VIDEO INTERVIEW TRANSCRIPT

Aronson, Jeffrey: transcript of a video interview (25-Apr-2016)

Interviewer: Tilli Tansey
Transcriber: Debra Gee
Editors: Tilli Tansey, Apostolos Zarros
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Aronson, Jeffrey: transcript of a video interview (25-Apr-2016)*

Biography: Dr Jeffrey Aronson DPhil FRCP HonFBPhS HonFFPM (b. 1947) trained in the University of Glasgow (1964-1973) and the Medical Research Council (MRC) Unit and University Department of Clinical Pharmacology, Oxford, under the late Professor David Grahame-Smith. He was Reader in Clinical Pharmacology at the University of Oxford, and Honorary Consultant Physician in the Oxford University Hospitals Trust until 2014, since when he has held honorary contracts as a Consultant Physician and Clinical Pharmacologist in Oxford. He was President of the British Pharmacological Society (2008-2009) and is now Emeritus President. He was Vice-Chairman of the Medicines Commission (2002-2005) and Editor-in-Chief of the British Journal of Clinical Pharmacology (2003-2007). He has been Chairman of the British Pharmacopoeia Commission’s Expert Advisory Group on Nomenclature since 2006. He was a Member of the Formulary Committees of the British National Formulary from 2006 and the British National Formulary for Children from 2003, and is now a Member of the Advisory Board of the British National Formulary.

[1]. CHILDHOOD AMBITIONS TO BE A DOCTOR, AND MEDICAL TRAINING

I don’t remember a time when I didn’t want to be a doctor, and I suspect that was because my mother put it into my mind. She was the twin of a man who was a very successful GP [General Practitioner] in Liverpool, very highly respected. He was married to another GP and together they ran a practice in which they were the senior partners with two junior partners, another man and a woman. So I suspect that’s where my desire to be a doctor came from. I don’t remember having doubted that that was what I would be, although I do recall on one occasion wondering if there were other professions I might pursue, and rejecting them out of hand. So becoming a doctor was never anything other than what I was going to be. It wasn’t, I think, a conscious decision I made myself. But deciding to be a Clinical Pharmacologist, of course, was something different. I graduated from Medical School in Glasgow, where I grew up, in 1970, having gone to the school in ’64. It was a six year course. And in those days you graduated, you did one year of what would nowadays be called ‘Foundation Medicine’, what in those days was called ‘pre-registration year’, or ‘house jobs’. And you would then either go into general practice or you would follow a hospital career, and your hospital career would take the form of either following general medicine, general surgery, or some laboratory specialty.

I decided that I wanted to do general hospital medicine in some form or another, but you didn’t at that stage decide on the specialty. You did your Senior House Officer jobs, SHO, you did your Registrar jobs, the next step up after getting your basic postgraduate qualification, which in my case was the Membership of the Royal College of Physicians. And then, you would become usually a Senior Registrar in some specialty. That would be the time you would choose your specialty, really quite late on. Nowadays the young doctors are expected to choose their specialty very early on, but I was unusual at that time because I decided to be a Clinical Pharmacologist almost as soon as I qualified in fact. And it happened because a neighbour of ours who was a Radiologist at the Western Infirmary, his name was Jake Davidson, a lovely man, saw me as I was coming home one day. We were neighbours, he lived across the road and he was doing his garden as I came home, and he came across to congratulate me on my recent results in the final exams. ‘What are you going to do?’ he said. Well, I didn’t know what course I was going to follow but he said to me, ‘What was

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your best subject?’ I said, ‘Well, that was [what we called] materia medica.’ Materia medica was an old Scottish name for what we now call ‘clinical pharmacology’.

