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THE BRITISH TRADITION AND THE NEW OUTLOOK*

BY

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Presidential addresses to the British Medical Association in the past have covered a very wide field. Some have been purely scientific; others have been retrospective; and yet others medico-political. My words to you to-day are not scientific; perhaps they are not progressive. They are rather an appeal to retain, in this uneasy world of change and planning, those traditional elements upon which the sound rock of British medicine has evolved and been built. What is this rock, so stable that it is the envy of other nations? It is, I am sure, that indefinable but intimate relationship which exists between the patient and his doctor. In this island of ours the family doctor has been for years, and still is, the bulwark upon which much of the happiness of the people so largely depends. He is not so much a prescriber of pills and mixtures as a psychotherapist and adviser, a confidant and trusted friend.

You know full well the problems, moral and sometimes spiritual, that come before all of us in our daily work. As a gynaecologist, perhaps I hear an undue proportion of people's worries that cannot in any way be classified as scientific medicine. What I have learnt to appreciate more than anything else during thirty-odd years of practice is the unclassified and officially unrecognized work that every day is performed by the family doctors of the British Isles.

A few weeks ago I was in the consulting-room of a medical man whose practice extends over a large rural area in the West Country. It was not a large consulting-room, but it was well equipped with the modern essentials for accurate diagnosis, and it was situated in a tiny country village overlooking the Wye Valley. My eye caught an illuminated framed address, and I asked the doctor's permission to read to you to-day a few sentences of that address. This is what it said:

"It is now seven years since you first came among us, and your patients and friends desire to take advantage of the opportunity thus afforded to present you with some tangible proof of their fullest appreciation of your great skill and untiring devotion in the exercise of your profession among all classes of the community in which you practise. To say that the poorer among us are some of your most grateful patients is at once a tribute to your honour and a source of admiration for you on the part of us all. We hope and trust that you will continue your beneficial work among us for very many years to come."

How many consulting-rooms in this country contain such testimonials? Perhaps not many, but well I know that the spirit is there, if not expressed. It is the "aura" that pervades the private sanctum of most family doctors where private and domestic secrets are exposed and discussed, and honest advice is given in the confidence that is enjoyed only by the sister professions of the Church and the Law. It is the essence of our British medical tradition.

My mind goes back to another experience. I was seated a few years ago in the large, perfectly equipped operating theatre of a State hospital in Utrecht. The surgeon, a salaried State professor, was performing an abdominal operation that is almost a daily occurrence in any large gynaecological clinic.

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The technique of surgeon and assistants was good, and the panoply of surgical ritual evident in all its detail. What impressed me, however, was the extreme length of the incision, which seemed to extend over the whole abdomen. At the close of the operation I sought the reason for this apparent "furor operandi." I was informed that the length of incision was to provide a good view for the audience at the back!

I could add other side-lights on the inner working of various State-controlled European hospitals, where the gods of science and technique, efficiency and statistics, override other considerations; but this incident will suffice to indicate some shortcomings of a system which perhaps some would like to see installed in this country. Social changes may be sudden and catastrophic, but more generally they are insidious in both their onset and their development. Medicine in Britain, so far as its practice is concerned, has been undergoing a slow major revolution during the last quarter of a century. The Ministry of Health, founded soon after the last war, and the legitimate child of the British Medical Association, was the concrete organic expression of those who recognized the importance to the nation of preventive as opposed to curative medicine.

The Traditional Link in British Medicine

While recognizing the necessity for a co-ordinating body, and admitting the immense services which the Ministry has contributed to the nation's health, I have viewed with some apprehension the inroads which have been made in recent years upon the influence of that traditional link of British medicine, the family doctor and his patient, and the swing towards State medicine. The bond between the Ministry of Health and the various health services administered by the local public health authorities is growing, communal services are increasing, and we may awake one day soon to find ourselves members of a co-ordinated State health service. I am convinced that neither the people of this country nor the bulk of the medical profession desire to become the regimented units of a system of bureaucratic control. The average man and woman to-day have very definite views about what they want in matters of health. They naturally desire efficient treatment, and they know what efficient treatment is and what it means. At the same time, the British public at heart dislikes communal methods of treatment, however efficient they are. How often does a patient on return from a visit to a public clinic say, "Well, I think that I will see him privately next time, and then I shall really know something"? This may be wrong in theory, but it is very true in practice.

