What is a Modern Physician?*

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The first thing to remember is that the patient is not just a pair of tonsils, or perhaps, a skin, a prostate gland, or a pregnant uterus. This is a person. And it is essential that you should treat the patient as a person, as an individual who has feelings just like you and I have, who has a family background like you and I have, who has personal, domestic, and business problems, as most of us have.

Now, the second thing I think we have to take into account is our own problems and our own ignorance. I personally feel that if ever I know anybody who knows more about the subject than I do that I can call him in, if it is necessary. One obviously does not want to bring in a very eminent thoracic surgeon merely because one's patient has an acute bronchitis. But one would always like to feel that if one gets into difficulties, one could.

I learned a great deal by being associated with two Sergeant-Surgeons to Their Majesties. (The office of the Sergeant-Surgeon is a very ancient one, and it his function to accompany the monarch into battle.) The first one that I knew was Wilfred Trotter. He became a fellow of the Royal Society because of his contributions to psychology. He was the man who invented the herd-instinct. Wilfred Trotter was primarily a brain surgeon, but he was an excellent general surgeon. When he was asked to come and see a very difficult patient, the patient always became like clay in Trotter's hands. And I know how he did it. He always listened to what the patient had to say, and he made it plain that he had listened, and not only that, that he had understood. I think this is the first function of any physician, whether he happens to be what you call, I understand, a pill doctor, a cutting doctor, or a talking doctor.

This second thing I learned from Sir Thomas Dunhill, who was Trotter's successor as Sergeant-Surgeon to the King. Dunhill was an Australian, and he started off as an assistant in a pharmacy in Melbourne, and he made enough money to put himself through medical school. He became an expert in thyroid surgery and operated upon the Princess Royal. He was such an extremely safe surgeon that he then was made Sergeant-Surgeon to the Queen. Dunhill would not operate on any of his patients unless I had seen them first. (He ran the surgical service and I ran the medical service together during the war.) He always liked for me to see his patients, in case he had missed something. I remember that he once told one of his patients, who was getting a little impatient, "Mrs. Smith, I'd like you to know that we like to make our mistakes before we operate, and not during the operation, or after." Dunhill was prepared to take an enormous amount of trouble. Queen Mary had some varicose veins. Dunhill did not know what to do about varicose veins, so he went to the Varicose Vein Clinic at St. Bartholomew's. There he watched the interns and residents injecting varicose veins. Then, next week, he went to see what they looked like, and he did some himself. Then, the following week, he went to see what his looked like. When he thought they were all right, he went and did Queen Mary's. So you see, I take the view that a specialist ought to be a physician, basically, and that he should put his specialty on top of being a physician, not instead of it. I frequently find my colleagues in the ear, nose, and throat department are quite unable to take off the patient's shirt. And eye doctors are rather like that, too. And I am afraid sometimes the psychiatrists are a little like this, too. I am not sure that I think this is a good idea. I think one wants to be a general doctor first, and then a special doctor.

Could I pass onto the "machine" side of medicine. I have spent a great deal of my time working in laboratories. One of the things that one learns when one works in laboratories is that things can go wrong. And you sometimes find results which you cannot repeat and you find that the standard reagent has been made up wrong; you find that something has happened so that a record that you were getting is not right. So I have come to regard the laboratory as fallible. And so, as I like to do things myself, and as I can take my own history, and as I can make my own physical examination, and as I can test the patient's urine myself, I tend to place as much or more reliance on the history and the physical examination and the testing of the urine, which are the things I do myself, as I may on the results which come on sheets of paper. The other thing that I like doing a great deal is to add to my own powers of visualization the powers which are added when you make a chap transparent in the x-ray department. I personally very much like to go and see any patient I have screened (fluoroscoped), so that I can actually see with my own eyes what happens when he becomes transparent, and compare that with what I can see when he is opaque. I have said enough about what I think about the problems of tomorrow's physicians, and I hope somebody is going to disagree with me.

Dr. Pickering: What do the residents feel is their chief problem, Dr. Thompson?

