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OBSERVATIONS OF A RETIRED PROFESSOR

BY

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It is indeed a pleasure to return to Kuala Lumpur — an opportunity to see my old friends — to see places I have known and enjoyed. I thank you for receiving me and asking me to speak tonight. It is a compliment, for many of you have been obliged to hear me before yet tonight you voluntarily submit yourselves to another session. That is a most gracious gesture. I thank you most sincerely.

Tonight I thought it would be best if I spoke about some matters with which I have been closely concerned since I returned to Scotland. About these matters I can speak from personal observations. I think they will be of interest to you in your great tasks here of sharing in the work of building up this new nation and society. I know something of what you seek and something of what you are doing for I avidly follow from the papers and from the news I get from friends, the events in this part of the world. My interest and affection for Malaya persists, it is not cast off by an act of retirement.

When I returned to Edinburgh in 1955 and met my old friends and colleagues there, we conversed about many things and not least we talked about the changes which had occurred in hospital and medical practice generally. We contrasted the picture of 1935 when I left for Singapore and 1955 when I returned to Edinburgh. The change made by the introduction of the National Health Service makes a fascinating contrast between the conditions under which doctors work, as they were then and as they are now. I know these things as a retired professor, as a spectator, not as a partisan.

The N.H.S. in the United Kingdom is the subject of study the world over. Yearly it is investigated, analysed and commented on by people from many countries — most frequently from the U.S.A. and Canada. Others from the U.S.S.R., from India and a score of other countries have been doing this and many of them I have met.

Let me start by saying that the scheme gives a medical service of the most comprehensive kind. The best of medical care is available to all and in a way it is free to all. Why then should there be doubts and criticisms about its suitability as a pattern for other countries to adopt? Why is it that even in the U.K. there are murmurings and doubts?

I cannot give you an analysis of all these criticisms in a brief period tonight. It is a subject that could form the basis of a course of lectures. It will suffice for our purpose if I indicate some of the fundamental difficulties and perhaps draw one or two lessons therefrom.

Perhaps the greatest difficulty with the N.H.S., when it was formed in 1947-8, was that a vast complex scheme was devised based on a political theory and introduced all at once. There were no precedents to give guidance. The scheme was all embracing and completely new. The country acted like a man presented with a large Chinese makan. It swallowed the lot and accepted the inevitable indigestion as well as the benefit of the food.

The scheme, however sound in theory and admirable on purpose, created overnight a rigid structure into which was forced the whole medical profession. The structure was maintained by a mass of regulations and formulae. A vast civil service department appeared. In order that the scheme should not be wrecked by opposition from the medical profession, Government had perforce offered or agreed to terms acceptable to the vested (not necessarily improper) interests of the practitioners and members of hospital staffs already holding appointments or in practice. The new service inherited or took over large numbers of old buildings at a time when the country, having spent its money and suffered severe damage in the war, had no means of replacing them.

I think it is fair to say that adherence to certain political dogmas added to the difficulties. The medical services had to be "free" in the sense that no direct charge would be demanded from an individual patient. Everyone was therefore forced into an insurance scheme to help pay for the N.H.S. whether he was a millionaire or in penury. And lastly there was the political error of promising everything to everyone no matter the cost or the difficulties. The cost proved to be enormous and has been growing ever since.

Now what to-day are the causes of friction and difficulty? First is that taken by and large a doctor gives his loyalty primarily to his patient. He and his patient together do not fit easily into the tidy scheme which a government seeks to establish. The G.P. in Britain is not a salaried official, nor is he a civil servant. In the hospitals a majority of the senior specialists refuse to work other than on a part time basis. The doctors fear the State as a monopoly employer. They do not believe that their profession can flourish when controlled by regulations and committees. Committees, in the doctors' mind are bodies appointed by the uninterested, formed of the uninhibited to do what is unnecessary. Doctors also fear that their profession may become a political plaything of contending political parties. It is for this reason that Sir Arthur Porritt in his presidential address asked this question, "Have we in the U.K. got the right form of organisation for the N.H.S. — is it not something which requires some other form of administration, planning and control, different from that of an ordinary government department?"

Another source of much questioning to-day concerns the fixed pattern in General Practice and hospital staffing. Doctors have lost their freedom of mobility. To enter any field of practice to-day, whether general or specialised, the young graduate has to follow a precise programme of preparation, on completion of this seek an appointment and when this has been attained he must stick to it for the rest of his life. He has but little chance of a change, either in his earlier years or later. He cannot start as a G.P. and specialise later or *vice versa*. It is even difficult for him to change from one part of the country to another.

The separation between the G.P. and the hospital specialist too has become wider. This is partly due to the developments of medicine itself, but in no small measure it is due to the terms of the N.H.S. There are no longer, even in the smaller hospitals, opportunities for those practitioners with special interests and skills. There could never be another James Mackenzie.

