Apples of discord[1]

Sir Douglas Black MD PRCP
President, Royal College of Physicians
11 St Andrew's Place, London NW1 4LE

My first thought of a title for this lecture was 'Apples of Sodom': but I felt that this might be misconstrued. So I have settled for 'Apples of discord', which is merely cryptic, and not positively misleading. You will recall that the original apple of discord was the one which Eris threw on the table at the wedding of Peleus and Thetis, saying 'For the most beautiful'. This led to the judgment of Paris, and so to the Trojan War. The apples of Sodom, on the other hand, are described thus: 'There are apple-trees on the sides of the Dead Sea which bear lovely fruit, but within are full of ashes.' Disappointing, perhaps, but scarcely catastrophic. There are other famous apples – those of the Hesperides; the golden apples of perpetual youth, the food of the gods in Valhalla; that thrown by Virgil's Galatea, and – equally legendary perhaps – that which startled Isaac Newton. From the USA, we have 'apple-polishing' as a synonym for flattery; and the Apple Tree Gang, who introduced golf at Yonkers, NY, in a six-hole orchard – an implant which seems to have taken. But I think I may have sufficiently discharged my Plain-Dealer's obligation to the first word of my title; and I proceed to divulge what this lecture is to be about.

I propose to consider one or two of the conflicts between those of us who practise medicine, and those who purport to speak for society: and, for good measure, one or two of the issues which seem to divide our own profession. And to end, it may be paradoxically, with a plea that perhaps so much conflict is not necessary, and that we should be deploying more charity in an effort to agree.

Some criticisms of modern medicine

There are two major lines of attack on the value of modern medicine, the more radical, exemplified by Illich (1974); and the (slightly) less radical, exemplified by Bradshaw (1978).

Let me introduce the first of these, with a starkness befitting the subject, by quoting two sentences from Ivan Illich: 'Within the last decade, medical professional practice has become a major threat to health. Depression, infection, disability, dysfunction and other specific iatrogenic diseases now cause more suffering than all accidents from traffic or industry.'

To comment on the semantics, what is 'specific', let alone 'iatrogenic' about 'depression, infection, disability and dysfunction'? But leaving aside the verbal flourishes, and recognizing how much still remains to be done, what are we to make of the judgment of a man who appears unaware of such matters as the disappearance of smallpox, and the development of specific treatments for most bacterial infections, to give only two examples? In a most valuable paper, Paul Beeson (1980) has compared the treatments advocated in the first (1927) and the 14th (1975) editions of Cecil's Textbook of Medicine, there being 362 disease states common to the two editions. In crude summary of his detailed analysis, in 1927 there were effective treatments for fewer than 30 diseases, while in 1975 more than half of the diseases were susceptible to effective treatment or prevention. It remains true, of course, that in this world nothing is certain except death and taxes: and immortality is not a National Health Service benefit. Many of the killing degenerative diseases, and the neoplasms, remain largely beyond the scope of effective medical intervention; but because we cannot do everything, it is a pretty desperate leap to affirm that we can do nothing but harm. And I regard such affirmation as an insult to humanity, of which we doctors are an integral part. Illich is also willing to criticize

[1]Lloyd-Roberts Lecture delivered to the Royal Society of Medicine, 18 November 1980

0141-0768/81/020092 09/$01.00/0

our profession for the relief of pain. There is one other aspect which should be mentioned before leaving the most radical attack on medicine – the value of soundly-based reassurance, described by McDermott (1978) as 'the technology-based ability to report negatives authoritatively and hence help maintain peace of mind'. Buried in that formulation are commendations of technology and of a doctor's right to authority, to which I shall return later. Correct reassurance is not an 'outcome' to be assessed on a par with cure or symptomatic relief, but it certainly does not lack value.

