V.D.—SOME RANDOM REFLECTIONS OF A VENEREOLOGIST*

BY

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Introduction

A few days ago I had a birthday which also marked the completion of 25 years as a doctor, and all those 25 years I have been associated closely with venereology.

Formerly it was the exclusive privilege of age to indulge in public reminiscences, and to point the moral to aspiring youth. But in our time it has become quite customary for youth to recount experiences, and the recent crop of war books has provided profit, amusement, and instruction. So with these excuses I may be permitted to indulge in reminiscence and speculation.

Choice of Venereology as a Career

I think it would profit each one of us to reflect on the reasons that attracted us to venereology.

In my case a large part was played by the inspiration of David Lees, the greatest teacher of venereology in the last 25 years. He was an inspired teacher and a great enthusiast. His memorial in our time is the large number of specialists he taught, and the recognition he won for a new specialty in one of the greatest medical teaching centres of the world : a centre moreover which is noted for its conservative attitude.

Apart from the personal influence of David Lees, while I trained as a physician, I became impressed with the very satisfactory therapeutic results in venereology, especially in comparison with the indifferent results achieved in other specialties such as neurology. There is no doubt about the attraction of and the satisfaction resulting from exact diagnosis by scientific methods, and therapeutics based on pharmacology with confident expectation of success. I think that in this respect our specialty has still a creditable record, and though now equalled by others, it still commands respect for scientific tests and specific therapy.

The preparation for work in venereal disease has to be wide, thorough, and scientific, and I greatly regret that many persons are now reaching specialist status in venereology, who have not had the discipline of training in a bacteriological laboratory, nor gained the width of outlook engendered by general medical experience. The training of a venereologist should be that of a scientific physician, but he should also have more than a nodding acquaintance with dermatology, urology, neurology, cardiology, and social medicine. This is difficult to achieve, and requires at least five years of systematic training in the first place, and thereafter a life-time of interest in all branches of medicine.

What are the advantages of specializing in venereology ? These are mainly service to mankind, warm human interest, a variety of professional interests, and the ability to cure the majority of one's patients.

What are the disadvantages ? These are well known. We work in unhygienic cellars, or inconvenient corners of hospitals. In our relations with colleagues and laity we are often considered to be outcasts. If we are honest we do not make money but only a very modest competence. By our colleagues we are often ignored until they wish to get rid of unpopular patients. This is a legacy of centuries of opprobrium, based on the work of " lock wards ", but partly earned by the indifferent professional training and practice of some venereologists.

Venereology as an Independent Specialty

In the first circular, RHB(48), issued by the Ministry of Health on the development of specialist services there is a sentence which should be engraved in gold somewhere in our archives :

> " *The diagnosis and treatment of venereal diseases constitute a separate clinical speciality and should not be left to become a minor interest of specialists in other fields such as dermatology.*"

This is the clue to our successful future. We must be prepared and willing to accept this respon-

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sibility, ready to fulfil all the exacting demands it implies. We have at present an opportunity which has never before been given to our specialty. In theory, at least, we meet our specialist colleagues on equal terms, with equal emoluments. We suffer, it is true, in that as a rule, we have still to work in very inconvenient premises, and we have to do much of our work in evening sessions. But we have the compensation of freedom from emergency calls.

What should be our relationship in the future with the two specialties most closely linked to our work in the past—dermatology and urology. I repeat, as a maxim, that we must work independently, but must have a happy working relationship with the other specialists with whom we most often share patients.

Dermatology.—It is still true that a venereologist must have a sound basic training in dermatology—but I am not sure that the reverse is equally true. And I think this basic training in dermatology can be completed in about 6 months. Thereafter it is of interest and usually very profitable to maintain a close liaison with a dermatological colleague, for the advances in their field may have a profound influence on our work. An example is the research work on BAL and also the investigations on cutaneous sensitization to drugs.

Urology.—Our relationship with urology is now less intimate than 20 years ago when we invaded the privacy of the genito-urinary tract with a formidable array of instruments for investigation and treatment. During my apprenticeship it was an exceptional patient who recovered from gonorrhoea without undergoing a fearsome series of dilatations, applications of caustic, antiseptic, and astringent chemicals, and instrumental investigation of varied types. Those who escaped, usually did so by the process of " default ". This naturally led to a very close association with the genito-urinary surgeon, for we had to achieve proficiency in many of his technical methods. And the genito-urinary surgeon was provided with an endless series of patients with chronic infection and structural damage to the tract. Some became very good venereologists, though their interest in syphilis was superficial and financial. Very few, however, entered the preserves of genito-urinary surgery through experience in venereology.

At present the pendulum has swung away from urology, and in my opinion it has swung too far. Very few cases of gonorrhoea need instrumental treatment, though I think that urethroscopic examination should be done (prior to discharge) on every patient who has had an infection of the urethra.

