

PATIENTS—A VIRTUE?

by

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TO-DAY it is my privilege to address you on behalf of my colleagues on the medical staff of the Royal. The giving of an oration, as it is now called, at the beginning of the winter term, is sanctified by a tradition extending backward in time for more than 150 years. It is customary to welcome, in particular, those of you who have recently begun their clinical studies, and this I do with great pleasure.

The choice of orator is not made by election, nor by selection, but by direction on the basis of sequential seniority. Seniority, the word itself, has an ominous ring for the young, indicating, as it may occasionally do, survival rather than achievement, a state sustained by the aphorisms and inexactitudes of the past. In medicine, as in other aspects of life, the gap between generations is wide, and widening; the giving of advice across this divide, except in the most general terms, is not always useful, and is seldom tolerated. Perhaps Lord Chesterfield had this in mind when, in a letter to his son he wrote; "Surely it is of great use to a young man, before he set out for that country full of mazes, windings, and turnings, to have at least a general map of it, made by some experienced traveller".

One may say, then, and slightly to misquote WB Yeats; "This is no country for old men", and it is therefore gratifying to see so many, even too many, young men and women ready, willing, and certainly able to undertake this journey, or pilgrimage, for such it is.

For this endeavour, each of you is endowed with different talents, none of which is too humble to be of value in the exercise of your chosen profession, nor too exalted to be beyond its requirements. It is the function of your teachers to help you to recognise and develop these talents, in the relatively short time which remains to you as undergraduates. Much of this time will be spent in this hospital, and in that part of the medical school associated with it. In discussing the relationship between these institutions Osler, writing in 1892, emphasised the "necessity of ample, full and prolonged clinical instruction, and the importance of bringing the student and patient into close contact, not through the cloudy knowledge of the amphitheatre, but by means of the accurate, critical knowledge of the wards".¹

Oscar Wilde's dictum that nothing which is worth knowing, can be taught, yet bears the corollary that it may be learnt. Such learning is an active process requiring enthusiasm, persistence, and, above all, interest on your part, though with sufficient exposure to the clinical scene some passive absorption of knowledge, and even wisdom, may also occur. The alternative to learning is the acceptance of forced feeding, leading, at best, to an uncomfortable feeling of satiety, or, at worst, to the regurgitation of undigested material, often on inappropriate occasions.

You may find that your early visits to the wards are embarrassing and difficult, steps into an unknown country. You will encounter, but not necessarily be welcomed by, the sister in charge and her nursing staff. They are not the doctors' handmaidens, but professionals in their own right who have served a long clinical apprenticeship. The knowledge you will acquire from them will help you to understand the overall care of the patients, and the advice you receive will prevent you from making, as doctors, many false assessments, and foolish decisions. Is it not strange, therefore, that the sister in our hospital wards who is, if anyone is, indispensable, should be at number six in a scale of ten, little more than half way up that awkward "salmon" leap? Those of you who look forward to a rewarding career in hospital medicine must ensure, if they can, that the particular status of ward sister be not further eroded, but indeed be enhanced.

The key to learning is observation, accurate and thorough, a faculty which is poorly developed in most medical students. Before looking, however, you must listen to the patient, and comprehend what he is trying to tell you. Sir George Pickering, in retirement, recalls that he used to tell his students "the patient is anxious to tell you a story, and it is your duty to repeat that story in language that you understand, that the patient understands, and that I understand. As the King advised the White Rabbit, begin at the beginning, go on to the end, and then stop".² The only requisites for the teaching of clinical medicine are patient, student, and teacher, regardless of whether they come together in a hospital ward, or a doctor's consulting room. Your instructors are, first and foremost, clinicians of very varied teaching ability, style, and temperament; such variety is advantageous, if you are to make your own assessment of what you have learnt. The correct approach to the patient, the gaining of his confidence, and the maintenance of that confidence through a long and trying illness, these are things that you must work out for yourselves from the examples set before you.

