Cum scientia caritas*

G. L. McCULLOCH, M.B., Ch.B., F.R.C.G.P.

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MY OWN translation of the motto of our College involves a transposition—"Scientific skill with loving-kindness". It is unfortunate that our English version of *caritas* has fallen from favour. The word 'charity' is uttered almost with a sneer and connotes pity. The verb 'to cherish' gives us a much more euphemistic version of the Latin, comparable with the Italian and French terms of endearment, *carissima* and *chèrie*. We may be on less sound etymological grounds if we suggest that 'care' and 'cure' are not unconnected with *caritas*, and that our care of our patients is analogous with the parson's cure of souls. The curate, the curator and the caretaker have affinities with ourselves. The end-results of our own continuous care in conjunction with whatever scientific skills we possess may promote the patient's cure from his affliction.

When our motto was chosen and decided upon during the earlier deliberations of the college council I feel that inspiration may have been derived from the example of James Mackenzie, who was the personification of the motto's purport. Mackenzie was a medical scientist who entered general practice as an assistant, as so many young doctors did in his day. The tragedy of a young woman in fatal heart failure in childbirth deeply touched his sense of *caritas* and set the course of his famous scientific investigations.

James Dundas Simpson had a strong scientific bent, as a glimpse into his consulting room used to demonstrate. There an apparent entanglement of Meccano, electric wiring, red light bulbs and a gramophone turntable in the top drawer of his desk answered the telephone when it rang during his off-duty periods. It looked Heath Robinson, but it delivered the message. He also carried around with him his own do-it-yourself accessories to his equipment as an anaesthetist at Addenbrooke's and neighbouring hospitals. Although I have no direct knowledge of his relationships with his patients, though I can guess how delightful they must have been, I was to experience an example of his *caritas* towards a fellow-practitioner once, when he was our provost and I was chairman of the Faculty Board. We often met at this formative stage of the faculty's existence. On this occasion it came out that the possibility of my getting away for my annual holiday was being jeopardized by the difficulty of finding a locum tenens. James at that time had a trainee assistant, and a brilliant idea. Term would be over at the university, his practice would not be at its busiest; if he were to give his trainee leave of absence for the period of my proposed holiday, would I care to . . . ? Perhaps he was bending the National Health Service regulations, but I found myself with an excellent locum and a most beneficial holiday.

The substance of what is to follow will be a mixture of nearly half a century of medical history with, if you will forgive me, a certain amount of autobiography. The War of 1914–18 brought about a high mortality of qualified practitioners and a necessarily high intake of medical students. For me as a medical student it also entailed a steep rise in the cost of living with no accompanying rise in my slender income, which was not grant-aided. Of their charity some of my teachers, whose memory I still cherish, allowed my final year class and examination fees to lapse until such time as I could earn them. Resident vacancies, especially in teaching hospitals, were as coveted

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as they were ill-paid. In some the remuneration was as low as £50 per annum. They were the plums for the opulent and specialist-inclined graduates.

The consequence of this situation was that in 1922, on the very morning after I had graduated and registered—a simultaneous process in those distant days—I plunged straight into general practice armed with a thermometer and a stethoscope, and precariously buoyed up with faith, hope and charity—faith in whatever knowledge I had succeeded in acquiring from my excellent teachers, hope that I should remember the dose of strychnine and which forceps blade to insert first, plus my inborn but, so far, undeveloped *caritas*. There was in addition that arrogance which the moment of qualification entitles us to by conferring upon us a sudden acquisition of enormous power over our fellow human beings. Within a fortnight I had exercised this right to the extent of certifying three of them as lunatics. Which brings out one fact of medical history. The word "lunatic" has disappeared from our terminology; we no longer certify and indefinitely incarcerate these unfortunates. Possibly this is a recognition of the fact that, in any case, we each and every one of us, are a little peculiar, an acknowledgement which should offset the aforesaid arrogance.

Within three weeks I had presided, in a state of considerable anxiety, at the physiological birth of a baby. And there was born to me on that same occasion an admiration for the skilful offices of the trained midwife which has never ceased to grow, so much so that now I seldom interfere at all in the highly expert procedures of these excellent, undervalued women.

Within two months I had become an assistant in the maelstrom of industrial general practice in the midlands of England. Here was the glamour of adventurous domiciliary obstetrics at the rate of 200 deliveries a year between three of us. Axis traction forceps, cranioclast, chloroform, lysol, ergot, needle, catgut—that was our armoury. A diagnostic examination, and we were engaged to answer the summons of a handywoman on D-day to cope with whatever we found on arrival at the house—occipitoposterior, breech, placenta praevia, hydramnios, hydrocephalus. Considering the crudities and environment our standards were astonishingly high. There was no case of puerperal fever, and no woman was the worse for her rag-and-bottle chloroform anaesthesia administered by the operating obstetrician himself.

