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WHAT IS THE JOB?*

BY

The Rt. Hon. Lord HORDER, G.C.V.O., M.D., F.R.C.P.

Between my own medical Alma Mater at St. Bartholomew's and King's there has always been a close relationship. In the latter half of the last century we sent you Richard Partridge and Arthur Farre. During the first half of 1900 we sent you no fewer than five of my own colleagues and friends: T. P. Legg, Emery, Tunnicliffe, Stanley Woodwork, and Colwell. More recently we have added Oakley and Magnus. You have not been so generous to us, but we have been grateful for Claye Shaw, one of my own teachers, for Geoffrey Harrison, and more recently for Eric Strauss.

If I pass from the more general to the more particular and personal view of King's men, I owe much to the teaching of Kingston Fowler, Burney Yeo, Nestor Tirard, and Watson Cheyne. I was happy to count as colleagues and friends Aldred Turner, Lambert Lack, Thomson-Walker, StClair Thomson, George Frederic Still, Robert Knox, and Arthur Whitfield. All these men added to the greatness of your school and to the growth and dignity of Medicine. Not to have known them would have argued myself unknown. But these are names which occur to my mind quickly; there are others in their generation that I am sure I should readily recall if I studied more closely the carefully documented volumes dedicated with such loyal devotion to King's men by Willoughby Lyle. Of King's men of the present generation, though I have ceased to belong to it, I could also speak with intimate knowledge. But that would be invidious. Suffice it to say—and I have plenty of reason for knowing—that they form a team second to none in the leading medical schools of the Empire. It is clear, therefore, that you have not only a great tradition to maintain but every stimulus and encouragement to this end.

Your New Job

And what, now, is the job to which you will put your hand, you who are just beginning, the "grind" of the preclinical part of your curriculum being over?—as to which I have said my say years ago on occasions very like this, but unheeded. I don't complain. Much better men have gone unheeded. My plea has always been that the anatomy, the physiology, the chemistry, and the physics of the preclinical studies of the medical student should be directed towards the actual examination of the patient.

I think we took a step backwards when we put the academic anatomist, physiologist, and chemist in charge

of preclinical studies. These men staked out large claims in their respective spheres as though medical students were in training for professorships in these subjects rather than being doctors in embryo. This view led me to plead for spending less time over the intimate structure of the organ of Corti and the theories of colour vision, and more time over surface markings of the viscera, the ophthalmoscope, the laryngoscope, the Thoma-Zeiss pipette, and other simple instruments by which the structure and functions of the normal body are studied. I urged these things so that when the student entered the wards he should not be faced with an entirely new animal in the shape of the patient.

I think that many preclinical professors do orientate more in the direction I have outlined than was the case a generation ago. But I still meet doctors who have never seen the optic disk clearly, nor the vocal cords at all.

But that reference to preclinical studies is a digression. You are now embarked upon the study of Medicine, and if you want a definition I can suggest nothing better than that Medicine is the art and science of healing—which was indeed the meaning ascribed to the word in primitive times. True, we have come to stress the importance of prevention of disease, viewing the doctor as a "health man" more than a "medicine man," but this enlarged connotation of the doctor's function is implicit in our definition.

Prerequisites for the Doctor

But if we ask the doctor not only to cure us of our ills but to keep us well there are two prerequisites to be considered. (i) The first is that the doctor must know all about the mind as well as about the body: he must know "human nature," as it is called, as no other person knows it. The Greeks held this idea very firmly, and, logical as ever, they did not consider that a doctor could play his part in the social economy if this desideratum was not present. (ii) The other prerequisite to keeping the fit fit, and making the near-to-fit quite fit, is that more attention must be given to providing the basic elements for the maintenance of health: enough of the right sort of food; warmth and shelter; access to the sun and air; a satisfactory job of work; leisure and the amenities connected with it. Obviously this second prerequisite to "positive health" is the business of the State rather than of the doctor.

