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## Editorials

### MEDICINE IN CONFLICT

Almost every week medicine creates headline news. Whether it is the prospect of a major advance in treatment against cancer, the latest development in imaging techniques or the lack of an intensive care bed for a sick patient, the topic quickly captures the public attention and, for a brief while, becomes news. More often than not, news is made because of conflict. This ranges from disputes between individual patients and doctors, to disputes between Ministers of Health, governments and representatives of the health professions.

There are perhaps a number of reasons why medicine has become so newsworthy and controversial. An increasingly secular Western world has come to expect both greater longevity and continuing good health. Death from infectious disease at a young age or in child birth, so common even 50 years ago, has become removed from the everyday experience of most people—thus such deaths when they occur are all the more shocking to the general public. Also the astonishing technological advances of the past 50 years have not only raised expectations of improved health, but also dramatically increased the cost of health care. The public is insufficiently aware that much of the overall improvement in health and longevity owes less to expensive technology than to improved nutrition, housing and education.

The rising cost of health care has made medicine much more politically sensitive and increased the potential for conflict between the profession, politicians and the public. Politicians are demanding better value for money and the general public are encouraged by politicians and doctors to demand greater access to care and to expect better results. Unfortunately medicine may not always deliver on its promise! A compounding problem arises from the competition between the health needs of people of working age and those of the increasing population of older people marginalized from health care without whose lifetime contributions the NHS would not exist. With the exception of Denmark, where a dip in spending has recently occurred, the proportion of the Gross Domestic Product spent on health care in developed countries has risen inexorably. Fuelled by the high expectations from 'high tech' interventions the large investment of public and private funds in health care has put the medical and nursing professions firmly in the political firing line.

There has always been tension between altruism and self interest within medicine. These apparently mutually exclusive attitudes have their respective origins in the ancient value systems of settled pastoral societies and nomadic self-sufficient hunter gatherers. The dichotomy between these attitudes is more apparent than real, as altruism encompasses elements of self-interest and vice versa. However, the failure to acknowledge the equal validity of the twin drives of altruism and self-interest has distorted debate concerning the position of doctors in society. The motives for pursuing medical research and clinical excellence, for example, include not only the altruistic desire to relieve human suffering but also the legitimate pursuit of self interest, career, fame and success. At times, over-emphasis by the profession on its' altruistic motives coupled with the perception that doctors enjoy a high standard of living, may have contributed to a degree of

public cynicism and increased the vulnerability of the profession to criticism and litigation. Similarly while the profession marches behind the banners of service and duty, the views of managers are probably closer to George Bernard Shaw's dictum that 'professions are conspiracies against the laity'. It is appropriate to consider whether the function of the Royal Colleges is to maintain standards or protect privileges—or perhaps both? It should not be forgotten that whatever privileges doctors may have, they are earned and can only be sustained through the maintenance of high ethical, altruistic standards.

With the rising cost of health care, doctors have found themselves increasingly playing the role of gatekeeper and arbiter of access to each and every level of the health care and social welfare systems. Doctors play a crucial role in defining the boundaries of sickness and health, and negotiate in various ways with their 'clients' as to who will be permitted to adopt the sick role and then, as a 'patient', to gain access to the benefits of the health care system. These decisions not only affect access to sickness benefits, but they may also legitimise as illness certain forms of behaviour which might otherwise be socially unacceptable or, at the other extreme, may determine access to expensive interventions such as haemodialysis and organ transplantation. The definition of the boundaries between health, disease and illness is a particularly difficult problem and to a large extent determines the balance between the demand for health care and the care needs as identified by current medical opinion. Definitions of disease, which are a product of medical science, are, of necessity, arbitrary categorical constructs. On the other hand illness is the role of sickness adopted and defined by those who have or believe themselves to have disease, or wish to be thought of as suffering from disease. The extent to which disease results in illness is as much a product of the individual's behaviour and circumstances as it is of the severity of the pathological process. Osler's aphorism 'it is not the disease the patient has, but the patient the disease has, which is important' has never had greater relevance. It may be asked to what extent cholera, tuberculosis, obesity, chronic fatigue, back pain or the consequences of smoking are 'diseases' which require medical intervention and to what extent they each reflect social, political or behavioural problems for which the medical model offers an inappropriate and inadequate solution. The question has no single answer but it does highlight the difficult and often ambivalent roles played by the medical profession as carer, advocate and social architect.