[2]. BECOMING A CLINICAL PHARMACOLOGIST

Materia medica had been around since probably at least the middle of the 19th century; it was a very old topic discussing how medicines worked. But clinical pharmacology had recently been invented as such, starting in the late 1950s and early 1960s. So I said, ‘Well, materia medica was my best subject.’ He said, ‘Well, you ought to be a Clinical Pharmacologist.’ I said, ‘What’s that?’ He said, ‘Well, you need to go and read about it, it’s in all the journals at the moment.’ He said ‘There are editorials discussing this new subject.’ I said, ‘Oh, right.’ So I went away and did what he’d said and I looked of course in the British Medical Journal [BMJ] and I looked in The Lancet, the two major UK medical journals, and sure enough there were editorials saying that here was a new speciality, clinical pharmacology. And I discovered then that there were reports being written about this. In 1969 the Royal College of Physicians had set up a committee to look into it and had produced a report under the chairmanship of Cyril Clarke. Sir Cyril Clarke later became President of the Royal College of Physicians. The World Health Organization produced a report on the future of clinical pharmacology in 1970, and it looked as if this was an up-and-coming important specialty and it appealed to me because I’d been very interested in how medicines work, what they do, what their side effects were and so on.

And I decided there and then that I’d be a Clinical Pharmacologist. And it appealed not just because I was interested in medicines but because it seemed to me to be a specialty that covered the whole waterfront of medicine; everything, every specialty, every subspecialty, whatever it was, had something to do with medicines and their therapeutic effects. And it seemed to me that all my interests, and I’d been interested in pretty much everything I studied in the undergraduate course, that all my interests would come together in the study of clinical pharmacology, and that’s how it happened.

[3]. CARDIAC GLYCOSIDES, DAVID GRAHAME-SMITH, AND OXFORD

I’ve had many interests over the many years I’ve been working as a Clinical Pharmacologist and I think that being a Clinical Pharmacologist I’ve been very lucky to be able to indulge those interests; and clinical pharmacology does bring a whole range of interests together. So I’ve been very fortunate. Of course there’s clinical pharmacology itself which is a rewarding career on its own, without anything else. There’s the interest in how drugs are discovered, how they work, how they produce beneficial and harmful effects, how to use them properly; everything about medicines is, for me, absolutely fascinating. And so the aspects of that, that I feel have been most fruitful from my point of view are first, the early research that I did into cardiac glycosides - specifically digoxin - and devising dosage regimens, describing how best to use that particular drug. Digoxin isn’t used very much nowadays, but when I look at the recommendations for how to use it they are all based on methods that I developed early in my research career. So I think that was very, very fruitful and very rewarding: to have been able to influence therapeutic practice in that way.

Then later on, when I became interested in mechanisms, physiological mechanisms of cation transport, a lot of the work we did contributed to understanding how adaptive responses to medicines occur. This was an interest of my erstwhile boss, David Grahame-Smith, who was Professor of Clinical Pharmacology in Oxford for nearly 30 years. And one of his major interests was in how systems in the body respond to interference by medicines and how they, as it were, fight back, how they adapt to the insults that medicines introduce and how they regulate themselves in order to oppose those effects that medicines have. And the whole business of adaptive response is an interesting biology in itself and I was able to contribute to that, in relation again to the cardiac glycosides - to digoxin - and how the sodium/potassium-ATPase [Na⁺,K⁺-ATPase; ATPase: adenosine triphosphatase] is capable of regulating its activity. And that led to studies of the physiology of that system and how it adapts. So that was, I think, very fruitful and interesting and it shed light on certain diseases such as renal failure and hypertension, which have abnormalities of cation transport associated with them. Then, latterly, I have been interested in adverse drug reactions, or side effects of
drugs, as they are commonly called. This was something that I became interested in because I became the editor of a major textbook in the field, which is called ‘Meyler’s Side Effects of Drugs’.