It has fallen to my lot to see great developments in Medicine, both in its science and its art: radiology, chemotherapy, endocrinology, thoracic and brain surgery,

*Slightly abridged version of the inaugural address given at the opening of the 122nd winter session of King's College Hospital Medical School.

psychiatry, physiotherapy, and the rest. Time will not permit me to enlarge about them. The contributions they have made to medical care have been incalculable. They have also opened up more channels for the ultimate choice of the practitioner, so that, if that intimate contact with the patient which general practice gives in such unique fashion does not appeal to his temperament, he can find his niche in some other branch of Medicine.

Some Mild Criticism

But I think the trend in the direction of new special branches of Medicine should be watched carefully. In respect of two of these I have some mild criticism to offer.

(i) Humanist though I am, and whole-hearted supporter of the thesis that Medicine should be made 100% available to the people, I have never been quite convinced that the notion underlying the new branch of it which has been called "social medicine" has justified itself. No colleague of mine brought a clearer mind to bear on most things than John Ryle, the first professor of social medicine in this country. But I cannot rid my mind of the thought that Ryle got this thing mixed up with his political views, which were markedly socialistic.

The claim staked out by social medicine has always seemed to me to fall well within the ambit of Medicine in the general, indeed in the Hippocratic, sense. "Consideration of the ultimate, as well as the intimate, causes of disease" does not give us a new, but only an extended, pathology. A patient's environmental conditions have in recent times been studied, and their aetiological importance stressed, more fully than formerly. This is good; such knowledge was always pertinent, but it was neglected. The extreme degree of lazy-mindedness in relation to a patient's conditions of life is shown by the doctor who is uncertain of a patient's age, *thinks* she has children but doesn't know how many, and cannot say if she is, or is not, past the menopause. It is just as culpable not to know the sort of atmosphere in which a man works, plays, and sleeps; but to elevate inquiry about these things into a special branch of Medicine is, I opine, redundant. The sphere of the medical officer of health is definite and requisite. So is that of the industrial medical officer. But the doctor should himself be familiar with the routine, the environment, and the habits of his patient if he is to be "guide, philosopher, and friend."

(ii) I would say much the same for the effort to make "psychosomatic medicine" a new concept. If Plato and his associates may be taken as our guides, they made it clear that the function of the physician was not limited to the study of the body of the patient only, but should include his mind also. Plato put significant words into the mouth of Socrates when he said: "There is no cure for the body apart from the mind. First then, and above all, the mind must be treated if the head and rest of the body are ever to be made whole. . . . Just here the mistake is made in regard to men: the attempt to treat the body independently of the mind." And in another place he says: "The part can never be well unless the whole be well." All disease was, to the Greeks, "psychosomatic."

The importance of retaining the environmental and what is quaintly called the "psychogenic" factors in general Medicine rather than segregating them for special study is greater to-day than ever before. This is so

largely because the doctor is faced less and less with plagues and epidemics resulting from virulent infections from without, and more and more with disease processes due in the main to troubles within. We have exchanged old diseases for new—typhoid and sepsis for cardiovascular disease and the psychoneuroses. Our "danger" is, indeed, "being human."

All the more reason, as I say, for integrating into one whole the physical, mental, and environmental factors entering into the patient's condition.

Direct Contact of Doctor and Patient

This integration, you will say, needs time and care and expert training. Of course it does. It involves what I have frequently termed a "close-up" between doctor and patient. Any system of medical care which does not make this "close-up" possible must fail, sooner or later, to attain its object. Speaking at the Welsh National Medical School as long ago as 1933, I said that "any increase in organization by which the doctor finds himself better equipped and less subject to wastage of time and effort is to be welcomed. The only inalienable factor, without which no good doctoring can really be accomplished, is the preservation of that direct contact of doctor and patient which experience proves to be essential." Further experience has not changed my view.