At the level of the individual, the presence of disease may be as much defined by the inclination and attitude of the individual doctor as it is by the attitude of the client and this again may become a source of conflict. A topical example is myalgic encephalomyelitis—is this an incurable disease of unknown aetiology or a form of illness behaviour? Some doctors and patient pressure groups argue the former while at the other extreme some regard it as a behavioural problem which does not justify expenditure of valuable and limited medical resources. All of those involved in such debates have legitimate vested interests. A significant part of the increase in demand for health care can be attributed to the worried well. Furthermore the expectations of patients, and their doctor's fear of litigation, often results in sophisticated and expensive investigations when the patient might be better served by restricting action to careful clinical examination and appropriate reassurance. The profession, whether it likes it or not, has acquired a responsibility for control of the public health care purse; in accepting this role the

profession at times comes into direct conflict both with its' own belief that the primary responsibility of the doctor is to the individual patient and with the beliefs and attitudes of patients. A serious challenge now facing the profession is to find ways of ensuring equity of access to health care for those in need, while minimising unnecessary and inappropriate demand and ensuring the most economically efficient delivery of health care. Doctors may be tempted to look back with nostalgia to a mythical golden age when medical practice was pure and unsullied, with compliant, deferential patients consulting considerate, courteous physicians. Life was never so simple.

Doctors cannot stand in isolation from the complexities of the health care systems in which they work. There are many sources of conflict arising from the state of flux in the NHS. 'Managed care' permits administrators to restrict the entitlement of a community to particular services said to be deemed medically necessary. The definition of 'medically necessary' is imprecise and subjective. Doctor may come into conflict with doctor when a clinical director or a chairman of a hospital committee exercises the power to obstruct the wishes of an individual consultant. In the community a general practitioner, unable to obtain a service for a patient at the community hospital, may have to seek this elsewhere at a considerable and inconvenient distance from the patient's home; here direct conflicts may occur between practitioner and hospital and between patient and practitioner.

Conflict arises when the needs of the individual patient are perceived differently by doctors and the organisation in which they work. Funding priorities within hospitals, health maintenance organisations and fund holding practices necessarily impinge on the freedom of individual doctors and individual patients to set their own priorities. In parts of the United Kingdom, the Health Service may no longer provide facilities for cosmetic surgery or the treatment of sub-fertility. Purchasers may decide to allocate more resources to hip replacements and less to varicose vein surgery, because the former is perceived to give greater health benefit. While doctors may feel confused and angry when these external factors impinge on their ability to help their patients, it is important that they contribute constructively and ethically to the debate on effective use of resources. If they do so, the rather artificial debate about whether a doctor's primary loyalty is to the patient or to the organisation for whom they work will disappear.

There are no simple comprehensive solutions, and the setting of priorities for the allocation of resources for health care in an open society will not be the exclusive preserve of government or the medical profession. The public debate must also involve tax payers, health economists, scientists, patient pressure groups and others. Doctors armed with the evidence of medical science and health economics must be active participants in this debate if an equitable and truly national health service is provided for those in need.

## ON SPECIALISTS

Special, specialise and specialist are words in everyday use. We all know their meaning. But, if asked to define precisely what constitutes a special set of facts or special pieces of information, we would be in difficulties; more so if asked to lay

down the precise amount and quality of skill and knowledge that a man or woman needs to acquire before being recognised as a specialist. A schoolboy with an album containing 500 stamps in some order might be considered a stamp specialist by his classmates, but would not be so considered by a commercial stamp dealer. There have been doctors recognised as specialists in various branches of medicine for a long time but at least in the United Kingdom such recognition has not represented a qualification; there have been no rules as to what constitutes a specialist. Specialist, unlike physician and surgeon, is not an official rank or title within the medical hierarchy. A need for a well defined rank has now arisen and Fellow of the Royal Colleges are already discussing the training and experience required for recognition as a specialist. We do not envy them this task, but suggest that it might help them first to read a book entitled *The Specialist*. It is only 29 pages, partially filled by excellent illustrations, but is full of wisdom. Published in 1930, it was an immediate success but now appears to be forgotten. The American author, Charles Searle, sets out the thoughts of a specialist on the qualities that lead to his success; although fictional it is based on the recollections of an old man whom the author knew.