[4]. ADVERSE DRUG REACTIONS

My interest in adverse drug reactions came about because, for some years, I have been editor of a major textbook in the field of adverse reactions called ‘Meyler’s Side Effects of Drugs’, first published in the early 1950s by a Dutch physician called Leopold Meyler, and which has been going ever since and is now, as I say, a major resource of information about adverse drug reactions. And because I was editing that textbook and had a huge amount of information coming through the text that I was editing, I found myself in a position to edit the information in different ways and to ask questions about the nature of these reactions that hadn’t been asked before. A major contribution that I and a colleague of mine, Robin Ferner in Birmingham, have made to the field is in the classification of adverse reactions. For many years a system known as A and B has been dominating the field, and in our view the system, the AB system, is founded on a misconception about pharmacological action. The misconception being that there may be effects of drugs that are not related to dose. It is a pharmacological principle that the more drug you have the bigger the effect [that] will occur. The idea that there may be effects that are not related to the amount of drug you have seems to us to be misconceived. We have therefore devised systems that deal with the question differently. And our classification system goes beyond dose relationships, it does go into other features such as time courses of reactions, individual susceptibilities, pharmacological mechanisms whereby reactions occur.

All of these add new information to the ways in which adverse reactions are classified and, through those classifications, give new insights into a range of problems in drug therapy. For example, how to prevent adverse reactions, how to avoid medication errors, and other matters. And all of that work is related to another interest of mine, which is in medical philology. So here we have an example of a second interest that I have been allowed to indulge, if you like, because it is relevant to my work in clinical pharmacology.

[5]. ‘WHEN I USE A WORD’: MEDICAL TERMINOLOGY

Words have been an interest of mine ever since I was a child. Again, I can’t remember a time when the use of words did not fascinate me, and it’s because that’s what we communicate with, that’s how we speak to each other. Why wouldn’t one be interested in words? I went to a school which had a very broad curriculum and my subjects at Scottish Higher Level, sort of equivalent to A-levels in modern times, were three science subjects, Maths, Physics, and Chemistry, and three humanities subjects, English, Latin, and Greek. And learning Latin and Greek is a very good grounding for understanding the English language. And my interest in words was fostered by studying those languages. And I continued my interest when I started studying medicine because so much of medical terminology is based in Latin and Greek. And for many years, I thought of writing about medical philology, medical words, but was largely put off because I thought that it was rather trivial by comparison with one’s scientific career.

For many years I thought it would be enjoyable to write about medical terminology, medical words, but there was a man called Bernard Freedman, who used to do that in the British Medical Journal, and I greatly admired his articles. When he stopped writing them I thought that I might take up the gauntlet but I was somewhat put off by the thought; I felt this was perhaps slightly trivial and that my scientific reputation might suffer as a result. However, when I realised that I didn’t have a scientific reputation worth preserving, I decided that it was worth writing about medical words.

So, after that, I started contributing articles on medical words, mostly to the British Medical Journal, who were very compliant. They published pretty much everything I wrote when I submitted it pretty much as it was written. I was very lucky they didn’t edit them very much, if at all, and they were willing to publish them all as fillers. In those days you could write 600 words. Since then they’ve contracted the requirements to 400 words because they are more short of space. But I’ve written probably about 100 of those fillers on various aspects of medical words.
I’ve written a dozen or so for the Quarterly Journal of Medicine and, from time to time I get invitations from other journals to discuss a specific word. I’ve a large postbag about those things. Nobody ever stops me in the corridor and says, ‘I did enjoy your article on Na⁺,K⁺-ATPase in Alzheimer’s disease in the Journal of Irreproducible Results.’ But they do stop me and say, ‘Great article in the BMJ on the word on’ or whatever. So they are very popular and I get a large postbag from doctors who like the articles, and ask me questions which gives me more material to write about. In the last year or so I’ve not stopped publishing them in the BMJ, I still do them from time to time but I now have a weekly blog, which the BMJ hosts very kindly, and I now write a weekly article on some aspects of words. And recently I’ve spent several of those articles, devoted several of those articles, to talking about words connected with the junior hospital doctors dispute with the Secretary of State for Health. Words such as ‘impose’ and ‘strike’. And that has been very interesting to develop.

