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From the Editor

A chance encounter

We met by chance. My intention was simply to collect a picture from Gale and Co, the oldest surviving picture framing and restoration company outside London. This business completed, an invitation followed to join the owner in the inner office. And there he was: Dr William Pitcairn (1711–91), president of the Royal College of Physicians (RCP) from 1775–85. Or at least there he was in a fine original 18th-century engraving of 1785 by John Jones who was active in London from 1775 to the turn of the century. Jones was an expert in mezzo tint and stipple engraving particularly of portraits painted by Sir Joshua Reynolds. He exhibited at the Society of Artists between 1780 and 1791 and served as engraver extraordinary to the Prince of Wales between 1790 and 1797. The engraving was made from the Sir Joshua Reynolds portrait still in the RCP collection and currently displayed on the heritage website as a fine picture urgently in need of restoration.

Pitcairn seems to have been something of an elusive figure. He receives but a passing mention in the history of the RCP. Even William Munk, who compiled his roll of all College fellows, noted that he was the oldest son of the Reverend David Pitcairn of Dysart, Fife, by his wife Catherine Hamilton of the 'ducal family of that name' but could recover few particulars of his general or medical education. He studied for a time with Boerhaave in Leyden and graduated doctor of medicine in Rheims. Rather remarkably at the opening ceremony for the Radcliffe Library in Oxford in 1749, on the recommendation of the trustees, the degree of doctor of medicine by diploma was conferred upon him.

Other information has now come to light. The Pitcairn family have been long established in Fife and one of their devoted descendants has traced the family back for nearly 600 years.[1] He was physician to St Bartholomew's Hospital between 1750 and 1780 and physician to both Christ's Hospital and the Blue Coat Schools. In the spring of 1770 he was successfully proposed as a fellow of the Royal Society by 12 fellows including Dr William Hunter and Dr John Fothergill.

> *A gentleman well versed in all branches of literature and natural history and especially distinguished by his application to botany and his success in rearing scarce and foreign plants.*

He had a botanical garden of some five acres at his country house in Islington. *Pitcairnia* is a genus of the botanical family *Bromeliaceae* (the pineapple family) with some 46 species which records his name to posterity.[2]

In the 18th century the physician's cane was part of his professional outfit and he would not have been seen in public or visited a patient without it. The gold-headed cane owned by Dr John Radcliffe (1652–1714) was engraved with his coat of arms and was handed on to Dr Mead and Dr Askew then to Pitcairn and his nephew Dr David Pitcairn and finally to Dr William Baillie (each engraving the cane with their own coat of arms) whose widow donated the cane to the RCP just before the 'new' College opened in Trafalgar Square in 1825.[3] The cane can still be seen in the heritage collection. Pitcairn can also be seen in the current exhibition at the College celebrating the pioneer fellows of the RCP and the Royal Society.

References

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Social determinants of health

In 1980 Professor Sir Douglas Black, when he was president of the Royal College of Physicians, delivered an uncomfortable message to the new 'Thatcher' government concerning the social determinants of the inequalities in health.[1] It was not a message the new government wanted to hear and the report was buried such that even copies of the report became difficult to obtain let alone any of the recommendations being put into practice. The wheels have turned gradually over the years and in 1999 the Acheson report on inequalities of health made 39 recommendations, similar in many respects to those of Black.[2]

Social determinants of health have figured prominently in recent years in the NHS plan, the National Service

Frameworks and Lord Darzi's report *High quality care for all.*[3] The recently published review on tackling health inequalities by Sir Michael Marmot challenges the government, individuals and organisations to assess their contributions to this agenda.[4] In this issue of *Clinical Medicine,* Kiran Patel, Peter Spilsbury and Rashmi Shukla (pages 130–3) discuss the leadership and advocacy role that doctors can play in addressing the effects of the social determinants of health and the contribution that they can make to improving the public's health.

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Acute medical care

The journal is circulated mainly to fellows who are established consultants. We are keen to publish articles of interest to the 'younger physician' – those in training for careers in hospital medicine, newly appointed consultant physicians and our Collegiate members. To this end we have appointed three younger physicians to the Editorial Board who are developing relevant new series.

The first contribution to the new series 'Acute medical care' will be published in the June issue of the journal. The author, Dr Tahseen Chowdhury, conceived the idea and provides the first paper. Contributions may be up to 1,000 words with a maximum of five key references. They should include five headings – case presentation, differential and most likely diagnosis, initial management, outcome and discussion. Contributions are welcome and invited. Further information is available from clinicalmedicine@rcplondon.ac.uk where contributions for consideration should be sent.

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Consultants: a chronic problem for acutely ill patients

Matt P Wise and Paul J Frost

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has recently published its report into the care of patients who died in hospital with a primary diagnosis of acute kidney injury.[1] The strength of this and previous NCEPOD reports is that they are based on expert appraisal of the care that patients actually receive and, moreover, selecting death as a criterion for case selection inevitably highlights deficiencies in clinical care or organisation.

One of the key findings of this latest study was that nearly a quarter of patients did not have adequate senior review. These individuals were judged by the expert assessors to have less good care overall. The lack of consultant involvement has been a recurring message from NCEPOD, being implicated in adverse outcomes for cardiac patients, trauma patients, emergency admissions and acutely ill medical patients.[2] Unfortunately, this observation is not new. Over a decade has now passed since the publication of a seminal paper by McQuillan and colleagues, which called for increased involvement of consultants in the management of acutely ill patients.[3] In spite of this, the latest census of consultant physicians in the UK showed that as few as 56% undertake twice-daily ward rounds for acute admissions, with only 12% performing continuous rolling review.[4] Moreover, the majority of consultants (78%) have other duties while being responsible for acute admissions and 55% have insufficient time to support trainees.[4] These alarming figures were in the context of whole-time consultants working in excess of the average contracted 11.3 programmed activities. Undoubtedly these data reflect an improvement over what would have been recorded a decade ago but still fall short of best patient care. It would without question make no sense to an impartial observer why the sickest patients are seen by the most inexperienced clinicians first and only seen by the most experienced at the end of the admission process.

Historically, consultants have been insulated from directly managing acutely ill patients by teams of experienced junior

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