During the present meeting we have been considering the Interim Report of the Medical Planning Commission. The report has already reached the general public, and it is interesting to note the reactions of the man in the street to the reforms which the Commission suggests. In a well-known women's paper I recently noted the following:

"'Group Medicine,' as advocated by the Medical Planning Council, means that private practice as we know it to-day will be more or less abolished, and that teams of doctors will be housed in Health Centres—a network of which will cover the country. To those of us who value a personal relationship with a doctor we have known and trusted for years, this scheme may seem disturbing."

This opinion is not isolated. Indeed, the view is gaining ground, both within and without the profession, that after the war medical practice, as we know it, will be no more. Personally, I do not believe that this will be so. Certain changes there will be—indeed, there must be; but so long as Clauses 24 and 26 in the Planning Commission's Interim Report are accepted as the foundation upon which all reforms are built the British tradition is likely to be maintained and strengthened. It is a healthy sign that criticism from the lay side is mainly concerned with this basic principle.

If, in all future discussion and legislation designed for the betterment of the national health, the sacred bond which exists in Britain between the doctor and his patient is not lost or indeed broken, then, in my opinion, the main suggestions of the Planning Commission can bring nothing but good to the community, and it should be our duty to implement the proposals with a willing acquiescence if and when we are asked to do so. The alternative, as I see it, is a system of salaried State medical service, which I believe to be detrimental to the national health and the personal interests of patient and doctor alike.

The Stimulus of Competition

The idea of working for a fixed salary has always been distasteful to me. It eliminates competition, it stultifies individual effort, and therefore is a bar to progress. Competition there must be; otherwise the stimulus to increased effort is removed, and the spice of life loses something of its piquancy. The active and progressive mind is not content to say, "So far and no farther," and a salaried post, however good, is not satisfying. We see this in all walks of life, and perhaps at no time better than the present. High and, in some cases, grossly exorbitant wages are being paid in industry in a misguided attempt to stimulate production. Fixed hours and high wages have not been followed by increased output. We see reports in certain industries of falling output due to "absenteeism." The well-paid and possibly tired worker, with no other stimulus to increased production than the verbal lash of the Government's or the union's mouthpiece, sits back in his chair and takes a day off. Human nature is the same in all occupations and all grades of society. Remove the stimulus for individual effort by limiting the individual's capacity for personal betterment, and a brake is applied to progress. We see the principle recognized even in Russia to-day, where 25 years after the establishment of the Soviet's "New Order" personal "rewards" in money or goods are awarded for outstanding individual service.

In our work exactly the same arguments apply. The medical profession is not a rich community in terms of the acquisition of this world's goods. It never has been and probably never will be. Nevertheless, the spirit of competition exists among us. It is a thoroughly desirable principle, and one which should not be suppressed. We see its application in several ways. Even among the whole-time Chairs at our universities, both pre-clinical and clinical, competition occurs when a Chair with a higher salary falls vacant. The university with its underpaid Chair may lose its scientific professor to its more opulent sister. Lord Dawson of Penn has recently drawn attention to the same matter in an admirable address on "Medicine and the Public Welfare," published in the *British Medical Journal* on May 9 last. It is a contribution which should be read and re-read by all who have the conservation of the national health and the welfare of the medical profession in their keeping. Lord Dawson refers to the disability which the existing State-aided hospitals in this country are under by reason of the fact that personal advancement of the medical staffs—in other words, a higher salary—can only be achieved by relinquishing clinical medicine for an administrative post. This is why many of the more active clinical minds, who see only the prospects of a dead-end in State-aided hospitals, have preferred, and still prefer, to link their fortunes to the gamble of an unpaid appointment on the honorary staff of a voluntary hospital.

Traditions of the Voluntary Hospital

The lure of the British voluntary hospital to-day is as great as ever it has been, thanks to its traditions, based largely upon the untrammelled conditions under which its staff work and the healthy criticism to which all are subjected. Its strength

lies in these traditions and the proved service that it has been able to render to the community.

It is a great day for the young physician or surgeon when he is chosen from his fellows as being worthy of a position on its honorary staff. He may not have a "sou" in his pocket, and he probably knows that years of hard work lie in front of him. At the same time he has the satisfaction of joining an institution where the only criticism he is likely to receive is the friendly judgment of his colleagues and his students. He is answerable only to his patient and to his own conscience. Further, he knows that material prizes are within his grasp should he prove worthy of the trust laid upon him—prizes that, perhaps, are not measured in terms of finance, but which will be more satisfying than worldly wealth when the retiring age is reached and the time comes for him to hand over his charge to another.