Robert Graves, born in Armagh at the end of the eighteenth century, introduced a method of teaching upon which the system of clinical clerkships is largely based. He used to entrust the care of particular patients to his senior students, requiring them to report to him the origins, progress, and present state of their disease. Such a laudable ideal is difficult to follow to-day, owing to the large numbers of students passing through the wards, and to the heavy clinical commitment of many of their teachers. In addition, the rapid and continuing advance of scientific knowledge requires that the student be involved in a programme of systematised teaching which, while it may be criticised as to detail and content, cannot be drastically curtailed. Indeed, we may be too ready to jump on the 'back-to-the-bedside bandwagon'; there were no good old days, and even if there were, they will not come again. Dickinson Richards, as Lambert Professor of Medicine at Columbia University, New York, highlights an inconsistency in our attitudes to changing times, and I quote; "For our students, we have thrown the lecture into outer darkness, as an outworn remnant of an earlier pedagogic era; but for ourselves, we teachers continue to lecture each other, almost incessantly. We dash all round the country, indeed half way around the world, winter and summer, spring and fall, leaving our appointed tasks, such as teaching students. And when we get there, what do we do? We sit down and listen to lectures, or worse still, we stand up and give them".³ These comments were made in 1953, before jet propulsion became a

significant force in the propagation and exchange of medical knowledge; they are certainly no less true to-day.

The process of learning is a combination of selective sensory input, analysis, storage, and recall. Of the senses, the olfactory is certainly the most evocative, followed by the visual and the auditory. The elusive and nostalgic aroma of phenolic disinfectants, and the cleanliness it implied, has long since gone from our hospital, to be replaced by the not so sweet smell of decay; the visual images of the patients with whom you have been in contact, and whose care you have followed, however, will remain with you long after the drone of the lecturer's voice is forgotten.

The concept of the doctor and his patient stretches back into the distant past; that of the patient and his doctor is nebulous and ill-defined. The doctor, even an activist, has maintained a definite, if variable, place in the society in which he lived, had not been notable for his humility, and has readily proclaimed his theories of disease, and infallible cures for everything from fluxes to fevers, and poxes to peptic ulcers.

Conversely the patient is a passivist, the word itself deriving from a Latin intransitive verb 'to suffer'. In English, the word has two separate definitions, firstly, as a person receiving medical care, and secondly, as being capable of accepting delay with equanimity. Combined, these definitions describe, with some accuracy, those sitting in silence in a doctor's waiting room, or enduring the more solemn camaraderie of the casualty benches. To these may be added others whose names are entered, and lie forgotten on the waiting lists of our hospitals.

The oft-quoted verse from Ecclesiasticus; "Honour a physician according to thy need of him" has a less sychophantic and more practical meaning if the original Hebrew version is consulted; it then reads; "Acquaint thyself with a physician before thou have need of him". It is only since the inception of the National Health Service in 1948 that every citizen could avail himself of this advice, and it is the basis of family medicine to-day. Dr Ian McWhinney, in his recently published book, defines the nature of this contract: "The commitment of the family doctor to the patient has no defined end point; it is not terminated by cure of an illness, the end of a course of treatment, or the incurability of an illness. In many, if not most cases the commitment is made when the person is healthy, before any health problem has developed".⁴ Borne along, as we are, on a tide of change, it may be useful to try to see ourselves as our patients see, and have seen, us, and to recall something of their suffering, resilience and expectations over the passing years.