Bradshaw, having had a medical education, is less radical to a limited extent, disclaiming that 'any individual doctor is criticized, let alone that the value of doctors is totally decried' (which would, I think, be Illich's position). He admits that 'there are many occasions on which it is essential to consult the best doctor one can find, and many others on which it is highly desirable to do so'. Nevertheless, he is critical of 'many aspects of modern western medicine': and in his summing up he opines that 'western doctors today are certainly more productive, directly or indirectly, of ill-health, in every sense than of health'. It is perhaps the 'high-technology' aspects of medicine, admittedly set in a 'high-technology society', to which he specifically objects. I am not in sympathy with this Luddite approach, given that technology remains ancillary to traditional medicine, and does not become an end in itself. I think most of us would prefer a CAT scan to an exploratory craniotomy, or even an air encephalogram. There is, of course, the further argument that preoccupation with 'high-technology medicine' may erode human sympathy, so necessary in the care of the sick. If this were necessarily true, I would be joining Bradshaw in his criticism, but my whole experience forbids me to accept it. With the advent of haemodialysis, the nephrologists whom I know well have become more caring, and more effectively caring – not less.

The doctor-patient relationship

Without proceeding to extreme criticism of modern medicine and all its works, many sociologists are concerned about the respective roles of doctor and of patient. They question the right of the doctor to hold and express authoritative opinions, when so much in medicine is still uncertain; and while generally accepting the therapeutic effectiveness of many medical interventions, they question whether the doctors are giving adequate psychological support, and communicating sufficiently with their patients. I think this matter must be looked at from the perspective of professional history, as well as from more recent sociological formulations.

Medicine has been regarded as a profession from time immemorial, and is still generally so regarded, even if the pressures of inflation in the past few years have occasionally led to statements, and more rarely even to actions, which it would be hard to look on as consistent with professional standards. The touchstone of professional conduct is that it places the interests of the client (in the case of medicine, more generally and better known as the patient) above the interests either of the individual practitioner or of the profession as a whole. The conflict implied in this statement is almost always resolvable on the basis of common interest. Given that doctors want to help their patients, and that patients want their help, only a tiny minority of transactions between patient and doctor do in fact conform to the model of an 'adversary situation', put forward by certain sociologists. Medical practice certainly has its trials and disappointments, but in my experience these have arisen from the facts of life, and only very rarely from those stereotypes 'the callous doctor' or 'the unreasonable patient'. Of course, the perception of illness always causes anxiety to the patient, and disease may end in tragedy; but it is my belief that this is well understood by both doctor and patient, in the great majority of cases. Should a doctor happen to get credit for a good outcome to which he has contributed but little, or conversely be blamed for a bad outcome which was inevitable, these things stick in his mind, it may be disproportionately, to the neglect of the common run of episodes where the contribution of the doctor is fairly assessed. In that context, I welcome the growth of medical knowledge in the informed public, and acknowledge the general contribution made by the media; certainly, medical articles and programmes can lead to anxiety, especially if badly presented, but it is at least possible that the presentation can be

providing a focus for anxiety, rather than causing it in someone who would otherwise be contented. To the same end, I welcome the emphasis laid by Charles Fletcher (1973) and others on communication between doctor and patient; good methods of communication should be both taught and even more important, exemplified in our medical schools.

Having deprecated one sociological model on the basis that it may create antagonism between doctor and patient, to their common disadvantage, I go on to criticize another, on somewhat different grounds. Talcott Parsons (1950) suggested in the early fifties that illness, which he described as 'the sick role', was a form of 'social deviance'; and that the doctor was an agent of society, dedicated to its correction. Rather surprisingly, this model has been criticized by later sociologists as being 'too medicocentric'; whereas it would, I think, be totally rejected by the majority of doctors. Of course, social factors play an important part both in the causation and in the expression of illness; and further, return to work and to a place in society is an important objective in the treatment of illness. However, while individual doctors have made notable contributions to social and occupational medicine, more doctors are engaged in one or other form of clinical care, whose focus is overwhelmingly on the individual, and only marginally, usually subconsciously, on society.

Although doctors have been aware informally that their approach to diagnosis and treatment is influenced by the circumstances of the consultation, sociological studies on medical practice have attempted to systematize the various relevant factors. Doctors with a sociological orientation can make a useful contribution, exemplified in a recent article by Eisenberg (1979). The contribution of the patient to the interview is influenced by his age, social class, financial circumstances, and his educational and ethnic background.

