

## Not strangers, but pilgrims

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I had some difficulty with both the subject and the title, bearing in mind that this oration is a welcome to the new students to the Hospital. It is common practice to deliver a lecture of some historical interest, often on one's speciality. I have resisted that for three reasons. Firstly, Dr Reginald Hall has dealt with the history of dermatology in an earlier paper in a most distinguished manner.<sup>1</sup> Secondly, while those who cannot remember the past are condemned to repeat it, it is probably more true that we learn nothing from history except that we can learn nothing from it. I cannot think that anyone here is consumed with the desire to know the origins of dermatology. Thirdly, though I feel the temptation to take this opportunity to advance a couple of my obsessions, I feel I should resist this.

One of these obsessions is to tell you why I have such an affection for dermatology — an affection that is shared with young doctors in the United States where it is the second most popular speciality. We deal with a young age group — 27 years on average, younger than ophthalmology patients, for instance. All our patients are ill: that is, have something physically wrong with them. It is probably the largest medical speciality, comprising 8% of all patients seen by doctors, and 75% of all industrial disease.

My second temptation is to tell you how dermatology as a speciality could have been better and how younger specialties could learn from this. In the rest of the world, dermatology has followed an independent specialty line and has prospered, with full university departments, larger numbers, funding for research, etc. In the United Kingdom a different path was taken some years ago by those who led us at that time, who felt that dermatology's best path was as a sub-specialty of medicine: that is, that dermatologists were physicians with an interest in skin, rather than forming a specialty group in their own right. The results of this controlled experiment of the UK versus the rest lead me to believe that the rest had chosen more wisely.

So, a path chosen can have importance for your own career but it may also influence the career of those who succeed you. I have for many years, had a great affection for Robert Frost's poem *The road not taken*:

'Two roads diverged in a wood, and I —  
I took the one less travelled by,  
And that has made all the difference.'

So I see medicine as setting out on a journey. The idea of life as a journey is common to many cultures and ages, both in mythology and in real life. Many of the epic journeys seem to have been by sea: Marco Polo, Columbus, Jason with

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his Argonauts who set out to capture the Golden Fleece, and Ulysses who made his long way home on a journey that has become a legend for man's journey through life. I think probably the greatest story of a journey is *Pilgrim's Progress*, written in 1670, of which Bunyan sold 100,000 copies in his lifetime, and which was translated into 190 languages.

My second difficulty was the title. I am worried lest my present title might sound rather like a sermon, as it is taken from Hebrews 11, verse 13. It refers to Abraham as 'a stranger and a pilgrim who went out not knowing where he was going'; which I think describes the young doctor's dilemma today and you may feel like the saints described in that same chapter: 'They all died not having received the promises but having seen them afar off'. I hope you don't die before the promise of a senior job is fulfilled though some of you may feel like it. I changed it to 'Not strangers' because I consider medicine one of the best fellowships one could enter. Perhaps a better title would have been 'Hats off to the past, coats off for the future'.

So, I see you as embarking on a journey rather as Pilgrim did. The journey has three parts — setting out, the journey itself, and the final destination, probably the most important part. It is important to have an aim in life.

## SETTING OUT

TS Eliot wrote a poem on his graduation, in which he described the future:

'Although the path be tortuous and slow,  
Although it bristle with a thousand fears,  
To hopeful eye of youth it still appears  
A lane by which the rose and hawthorn grow.'

So really the simple purpose of this Oration is to point out a few roses which will cheer your path and warn you about some thorns.

You have set out in medicine. What are your reasons for doing so? I thought it would be interesting to look at the expectations of youth setting out and to compare it with the experience of a mature doctor. So I sent a questionnaire to five groups, as shown in Table I.