Concepts of health care in both the InnuIt and Indian communities in Northern Labrador, prior to European colonisation, were reviewed by Sarsfield in 1977.⁵ Health was considered to be an individual strength, with the needs, sanctions, and support of the group coming to bear in a specific illness situation. Those responsible for healing were of the same culture as the sick, and the alternative of employing a foreign or unfamiliar healer was inconceivable. The Indian medicine man and the InnuIt shaman combined the roles of mayor, doctor, and priest in to-days society. These healers were obviously totally familiar with the culture and customs of the people, were skilled at psychosomatic diagnosis and therapy, and were practical pharmacists who understood the empirical properties of a multitude of plants, berries, roots, and herbs. The key factor was that medical care was by the people, and not to them, and was an integral part of their way of life. With the coming of

Europeans, and their gradual assumption of responsibility for the spiritual and physical care of the native people, a new conflict became apparent. The old beliefs came under attack, as they were perceived to stand in the way of conversion to Christianity, and to the acceptance of civilisation. History has shewn that these terms are not necessarily synonymous, nor is their active propagation necessarily beneficial. The Indian and Inuit healers were caught up in this conflict, with their interrelated gods, medicines, concepts of health and disease being not only quashed, but denounced as being sinful. Paradoxically, the colonisers brought with them not only new ideas, but also new diseases, such as measles, smallpox, influenza, venereal disease and tuberculosis, which the old healers were singularly unable to treat.

An earlier example of communal interest in the care of the individual is provided by Herodotus following a visit to Babylon in around 450 BC. He describes how the people brought their sick into the market place, "Then, those who pass by the sick person confer with him about his disease, to discover whether they have ever been afflicted by the same disease, and advise him to have recourse to the same treatment as that by which they themselves, or others they have known, have been cured. And they are not allowed to pass by any sick person without enquiring the nature of his distemper".

The first known institutions to provide inpatient treatment for the sick were within the sanctuaries dedicated to Asclepius. Epidaurus was the principal centre, though the original home of the cult was in Tricca, in Thessaly. In the Asclepia certain rites were observed. After baths, fasting, and sacrifices, the patient was permitted to spend the night in the temple where he slept on a couch near the statue of the god. This was the period of incubation. During the night Asclepius would appear to the patient in a dream, and in the morning the priest would interpret the dream, and prescribe appropriate therapy. In such a setting was Wealth, or Plutus, cured of his traditional blindness in the comedy of that name by Aristophanes, first performed in 388 BC.

While many instances of successful treatment in the Asclepia were recorded, intending inmates were subject to careful selection by the attendants. Neither birth nor death was permitted to occur in the presence of the god. If a sick man was seen to be dying, he was removed from his couch, taken to the gate, and left to die on the hill side. Likewise, a woman going into labour whilst undergoing treatment for another illness, was mercilessly cast out. During the second century BC, these temples developed into resorts resembling the spas of more recent days. Patients stayed for longer periods taking baths, drinking the waters, and were disciplined by a strict regime of exercise and diet.

Turning to domiciliary medicine of that time, Plato commented on the different attitudes of doctors to the slave and the freeman. "Slave doctors do not talk to their patients individually, nor do they permit them to talk about their complaints. He prescribes what experience suggests, gives his orders, and is on his way with a show of urgency. But the doctor attending a freeman goes to the patient, rather than the patient to him. He carries his enquiries far back, and goes into the nature of the disorder; he talks to the patient, and to his friends, and will not prescribe for him until he has first convinced him. At last, when he has brought the patient more and more under his persuasive influence, he attempts to effect a cure".⁶

In the Roman Republic, the citizens, proud and self-sufficient, had no need of physicians, according to Pliny the elder. The head of the household looked after the physical well-being of his family and slaves. He consulted, and, where necessary, propitiated, the appropriate household gods, of which there were many, representing almost every bodily organ, function, and symptom of disease. In cases of a more serious nature the Sibylline books, acquired at great expense by Tarquin, and preserved in the Temple of Jupiter, were consulted. At least the citizens were spared the hazards of iatrogenic illness, but following the fall of Corinth in 146 BC, Greek physicians came to Rome in increasing numbers, though they were accorded a lowly status, and despised because of the high fees they charged. A greater variety of medical advice and treatment became available to the people with the appearance of experts in particular fields of medicine. Cicero deplored this development; "Do you really suppose", he wrote, "that in the time of the great Hippocrates of Cos there were some physicians who specialised in medicine, and others in surgery, and yet others in ophthalmic cases? Or that even literature with Aristophanes or Callimachus were such entirely separate subjects that nobody embraced culture as a whole".⁷

In the early days of the Empire, however, Rome contained many specialists, most numerous being the oculists, who largely devoted themselves to the preparation of salves for the eyes. As many of these applications contained copper or arsenic, it is not surprising that the cure was often worse than the disease.