I have not myself been favourably impressed by the "new look" which the practice of Medicine in this country has recently worn. The fact that it allows the doctor and the patient to meet so seldom and for so short a time is my main reason for not liking it. Moreover, believing that the greater part of whatever virtue lies in medical care is resident in the personality of the doctor, and seriously doubting if you can nationalize personality as you can gas and electricity and the railways, I never thought a State Medical Service which did not take this basic fact into account was likely to prove a great success.

I did believe, strongly, in the State giving every facility to doctors to function in the way I have just now outlined, whether it be in the surgery, in the home, or in hospital. I believed in regionalization (and at the same time rationalization) of the hospital services. I believed in adding the dependants of the workers to the National Insurance Scheme. I believed in making the whole of Medicine available to every citizen. But in my creed it was to be *our* Medicine, not Medicine as conceived by, and purveyed from, the bureau.

The pity of it! A little statesmanship, a little humility, a little consultation, an advance by evolution rather than by revolution, and the "new look" might have been quite attractive. A great opportunity for the time being has been missed; but surely only for the time being.

Well, there are two *clichés* that are apposite to my main theme. Both of them are from the French, and, taken together, they point the moral of most of these remarks. "Le plus ça change . . ." and "Toujours le malade . . ."

The Vocation of Medicine

Few doctors can have seen more changes on the face of Medicine during a lifetime than I have, and I doubt if they will have come to closer grips with their patients. At first blush I might think that when I was at your

stage of my career I was luckier than you are in that I had the ball at my feet and you have not. How foolish! The ball *was* at my feet, and again and again I muffed it. The ball is at *your* feet just as much to-day as it was at mine half a century ago. The ball is the patient.

Don't think because the chemists present us with a new antibiotic every month, and hormone synthesizers never seem to go to bed, that we have got control of all the diseases flesh is heir to. Resistant strains of bacteria mock the antibiotic-monger, and hormone side-effects teach us humility. Cancer still rears its ugly head as a persisting challenge, not less in respect of its essential cause than in the care of the cancer patient. More than this, a "sick headache" and a "common cold" still elude our treatments—or should I say "therapy"? And only the *Readers' Digest* knows all the answers.

Realizing all I do—and I include the jolt that Whitehall, in its ignorance and precipitancy, has given it—would I take up Medicine as a vocation if I were starting again? Certainly I would. It is a good thing that we have committed ourselves to. It presents life to us in full gamut. If we are realists like old Montaigne we "find a ravishing kind of satisfaction in pleasing another and in doing a just action." If we are idealists, let us turn to the reflections of a great clinician, Peter Mere Latham:

"Diseases are not abstractions," he says; "they are modes of acting, different from the natural and healthy modes—modes of disorganizing, modes of suffering, and modes of dying; and there must be a living, moving, sentient body for all this.

"This body must be your study and your continual care—your active, willing, earnest care. Nothing must make you shrink from it. In its weakness and infirmities, in the dishonours of its corruption, you must still value it—still stay by it—to mark its hunger and thirst, its sleeping and waking, its heat and its cold; to hear its complaints, to register its groans.

"And is it possible to feel an interest in all this? Ay, indeed it is; a greater, far greater interest than ever painter or sculptor took in the form and beauties of its health.

"Whence comes this interest? At first perhaps it seldom comes naturally: a mere sense of duty must engender it; and still, for a while, a mere sense of duty must keep it alive. Presently, the quick, curious restless spirit of science enlivens it; and then the deliberate choice of the mind.

"When the interest of attending the sick has reached this point, there arises from it, or has already arisen, a ready discernment of diseases, and a skill in the use of remedies. And the skill may exalt the interest, and the interest may improve the skill, until, in process of time, experience forms the consummate practitioner."