Dr. W. T. Thompson, Jr.: I think that among the very real problems we face here, as we talk with members of

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the department who are in training, are how much training is necessary, and what should the goals of training be in terms of future practice. In other words, what is the place of a general practitioner versus one who is a superspecialist. We have an interesting decision in this school regarding the role of the general practitioner in medical education and also in service to the public. There is no question that he is an essential man in our medical community, and yet we have some difficulty in knowing specifically what his role may be. We tend to think that it varies from place to place. Some of the men here in training in the department of medicine doubtless are going to be general practitioners. Others may be uncertain as to what a family internist is and how much training he needs. I wonder if your staff thinks about their long-range goals in their formative years, and has similar problems about how to make these decisions.

Dr. Pickering: I think we have. I think these are very general problems. Regarding the first question, about the length of time that one should take over training, I think this must vary a good deal. On the one hand, the advantage of this period of training is that you can work under a lot of people who will tell you a great deal. Your responsibilities, in a way, are rather limited to the kind of responsibilities that you get in a hospital. On the other hand, there is your desire to be an independent person, so to speak, and the fact that, in a way, your training is going to be for the rest of your life. I have learned, I think, really more since I became a responsible person than I did when, so to speak, I was responsible to someone else. So I think everybody probably will have to decide to choose between these two kinds of considerations.

You know, there was a time when James MacKenzie, who was a general practitioner and a physician and surgeon to the Royal Victoria Hospital in Barkley, made a lot of his important observations when he was operating on the abdomen of patients without any anesthesia. Well, our general practitioners do not operate on the abdomen now. A lot of them used to make considerable income by taking out tonsils and adenoids. They don't take out tonsils anymore. I think the general practitioner is terrified of treating fractures because it is not true that the bones are full of red and yellow marrow; they are full of black ingratitude. Unfortunately, they have a horrible habit of producing large amounts in damages and therefore practitioners are a little bit wary of them. They tend to always get sent to the orthopedic surgeon now. So, with us, the general practitioner has almost become a family physician. I think we increasingly feel that the general practitioner should have some training in surgery, and, of course, ear, nose, and throats are very important because they are so common in country practice, and skins are important because they are very common, and pediatrics is important because there are lots of children, and psychiatry should be important because many of the problems have to do with the mind. Yet the main training ought to be in internal medicine because it has to do with the whole lot, really. And it has to do with the patient as a whole. I think the important thing about the general practitioner is that he is better at deciding if he needs specialist help, and, if so, what specialist to call in, than the patient is himself. I think this is one of his major functions. Whether another general practitioner should take part in his training, I do not have any very strong views. Our general practitioners feel they should. But, I think they inevitably take part in the training of the family physicians afterward, because he joins a group of them and they train each other.

Question: Would you tell us some differences between postgraduate education in Great Britain and here?

Dr. Pickering: Yes. In Great Britain it is less organized than it is here, and there the postgraduates have to pick up what they can. Here they have a great deal provided for them in the way of seminars, conferences, and lectures. I think it is better organized in the United States than in Great Britain. We are trying to organize it and I hope we are going to get better.

Question: Has socialized medicine affected the number of people going into specialization?

Dr. Pickering: Yes. It has increased them. At least, I would think it has increased them. By the way, why do you call it "socialized medicine?" It is very interesting. What we say is that we have got a National Health Service, but I always get asked a question of this sort about "socialized medicine." Really, the war started all this. You know, I often tell people that the architect of the National Health Service is a chap called Adolph Hitler, because we developed the National Health Service during the war. It was called the Emergency Medical Service, and it simply continued into the National Health Service. What happened was that, during the war, the big London teaching hospitals and the big city hospitals were evacuated because of the fear of bombing. Lots of country places were upgraded, including the old workhouse infirmaries, and they got staffs of decent physicians and surgeons attached to them. It has been a policy of the National Health Service to see that a place like, say, Cornwall—which you know is way down in the southwest tip—that this is served by a pediatrician, an obstetrician, a physician, and a surgeon, so that disease was covered. Before they went there, because the community was not rich enough to support these people by private practice, the local inhabitants were rather badly served, except for those who were rich enough to go to London or one of the other big cities. So my answer is that the National Health Service has increased the number of specialists. The main complaint with the Service, and this is very justifiable, is that the general practitioners have a little more paper work in that they have a lot of certificates to sign. But they do not have to send out bills. They are largely cut off from hospital practice, and they have not done as well financially as the consultants. I think the main problem in our National Health Service now is to make family practice sufficiently attractive to draw good people into it. There is a working party at the moment trying to achieve this.

