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I BELIEVE.....

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I believe in being brief. Writing has always been a struggle for me and I can see no sense in prolonging the torture for myself and my readers. Al Kligman, a master of concise dermatological thought, once told me that if you could not interest an open-minded reader by the end of the first paragraph, there would be little chance of getting any message across later. I wonder how many readers in the past have left me after those first crucial sentences. In any case I am not going to record all my beliefs here: some are too personal to reveal, even to readers of *Proceedings* of our College! I will not bare my soul in public and maybe that is good because some people are more interesting if you are not sure what they believe.

How do I start? Perhaps a birthday story is as good a way as any. My father qualified in medicine at Edinburgh in 1930. Like so many Scottish graduates of that time, he moved south and eventually settled in the flat fens of Lincolnshire, a remarkable contrast to the rivers, lochs and mountains of his home in Aberdeenshire. But my parents wanted me to be born in Scotland and so, shortly before the war, my mother, accompanied by a Lincolnshire midwife, returned to Edinburgh. Five years ago that midwife's granddaughter, then a medical student at Edinburgh, showed me (to my astonishment) her grandmother's account of my appearance in this world, neatly summarised in a midwife's register. I was clearly difficult from the start. The renowned obstetrician, J. D. Sturrock put my mother and my uncle (the general practitioner in attendance) out of their misery by his deft use of high forceps. Champagne then flowed freely in Waverley House, Queen's Crescent, where I was introduced to the extended family of Hunters and Alexanders.

Nothing since then has shaken my strongest belief in the prime importance of a close, loving and caring family, an aspect of my life in which I have been very lucky; but I can sense my children laughing their heads off as they read this. 'Dad and family life? We never see him. He's either in the hospital, hiding in his study, lecturing abroad or playing golf with his chums'. My trump card has been Ruth, my wife, who has kept our family together and has been the saving grace of this peripatetic academic. Thank God, I have never taken her for granted.

'Thank God'. Yes, I almost believe in some form of supreme superhuman being. Like thousands of Christians I have recited the Creed many times. 'I believe in one God the Father Almighty.... And in one Lord Jesus Christ, the only begotten son of God.... And I believe in the Holy Ghost.....'. It is embarrassing, even pathetic, that I have only recently begun to think seriously about these words. In my own case, 'I

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want to believe' would perhaps be more honest. Everything comes down to faith, but this short word and simple concept has exercised far more enquiring minds than mine. Doctors and scientists, and I am no exception, wrestle with its implications, not least because in our professional lives we must eliminate supernatural influences from our understanding of the human body. Religious faith is not acquired easily. Much more time, thought and prayer are needed than I have ever given to it. Nevertheless, I would love to have a firmer faith and envy those who face the triumphs and tragedies of life armed with this spiritual attribute; their strength and courage often reflect it.

I also believe in another less spiritual faith - self-confidence. My experience at the fringes of top class academe and of amateur sport has made me think about the characteristics shared by successful players in these very different pursuits. The power of the gene is obvious. Rarely it produces an intellectual giant or sporting legend, more often a sharp young scholar or someone with 'an eye for a ball'. Although much of confidence is constitutional, much too can be acquired by experience and practice, and through encouragement and even self-analysis. Whatever its origin, self-confidence is fundamental to success. Whether it is an MRC grant application, or a guest lecture, a short putt or a tight corner (fighting for your department or being three down and four to play), you are doomed without an inner feeling that you can, and certainly will, win the day. Interactions between confidence and reality tell us when we have attempted something too ambitious. This is a useful brake: without it we would pursue impossible goals and our confidence for even simple tasks would be sapped. The prospect of writing this paper was daunting. Only when I decided to avoid 'high-falutin' beliefs did I feel a gentle breeze of confidence and was able to ink my quill.

