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book reviews

Living medicine: recollections and reflections

By Margaret Turner-Warwick. Royal College of Physicians, London 2005. 326pp. Hardback £25, paperback £15.

Dame Margaret Turner-Warwick tells us in the introduction that her book was written for her family. We can be grateful to them for providing her with the stimulus to write for it helps us to understand the past and is also an intelligent guide to how medicine can retain its position of trust in society in the future.

Dame Margaret witnessed and participated in a remarkable period of medical advance during the third quarter of the twentieth century. For a practising doctor the introduction of antibiotics and corticosteroids and, in the UK, the creation of the National Health Service, transformed the ability to provide effective treatment. The concurrent development of clinical science provided the evidence on which these developments were based.

She had qualified in 1950, the first year in which the number of cases of lung cancer in the UK exceeded those of tuberculosis and the year Austin Bradford Hill published two seminal papers. These were the results of the first clinical trial demonstrating the long-term efficacy of combination treatment for tuberculosis with streptomycin and para-aminosalicyclic acid (PAS) and, with Richard Doll, the case-control study which first suggested cigarette smoking as a causal link to the progressive increase in the incidence of lung cancer during the 1930s and 1940s.

Aneurin Bevan believed that the NHS, by improving the health of the population, would eventually pay for itself. However, the increasing cost of healthcare and the most effective means of providing it had been a constant theme of the past 40 years and had led to sharp disagreement, and on occasions conflict, between government and doctors. This period also witnessed an increasing expectation among patients and the public of both the quality of clinical care and the behaviour of doctors. In our time widely reported scandals, such as those at Bristol and Alder Hey, have led not only to highly publicised reports and increased government regulation but also to questions about whether doctors can be trusted and, by extension, deserve self-regulation.

The book is in two parts: in the first Dame Margaret describes her life from childhood, to becoming a doctor in a male-dominated profession. In the second part she reflects on the problems currently facing the profession. She brings knowledge and experience gained as a hospital physician, a professor of medicine, the dean of the National Heart and Lung Institute, the president of the Royal College of Physicians and a chairman of a hospital trust. She also brings an understanding gleaned from her experiences as a patient, with ear infections during early childhood, tuberculosis as an undergraduate and breast cancer while a practising physician.

She was the third of four daughters born into a professional family with a strong culture of education and intellectual achievement; a family in which the children were told to 'expect no dowries' but who received family and financial support to pursue a professional career. Her undergraduate career as a scholar at Lady Margaret Hall, Oxford, was an extremely happy and intellectually stimulating period. She recounts her clinical career from medical training to consultant posts, initially as a general physician with an interest in rheumatology at Elizabeth Garrett Anderson Hospital, later as a Senior Lecturer with Guy Scadding at the Institute of Diseases of the Chest before succeeding him as the Chair of Thoracic Medicine.

Her personal and professional encounter with tuberculosis, which she developed in her final year at Oxford in 1946, is particularly instructive. It was treated, because of family concerns about the effects of food rationing in UK, in a sanatorium in Switzerland. This was before the advent of chemotherapy, and artificial pneumothorax

and phrenic nerve crush were used. Her year in the sanatorium brought her into close contact with her fellow patients whose hopes and fears she came to know well. She conveys the excitement she later experienced, while a doctor in training in the 1950s, because of the successive introduction of streptomycin, PAS and isoniazid, which together provided for the first time a realistic hope of a medical cure for tuberculosis.

In the second part of the book she provides a perceptive analysis of what patients really want and why so many feel that their needs are not fulfilled in today's highly-regulated healthcare system, stemming from limited doctor time and erosion of continuity of care. She also addresses the reasons for the poor morale among today's medical professionals.

An important theme running through the whole book, implicit in the first part, explored more explicitly in the second, is the primary commitment of the doctor and the clinical staff team to serve their patients' best interests before their own. This is the basis of medical professionalism and of the trust given to doctors by their patients, and the reason society allows self-regulation. This patient-centred approach provides the foundation for her clinical work and directed her research ('from bed to bench').