The Greeks and Romans believed that the Fates ruled their lives. Clotho spun the thread, Lachesis was chance, that element of luck that every man could reasonably expect, while Atropos arbitrarily cut the thread, bringing life to an end. Additionally, Nemesis hovered ominously overhead, ready to strike down the evil doer, or one who appeared to enjoy excessive and unmerited prosperity. Under these circumstances, the average citizen kept his head down, bore illness with fortitude, and did not expect cure or preservation from death as a result of medical intervention alone.

While Christianity was, in part, a revolt against pagan materialism and superstition, its followers too could not accept a natural cause of disease, nor could they envisage a cure as being other than miraculous. Following the closure of the Asclepia by Constantine in 335 AD, many Christian hospitals were established throughout Europe, the earliest in Britain being probably at York in the tenth century. In these institutions, patients received care and comfort, and assistance to bear their misfortunes, rather than treatment of their underlying disease. Many inmates would not be described as sick to-day. A London citizen, Robert Copland, described those who could expect to be admitted to a hospital, probably St Bartholomew's:⁸

They that be at such mischief
That for their living can do no labour
And have no friends to do them succour:
As old people sick and impotent,
Poor women in childbed here have easement.
Weak men sore wounded by great violence
And sore men eaten with pox and pestilence,
And honest folk fallen in great poverty
By mischance or other infirmity;
Wayfaring men and maimed soldiers

Have their relief in this poor house of ours;
And all others which we deem good and plain
Have their lodging here for a night or twain:
Bed-rid folks, and such as cannot crave
In these places, most relief they have,
And if they hap within our place to die
Then they are buried well and honestly.
But not every unsick stubborn knave,
For then we should over many have.

There is little evidence that, during the middle ages, the monasteries contributed significantly to the care of the sick. The infirmaries attached to them were essentially to accommodate sick members of the order themselves. While many so-called hospitals were temporary refuges for travellers and pilgrims, most in the truer sense were lazar houses, where sufferers from leprosy were compulsorily isolated. To them a harsher charity was meted out. Lepers, or 'Christ's poor' as they were generally known, were looked upon by the Church as the living dead. They were torn from their families and friends, a form of the burial service was read over them, and the more fortunate were entombed in the lazarettos: others were banished to end their miserable lives begging for food and alms by the roadside.

In rural areas, where 90 per cent of the population lived in small village communities, most medical care continued to be on the self-help basis. It is improbable that the skills of professional leeches were available to those who could not pay for their services. The lady of the manor dabbled in household medicine, and Salzman considered that "she was skilled in compounding medicine from herbs which she administered to the household and her poorer neighbours, she being often the unofficial doctor of the village".⁹ Other women, of more humble standing, also provided simple treatment for the poor. One of Chaucer's characters is confident of her homespun remedies—

"Let me urge
You free yourself from vapours with a purge
And that you may have no excuse to tarry
By saying this town has no apothecary,
I shall myself instruct you and prescribe
Herbs that will cure all vapours of that tribe
Herbs from our very own farmyard".