Physicians are regarded as either interventionist and disease-oriented, or oriented towards the maintenance of health – a distinction with which I disagree, believing that ideally both outlooks should be brought into service, and that practically there is a continuum of attitudes both between doctors, and also in the same doctor under different circumstances. The way in which the doctor interacts with his profession is also important. He imbibes diagnostic and therapeutic habits from his colleagues, and his approach to the patient is also modified by the system of health care in which he operates. Eisenberg illustrates the influence of professional style by contrasting the ways in which physicians and surgeons make decisions. He quotes a study which indicated that in medical wards there was a significant degree of delegation of responsibility and authority, so that 'the medical house officers based their decisions, to a large degree, on consensus with the chief resident or visiting physician presiding and leading the discussion'. Whereas 'on surgical wards, decisions were made by the chief resident and orders were given to all members of the hierarchy'. This dichotomy of practice may be justified by greater time being available, as a rule, for medical decisions to be taken by consensus; whereas on surgical problems 'the emphasis is on action and punctuality'.

In addition to the personal characteristics of doctors and patients taken separately, there are various models of the doctor–patient relationship. Ideally, this may be one of 'detached concern', but in practice the pattern varies. Szasz & Hollender (1956) described three models: activity-passivity, in which the physician is in control and the patient is passive; guidance-cooperation, in which the doctor advises and the patient is expected to comply; and mutual participation, in which the physician helps the patient to help himself. The obvious partiality of these authors for the third of these models is no doubt commendable; but in real life the second is more frequent, partly because it is more attainable. In my own experience, patients do not welcome undue exposure to the doctor's decision-making dilemmas, and their response to discussion and explanation is often to say 'Well, doctor, I leave it to you'. There are of course exceptions, usually among the less gravely ill.

One author has had the hardihood to characterize 'the undesirable patient' (Papper 1970). He mentions physical attributes – the ungrateful and obnoxious; those with untreatable illness, or those with no physical illness; and 'those who are undesirable because the physician considers them to be a distraction to preferred tasks, such as reading or laboratory research'. With conviction which amounts to certainty as the fourth of these categories is approached, I

would regard these as characteristic of the undesirable doctor, the patient being merely unfortunate.

The dangers of safety

'*Primum non nocere*' is an admirable motto for this or any other society. But when we come to apply it practically, we commonly discover that our choice is not between risk and safety, but lies among alternative courses of action, or inaction, none of which is absolutely safe. As Card & Mooney (1977) have shown, while there may be reluctance to 'set a value on human life', it is possible in certain situations to determine within broad limits the cost of particular measures, and the number of deaths which their adoption would prevent. From this information, it is possible to calculate the implied value of a human life. Their examples make it clear that whatever determines the decisions of society in these matters, it is not cold financial logic. The general introduction of child-proof drug containers, estimated to cost £1000 per life saved, was postponed on grounds of cost; conversely, following the Ronan Point disaster, strengthening of tower blocks was undertaken whose likely cost was £10 million per life saved. These two examples may give a clue to the considerations which make society deviate from what would appear to be financial sanity. Mortality associated with drama, as in an air-crash, moves us profoundly; whereas the higher mortality on our roads attracts no comparable notice.

I believe that the disproportionate effect of drama has had a very damaging effect on our approach to drug safety regulations. For affected individuals and families, the effects of thalidomide have been a unique tragedy; but it has also been something of a tragedy for society, sparking off attitudes and regulations which have led at best to great delays, at worst perhaps to actual losses, in therapeutic innovation. It is easy to blame 'the media', and this has been done amusingly by Rouse (1980), invoking the 'Drayton Factor':

'Ill news has wings and with the wind doth go,
Comfort's a cripple and comes ever slow.'

But I consider that the media detect and reflect public attitudes, rather than create them. It may even be an oblique compliment to modern therapeutics that the occasional failures, being unexpected, are scrupulously reported, whereas the quotidian successes go unremarked. This charitable view may gain some support from the willingness of the media to report even successes if they are sufficiently uncommon – kidney transplants are no longer news, heart transplants and limb replacements are.

