Papers and Originals**British Medical Association***ONE HUNDRED AND THIRTY-FIRST ANNUAL MEETING, OXFORD, 1963***President's Address****MANNERS MAKYTH MAN**

A PLEA FOR THE IMPORTANCE OF CHARACTER IN MEDICINE

BY

Sir GEORGE PICKERING, M.A., M.D., D.Sc., F.R.C.P., F.A.C.P., F.R.S.*Regius Professor of Medicine, Oxford University*

It is a rare privilege for a speaker to have an entirely captive audience. Not only would it be impolite of you to leave before I have done, but you might miss the President's reception. Consequently, I feel I have you almost as much in my power as has a Sunday preacher delivering his sermon. Taking my cue from him, I have sought a text. I have chosen "Manners makyth Man," which William of Wykeham adopted for one of his two foundations, that at Winchester. It is not altogether inappropriate, because Wykeham's St. Mary's College in Winchester was destined to revolutionize the education of young boys, while his foundation at Oxford contributed greatly to the pattern of life and teaching in both the ancient Universities. Moreover, many of us were fortunate enough to enjoy music last night in Wykeham's foundation, little changed after nearly six centuries.

Wykeham's Primary Purpose

Wykeham's motto has always delighted me by its simplicity and challenged me by the obscurity of its meaning. To understand it we must consider Wykeham's time, his character, and his purpose.

Wykeham was born in 1324 and died in 1404. In 1367 he became Bishop of Winchester and Lord Chancellor. In 1369 he began to buy land in Oxford for the ultimate housing of New College. In 1373 he started a small school in Winchester to prepare his future foundation. The foundations themselves took place in 1379 in Oxford and 1382 in Winchester.

During his life a series of events profoundly disturbed Wykeham—the fall in standards of scholarship and morals of the clergy, the misery and suffering inflicted by the Hundred Years War, and the tremendous loss of life and wealth inflicted by the Black Death in 1347–8 and its recurrences in 1361 and 1369. Wykeham's primary purpose was to reform the clergy by educating them from boyhood and through manhood. He was shrewd enough to see that the attitude of mind acquired in youth would determine what kind of man the boy would be, a principle used effectively by the Jesuits. He saw that the longer an adolescent was encouraged in certain attitudes of mind and exposed to certain rules of conduct the more firmly drawn would his character be, and the more predictable his behaviour. He also realized that what was wrong with the clergy was not only lack of learning, but loose conduct. Which he thought the more important is impossible to say, but for the motto of his school he did not choose "Learning makyth Man," but "Manners makyth Man."

Wykeham's school at Winchester proved so successful in supplying a need to the society of his time that it was followed by other schools, which developed along similar lines. It proved in fact to be the prototype of an educational system that still remains peculiar to this country—that of the public schools. The public schools are nowadays much criticized, particularly by those of the left. Nevertheless, they are closely linked with another system peculiar to this country—the British commonwealth of nations. It has been said that the battle of Waterloo was won on the playing-fields of Eton. It can equally appropriately be said that the British Empire was won, kept, administered, and finally given back by the products of the public school system. The British Commonwealth is unique in world history. It is unique because of the idea that lay behind it, the idea that colonies should become self-governing and ultimately entirely free, as of right. This was not a product of learning, it was a result of an attitude of mind and of a system of conduct. It was in fact the outcome of the concept "Manners makyth Man."

A Real Danger

This is all very well, but you may justly ask what possible relevance it can have to the British Medical Association Meeting in 1963. I hope to show that the idea embodied in "Manners makyth Man" is almost as important at this juncture in medicine as it was in Wykeham's time in the Church. I take it that I need not detail the ways by which in the alleviation of human suffering the conduct and character of a doctor are at least as important as, perhaps more important than, learning. The ethos of medicine is of no less significance than the science. While the science is progressing rapidly there is a real danger—as perhaps never before—that the ethos of medicine will be lost. If it is lost the most precious part of our professional heritage will be squandered, perhaps irretrievably. It is because I think this danger is not fully appreciated that I venture to bring it to your notice.

Two series of events endanger the ethos of medicine. One series, represented by the vast growth of knowledge and the development of specialism, is happening within the profession; the other, the impact of the welfare state on university education and the organization of medicine, is part of a general change in our society. Let me deal first with the effects of changes within the profession.

In the last quarter of a century the practice of medicine has been utterly changed by the spread of the experimental method of science into clinical medicine and surgery, with

the staggering increase in exact knowledge and the possibility of using it in the interests of the patient. This is altogether desirable, but it has two consequences that are our immediate concern. The first is the amazing development of exact techniques culminating in the use of electronic and other machines. The ultimate goal of such developments is seen as the replacement of the physician by a computer into which information concerning the patient's illness will be fed, and out of which will come the differential diagnoses in order of probability, a programme of tests which should be made to explore these diagnoses further, and the appropriate treatment for each. This is no idle dream, because of course the doctor as a diagnostician is performing very inaccurately and with limited information just what a computer is designed to do. We can imagine a central medical authority ensuring that the latest exact data got by the scientific method would be fed into the machine so that its accuracy should be at a maximum.