Question: That's one of the big problems we face, and how do you go about making it attractive?

Dr. Pickering: I think there ought to be a lot more ancillary help. I would have thought it would be desirable for family practitioners to prac-

tice from health centers in which they had secretarial help, record keeping, a nurse or two, a laboratory, some x-ray equipment, and that they would arrange their time so that they worked something like an 8-hour day, instead of being on call the whole time.

Question: The problem here is not the ancillary help, which most of the practitioners can afford to hire. The 8-hour day is one of the problems. But, I think another real problem is that practitioners feel cut off in many cases; they are so busy with their practice that they don't have time to keep up, and they get farther and farther behind. That is why so many of them come back for house-staff training after some years of training.

Dr. Pickering: Well, we have the same problem, only more so.

Question: We had a general practice internship setup here. The usual procedure was to stay in it one year and then go into some specialty. Another thing about the local doctor—and he may have got himself into it—is that he has made himself a middle man. He feels he is just shifting or directing patients to specialists, and feels quite limited in scope and power.

Dr. Pickering: Our best ones are very powerful with their patients. They won't allow a surgeon to operate if they do not think he is right. And I think this is a good thing. We have some extremely competent general practitioners around about Oxford, and they are terribly useful because they save their patients from all kinds of things that are not in their patients' interest to have done.

Question: Our patients seem to get their direction from the *Readers' Digest*. Actually, I believe our patients are a little harder to manage. They come up with ideas of their own. They ask the bus driver what he would do, read the *Readers' Digest* or *Time*, and then come up with pretty firm ideas about where they are going and who they are going to see.

Dr. Pickering: One of the important functions of my general practitioner is to protect me from the orthopedic surgeons, whose teeth water every time they see me.

Question: Can your patients get to a consultant without going through a general practitioner?

Dr. Pickering: Difficult. Most consultants will not accept a patient unless he is sent by a general practitioner. It can be done, but it is not easy.

Question: I wonder how often your general practitioner's hand is guided or forced when a patient comes to them with some idea of who he wants to see. This to me seems to leave no defensive position at all.

Dr. Pickering: He has got to do that. If the patient says, "I want to see someone," he has to send him there.

Question: One of the objections to the National Health Service is that there are so many unnecessary calls on the physicians. What do you think can be done?

Dr. Pickering: I don't think anything can be done. There always have been a lot of unnecessary calls. There always have been patients who abuse their doctors. I remember vividly meeting a Canadian doctor who told me that his father was a general practitioner in the country in Ontario. When he was about 12, his father got a night call in the winter. Because there was a lot of snow on the ground, the old doctor took his son with him. They had to dig themselves out of one or two snowdrifts. When they got to the farmhouse, the baby was born, and the grandmother upbraided the doctor for being late. As they were going away, the boy said to his father, "Dad, why did you stand for that sort of thing?" And the doctor said, "Well, son, you know, this is just one of those things. This is the sixth child I have delivered for them, and they haven't yet paid me for the first one."

Question: Does the general practitioner, by being denied the privilege of seeing the hospital patients, have his perspective seriously narrowed? Can he stay "modern" without hospital experience?

Dr. Pickering: Well, I think that depends how the local hospital caters to him, what advantage he takes of it, and how he reads. But I see your point. On the other hand, it has protected the patient a great deal because we do not now have incompetent surgeons trying to remove breasts and that sort of thing.

Question: Has there been any change in the quantity or quality of young men who aspire to be doctors in Great Britain?

Dr. Pickering: It is generally supposed that the quality has fallen off, but the quantity is terrific. We still only take about one applicant in six or seven, but I am constantly being pestered by schoolmasters and parents who cannot get their boys into medical schools. I think the falling off in the quality of the students reading medicine is a general phenomenon. I know it is happening at several schools in this country. I think it is because there are many attractive alternatives, such as space research, agriculture, physics, and even business.

Question: Is there any truth in the claim that this country is draining England's medical brains?

Dr. Pickering: Oh yes. But you've been doing this now for about 300 years.