[6]. ‘WHEN I USE A WORD’: ‘XANTHOS’ AND SUBARACHNOID HAEMORRHAGE

The first article I wrote was stimulated by a teaching session with some medical students. We had just seen a young man who had had a fight with his landlord and some time later had suffered a subarachnoid haemorrhage, a bleed from one of the blood vessels in the brain, trickling blood into the cerebrospinal fluid. And we’d done a spinal tap, a lumbar puncture, and the fluid we got out was not, as people generally describe it, gin-clear, crystal clear fluid, but yellow in colour.

Now yellowing of the cerebrospinal fluid, rather than the gin clear appearance, is evidence that the bleed, the subarachnoid haemorrhage took place some time before, because it takes time for the erythrocytes in the blood to break up, for the haemoglobin to break down and colour the fluid yellow. So the lesson from this was that probably subarachnoid haemorrhage was not related to the fracas that he’d had with his landlord, which was a separate event, because it had happened some time later. Now the technical term for this yellowing is a Greek word xanthochromia [ξανθοχρωμία], which literally means ‘yellow colour’ and so I asked the students if they knew the meaning of the word xanthochromia, and we discussed the Greek word xanthos [ξανθός], which is a sort of bay colour rather than yellow. And we discussed other medical words with xanthos in them, such as xanthelasmas [ξανθέλασμα] and xanthelasma are little growths usually around the eyelids which look a little yellow. They are deposits of lipid under the skin. Xanthomata [ξανθόματα] are similar yellow deposits but usually overlying the tendons of the backs of the hands, or the elbows, or the knees or the ankles. And we discussed xanthines [ξανθίνες], which are compounds which turn yellow when they are reacted with nitric acid. Caffeine is a xanthine [ξανθίνη] so we discussed the pharmacology of coffee, and we discussed the pharmacology of theophylline, which is used to treat asthma and is a xanthine.

And the tutorial was going very well, we were covering a range of topics all arising out of this single Greek word. And I asked the students, ‘Now, can you think of any other medical terms involving xanthos?’ One young girl said, ‘Yes,’ she said, ‘Chrysanthemum.’ Of course chrysanthemum is from chrysos [χρυσός] which means gold and anthos [άνθος], a flower, nothing to do with xanthos. So I stopped the tutorial at that point and went back to talking about subarachnoid haemorrhage. But it struck me that this was an amusing episode that others might like to hear about, and so I wrote it up as a filler for the BMJ. It was my first piece on words. Interestingly, somebody wrote after the publication of that piece, it was called ‘Curious, yellow’, after a movie that was current at that time, and said, ‘You see, these Oxford students, they get it wrong, they don’t have a classical education.’ And I was able to reply, ‘Well, actually she did her preclinical at Cambridge.’

[7]. CARDIAC GLYCOSIDES AND MEDICAL HISTORY

I was never very good at history at school - we didn’t have very good history teachers. I recall one who used to sit there reading from the textbook, and it was deadly dull. But the one area of history that did fascinate me was the history of science, and indeed I recall an examination where I managed to scrape 50%, 20 marks of which came from the essay on the history of science, 20 out of 20, and scraping marks in the other four subjects to make up the 50%. So history of science, history of medicine, always fascinated me, but it was part of my interest in medicine as a whole. And I think it’s actually important for doctors to be interested in the history of their subject, because it teaches you many things that you don’t learn from other aspects of
medicine, either from the textbooks or even in clinical practice. So when I came to write my Thesis on the clinical pharmacology of the cardiac glycosides, specifically digoxin, I thought that I ought to write a chapter on the history of the subject. Now if you’re writing a Thesis on genomics, there isn’t a lot of history to cover even if you go back as far as Gregor Mendel, let’s say. But the modern history of genomics is rather short, relatively short. The history of cardiac glycosides goes back hundreds of years, and so I found myself researching the history in some depth. The major feature of that history is a monograph that was published in 1785 by a Birmingham physician called William Withering, who is famous as the first physician to have used foxgloves, which is where the cardiac glycosides come from, or some cardiac glycosides come from, in the treatment of what he called ‘dropsies’, namely ‘abnormal collections of fluid in the body’.