But for most people, personal illness was of small account compared with their suffering resulting from the recurrent and apocalyptic succession of war, famine, pestilence and early death. Continual wars were followed by the dismal sequence of pillage, destruction of crops and homes, leading in turn to famine and epidemic disease. To have lived in Europe in the 14th century would have been to experience the appalling synergism of the Hundred Years War, the terror of the Inquisition, and the advent in 1348 of the great mortality, or, as it came to be known, the Black Death. In his introduction to the Decameron, Boccaccio left a vivid account of the plague, as it affected the city of Florence. He gives an accurate description of the clinical features, emphasising the ominous prognosis of the development of a petechial rash, and continues; "Either the disease was such that no treatment was possible, or the doctors were so ignorant that they did not know what caused it, and

therefore could not administer the proper remedy". Quacks and charlatans abounded, but multitudes of people were left without care, brother abandoned sister, and wife her husband. In spite of attempts to control movement of people into Florence, between March and July, 100,000 persons perished. It was in Venice, in that year, that a board of health was formed to isolate all travellers from the East on an island offshore; the period of such isolation to be forty days, arbitrarily chosen to correspond to the length of Christ's stay in the wilderness, from which the term quarantine is derived. The plague reached England in the Summer of 1348, spreading to Scotland, and later to Wales and Ireland. It was to remain endemic in Britain for the next three hundred years. Thomas Nashe echoes the fatalism of those days:

Rich man trust not in wealth;
Gold cannot buy you health;
Physic himself must fade;
All things to end are made;
The plague full swift goes by;
I am sick, I must die.

Small wonder that the best preventative against the plague were the three adverbial pills, "quick, far, and late"—go quick, go far, return late.

One may observe, as at first hand, something of life, death, and doctors in seventeenth century London through the writings of John Evelyn and Samuel Pepys, diarists, contemporaries, and friends.^{10, 11} Pepys underwent a lithotomy for bladder stone at the age of 26, two years before he began his diary, and celebrated each anniversary of the operation in a day of solemn thanksgiving. Eleven years later, Evelyn writes; "I went this evening to convey Mr Pepys to my brother Richard, now exceedingly afflicted by the stone, to encourage his resolution to go through the operation". Pepys, ever an enthusiast, but often lacking insight, brought with him his own calculus, suitably mounted, and as big as a tennis ball. Unhappily the sight of this exhibit did nothing to strengthen Richard's resolve, and he died a year later in great misery, without having had surgery. Years previously, in Paris, Evelyn visited the hospital of La Charité where he saw the operation of cutting for stone. He records, in May 1650; "A child of eight years old underwent the operation with most extraordinary patience, and expressing great joy when he saw the stone was drawn. The use I made of it was to give Almighty God hearty thanks that I had not been subject to this deplorable infirmity".

Pepys had many medical friends, some of whom he used to encounter at meetings of the Royal Society. At one such meeting, early in 1666, which had adjourned to the Crown Tavern, he describes how, "Dr Goddard did fill us with talk in defence of his and his fellow physicians going out of London in the plague time". Pepys did not find his excuses convincing, but the discussion was a long one only terminating, as he tells us, "when poor Dr Merritt was drunk, and so all home". The exodus of physicians from London during the plague allowed the apothecaries to become firmly established. When the plague receded, patients found the apothecary in his shop to be easily available, able to provide a diagnosis, dispense his own prescription, dress wounds, and even bleed, without the help of a physician. This facility was to be legitimised by a ruling of the House of Lords in 1704 which allowed an apothecary to prescribe for a patient without the intervention of a

physician. He could not charge for such advice, but only for the medicine, hence the habitual expectation of a bottle of physic which has been ingrained in patients ever since.

When Pepys was 35, he began to have trouble with his eyesight, and he records, "And then to Westminster to Dr Turberville about my eyes, whom I met with, and he did discourse, I thought, learnedly, about them, and takes time, before he did prescribe me anything, to think of it". Obviously a model consultation, but Pepys' confidence was to be somewhat lessened a fortnight later when he met up with some medical friends, including his eye specialist, at an ale-house in the Strand, to watch a Dr Lowrie dissect some sheep's eyes. He thought it strange that, "This Turberville should be so great a man, and yet to this day had seen no eyes dissected".

