Medicine's core values

Medical care does add to life expectancy

EDITOR,—In their editorial on the future of medicine Ian Morrison and Richard Smith comment on politicians' "reluctance to invest heavily in health services when they have only a small effect on health."¹ Smith's editorial two weeks later, on medicine's core values, includes a similar statement ("If health care has only a limited impact on the health of the population . . .").² The belief that medical care contributes little to health harks back to the conclusions drawn by McKeown from his epidemiological studies of public health data from the years before 1971.³ Modest challenges have been made to McKeown's data and conclusions, but they remain the basis for the widely held view that Smith expresses.

In the quarter century since McKeown's work was published there has been an explosion of medical treatments, many of which have been shown in clinical trials and meta-analyses to result in considerable improvements in health. On the basis of these secondary sources my colleagues and I have assembled an inventory of the contributions of medical care to life expectancy⁴; adding these up, we estimate that medical care can be credited with three of the roughly seven years of increased life expectancy experienced in the United States and Britain since 1950. We also credit clinical services with the potential of extending life expectancy by an additional one and a half to two years if they were provided more widely.

As Morrison and Smith state, health may result "from a combination of social, economic, and psychological as well as purely biological phenomena," and they are probably right that "most doctors now understand this." But what most of us have failed to appreciate is that there are no data documenting whatever contribution social, economic, or psychological phenomena may have made to the increase in life expectancy during the century; nor do we have any but the vaguest idea of the mechanism by which they may affect health. McKeown attributed the dramatic increase in life expectancy of the previous 100 years to nutritional, environmental, and behavioural factors, but he conceded that the evidence was no more than circumstantial. He believed that he had shown that medical care was not responsible and therefore a best guess set of social and environmental factors must have been responsible.

The governments in Britain, the United States, and Canada have placed great emphasis on the role of lifestyle, including diet, exercise, and substance misuse, on health. While these are without question of great importance to the health of some—perhaps many—of the population, their modification has yet to be shown to have had a favourable impact on the population's life expectancy. Indeed, the ill effects of unhealthy lifestyles continue to mount. More to the point, the potential beneficial effect on life expectancy of behavioural modification, based on solid epidemiological data such as those recently reported by Richard Doll and colleagues,⁵ is no greater than, and possibly less than, the benefits that could accrue from wider access to clinical services that have been shown to be effective.⁴

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We prefer short letters that relate to a recently published article and we are unlikely to publish letters longer than 400 words and containing over five references. Letters may be shortened. Your letters should be typed with double spacing and include a word count. All authors need to sign the letter and provide one current appointment and address. We encourage you to declare any conflict of interest. Please enclose a stamped addressed envelope if you require an acknowledgment.

- 1 Morrison I, Smith R. The future of medicine. *BMJ* 1994;309:1099-100. (29 October.)
- 2 Smith R. Medicine's core values. *BMJ* 1994;309:1247-8. (12 November.)
- 3 McKeown T. *The role of medicine: dream, mirage, or nemesis?* Nuffield Provincial Trust, 1976.
- 4 Bunker JP, Frazier HS, Mosteller F. Improving health: measuring effects of medical care. *Milbank Q* 1994;72:225-58.
- 5 Doll R, Peto R, Wheatley K, Gray R, Sutherland I. Mortality in relation to smoking: 40 years' observations on male British doctors. *BMJ* 1994;309:901-11.

Both knowledge and compassion are needed

EDITOR,—Kenneth Calman calls for a full debate on the purpose of medicine and its basic values and a continuing review of medical education, emphasising diagnosis and high ethical standards.¹ Western medicine, classed as a caring profession from the fourth century to the present day, owes a great debt to the Christian faith and individual Christians for its caring tradition and its progress.²

Dr Thomas Sydenham (1624-89) has been called the "English Hippocrates" and the "father of English medicine." He laid the foundations of careful bedside observation, clinical description, diagnosis, and rational treatment. His contributions to medical teaching include classic descriptions of gout and chorea in rheumatic fever. His ethical values and priorities are worthy of reconsideration by the profession today.

In his "Medical Observations concerning the history and cure of acute diseases," published in 1668, he wrote:

Whoever takes up medicine should seriously consider that he must one day render to the Supreme Judge an account of the lives of those sick men who have been entrusted into his care. Secondly, that such skill and science as, by the blessing of Almighty God, he has attained, are to be specially directed towards the honour of his Maker and the welfare of his fellow creatures: since it is a base thing for the great gifts of heaven to become the servants of avarice and ambition. Thirdly, he must remember that it is no mean or ignoble animals that he deals with. We may ascertain the worth of the human race, since for its sake God's only begotten Son became man, and thereby ennobled the nature that He took upon Him. Lastly, he (the doctor) must remember that he himself . . . is bound by the same laws of mortality and liable to the same ailments and afflictions with his fellows. Therefore let him strive to render aid to the distressed with the greater care, with the kindlier spirit and with the stronger fellow feeling.³

The motto of the Royal College of General Practitioners, "cum scientia caritas," emphasises

the need to pursue both knowledge and compassion.