And his text is actually very perceptive. He studied about 160 cases of dropsies and showed the types of dropsies in which the foxglove was beneficial and the types of dropsies in which it wasn’t. And he was able to show, for example, that heart disease causing dropsy responded to foxglove whereas ovarian disease, for example, and other forms of collections of fluid in the body, did not. So I decided I would have to study the history of the subject in some depth and of course it goes back before Withering, but his was the main topic, and so late 18th century pharmacology and therapeutics became a topic of interest to me. And, in fact, I made some original discoveries in the field. I can’t say I really appreciated that at the time, to be honest.

I was very fortunate to meet Charles Webster, who at that time was the Wellcome Reader for the History of Medicine at the University of Oxford and is now Fellow of All Souls College and well known for his history of the National Health Service. I met Charles because I was a graduate student at Corpus Christie College where he was the Librarian Fellow. And so I sought his advice about researching and writing this history of cardiac glycosides that I was interested in doing. And he asked me to send him the material I’d produced so far and when he read it he said he thought it was very good and that I ought to write it up as a piece of research. Well, I was very reluctant to do that because I didn’t think that I was qualified as a medical historian and that it would be arrogant of me to - presumptuous of me to try to enter into a field that was not my own, and in which I consider myself to be pretty much amateur. So I didn’t do that but I wrote it up as a chapter in my Thesis.

[8]. FOXGLOVES IN MEDICINE

1985 was the 200th anniversary of Withering's publication in 1785 and I thought it would be a good idea to publish a celebratory volume. And so I approached Oxford University Press and suggested a history of the use of foxgloves in medicine over the years because by that time I’d amassed a lot more information about the subject including the history of the 19th century and of course the 20th century, some of which I’d been involved in myself. They agreed. And I suggested, almost as an afterthought really, that we should accompany my own history of the subject with an annotated edition of Withering’s original monograph, because nobody had done that before. So we got a copy of the monograph on loan, I think it was from the Royal College of Physicians, and produced a facsimile, which I annotated in the margins, explaining all the 18th century terms that might not be familiar to modern physicians, explaining who the people were to whom Withering refers in his text, botanists, herbalists, other physicians, explaining the nature of the experiments he did and the observations he made, the possible diagnoses and the cases he describes. And I then appended to that my own history of the use of the foxglove throughout the centuries since then, and it was called after his book [which] was called ‘An Account of the Foxglove and Some of its Medical Uses’, so I called mine ‘An Account of the Foxglove and its Medical Uses 1785-1985’. That was published to mark the bicentenary and a short, a small print run of about 800 volumes, I think, which now sells on Amazon and other places for some sorts of ridiculous sums, I don’t know how much. It was also, to my surprise, translated into Spanish, and that happened because a German drug company, one of the Boehringer, either Ingelheim or Mannheim, I can’t remember which, decided they wanted to send copies of this around South America in Spanish as a kind of advertisement for their products.

At first I demurred, I didn’t want my book associated with a drug company as an advertisement, but the publishers persuaded me that they had agreed with the company not to put their logo on the book, on the
translation, and so I agreed to have that done and I believe they published 3,000 copies in Spanish translation. I can't speak to the nature of the translation, but it exists and it presumably was spread around various South American countries at that time. That text that I wrote led me into other areas in medical history and I have written occasionally articles about other aspects of the history of pharmaceutical compounds, of therapeutic compounds, and I was then subsequently invited to become a Member of the Wellcome Trust's History of Medicine Units and Grants Panel. A very good friend and colleague of mine, Irving Loudon, who had been a general practitioner in Wantage in Oxfordshire and had given up general practice to become in the end a very eminent medical historian researching obstetric history, had served as the medical Member of the Grants and Units Panel and he suggested that I might be invited as the token doctor on to that panel, and so I joined it and spent 7 years on that panel learning a lot about medical history from professional historians, and a very interesting and educative time it was.

