormous capital investment in high-grade equipment, the whole set-up could easily grind to a halt if nothing is done to remedy the shortages of radiographers and technicians, whose training takes only two or three years.

This most striking contrast between the two institutions is in this provision of non-medical staff. In contrast to the chronic problems at the Marsden, Professor Tubiana told me there is no serious shortage of nurses, radiographers, or of staff such as porters—probably because so many come from Spain, North Africa, Portugal, and Yugoslavia. Just as interesting, however, in the context of the financial problems of the N.H.S., is Professor Tubiana's assertion that the institute can probably run virtually all the money needs for new treatment equipment or for running costs. The explanation is, he said, simple: "In France cancer is a magic word." Another factor is the high status of the institute. Of the patients treated there perhaps 10% come from overseas—but then any foreigner coming to France for radiotherapy would be virtually certain to go either to the Gustave Roussy Institute or the Curie Foundation.

Almonds, all the French patients receive their treatment free of charge since they are covered by the social security scheme. The 5% of patients not belonging to the social security scheme pay fees at the rate of almost £30 per day. Some of the staff at the institute see private patients but Professor Tubiana himself has no private practice.

Sir David too, sees no private patients and indeed holds strong personal views on the purpose of a postgraduate institution such as the Marsden. "Investigation and treatment here is very expensive," he explained, "and this can be justified only if patients are receiving the very best clinical management combined with the best possible humanitarian attention to their personal and social problems. At the same time the hospital must be advancing knowledge in the specialty of oncology if it is to justify its existence. To me these aims
are no longer compatible with the tradition of staffing with part-time consultants much concerned with private practice as well as with their N.H.S. commitments. The pattern of care in units such as this should be one of consultation in special units so that there can be a combined medical, surgical, and radiotherapeutic approach to the patients, with time allowed for research and assessment." His attitude to private practice in special units is perhaps debatable; but he holds to his belief that the management of cancer could be improved within the N.H.S. and that the special centres should lead the way. At present, he said, some patients' treatment is not ideal—largely because those treating them are unaware of the better methods of management already developed elsewhere.

Rare conditions, such as acute leukaemia, choriocarcinoma, and childhood cancer, should be collected on a national basis and treated in a few specialist centres. Others such as testicular tumours and lymphomas should be organized on a regional level. Common cancers clearly should be treated at district hospital level, but there the regional oncology centres had an important role in encouraging accurate recording of data, seeing that each hospital knew what was going on in the rest of the region, and in careful comparison of treatment methods. "The results obtained should be known to all doctors in the region," he added, "then general practitioners would know where to refer their patients and hospital doctors would know about the special units and what they were achieving."

Any Questions?

We publish below a selection of questions and answers of general interest

Postmortem Blood Alcohol Levels

Is there any appreciable difference between the concentration of blood alcohol obtained post mortem and of blood taken at the scene of the accident? Post mortem, can alcohol produced by fermentation be distinguished from alcohol which has been consumed?

In the comparatively few cases for which both samples have been available, there has been no significant difference—assuming that death followed immediately as a consequence of an accident.

Ethanol produced by fermentation cannot be distinguished in necropsy specimens from ethanol consumed before death. If a gas chromatographic method of analysis is used, however, additional peaks will be noted on the chromatogram which represent other fermentation products. Also, there is often a build-up of gas pressure in the container, which the analyst should take note of together with the "bubbly" appearance of a fermenting specimen.

Cholesterol Levels in Multiple Sclerosis

Is the blood cholesterol raised in multiple sclerosis, and has any trial been done using clofibrate for this condition?

A careful study of the levels of total cholesterol esters and of cholesterol linolate has been made in a series of 35 multiple sclerosis patients and 23 normal subjects. When the patients with multiple sclerosis were graded according to activity of the disease, it was found that the level of cholesterol linolate was reduced in patients showing evidence of recent deterioration, the mean level in the eight patients showing the greatest deterioration being 152 μmol/ml compared with a mean of 217 μmol/ml in the control group. The level of total cholesterol esters also showed a significant though less striking fall in the group showing the greatest deterioration. However, as a preliminary to studying the effect of clofibrate on platelet adhesiveness in patients with multiple sclerosis, Millac et al. reported that "the mean pre-treatment serum cholesterol value" was within the normal range. Attempts to link multiple sclerosis with heavy fat consumption are unconvincing. Reports that platelet stickiness was increased in multiple sclerosis and that this might be of significance in the pathogenesis of the disease prompted a double-blind trial of the effect of clofibrate on platelet stickiness and another on the clinical effects of clofibrate on the course of the disease. The drug was found to reduce plasma cholesterol and total esterified fatty acids within three months of commencement and to maintain the reduction for the fifteen months of trial. (A dummy group treated with corn oil showed no changes). Platelet stickiness was not affected by clofibrate during this trial, though the number of circulating platelets was reduced. The double-blind therapeutic trial of clofibrate in multiple sclerosis involved 40 patients for twenty months and showed it to be without significant effect on the clinical course of the disease.


Drug Treatment of Chronic Alcoholism

Are any drugs of value in the treatment of chronic alcoholism?

Drugs have a limited place in the treatment of alcoholism. The danger of substituting dependence on a sedative or tranquilizer for dependence on alcohol should always be borne in mind, as should the risks to the patient's life if he mixes his alcohol with prescribed drugs.

In the chemotherapy of alcohol withdrawal, a conservative approach is usually to be preferred rather than too courageous medication, and many withdrawals will in fact need little or no drug treatment. When, however, drugs are employed in these circumstances the aim is to abort the onset of delirium tremens, for once this is well established drugs are relatively ineffective. Logically, an substance which is to be of use in suppressing withdrawal symptomatology should be one which shows cross-tolerance with alcohol, and though an extra ordinary range of preparations has from time to time been...