The General Practitioner to-day complains bitterly about the "paper work" — perhaps an inevitable sequel to any form of organised service. But in Britain the Welfare State demands an excessive number of certificates. In all too many instances a medical certificate is needed to draw this benefit or that. It is no good going off work with a headache unless you have a " line " and then another to say the headache has gone before you resume your job. No parent can say Little Willie wasn't fit for school — a Dr. must certify the fact. Above all the doctor most resents (and I'd say this is at the bottom of much of the strife between the Government and the profession) the many petty regulations which affect his everyday life. Each item of service has to be noted, all records kept meticulously to date. This mass of paper is not for the benefit of their patients but to claim payments in small sums from which calculations determine the doctor's income. In many instances doctors complain that the "free service" is in itself a source of difficulty. Whilst the majority of patients are reasonable and thoughtful, a minority abuse their "rights". Demands are made for medical care for the most trivial ailments, unnecessary demands for home visits late in the evening or at night or at week-ends. Demands for medical certificates are made on the slightest or most dubious grounds. Hospital staffs are expected to attend to demands with the promptitude of a salesman obliging an exacting customer. All these experiences have raised in the minds of many the question of whether there would not be a great improvement if a patient had to pay a small sum for each service he seeks.

These things I have observed and I have asked myself whether they have any lessons for the doctors in Malaya. You have a great opportunity — you are an expanding service. You are not weighed down with vast old hospitals. You have a flexible free type of General Practice. As you plan for the future what pattern will you adopt? I shall not presume to tell you but I suggest that you will need to give the deepest thought to the problem. You will do well to study the advantages of this or that system but you must also study its snags. Perhaps the most

important lesson of all is that you gain by going step by step. Experiment and try out before you adopt in permanent form an all inclusive scheme.

Above all remember that as medicine develops there must be change and growth in the forms of its practice — avoid rigidity of mind, of forms and of pattern.

It has been fascinating to look again and observe University work and thought in Edinburgh, to observe the changes that have taken place and contrast Edinburgh with Malaya. Was what I tried to do in the early formative days of the University here in accord with the aims and plans of those working elsewhere? Would our achievements here be regarded in the United Kingdom as good or bad or barely passable?

Both because I have known so many of the Edinburgh University staff for many years (I can say that the Senior Professor in the Medical Faculty is an old student of mine) and as a member of the Faculty I have admirable opportunities for seeing things from the inside; without being a departmental head I can take a detached objective view. The main change has been in the whole assessment of academic purpose and aim. The major objective to-day is research. This applies not only to the departments of basic sciences but also to the clinical departments. Research has always been an important part of the University's work. In the older Edinburgh Medical School I knew thirty years ago, teaching would, I think, have been mentioned first — Teaching and Research — to-day — Research and Teaching. From this has followed a change in the concept of the type of person acceptable as a Professor. Indeed the curious and disturbing situation has arisen that it is easier to become a Professor in a clinical subject by working in a research institute than by working in a clinical department. The University Lecturer in a clinical subject may be passed over in favour of a research worker. Teaching methods too have changed. The older didactic teaching which demands some degree of skill and wide knowledge of his subject from the teacher has been replaced by more informal tutorial discussions, by essays and by a greater insistence that the student works on his own. It is held that the undergraduate develops a better concept of what learning is and of how to learn for himself. I confess I am prejudiced. The son of a teacher and the pupil of one of the greatest didactic teachers Edinburgh ever produced, I find it difficult to accept the proposition that good teaching in the classical style is no longer a worthy academic occupation. Note I say good teaching. I have observed that some of those who are most critical of didactic teaching have little or no ability in that difficult art. A lecture confused in its construction, poorly delivered, merely dictating material which can be obtained from any textbook is to be condemned. Good didactic teaching is an art. The person who is good at it is recognised at once by his students as being a teacher of high quality. For many students such teaching is the one way in which they can learn. It is true that for others this type of teaching is of much less

value. I have always held that there are as many ways of learning as there are students in the class and there are as many ways of teaching as there are of learning.

Here I would tell you of a personal experience. My son failed in one of his subjects in his second professional. His teacher was one of the most ardent supporters of the new method. I undertook to salvage the damage although I now possessed the most meagre knowledge of this particular subject. It was a matter of applying an old teaching technique. Three months later he not only passed but was congratulated on having made such an improvement.

Well now what we are seeing is a modern trend in University patterns which must be carefully studied and assessed with objectivity. The careful guidance of the undergraduate, the instructional obligation of any university is, I believe, something at least as important as research. Research has a glamour and appeal for some men and for some it is so attractive that any other activity that makes calls on their time or energy is regarded as a nuisance and a distraction. Perhaps some of the criticisms by the research worker of the older methods of teaching is a rationalisation of his own limitations.

One thing is certain, however, the importance of research work is increasing. To achieve a significant output of research by university departments, the basic sciences and the clinical departments require adequate staff to devote time to this aspect of their work. Particularly in the clinical departments there must be adequate facilities for it.