TABLE I  
*Number of questionnaires sent out and returned*

	<i>Sent out</i>	<i>Returns</i>
Students	157	157
Junior doctors	150	69
Northern Ireland consultants	150	106
General practitioners	150	96
RVH consultants	170	116

The questions were: 1. What made you choose medicine, and have your expectations been fulfilled? 2. What qualities do you consider make a good doctor? 3. What do you think could have been added to the medical curriculum to improve your medical education? Those questioned were asked to score 0–5, 0 being of no importance, 5 very important. Table II is made up by adding together those who put down '4' or '5' in the column.

TABLE II

*When you applied to study at university, what made you choose medicine? The percentages replying 'important' or 'very important' to the different modalities (4 and 5 on a scale 1 to 5)*

	Students (%)	Doctors (%)	Doctors' expectations fulfilled (%)
Job satisfaction	86	76	91
Helping people	66	62	92
Challenging job	55	47	92
Scientific interest	49	39	82
Comfortable income	40	29	86
Job security	38	43	76
Personality suited to profession	37	28	93
Opportunity for leadership	30	7	76
Social status	19	16	83
Potential for very high earnings	14	5	42
Did not know what else to do	12	10	—
Parental influence	11	17	—
Peer group pressure	5	3	—
School careers advice	5	4	—

One of the interesting outcomes was that in every modality the fulfilment of expectations had been much higher than the expectations themselves. There cannot be many professions in which that is the case. I was very gratified to see that the reasons which we might consider to be the rather better ones, such as helping people, job satisfaction and looking for a challenging job, came out highest. I was especially pleased that this also applied to the students. For a number of the modalities it was interesting to look for differences between the various groups of doctors. Those who became consultants had higher expectations of scientific interest, which were generally fulfilled. Otherwise there was remarkably little difference between senior house officers, general practitioners and consultants.

On setting out on the medical journey, one's luggage consists only of three things — intellect, character and training — and two of these one can do nothing about, because they are handed to us: it is difficult to put weight between character and intellect. As the years have gone on, I have become more and more convinced that hard work and dedication will outlast and outrun intellect. Any consultant in this room, could name without thinking too hard, not a few with a mediocre undergraduate performance but a brilliant postgraduate career. HJ Walton, Professor of International Medical Education at Edinburgh, confirms that this is not just an impression.<sup>2</sup> To summarise his evidence, intellectual ability accounts for about 35% of the observed variance, and the addition of personality and motivation measures accounts for up to 75%.

The answers to the second question are shown in Table III. Most people thought that high intelligence was not one of the most important things, and that the most

important characteristic of all was common sense, followed closely by keeping up to date with the subject, integrity and being a good communicator. As before, students and doctors were very similar in their perceptions.

TABLE III  
*What do you think makes a good doctor?*

	<i>Students</i>	<i>Doctors</i>
	%	%
Commonsense	97	98
Good communicator	94	92
Keeping up to date with subject	93	96
Readily available to patient	89	81
Bedside manner	89	86
Ability to get on with others	88	83
Integrity	85	92
Hard worker	82	88
Most effective at age 35 – 45	62	52
Efficiency at seeing patients	54	54
Having time for patients	52	65
Interests outside medicine	52	46
Leadership qualities	40	39
Good academic background	40	28
Good at administration	26	31
Most effective at age 45 – 55	22	37
High intelligence	19	18
Interest in research	13	6
Retiring manner	6	3

The only piece of luggage we have a choice about is our training. You are now committed to this medical school. We all say that Queen's is one of the best medical schools, but how do we know? How can it be assessed? Is it the amount or quality of research? One couldn't say there have been many discoveries made in Belfast to revolutionise medical care or medical teaching. Is it the quality of the graduates? How can we assess quality? It is easy with a football team or a business. As CS Lewis said, the purpose of education is not to cut down jungles but to irrigate the desert. How do we know if we are growing the right plants, or applying the best fertiliser, or doing it better than other people? One thing I have little doubt about is that Queen's University has been the most caring medical school. Though I cannot get figures to prove it, I believe it has made the greatest contribution to the Third World of any University because of the strong Christian commitment of its medical intake from both communities.