The younger specialists may never have seen or used such museum pieces as Kollmann's dilator, Mill's suction bougie, or Ultzmann's catheter.

But very few of the younger generation of venereologists now receive adequate training in urology, and they may therefore be unfamiliar with many of the less common anatomical variations of the urethra, and are inexperienced in the diagnosis of the types of infection which masquerade as venereal disease. I am convinced, too, that sound basic training in diagnostic urology would produce a more satisfactory approach to " non-specific " infections of the genito-urinary tract. I am convinced that as gonorrhoea declines in frequency and importance, we shall take a more realistic view of the importance of the non-gonococcal infections of the genito-urinary organs, and develop a more effective system of investigation and a better technique of treatment.

Internal Medicine.—Our relationship with this branch of study is constantly becoming more important and more intimate. I am convinced that the training of a venereologist is predominantly that of a physician. A young physician has to master the basic sciences, then general medicine in great detail, and often a subdivision of medicine such as diseases of the digestive organs or of the respiratory system. So the venereologist should train, but after the basic sciences and internal medicine are mastered he should acquire special skill, knowledge, and experience in the problems of venereal disease.

A venereologist cannot be expected to have the detailed knowledge and experience in each special field acquired by the cardiologist, neurologist, gynaecologist, psychiatrist, and all the others, so we must arrange our work and our personal relations in such fashion that we can cooperate readily and profitably with our colleagues who have greater skill in these special fields.

Organization of Venereology in the National Health Service

The organization of the venereal disease services in Great Britain is still in the formative stage, and it is vital to our future that we should plan wisely. The National Health Service is organized in *Regions* based on university centres, the *Teaching Hospital Group* being regarded as the central part of the regional service.

I consider that each Region should have a consultant venereologist of senior status, who would have, in addition to the usual clinical work of a clinical consultant, two important functions : (*a*) as adviser to the Regional Hospital Board, (*b*) as

lecturer in the Teaching Hospital with responsibility for the training of registrars. He would be entitled and expected to secure information and advice from his specialist colleagues regarding the venereal disease services of the Region, and this might be secured by formation of a committee representing the geographic sections of the region. In the same way, the training of registrars, especially in the later (clinical V.D.) part of their experience, should be delegated in part to other consultants. There are many advantages of this system, especially for administrative purposes, and surely there can be little fear of dictatorship, as any medical man can appeal directly to the Senior Administrative Medical Officer, or to the Regional Board.

Such regional directors should have a higher scale of remuneration to compensate for the worry and responsibility ; this would provide an incentive to the most able venereologists to pursue their subject with all their powers, and would lessen the temptation to dissipate their energies in other channels. It seems probable that this organization will be desirable if the hope of " awards " proves illusory to all or most venereologists. Otherwise many of us would be well advised to take up pig-farming or some other profitable side-line.

Military Venereal Disease Services

Many distinguished members of our specialty trained and received great experience of venereology in the medical services of the armed forces, especially the R.A.M.C. But the day seems to have passed when this was the best nursery for venereologists. I have been told, but I hope it is not true, that eminence in a clinical subject was an almost insuperable obstacle to promotion to the highest ranks in the army medical service. Certainly in the last world war the glittering prizes came to those who had avoided specialism, and remained " administrative " ; though most of us have often doubted the wisdom, experience, and even the intelligence, of these high-ranking and much decorated warriors. The advent of war found the Services almost devoid of clinical specialists and advisers who were also familiar with the military machine and the special problems which war creates. We improvised and emerged without disgrace, or even with credit, but I am convinced that this state of affairs is unnecessary and is part of our military unpreparedness. I suggest that young specialists who would be liable for military service in war should be seconded to the Forces for, say, six months training and experience. Alternatively a number of civilian specialist appointments in the Army should be created, the holders of which would in the event of war be pre-eminently qualified for responsible posts in the higher ranks, such as that of command specialist. This would go far to avoid repetition of the years of muddle and waste and frustration which we all remember, and I think the creation of such posts might be an admirable supplement to the experience and training of the younger venereologists, and at the same time would tend to maintain the highest standards of practice in military hospitals.

I should like to be reassured too that the prevention of venereal disease in the armed forces was receiving adequate attention and that the best methods were being used. I confess to some anxiety regarding the bad moral effect and inculcation of reprehensible habits which may attend compulsory military service for youths of 18 years. I should like to be sure that military brothels and chemical prophylaxis were not the only rival claimants to military hygiene.

Prevention of Venereal Disease

The incidence of syphilis has fallen dramatically in parts of Great Britain, but in other areas there is little diminution. The incidence of other venereal diseases has fallen very little, even though we have such an effective specific remedy in penicillin. What are the reasons for this failure? The attack on early syphilis must be two-fold. We need first effective treatment to control contagion and prevent relapse, and secondly an epidemiological approach to the disease with adequate means to conduct effective investigations.