The danger to drug development from inordinate delays in satisfying safety regulations may later be extended to therapeutic practice in general by the concept of 'strict liability', especially if no mitigation is allowable for so-called 'development risks'. In a nutshell, this means that if anything goes wrong in a patient who is taking a drug, the maker or supplier of the drug or both, are liable for compensation, even if the adverse effect was quite unforeseeable at the time when the drug was developed and even if there is no real proof that the drug was in fact responsible for the effect. In its statement on 'Strict Liability' to the Medicines Commission, the Royal College of Physicians drew attention to the dangers of 'defensive medicine' inherent in this approach; and I would also refer you to David Kerr's (1980) recent article on the costs of safe medicine, from which I would like to quote a couple of sentences: 'I hope I shall never be expected to explain to my hypertensives, already reluctant to take their drugs regularly, that there is a remote risk of heart failure, asthma, jaundice, diabetes, impotence, nightmares, motor accidents, gout, depression and writers' block. A few more massive awards in our courts on dubious grounds may compel me to do it.'

Arguments of the type which I have been advancing could be (and indeed have been) construed as evidence of professional self-protection, so I must emphasize that the ultimate loser in all this will be the patient, who will pay more, whether as an individual or a taxpayer, for the medicines which he needs; who will find himself so bombarded by safeguards as to lose all confidence in his treatment; and who may turn away from prescribed remedies to nostrums whose effectiveness and safety are equally unwarranted. Some would regard this last as a

consummation devoutly to be wished; I suggest that they go to history and biography for accounts of the illnesses suffered by our forbears.

Conflicts within medicine

It is a risky thing to say, but I believe that the majority of doctors might find themselves in broad agreement with what I have been saying. This comfortable intraprofessional comformity must now be abandoned, as I turn to some issues on which there are considerable differences of view within my own profession. The potentially divisive issues which I now propose to consider are the place of technology in medicine; the means of assuring an acceptable standard of practice; and the number and selection of medical students.

Medical technology

I have already touched on this matter in commenting on the views expressed by John Bradshaw (1978). For a full statement of my own views on the matter, I would refer you to a recent commissioned article (Black 1980), which gives illustrative examples of the pervasiveness of technology in modern medical practice. In general terms, no doctor anxious to practise clinical medicine to a high standard would wish to be without the help available from the pathology laboratories, the radiology department, and facilities for clinical physiology and endoscopy. There is, of course, a problem of perspective; these facilities are complementary to bedside skills, and do not replace them. Similarly in relation to therapy, facilities for resuscitation and life-support systems are ethically neutral assets, whose actual value depends on clinical judgment. Much has been made of the risks of 'over-dependence' and 'dehumanization' which are attributed to medical technology; the defence against such risks to the extent that they may exist, lies in sound general standards of clinical practice.

Although a great deal of technology applied to medicine is demonstrably cost-effective, with savings in hospitalization and in the avoidance of prolonged ill-health, there are certainly problems at the margin, when – as it must be – the economic dimension is brought in. This is not a suitable area for easy generalizations. On the one hand, if ideas are subjected to economic pessimism before they have even been developed to the prototype stage, there is a real risk of stifling fertile innovations. At the other extreme, generalization of diagnostic and therapeutic procedures with no prior economic analysis can mortgage resources of capital and revenue which might be better deployed in other ways. It is not, in my view, possible to apply economic analysis to 'technology in general'; what is needed is detailed study of particular innovations, at the stage between development and generalization. Such analysis has to consider not only the costs of the proposed technique in isolation, but also the costs of alternative procedures; the possibility of improvements or 'economies of scale' in the proposed technique and in its rivals; and the value and likelihood of possible outcomes arising from application of the technique. I would commend to you for study two recent analyses of this type. The study by Stocking & Morrison (1978) of the whole-body scanner indicates the complexity of the issues involved. Alexander Leaf's (1980) account of the rejection, for the present, of cardiac transplantation in the Massachusetts General Hospital by the Trustees gives two important lessons: that the 'opportunity cost' of a proposed procedure must always be considered; and that it is the medical task to define the issues, but not to have the sole voice in the choice. Leaf's final two sentences are worth quoting: 'Not all will agree with the decision of the Trustees, and some will argue that only the professions should be involved in such determinations. If one considers that the medical profession has historically been fostered and preserved to serve a societal need and not to supply physicians with a privileged status, one can find little argument with the course that the MGH Trustees thoughtfully and responsibly followed.'

