BRITISH MEDICAL JOURNAL

LONDON SATURDAY FEBRUARY 11 1961

British Medical Association

ONE HUNDRED AND TWENTY-NINTH ANNUAL MEETING, AUCKLAND, 1961

President's Address

MEDICINE AND HEALTH ON A COMMONWEALTH BASIS

BY

Sir DOUGLAS ROBB, C.M.G., M.D., Ch.M., F.R.C.S., F.R.A.C.S., F.A.C.S.(Hon.)

Surgeon, Greenlane Hospital, Auckland ; Pro-Chancellor, University of Auckland

The British Medical Association, for gathering for its 129th Annual Meeting in Auckland, finds itself further from home than ever before. Nevertheless, we hope it may feel really at home as it meets with the New Zealand Branch—so great are the affinities of origin and outlook between us. It has happily brought home again, as the immediate Past-President, our distinguished fellow-countryman Arthur Porritt, whom we are proud and delighted to welcome, along with other homing New Zealanders and visitors from many parts of the Commonwealth.

I feel it appropriate at the opening of a great medical gathering such as this to reflect for a moment upon the nature of our calling. The essence of it surely is compassion—a matter of the heart, whereby we seek to help the injured, the sick, and the disturbed. However much we may become absorbed in means to serve this end, we do ill to lose sight of it. For all our science, our knowledge, our skill, and the various organizations that we build up in order to apply these things are of a secondary nature. They may be vastly impressive, and may overshadow the more elementary act, but periodic recourse to the original vision, which I think all of us experienced as students, is a good thing and redeems our work from being just another task or occupation.

In his Presidential Address at Torquay in 1960,¹ Sir Arthur referred to the growing implications for the Association of its Commonwealth relations. He was exploring ways in which the service of medicine could gain unity in the great variety of its experience, and in which it could better convey its beneficent message to all the sorts and conditions of men that it has to serve.

Those of us who are living our lives in distant Commonwealth countries, returning at critical periods to the Homeland for refreshment and inspiration, have developed some conception of the possibilities of a fuller interchange—an interchange to be modified, no doubt, as the participants grow and mature, as Canada and Australia have already done. My own outlook was enlarged last year, when I had the honour to travel in Africa as Sir Arthur Sims Commonwealth Professor, and visit the medical schools and hospitals of the Union, the Federation, East Africa, and Ethiopia. The appointment concluded with a round of visits to the surgical

departments of six British medical schools, and seeing the working of the Royal College of Surgeons a little more intimately from the vantage-point of the guests' flat. Such a tremendous experience could, I am quite sure, be paralleled in India, Pakistan, Malaya, and other Asiatic countries and in other countries within the Commonwealth. It showed what a great deal remained to be done, in service, in teaching, and in research.

The Theme

What I would like to do is to put all these things together, and to outline a picture of what medicine and health would look like if we could handle them, not as at present on a series of national bases, but on one single Commonwealth basis. The fact that such a conception must belong to the future need not necessarily deter us. I do ask to see the distant scene, believing that if we have a clear idea of the goal before us we are more likely to take reasonable and useful steps towards it in the meanwhile.

The first thing we see in this Commonwealth picture is medical *service*, our fundamental task, most unevenly distributed. In certain parts it is quite a struggle for a doctor to get medical work to do, and a proportion of what is done is of a trivial nature—unimportant medically. In other parts there are large numbers of human beings with little or no prospect of service, and where buildings and equipment are pathetically inadequate to the demands that are or should be made on them.

In the *training* of workers in medical, nursing, and ancillary services, and at all levels—school, university, undergraduate, and postgraduate—again we recognize the grossest inequalities. Some countries are well provided for—others have a great deal less than the bare necessities. Within the orbit of the more mature countries we see the United Kingdom cutting down the number of students to be accepted annually for medical training under the influence of the Willink report, and at the same time relying on large numbers of graduates from India, New Zealand, and elsewhere, during their postgraduate period, to keep the hospitals going. In New Zealand, on the contrary, one of the chief factors favouring the establishment of a second medical school is the hope that the increased number of graduates that

would result would help to staff the hospitals of the country, impoverished as they are by the very process which assists those in the United Kingdom. Clearly, the more developed countries can assist the less and should be making every effort to do so; but how is this best done? By receiving trainees from abroad, or by taking part in building and staffing schools in the outlying territories? Was New Zealand wise, for example, in contributing £1m. to the All-India Medical Institute in New Delhi under the Colombo Plan, when she finds it difficult to provide training on her own ground for her own students and to fill her own needs? Decisions on the costly business of medical education could be made on a wiser basis were it possible to view the Commonwealth task as a whole.