Lem Putt of Sangamon County was a carpenter who specialised in the building of outdoor privies. He does not say much about his skills as a carpenter, and we assume that as a technician he was competent. He attributes his success in his speciality to three things. Firstly, an understanding of the needs of his individual customers some of whom have disabilities which influence his designs; secondly, the effects of his work on his customers' neighbours; thirdly, consideration of the aesthetics and the comfort of occupiers, having regard to the direction of the prevailing wind and the need to face East. For example:

So I built his door like all my doors, swingin' in, and, of course,  
facing east, to get the full benefit of th' sun. And I tell you,  
gentlemen, there ain't nothin' more restful than to get out there in  
the mornin', comfortably seated, with th' door about three-fourths  
open. The old sun, beatin' in on you, sort of relaxes a body—makes  
you feel m-i-g-h-t-y, m-i-g-h-t-y r-e-s-t-f-u-l.

Thus his success as a specialist was due not so much to his technical skill but to understanding of the psychological, sociological and environmental features of those he served. Lem Putt was not averse to 'a little paper hangin'' on the side. There is wisdom in thus not allowing other skills to atrophy while developing as a specialist.

Has the privy builder in former times and in the backwoods of the USA a lesson for contemporary medicine? We think he has. First there are the technical skills required. World War II showed that men and women could be trained within a year or less in many complex tasks from piloting a Spitfire to becoming an interpreter of Japanese. Most young doctors with a good knowledge of the underlying medical sciences could be trained within a year at a centre of repute, which has a suitable case-mix, to use the range of sophisticated techniques required in a particular speciality. Furthermore technical skills could be accurately assessed and high standards assured. Much more than a year would be required to gain the experience necessary to judge whether or not a particular patient was suitable for high technology investigation and treatment. This requires understanding of the psychological, sociological and environmental influences such as Lem Putt had acquired. For doctors, as for carpenters, the key to success in

specialisation lies in the quality of training received, in which a structured experience is built upon a thorough understanding of the science basic to the specialty. In the present state of flux within the organisation of the NHS there can be no possibility of producing appropriately trained specialists in the numbers required unless the number of consultants (trainers) is increased, the schedules of service for the trainees are arranged to provide the range of experiences required in the time available, and the present climate of frustration and conflict is replaced by one receptive to vision and which engenders enthusiasm.

We do not envy those who have to make a decision as to how long a person must work in special departments before accreditation as a specialist. Clearly it should be measured in years, but not too many. The stultifying effect upon senior registrars of excessively prolonged waiting before obtaining the full responsibilities of consultant status is well known. The prospect of an overlong apprenticeship could discourage some of the best young graduates from entertaining a career as a specialist.

Should a doctor accredited as a specialist remain accredited for life? There are three circumstances which may make this undesirable. First specialities with a large technological component require a level of manual skills and co-ordination of eyes and hands which deteriorates with age. Secondly a specialist who had been at great pains to master a difficult technique might be loathe to give it up when new developments had shown it to be no longer appropriate. Thirdly, when a technical procedure is superseded the older specialists may find it difficult to develop new skills.

When the new techniques appear it soon becomes apparent which (younger) specialists are best placed to exploit them. Equally, the great majority of more senior specialists easily recognise when the learning process is impeded by age. Continuous assessment of every accredited specialist would be wasteful of time and money. When the great white plague of the earlier part of this century was driven out of many countries by pharmaceutical advances, the full time tuberculosis specialists translated into the wider fields of respiratory medicine. Herein lies the advantage of doing 'a little paper hangin'' on the side.