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- 1 Calman K. The profession of medicine. *BMJ* 1994;309:1140-3. (29 October.)
- 2 Aitken JT, Fuller HWC, Johnson D. *The influence of Christians in medicine*. London: Christian Medical Fellowship, 1984; vii:66.

Profession should not have to make decisions concerning rationing

EDITOR,—Perhaps Sir Maurice Shock tries to live up to his name, but his attempt to shock us out of our mind set merely irritates when he exhorts us to "speak authoritatively and sensibly to the consumer" while agreeing that such a consumer is "protected, encouraged to be autocratic, and persuaded of his or her power."¹ There is enough confrontation already without our gratuitously adding to it. My real bone of contention, however, is with his view that "doctors must be willing to 'get their hands dirty' with making decisions on allocation of resources."

I believe that such decisions concerning rationing should not be made by doctors. Allocation of resources, or rationing, should be done by an elected government or, if the government wish to devolve some of that power, by locally elected assemblies—that is, local government—but not by non-elected, sectional interests. It is deceitful of the government to talk of devolving power to general practitioners, for example, by giving them a budget while it continues to hold the purse strings. If the budget is cut at any time the general practitioners are still under contract to provide the same level of service and so have to engage in some form of rationing. Hence devolving budgets while retaining the power to limit them is a convenient smokescreen behind which a government can dump on to the profession its more difficult and sensitive decisions concerning rationing. This seems to be wrong on whatever grounds one considers it, whether ethically, constitutionally, or professionally.

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- 1 Smith R. Medicine's core values. *BMJ* 1994;309:1247-8. (12 November.)

The consultation is foundation stone of medicine

EDITOR,—Although James Spence's definition of "the essential unit of medical practice" may be slightly old fashioned,¹ there can be no doubt that the foundation stone of medicine is still the consultation. The various core values espoused by David Morrell and Kenneth Calman¹ may help us to improve the way in which we go about the consultation but do not detract from its central role. It will not do for this definition to be abandoned simply because it makes doctors who do not have direct contact with patients feel uncomfortable. These doctors, who may well

include editors of leading medical journals, will have to find their own ways to resolve this discomfort.

I was disappointed to see Morrell pulling out the old chestnut of "commitment." The danger in the current NHS culture, which knows the cost of everything but the value of nothing, is that commitment is free to the user but may be expensive, in more than simply monetary terms, to the provider.

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Are based on Christian ethics

EDITOR,—It is encouraging to see the profession discussing its core values, with the lead given by the chief medical officer¹ and the summit meeting reported by Richard Smith.² Coincidentally, the Sheffield group of the Christian Medical Fellowship held a day conference in the midlands on 5 November to discuss "foundations and the future." Many of the core values that we agreed were identical with those highlighted by Smith—namely, "caring, integrity, competence, confidentiality, and a high standard of ethics." We particularly identified with Professor David Morrell's plea that the doctor-patient relationship should be "a real human relationship based on love, caring, and sharing."

Our discussions, however, went one stage further: we asked where these core values come from and how they can be sustained in the future. Perhaps we have become so used to the Judaeo-Christian principles that have inspired our profession for centuries that we assume that they will always be there. These values do not arise from scientific medicine itself, nor are they the "natural" attributes of doctors, who are mere humans. If the clergy do "escape into a niche market," as Sir Maurice Stock suggested,² and we lose the unique inspiration of Christ's example of love and service the future could be very different. After all, we have experience in this century of how the abandonment of the Christian ethics led to the tragedies of Nazi Germany. It would be folly to rely on mere tradition or the naive assumption that doctors are somehow different from the rest of humanity.

To maintain the profession's core values in the future an inspiration and an ethic that can withstand the pressures ahead are needed. We, like many others, have found this in the Christian faith.

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1 Calman K. The profession of medicine. *BMJ* 1994;309:1140-3.
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2 Smith R. Medicine's core values. *BMJ* 1994;309:1247-8.
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Profession needs to open itself up

EDITOR,—The debate about core values in medicine reminds us that the profession is at an important crossroads.¹ As the demand for more openness in medical practice grows doctors, understandably, feel threatened. To add insult to injury, their field of work seems to be breaking up as others become involved in aspects of practice that were once their unique province.