In research also there are surely many opportunities for mutual advantage within the Commonwealth. It is not only a matter of the distribution of money and talent, and the dire need for relief from some of the plagues, but the great help that can come from the fresh look at an old problem by someone whose past experience may well include analogous situations. What trophies are waiting to be won in Africa—for example, the problems in nutrition, in trauma, the unanswered riddles in cancer, intestinal obstruction, infectious disease, and parasitology. The road to the prevention and cure of cancer of the gullet in London or in Auckland may well run through Uganda or Zululand.

Can we imagine, then, an all-embracing medical plan for service, for teaching, and for research over the wide Commonwealth?

Present Efforts

Many past and current endeavours point the way. The people of Great Britain and the Commonwealth have a great and laudable tradition of interest in under-developed lands and of service to them in medicine and in many other fields. I am full of admiration for those who are carrying on this task in Africa and elsewhere at the present time, whether under government, university, military, commercial, or religious auspices. Conditions of all sorts are often uncongenial, climates hard, and facilities poor, and I would feel that they require, and must usually evoke, in such men and women a missionary-like zeal for service. At least, however, they can feel they are fully extended and that their talents are being used to full advantage—there is little time for the frivolous or the trivial or the meretricious task. Undoubtedly these labours have represented one of the finest contributions towards the conception of the brotherhood of man that the world has seen. What we would like to adumbrate is the modern development of this service—greatly extended, made more consciously effective, and shorn of undesirable elements such as paternalism and patronage. Any assistance given must be the consequence of an expressed desire for it. It must be, as C. P. Snow says, entirely a matter of help on a basis of mutual respect and equality, coupled with a readiness to retire as soon as the need is met and the developing country can manage on its own.

Voluntary associations and mutual assistance plans may be mentioned—Great Ormond Street and Makerere College in Uganda; Bristol and East Africa; and the proposed sponsorship by Birmingham University of the new medical school that is being planned in Salisbury, Southern Rhodesia. The Conference called in November, 1958, by our own Association,⁷ under Sir Arthur Thomson, was admirable in facing the difficulties in the

way of filling medical posts overseas. The *Lancet* has discussed the problem,⁴⁻⁶ and the conception of "proleptic" appointments in the United Kingdom put forward by Professor Charles Wells is a potentially valuable way of ensuring a period of overseas service by a senior registrar before he takes up his full appointment in the United Kingdom.

Professor Julian Taylor's filling of the Chair of Surgery in Khartum after retiring from University College Hospital sets an admirable example that I know is making other senior men think. Orthopaedic training throughout the Commonwealth should be greatly enriched by the plans of H. J. Seddon, arising as they do from the experience gained by him and Professor Moncrieff and others in their visits to Colonial territories, sponsored by the Colonial Office and the Nuffield Foundation. There are many others that I have not mentioned, and more again that I have not heard of. It is in no mood of depreciating these efforts—their motive, their scope, or their methods—that I suggest that something much more comprehensive is needed. Let us build on these and other plans, and in their spirit, but let us glimpse the full picture.

Mechanisms Needed

In order to give effect to this conception, which may well seem at first sight so visionary as to be quite impracticable, it may be useful to think of two stages—the developmental and the more complete.

Developmental Stage

In the developmental phase one could imagine a considerable multiplication of arrangements like the present voluntary ones. One could almost think of an association or a club of which hospitals, universities, or even governments wishing to take part in the scheme could become members. Certain conditions would need to be laid down, such as minimum establishments in, say, an African hospital, so that any person taking up duty there would not only not waste time, but also be so placed as to make his most effective contribution. There would need to be enough space and facilities such as library and photographic services, and enough nursing, secretarial, and follow-up staff, to be fully effective. It is clear, of course, that these conditions—often in the hospitals that most need the help—do not now pertain. In the more developed countries also, proper provision of facilities for the reception and utilization of incoming exchange men is needed—again, that is by no means always present now. For example, in Auckland here we would need to set up university units at least in medicine, surgery, and pathology to add to our existing one in obstetrics and gynaecology, as a guarantee of good conditions for the visitors, should we seek to play our part.

