

The medical staff round

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For many aspiring physicians in West London attendance at the medical staff round at the Royal Postgraduate Medical School on a Wednesday morning is worth a tedious journey. The Stamp lecture theatre provides the stage for that unique combination of clinical medicine, scientific observation, open debate, and sheer theatre which one either loves or loathes. Today most hospitals in the UK have a weekly medical meeting. In clinical schools these may be designated grand rounds but it is probably true to say that despite the name most pale before the drama of a Wednesday morning at Hammersmith which Chris Booth did so much to nurture and develop. So what makes Hammersmith rounds so different?

Before trying to answer that question it is worth looking back briefly at the development of postgraduate medical education. In the UK present educational structures are largely a product of the last 30 years. In the 18th and 19th centuries aspiring physicians went to Edinburgh or to great European centres such as Padua, Leiden, Paris, or Vienna. Americans did the same. Indeed from 1870 to 1914 virtually the entire medical faculties of Harvard, Yale, Johns Hopkins, and Michigan had studied in Germany.¹ The European centres had developed large hospitals and clinics which allowed science based on detailed clinical observation to flourish. Here were the roots of the grand round. American physicians brought back new ideas. They realised that caring for the poor sick provided the opportunity to learn.² American hospitals developed rapidly, especially in response to the advent of 'safe' surgery, and at the turn of the century European style polyclinics began to be established. On the other hand the inadequacies of the medical schools led the AMA Council for Medical Education to persuade the Carnegie Foundation for the Advancement of Teaching to undertake a study. In order that this should be independent the task was given to Abraham Flexner, a secondary school educator with no special knowledge of medicine nor of medical education. He prepared himself by first meeting the Faculty of The Johns Hopkins Medical School and then carrying out extensive fieldwork before submitting his report.³

Flexner also looked at Britain and offered his views in refreshing language. 'The German clinician and the English physiologist desire primarily scientific

repute. Success is conditioned by scientific achievement. The English physician reverses the relationship. Intellectual ability is honoured. The English consultants are cultured, charming, and able men, excellent physicians, occasionally distinguished contributors to scientific knowledge, but the system does not seek out, does not reward effort or achievement in a scientific direction . . . (clinical science) is not the breath of their nostrils. . . . The great lights of British medicine are prominent personages; their patients distinguished, their incomes large, their expenditure lavish. . . .'

In Britain the first sign of official interest in medical education came with the Report of the Royal Commission on the University of London (1913). France and Germany were more than 50 years ahead with books on medical education by such prominent clinical scientists as Claude Bernard⁴ and Christian Billroth.⁵ Almost certainly the European centres had the forerunners of our postgraduate teaching rounds. Be that as it may the Royal Commission recommended the establishment of academic clinical units. The first full time medical units were set up at St Bartholomew's, University College Hospital and St Thomas's. Indeed the unit at UCH so impressed representatives of the Rockefeller Foundation that they made a gift of nearly a million pounds for buildings and endowments. Yet by 1930 there were only five full time chairs of medicine throughout the country and no medical school was able to rise to the challenge of offering medical education for postgraduate students. So the Postgraduate Medical School came to be founded on the site of a Poor Law Hospital in the London borough of Hammersmith and modern postgraduate education was to be developed in caring for the indigenous poor of West London. Shades of our European heritage!

Francis Fraser, then Professor of Medicine at Bart's, took up the challenge. He was able to appoint a Reader and four assistants: Geoffrey Jennings, Charles Stuart-Harris, Guy Scadding and Paul Wood. Gastroenterology was not represented. All these specialists were full time salaried employees barred from the rewards of private practice. One can imagine the contempt of their contemporaries in the London Medical schools. One can also imagine the fierce determination which led to the establishment of the staff round. These were clinicians with a

burning desire to know. Everything was small scale except for the clinical workload. So the earliest clinical science was based on bedside observation and the staff round (six tenured staff and six house officers) took place around the bedside. From the beginning, Wednesday morning was sacrosanct. No outpatient clinics and all routine ward work completed by 10.15 am. The staff round lasted until 11.30 and was followed by a clinicopathological conference, a pattern which has persisted for more than half a century.

During the war, which could so easily have killed the new venture, one can imagine the excitement of Graham Bull describing the effective management of acute renal failure in victims of the blitz with 'crush' syndrome or Sheila Sherlock discussing the histology of the first liver biopsies to be taken from patients with hepatitis. After the war the Postgraduate Medical School received a flood of British and Commonwealth doctors eager to develop their skills. The staff round moved to the Lower Lecture Theatre where cardiorespiratory physiology and clinical hepatology dominated the presentations. By 1965 it was clear that new developments were needed if Hammersmith was to continue to lead. The following year Christopher Booth took over and broadened the spectrum of clinical endeavour by stimulating growth in biochemistry, immunology and infectious disease. His enthusiasm, his breadth of general knowledge and his capacity for leadership gave fresh impetus to the staff round. It remains without equal because, as from the beginning, every consultant physician attends; because the centrepiece is the patient who is presented in person; and because the junior staff present data which show their ability to observe and to investigate as if the patient's illness was designed to help further our knowledge of disease. Thus a good Hammersmith presentation is not a rare case briefly described and then annotated in detail by the presenter and fulsomely discussed by an acknowledged expert; it is the presentation of new observations for discussion. The end result is a debate which is testing for junior staff, usually exciting and often heated, but never intentionally unkind. Each year cases are presented which may eventually alter the textbooks as did the patient with intractable constipation as a result of the secretions of a unique tumour;⁷ or the patient with the blind loop syndrome who became comatose after treatment with broad spectrum antibiotics;⁸ and more recently the study of fructose intolerance extending from the skill of the clinician

making the diagnosis in a gastroenterology clinic to the solution of the gene abnormality.⁹

In this Festschrift we present three cases from Cambridge which might have made the Hammersmith round. In a way this is appropriate as Chris Booth was a registrar at Addenbrooke's where he must have made some of his first attempts at case presentation. Moreover, with his love of history especially that related to medicine, perhaps he recalls the statement by Flexner who on looking around the English scene 80 years ago commented 'Could the medical school in Cambridge be completed on a daring basis, English medicine might react as American medicine did to the stimulus of Johns Hopkins'. Cambridge was to lie dormant for three quarters of a century and Hammersmith took up the challenge. Chris Booth has played his part in maintaining the freedom for healthy research and development in clinical science which in Britain was first most clearly expressed at the Postgraduate Medical School. We must not allow those who seek to reform the National Health Service to ignore the importance of that freedom.

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