How should the profession respond? It is disappointing, although hardly surprising, that a large section of it seems to wish to retreat into an ever smaller and more tightly defined core to

remain proof against further invasion by the uninitiated. The alternative is to accept that, to evolve and survive, medical practice needs not to withdraw into itself but to open itself up, to develop new models, to embrace new paradigms, and, importantly, to move away from the narrow biomedical focus on which our teaching has been, and largely still is, based.

This is difficult for clinicians whose working life revolves round a high pressure cycle of interactions with ill patients, but the alternative is to restrict medicine and those who practise it to a limited and ultimately shrinking role. Instead of defending the past the profession needs to create the medical practice of the future. The signs are that this will entail even closer scrutiny of what we do clinically; learning to cooperate with others in creating systems that allow us to practise effectively; and doing more than paying lip service to the idea of incorporating prevention and health promotion into mainstream clinical practice.

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Should include respect

EDITOR,—Richard Smith's editorial on the summit meeting on medicine's core values indicates a misunderstanding within the profession of the concept of respect.¹ The answer to the question "How . . . could doctors balance respecting each other with having to act to stop a colleague who might be harming patients?" is that no balancing is required. Genuine respect for a person (which must be earned rather than demanded) includes a respect for his or her integrity, desire to contribute, and ability to receive bad news and use it constructively. Thus respect for a colleague who may be harming patients requires not hiding the truth and devising complicated ways of working around it but gently but firmly breaking it. Indeed, withholding the truth in this situation would be an act of patronising cowardice, whereas genuine respect requires courage and humility. Perhaps it was this diminished perception of respect that led to its exclusion, and the exclusion of anything resembling it, from the final list of core values. This seems a pity because without it the list seems not to encompass some of the important points raised during the meeting.

It would be interesting to know what hard evidence there is to support the assertion that doctors and managers have value systems that are in fundamental conflict. As someone who is neither but who educates both, I find their values to be similar. They sometimes surprise each other, however, by discovering that members of neither group have two horns and a tail.

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Statement of intent needed

EDITOR,—The debate about the core values of our profession seems to rest on a series of isolated notions and objectives.¹ Would it be helpful to attempt to draw these ideas together in a single statement of intent? If so, I offer my version of what such a statement should encompass in its description of a doctor's obligations and rights.

To care for sick, old, frail, and weak people. To respect their privacy and their dignity, to earn

their trust, and to help them understand what is happening around and within them. To encourage healthy behaviour and to manage preventive and screening programmes in the knowledge that the fruits of this work will not come as quickly or easily as some would suppose. To take part in debate about the proper allocation of resources for health in a civilised society and to ensure that those who report and comment on these matters acknowledge that ever increasing demands on health services cannot be met by efficiency savings alone and that responsibility for the dilemmas that confront clinicians and managers each day lies with the public as a whole. To build on working relationships with other health professionals and to acknowledge their skills and experience without apologising for our own hard earned skill. To develop a common language and understanding with managers, most of whom share our sense of vocation and commitment to health care. To take the lead in medical audit and continuing education for doctors so that the government and patients can be confident that they will be given care that is proved and effective. To point out from time to time that quality is by definition not susceptible to measurement and that performance should not be judged solely in terms of figures.

Finally, to remember that as well as having responsibilities to our patients we have a responsibility to ourselves and our families. To admit as a profession, and as individuals, that we sometimes feel unable to meet the demands that are placed on us. To make it clear that, while we cannot expect guarantees of comfort and security which are so manifestly denied to others in Britain and abroad, our patients should not be cared for by men and women who are exhausted and demoralised.

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The right to speak out

EDITOR,—Kenneth Calman's article reflects his current view of the standing of the profession and gives us an insight into present thinking at the Department of Health.¹ The profession as a whole perceives itself as under great threat at present, so to have such a statement by the chief medical officer is valuable. The article seems to be soundly argued, and I suspect that much of it is common ground. One notable omission, however, I found disquieting—namely, the absence of any mention of our duty as medical practitioners to speak out to ensure that the highest possible standards are maintained when we believe them to be under threat. If we become afraid to do this then medicine in Britain is in danger indeed.

Although I am retired, inevitably I chance on past colleagues. Almost universally they admit to being afraid to speak plainly when they see standards slipping, for fear of losing their jobs. Whether their fears are well founded I find it difficult to judge, but their fears are real to them, and growing.

Recent examples of how dangerous this fear to protest can be are not far to seek: doctors in Iraq feared to speak out when called on to amputate limbs in the name of their country's law for fear of facing the severest consequences.² This is, of course, an extreme example, but nearer home surgeons have told me that they dare not complain when they find nursing levels on postoperative wards seriously inadequate. That is a grave charge that needs answering.

I am sorry that this point does not feature in Calman's article. The present climate of management surely has much to answer for if the urge to