A system of reliable recommendation by responsible heads in government or institutions would be required, based as much as may be on a knowledge of the person to be sent and an awareness of the conditions he would be likely to meet on arrival. Living accommodation at each end should be available so that no delays and frustrations should diminish the great advantages of air travel. It would amount to the provision at both ends of funds and equipment over and above the bare needs (and heaven knows these are bare enough in many countries to-day) to allow a percentage of staff and trainees to be exchanging abroad. Additional needs would be a central secretariat which, in time, would

become a big affair, and a certain capital sum for management and for backing at least the initial stages. London would be the obvious place for the setting up of such a secretariat. I would think the B.M.A. headquarters would be a good place, building on existing experience and contacts. No doubt the time might come when that would not be large enough. Outlines for a Commonwealth Medical Association have been adopted recently by the Council of the B.M.A. and were discussed by the Commonwealth Conference here last week. Perhaps these could be developed to meet the need.

That the British Government and others are alive to the needs is shown by the White Paper of October, 1960, "Service with Overseas Governments," and their generous provision of some £12-£16m. a year to give effect to them. The idea is to make it as easy for a Colonial or comparable territory to employ an overseas officer as to pay one of their own number. The money would go towards inducement to go overseas, to children's and education allowances, to pensions, leave passages, and compensation in case of premature retirement. They had already set up in 1957 an Overseas Services Resettlement Bureau, which has done good work in an admittedly difficult if not gloomy situation. The *Lancet* points out editorially, however,³ that the future may be brighter than the immediate past, and calls on all concerned to understand the problems and assist where possible.

In similar vein Professor Kenneth Hill⁴ writes that the chief need in the U.K. is a change of attitude by the hospital and university authorities towards overseas service. Such service is evidence of enterprise, achievement, and power of adaptation, and it should make a man more, not less, worthy of subsequent appointment to a post in U.K. He praises the 1959 Commonwealth Education Conference and the steps taken by it to achieve similar objects in the field of education. On these lines he advocates a Commonwealth Medical Council for the supply of officers overseas and details a code of secondment to be followed by employing bodies in the U.K., and a code of terms of service to be adhered to by the overseas authority.

Similarly in medical research there have been wise provisions made² for correlation of activity and continuity of effort between Colonies and the newly independent countries, which forfeit automatically their eligibility to receive funds from the British Government. The recently appointed Tropical Medicine Board under the M.R.C. is to advise the Secretary of State for the Colonies on all medical research in the Colonies financed from the Colonial Development and Welfare Funds, the M.R.C. on all medical research in or for the independent Commonwealth countries financed from U.K., and the M.R.C. on all medical research in or for tropical and subtropical countries financed from its own budget. In this way both the work and the careers of the workers should be better safeguarded, and inducements provided to embark on such a career. Can we discern here the germ of a more effective plan for medical research throughout the Commonwealth? Adherence to such a plan presupposes great insight into the delicate and easily blighted activities under consideration, but we may hope that this is developing.

The More Complete Stage

In a more mature phase the undertaking might reach large dimensions with permanent headquarters and an extensive staff whose business it would be to gain and

maintain detailed knowledge of conditions in all places working under the scheme. One would hope ultimately for uniform standards of education for medical, nursing, and ancillary trainees. Here is a tremendous field for co-operation between the General Medical Council and its corresponding bodies overseas, to say nothing of the Royal Colleges of Physicians, Surgeons, and Obstetricians and Gynaecologists. A great deal has been achieved within the United Kingdom, Australia, New Zealand, South Africa, and Canada in these respects already, particularly by the Colleges—that is, the easier part of the task. To bring in the African, Asian, and other countries on a reasonable basis, fair to both sides, may demand years of educational effort and statesmanship.

Then there are the tiresome but very important matters of reciprocity regarding terms of service, superannuation, and the like. Nothing less, finally, will be needed than the possibility of completely free movement without penalty throughout the participating countries by persons engaged in these services. And need we balk at the same privilege for the citizens? Steps in this direction have been taken by universities, and in the field of health benefits in certain of the more mature countries, but there is obviously still a long way to go.

