Medicine's core values

Medical care does add to life expectancy

EDITOR,—In their editorial on the future of medicine Ian Morrison and Richard Smith comment on politicians' "reluctance to invest heavily in health services when they have only a small effect on health."[1] Smith's editorial two weeks later, on medicine's core values, includes a similar statement ("If health care has only a limited impact on the health of the population . . ").[2] The belief that medical care contributes little to health harks back to the conclusions drawn by McKeown from his epidemiological studies of public health data from the years before 1971.[3] Modest challenges have been made to McKeown's data and conclusions, but they remain the basis for the widely held view that Smith expresses.

In the quarter century since McKeown's work was published there has been an explosion of medical treatments, many of which have been shown in clinical trials and meta-analyses to result in considerable improvements in health. On the basis of these secondary sources my colleagues and I have assembled an inventory of the contributions of medical care to life expectancy[4]; adding these up, we estimate that medical care can be credited with three of the roughly seven years of increased life expectancy experienced in the United States and Britain since 1950. We also credit clinical services with the potential of extending life expectancy by an additional one and a half to two years if they were provided more widely.

As Morrison and Smith state, health may result "from a combination of social, economic, and psychological as well as purely biological phenomena," and they are probably right that "most doctors now understand this." But what most of us have failed to appreciate is that there are no data documenting whatever contribution social, economic, or psychological phenomena may have made to the increase in life expectancy during the century; nor do we have any but the vaguest idea of the mechanism by which they may affect health. McKeown attributed the dramatic increase in life expectancy of the previous 100 years to nutritional, environmental, and behavioural factors, but he conceded that the evidence was no more than circumstantial. He believed that he had shown that medical care was not responsible and therefore a best guess set of social and environmental factors must have been responsible.

The governments in Britain, the United States, and Canada have placed great emphasis on the role of lifestyle, including diet, exercise, and substance misuse, on health. While these are without question of great importance to the health of some—perhaps many—of the population, their modification has yet to be shown to have had a favourable impact on the population's life expectancy. Indeed, the ill effects of unhealthy lifestyles continue to mount. More to the point, the potential beneficial effect on life expectancy of behavioural modification, based on solid epidemiological data such as those recently reported by Richard Doll and colleagues,[5] is no greater than, and possibly less than, the benefits that could accrue from wider access to clinical services that have been shown to be effective.[4]

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1 Morrison I, Smith R. The future of medicine. *BMJ* 1994;309: 1099-100. (29 October.)
2 Smith R. Medicine's core values. *BMJ* 1994;309:1247-8. (12 November.)
3 McKeown T. *The role of medicine: dream, mirage, or nemesis?* Nuffield Provincial Trust, 1976.
4 Bunker JP, Frazier HS, Mosteller F. Improving health: measuring effects of medical care. *Milbank Q* 1994;72: 225-58.
5 Doll R, Peto R, Wheatley K, Gray R, Sutherland I. Mortality in relation to smoking: 40 years' observations on male British doctors. *BMJ* 1994;309:901-11.

Both knowledge and compassion are needed

EDITOR,—Kenneth Calman calls for a full debate on the purpose of medicine and its basic values and a continuing review of medical education, emphasising diagnosis and high ethical standards.[1] Western medicine, classed as a caring profession from the fourth century to the present day, owes a great debt to the Christian faith and individual Christians for its caring tradition and its progress.[2]

Dr Thomas Sydenham (1624-89) has been called the "English Hippocrates" and the "father of English medicine." He laid the foundations of careful bedside observation, clinical description, diagnosis, and rational treatment. His contributions to medical teaching include classic descriptions of gout and chorea in rheumatic fever. His ethical values and priorities are worthy of reconsideration by the profession today.

In his "Medical Observations concerning the history and cure of acute diseases," published in 1668, he wrote:

Whoever takes up medicine should seriously consider that he must one day render to the Supreme Judge an account of the lives of those sick men who have been entrusted into his care. Secondly, that such skill and science as, by the blessing of Almighty God, he has attained, are to be specially directed towards the honour of his Maker and the welfare of his fellow creatures: since it is a base thing for the great gifts of heaven to become the servants of avarice and ambition. Thirdly, he must remember that it is no mean or ignoble animals that he deals with. We may ascertain the worth of the human race, since for its sake God's only begotten Son became man, and thereby ennobled the nature that He took upon Him. Lastly, he (the doctor) must remember that he himself... is bound by the same laws of mortality and liable to the same ailments and afflictions with his fellows. Therefore let him strive to render aid to the distressed with the greater care, with the kindlier spirit and with the stronger fellow feeling.[2]

The motto of the Royal College of General Practitioners, "cum scientia caritas," emphasises the need to pursue both knowledge and compassion.

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1 Calman K. The profession of medicine. *BMJ* 1994;309:1140-3. (29 October.)
2 Aitken JT, Fuller HWC, Johnson D. *The influence of Christians in medicine.* London: Christian Medical Fellowship, 1984; vii:66.

Profession should not have to make decisions concerning rationing

EDITOR,—Perhaps Sir Maurice Shock tries to live up to his name, but his attempt to shock us out of our mind set merely irritates when he exhorts us to "speak authoritatively and sensibly to the consumer" while agreeing that such a consumer is "protected, encouraged to be autocratic, and persuaded of his or her power."[1] There is enough confrontation already without our gratuitously adding to it. My real bone of contention, however, is with his view that "doctors must be willing to 'get their hands dirty' with making decisions on allocation of resources."

I believe that such decisions concerning rationing should not be made by doctors. Allocation of resources, or rationing, should be done by an elected government or, if the government wish to devolve some of that power, by locally elected assemblies—that is, local government—but not by non-elected, sectional interests. It is deceitful of the government to talk of devolving power to general practitioners, for example, by giving them a budget while it continues to hold the purse strings. If the budget is cut at any time the general practitioners are still under contract to provide the same level of service and so have to engage in some form of rationing. Hence devolving budgets while retaining the power to limit them is a convenient smokescreen behind which a government can dump on to the profession its more difficult and sensitive decisions concerning rationing. This seems to be wrong on whatever grounds one considers it, whether ethically, constitutionally, or professionally.

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1 Smith R. Medicine's core values. *BMJ* 1994;309:1247-8. (12 November.)

The consultation is foundation stone of medicine

EDITOR,—Although James Spence's definition of "the essential unit of medical practice" may be slightly old fashioned,[1] there can be no doubt that the foundation stone of medicine is still the consultation. The various core values espoused by David Morrell and Kenneth Calman[1] may help us to improve the way in which we go about the consultation but do not detract from its central role. It will not do for this definition to be abandoned simply because it makes doctors who do not have direct contact with patients feel uncomfortable. These doctors, who may well