

THE MAKING OF A DOCTOR
Reflections on Attitudes, Ability and Aims in Medicine

by

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**THE ADDRESS TO THE STUDENTS AT THE OPENING
OF THE WINTER SESSION ROYAL VICTORIA HOSPITAL,
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IT has long been the tradition of this hospital for a member of the medical staff, appointed to the duty by his colleagues, to deliver an address to the students at the commencement of the winter teaching session. Indeed, it was already an old-established custom in 1852 when Dr. Andrew Malcolm graced the office of orator.¹ I feel greatly honoured to have been entrusted with this very special responsibility and to tread in the steps of those who, over the years, have made the Royal Victoria Hospital what it is today.

In 1903, Sir William Osler,² distinguished physician and teacher, celebrated essayist and acknowledged master of the orator's art, addressing undergraduates of the University of Toronto said: "Of the value of an introductory lecture I am not altogether certain. I do not remember to have derived any enduring benefit from the many that I have been called upon to hear or from the not a few that I have inflicted in my day. On the whole, I am in favour of abolishing the old custom . . ." If that was how Sir William truly felt about an occasion such as this, who am I to disagree with him, if only for today! And yet, I wish that he had had the privilege of being a member of the medical staff of the Royal Victoria Hospital and of sharing our traditions because I am sure he would have found inspiration in the wisdom and oratory of his colleagues. They would have included the late Dr. R. S. Allison's "Olympians,"³ Sir William Whitla, Professor J. A. Lindsay, Dr. William Calwell, Dr. H. L. McKisack, Mr. A. B. Mitchell, Dr. W. B. McQuitty, Mr. Robert Campbell and Dr. John Walton Browne who, as chairman of staff, participated in the Loyal Address of Welcome to their Majesties King Edward VII and Queen Alexandra at the official opening of the Royal Victoria Hospital on 27th July of that same year, 1903.⁴

It is on these occasions that we are especially conscious of our links with the past, with the long line of our illustrious predecessors who practised and taught in this hospital and in its forerunners, the Belfast Dispensary and Fever Hospital, first opened in Factory Row in 1797 and later moved to West Street, Smithfield, and then the Belfast General Hospital built in Frederick Street, opened in 1817 and renamed the Belfast Royal Hospital in 1875. They devoted their work, wisdom and skill to the service of their fellow men and were diligent and faithful trustees of that great heritage which we are proud to cherish today. It reminds us that we, being many, are all members of one body.

I wish to take this opportunity to express sincere personal appreciation and thanks for wise counsel and valued help to colleagues and friends who have now fulfilled their appointments at this hospital and whose daily leadership, companionship and support we shall all greatly miss.

It is my privilege this morning, on behalf of the medical staff of the Royal Victoria Hospital, to extend a warm and friendly welcome to the whole student body and especially to those who have most recently been admitted to the practice of this hospital. During the next three years you will spend many hours within its walls and it is my hope that, as you gradually become familiar with its wards and corridors, clinical rooms and lecture theatres, outpatient departments and operating suites, and begin to recognise more of the faces of the hospital community of some six thousand people who spend their working lives on this campus, you will feel great affection for and loyalty to this institution, standing as it does for the highest ideals of our deeply troubled and careworn human society. At first it may seem a very large and even rather daunting place, its never-ceasing activity taking no account of the passing hours, but as you absorb its atmosphere and get to know its sights and sounds I hope that you will feel humble pride in belonging to this hospital, to this medical school and to our profession, all of which have for their ultimate purpose the protection of health and the immediate provision of skilled treatment and compassionate help for those whose lives are impaired or endangered by illness or injury.

This morning we celebrate your coming, for in this annual renewal of our profession by gifted young people with keen minds, warm hearts and a fresh outlook lies the promise for the future. We are very conscious of our duty to you who look to us for inspiration, instruction and guidance and who, in a few short years, must be ready and willing to accept the weight of our responsibility. As Cassell⁵ put it: "One of the most wonderful things about medicine is its continuity. Doctors are trained by other doctors. Each physician, then, is not only himself but is made up of other men, and each teacher becomes a part of his students." Our thoughts, hopes and good wishes will go with you in your undergraduate and postgraduate career.

