

# Extending the Art of Medicine

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First, I must thank Professors Barton and Lee for inviting me to give this inaugural Eric Cruickshank lecture, and I am pleased to see so many of his former students here. It gives me an opportunity to say how much he meant to me personally, the Department of Medicine, the Faculty of Medical Sciences and the University as a whole. I have often quoted something he said to me about fifty years ago. "He serves his master ill, who remains a pupil still". I hope that my account of who he is, what he stands for and what he has transmitted and continues to transmit across generations will be some small repayment to a master as I try to stitch some of the threads of the past that were dyed by him into the tapestry of the future. There will be other lecturers in the future who will use this occasion to expound on some critical, current health issue, but I hope you will forgive me if I focus this first lecture on the legacy of Professor Eric Cruickshank himself.

In speaking of my dead friends, I often use the present tense deliberately, because I believe that the contribution of major figures is very much a living thing to those who know them and the fact that Professor Eric Cruickshank is not physically here does not really diminish my appreciation that his legacy is something of the present.

I also congratulate the Department of Medicine, Mona, for establishing this lecture. It is proper that we remember our academic and other forefathers and revere them as heroes when appropriate. I often quote Sir Arthur Lewis in that the maturity and development of a society can be measured by the extent to which it lauds its heroes. I believe that the creation of identity which is so important for our societies is favoured by the recounting of the exploits and achievements of our heroes. It is part of the traditions of our people, whether it is in the oral history of our ancestral griots or in the funeral wakes that were so much a feature of my early youth, in which the exploits of the departed were glorified and often magnified, when men spoke in tongues loosened by fiery spirits that were of earthly and not heavenly origin.

I have chosen as a title a topic that is an obvious reference to the opening lines of the aphorisms of Hippocrates (1, 2) "*Life is short; the art is long, opportunity fleeting, experience delusive, judgment difficult*". I will try to discuss how the art of medicine as practiced by Professor Eric Cruickshank has lengthened beyond the traditional boundaries to areas to which he often referred, but perhaps did not fully grasp.

But let me tell you how I came to know him. My first meeting was when he and Sir Philip Sherlock came to Barbados in 1951 to carry out interviews for entry into the University College as it was then. The interviews were held in the beautiful gardens of the Barbados museum, and as I prepared mentally for mine, I walked through the gardens and noted the Latin names of some of the trees. During the interview, Professor Cruickshank, displaying his naturalist interests that later I would get to appreciate even more, looked through the window and asked me what I knew of the tree we could see. Primed as I was with my recently acquired knowledge, I expounded on its shape and its flowers that were derived from its Latin name. He was suitably impressed. However, the following day, my botany teacher who met him at a party in the evening of the interview, came to tell me that Professor Cruickshank was so impressed by my knowledge that during the break he had gone out to look at the tree himself and found that the name I had given did not belong to the tree we were discussing but to another tree in the garden. He remarked to my master that he liked my positive approach even though I was wrong. This of course has always been the basis for my advice to students. Once the examiner asks you a question, you should be positive in your presentation.

The second time I met or rather saw him was in my first term at Mona. We were told that traditionally at least one student every year had a manic episode and had to be institutionalized. So when one of my classmates duly became manic, the young Professor Cruickshank was summoned.

I will never forget the rather large student rushing menacingly at the smaller professor and the professor calmly putting a half-nelson on him, throwing him to the ground and injecting the paraldehyde. This time I was impressed!

But it was not his wrestling credentials which brought Professor Eric Cruickshank to Mona. Because so many of you do not know him, let me tell you a bit about him. I am grateful to his son Kennedy for many of these details. He was a brilliant graduate of Aberdeen University and after qualifying with honours, he spent a year in Boston at the Massachusetts General Hospital as a Fellow in surgery! On return to Scotland, he was called up to the army and was sent to the Far East where he spent five years as a Japanese prisoner of war in the infamous Changi camp in Singapore. He had the responsibility of taking care of some 6000 prisoners in whom he observed the most devastating effects of various vitamin deficiencies and some of man's grossest inhumanities to man.

After a few years back home to recover and to write up his experience with nutritional deficiencies for his MD thesis

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and ascending the academic ladder rapidly, he was appointed Professor of Medicine in the new University College of the West Indies in 1950.