I believe that many academics have a lot to learn about that old fashioned, and often derided virtue of team spirit. I learned early at university about the problems of prima donnas in teams. Their innate talent has to be squared with their failure to practise, to bring others into the game and to take advice. One or two such personalities in a team is the limit, and then never should they be taken on their terms. Anyone with experience in team sports must know about that rare but remarkable feeling when the whole combination clicks, and a series of synergies fires off a chain reaction which leads to a result undreamed of by any of the individuals. The gold medal won by the British hockey team in the 1988 Olympics at Seoul is a shining example of what I mean. Of course academic departments that wish to succeed in the highest league need their scientific stars and intellectual heavyweights, as much as England required Bobby Charlton and Nobby Stiles to wrest the World Cup in 1966. However, I believe it is not too far-fetched to suggest that academics lag years behind our sportsmen in knowing how to harness prima donnas and to encourage team spirit.

I was born competitive and it has not always been easy to live with this trait. I still get a buzz from winning, even at the most social of games, and I had to work hard at disguising my irritation at losing quickly at chess to my eight year old nephew at Christmas. Narcissism rules and at interviews, I will always go for the most competitive applicant, given a fine balance between other qualities. I was delighted when hospital-based clinical subjects in our faculty were rated 5a in the 1996 Research Assessment Exercise, but upset when some other units fared less well than I felt they deserved. Although there will always be mixed feelings about league tables for schools and universities, and the criteria by which they are established, I am

convinced that they have improved, and will continue to improve, standards. I believe that league tables are here to stay.

Given time it would be easy to write a book, rather than a few paragraphs, on beliefs which emerge from working in our NHS for many years. Events have reinforced my belief in honesty, straight talking, simple English, common sense, and in the need for the doctors, not politicians, to lead the way. I must be especially selective. A non-medical person might be forgiven for thinking doctors to be a whinging, self-pitying bunch, as depicted all too often in the news. This is unfortunate, as I suspect that most of us know how lucky we are. What other profession offers the diversity found in medicine? The escalating development of new drugs, treatments and advances in the understanding of disease make our work extraordinarily interesting. The huge changes in administration of the health service also ensures a life free of boredom. I would not swap my lot for that of anybody else, but I have some significant concerns.

My worst fear and belief is that we have backed the wrong health-care system. By all accounts it worked well in the forties and fifties, but since then it has become increasingly bureaucratic, complex and outmoded. Our stoical patients, generally resigned and passive, are surely not fooled by juggled statistics, for example, on waiting times. Too many of them have little say in choosing the doctor or specialist to manage their problem. I regret that most of us, except the disabled, poor and deprived, would be better off in most other countries in the European Community where state and private systems have been integrated more successfully. Moreover, unless more of our highly qualified general practitioners, the backbone of our present system, develop special interests and are given the right facilities, they too will become increasingly frustrated and undervalued by both patients and hospital doctors.

The current purchaser-provider arrangements were a major change. There have been undoubted improvements in the service brought about by competitive tendering but overenthusiastic pursuit of the principle has too often been at the expense of benign and effective monopolies. Inadequate funding (in 1993 the percentage share of total expenditure on health was in the UK 7.1, in France 9.8, in Greece 5.7, and in the USA 14.1)[1] is the main reason why so many recent and sensible developments in the health service appear to be foundering. Of course we expect that public money should not be wasted on health: but incessant penny-pinching and efficiency savings are absurd ways to proceed especially when conducted in the shadow of incompetency and far more expensive political gaffes. Over £200m are due to be spent on building two new teaching hospitals in Edinburgh (population 450,000) - which it cannot afford. For once the Edinburgh hospital doctors spoke with a united voice; one new major teaching hospital would be best, but a rebuilt Western General and a new Royal Infirmary would be better than further patching up and development of the present old and decaying hospitals. The citizens of Edinburgh were unaware of the complex implications, not all financial, and inept politicians and compliant senior civil servants blew the chance of a lifetime to promote a single great hospital in Edinburgh and, at the same time, to save money spent wastefully running two hospitals. Sense could even prevail at this eleventh hour.

I believe that further privatisation in the NHS by design, rather than by default or stealth, is inevitable in the future. We will soon learn more about 'managed care', so feared by many in the USA, and when our nation finally realises that it cannot

afford a truly comprehensive high-quality health service, there will be another surge of activity amongst insurance companies.