The patient admitted within the walls of a British voluntary hospital knows also the human atmosphere, apart entirely from efficient medical service, that is a tradition of the institution. He knows that he is not a mere cipher in the medical organization of the State. His case is the personal responsibility of a surgeon or physician, whose services are available to him at any time of day or night, should they be required. There is no question of official hours of duty, just as there is no "clocking in" and "clocking out" for those responsible for his welfare.

Difficult times undoubtedly lie ahead for the voluntary hospitals owing to the economic conditions which are likely to prevail at the conclusion of the present political world upheaval. These difficulties must be faced, but in planning for the future let us not cast aside as worthless those traditional principles which have placed the voluntary hospital in its present honoured position. Rather let us incorporate them in the State hospitals of the future. Part-time as opposed to whole-time service, with a corresponding reduction in fixed salaries, combined with freedom of action in professional matters, would remove many of the disabilities under which the medical officers of public assistance hospitals now work.

On the other hand, State aid may be necessary to supplement the income derived from contributory schemes in the case of existing voluntary hospitals. Donations and legacies are likely to become less and less as the State increases its demands upon the private purse for the development of social and other services. The provision of State aid, however, need not necessarily imply State domination. This important principle receives expression in Clause 72 of the Planning Commission's report, in which it is stated that the Regional Council or authority "would not interfere with the internal organization of individual hospitals." I trust that this very important observation will never be overlooked should the establishment of Regional Hospital Councils become an accomplished fact.

The Rising Generation in Medicine

During the short time that remains may I draw attention to a few matters which concern the rising generation in medicine? The medical student to-day is entering upon his career at a very difficult time, and I am profoundly sorry for him. The young people who one day will be shouldering our responsibilities are trying to assimilate the necessary facts and experience to satisfy the examination boards under conditions which are not conducive to the maintenance of our best traditions. Their interests are divided between professional and national duties. They are under an obligation to qualify in the shortest possible time, and they receive their education at the hands of a depleted staff whose members are often overworked and unable to give of their best. The profession has become purely utilitarian. At no time, therefore, is it more important to instil into the student mind those high principles which for so many years have guided the practice of medicine. There is, I fear, a growing tendency among students to-day to regard medicine purely from a materialistic standpoint. Even before the war many of the newly qualified, anxious to convert their acquired knowledge into terms of solid cash, rushed into contract or panel practice without holding any hospital house appointment whatsoever. Since the war the shortage of medical personnel has led to a greater demand for the newly qualified student, and the high fees now paid to temporary locums and assistants cannot but

be harmful in the future when the period of present cheap money is past.

Another present-day aspect of medical student life which personally I much regret is the innovation of political student societies. It is a tradition of British Medicine, as it is of the British Red Cross, that our service is independent of political creed. The doctor should be entirely impervious to political influences. His concern is with the great essentials of birth, life, and death, which transcend all other considerations, and he should resolutely turn his back to the rival claims of political factions both at home and abroad.

Faults in Medical Education

In the present wave of optimistic post-war planning it was not to be expected that the perennial subject of medical training would escape the infection. It is well that this should be so, for it is obvious to most of us who are responsible for the teaching of clinical medicine that our present methods fall short of what is desirable, or in fact necessary, to equip the student for the world in which he will carry on his life's work after he leaves his "Alma Mater." The main object of our medical schools should surely be to produce the finest type of that traditional and honoured symbol of British medicine to which I have already referred—viz., the family practitioner. Are we doing that to-day? It appears to me that the whole system of our medical training requires revision, and therefore I welcome the fact that an Interdepartmental Committee on Medical Schools is already at work on this important matter. A major fault in our present medical education is the lack of cohesion between those responsible for welding the individual parts of the finished machine. Each teacher and each department, influenced no doubt by the advance of knowledge and anxious to communicate that knowledge to their students, overweight their subject with a mass of detail that can only harass the student mind and increase his anxiety as the examination time approaches. The pre-clinical teachers, endeavouring no doubt to establish a sound framework upon which modern clinical medicine can be built, try to crowd more and more into their lectures and classes. The surgeon makes his dressers stand long hours and witness tiring operations which the majority will never be called upon to perform. The clinical physician asks for the attention of his clerks while he discusses the intricate and highly scientific details of some knotty problem which most of his audience may never meet. The result of all this is that the average student finds himself qualified, and launched into a world which offers a strange contrast to the one where he has been educated. Shock No. 1 will be the revelation that concentrated scientific knowledge is not the only, or indeed most important, asset when in contact with his fellow-men and patients. He will find that he must be a human being first, and a doctor after. Shock No. 2 when he enters practice will be the discovery that he may not have available the necessary adjuncts for the application of all that he has learnt. There are other shocks in store for him, but let us hope that they will be fewer when the work of the Planning Commission reaches fruition.