Over the past three decades medicine has undergone more profound and rapid changes than at any time in its history. In the United Kingdom, the most important of these was the introduction of the National Health Service on 5th July, 1948, recently described by Sir Francis Avery Jones⁶ as "potentially . . . one of the finest advances in social humanity in this century." Its reorganisation in 1973, however, led to the erection of a top-heavy administrative structure that almost wrecked communication between doctors and administrators and initially slowed progress. Changes of attitude have occurred within our own profession as a reaction to the unremitting burden of clinical responsibility, inadequate staffing, long hours and successive pay policies. Still fresh in our memories are the unprecedented events of last winter when the country witnessed the effects, and noted the implications for the future, of the growth of industrial-style disruption of hospital services by trade-unionists representing the interests of low paid health service workers and demanding a voice in management decisions. Many changes have sprung from the clinical application of major scientific discoveries and sophisticated technological advances that have brought great benefit to the patient. Yet others have arisen in response to the growing hopes and expectations of society.

Within the span of my professional lifetime, medicine has experienced a peaceful revolution of major proportions and there is as yet no indication that the pace of change is slowing. On the contrary, to give but one simple example, such is the flood of new information flowing in from every quarter that the pool of knowledge has widened into a veritable sea and every doctor and every student is faced with the problem of how to manage this embarrassment of riches.

It therefore seems appropriate to pause in the midst of these changing times to consider those personal attitudes, academic standards and clinical principles that are likely to be important in determining the kind of medicine that you, our heirs and eventual successors, will practise in years to come and how we as a profession can best use our influence to safeguard its character and quality. The outcome of these deliberations is far from academic for those of us who today are seated in the front stalls of this house for, as increasingly likely clients, we have a strong personal interest in any service to be provided by those at present occupying the gods but who will surprisingly quickly find themselves sitting nearer and nearer to the front! It is to you that I wish largely to direct my thoughts this morning and in so doing I would respectfully ask for the goodwill and forbearance of my senior colleagues.

The future of our profession depends primarily on the quality of its members. This is determined by the careful selection, from large numbers of well-qualified applicants, of those to be admitted to medical school, their successful completion of a long and exacting course of undergraduate training involving studies and examinations in more than twenty subjects to provide a broad basic medical education, and the attainment of a satisfactory standard of performance in pre-registration and post-registration hospital appointments designed to ensure competence in general or specialist fields.

In a thoughtful and timely commentary on the contemporary scene, Horrobin⁷ drew attention to "one of the illusions of both laymen and doctors that individuals are admitted to the medical profession at the time they receive their . . . degree The nature of the course followed and the examinations set are supposed to determine whether people will become doctors or not. This is an illusion because in most countries the failure rates of students going through medical school are now extremely low. For the most part, people are selected to become doctors at the time they enter medical school."

What is it then that determines what kind of doctor a person becomes? Horrobin considers that only two factors are important. The first is the kind of person who enters medical school, since intelligence and personality traits are little altered by education after the age of 20. The second is whether the philosophy of the medical school emphasises learning or teaching as the key educational process.

THE SELECTION OF MEDICAL STUDENTS

Today as never before in Britain young men and women prefer the career of medicine to all others.⁸ What hopes and dreams are reflected in this choice! In answer to a recent questionnaire prepared for a conference arranged by the Gen-

eral Medical Council to discuss the selection of medical students,⁹ those applying for places in medical school most often gave as their principal reason for choosing a career in medicine a wish to provide help and advice to those in physical and mental distress. Next in order came intellectual curiosity about the physiology of man, closely followed by the opportunity it offers of engaging in useful medical research. They did not overlook the fact that medicine is a secure profession and carries a good salary but few admitted being influenced by its good social standing. It is of interest that more than one-third of the applicants had already decided on medicine as a career before they entered their 'teens and for four out of five it was their established aim by the age of 15, younger than most other professions.

Analysis of "A" level academic standards and social class distribution of final year medical students in Northern Ireland¹⁰ throws light on some of the reasons for their career decisions. Of those responding to a survey carried out by the Northern Ireland Council for Postgraduate Medical Education, 5.8 per cent had obtained four or more A grades at "A" level, 15.2 per cent had three A's, 15.2 per cent had two A's, and 29 per cent had one A (together with other grades), while 34.8 per cent had at least three B's. These grades represent a very high overall academic standard indeed. The survey also showed that 66 per cent of these final year students belonged to social classes I and II compared with an expected 22.8 per cent, while over 15 per cent had one or more medical parent. Children of professional parents were thought to have advantages in academic ability, educational opportunities and financial backing that helped to equip them for entry into medical school.