Evelyn himself lived to be 86, but of six sons and three daughters, only one daughter survived him, an appalling mortality in a well-to-do family. On the 27th January 1658 he writes; "After six fits of quartan ague died my dear son Richard, to our inexpressible grief and affliction, five years and three days old only, but at that tender age a prodigy of wit and understanding". No mention is made of calling a doctor, but he voices some criticism of the domestic nursing care. "In my opinion, he was suffocated by the women and maids that tended him, and covered him too hot with blankets as he lay in a cradle, near an excessive hot fire". Three weeks later his youngest son also died. "Seven weeks languishing at nurse, ending in a dropsy". Two of Evelyn's daughters died of smallpox, and he himself contracted the disease while travelling in Switzerland. In Geneva, he sent for a physician and he writes; "The doctor persuaded me to be let blood. He afterwards acknowledged that he should not have bled me had he suspected the smallpox, which broke out a day later. He then purged me and applied leeches, and God knows what this would have produced if the spots had not appeared, for he was thinking of bleeding me again". With the decline of bubonic plague, smallpox continued to be the most feared of diseases for the next two hundred years. While the incidence was high, many patients recovered, bearing their pock marks as reminders of man's mortality.

But British troops, returning home after the battle of Ramilles in 1706, brought back with them another evil contagion, a taste for gin. The next fifty years were notable for frenzied and widespread consumption of cheap spirits distilled from surplus corn, rotten fruit, and even sawdust. In London, for the years 1740-1742, the ratio of burials to baptisms rose to be two to one. A Middlesex magistrate wrote, "In the early part of my life (I remember almost the time that Hogarth has pictured) when every house in St Giles, whatever else they sold, sold gin, every chandler's shop sold gin, the situation of the people was terrible". The College of Physicians petitioned Parliament against spirituous liquors as rendering the poor not fit for business, a burden to themselves and neighbours, and too often a cause of weak, feeble and distempered children. John Fielding, in 1776, declared that; "These shopkeepers have conveyed more to the regions of death than the sword or the plague."¹²

In the midst of this orgy of self-destruction, and, perhaps, because of it, more philanthropic ideals prevailed, which were to lead to improved medical care for the poor, especially in the cities. Hospitals were founded by private individuals, and maintained by voluntary subscription, in London and the provinces, though the period of their establishment was coincident with the highest death rate of the

century. This was scarcely surprising, as most were ill-ventilated, and ravaged by fever; a Dr Percival commented in 1771; "It is a melancholy consideration that these charitable institutions, which are intended for the health and preservation of mankind, may too often be ranked amongst the causes of sickness and mortality".

Of greater importance to the health and well-being of the citizens were the dispensaries, the first of which was established in 1769, due, in part at least, to the instigation of John Wesley. The dispensary was to provide a place at which the poor might attend for advice and free medicine, while those who could not attend were visited at home. In these centres, the patients were instructed in the fundamentals of hygiene, and the doctors learned something of the diseases associated with poverty and squalor. Following Jenner's work in 1798, many dispensaries undertook free vaccination, and in the early 19th century were responsible for measures to control typhus, and to isolate cases of infectious disease.

The cholera epidemics of the mid-19th century led to demands for reform in housing and sanitation. The wealthy townsman was not immune from infection, for his water supply was no safer than that in the slums, and typhoid was to cause the death of the Prince Consort in 1861. The threat of cholera led to the passing of Chadwick's Public Health Act in 1848, which was both ineffective and unpopular. To the Victorian mind, charity was a commodity which it was more blessed to give than to receive, and certainly not something to be officially imposed. In May 1848, the 'Economist' newspaper, opposing Chadwick's Act, declared unctuously "Suffering and evil are nature's admonitions; they cannot be got rid of; and the impatient attempts of benevolence to banish them from the world by legislation, before benevolence has learnt their object and their end, have always been more productive of evil than good".¹³ Later, following Chadwick's dismissal, the "Times" was to add; "we prefer to take our chance of cholera and the rest, than to be bullied into health".