His description of the trip to Jamaica bears repeating. *"I was the Senior lecturer in Medicine at Aberdeen University when I was appointed for the new University College of the West Indies. I arrived in Jamaica in October of 1950. I flew on a BOAC Constellation via Lisbon, the Azores, Bermuda and The Bahamas to Kingston – nearly 40 hours. This was considered a safer aircraft than the two Tudors, Star Tiger and Star Ariel which had disappeared in the Bermuda Triangle. One of these planes was carrying the Royal Charter of the UCWI. I was met by the Principal, Dr Thomas Taylor and Arthur Hendricks who owned a Rolls Royce and drove this to the steps of the aircraft – it seemed a good beginning!"*

In his own account of those early years, he described the challenges of opening clinical teaching at the Kingston Public Hospital where "Drs Whitelocke and Chambers were very helpful". He was the first Dean of the Medical Faculty. He helped to oversee the building of the Hospital, the nurses' home and the move of the Department of Medicine from its original home in the outpatient Department to its present site. His most notable academic research achievement was the description of an unusual neurological syndrome which he designated, *Jamaican Neuropathy* (3–5). This syndrome has subsequently been renamed tropical spastic paraparesis and is known now to be caused by the Human T-cell Lymphotropic Virus Type-1 (HTLV-1) retrovirus.

Let me interject some personal data here which show his influence on me. I knew him as a student, and I have no doubt that it was his logical approach to clinical especially neurological diagnosis that was a major factor in my deciding to practice internal medicine. I was his intern and it was he who advised and supported my application for a Glaxo Scholarship to go to London for my postgraduate examinations.

I still have the telegram of congratulation which he sent me when I passed my examination for membership of the Royal College of Physicians. I was his registrar and on completion of my year with him, he arranged for me to meet with John Waterlow one Sunday morning, when over several glasses of rum I accepted the offer to work in the Tropical Metabolism Research Unit. I succeeded him as Professor of Medicine and he cared so much that he wrote me a personal letter enquiring whether I had any regrets about having accepted the chair, and offering his support. I do not have to say "alas" when I say "I knew him well". I am sure that there are many of his students who can attest to his many personal kindnesses.

He was to me and many of my generation, a superb practitioner of the art of medicine. Tomes have been written about that art, jazz musicians have even found a similarity with their music (6) although there have been skeptics about

its value. Voltaire is quoted as saying "*The art of medicine consists of amusing the patient while nature cures the diseases*" (7). It is also well to distinguish between various connotations of art.

There is art described as "*a product of human activity, made with the intention of stimulating the human senses as well as the human mind; by transmitting emotions and/or ideas*", or "*a visual object or experience consciously created through an expression of skill or imagination*" (8). Then, there is art in the sense used by Hippocrates to mean the mastery of a craft or set of skills. But I believe that the art of medicine extends beyond just the mastery of skills, and includes passion, compassion and ethics or morality in their fullest dimensions. Professor Cruickshank's life was not short as *per* Hippocrates, but I will show that his art is indeed long.

His mastery of the skills of his craft was impressive to all of us who were taught by him and he displayed them without the props and theatrics which I saw in other places. He did not need a gold headed pin to test for cutaneous sensation or the key of a Bentley to demonstrate the Babinski reflex. The skills were not only those of the physical examination, but they included the skill of extracting from the patient the details about his or her social environment and insisting that we students do likewise. Woe betide the student who presented a patient's data without having delved into the family history and elucidated the social background which clearly impacted on illness as well as disease.

I recall vividly his interaction with patients, nurses and students. He had no time for sloppiness of thought or dress, and I have heard him say and have repeated: "*a tidy appearance denotes a tidy and ordered mind*".

He did not go quite as far as Hippocrates who wrote in the work "On the Physician":

*"For the physician it is undoubtedly an important recommendation to be of good appearance and well fed, since people take the view that those who do not know how to look after their own bodies are in no position to look after those of others"* (2).

His mastery of his craft showed in his attention to the individuality of the patient. He would have been chagrined at the blind application of protocols and guidelines without taking account of the particularities of the individual patient. I am sure that for him evidence would not have been restricted to the results of the latest meta-analysis or findings from the Cochrane Collaboration. He would have tempered them with the results of his own analysis of the particularities of the individual patient and his or her environment.

The use of the five senses and reason are the basis of good medicine in the Hippocratic tradition. Of course, the limitations of this approach were eventually exposed because the Greeks did not permit autopsies and hence it was not possible to verify the diagnosis in those who died. With the passage of time and the advent of technology, it became possible to supplement, but not replace the use of the senses

to arrive at a diagnosis and we came to recognize that much of the art of medicine lay in the application of the science of medicine.

But even the Cartesian reductionism and the separation of mind from body did not erode significantly the fundamentals of the art of medicine. However, we have been observing recently a change as great as or greater than that which modified the Hippocratic approach. The advent of technology is slowly replacing human interaction. I saw recently a sign in a clinical laboratory which said that 65–75% of the diagnosis is based on the results of laboratory tests.

Physicians on television listen to the chest through the patient's clothes! Caricatures of our profession have patients taking a drop of blood onto a filter paper, sending it through the mail to a laboratory, attaching themselves to their cell-phones or some such device which are connected to a call centre on the other side of the world and receiving their soma or other medication in the mail.