It has been widely held that academic merit is the principal criterion for the selection of medical students and in numerous medical schools throughout the world, including Queen's, the selection procedure has been so refined as to result in the admission of the good basic science student who will survive the difficult biological science curriculum.¹¹ It does not take special account of the individual's ability to relate to people; it merely satisfies the educational requirements of the medical school.

Many have expressed dissatisfaction with the methods of selection usually employed, favouring as they do the crammer and the student with a good memory as well as the truly intelligent. In any case, there is no assurance that a bright or even a brilliant student will be a good doctor. This emphasis on academic performance results in the evaluation of only a narrow range of attributes and in the neglect of many other qualities that are desirable in medical students and doctors. "Should academic merit be the sole basis for selection to a profession which demands this and so much more besides?" asked Thompson.¹² "Are we to take no heed of integrity, resolution, personality and character in the broadest sense . . .?"

Interview has long been the traditional method of assessing personality, motivation and bearing. In 22 of the 31 medical schools in the United Kingdom, including all 12 of the University of London medical schools and 10 of the 12 English provincial schools, interview is an established part of the selection procedure and is accorded special importance in some.¹³ On the other hand, accept-

ance of applicants for places in the Belfast, Welsh and five Scottish medical schools, is usually based entirely on their academic qualifications and headmasters' confidential report.

Motivation is acknowledged to be a major determinant of medical school performance and its assessment is therefore one of the principal aims of an interviewing panel. It is, of course, recognised that some applicants may prepare for the interview by working out in advance the "right" answers to the relevant questions. The exclusion of obviously unsuitable candidates is another of the functions of the interviewing panel and where interviews are not held, much depends upon the frankness, accuracy and relevance of headmasters' confidential reports on the attitude, ability and character of the applicants. On the other hand, some consider that, as a method of forecasting future performance, interview has less validity than academic qualifications because those involved tend to favour candidates who are articulate and pleasing in appearance though these are not among the principal qualities that will determine their effectiveness as doctors.¹⁴

By far the most comprehensive and exhaustive selection procedure is that devised by McMaster University Medical School in Hamilton, Ontario, which opened for students in 1969.¹⁵ Qualities being sought include academic competence and the capacity for self-directed learning, self-assessment and problem-solving required by the McMaster system of learning. The aim is to enroll a class of students with very varied educational standards, social background and life experience because such variety is considered to be of benefit in meeting the medical school's objectives and also in enriching the contribution that class members make to each other's education.

Selection is based on information provided by an autobiographical sketch and a personal letter stating the applicant's aims and motives in life, his academic qualifications, three confidential references, a 45-minute interview and, finally, his performance in a simulated group tutorial with other applicants. In this, he is observed from behind a one-way window by a three-person team comprising a member of the university faculty of medicine, a medical student and a nominated member of the public! As a result of the efforts of hundreds of interviewers and assessors, who in 1976, gave more than seven thousand hours of their time, out of a total of 1,897 applicants 100 were eventually accepted for admission to the medical school. Important members of the university academic staff are convinced of the effectiveness of these laborious and lengthy selection procedures but others have reservations about whether they achieve their aims.¹⁶ There is as yet no clear evidence that the students so selected and trained make better doctors than those from other medical schools but no final judgement will be possible for a number of years. One can only feel profoundly thankful that mercifully, so far, we have all been spared such an ordeal!

Inevitably the talents and personalities of each new intake of medical students ultimately influence the numbers of doctors in different specialities, their distribution in industrial, suburban and rural areas and their views of what patients need and should expect from a doctor. Several studies in America have shown that applicants of exceptionally high academic standard tend to prefer positions

in teaching and research, and to seek posts in large centres with excellent laboratory and library facilities. In one study, doctors with a strong preference for scientific subjects and a highly rated performance in premedical courses in science tended to be over-represented in pathology, anaesthetics and surgery and under represented in internal medicine, paediatrics and psychiatry.¹⁷ Despite their undoubted intelligence they were unwise enough to allow themselves to be judged by a panel of psychologists who came to the conclusion that they were lacking in sensitivity to others, in breadth of interest, originality and social presence and were rather inclined to be rigid!