'Quality assurance'

Doctors and patients have a common interest in ensuring that medical practice reaches an acceptable standard; but there are wide divergences of opinion as to the best methods of

assessing standards, and – more difficult still – what is the appropriate action when minimum standards of practice are not reached.

Good clinical decisions require a wide base of knowledge, an ability to communicate with patients, and a conscientious approach to the work. The information base required for medical practice, particulaly perhaps in relation to medicines, has expanded rapidly, and is still expanding. Concurrently, the opportunities of 'keeping up-to-date' have also expanded, thanks to initiatives from the pharmaceutical companies, the Nuffield Provincial Hospitals Trust, and the Health Departments, more or less in that historical order; while continuously the voluntary medical societies and the medical journals have played an important part. The generalization of postgraduate centres has provided a venue for formal and informal contact between doctors who may have previously worked in comparative isolation. Many doctors now work in teams, almost universally in hospital, and increasingly in the community; this provides further opportunities for exchange of information, and also for informed assessment of performance. The medical profession is not always given enough credit for the effort which it has made, with some outside support, to provide the facilities for continuing education, including self-education. However, while the general level of relevant information is probably as high as it has ever been, no honest doctor would claim to know all that he should know, and a minority of doctors might have to be classed as ignorant, and even 'invincibly ignorant', in the sense that they take little or no trouble to follow the march of knowledge. To an extent, relative ignorance may be compensated for by personal qualities of empathy and conscience, and I have known doctors, well-liked by their patients, who could not be regarded as well-informed. From what we know of the learning process, I see little virtue in compulsory recertification, in financial inducements to attend courses, or indeed in compulsory courses: knowledge cannot be administered by stomach-tube, it depends on a modicum of curiosity in the recipient. It follows also that those who try to instruct in speech and in writing have responsibility not only for the soundness, but also for the interest of their message, which perhaps brings me to the second component of the basis for good clinical work – adequate communication between doctor and patient.

I believe with Charles Fletcher (1973) that the basis of good communication has to be laid in the medical school. Courses in behavioural science should include the theoretical basis of communication; medical teachers on appointment should have a course in the techniques of communication, lest theoretical precept be vitiated by bad example. But the most important thing is practical teaching, and above all practical experience, both in acquiring information from patients and imparting it to them. For this reason I am a strong advocate of the attachment of students in small groups to district hospitals, and also, in outpatient teaching, of limiting the number of students in any consulting-room to one or two, so that they can witness a real consultation, and not be passive recipients of a teaching session. The techniques of communication between individuals are largely different from, and in the long run more important than, the techniques of class-room instruction.

What can we usefully say of conscientiousness, which is so much an individual matter? For the extreme case of dereliction of duty, the sanctions of the General Medical Council remain: and the operations of that body are being made more sensitive by the possibility of suspension rather than outright removal from the register; and by the recognized distinction, in general, between doctors who are sick and those who are faultily motivated, difficult though this may be to establish in the particular case. On the more positive side, I believe our profession is fortunate in that the general thrust on its individual members is towards giving a caring and worthwhile service to our patients. We are not, of course, practising in Utopia, and some doctors grumble unreasonably about patients, and of course some patients about doctors; but these exceptions do not invalidate the general picture of a profession with high ethical standards.

When we come to the key question – 'Is enough being done to maintain standards of practice, or should we be doing more?' – we face quite sharp disagreement. There are strong public and parliamentary pressures to bring medical practice under closer scrutiny, whether

by the Ombudsman, or in some other way. Some members of the profession maintain that all such pressures are to be resisted, without argument and without compromise, and that we should have nothing to do with medical audit, quality control or whatever. I take a different view, believing that quite irrespective of outside pressures (but also as the best way of resisting them) we in the profession should be studying both the process and outcome of our interventions, with a view to improving standards of practice still further. Like other Colleges and Faculties, the Royal College of Physicians is active in maintaining standards in training, in the appointment of consultants, and in continuing education. More specifically, I welcome the activities of the Medical Services Study Group within the College, directed by Sir Cyril Clarke and supported by the King Edward VII Hospital Fund, which in many ways is seeking to extract the lessons from past practice, with a view to improving practice in the future. Doctors have shown themselves willing to take part in collaborative research with the Group, for the improvement of practice.