As to possible first steps, could we imagine the British Government either calling a representative conference on the subject or, alternatively, appointing a select committee to prepare recommendations for an initial organization to deal with the problem? The Commonwealth Education Conference sprang from a meeting of Finance Ministers—perhaps a meeting between the Ministers of Health and Education of the Commonwealth could consider and launch the health plan. W.M.A. and W.H.O. would both be interested, but, being international bodies, would seem to have added difficulties on that score at the outset. Limitation initially to the countries of the Commonwealth should make for an easier start.

May we express the hope that such a constructive, complicated, and difficult task might be handled by men with vision and with special feeling for it, using a minimum of administration, and a maximum of the many genuine impulses towards these objects that exist now and that might be expected to be forthcoming increasingly in the future.

Difficulties in the Way

The adumbration of these plans at once conjures up the difficulties. We find it hard enough to hammer out our health services on a satisfactory basis in our own individual countries. We are now asked to fuse them all into a universally acceptable one. The urgency of the greater task could well expedite the conclusion of the lesser ones. In the first place we must expect the cost to exceed that spent by the various countries merely for their own services as we see them now. There are, of course, a number of agencies meeting in part these extra costs already—the great foundations, the universities, and certain of the Governments. Private bodies, churches through their medical and other missions, and institutions such as the Royal Colleges and London House also make valuable contributions. In the latter we have the practical outcome of a vision of international service, conceived largely on a Commonwealth basis. The universities of the Commonwealth, likewise,

have made and are making a great contribution towards the more even distribution of knowledge and skills throughout the world. The Colonial Development Corporation is also an important instance, and in countries such as the U.S.A. and, more recently, Western Germany we see others in the various forms of overseas aid on a huge scale. Happily it seems inevitable that this distribution over the uneven earth should continue—what we are considering is an extended version of the process, and its greater effectiveness.

Differing educational standards and potentialities in the various countries constitute an obvious difficulty to be met only by persistent efforts to bring all areas up to at least an acceptable minimum. This, again, will cost money—a good example is the recent blue-print for education in Nigeria. A great deal of money is required for the education of an undeveloped country of 40 million people, and, certainly in the near future, it must be achieved by a process of sharing. This idea is steadily becoming more accepted in these days of great, if not superfluous and ostentatious, rates of consumption in some countries—the “affluent societies.” The contrast between malnutrition and emaciation in one country as the dominant medical picture, and obesity and vascular degenerations as the besetting sins in a neighbouring one, cannot be harboured for long in a world so full of aeroplanes, radio, and television.

One great difficulty concerns the attitude taken up towards these matters in different countries both by the people as a whole and by interested individuals. Many are not troubled and are not inclined to make any effort. Others who might be sympathetic are deterred by real difficulties. It is a thought to move one's wife and children to a foreign country for two or more years, particularly if the children are at school age. The professional hazard—losing one's place on the home ladder—is a real one, and can be corrected only by a change of outlook on the part of those in authority, and indeed of the people as a whole. The idea that time spent in work abroad is wasted, or that the work is necessarily of a lower calibre than that done at home, is just not true. On the contrary, a man's training for his life's work in the United Kingdom or in New Zealand could in almost every instance be greatly enriched by well-chosen periods abroad. But, finally, nothing short of a genuine appreciation that all are parts of the whole can meet these difficulties. In the meantime proleptic appointments in a country like the United Kingdom, and various alternatives such as promising appointments of suitable grade on return, and the development of pension systems which would not be affected by such moves, must be relied on.

This cautious attitude towards overseas service is a particular difficulty in the United Kingdom. In more distant lands, such as New Zealand, for obvious reasons the idea of moving about is more accepted, as it is believed, with some justification, to engender greater knowledge and experience. But in every land there is a good deal of complacency and unreadiness to look beyond the immediate task and the local interest. To overcome this we must hope that the impact of T. C. Routley's “One World in Medicine”¹⁸ will somehow or other oblige us to react more generously.

Prizes to be Won

Apart from the satisfactions, already mentioned, of distributing beneficent service more widely where it is

greatly needed, and the opportunities of achieving scientific and professional progress, there are other advantages to be considered.

