Correspondence

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Changing Face of Medical Practice

SIR,—While agreeing with the humanity in Dr. George Birdwood's Personal View (20 December, p. 740), I could not help but reflect that as a profession we are now so firmly gripped by technology that we probably cannot escape. My father, a general practitioner, certainly practised a very different sort of medicine from that practised by his son, a regional hospital physician, and it was different not so much in degree as in kind. In his day treatment was limited to insulin, thyroid extract, iron, liver extract, digitalis, the new mercurial diuretics, barbiturates, simple analgesics, morphine derivatives, and harmless mixtures. Medical diagnosis and investigation were more of academic than practical importance, for there was little that could be done for most diseases. There was time for sympathy and discussion, and patients did not expect very much. Paradoxically the doctor was held in greater esteem than he is nowadays.

Since those days, and I can remember the beginning of their end with the discovery of sulphanilamide in my first clinical year as a student, the practice of medicine has altered out of recognition. Increasingly complex techniques, the necessity for early diagnosis, and multitudes of tests affect not only the hospital doctor but also the general practitioner. Quantities of new drugs, all with potent actions and equally potent side-effects, deluge us with all the powerful persuasiveness of modern advertising. No sooner do we learn the trials and tribulations of one drug than it is replaced by another.

No wonder sympathy is a falling priority, for doctors are human, and there is a limit to the human capacity to absorb and transmit all this and sympathy too. In any case, simplistic explanation, reassurance, or commiseration is no longer enough. A section of the public regards going to the doctor as comparable with taking their car to the garage. He's there to cure them; if he can they accept it as a matter of course; if he cannot they are not slow to express dissatisfaction. A small section, but it grows. It is depressing and regrettable, but I do not believe the planners are solely to blame. Although they contribute their share, they are in a sense the victims of the technological juggernaut which is trampling us all beneath its formidable progress.

I doubt if we can revert to the gentler manner of a bygone age. In those days, some surgeons, I remember, seemed brusque and matter-of-fact, occasionally to the point of callousness. This I suspect was a reflection of technical expertise and lack of time. Now and in the future professional know-how seems likely to compete increasingly with the sympathy and understanding which accompanied therapeutic helplessness.—I am, etc.,

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Value of Necropsy

SIR,—Post-mortem examination of a patient is still one of our most valuable sources of medical knowledge. The revelations of the post-mortem room are often surprising and always instructive.

As with any other examination of a patient, the physical findings post mortem need to be interpreted in the light of a comprehensive history. In hospital practice the pathologist can study clinical notes and can reach an informed conclusion.

When a death has been reported to the Coroner it is usually because the practitioner is uncertain of the cause of death. It would seem obvious that this is just the situation where every scrap of medical information should be available for the pathologist.

It has been extremely disturbing to find that over recent months cases of sudden death have undergone post-mortem examination on behalf of the Coroner, without any request for medical history from the patient's doctor. I fail to see how the pathologist can play his decisive role in such circumstances. The need for medically-qualified Coroners seems clear—I am, etc.,

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Facial Pain

SIR,—May I congratulate my colleague Dr. John B. Foster on his excellent article on facial pain (13 December, p. 667).

I am aware of the context in which this article was written, namely by a neurologist, in a series on practical neurology. For this reason I would have thought that attention might have been drawn to the fact that dental disease is the commonest cause of facial pain.[1] Dental caries is not always readily diagnosed and requires a careful clinical examination, dental radiographs, and vitality tests to diagnose it and its sequelae.[2] I would, with respect, disagree with the statement that "Temporomandibular neuralgia" is most commonly seen in middle-aged women. It is my experience, and that of others, that mandibular joint dysfunction with its resultant symptoms is usually seen in younger women.

I do urge practitioners, both medical and dental, to consider dental disease as a common cause of facial pain and make an active effort to exclude it before considering less common and esoteric syndromes.—I am, etc.,

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REFERENCES

1 Miller, H., *British Medical Journal* 1968, **2**, 577.
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