Moving nearer to the clinic, I believe that scientific advances will provide my successors with ever-more sophisticated tests, but that these will pose increasing problems for the clinicians who use them. HIV testing has already had a profound effect on pre-test discussion with patients.[2] Many doctors must shudder over the implications of a range of currently available diagnostic tests including antibodies to other (presently incurable) viral infections, antigen markers for tumours and even cytological and histological examinations for pre-cancer and cancer, not to mention genetic profiling. Positive results may carry news for some patients as serious as a positive HIV test, bringing inevitable changes in lifestyle and potential refusal of life insurance. Pre-natal testing for severe diseases, leading perhaps to the termination of a pregnancy, has been welcomed by many, but it causes much religious and ethical controversy and a burgeoning number of law suits. Genetic tests for cancer susceptibility will raise further moral issues.

In facing these changes a belief of Anne Atkins, a journalist, mother and wife of a vicar, seems relevant. 'I believe the most dangerous modern trend is a creeping intellectual sogginess brought about by excessive political correctness. Because we are so frightened of hurting feelings, we rarely admit that anyone might be wrong. The corollary is that others with alternative views cannot be right. Many, even quite intelligent people, have apparently lost a concept of objective truth.'[3]

I wonder what Anne Atkins would think of *Tomorrow's Doctors* with its far reaching recommendations for the teaching of medical students.[4] No shortage of political correctness appears here - but I applaud any reduction in factual overload, and increased integration of the contributions from basic scientists and clinicians. I also welcome greater emphasis on self-learning, including 'special study modules', providing its *raison d'être* is academic rather than financial, and not just to reduce the number of teachers in medical schools. I can see no effective alternative to small group and one-to-one clinical teaching, which should be protected at all costs. A 'core curriculum' which ignores teaching on diseases which have a high prevalence in the community should apoptose. I teach undergraduates and trainees for three to four hours each week; it gets more, rather than less, difficult but is still fun. I have received a little teaching on how to teach, but this did me as much harm as good. An engrained belief of mine is that one should enjoy learning to learn and, with the odd exception, I have found teaching by educationalists lustreless. I have no time for professors too senior or eminent to profess their knowledge by teaching, least of all for those working in clinical medicine.

I am ashamed to admit that I never thought much about research until I qualified but, since my first biology lesson at school, I have always enjoyed pottering in laboratories and the company of scientists. I regret that nowadays I have no time for personal laboratory work, but I still find it stimulating to get out of my office into the laboratories. Thank goodness that a refreshing air of optimism prevails there, though this has long since disappeared in too many of my other activities.

If there is a God, He or She must be chuckling about our attempts to explain the basis of common disorders. Embarrassingly, in my specialty, the causes of psoriasis and atopic eczema remain mysteries, though our knowledge of their pathogenesis has increased. The same can be said of many conditions involving other systems such as rheumatoid arthritis, asthma and ulcerative colitis, let alone coronary artery disease, diabetes and cancer. Research follows fashions and it will be interesting to see how

long cytokines, adhesion molecules and nitric oxide hold the centre of the inflammation stage now that histamine, cyclic nucleotides and arachidonic acid metabolites have moved into the wings. Nevertheless, molecular genetics has been a revelation. Genetic studies of families with inherited disorders using modern technology, computerised analysis and clever statistics, have already identified and sequenced many abnormal genes. The functions of the affected proteins are now clearer and explain the extraordinary combinations of signs seen in some conditions. Who would have believed ten years ago that a rare disease with blistered skin (epidermolysis bullosa) associated with muscular dystrophy, was due to a single abnormal gene coding the protein, now known as plectin.[5] But we may have to wait for a long time to see clinical gains follow these discoveries. I hope, rather than believe, that effective gene therapy is around the corner, but I suspect that most practical advances, in the short-term at least, will come from the time-honoured approaches of epidemiology and pharmacology.

I will retire at sixty: my father told me that you should stop eating a good meal when you still felt like more. I know that my beliefs in three years' time will be different from those which I hold now, but that does not worry me; I feel uneasy about those who never change their minds. In any case I do not believe in looking back and I doubt if I will read this again. I believe I would have made a better job of this egocentric trip if I had not sandwiched its composition between Christmas and Hogmanay, and I guess that I am not alone in believing that I could have done better.

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I believe in plain English. John Savin has, over the years, nurtured this belief. I am grateful to him once again for removing much turgid and convoluted prose from the final manuscript without changing the meaning.

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