Number and selection of medical students

I find myself in disagreement with two statements which are often made, and which seem to have some support – that we are now training too many medical students, and that we pay too much attention to examination results in selecting them.

In approaching the numbers of medical students required, I have to state a bias and an assumption. The bias arises from experience of the effects of the Willink report, which reduced the numbers of medical student entrants until its fallacy was exposed by LaFitte & Squire (1960). The assumption is that, while movement of doctors for training purposes is desirable, the established posts in the health services of a country should almost entirely be occupied by those who have trained in its own medical schools. Our present state of dependence on doctors trained in the developing countries is not ideal for this country, and is of course severely damaging to the countries who have trained them at great expense. I intend no disparagement to individual doctors from the developing countries, many of whom have done their postgraduate training here, and are now doing excellent work in established posts. But we cannot escape the obligation to ensure that our own production of doctors is adequate to make this a temporary state of affairs. When this imbalance has been corrected, it may of course be necessary to reduce once more the admissions to medical schools. There may also be economic constraints on what we can afford; but we must not make virtues of such necessities. We must of course continue to welcome overseas doctors for advanced training, followed by return to their own countries; but we must correct our dependence on them for career posts, especially in the shortage specialties.

On the other matter – the stress laid on examination performance in selection of medical students – I would certainly not wish to maintain either that intelligence is all that is required of the doctor, or that it is infallibly assessed by the results of 'A' level examinations. As a former admissions tutor, I have seen too many highly-qualified students run out of motivation, and too many whose 'A' level examination results have been inflated by intensive coaching, to hold either of these views. But I would just as strongly oppose another view which is sometimes put forward, that the practice of medicine, so far from requiring high intelligence, is so boring and repetitive as to make it suitable for well-upholstered mediocrity. I suppose it is possible that a doctor can be too clever, but he cannot be too intelligent; and on a lower plane the ability to pass examinations is no handicap to a medical, or any other, student. Having thus exposed my élitist cloven hoof, perhaps I can go on to say that the children of doctors deserve some preference, since they at least know what they are letting themselves in for; and that the best evidence of good and appropriate motivation is furnished not by pious declarations of intent, but by a demonstrable interest in natural history, better still in human beings, perhaps best of all by a voluntary period of hospital work. So I would plead for a balanced selection process, with a reasonable examination performance regarded as a valued asset.

From conflict to creativity

Controversy may either be sterile, with blinkered combatants entrenching themselves in fortified camps; or creative, with the participants gaining understanding of previously unconsidered attitudes and arguments. The old Adam in us admires 'a bonny fighter'; but surely the second of these courses is the better one to follow, if we can but manage it. To do so, we need the old-fashioned virtues of humility, charity, and uprightness. Humility preserves us from an obdurate attachment to our original point of view, the dangers of which are pointed out in one of Coleridge's aphorisms: 'He who begins by loving Christianity better than Truth will proceed by loving his own sect of church better than Christianity, and end by loving himself better than all.' Charity could be regarded as the ourward and visible expression of an inward and spiritual humility – in withholding esteem from ourselves, we freely grant it to others. A charitable attitude in controversy not only turns away wrath, it lays the basis for future understanding and cooperation. Where then does 'uprightness' come in? – a word which I only use after some hesitation. I think it comes in exactly as it was expressed in the famous words of Abraham Lincoln in his Second Inaugural: 'With malice toward none; with charity for all; with firmness in the right, as God gives us to see the right.' In our present context, I think this means that having probed the weaknesses in our own position, having accepted the strengths in that of others, we must still arrive at and proclaim a position which we are prepared to defend. Perhaps I can best illustrate my meaning by going away from the medical field, and commenting on the debate between those who advocate a literary and those who advocate a scientific education – as if these were exclusive.

In his book, 'Literature and Science', Aldous Huxley (1963) sets the scene as follows: 'Snow or Leavis? The bland scientism of "The Two Cultures": or, violent and ill-mannered, the one-track moralistic literalism of the Richmond Lecture? If there were no other choice, we would indeed be badly off.'