A parallel development is the growth of specialism, a process that has advanced much further in the United States than here. If you are a wealthy patient in Los Angeles, for example, you have your own paediatrician, otorhinolaryngologist, cardiologist, gastro-enterologist, and of course psychiatrist. When you are sick you do not call the general practitioner; you call in the appropriate specialist. Perhaps I am an old-fashioned reactionary, but from what I have seen done to patients I doubt if this practice is in their best interests. It may happen that no one is responsible for the patient as a whole. All that the patient may need is a little help in solving some of his or her domestic difficulties or changing some of his or her habits. Yet instead they get stupefied by drugs or afflicted with unnecessary surgery. If the doctor is to be replaced by a machine the ultraspecialists are carefully fashioning that role for themselves.

The Core of Medicine

What is lacking in all this? What does the wise old family doctor give that the machine cannot? It is not professional skill or scientific knowledge; it is human sympathy and understanding that form the very core of medicine. Wilfred Trotter first made me realize the importance of this. When I would ask Trotter to see a particularly difficult patient the difficulties immediately vanished. I watched, I marvelled, and I hope I learned. Trotter always listened to what the patient had to say; he understood what the patient was trying to say; and he made it plain to the patient that he understood. Nine-tenths of the difficult patients that I see are difficult because their doctor has been unable or unwilling to appreciate their fears or peculiar problems, or has been unable to help allay or solve them. Inability to do so is to fail your patient half the times he or she seeks your help. Unless the doctor is utterly devoted to his patients and prepared to take immense trouble to understand their problems he is inferior to a machine. It is only by virtue of that rather intangible and neglected quality, his attitude of mind as expressed by devotion to his patient, the real ethos of medicine, that he becomes superior.

That this quality, professional ethos, has survived is because it had a survival value. In the competitive world of private practice such were the specialists to whom general practitioners sent their patients, such were the general practitioners most highly recommended and therefore with the biggest and most lucrative practices. Deans of medical schools chose such students because ultimately they were

going to bring the best practice to the staff; examiners looked for these qualities and staff members appreciated professional integrity among their colleagues. All this seems to be changing. In the new atmosphere of the welfare state there is no built-in mechanism to ensure that character is emphasized in selection of students or that professional ethos is rewarded in professional achievement. The ethos of medicine is seemingly a functionless vestige like the vermiform appendix or accessory nipples.

The paradox is that, despite the fact that the welfare state seemingly attaches no values to professional ethos, it is utterly dependent on it. In the competitive world that preceded it laziness, selfishness, bad manners, and dishonesty all seemed to carry penalties in the alienation of colleagues and patients. Nowadays they need not ruin a man once he is established. In fact, in the consultant sphere, were it not for merit awards, they would make very little difference to his financial welfare or security. And so, unless men of high character are recruited, and professional devotion is respected and rewarded, the very high standard of professional behaviour may be lost.

The Potential Doctor

So far as student selection is concerned I have had the good fortune to see the change in emphasis from all points of view, having been a schoolmaster, an acting dean, a member of the University Grants Committee, and a parent with an interest in his own children. Because the State now pays the major part of the cost of converting a school-boy into a doctor, those who are responsible for the selection of students are anxious to ensure that academic merit is the only basis on which university entrants are selected, and that there should be no monkey business that smacks, or seems to smack, of nepotism or unfairness. Marks in examinations are naturally free from any such taint; so marks tend to be the chief criterion for selection, and examination success during university career the proof of that selection. While writing this, I met a headmaster of one of our distinguished public schools who has a boy of reasonable intelligence and great integrity and strength of character. He thinks, and I have no doubt rightly, that the boy is the stuff of which the best doctors are made. But he cannot get him into a medical school. Even St. Mary's, which under Lord Moran's unorthodox deanship was on the lookout for character and as a result had the most vigorous lot of students with whom it has been my privilege to work, will not take him. They are afraid that he may fail his examinations. Even they seem to have succumbed to prevailing opinion and practice.

Thirst for Examinations

This is all very tragic. I fear that what we are selecting for our future doctors may be nothing more nor less than "swots." If some of them happen to be boys of spirit and character—well, that's a fortunate accident. Pedantry and the pursuit of mediocrity are in the ascendant, and they will be until some group of university teachers has the insight and the courage to say, "This has gone too far—if we systematically neglect character we shall ruin our society, and particularly medicine."

When we come to medical education the situation is much the same. In the many excellent reports on education that have appeared during the last thirty years—and some of them have actually inspired changes in the curriculum—I can recollect none that deals with the preservation, let alone the enhancement, of the ethos of medicine.