Much of this would be anathema to Professor Eric Cruickshank and the great physicians of my day such as Kenneth Stuart and Harold Forde who gave us the pleasure of watching them build a diagnosis based on careful observation of the patient, painstakingly elucidating the story of his illness and his environment and a careful physical examination, then to be supplemented by the laboratory data. I am no Luddite, but I will rue the day when the skills, knowledge and wisdom of the good physician are replaced by a machine.

He was passionate about his craft and in that passion I think lay always the seeds of his success. I use the expression in the sense that Hegel used it. "*Passion is that which sets men in activity, that which affects practical realization*" and as Hegel would say in his lectures on the Philosophy of History, "*Nothing great in the world has been achieved without passion*" (9).

A great physician's compassion is really the active wish to alleviate the suffering of his patients, curing and healing when possible, caring and comforting always. The great physician is not ashamed to wear the pyjamas of his patient's illness.

The morality of the art of medicine is perhaps best codified in the Hippocratic Oath (2).

*"I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of patients, and abstain from whatever is deleterious and mischievous.*

*Into whatever houses I enter, I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further, from the seduction of females or males, of freemen and slaves.*

*Whatever in connection with my professional practice, or in connection with it I see or hear, in the life of men, which ought not to be spoken abroad, I will not divulge, as reckoning that all such should be kept secret".*

As I matured in the profession and looked back at what Professor Eric Cruickshank represented, I was sure that the

mastery of his craft and his passion for it would have made him embrace the goals of medicine which Daniel Callahan at the Hastings Center and a group of colleagues put forward in response to what they saw as the need to maintain the integrity of the profession "in the face of political and social pressures to serve anachronistic or alien purposes" (10). They described four goals which spoke to the core values of medicine. These are:

- C The prevention of disease and injury and promotion and maintenance of health.
- C The relief of pain and suffering caused by maladies.
- C The care and cure of those with a malady and the care of those who cannot be cured.
- C The avoidance of premature death and the pursuit of a peaceful death.

When I speak to young physicians, I have noticed that it is the last goal which poses tremendous difficulty. Man's ability or ambition to change nature knows no bounds and it is not infrequent to find physicians with the attitude that death is a failure. It is that view that has led in part to the popularity of living wills. But there comes a time for everyone when he or she must pass on. The document from the Hastings Center puts it as well as I have seen it put.

*"Thus the humane management of death is the final and perhaps most humanly demanding responsibility of the physician who is forced to recognize in her patient both her own fate and the inherent limitations of the science and art of medicine, whose compass is mortal and not immortal beings". Death is not an enemy. "It is death at the wrong time (too early in life) for the wrong reason (medically avoidable or treatable at a reasonable cost) and coming to the patient in the wrong way (full of relievable pain and suffering and excessively prolonged) that are the appropriate enemies (10).*

I can hear Eric Cruickshank saying "Amen" to the above.

Eric Cruickshank would tell us that he came from the Scottish tradition which, according to him, was the cradle of social medicine. It was a part of his understanding of health that led him to insist on knowing what are now coming to be known as the social determinants of illness. It was for this reason that he promoted the formation of the Department of Social and Preventive Medicine which was born out of the Department of Medicine. He had no doubt that it was right and proper to pay homage to the two daughters of Aesculapius – Panacea and Hygeia. Panacea, the all healing, is the goddess of the cure. She was worshipped by the sick with the hope of cure or healing. Hygeia was the goddess of the healthy and prayers to her were for maintaining health. Hygiene is etymologically derived from the name of the goddess Hygeia.

Eric Cruickshank saw that concern for health was not complete without paying homage to Hygeia. I will now contend that it is time to accept that the art of Panacea, the art

of the Hippocratic Oath must be extended to embrace Hygeia.

This is the art of caring for the public's health and not simply the art of maintaining a sanitary environment which to many students is the extent of the appreciation of hygiene. It is no longer possible to think of health without removing the schism between the personal care medicine and that of the care for populations. I have met those who care for the public's health who are dismissive of the personal care physician as being almost selfishly and arrogantly eclectic. Similarly, there have been eminent physicians who have argued passionately that the personal encounter physician has a major influence on the health status of our society as a whole (11). Clearly both are important, and I have had the good fortune in my own professional career to appreciate how the art of medicine as taught by Eric Cruickshank is applicable wherever and however one pursues the essential goals of medicine.

If we examine some of the major health problems of the Caribbean region, we would see how the extension of that art is applicable. I will refer to the Report of the Caribbean Commission on Health and Development established by the Heads of Government of the Caribbean Community which I had the honour to chair. That Report pointed out that the major health problems facing the Caribbean as a whole were HIV/AIDS, the chronic non-communicable diseases and the health sequelae of injuries and violence (12). The data on these, at least the first two are well known, and I will give only the briefest account of them. At the end of 2007, there were some 230 000 persons in the wider Caribbean living with HIV with about one quarter of these living in the CAREC member countries, which is essentially the CARICOM region. In 2005, there were some 2500 cases reported from those countries.