In addition there must be a modernized appeal to the public to secure universal support for our work of investigation and treatment. It appals and depresses me when I consider the numbers of men and women who default at a stage when they are probably uncured or may become active agents in the spread of disease. It is far too widely believed that a " shot " of penicillin is synonymous with the cure of gonorrhoea. Part of this is a legacy from the military expediency which was forced upon us by man-power shortage, especially overseas, where also we had less concern with the civilian population than at home. Some of the younger venereologists are still imbued with the idea of rapid relief rather than with that of certain cure.

In many industrial areas of England the default rate in contagious venereal disease is still very high, and many patients will undoubtedly suffer from the late effects of infection and act as carriers. This is a serious public health problem, and can be solved best by close cooperation between the local Medical Officer of Health and the venereologist. The

sociological work of the venereal disease clinic is of equal importance with its medical work, but the two must work as a team and not as separate organizations.

I have no doubt that prostitution is the largest source of venereal disease in Great Britain today, as it has always been in every land. Three years ago, Leeds was notorious for street prostitution and a number of brothels and houses of assignation flourished. By the pressure of strong public opinion, police action was speedy and efficient. A short spell in prison was frequently imposed instead of a nominal fine, the principal merit of this prison spell being the chance to make a diagnosis and commence treatment of venereal disease. Quite frequently the treatment was continued, for our social worker had an excellent understanding and cooperated closely with the prison medical officer. We did not act as police informers, but I have no doubt that the inspector charged with this difficult task was receptive to hints that a lot of venereal disease was again coming from " So-and-So " street. The scheme of treatment, especially for early syphilis, was planned so that a short intensive phase was likely to produce a high percentage of cures, and we hoped that all would have freedom from contagious relapse. The intensive treatment of early syphilis is often best done in hospital. This usually secures completion of the early phase of treatment in a period of three weeks, and isolation hospital beds proved very suitable for the purpose.

The problem of prostitution is not insoluble, and toleration is the reason for its flourishing. It has been attacked on moral and religious grounds, and even on economic grounds without much effect. If it is tackled as a public health problem and every painted street-corner wench is recognized as a carrier of disease rather than as an unfortunate victim of society, then the " racket " can be broken. The promiscuous woman is as much a public danger as the dysentery carrier. There is no glamour in prostitution ; it is thinly-disguised commercial vice, and is usually well organized and highly profitable. The bugs that batten on the victims' blood are the property owners, the mesdames, the souteneurs and pimps, some publicans who permit their premises to be abused, and many of the dance halls. The primary attack on all this must be made, I think, through public opinion. If public opinion is strong then the law will act vigorously and the police will prove efficient instruments of the law. But a lessened income from prostitution would be the best fruit of a strong public opinion, and would do most to reduce the numbers of " fallen women ".

We must, as authoritative advisers of the public on venereal disease, lead in the formation of public opinion in this matter and press for the provision of an efficient organization to trace every contact of every contagious venereal disease case and every defaulter whose disease may prove a danger to himself or others.

Future of Venereal Disease as a Specialty

The remote future of our subject is a matter for speculation. I predict that we shall go through two phases. The first will be one of considerable development as a separate specialty taking greater interest in the numerous varieties of infection of the genito-urinary tract and full integration with preventive medicine.

The second phase, which I do not expect to begin except perhaps in some of the larger and more progressive teaching hospitals, is the integration of the venereal diseases with general internal medicine. They would then be regarded as a group of diseases due to infection with specific organisms, and susceptible to treatment by chemotherapy. Their management would be entrusted to a physician and would be regarded as a problem in bacteriological diagnostics, chemotherapeutics, and public health, just as cases of, say, *Salmonella* infection are regarded to-day. Such a policy would not be a retrograde step, but would solve the sociological problems which hamper so much of our work in treatment and in preventive medicine. I am prepared to give it a trial and to endeavour by this means to educate both the general public and our own profession to a more rational view of the so called venereal infections. A pilot scheme, developed in a medical polyclinic, would be a useful testing ground. I am aware that many of my colleagues already conduct venereal disease clinics which are in every way medical clinics, in a medical department, with no obvious relationship to the despised and opprobrious venereal diseases section. I can see no reason to separate the chemotherapy of syphilis and gonorrhoea from the similar treatment of tuberculosis or staphylococcal infections, or from the scientific management of anaemia and vitamin deficiency. I believe that physicians will have their special interests, studying a group or type of disease, just as gardeners may develop an interest in carnations or onions, but the greatest benefit to the greatest number will eventually come from the reduction of ultra-specialism. In our field we have little to lose and much to gain from an attempt to become physicians who study syphilis, gonorrhoea, and similar diseases as a special hobby. But to achieve this we must train ourselves and must prove that we are worthy followers in the lead set by the old masters, such as Hunter, Osler, and Hutchinson.