Perhaps this ethos has always been so much beyond reproach that no improvement was needed. But I suspect that it was rather because it was taken for granted and, indeed, overlooked. Twenty years ago I remember several examiners remarking to me, "That man was unkind to his patient. I don't think he's fit to be a doctor. I shall fail him." Recently, I have not heard this. Again, I suspect this is because of the rule of the pedants: "You can't," they will say, "fail a man in his examination because he is unkind to his patients. That isn't what examinations are for. He knows his work." And so once more it is the attitude of the potential doctor to his patient and to his work that goes to the wall. It doesn't matter.

Here let me say that one of the major endemic diseases in our society is that disorder that thirsts for examinations. Examinations are a rash or morbid eruption on the body of democracy. They are thought to be fair. The current thirst is to make them even fairer by making them so objective that they can be marked by a computer—the device known in America as the multiple-choice method. However, what is overlooked is that, like other tricks, this trick can be learned, and a high performance in such tests is not synonymous with profound knowledge. What the enthusiasts for such methods overlook entirely is the educational function of examinations. If it becomes known that a sympathetic, understanding, and kindly attitude is also

valued, and indeed required, then that attitude is the more likely to be forthcoming and indeed become a habit.

Conclusion

I have already outlined why the State monopoly of medical practice provides conditions that are not unfavourable to the "9 to 5" mentality, and the substitution of the form for the substance. If this happens the chief victims will be the public, their patients. But medicine, too, will have lost something, and I for one would not really care to be connected with it any more. The National Health Service has so much good in it that there would be few amongst us who would care to bring back the old days. All the more reason for protecting it from this its greatest danger by trying to ensure that those we take into medicine go into it because they feel some vocational call, and have the right kind of character as well as intellect.

Thus I come back to my text. The welfare state is one of the most substantial attempts to translate an ideal into practice. Naturally, not all of its implications were foreseen. Medicine perhaps presents the outstanding example of how greatly the realization of this modern attempt at Utopia depends on character, on an attitude of mind. I do not think this has yet been realized. And I fear that, unless it is, our attempt at Utopia will destroy itself. Manners maketh Man.

BILIARY AND RENAL COLIC

BY

E. B. FRENCH, M.B., F.R.C.P., F.R.C.P.Ed.

W. A. T. ROBB, M.B., F.R.C.S., F.R.C.S.Ed.

Western General Hospital, Edinburgh

It is popularly believed that all pain described as colic is paroxysmal or gripping in character. Whereas this is often true when pain arises in the small or large intestine (whence the word is derived, "colike . . . ingendreth in a gutte named colon"—Shorter O.E.D.), only rarely is it true of the pain of biliary or renal colic. In these instances, therefore, the term is misleading and may be responsible for a common misconception of the type of pain usually associated with biliary and ureteric calculus.

The belief that the pain of these colics has an intermittent wave-like pattern is evidently fairly widespread, for it has frequently been encountered in discussion with colleagues and during the teaching of students and postgraduates in London, Edinburgh, and Glasgow. Other people take the view that a colic is any pain which makes the patient restless. Though this is commonly true of patients with biliary and renal colic, some prefer to lie still, while a few with pain from acute myocardial infarction may pace about for relief.

It is obvious that familiarity with the usual features of a pain and its commoner variants is of immense diagnostic value. The present inquiry was made to emphasize in particular the time/intensity patterns of biliary and renal colic, but it was finally prompted by the unusual experience of meeting a patient with cholelithiasis in which the pain was truly intermittent. One of us (E. B. F.) studied and analysed the symptoms of 50 consecutive cases with a final diagnosis of gall-stone colic which were admitted to the gastro-intestinal unit at the Western General Hospital, Edinburgh. Similarly W. A. T. R. studied 50 consecutive patients admitted with "renal" colic to the urological unit.

Methods

Choice of Patients.—When a patient was admitted to these units with a provisional diagnosis of biliary or renal colic one of us was notified. Cases had been collected by transfer from other units, from out-patient consultations, or by direct admission from general practitioners.

Clinical History.—History was not obtained on a prescribed form. Particular attention was, however, paid to the analysis of pain in accordance with the scheme described by Ryle (1948). Those patients with biliary colic were also asked directly whether they had observed changes in the colour of the urine or stool, and also whether they had had previous indigestion. In renal colic direct inquiry was made about difficulty or discomfort on urination or about discoloration of the urine.

Validity of History.—In biliary colic this was assessed in three ways. (1) The description of pain was compared with that recorded in the resident's notes. (2) A senior student was asked to question 10 consecutive patients of the series about their symptoms in accordance with the method of analysis of pain described by Ryle (1948). It was explained to the student that the object of this request was to find out whether pain analysis by this method would result in agreement between the two observers. (3) Parous women were asked for an account of pain in labour, as a test of the reliability of their memories. None of these tests were applied to the histories of renal colic.

Biliary Colic

Firstly a case history of a common type of attack is given in order to provide a standard with which the variations may be compared.