Too often it is assumed that there is only one model of the good student or the good doctor, for medicine now offers such a remarkable range of occupations, some involving constant contact with patients while others are completely divorced from the clinical scene. The methods of selection should therefore provide a variety of talents and personalities that together include all the kinds of excellence that medicine encompasses. Some, but not all, members of each incoming year should be of the highest academic standard, some should be scientifically orientated, some should manifest the good character and social presence that most interviewers favour and many should be deeply responsive to humanitarian issues. It is fortunate that there are so many gifted young people who wish to make a career in medicine and it rests with the university faculties of medicine to ensure that they also possess those qualities of sympathy and understanding that are needed to preserve the humanitarian aims and essential caring role of our profession. Bernard Shaw said: "Unless a man is led to medicine or surgery through a very exceptional technical aptitude, or because doctoring is a family tradition, or because he regards it, unintelligently, as a lucrative and gentlemanly profession, his motives in choosing the career of a healer are clearly generous."

UNDERGRADUATE MEDICAL EDUCATION

There must be many here this morning who still remember the enormous feeling of relief that the news of acceptance by the Faculty of Medicine brought, not only to ourselves but also to our long-suffering parents, and the sense of excitement, anticipation and slight apprehension as we started out on one of life's great personal adventures. Such emotions are only to be expected when it is remembered at what age the decision to become a doctor is made and how intense the competition for places in medical school. In addition to their early commitment to medicine, future medical students have a distinctive blend of ability and attitude, a combination of scientific interest, academic achievement and concern for other people.

How important it is then to harness this energy and enthusiasm at the beginning of the student's professional training and to avoid undue delay in introducing him to the clinical scene. This has been found to stimulate interest in and give perspective to his studies in the biological sciences which are otherwise liable soon to be forgotten! The importance of this clinical experience was recognised at

Newcastle, and subsequently the University of Southampton introduced a new five-year curriculum which, in acknowledgement of an almost universal wish on the part of students, includes such early patient contact. This helps them to acquire skills in communicating with a wide range of people and, as a result, they have much more confidence when they begin formal bedside instruction.

In his recent book, "Quest for Excellence in Medical Education" Sir George Pickering⁸ said: "Undergraduate education should have as its principal aim the training of the student's mind so that he knows how to learn, that he has acquired the basic discipline of scholarship and the habit of self-education." If all day, every day, students are fed ephemeral facts instead of being helped, while at medical school, to prepare for a lifetime of study, of learning by their own efforts, they are likely to become doctors whose education has resulted in the atrophy of the only characteristic which would have enabled them to remain competent throughout their professional lifetime, their ability to learn for themselves."

Dr. Sydney Burwell, one-time Dean of Harvard, must have caused quite a stir when he told his pupils: "In ten years time you will discover that half of what you were taught has proved to be wrong, and neither I nor any of your teachers knows which half."

Dr. Andrew Malcolm,¹⁸ beloved physician, memorable clinical teacher, enthusiast in pathology, accomplished historian and tireless philanthropist, emphasised the crucial importance of the active role of learning when, almost 130 years ago, he wrote: "The pupil must be regularly taught to examine and distinguish disease for himself . . . after the most elaborate teaching which the systematic schools and colleges can supply, the student must, at last, sit down at the bedside of disease, and, in all humility, inquire of nature herself as to her secret workings . . . and frequently he will experience the sad truth that man is often fonder of proving his own fancies than humbly recording the simple answers of nature – the touchstone of truth. And further, when we reflect what may be the amount of happiness or misery which may flow from a right or a wrong interpretation of her physical works . . . , the importance of extreme care, vigilance and perseverance in the teaching of her ways . . . cannot be too strongly enforced." This deep concern about needless errors in diagnosis caused by lack of proper care in clinical examination and by the irresponsible pursuit of unsubstantiated theories is a mark of Malcolm's clinical integrity and professional authority.

Like the artist, the writer and the musician, you, the doctors of tomorrow, must learn and become skilled in using the techniques of our profession. By far the most important of these is the ability to communicate, often at a deep and personal level, with complete strangers whose care becomes your responsibility.