He goes on to plead that writers should try to convey to their readers some of the insights which science has given into the human condition, and the nature of the universe. He recognizes, of course, the essential difference between language as used by scientists to achieve maximum clarity and definition, and as used by authors, with every device of sound, syntax and veiled allusion, to bring in overtones of emotional awareness. The scientist is concerned with the public and universal, the artist with the private and particular. Huxley's book is addressed to authors, urging them to make the effort, first to understand, and then in their own way to express, modern cosmogony – just as their predecessors were able to distil imagery from the cosmogony of their day: think of Lorenzo's (quite inaccurate) description of the starry heavens, so marvellously set to music by Vaughan Williams. I believe that the scientist has a duty here as well, to labour sufficiently at the craft of writing to make what he has to say not only unambiguous and intelligible, but also both readable and capable of striking the imagination. Even in purely technical writing, he can be at least grammatical; but for some of us at least, the responsibility seems to go beyond that. We cannot all be like Lewis Thomas or Peter Medawar; but we have a certain duty to write for a wider public in ways which do not offend every canon of literary craftmanship. A sharp-tongued physicist is said to have advised a colleague to publish his collected works under the title 'Tales of Mystery and Imagination'. The recipient of this advice was neither pleased nor amused – but might I just question whether some infusion of these elements in scientific writings might not help to correct the picture of the scientist as the antithesis of 'the man of feeling'. Sherrington lost nothing of his scientific stature through being also a poet, and giving his Gifford Lectures on 'Man and his nature'.

The synthesis of human and scientific values, desirable for any man, is particularly necessary for a doctor. For as Hippocrates put it so long ago, 'Where the love of Man is, there also is love of the Art' – an art which since his day has been enriched and transformed by the fruits of science.

Why did I hesitate earlier to use the word 'uprightness'? Because our country seems to me to be going through what I hope is merely a 'bad patch', in which intellect and morals are alike

the objects of scorn – the one by the 'inverted elitism' so alarmingly displayed in some of the comprehensive schools, the other by the friends of 'the permissive society', which has not visibly brought us to a reign of peace and happiness. I wonder if Disraeli would still be prepared to say 'We know no spectacle so ridiculous as the British public in one of its periodical fits of morality.' Were it not also tragic, I would regard our present fit of immorality as being distinctly more ludicrous.

Why did I then in the end decide to use it? Because I believe that our national recovery, for which I pray, will come not from North Sea oil, nor from sociological theorizing, nor from tolerance divorced from compassion; but from a revival of true integrity, free alike of self-righteousness and of hypocrisy. In that belief I wish to stand and be counted.

References

Beeson P B (1980) *Medicine* **59,** 79-99
Black D A K (1980) *Journal of Medical Engineering and Technology* **4,** 119-121
Bradshaw J S (1978) Doctors on Trial. Wildwood House, London
Card W I & Mooney G H (1977) *British Medical Journal* ii, 1627-1629
Eisenberg J M (1979) *Annals of Internal Medicine* **90,** 957-964
Fletcher C M (1973) Communication in Medicine. Nuffield Provincial Hospitals Trust, London
Huxley A (1963) Literature and Science. Chatto and Windus, London
Illich I (1974) *Lancet* i, 918-922
Kerr D N S (1980) *Journal of the Royal College of Physicians of London* **14,** 135-156
LaFitte F & Squire J R (1960) *Lancet* ii, 538-542
Leaf A (1980) *New England Journal of Medicine* **302,** 1087-1088
McDermott W (1978) *Perspectives in Biology and Medicine* **21,** 167-187
Papper S (1970) *Journal of Chronic Diseases* **22,** 777-779
Parsons T (1950) *American Journal of Orthopsychiatry* **21,** 452-460
Rouse R (1980) *World Medicine* **15,** 12 July, 31-32
Stocking B & Morrison S L (1978) The Image and the Reality. A Case-Study of the Impacts of Medical Technology. Nuffield Provincial Hospitals Trust, London
Szasz T S & Hollender M H (1956) *Archives of Internal Medicine* **97,** 585-592