In Professor Roddie's inaugural lecture *An excellent medical school*, he deals with all these points, and in my opinion this should be required reading for all medical staff and medical students.<sup>3</sup> I think the worst fault that people in my generation fell into was to convince ourselves that we had an excellent medical school and

not question, as Professor Roddie has done, whether indeed we did, or if we did, what was necessary to retain its excellence. The things which my respondents considered would improve medical education are shown in Table IV. It would seem that most people felt there was not great room for improvement. It is interesting that computer skills, avoiding litigation and an illness of your own, came high, but highest of all came interests outside medicine.

TABLE IV

*Do you feel experience/knowledge of any of the following would be helpful in your medical curriculum?*

	<i>Students and doctors (%)</i>
Interests outside medicine	48
Computer skills	45
In illness of your own	41
Advice on avoidance of negligence claims	37
Administration/organisation	36
Teaching how to get on with colleagues	36
Statistics	32
Court witness technique	27
Experience in nursing	23
Teaching in leadership	21
Typing	20
Shorthand	13
Social sciences	12
A foreign language	10
Photography	5
Other (please specify)	(70)

Most people probably do not know that the Medical Library Association was inaugurated in Belfast on July 28, 1909,<sup>4</sup> and the distinguished first president, who gave the inaugural lecture, was Sir William Osler, and in Belfast he said, 'One of the best features I find in my "old country" colleagues is the frequency with which they have hobbies. No man is really happy or safe without one, and it makes precious little difference what the outside interest may be — botany, beetles or butterflies, roses, tulips or irises, fishing, mountaineering or antiquities — anything will do so long as he straddle the hobby and ride it hard'. His lecture was packed with good advice: 'In the case of our habits, we are only masters of the beginning, the growth by gradual stages being imperceptible like the growth of a disease'. In this he was referring to reading. It is interesting to see how little times have changed, because he said, 'How can a busy man read, driven early and late, tired out and worried? He cannot. It's useless to try, unless he has got into the habit when he was not so busy. Then it comes easy enough and the hardest workman in the land may read his journals every week, even if he has to do it in his carriage'.

The future may seem bleak to you with over-intake into medical schools but this has only increased by 0.35% from 1979. You are in a vastly superior position to medical students in other countries. For instance, Italy has 30,000 unemployed doctors, Spain has 20,000, Mexico has a national union of unemployed physicians with a membership of 50,000, and one medical school in Europe, Naples, admits over 7,000 students a year. You are joining a profession with 88,000 members in Britain, of whom 24,000 are in general practice, 11,000 are senior hospital doctors and 20,000 junior doctors: 56% of you will finish in general practice, 27% as senior hospital doctors, 5% as academics and 5% in community health. About one person every other year in the medical school will not bother to register, but, once registered, only about 0.2% leave the practice of medicine which must be a very much lower proportion than in other professions. Bearing in mind that many of those who leave do so to occupy distinguished positions in other professions, this would suggest that doctors are well fulfilled in their profession.

## THE JOURNEY

Having started, we think about the journey. In my view the best guide is a Christian faith, but there are others, and we will concentrate on those today. There are a number of roses and thorns which I wish to discuss, and they are not meant to be exclusive.

## ROSES

**Colleagues.** The best help you have are good colleagues and friends and a happy environment. I think one of the unique features of the medical profession is the support and friendship which one receives from colleagues over the years. I look round other professions and I do not see the same degree of colleague support. Perhaps the best asset we have is our happy relationship with the nursing profession. Some are working hard to destroy this. Don't let them. Nevertheless, that does not mean to say that we are always in agreement, but healthy disagreement with one's colleagues is valuable. It is said, when two men in business always agree, one of them is unnecessary.

Beware of advice from so-called wiser experienced colleagues. I have seen some catastrophic advice given to young men by so-called older wiser colleagues. The notion that as a man grows older his illusions leave him is not quite true. What is true is that early illusions are supplanted by new and, to him, equally convincing illusions.