A High Calling

You may think I am taking a very lofty view of the doctor's function in society. I am. I can say with conviction to any one of you: "High is our calling, Friend." And you know the tributes to their doctors paid by Samuel Johnson, Stevenson, Henley, and others? But it is not only the poets who place the doctor's function at a high level. Karl Marx was, in the opinion of many, "of the earth, earthy." Yet no man paid a higher tribute to Medicine and to those who practise Medicine. "For thousands of years," he said, "Medicine has united the aims and aspirations of the best and noblest of mankind. To deprecate its treasures is to discount all human endeavour and achievement as naught."

This thing will go on, of course—*must* go on. And, as I am not one of those who think that "the former days were better than these," I look forward as well as back. I think the wise man was a bit bilious when he apportioned dreams to the old and visions to the young. I dream dreams, it is true, but I also see visions. I see the Science and Art of Medicine, doctoring, the care of the patient, attaining an even higher place in the social economy in the future than it has ever done in the past. Someone has said that the technology of Medicine has outrun its sociology. It will fall to you to make this adjustment, and make it without sacrificing the individuality of the patient who places himself in your hands with such confidence and with such hope.

In all this I know that you King's men and women will continue to pull your weight. Folk fail only "when," to quote the wise man again, "they shall be afraid of that which is high," and this is surely a condition unthinkable at King's.

THE TREATMENT OF CLINICAL PNEUMONIA WITH ANTIBIOTICS

REPORT BY A SUBCOMMITTEE
OF THE ANTIBIOTICS CLINICAL TRIALS (NON-
TUBERCULOUS) COMMITTEE OF THE MEDICAL
RESEARCH COUNCIL*

The introduction of the newer antibiotics, "aureomycin" and chloramphenicol, raised the question whether one of these might not be a better primary treatment for pneumonia than penicillin or the sulphonamides. When a case of pneumonia is first seen the aetiology is not known. It seemed possible that the reported action of aureomycin and chloramphenicol on a wide range of aetiological agents, including certain bacteria, rickettsiae, and viruses not susceptible to penicillin, might make one of the newer drugs a better all-round weapon for the general practitioner. When this trial was initiated it was already known that aureomycin was effective in certain types of pneumonia (Collins *et al.*, 1949; Finland *et al.*, 1949; Olshaker *et al.*, 1949; Woodward, 1949). There was a good deal less information about the use of chloramphenicol in pneumonia (Olshaker *et al.*, 1949; Recinos *et al.*, 1949; Woodward, 1949), but on theoretical grounds it seemed worth trying. The object of the trial was therefore to find out which of the antibiotic drugs was the best one to use when a clinical diagnosis of pneumonia had been made.

*Members of the Subcommittee: Dr. J. G. Scadding (Chairman), Professor C. H. Stuart-Harris, Drs. T. Anderson, H. Joules, J. Knowelden, and J. W. Crofton (Secretary).

Clinicians and Pathologists.—Central Middlesex Hospital: Drs. H. Joules, R. S. Francis, and K. P. Ball (Clinicians); J. D. A. Gray (Pathologist). City General Hospital, Sheffield: Professor C. H. Stuart-Harris, Drs. C. S. Darke, K. J. Milne, E. G. Rhind, and F. J. Flint (Clinicians); M. Pownall, J. C. Appleby, D. A. Tyrrell, C. P. Beattie, Z. Franks, M. W. A. Gatman, S. Varadi, and L. G. Cook (Pathologists). Hammersmith Hospital: Drs. J. G. Scadding, J. W. Crofton, J. W. Fawcett, and D. G. James (Clinicians); W. Hayes, D. A. Mitchison, G. M. Ross, Hilda Boffa, D. R. Barry, M. Millard, and O. G. Jones (Pathologists). Knightswood Hospital, Glasgow: Drs. T. Anderson and Alison M. T. Drimmie (Clinicians); N. R. Grist and Joan B. Landsman (Pathologists). Central Public Health Laboratory, Colindale: Drs. B. E. Andrews, B. P. Marmion, and A. D. Macrae. Statistical Research Unit, Medical Research Council: Drs. J. Knowelden and J. T. Boyd.