The spread is now firmly heterosexual and major causes for concern are that AIDS is now the leading cause of death among persons in the 25–44-year age range and that young females represent the group that is being infected predominantly. Mortality is decreasing with wider availability of antiretroviral therapy. There is guarded optimism in that in many Caribbean countries there has been a decrease in prevalence rates in pregnant women and an impressive interruption of mother-to-child transmission. However, there is still a low perception of individual risk and the environments in general do not support the adoption of prevention strategies (13). The chronic non-communicable diseases (NCDs) are assuming increasing importance globally and the Caribbean is by no means spared from what I have described, on another occasion as a coming *tsunami*. Heart disease, diabetes mellitus and stroke are on the increase, although we know the risk factors which are driving the epidemic. These are essentially, obesity, tobacco use and physical inactivity. We estimate that at least 25% of Caribbean adults are obese, a similar percentage have elevated blood pressure and the prevalence of diabetes reaches as high as 10 per cent in

several countries. Physical activity is decreasing and still too many adults smoke (14). It has been salutary to note that these two disease groups have attracted attention at the highest political levels.

Last September, the Caribbean Community and Common Market (CARICOM) Heads of Government met in a summit and issued a 15-point declaration that included the steps to be taken to address specifically the chronic non-communicable diseases (15).

I am pleased to note that more and more of our countries are having national consultation on NCDs, and I hope the Caribbean Wellness Day scheduled for September 13, 2008, will provide yet another stimulus for creating what we hope will be a wellness revolution in the Caribbean.

It is true that several disciplines have to be involved in addressing these diseases but I contend that one can still discern the need for the components of the art of medicine as was described above. I would urge health-workers to beware of the siren song that says that these major diseases are not health problems. This is sophistry. These diseases are cause for concern because people become ill and die. They are as much of a health problem as is lethal yellowing of coconuts an agricultural problem. It is true that much of the solution extends beyond the traditional health disciplines, but that must not detract from the fact that we must keep them squarely in our view.

If we are to be effective participants, leaders and advocates for the control of these and other major diseases which may reach epidemic proportions, there are a range of skills to be mastered. First among these is the skill which is central to the art of medicine as I posited above, and that is collection of the necessary data and mastery of the relevant information.

The information may not come primarily from personal observation, but it is information nonetheless. It will be gained from such disciplines as epidemiology and biostatistics that are firmly part of the armamentarium of the modern public health worker. The fact that some of these skills are practised by non-physicians does not make them any less part of the art of medicine. It is the management and effective presentation of that information that will be the detonator for change.

The physician has to become knowledgeable of such disciplines as economics and politics. The description of the most cost-effective interventions to be applied at the population level to address these diseases will be a joint exercise between the physicians and other colleagues. The passion and compassion that are so evident in personal encounter medicine are equally patent when there is concerted effort to address the health problems at the population level. Although Hippocrates considered the physical environmental as relevant to an understanding of the individual illnesses, it is equally essential to appreciate that it is critical to change the enabling environment if one is to address these diseases in the population as a whole. The stigma and discrimination

which surround HIV, the homophobia and the reluctance to address commercial sex-work are part of the environment which makes the public health response to HIV so difficult. The change of this environment is no less important to the problem of AIDS than was the closure of the Broad Street pump to the epidemic of cholera in John Snow's London (16).

The passion, compassion and ethics or morality which are such a part of the physician's art are in high relief in dealing with populations as a whole. It is compassion and a sense of moral indignity which makes the world and all health-workers particularly, cry out when confronted by the social injustice that results in health inequity.

This inequity is played out in the high disease burdens borne by the underprivileged and the extent to which health is unfairly distributed across the social spectrum. The Caribbean is by no means free from these health inequities.

The remedies may not lie peculiarly in the domain of the traditional medical disciplines, but it is part of our responsibility to establish what is upon the people and to assist in elucidating the root causes. Henry Sigerist, the doyen of medical historians described doctors whom he considered to be great in this way (17).

*"When we look back into the past, we see an endless train of doctors on the march. Their dress, their language, their social position varies; their outlooks and their methods change from age to age. Some have a urine-glass in their hands, others a stethoscope. Yet one and all, from the shamans of primitive tribes down to the scientific physicians of our own day are inspired by the same will. They seek the same goal and are guided by the same idea. Many of them have been veritably great"*

I am not sure whether Eric Cruickshank would qualify for Sigerist's list, but for many like me he is great, and I hope I have shown why we should honour him. He helped to create the infrastructure of an institution that is responsible for

much of what takes place in addressing the health problems at least in the Caribbean. His greatness lies in a legacy that operates not only through things physical but through the transmission of what I consider to be the essentials of the art of medicine.

Long may that legacy continue!

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