[9]. DOCTORS AND MEDICAL HISTORY

So should doctors be interested and take part in medical history? Yes, I think absolutely they should. Traditiona|ly, the role of doctors in medical history has been seen as the retired physician who, Dr Whatever, who in his or her retirement writes the biography of a famous man or woman. And very often these are rather amateurish products that are of minimal interest other than of bringing perhaps some people who won't have read about them before to the subject.

I think that these amateur historians are rather looked down upon by the professionals, partly because very often what they produce is not of very high quality from the point of view of the professional historian and partly because over recent years medical historians have become more interested in social history rather than the history of ‘the great man’ or ‘the great woman’ in medical history. I think that's a pity, because I think there is value still to the history of some prominent individual still worth writing, and there are plenty of prominent individuals who have not had biographies told, so there is still room for that kind of research, provided that it’s done properly, and I think that people who retire from medicine and want to indulge their interest in history could well be advised to speak to professional historians about how they ought to go about it. So I think there’s value in that.

I think there’s also value in medical history for younger doctors and medical students, and I would introduce them at a very early stage to some medical history in their course, because medical history teaches you a lot of things you won’t learn otherwise. There’s a lot to learn, for example, in the field of ethics. There’s a lot to learn about dealing with uncertainty, how to deal with textual evidence, a lot to learn, I think, from history of medicine that the practice of medicine today could well benefit from. And I think we should be encouraging medical students to take special study modules, for example, or to do a small project in the history of medicine. And to try to encourage doctors as they go through their careers to take interest in the type of history that’s relevant to their own subject. I think you do learn a lot that you wouldn’t learn otherwise, so I think we should be encouraging the introduction of the history of medicine at all stages in medical careers. It doesn’t have to be a lot, it doesn’t have to be dominant, but just an awareness of the historical relevance to whatever subject you’re studying can, I think, be very useful.

[10]. CAREER REFLECTIONS AND THE ROLE OF LUCK

Did anything go wrong in my career? I wouldn’t say anything went wrong, as I can’t complain, but things sometimes went differently than I expected them to. And that illustrates that you cannot really control your own destiny very much.

Luck plays a huge part in one’s career, being in the right place at the right time, not something you can organise, arrange in advance. Or maybe it’s somebody else’s action over which you have no control whatsoever that influences your own pathway. And I can give you an example of that. When I had decided to become a Clinical Pharmacologist, I went to see Abe Goldberg, who was the Professor of Materia Medica, as it was called, in Glasgow. I had known Abe when I was a final year student in his firm, in the Western Infirmary in Glasgow, when he had a titular professorship, but a year or so later he became Professor of
Materia Medica. So I went to see him because I wanted to pursue a career in clinical pharmacology. And we discussed it. At the same time I went to see the Dean of the Medical School at the Middlesex Hospital in London, and I knew him because I had been awarded a Nuffield Foundation bursary to study in my final year for one term at the Middlesex, and had thoroughly enjoyed doing my surgical attachment at that time in 1969, the last third of 1969. So I went to see him to discuss the possibility that I might become a Clinical Pharmacologist. He suggested that I might be interested in doing a PhD with the Professor of Pharmacology in the Middlesex Hospital, a man called Franz Hobbiger, who was interested in the pharmacology of the parasympathetic nervous system, cholinergic transmission.