The existence of large areas within the Commonwealth needing service and development can be fairly regarded as a boon rather than an onerous task. How many well-developed countries, full of the arts and sciences and practitioners thereof, seem to be bursting at the seams, with no internal outlet for what has become a surplus of talents and trained men. Sweden, Holland, and Denmark are examples, and their nationals are to be found in many foreign countries. Perhaps the position is something like what we used to be told about capitalist economy in advanced countries—that they could not help producing too much and inevitably became involved in various struggles to dispose of the surplus profitably. In this case we should be thankful that we have this honourable and humanitarian outlet ready to hand within our own Commonwealth. The alternative would be a steady inturning of our energies where they cannot be fully utilized, with all the resulting tensions that that can lead to.

The very progress and success of medicine in these latter days may also emphasize the value of our Commonwealth outlet. Suppose, for example, some simple methods came about for dealing with cancer or some of the degenerative diseases. We might almost overnight find we had a lot of medical talent unemployed. In tuberculosis we have seen a diminution in some countries in the hospital accommodation and the medical talent required of recent years. The same process on a larger scale might lead many of us into wasteful infighting for individual survival. What an honourable alternative lies before us! And I personally would not limit our interest to Commonwealth countries. I would include any friendly country, like Ethiopia, that wished to join, so long as we had enough resources to permit us to do so.

Closer to hand, I think we can see in this proposition something for all of us. Every kind of medical man and every kind of health operation is needed. I am told that there is a great need for medical men for general duties in various parts of Africa—general practice, simple public health, and sanitation. What better change and challenge could there be to a general practitioner in the United Kingdom or in New Zealand, rather harassed and bowed down by the daily and nightly demands made upon him, than the prospect of a tour of duty in Uganda or Tanganyika for, say, two years? Even if he found the effort of facing up to the undertaking a great one, I feel sure the general experience, the geography, and the human problems he would encounter could not fail to interest him and enrich his life. We have spoken about specialists and the unique experiences and challenges that await them in underdeveloped lands. In reverse, can we not feel that a term of, say, two years in England, or in New Zealand, under good conditions of climate and work, would be very refreshing to a man or woman who has worked for some years in a tropical country?

Our institutions, too, may derive fresh life and energy under the demands of some such scheme as this. The B.M.A., for example, with its substantial Headquarters and almost world-wide organization, seems well suited to develop some of the functions that would be called for. The Colleges, too, would find their usefulness expanding. Government departments, bodies like the World Health Organization and the World Medical

Association, would receive a fresh impetus. Perhaps, as we have seen, our own B.M.A. Commonwealth Conference and Overseas Committee can take the initiative.

But the overwhelming satisfaction of achieving this co-operation—and in what field is there more prospect of success than in medicine and health?—would lie in the substantial step it would represent towards human brotherhood and co-operation. We are already, through the advent of the radio and the aeroplane, one world, for better or for worse. Here is a chance to emphasize the good in contrast to the many opportunities for evil. All the peoples of the world suddenly seem to have grasped the idea that they need not continue in hunger, poverty, ill-health, and ignorance. They know with Isaiah that every valley can be exalted and every mountain and hill laid low, and they are determined in action to bring about the changes they desire. The newly awakened countries may not know clearly what the good life is, or how to achieve it—any more perhaps than we do in the wealthier countries; but they do recognize some of the bad features of their present condition, as we do, and they will try to remedy them. They see in technology the way to grow more food, secure more shelter, and gradually to ameliorate their lot. How proper it is for us, who for the moment—perhaps a very fleeting moment—know a little more about these things, to wish to help; how dismal our failure if we sit at ease in our Zions and do nothing. In terms of practical politics and even of self-interest it may be better to lend a hand—when and where it is wanted—while the brief opportunity is there.