**Etiquette and ethics.** You might think these should be considered among burdens, but, in my opinion, the reverse is true. I am sad to see that the word 'etiquette' is being dropped from the new BMA handbook on medical ethics. It is said to have virtually disappeared from current usage in the English language, and we now talk about professional behaviour. Professional behaviour is really good manners towards one's colleagues. It may be that the hardest thing young people today have to do is learn good manners without seeing any.

Medical traditions themselves are important. Don't disparage them. As a result of your forebears you are going to be placed in a privileged place in society. This is a sweet-smelling rose. It is impossible to over-estimate the benefit of public goodwill towards the medical profession. I hope younger colleagues will continue that, and I see no reason to suspect that they won't.

**Health.** Doctors have significantly good health. Standard mortality rate for those aged 20–64 in the last decennial supplements of occupational mortality show that doctors have a standard mortality rate of 66, as opposed to the normal of 100. There are, however, two diseases from which doctors suffer a statistically significant excess in mortality. Firstly, suicide — the standard mortality rate for doctors is 172 and there are about 65 suicides per year in the UK. It may be that this relates to the stress of the medical profession, but an important factor may also be the ready availability of methods of suicide. Secondly, diseases of alcoholism — Professor Rawnsley has shown that the rates for doctors for admission with alcoholism to Scottish psychiatric units is about three times those for controls.<sup>5</sup> That this is a problem is confirmed by the standard mortality ratio for physicians and surgeons for liver cirrhosis (311 in 1971). We probably have a duty to two groups in this regard. Firstly, to medical students and younger doctors we should point out that the medical profession has a problem which many believe begins in student days, including Professor Anthony Clare, as evidenced in his Snow Lecture to the British Association of Anaesthetists in 1986 (unpublished). Perhaps we should make it more difficult rather than less difficult for students to consume large quantities of alcohol. Our second duty is to our patients who take their example from us. Doctors who gave up smoking have had a major effect on the general population. It has been said that a doctor only regards a person as an alcoholic when he drinks more than himself. If they take their standards from us, then they are in trouble. You are entering a stressful occupation, as a very recent paper has shown, more so than any other profession, but it is an enjoyable one, even at a junior level.<sup>6</sup>

Doctors have a much better rate of health in most things, eg, carcinoma of the bronchus, standardised mortality 25, ischaemic heart disease, standardised mortality 22, and the lowest standard mortality for doctors, 12, is for ulcer of the stomach and duodenum. There is a very common belief that, if one retires early, it increases one's expectation of life. It has been said that, if one retires at 60, one may have a life expectation of 10 years, as opposed to one year when retiring at 65. The belief is widespread and pervades the whole UK. The figures from the Registrar-General (England and Wales) are shown in Table V. These figures may be slightly skewed by those retiring early from ill health, but the message is clear. If you are retiring early to enjoy a longer life, you won't. An argument has been put forward that it would cost the pension fund too much to allow doctors to retire early. These figures do not support this.

TABLE V  
*Life expectancy of medical pensioners in the United Kingdom*

<i>Age at retirement</i>	<i>Life expectancy in years</i>	
	<i>Males</i>	<i>Females</i>
30	20.0	34.3
35	19.3	32.0
40	18.3	29.6
45	17.2	26.9
50	15.8	24.1
55	14.1	21.0
60	14.9	22.5
65	14.2	18.4

It would be interesting to know if different specialties have different health rates. I was not able to find any figures except those in a study of 1020 United States physicians who died between January 1978 and March 1979 (Table VI).<sup>7</sup> There are more octogenarians among the ENT and eye specialists, with the dermatologists in third place. No family doctors survived to this age.