So I met Hobbiger and he said ‘Yes,’ he’d be very interested to have me come and do a PhD. The one downside as far as I was concerned was that it was paid non-clinically, the salary was not as good as I would have if I was doing a clinical job, but that didn’t bother me. I thought that one ought to be trained in a scientific discipline such as pharmacology if you were going to be a Clinical Pharmacologist. And so I was willing to come and work in the Middlesex Hospital. I went back to Glasgow and discussed it with Abe and he said, ‘Yes, very good. Good idea. Hobbiger’s a good man, you’ll be well trained there. Do it.’ So I was ready to write my letter, when the post office workers went on strike under the leadership of Tom Jackson, who was head of the Union at that time. Now there were no faxes, there was no e-mail - there was the telephone, but I had to write a letter. So I decided just to wait until the postal strike was lifted. Meanwhile, while I was waiting, Abe Goldberg phoned me and said, ‘I’ve been thinking about your discussion with me about going to London’ and he said, ‘I think it’s not such a good idea after all.’ I said, ‘Oh.’ He said, ‘Yes, I think you would be well advised to complete your postgraduate medical training first and then you can go on and do your scientific training.’ Well, I was very disappointed by this advice, because I was really keyed-up by this stage to go to London, which I found very exciting.

But I reflected and realised this was really very good advice, that if I took time out to do my scientific training it would be very difficult for me to come back into medicine, whereas I could always postpone the scientific training until I had my clinical qualifications sorted out. So, much though I was keen to go and work in London, I decided to accept Abe’s advice, and I am sure without doubt that that was about the best advice I ever received in the furtherance of my career, and I did what he suggested. I stayed in Glasgow to undertake my postgraduate training, and then went on and specialised in Clinical Pharmacology. But if it hadn’t been for Tom Jackson and the post office workers, I could well have gone down to London at that stage and my career would have taken a totally different path.

[11]. REFLECTIONS ON CHANGES IN MEDICINE

So what major changes have there been? Well, there have been major changes in every aspect of the things in which I’ve been interested. Medicine has changed enormously over the years. It used to be great fun. I’m not saying that medicine isn’t a serious matter, taking care of individual patients is a very serious business. But it should be fun as well for those that are doing it, because unless it’s good fun, unless they’re enjoying what they’re doing, they won’t do it as well as they would if they’re enjoying it. And I think a lot of the enjoyment has gone out of medicine with increasing bureaucracy in the way it’s run. And several things have contributed to that: the increasing demands of appraisal, annual appraisal, 5 yearly revalidation, the stresses and strains that all those processes put on individuals, I think, have reduced the amount of enjoyment that you get from the subject, making it much more difficult to practice. The Working Time Directive that was instituted by the European Union, which is good for junior doctors because they have to work less hard, has meant that care has become fragmented, because no longer are the same doctors available for long durations of time to look after the same patients. So the junior doctors are no longer experiencing continuity of care of the same patients that they used to. This means that they come and go, they see a patient for a short period of time, hand the patient on to somebody else who then hands the patient on to somebody else and so on. And the care tends to be fragmented.

I think this is bad for the doctors and perhaps bad for the patients as well, because the care that they take is more likely to be discontinuous and therefore the history of the patient, the history of the patient’s complaint, the way it has proceeded, and all the important facets of what went before, will be lost because
the same individual is not looking after the patient all the time. So I think there are changes there that I regret that I think have taken the enjoyment out of medicine, and have taken the continuity out of medicine making it much more difficult to practice high quality medicine than we used to.

Of course there have been positive changes as well. The number of beneficial medicines that we have now is really quite staggering. The advent for example of monoclonal antibodies has brought a whole range of very highly specific treatments into medical therapy and allowed us to tackle problems that we couldn’t tackle before. A lot of treatments for cancer, for example, are now available that have improved prognosis enormously. There are cancers now we can cure that we couldn’t cure when I was a medical student. There have been a lot of wonderful therapeutic advances. Of course, that in its turn has brought problems as well, because these new medicines are exceptionally expensive and the budget available for treatment is limited. And so the modern business of deciding whether a drug is cost effective, in other words whether it is good value for money, has become a major problem. And a lot of people find it difficult to understand why a new medicine that might transform their lives, might improve their outcomes, cannot be made available because it’s just too expensive. And that’s difficult for people to understand and I appreciate that. But there are real problems about budgets, about how much we can afford, and about how the activities of drug companies, which are very expensive, in drug development - drug discovery and drug development - can be kept in check so that they can make a reasonable profit from their activities, enough to fund future activities and the discovery of new medicines while at the same time allowing us to live within our budget. And that is a difficult problem that is really a very modern one, with all the new medicines we have that are so very expensive.