To convert some of my criticism into practical politics, is it not possible for those responsible for the organization of medical training to envisage a more generalized and less comprehensive course of teaching than that now in being? Let there be in medicine a "School-leaving Certificate" at the end of, say, a five-years curriculum, as distinct from a "Higher School Certificate" awarded at the end of a further year's training devoted to some special aspect of medical work. Certificate A would not entitle the holder to the independent practice of his profession, but it would qualify him to become an assistant in family practice or in any of the special aspects of medicine which appeal to him. At the end of a further year's work he would secure Certificate B—i.e., the higher qualification—which would launch him upon his life's work. The concept of attaching a Certificate A student to a doctor engaged in the work of general practice appeals to me as a modern counterpart of the old apprenticeship system. The young man fresh from hospital would gain the experience he now lacks and learn to appreciate the fact that in life it is not so much what one does as how one does it. On the other hand, the older family practitioner would constantly be in

touch with the vitalizing stimulus of the young and active scientific mind. Surely nothing but good could evolve from the liaison.

Prospects in Medical Practice

And, finally, what prospects have we to offer to the medical man or woman of the future? If the major proposals of the Planning Commission are accepted in principle and duly implemented I think we may safely say that many of the difficulties under which the profession now works will have been removed. The doctor of the future will have the satisfaction of doing good work with the increased facilities that are available to him; he will be better able to apply to his patients those methods of diagnosis and treatment which he was taught during his student years; and, finally, owing to the co-ordination of all the various health services, he will know that he forms an integral part of a great organization whose sole object is to maintain the health and happiness of the nation it serves.

My theme to some may have appeared retrogressive or irritating. I can only reassert my personal conviction that, whatever "new order" may arise in the conduct of medical practice, the future happiness of our people is intimately bound up with the maintenance of our British tradition in medicine that a patient is a patient and not an impersonal unit in a system.

MALINGERING

BY

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The brief references to malingering (the conscious adoption and exploitation of symptoms of illness, physical or mental) in standard textbooks of medicine may be regarded as silent testimony to the rarity with which the condition is encountered in civil life. On the other hand, there may be lack of interest in the subject or difficulties in the clinical approach.

I have met with three civilian cases. The first was that of a vagrant to whom the prospect of a sound night's sleep with an assured breakfast to follow was sufficient motive: some months previously he had undergone a three-weeks investigation at the same hospital for his alleged gastric complaint and had been dismissed at the end of that time as a case of functional disorder: he hinted vaguely that identical investigations had been performed at other hospitals in the interval between his two admissions, with similar results. The second case was also that of a vagrant, similarly motivated, who trafficked on his habitual pallor and prematurely senile appearance to secure admission to hospital for investigation as a potential anaemic. In the third case the man, like the schizoid Hamlet, was resolved to "put an antic disposition on" in an endeavour to, in his case, escape from the pressing attention of the police for illegal misappropriation of money. These three were clearly abnormal people. Other cases are occasionally encountered (particularly in connexion with alleged injuries—of which no evidence shows—sustained in motor-car accidents) in which the diagnosis of malingering cannot be applied, solely through the lack of a confession to that effect from the "patient," whose desire for monetary gain overrides his truthfulness: these cases, of course, are altogether distinct from the genuine traumatic neuroses occurring in the same circumstances.

Wartime Cases

In wartime, perhaps because of the importance of morale and discipline, more frequent references to malingering appear in medical literature, although it is generally assumed that, so far as the war of 1914-18 was concerned, it was of rare occurrence (War Office Report, 1922a). Hurst (1940) lays down two criteria for the certain diagnosis of malingering—either detection *in flagrante delicto*, or an unforced confession from the man in accordance with the facts observed. The methods adopted by malingerers vary: a comprehensive account of these is given by Buinewitsch (1941).

In the examination of neurotic patients the physician often adopts a too confiding attitude, or, on the other hand, a