TABLE VI  
*How specialty relates to longevity in the USA*

	<i>Percentage of doctors who died at this age</i>				
	<i>Less than 50</i>	<i>50-59</i>	<i>60-69</i>	<i>70-79</i>	<i>80 plus</i>
Otolaryngology	0	5.6	18.1	34.7	41.7
Ophthalmology	3.1	9.4	17.2	40.6	29.7
Dermatology	8.3	8.3	25.0	29.2	29.2
Internal medicine	8.9	14.9	28.6	26.8	20.8
Paediatrics	4.2	22.5	28.2	25.4	19.7
Obstetrics/Gynaecology	13.7	9.8	28.4	32.4	15.7
Orthopaedics	8.3	8.3	39.6	29.2	14.6
Preventive medicine	0	3.2	38.7	45.2	12.9
Surgery	10.8	21.6	33.1	21.6	12.8
Family practice	25.0	41.7	29.2	4.2	0

From: Mostafa MFD, Freeman RA.<sup>7</sup>

## A FEW THORNS

**Litigation.** Litigation is a worrying problem, increasing not only in numbers but in the amount of awards given. It is very difficult to get exact figures (the Defence Unions don't give theirs). The figures for England are shown in Table VII, which works out about one claim per 25 doctors. In Northern Ireland there is a higher rate (1980 — 77 cases; 1984 — 197 cases): with about 2,500 doctors this is one case per 12.5 doctors per year. If you multiply this by 40 (the average working life of a doctor), it would suggest that, if the present rate continues, and we have no reason to suppose it is going to get any less, then a doctor in Northern Ireland can expect to be sued on average three times in his lifetime. One cannot imagine that medical practice is any worse here than in England, so this difference must be due to two things — the proclivity of the local population for litigation, and the zeal of certain solicitors to look for new business. An interesting sideline is that a hospital has three times the chance of being sued by its staff than it has by the patient.

TABLE VII  
*Claims against hospitals — England*

	<i>No. of cases</i>	<i>Payments £</i>
1981/82	2,791	3,437,363
1982/83	2,990	3,569,019
1983/84	3,266	4,839,175



**Administration.** Having had some experience of medical administration, I believe it is essential for doctors to be involved. However, I think I should say that it can be a snare and a delusion — a delusion that you are doing any good or in any way helping the patient. Administration, be it medical or other, only redistributes resources. It doesn't create medical wealth. One can very quickly suffer the delusion that one is actually improving the lot of patients. Nothing could be further from the truth.

There are only three groups of people who create medical wealth — those who finance it, those who deliver it, and those who move the frontiers forward in research. The Government allocates most of the resources and in this country there is a very low total health expenditure (Table VIII). With the exception of Sweden, public health expenditure as a percentage of the gross domestic product in the UK is not greatly different from the average in other countries. The difference is in the amount contributed by private sources. Even in Sweden 0.8% is supplied from the private sector as opposed to only 0.7% in Britain. Perhaps we do need more private input to health. I find it hard to know whether to consider private practice as a rose or a thorn in the body medical. I think, on balance, it has a greater effect for good than bad.

TABLE VIII

*International comparisons.**Health expenditure as percentage of gross domestic product, 1983*

	<i>Total health expenditure</i>	<i>Public health expenditure</i>
USA	10.8	4.5
Sweden	9.6	8.8
France	9.3	6.6
Netherlands	8.8	6.9
Germany (GFR)	8.2	—
Australia	7.5	4.9
Italy	7.4	6.2
Austria	7.3	4.6
Norway	6.9	6.2
Japan	6.7	5.0
Finland	6.6	5.2
Denmark	6.6	5.6
Belgium	6.5	6.0
UK	6.2	5.5
Greece	4.7	?

Administration is also a snare because it takes time, and some get involved in it when they should be committed to other things. It is a particular snare to younger doctors for it may detract them from research, which should be a main function in a teaching hospital after duties to patients and teaching. I don't know what makes one a success in administration, but I do know what makes a failure, and that is

trying to please everyone. The best advice I know is the best is the enemy of the good — the advice that Sir John Harvey Jones, the most successful chairman Imperial Chemical Industries ever had, gave to his younger staff. What I mean is that the relentless pursuit of the perfect solution to a problem often means that nothing gets done. Walter Lippmann expressed it better than I can when he said: 'A rational man acting in the real world may be defined as one who decides where he will strike a balance between what he desires and what can be done. It is only in imaginary worlds that we can do whatever we wish'. This is not only true of administration but of research. I have found more research abandoned because it aimed too high rather than too low. It is also true that the pursuit of the best for one unit means abandonment of the good for someone else.

