It is a very great privilege for me to deliver this Heberden Oration. Heberden was a remarkable man, hence the title of this talk: clinician, scientist and scholar. He exemplified all three. Heberden lived between 1710 and 1801, a fascinating time in the history of medicine, with the 18th century showing significant advances in medical practice and the understanding of disease; the time of the Hunters and Jenner. However, Heberden’s legacy goes beyond the 18th century, and the practice of medicine owes him a great deal even today. Heberden’s legacy remains. It is said that Dr Johnson in his last illness called for ‘Dr Heberden, ultimus romanorum, the last of our learned physicians’. I take this, therefore, as the text for this oration, and look at the training of physicians, their future work pattern, and their role as scientists, clinicians and scholars.

THE CLINICIAN

The first major issue to be considered is that of clinical skills. These are often forgotten in these days of exciting molecular biology, genetics and imaging technology, but for the patient, and for the outcome, the skills of history taking, inspection and examination, followed as required by further investigation, still remain the foundation of good clinical practice, and of making the diagnosis and discussing treatment. In the past, and certainly in Heberden’s time, the doctor had to rely almost entirely on clinical skills. We now have much more to offer both in diagnosis and treatment, but the patient and the public expect a doctor who is competent and who knows where to turn if there are problems, and who provides high-quality care to the patient.

This raises one of the most important issues in contemporary British medicine, that of the relationship between the generalist and the specialist. For a speciality like rheumatology this is particularly relevant. How far should the rheumatologist go in giving up general medical practice to become a full-time rheumatologist, and what is gained or lost by such a process? The Chief Medical Officer does not have a simple or easy answer to that question. However, it is certainly one which most specialities are currently considering. It is relevant not only to individual specialities, but to the practice of medicine as a whole. Patients are nowadays confronted with such a broad range of doctors that it is important that those who look after them have the widest range of skills available and are able to care for them on a holistic basis.

One of the key clinical skills, of course, is that of communication. Almost all complaints against doctors and other professionals relate to some failure in communication, rather than to a technical issue. Communication, therefore, is something we should value and, as communication is a two-way process, listening to patients is a skill which requires cultivation. All of this comes together in a holistic approach to patient care associated with working with a team of colleagues from different professional backgrounds, with a wide range of skills, backed up by common sense. Within this range of clinical skills, ethical decisions remain of great importance. Almost all areas of clinical practice are increasingly affected by decisions based on values, and these values need to be thought about and considered not only within the medical profession as a whole, but also within individual specialities. This is also why the process of education, and in particular continuing education, is so important in clinical practice. The value of audit and continually reviewing practice is part of that. Thus, education and training are important, although there is an important distinction between the two words. ‘To be trained is to have arrived, to be educated is to continue to travel.’ As part of this, the education of teachers is also important and we perhaps give less emphasis to this than we might.

At the heart of all this, of relevance to every speciality, including rheumatology, is the assessment of competence. This is an issue which each speciality needs to consider and with the new speciality training procedures it is of great importance that competence is clearly defined. In addition to this, as the specialist develops, peer review and mentoring also become of great importance.

THE SCIENTIST

Medicine is very much part of science, and the research dimension of clinical care is vital. Heberden would have been very familiar with the works of Francis Bacon, who made it clear that ‘man who is the servant and interpreter of nature, can act and understand no further than he has, either in operation or in contemplation observed of the method and order of nature’. Bacon and Heberden were both concerned with observation, and in the ordering of nature. So it is with today’s doctor, who should be full of curiosity, intrigued with the differences between patients, and with a wish to know more about disease and health. With science, of course, comes some degree of certainty and indeed much of the public perception of science relates to the power of science and the way in which it has changed clinical practice. Of relevance to this are
the theories of disease which have been developed over the centuries. In earliest times, theories of disease related to humours, then in the 17th and 18th centuries the mechanistic approach to human health became relevant. In more recent times, developments have been related to our understanding of the molecular basis of disease, and most recently, perhaps, a return to a holistic approach to understanding health and illness. Indeed, reviewing the history of medicine is like reviewing the reclassification of disease.