At first it may be difficult for you, as healthy young people only a year or two away from the scenes of your schooldays, to come to terms with this enclosed community set aside from the busy world and to relate to its unfortunate members, the range and variety of whose symptoms may leave you bemused and dismayed. Be not disheartened. The hours that you spend at the bedside and in the outpatient clinic will be by far the most important and rewarding of your under-

graduate career. By showing to the patients friendly interest and concern you will gain their confidence and also your own, and will thus establish with them a professional relationship. As you gradually learn the vocabulary and become increasingly fluent in the special language of clinical medicine, phrasing your inquiries to suit people of all ages and from every walk of life you will begin to sense in their replies something of the uniqueness of the individual and of his reaction to his illness. As important as the words that are used are the gestures which accompany them and which sometimes convey meanings for which mere words seem quite inadequate. You must learn to observe the whole man, his movements, his attitude and his bearing, for therein may be discerned mute reactions to life's difficulties and disasters.

Often a diagnosis can be established from the history alone and the careful physical examination which should invariably follow may be entirely normal. One is then very conscious of how imprecise are the techniques of examination and this is nowhere more evident than when the clinical findings are compared with those dispassionately displayed by the pathologist. I would therefore urge you to take every opportunity of making such a comparison in order to improve your examination technique and your interpretation of the clinical data.

You will soon begin to realise that some of the outpatients and many of those admitted to the wards are not newly ill and that the diseases that led them to seek help from their doctor have long been present. Indeed the great majority of "emergency medical admissions" are the result of the sudden breaching of a clinical threshold in the course of a longstanding, often progressive disease. In some patients the acute illness follows a period of ill health but in others the sudden change from a symptomless to an acutely symptomatic state belies the true chronicity of the underlying disease. And yet it is at this stage of the disorder that sophisticated and expensive diagnostic and therapeutic techniques are likely to be brought into use, when the prospects for successful intervention are far less encouraging than they might earlier have been.

When by Grace, effective treatment and good nursing the patient recovers and the illness is at an end, we must remember that, despite the transformation of the clinical state, the underlying disease often persists. There is, in effect, a critical distinction to be drawn between illness and disease and, in the present state of knowledge in medicine, it is important to recognise that the care and treatment of the former and the cure of the latter may be quite different concepts. How fortunate we are that our great Designer foresaw the inevitability of fair wear and tear and thoughtfully incorporated in every system sufficient spare capacity to provide us with a generous margin of safety!

The range of illness seen in hospital is a very important but inevitably limited and unrepresentative part of the whole spectrum of ill health to be found in the community. It is therefore essential for today's student to have the opportunity of broadening his experience through domiciliary practice so that as tomorrow's doctor he will be alive to the tremendous challenge and the many opportunities presented by this major branch of medicine. It is likely that at least half of our young colleagues will become general practitioners and join the ranks of those

who cope with the 90 per cent of medicine that occurs outside hospital. The family doctor, working under the relentless tyranny of time's fleeting minutes, is almost invariably the first to be faced with life's many problems and the responsibilities that he carries must often seem unlimited. At one moment he is required to respond sensibly, effectively and without hesitation to some unforeseen emergency and at the next he must endeavour to detect and recognise the earliest clues of disease, reacting with discrimination to the countless early-warning signals of physical or mental strain. He must distinguish the medical from the social, the somatic from the psychiatric and the important from the trivial so that he may advise and guide, reassure and comfort and, where possible, institute effective treatment. In trying to meet his responsibilities, however, he does not often have such ready access to diagnostic aids that are available to hospital medical staff.

The general practitioner, because of his close relationship with his patients and his knowledge of family circumstances, is in a strong position to perceive the ill-effects of an unhealthy life-style and may be able to use his professional and personal authority to redress an unfavourable situation. At the present time, behavioural influences such as cigarette smoking, excessive drinking, overeating and sedentary habits are major causes of ill health in western society. As McKeown¹⁹ has said: "Our habits commonly begin as pleasures of which we have no need and end as necessities in which we have no pleasure. Nevertheless we tend to resent the suggestion that anyone should try to change them, even on the disarming grounds that they do so for our own good."

The value to students of observing and participating in this kind of medicine must surely be crucial. In addition, they can practice their interviewing skills on patients who may still await a diagnosis and whose complaints retain their original description.