Looking back on my own assessment of what should have been asked for my own old department, I confess to have made inadequate demands. In your new developments I trust that you will make good my shortcomings. You are expanding rapidly. Surely the time is near when compromise and "will have to make do" will be over. Do not let yourselves be conditioned to such lines of thought. Can I suggest that you might very well consider carefully (if you have not already done so) whether amendment, addition to, alteration and even abandonment of earlier policies are required?

Let us pass to another field which I have been observing, that of Postgraduate Education. Both as the Director of Studies and as examiner in the Fellowship both in Edinburgh and London, I have been favoured with remarkable opportunities to see and learn. I have been trying to see how far the plans I formulated (but seldom accomplished) when I was in Malaya would meet the requirements of those who seek higher diplomata.

Why is it that so many men fail to pass these examinations? It is easy to say the standard is high or that many men have not the necessary ability. Both these things are true but they are not the whole answer. I would assert that there are many other factors of which the following are perhaps the important ones.

1. Inadequate preparation. All too many candidates assume that all that is required is to attend a course and then sit for the examination. But few if any of the courses are planned to achieve this. They are planned on the assumption that the candidate has already had considerable hospital experience and has read pretty widely, not only the standard texts but also some of the more important journals and is aware of modern ideas in his subject. The courses seek to organise his knowledge and emphasise what is important and deal with recent developments. The courses will *not* make good defective teaching in the basic sciences. In Malaya we can pat ourselves on our backs pretty generously. We have had a quite outstandingly high standard of success in the Fellowship.

It has been a real pleasure for me to see so many of my old students and housemen succeed. One reason for coming back to Malaya is to see how they are getting on in their more advanced work. On the medical side in Edinburgh I would quote the remark of one of our ablest and experienced examiners, "I always like the men from the University of Malaya, they are such nice people and so well trained."

2. Too early specialisation. Neither the F.R.C.S. nor the M.R.C.P. is an examination in a narrow field. When a candidate tells his examiner that he has only done orthopaedics (for example) he must not suppose that the examiner will excuse his lack of knowledge of the other branches of surgery.

3. Inadequate clinical experience. These examinations attach great importance to clinical work. The candidate must show his ability to take a history, make a systematic examination of a patient and then give a rational and practical assessment of how his patient should be managed. Students must not assume that the ability to quote the standard texts is either adequate or essential. In the orals the examiner is trying to find out how the candidate reasons rather than trying to find how many facts he remembers.

4. Lack of experience in the United Kingdom. The disease pattern in the United Kingdom differs from that in other parts of the world. The method of dealing with the problems, the methods of approach to the diagnosis and even the plan of management are not quite the same. You need some time to adjust your thinking so that it becomes in accord with the examiners in higher studies. You want to have your mind attuned to theirs — to get on the same wave length. I believe therefore that a period of work in a United Kingdom hospital is most valuable to men from other countries seeking higher diplomata. I have often found that when a man has failed in an earlier attempt and then takes a job for six months, he does much better in his next attempt even though he may not have had much time for further reading.

5. Mistakes in selection of candidates for overseas study. Such men must be chosen with the utmost care. It is my most unpleasant duty at times to tell some man who has been repeatedly failing that he should

give up and go home and choose some other branch of medicine. Such a man may have spent several years of his life and cost someone large sums of money. He is disappointed and in his own eyes disgraced. Of course he will always quote somebody who passed at the fifteenth attempt and point out that the Colleges have taken the view that they will not disallow reappearances. But he is a tragic figure. It behoves the parents and authorities in Malaya to try hard to prevent such men from ever being given a scholarship to go overseas. Scholarships must be reserved for those who have a reasonable chance of success in a postgraduate examination.

Lastly, as your representative on the Council of the British Medical Association, I have observed closely the workings and the problems of a medical association. Doctors and politics do not properly mix. Doctors want to be left alone to get on with the job of treating their patients. But in modern societies governments interfere in a multitude of ways with medical matters and the work and lives of doctors. Now government departments, however high their purposes and however well meaning and earnest their staffs, are not immune to human frailties and limitations. They can miscalculate, they can over-administer and try to tie everything into neat compartments. On the plea of seeking the welfare of the majority, they can bear heavily on our profession, and our profession is politically weak.

In Malaya you have an expanding and developing medical problem. If the doctors in this country are to exercise a proper influence in shaping these developments, if they are to be able to guard their own legitimate interests, if they are to lead in those projects which will determine the medical pattern here, then doctors must ensure that their own medical association is strong. It must speak with the nearest possible unanimity for the doctors of the country and speak with a full sense of responsibility.

I am charged with the pleasant task of bearing greetings from the British Medical Association to you. We shall watch your progress and the part you play in planning the new form of society in Malaya. We would wish you to be wise and strong.

I have returned to Malaya for only a few days. This is a wonderful experience. I have come back to a country I love and to friends I value. I have talked to you tonight on several matters with my experience and knowledge of this country as a background. In thought I shall never leave Malaya. I am tonight not your old pedagogue, teaching and preaching, but one of yourselves returning from afar, speaking of what he has seen.

I thank you one and all and offer you my sincerest good wishes that they may go with you in the days ahead.