Look at three common diseases seen by rheumatologists: rheumatoid arthritis, ankylosing spondylitis and muscular dystrophies. Each of these has changed its classification over the last 20–30 yr. The rapid expansion in molecular biology and genetics has allowed, for example, the reclassification of muscular dystrophies, and the better definition of arthritis has allowed classifications to develop, which in turn mean more directed and focused treatments. It is the same with other common diseases. Diabetes, once considered to be one disease, is now known to be several. Coronary heart disease, once thought of as a single entity, is now a mixture of diseases which can be classified and reclassified, and will continue to be so with further discoveries in science.

The evidence base of clinical practice has been emphasized a great deal in the last few years. The need to define outcomes and effectiveness has been strongly supported. This must be the way forward, but for most specialties, including rheumatology, it is not a new concept. However, what it has done has been to focus activity on improving the outcome and to consider such outcomes, not only in terms of cure or remission, but also in terms of quality of life.

The scientific basis of medicine also raises the issue of public involvement in health care and in the understanding of health and disease. Many of the issues of treatment, of diagnosis, or of an understandiing of the disease itself, involve issues of risk. To clarify such issues, definitions of risk assessment, an understanding of perceptions of risk, a need to communicate such risks frankly and openly to individual patients or to the public need to be emphasized. Many new developments in clinical practice do involve risk. Many of the new diagnostic techniques have risks inherent within them, and the public need to be assured and should be made aware of, and feel part of, such developments. Recent scares in the press about medicines, investigations, or treatments, have only served to highlight the importance of this topic. Within this there is the responsibility of the rheumatologist, not only to present such issues to an individual patient, but to act as a spokesman to the broader public about changing clinical practice and in explaining often quite difficult concepts to the public as a whole.

THE NEED FOR SCHOLARSHIP IN MEDICINE

It may seem strange at a meeting concerned with science and outcomes to raise issues of scholarship, but it is considered to be of some importance. Why is it important, and what is its value? A scholar may be defined as ‘one whose learning is extensive and exact’. In biblical terms, it is about wisdom. ‘Wisdom is the principle thing: therefore get wisdom and with thy getting, get understanding.’ (Proverbs 4, 7) But this requires time, experience and the need to keep up to date. The knowledge base of any speciality cannot be compartmentalized. This is best illustrated by using the analogy of the map. The detail of the map, the towns and villages, can be related to each individual speciality and the extensive knowledge required of a relatively small area. The larger map taking in an entire country is analogous to the practice of medicine as a whole. Moving into related continents, there are links with other disciplines which in terms of rheumatology must spread to sociology, psychology and engineering. However, there are broader links to distant continents, with other areas of knowledge such as philosophy, literature and the arts. The scholar, and those that seek wisdom, require contact with and understanding of each of these components of the map. They provide a global view.

Consider first rheumatology. The knowledge base is not just about the clinical picture of the diseases and the understanding of bones, joints and muscles, but extends into genetics, epidemiology, immunology, pharmacology and engineering. Once issues such as quality of life are considered, then it links immediately into other important disciplines. Thus, the importance of scholarship emphasizes breadth and depth, range and experience, connection to wider values and to ethical issues.

This takes the discussion into the role of the humanities in clinical practice. Some years ago, I was involved in a short course for medical students and nurses entitled ‘Literature and Medicine’. This course continues to take place and covers books, poems and plays, and has subsequently extended into the arts generally [1, 2]. The purpose of this course was to ensure that medical students were able to think beyond their own discipline, and to give them further breadth of experience and emotion. In doing this, it has provided an interesting way of teaching and learning difficult areas such as ethics, and at the end of the day provided considerable relaxation and pleasure to those who took part. Perhaps the highest point in the process of education is the ability to converse with others, and the breadth and depth of scholarship allows that to be developed even further.

To return to the title of this talk: clinician, scientist and scholar. How can these three areas be synthesized in relation to professional responsibility? Perhaps the most obvious way is in communication with patients, and the presentation to patients and the public of specialized knowledge in the context of wider values and of emotions and feelings. The implications of this conclusion are considerable, but relate particularly to the education of doctors. There is a danger that the process of education can become narrow and
specialized, and look away from the broader more holistic view of health, and health care.

CONCLUSION

I have tried to demonstrate that the legacy of Heberden as clinician, scientist and scholar remains relevant today. The doctor of the future must retain strong clinical skills, and have the curiosity motive which allows him or her continually to explore and develop a speciality. In addition to this, however, the scholarship dimension gives breadth and depth to the individual doctor, which should not only provide effective and holistic care for the individual patient, but great satisfaction for the individual clinical practitioner.

REFERENCES