Dame Margaret argues powerfully that this professional commitment should be the foundation of the profession's relationship with both government and management, with each partner in the provision of healthcare recognising and respecting the value of the others' contribution. Medicine, she believes, is at a crossroads: doctors can choose to become contracted employees or, in the interests of better patient care, assert their professional values, working in partnership with other professionals, both clinical and non clinical. She quotes Relman's division of the evolution of health services in the USA into three eras: the Era of Expansion (from the 1940s to 1960), the Era of Cost Containment (from the 1960s to the 1980s) and the contemporary Era of Accountability and Assessment. The three eras coincide with changes in the UK both in the organisation of the NHS and in the professional–managerial relationship. Her analysis of current problems in the NHS leads her to the conclusion that a new culture, rather than additional resources, is required, and she recommends a fourth era of 'partnership and trust' with mutual respect between those responsible for patients, for the organisation of the NHS and for the management of the service, based on intelligent accountability and regulation. She quotes Onora O'Neill: 'If we want a culture of public service, professionals and public servants must in the end be free to serve the public rather than their paymasters.' This must surely be right.

The book reflects Dame Margaret's continuing concern for patient care, and provides thoughtful analyses of her professional life and of the current concerns of the profession. It will be read with pleasure and benefit by those both within and outside the profession who wish to appreciate the privilege and responsibilities of a career in medicine and to understand the changes in its practice and organisation in the UK during the past 50 years, and by those concerned for its future. Throughout the book she displays an unfailing generosity of spirit and an intelligent optimism for the future.

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Difficult conversations in medicine

Edited by Elisabeth Macdonald. Oxford University Press, Oxford 2004. 254pp. £19.95.

About 100 years ago Lewis Thomas, the American medical scientist and writer, used to accompany his father, a country doctor, on his rounds. He wrote: 'In my father's time, talking with the patients was the biggest part of medicine, for it was almost all there was to do'. By the time he himself entered medical school, scientific technology had moved on and, despite its obvious benefits, it has since taken most of the blame for the erosion of doctor–patient relationships.

I'm not sure this is warranted. When I entered the wards as a medical student almost 60 years ago there was very little in the way of technology, yet communication between doctors in the wards and their patients was minimal. I recall long ward rounds with the professor and his (always!) large entourage moving from bed to bed, a scanty greeting to the patient, then at the end of the examination a group discussion at the foot of the bed, out of the patient's hearing. There would then be another scant word, this time of reassurance, and we would move on. Very little information was provided, therapeutic options and choices were not discussed, the patient was told what would be done. One never disclosed bad news; the accepted practice was to tell the relatives but not the patient when things looked bad. In order to make sure the patient didn't know what was going on we used code words – luetic disease for syphilis, Neisserian infection for gonorrhoea, mitotic disease or a space-occupying lesion for cancer, Hansen's disease for leprosy, Koch's or acid-fast infection for tuberculosis.

Perhaps, hospital medicine was different from general practice: consultants were busy men, so junior doctors might have been expected to do the talking. This was a mistake. We had received no training at all in the skill of communication and the reticence of our chiefs meant we had no model from which we could learn good – or bad – practice. We floundered and blundered along, embarrassed by the need to camouflage bad news or our inability to deal adequately with questions. The doctor–patient relationship was a poor lop-sided arrangement – before technology took root.

Much improvement has taken place since then, in spite of the technological revolution. Ward rounds are no longer like military processions; in general, information is imparted more freely, choices are outlined and options are discussed, and patients are encouraged to express preferences. But, it seems, more needs to be done to satisfy the demand for equality in decision-making, to dispel any last vestige of authoritarianism. Young doctors, therefore, need to be trained to communicate sensitively and sympathetically, especially when the topic is difficult, to 'engage with' patients, to 'empower' them through 'patient-centred consultation'. (I use quotation marks because I live in hope that the new jargon is transitory and will soon be jettisoned.) This need for training is the theme of Dr Macdonald's book. It is aimed at professionals in the early years of medical practice, but contains enough good sense to enlighten the elderly whose less acceptable habits may be entrenched.

I found this a readable and useful book. The most valuable chapters are those written by the editor, herself – nine of a total of sixteen. Dr Macdonald's advice is clearly based on a long and thoughtful contact with patients in one of the most difficult of all specialties,