**Age.** Another thorn is age — your own and the patient's. It astonishes me that anyone can find merit in the argument that there should be no retiring age. I feel the problem is one for the General Medical Council. I find it surprising that, over the age of 70, one has to undergo a medical examination to carry on driving a car, and yet one is allowed to go on doing a much more dangerous thing, treating patients, without any check on mental health, eyesight or other faculties. My knowledge of doctors further leads me to the view that a person over 70 is more likely to have problems than somebody just finishing their resident year. The General Medical Council figures confirm this, and it is extraordinary that this body should be considering a second year of compulsory training, while doing nothing about control of ageing and perhaps even dementing doctors. The other problem is the age of your patient: 15% of the population are over 65, and require 50% of the health resources. Quite clearly, if you don't like looking after old people you shouldn't be taking up medicine.

There are other burdens which will be added to your shoulders, which we have avoided, such as investigation about your cost-effectiveness and your performance indicators. I wish I had time to give you my views on these.

## **JOURNEY'S END**

'What are you aiming for?' Bunyan's Christian said, 'Whither must I fly?' Then said Evangelist pointing with a finger over a very wide gate, 'Do you see yonder wicket gate?' The man said 'No'. Then said the other, 'Do you see yonder shining light?' He said, 'I think I do'. Then he said, 'Keep that light in your eye'.

What shining light can be kept in your eye? Is it money, a successful department, personal fame, contribution to medical science, service to patients? I feel it is important to have some guiding principle. Thinking about a standard or aim leads us to the original symbol of medicine, namely the snake on a pole. The staff of Aesculapius has represented medicine since about 800 BC. This is a staff with one snake wound round it. Greek mythology describes how he discovered a magical herb when he observed a snake rejuvenate a previously dead companion by placing the herb in its mouth. No one knows why the Caduceus, which is two snakes intertwined, has gradually been chosen to represent medicine, though it didn't appear until after 1800. It is particularly significant when two wings are added on top of the snakes to make the medical symbol of that into Hermes or Mercury. Everyone knows that Hermes is the God of Commerce. So you can choose whether you wish to have a single snake or the double snake with the wings as your guiding light.

One cannot discuss the snake without referring to the serpent which Moses set up on a pole, which we might like to think of as the basis of the medical symbol,

although it does not appear to be so. But I think it is relevant to us. Perhaps it is a symbol of the faith which patients have in the medical profession, but it is interesting that having given the people this symbol of healing, God should tell Heziakah after many years to destroy it. I think there are two things we can learn from that. Perhaps the snake had served its usefulness and we should not hesitate to cut out anything that has ceased to be useful and move on to the new. I think the medical profession has been exemplary in moving with the times. However, I believe the greater meaning for us is that the snake was to be destroyed because the people came to worship it and to burn incense to it. In an oration such as this, one is in danger of worshipping the profession and the art of medicine, so that something which was given to us for the good of our patients can be a thing to be worshipped and admired for itself.

Our primary purpose in medicine, therefore, should not be to improve the profession, improve our hospital, or to improve our medical standing or income, which are legitimate and right in their place, but come under the worship of the snake. These all can be taken from you, but what you have done for your patients, never. It seems to me we have been given gifts and trained in healing, and that the shining light towards which we should aim should be the simple task of doing the best for our patients. Our success and failure may be judged on that. So, I welcome you to a wonderful profession where the roses greatly outnumber the thorns, and on behalf of the medical staff, may I wish you a safe, satisfying and successful pilgrimage.

I should like to express my sincere thanks to Professor Robin Shanks and Dr Noel Wright for their help during this survey.

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