But, beside this moderately scientific, but highly gratifying achievement there was the great frustration in medical therapy. Here was almost no science at all. One spoke at that time of the art of medical practice. It was, in fact, the art of the bedside manner which concealed the deficiencies of our potential for combating the mass of morbidity in the working population. It must be remembered that in 1922 insulin had not yet been brought into play. Diabetics of all ages died in coma or of sepsis. Our principal tranquillizer (a word not then in use) was bromide of potassium, used also, with poor success, as an anticonvulsant in epilepsy. Barbitone was available, but its potency was rather feared. The real therapeutic function of the general practitioner was to organize and supervise nursing and to relieve pain. We had opium and morphia and *caritas*. The battle against disease itself was a losing one, but we were able to win some mastery over the worst of physical suffering.

For this last purpose we have today rather more shots in our locker; but the principle remains the same, especially in the case of the terminal pain of cancer. My observations of the methods of some of my younger colleagues have made me wonder why they appear to be afraid of morphia for this condition. The patient who is going to die cannot become an addict. I have always been a dispensing doctor, and have not forgotten how to extemporize. Any cancer patient who can swallow can be given the solution of morphine hydrochloride. This can be added without the patient's knowledge to any National Formulary mixture or linctus in increasing doses to keep just ahead of

the increase of pain. So long as the patient is happy—and this does keep the patient and the attendants happy—it matters little that the dose of morphine may greatly exceed the official maximum. The simultaneous use of chlorpromazine reduces the amount of morphine required, for there is no doubt that this very fine tranquillizer diminishes the patient's perception of pain. Yet I still hear of instances where it is withheld.

I would not say that we felt an actual sense of frustration in our therapeutic powerlessness. We were used to the perpetual task of relieving symptoms. Almost the only specific treatments available were mercury for syphilis (mostly administered at hospital venereal disease clinics), digitalis for the failing heart, iron for iron deficiency anaemia, and thyroid extract for myxoedema. Raw liver was beginning to be used for the treatment of pernicious anaemia. We had to watch fine young men and women slowly die from tuberculosis, coughing and expectorating to the last. We had to send children and adults with diphtheria to isolation hospitals, not knowing if they would return alive. We saw many young people with chorea. Gargles and aspirin for tonsillitis had little effect in preventing sequential acute rheumatism or malignant endocarditis. Meningococcal infection, when not fatal, resulted in severe mental handicap. Encephalitis lethargica, a disease which has disappeared, left young people drooling with severe Parkinsonism.

This all sounds terribly dismal. There was not much joy in it. There was a sense of relief when the fittest of our patients survived. There was the reward of gratitude for the 'cures' attributed to our devoted care. But the real joy of general practice lay in successful diagnosis. It is safe to say that in the period of medical history I am describing—nearly half a century—however many new techniques it has seen introduced, there has been no change in the basic principles of diagnosis. The general-practitioner clinician, usually the first to see the patient, must extract the history, discover the symptoms, observe the physical signs, and apply his knowledge and acumen to all these. This is the pivot upon which the whole of general practice revolves. At this point we determine our future actions, and hence our patient's future. We may decide simply to reassure, we may decide that we ourselves can undertake treatment, we may consider reference advisable for further investigation, we may decide that a second opinion is necessary. And if and when we find that our decisions have been the right ones for our patient, then we have our reward. This has always been so, no matter under what auspices we may have practised.

The auspices under which we practise has always been a delicate topic. One of the great benefits which our college confers upon its members is the escape it provides from the rancours of medical politics. But there are points at which the academical and the political meet, the points at which the highest principles are involved. I will only postulate here that, ideally, a general practitioner should enjoy complete clinical freedom, freedom from any fear, whether it be of his patients, of any colleague or of those in legalized authority, freedom from want, sufficient time to perform his professional tasks well, and assured leisure to benefit from a happy domestic and social life. I am fortunate in that I have found myself enjoying all these things under the present auspices, together with ample clinical material.

But I must return to certain points in this history, and especially to the great turning point in general practice. The care of pneumococcal pneumonia, lobar pneumonia as we used to call it, with its rusty sputum, its pain, its fever, its delirium, its ten days of acute suffering and anxiety, its crisis followed by death or a long period of resolution and convalescence, was a frequent task of daily, sometimes twice daily, visiting and advising. Then in the 1930s came sulphonamide with its ability to conquer dramatically not only the pneumococcus, but even the more dreaded meningococcus. At last we had

in our hands an effective therapeutic weapon for the treatment of an acute illness in the patient's home. Within 24 hours of the onset of symptoms the temperature was falling and rapid recovery was within sight. It is true that the introduction of insulin had preceded sulphonamide, but our diabetics were dealt with by the hospitals in special clinics. We were also treating scarlet fever at home with antistreptococcal serum.