In the latter part of the 19th century, in the larger towns and cities, many patients sought the services of the casualty officer attached to the local voluntary hospital. Robert Bridges, as casualty physician at Barts in 1878, reported that 150,000 patients had passed through his department in the preceding year. Significantly, perhaps, Bridges himself was to give up medicine altogether four years later for the gentler muse of poetry, and was eventually to be appointed Poet Laureate. He records that the doors were opened for one hour only at nine am, being held ajar by two porters in livery, who allowed the patients to squeeze in one by one. Each had to answer a crucial question which determined him, rightly or wrongly, to be a medical or surgical patient. By 10 o'clock five hundred patients were ranged on forms, the women engaged in conversation, the men waiting in silence. Medicine was dispensed from two large jugs, one containing a cod liver oil preparation, and the other Queen Anne's mixture of quassia and iron, which was specific for the many sufferers from atonic dyspepsia. He found the examination of women patients to be tedious and time-consuming: "With the lowest estimate of female garrulity", he writes, "we must recognise the feat accomplished in giving separate audience to the troubles of 150 women in three hours and a quarter; even though their complaints were generally less worthy of attention than those of men, and though I learnt to make them stand with their tongues out much longer than was necessary for medical diagnosis".¹⁴ Local doctors were incensed by these attendance figures, and the lost

income to them which they represented. Yet a century later, in 1981, 60,000 patients passed through the Accident and Emergency Department of the Royal, with the full acquiescence of their general practitioners.

In rural areas, the doctor was the virtual prisoner of his patients, who were banded together in sickness clubs and friendly societies.¹⁵ A commissioner from the 'Lancet', investigating the situation, reported, "To satisfy these patients, it is necessary to give them a lot of medicine; it must be a dark medicine, with a strong taste, preferably of peppermint. Something warming is required, so that when any friends call at the patient's house, he can offer them a glass". Following the passing of the Medical Act of 1858, the status of the general practitioner improved. He was idealised in Anthony Trollope's Dr. Thorne, of whom it was said that he added the business of a dispensing apothecary to that of a physician, as was then the wont of many country practitioners, and as should be the wont with them all, if they consulted their own dignity a little less, and the comforts of their customers somewhat more. Conversely, Trollope was scathing in his view of the physician of his day. Vain, inclined to name-dropping, and jealous of his aristocratic clientèle. While he charged no fee for his services; "The physician", he wrote, "should hardly be aware that the last friendly grasp of the hand had been made more precious by the touch of gold".

In 1689, Hugh Chamberlen, a Huguenot, put forward his proposal for the 'Better Securing of Health', "a complete constitution of physick whereby all sick, poor or rich, shall be advised and visited by skilful physicians and surgeons for all diseases except pox, midwifery, and cutting for stone, for a small yearly certain sum assessed on each house, not the third of what is now spent on Apothecaries bills in a healthy year". His scheme was not taken up, and the patient has had to wait for a further 260 years before a comprehensive service became available to him. Now, Christ's poor of yesterday have become the consumers of health care of to-day, though with very limited consumers rights. Claiming to represent the patient in this role is the Patients' Association, whose chairman, Dame Elizabeth Ackroyd, kindly accorded me a brief interview. It should be said that this Association, whose offices are situated in the Fabian Society Building in London, inclines, spectroscopically, more toward the infra red than the ultra violet. This is reflected in the adoption of a fairly militant attitude toward such matters as the complaints procedure, which is seen to be inadequate and biased in the doctor's favour, and hostility to private practice in NHS hospitals because of its divisive effects as between medical and other staff. Concerning information, it was the Association's view that this would be improved if the patient were to be allowed access to his own records, a view with which most doctors disagree. Regarding the general image of the doctor, Dame Elizabeth felt that because patients increasingly see themselves as consumers, they are less ready to take their doctor on trust: but if they have a good doctor, who listens to them, then they have as much confidence in him as they ever did. They are often worried about the ethical and practical problems of changing from one doctor to another, and afraid to ask for a second opinion, an option which is seldom offered to them. On the broader question of group practices, these are wholly acceptable to most patients, though older people would still prefer to see the same doctor on each visit. Surprisingly, perhaps, very few complaints were made about deputising services. People were glad to get a doctor to come to their house at all, since, in large cities,

most doctors did not live anywhere near their practices, and were thus completely inaccessible to their patients at night and at weekends. In general, it appeared that most patients who went into hospital were very satisfied with their treatment. Their main niggles were waiting lists, and waiting times, noise, and nurses, a minority of whom were inclined to push them around, and some patients complained about being used for teaching and research. But it is not as consumers that most patients see themselves, which is fortunate, for they will always consume more than we can provide, on the Parkinsonian principle that needs expand to match the help available.