UNDERGRADUATES' CAREER PREFERENCES

In no other profession do graduates from the same vocational degree course enter occupations so diverse as, for example, general practice, surgery, psychiatry and laboratory medicine in which the job content, the working environment and the personal attributes required of the practitioner vary so enormously. The student's ultimate choice of career is likely to be influenced by his attitude to patients, to solving problems and making decisions, to working as a member of a team and to such intrinsic differences between the specialties as the success rate in curing, the skills required, the scientific content, the opportunities for research and the personal, intellectual, financial and social satisfaction that each gives. In McKeown's view, however, "the really potent influence on students, and through them on the subsequent operation of the health services, is neither the selection procedure of medical schools nor the design of medical curricula; it is the image of medicine which emerges from the range of activities and interests

of the teaching centre Inevitably students acquire their concept of practice from the example provided by their teachers, and they leave the hospital aspiring to engage in the work they saw when training." It is therefore important that they have the opportunity of gaining experience of as many different aspects of medicine as possible.

In recent years the departure of a considerable number of doctors from the United Kingdom and serious staff shortages in such important specialities as laboratory medicine, radiology, geriatric medicine, anaesthetics and community medicine, have stimulated interest in the career preferences of undergraduates and graduates. In Northern Ireland, 56 per cent of all career posts are in general practice but the survey carried out in 1977 by the Northern Ireland Council for Postgraduate Medical Education and the Medical Faculty of Queen's University²⁰ showed that only 23.9 per cent of final year medical students gave this discipline their first preference compared with 53.6 per cent who chose a career in hospital clinical work. This discrepancy between the students' ambitions and potential openings in the National Health Service was the most striking fact to emerge from the survey, and it seems that career decisions in medicine, as in other walks of life, are not based primarily on such logical considerations as career prospects. However, in view of the prevailing financial climate and job situation in the Western World, our young colleagues will need common sense and wise guidance in choosing their life's work, but they may find comfort in Pickering's words: "Perhaps the outstanding feature of contemporary medical education in Britain is the high quality of its students In every university, medicine is by far the most sought-after faculty In the past, the shortcomings of the average medical graduate could be attributed to low intellectual quality; today such faults as he has can be justly attributed mostly to his (medical) education." I must say that I think Horrobin went a good deal too far in pursuing this theme when he wrote: "There has been a dramatic change in the last 20 years. Before that, medical students were certainly not the brightest students: their stereotype was that of the cheerful games-playing oaf rather than the studious intellectual with straight A's"! ! Nevertheless, we who have been privileged to share in the education of generations of medical students and to observe their progress and maturation into competent young doctors, have never failed to be impressed by the transformation that invariably occurs in the first few weeks of their housemanship as they cheerfully and responsibly face up to the professional duties for which the long years of undergraduate training have prepared them. Then it matters little what they have been taught, only what they have learned.

THE FUTURE OF INTERNAL MEDICINE AND OF THE GENERAL PHYSICIAN

Over the past decade, physicians have felt concern for the future of internal medicine because of the changes that have occurred in the character of their work in the medical wards and outpatient clinics. These have been mainly due to two quite separate causes.

The first is the increase in the number of specialist physicians and in the size of their units. Many patients, whose disorder the general physician was trained and once considered competent to manage, are now referred directly to specialists who have access to large, well-equipped departments where excellent outpatient and inpatient investigation and treatment are provided. Such is the scientific complexity and technical sophistication of the work, that medical staff establishments at both senior and junior level are high, and advanced research in very specialised fields is an integral part of the activity of these departments.

The second major factor is the increasing age of the population and the consequent rise in the incidence of diseases of old age requiring treatment in hospital, and often resulting in substantial physical and mental disability and social incapacity. Because of a significant migration from Belfast of those in the socially supporting age group 40-64, serious inner city poverty and social deprivation, staff shortages in the community services and the failure of government to provide an adequate range of accommodation for the elderly, the medical wards have been transformed by the long-term occupation of many of their beds by frail and disabled elderly people. The consequence is not only the misuse of much-needed skilled and costly services: in addition, those who would greatly benefit from personal and nursing care in a less clinical and more tranquil environment must spend the last months or years of their lives in small crowded wards lacking in appropriate facilities where their needs inevitably compete with those of the newly admitted acutely ill, the majority of whom are also elderly. Surely those who experience the heartbreak of severe disablement and cannot go home deserve accommodation and supporting services suited to their personal, intellectual and clinical needs, while those who suffer serious illness, whatever their age, should have the assurance of prompt admission to acute medical units that are staffed and equipped to provide expert treatment and skilled nursing care. The general physician, who continues to be responsible for the reception and treatment of most emergency medical admissions, could then apply sensible clinical principles in the management of his unit.