A decade later, in September 1943, Anglo-American forces established a beach-head at Salerno, south of Naples. At that time I was serving in a hospital ship which was evacuating the casualties. The general clinical picture was of very ill patients with stinking wounds. A few months later I was helping to evacuate casualties from the beach-head at Anzio, north of Naples. Between these two episodes we carried on board our ship two senior medical officers in charge of two wooden crates. The contents of the latter were said to be worth two million pounds, and marked another major event in medical history. They were the first consignment of penicillin. From the Anzio beach-head we took fitter, happier patients with clean wounds.

There is little need for me to enumerate all the other steps forward that have been taken in the provision of potent effective therapy in general practice. The most notable are the broad-spectrum antibiotics, the tranquillizers and antidepressants, the oral diuretics and the hypotensives. It is difficult now to imagine doing our work without the help of these drugs, and to remember how helplessly inefficient we were before their advent. One of the chief incidental differences in present-day practice is very like that contrast I have just mentioned between Salerno and Anzio. In the 1920s most of the patients we saw were in poor shape. In the 1960s our patients are for the most part in very good shape—physically.

In the early hurly-burly of intensive practice amongst a high-morbidity population there was little time to think. Later on, as a principal in surburban practice, I must have become more perceptive, for I began to see that a person who took the trouble to sit in my waiting room had come with a personal problem which was not necessarily simply the actual physical condition displayed. Every patient, I came to realize, was living in the daily environment of home and work and relatives and neighbours. The word 'stress' began to enter into our jargon. It is a word I have not heard used so much recently. I think the psychiatrists have a number of polysyllabic substitutes for it. There came about a gradual change in my attitudes. I was inclining more to take cognizance of the whole patient rather than of his assumed malady. This is part of the great revolution which has taken place in general practice. As a consequence of the many advances in preventive medicine and effective therapy we see far less somatic morbidity, and we find ourselves faced with the more exacting task of considering the person as a whole than of simply dealing with a physical syndrome.

To some extent the difference between general practice and hospital practice is most pronounced just at this level. The general practitioner is dealing with the human person in his everyday habitat, and has to take into account that whatever he advises his patient to do will produce reactions and repercussions in relation to domestic, educational and social circumstances. The patient in hospital is as captive as an animal in a zoo. He has been removed *in toto* from all that is familiar, and has become virtually something in a laboratory to be subjected to all sorts of unfamiliar processes and routines. I attended a postgraduate symposium on geriatrics at which we were told that our patients, on admission to the unit, were weaned off the drugs with which we had been zealously plying them in their homes. Well and good. These elderly people underwent rehabilitation in the security of the hospital ward. Then they were returned to the stresses of their old environment, and soon it became necessary for us to administer once again the same old drugs to relieve the same old distresses. An octogenarian widow used to receive the occasional visit from me—my routine geriatric look-in. One day she appeared to me to be less well than usual. I got her to loosen her blouse so that I could at least

make the gesture of listening to her heart sounds. When I applied my stethoscope, "Don't go too low, doctor", she said. Of course I soon brought into the light of day the breast cancer she had been concealing from everyone. She simply said she wished not to have anything done about it. I allowed her to die in the comfort of the surroundings she cherished. Whatever beneficent therapeutic measures would have been applied to her fatal disease, she would have been profoundly unhappy in hospital, and I should have failed in *caritas*.

Here is to be found one of the chief differences between the me of the 1920s and the young graduate of the 1960s, for whom I have great admiration and considerable envy. He has had a wonderful scientific training. But, unless and until he has had the opportunity of inside knowledge and experience of general practice, he remains hospital-minded. This does not mean that I have not the greatest respect for, and appreciation of, hospital staffs and their magnificent achievements. Day by day I am solving the problems of people in their natural environment. My insoluble problems I hand over willingly and confidently to the hospitals. I have had opportunities of observing newly-hatched doctors suddenly let loose in general practice. They are full of knowledge of the latest techniques and therapy. I always learn from them. It is part of my post-graduate education. But, having lived their clinical lives under the tutelage of consultants in the centrally heated atmosphere of the hospital, I find that every patient they set eyes upon in my consulting room is at once a potential candidate for the operating theatre, the laboratory or, at the very least, the radiology department, or is liable to be deprived of his or her martyrdom badge.