It is not only in medicine and health that Commonwealth-wide co-operation is promising. The British Association meeting at Cardiff in September, 1960, talked about food production and mouths to be fed on the world scale. It was obviously again "one world" where mutual interdependence and co-operation seemed desirable, indeed inescapable. Progress in agriculture and in health go very much together, the one helping the other towards human betterment. It was Lord Bruce of Melbourne who wished to contrive this marriage some years ago at the United Nations. Similarly, in science generally we can hope for valuable results by wider co-operation. Again the process should be an easy one. For the principles on which the scientist works are of universal validity and application, and men meet in scientific discussion on equal terms, without any reference to class, creed, or colour. One world of science is therefore already with us in principle—let us have it in practice and directed towards beneficent ends. The final union of all mankind is the ultimate hope, in the Parliament of Man and the Federation of the World.

The Theme Again

There have been many major proposals and steps towards united efforts in recent years which should encourage us to feel that a comprehensive scheme for health in the Commonwealth is not too visionary and that it might be realized even in five to ten years' time. We still remember the feeling of wild surmise early in the war when Mr. Churchill proposed for us a common citizenship with France. Since the war there have been various plans for economic co-operation, common markets, and so forth between units and nations hitherto considering themselves as inviolable units. Even in defence we have the proposal to vest the Western European atomic weapons in an association of States rather than in one or more individual ones. These plans

have made real progress, and in a few years many things that seemed utterly unrealistic have, in fact, come about. In the same way the current proposals, looked back upon from ten years hence, may seem quite modest. There has been great success already in international co-operation in science, in health, and in education.

Probably the chief obstacle, as always, lies in ourselves. We need—even as doctors—more of the compassion towards our fellow men that is our distinctive mark, so that we will want to spread our net of service wider. We need also the touch of imagination that will enable us to glimpse greater possibilities. The man with the muck-rake in *The Pilgrim's Progress* is too much with us. He was so bent on heaping together the dust and the leaves that he never looked up, and never saw the celestial crown above his head. Let us straighten our backs and look up.

REFERENCES

- ¹ "Commonwealth and Common Health," Sir Arthur Porritt, *Brit. med. J.*, 1960, **1**, 1907.
- ² "Medical Research in the Colonies." Leading Article, *ibid.*, 1960, **2**, 588.
- ³ "Coming Home and Going Abroad." Leading Article, *Lancet*, 1960, **2**, 1013.
- ⁴ "A Time Abroad." Leading Article, *ibid.*, 1959, **1**, 767.
- ⁵ "On Being Seconded." Personal Paper, *ibid.*, 1959, **1**, 778.
- ⁶ W. C. W. Nixon, *ibid.*, 1959, **1**, 831.
- ⁷ "Filling Medical Appointments Overseas." Report of B.M.A. Conference, *Brit. med. J.*, 1958, **2**, Suppl. pp. 220-224. Leading Article, *ibid.*, 1958, **2**, 1279.
- ⁸ "One World in Medicine," T. C. Routley, *Brit. med. J.*, 1958, **1**, Suppl. p. 21.
- ⁹ "Medical Service Within the Commonwealth and Other Countries Overseas," Kenneth R. Hill, *ibid.*, 1961, **1**, 117.

CIGARETTE SMOKING AND ISCHAEMIC HEART DISEASE

BY

B. BRONTE-STEWART, M.D., M.R.C.P.

Physician and Senior Lecturer

(From the Department of Medicine, University of Capetown, and Groote Schuur Hospital, Capetown, South Africa)

Attention was drawn to the association of cigarette smoking and mortality from ischaemic heart disease in two surveys on smoking habits and lung cancer (Hammond and Horn, 1954; Doll and Hill, 1956). The following points are worthy of emphasis: that this finding was an incidental one; that the two surveys were quite independent, one being carried out in the United States of America and the other in Great Britain; and that a graded association existed in that the mortality increased in proportion to the amount smoked. Higher mortalities were seen in those who smoked cigarettes as opposed to pipes or cigars. Despite this, the finding has been the subject of criticism in its statistical aspects (Berkson, 1955).

Epidemiologically, too, there is a relationship between the prevalence of ischaemic heart disease and fashions in tobacco consumption. Since the invention of the cigarette-making machine in 1880 (*Lancet*, 1957) the fashion of pipe smoking has given way to cigarette smoking, and the increasing rate of tobacco consumption in this manner parallels the increasing mortality from ischaemic heart disease (see Fig. 1). In England, too, the higher mortalities of the professional and executive classes seen in the occupational mortality statistics of the Registrar-General (1954) could be attributed to the