Rudyard Kipling, addressing the students of the Middlesex Hospital in 1908, likened the patient's attitude to his doctor to that of the non-combatant toward the troops fighting for him. "We patients", he said, "console ourselves with the idea that it will be your business to make the best terms you can with death, on our behalf, to see how best his attacks can be longest delayed or diverted, and when he insists on driving his attacks home to us, that it shall be according to the rules of civilised warfare".¹⁶ But he also reminded his audience that the esteem in which the doctor is held, and the privileges he enjoys, relate to the patient's belief that his doctor will be available to him, however inconvenient the time or the place. But, in personal terms, what the patient requires of his doctor is clear: from Plato, Pepys, Pickering, and even the Patients' Association, the message is the same. He wants to discuss his illness, he wants the doctor to listen to him, and then to be decisive in his advice and treatment. He also has certain prejudices.

"I don't want a father figure as my doctor, just a good plumber", was the trite comment of a young social worker at a meeting in Dublin some years ago.¹⁷ She may be assured that the plumbers are getting better all the time, but the father figure is inescapable.

"The whole earth is our hospital", wrote T.S. Eliot

.....
"Wherein, if we do well, we shall
Die of that absolute paternal care
That will not leave us, but prevents us everywhere".

While the patient may reject the para-clinical caress of his practitioner, the outstretched arms of the Welfare State enfold him in a far more deadly embrace.

To-day's citizen still dislikes being bullied into health. Katherine Whitehorn, a regular columnist in the "Observer", accepts the propriety of measures, such as vaccination, as protection against specific physical ailments. She is critical, however, of the general urge toward prevention of illness involving changes in the life style of the individual. "I never elected anyone", she writes "to the right to make me healthy myself; or the moral right to make me feel my unhealthy habits are a sin against the religion of medicine".

The relationship between religion and medicine is, at best, a fragile symbiosis. While he may be sustained by his own beliefs and faith, the patient is unsettled by an excess of piety in his doctor. Admittedly, he seldom experiences it, and even Chaucer's physician, a pilgrim to Canterbury, was ill-versed in Holy Writ. George Eliot considered that the respect felt for the doctor with but little religion reflected the age-old association of cleverness with the evil principle, still potent in the minds,

even of lady patients. "It is certain", she continues, "that if any medical man had come to Middlemarch with the reputation of having very definite religious views, of being given to prayer, and of otherwise shewing an active piety, there would have been a general presumption against his medical skill",

Having fairly constant likes and dislikes, though with changing expectations, the sick person needing care is a fundamental concern of society, whether primitive or complex. "Virtue is the roughest way" wrote Sir Henry Wotton, and it is exemplified by the patient who has endured much, with cheerfulness and courage, qualities which may be observed daily in our hospital wards. Through the ages, the doctor has been lampooned for his avarice, vanity, and incompetence, by none more so than Moliere, in his seventeenth century comedies. Yet, while aware of our frailties, the patient has continued to shew a remarkable fidelity toward those who have set themselves up as his healers.

Medicine embraces the trivial and the serious, and is illuminated by both comedy and tragedy. In your career you will experience disappointment, but also enormous satisfaction, and to survive its undoubted tribulations you require both a sense of purpose, and a sense of humour.

For me, the virtue of those for whom it is our privilege to care, is crystallised in the words of Helen Keller. "Although the world is full of suffering, it is full also of the overcoming of it".

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