What, you may well ask, is a martyrdom badge? It took me many years to discover that what I put into a bottle and handed to the patient did not always serve its intended purpose. The bottle of brightly-coloured hideously-flavoured medicine costing almost nil, which is now replaced by a kaleidoscopic array of extremely expensive capsules and tablets, affords proof positive in the home that mother or wife or husband is quite unfit to cope with some part of the demands of domestic or social or occupational life. It is an enormous help to these people to have this badge as their means of gaining, it is to be hoped, a part of that sympathy of which they have been starved. Whatever these things may contain, our giving them to the patient, short of poisoning him, is good therapy. Indeed, nowadays they are an absolute necessity.

Just pause a moment to think who or what the person is whom we call "the patient". Having begun at conception as a random half of the mosaic pattern of all the genetic attributes of his father combined with a random half of the mosaic pattern of all the genetic attributes of his mother, he can only be regarded as an unique individual with his own unique reactions. Physically his eyes may be blue or brown, his hair black or blonde, his stature tall or short. Mentally and temperamentally he may be alert or lazy, excitable or placid, smiling or sombre, witty or dull, courageous or cowardly, rash or cautious, nimble or clumsy, athletic or artistic in an infinity of permutations. His yea or nay to any alternative proposition will be governed in part by his unalterable genetic pattern, and in part by the extent to which his character has been shaped by all the environmental factors to which from birth he has been and is being subjected—parental, social, educational, occupational, traumatic. These unique and complex individuals make up our practices. Although proportionately they are much less liable than ever before to suffer from real treatable somatic illness, they are the victims of a number of stresses which the tremendous uprush of public awareness has brought about. The more they know and think about atom bombs, brinkmanship politics, the precariousness of the national economy, pressure advertising, violence, unrest, disease, their own bodies, diet, drug addiction, their sex life, the more they need our help. We cannot stop them reading the papers and the paperbacks and watching television. And many other of their environmental stress factors are irremovable. They have to live

with other people, they have to work. There are more thoughts in their heads than ever before of the possibilities of adultery and divorce, of premarital sexual indulgence, of homosexuality, of whether to get out of an unexpected pregnancy, of whether or not to have an unwanted child adopted, of how to avoid having to care for the elderly. Psychiatry may help by analysing and explaining an individual's problem, but it returns the individual to the same environment of pressures and stresses—and to the general practitioner's care.

All this makes me wonder whether the ignorance and unawareness of the 1920s may not have been a blissful counterweight to the burden of physical miseries and deprivations of those days. Our present general awareness and affluence go hand in hand with anxiety and discontent. Herein we find a vast volume of change as between the 1920s and the 1960s in the sort of problem that the general practitioner is likely to encounter when the patient enters the consulting room. This change demands an altered outlook on the part of the general practitioner, and is one of the factors which has made essential the development of the Educational Foundation of our College. With all his splendid physical scientific equipment the new general practitioner will have need of a proportionately greater measure of faith, hope and charity than did I in 1922.

How, we must ask, have all these revolutionary changes, human and scientific, in the picture of general practice affected its attraction as a vocation? The answer is to be found here in the membership of the Royal College of General Practitioners, in our coming together to share that common interest which the exercise of our scientific skills with loving-kindness brings about. There is no doubt that the modern young doctor entering general practice is already a highly trained and well equipped medical scientist, and that the human material he will daily encounter will be enough to satisfy his every clinical urge. He will experience the pleasures of paediatrics, he will witness the courage of the elderly, he will share the joy and hopes of expectant mothers, he will find special interests in the many branches of medicine he will encounter day by day. He will observe the ways of people living in their normal environment. In addition he will find opportunities for recording and research and education according to his bent. If he is fortunate enough to find himself working in anything approaching the ideal circumstances I postulated earlier, he will discover that the preoccupations of general practice will be utterly satisfying providing that his scientific skills are exercised with a sufficiency of *caritas*.

Avicenna on boating and sailing

To go out in a small boat, or in a larger sailing vessel is beneficial for lepra, dropsy, apoplexy, dilatation of the stomach and coldness of the stomach. For if the person is near the shore he is incited to vomit, and then when that subsides, the stomach is benefited. But to go on the high seas is more efficient for clearing up such disorders as we have named, because the mind is diverted by successive gladness and misery, and the organs of nutrition receive benefit in proportion to the exercise of the body itself.

A treatise on the canon of medicine of Avicenna incorporating a translation of the first book. O. Cameron Gruner, M.D. London. Luzac & Co. 1930. p. 386.