Many senior registrars now find less to attract them to a career in internal medicine and prefer to train in one of the specialties in the expectation of greater intellectual stimulus and better opportunities for research while at the same time avoiding those difficulties faced by their medical colleagues.

The question then arises, does the general physician have a continuing role or should all future appointments be filled by specialists? The answer is of considerable importance because of the imminent retirement of large numbers of general physicians who took up their consultant appointments in the early post-war years and at present constitute the largest group of medical consultants in the hospital service. It does not seem practicable for every acute hospital to carry its own full complement of specialists and in many it is probable that medical emergency admission and outpatient referral services will be provided by physicians with broad clinical experience though others will undoubtedly have a specialty commitment. In some large teaching hospitals in the United Kingdom, specialist physicians routinely participate in general medical emergency reception but in others,

including the Royal Victoria Hospital, the medical take-in units mainly depend upon general physicians and it seems unlikely that specialist units could or would wish to take on the mountain of work arising from take-in.

I would like to pay tribute to the surgeons of the Royal corridor for the expert way in which they treat general surgical emergencies while at the same time providing for the whole of Ulster a specialty referral service that is not excelled anywhere in these islands.

The general physician has been trained to consider each patient's problems in depth and also to maintain broad interests and acquire wide experience in clinical medicine. He is therefore well-qualified to guide students who have recently arrived on the hospital scene, at the most impressionable and formative stage of their undergraduate career, to help them develop a global view of the patient and his illness and to generate a sense of vocation and purpose in those participating in the introductory clinical course. "The mastery of such clinical methods is perhaps the most important objective of the clinical curriculum."⁸ The medical wards and outpatient clinic should provide both students and post-graduates with a wide range of relevant clinical experience including the opportunity to become familiar with practical therapeutics and the techniques of investigation. The general physician has an essential part to play in the training of his successors. As senior registrars, they should have adequate experience of working in busy medical units and should not depend entirely upon rotation from one specialty to another.

TEAMWORK IN MEDICINE

The close personal and confidential nature of the doctor-patient relationship has long been at the centre of the practice of medicine. In acknowledgement of our responsibility to those in our care we undertake to do everything possible to relieve their symptoms and aid their recovery. This often means enlisting the help of those in other professions, and learning to work as members of a team is an essential part of our training. I hope our young colleagues already appreciate that looking after sick people in hospital calls for such teamwork in which members of the caring professions, scientific and technical staff, administration, clerical, catering and supporting services all play their own essential roles.

It has been said that modern scientific medicine is essentially an affair of the intellect, but to regard a malady as an intellectual puzzle could divert our attention away from the patient as a person and cause us to forget that his present and future are involved.²¹ In the course of our clinical work we should remember that those who are most intimately and constantly in touch with the patients are the nurses. They see the consequences of illness, observe the effects of treatment and are especially conscious of the personal needs of the individual. Upon them falls much of the responsibility for maintaining the patient's morale while he comes to terms with his illness, and for helping him over the numerous difficulties that may arise during his stay in hospital. It is fortunate therefore that as resi-

dent pupils and pre-registration housemen you will have the opportunity of working closely with the nursing staff and gaining personal experience of their ministry of sympathy and support. You could not do better than learn from them.

The atmosphere in a clinical unit greatly depends on the character and personality of the ward sisters and it is they who determine the quality of life for the patients and medical staff. Those who have had the good fortune to work in this hospital are very conscious of the special gifts of heart and mind that are to be found in Royal nurses who, more often than they realise, act as our consciences.

I feel sure that in years to come the ideals of this hospital and the friendships that have been formed here will be a source of inspiration and strength. I hope that, for you, medicine will always be full of interest and enjoyment and that in blessing your patients it will also bless you. Our profession has a caring and generous tradition and a position of affection and respect in the community. In seeking appropriate remuneration for our work let us not endanger that which so greatly enhances our job satisfaction and our sense of purpose in life by behaviour that is out of character with our calling. Rather, may we, in partnership with colleagues in other professions, make our full contribution to the health and happiness of the individual and of society which we serve. Freely we have received: freely let us give.

And finally, in the words of Sir William Osler, let us "remember what we are – useful supernumeraries in the battle (of life), simply stage accessories in the drama, playing minor but essential parts at the exits and entrances or picking up, here and there, a strutter who may have tripped upon the stage."

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