And I don’t think we’ve yet found a perfect way of dealing with that, but we are slowly coming to terms with the problem through persuading drug companies to give discounts on certain medicines in order to allow the Health Service to afford how to use them. So, I think, that’s been a major change in medical practice that affects us all.

[12]. FUTURE OF CLINICAL PHARMACOLOGY AND GENERAL MEDICINE?

What about the future? Well, as far as clinical pharmacology is concerned, my own specialty, I’d like to see more recognition of its importance, because I think in the last 15-20 years, that has been underestimated. The discipline grew up in the late 1950s through the 1960s and 1970s, became very strong throughout the 1980s, but then in the 1990s and I think partly due to the malign influence of research assessment exercises, what we now would call the ‘Research Excellence Framework’, whatever that means, clinical pharmacology was regarded as being not as important as other specialties, which were thought - I think wrongly - thought to contribute more to those research assessment exercises. And so the numbers of Clinical Pharmacologists during the 1990s and in the early 2000s started to decline. This, I think, had a bad effect on teaching of therapeutics, and that secondly will have knocked-on to reduced quality of care of patients, because every doctor is a prescriber and every patient receives some medicine or other at some time. And unless you understand the principles of therapeutics and clinical pharmacology, how drugs work, how to use them, how to avoid adverse reactions, then you are not going to practice medicine to your best ability in my view.

In the last 10 years or so we have made efforts at the British Pharmacological Society to reverse this trend through many activities, such as talking to the regulatory authorities, the General Medicine Council, government organisations of one kind or another, through talking to the press to publicise the need for clinical pharmacology, through studies of the relevance of clinical pharmacology and of its financial benefits to the health system. We have tried to increase the profile of the subject and have succeeded to some extent. The numbers of Clinical Pharmacologists now in the country have ceased to fall and are now again on the rise, in parallel with the rising number of other physicians and doctors in other specialties. So that’s good news for the subject, but there’s still a long way to go and I hope that those who are involved in having influence in the development of subjects such as clinical pharmacology will begin now, perhaps continue, to realise how important it is for general medical practice, because everybody uses medicines and everybody takes them. So I think for the future of the subject, I think that’s how I would like to see it develop.
As to the future of general medicine I would like to see an end to all the bureaucratic control that we have at the moment. I think that regular appraisal, regular revalidation, is politically correct, it looks good to the public that doctors are being scrutinised all the time, and I don't have any objection to proper scrutiny, but I think that the systems we have are too bureaucratic and in many respects unnecessary. So I'd like to see an easing off of that regulation.

I'd also like to see increased continuity of care, particularly by junior doctors. And I think the junior doctors do a terrific job. They work hard, the job they do is not easy, and in contrast to when I was a junior doctor, when you could be on duty for quite long periods of time but not doing very much for part of that time, nowadays the doctors are on duty for short periods of time but they are busy all the time and the job is really very stressful. There is poor continuity of care because they don’t have the time to continue following patients through, and I’d like to see that changed. I think the only way I can see that happening is for more doctors to be appointed, and I think, politically, that’s unlikely to happen because the budgets are constrained and this government certainly, and I suspect most governments would be, reluctant to fund greater numbers of doctors. The Treasury is unlikely to want to give funding for that kind of activity, but I can't see any other way of improving the ways in which junior doctors are carrying out their difficult tasks, other than by sharing out the pressure, the burden of care, that they currently have to see to. So I hope that some enlightened Health Minister, of whom we have seen very few in recent years, may see the importance of that and perhaps persuade Government and the Treasury to fund medicine in a different way, and fund doctoring in a different way. I can’t say I’m very hopeful of that.

[END OF TRANSCRIPT]

Further related resources: