The doctor in society

ALISTAIR COOKE

If any of you happened to be present at the speech I gave some years ago to the Royal College of Physicians (on "The layman's specialty: hypochondriasis"), you will know that this is not the first time that I have appeared as a lay preacher before the College of Cardinals. I ought to have been put off by that first occasion, which was a lecture before the Annual Convocation of the Mayo Graduate School of Medicine. In the main, it was a lament for medical jargon, and an appeal to doctors not to use it in talking to patients and laymen. At the end, I ventured the reflection that "of course, the impulse towards jargon is very much a matter of character; and it is likely that you can no more cure a naturally pompous person than you can reflower a virgin." This speech was printed, alas, in the Mayo Clinic Bulletin and went around the world. Practically the first letter to fall on my doorstep was one from the department of gynaecology at the University of Tokyo. It said simply: "But, Mr Cooke, we do it!" From now on, I shall watch my metaphors.

The title I chose for this address, "The doctor in society," sounds very important. But I shall try very hard not to be important. What I have in mind is the daily relation of the doctor (most especially the internist or general practitioner) to the patients he sees and the cures or placebos he offers them. Most of all I want to address myself to the psychological assumptions on which both doctor and patient gauge each other's character and temperament and adjust their attitudes accordingly. If I have anything to offer to doctors, who have spent their lifetimes with this problem, it may be to sharpen some of the differences that I have noticed, in Britain and America, between what the doctor expects of the patient and what the patient expects of the doctor.

Some of you may be disappointed to infer—correctly—that I am not going to discuss certain social themes that have been well aired by people far more knowledgeable than I: such things as the proper distribution of rural and city doctors; profit-making private clinics, let alone the large and universal problems of socialised medicine versus private practice, and the never-ending arguments that flow from a national health insurance system about how thorough a clinical routine can be applied to a horde of people in the waiting room who are there because the service is free. I will only say in passing that very few people I have ever heard of are willing to put money aside for health insurance. All systems so-called would be better labelled sickness-insurance programmes.

One of the sharpest differences between Britain and America is how much the doctor expects the patient to know about the working of his body in general and the particular troubles he is susceptible to. Nobody has written more aptly about this—as about many other relations between doctors and patients—than

the late Richard Asher. At your annual meeting 22 years ago, he said: "Indirectly, a little knowledge of medicine in the hands of our patients may benefit doctors. It is hard for a salesman to remain honest if his customers have no idea whether his goods are satisfactory or not. Blind, ignorant faith in doctors is not always to their benefit, although we appreciate it highly on the rare occasions we obtain it. Heaven defend us from the kind of patient who comes to us and says: 'I want you to have my 17-keto-steroids estimated.' How much we prefer the patient who says: 'I leave it to you, doctor.'"¹

I am sure that while these two types stake out the extremes of the general practitioner's experience, there are many more varied types in between—suppliants, admirers, doubting Thomases, paranoiacs, know-alls, pests. Certainly the technically inquisitive patient is far more common in the United States. In my frequent shuttling between the two countries, I have often thought that British doctors are lucky in having, in their educated patients especially, an ignorant laity that would rather remain so. This must have something to do with the persistence in Britain of C P Snow's two cultures, which encourage the automatic decision among university students to go into the arts or sciences on the presumption that the twain are never meant to meet, and with the general presumption of writers, lawyers, musicians, artists that no intellectual or social prestige is lost by regarding the sciences as beneath their notice. In glaring contrast to this national prejudice, I think of the not unusual American career of the late Robert Tyre Jones, junior, of Atlanta, Georgia. If he had been an Englishman, I doubt whether before he became the greatest golfer in the world he would have acquired an honours degree in English literature from Oxford, a law degree from the Middle Temple, and an engineering degree from Manchester.

I find that in even the most distinguished British biographies of literary figures, musicians, and artists, 500 pages of the most scrupulous scholarship will end with the note that the great man or woman tired easily, was in increasing pain, and friends knew that "the end was near." Nearly 50 years ago my first American friend, who was then a premedical student at Yale, on coming to the end of a biography of some eighteenth-century writer (it could just as well have been a twentieth-century figure) said: "What is this listlessness that killed him? Was it an anaemia, diabetes, encephalitis, or what?" An annoyingly large number of Americans, from all sorts of background, tend to want to know. And so the American internist expects to be burdened by this nagging demand—from a lawyer, a housewife, an actor, or a real estate broker—for a technical explanation that would bore or bewilder the more stoical Briton.

This marked difference can be taken to imply that Americans are much better informed than Englishmen about medicine. I used to think so, because I regularly heard them use medical terms with enviable flipness—such as rhinitis, congested sinuses, deviated septum. Britons, on the other hand, tended to go around grumbling about their sniffles or catarrh (catarrh in my youth covered everything from pneumonia to a brain tumour). I remember becoming so ashamed of my lumpish ignorance of

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such things that I stopped talking about lumbago (or "rheumatics"), and I learnt to toss off words like sacroiliac and slipped disc (even after an orthopaedic surgeon asked me what I meant by a slipped disc). It took some years for me to discover that the ordinary American layman was no more knowledgeable than his British counterpart. He simply yielded to the national love of Latin and Greek polysyllables, especially if he knew no Latin or Greek. Thus, I was greatly impressed when I heard somebody say, at a cocktail party, that he had had a lesion of his clavicle. I tiptoed off to the dictionary to learn about this exotic affliction. What do you think? He had hurt his collar bone.

Viruses

Another word that is very popular in America is the magic word: virus. All suffering people drop it to explain a snuffle or a sleepiness instead of everything from cancer to the common cold. I used it myself freely till, to my shame, a doctor present said something like: "I don't think it's a virus. I doubt it has protein coat." That is a stopper, if ever I heard one. I looked *that* up too, and I am ready for any pedant who fixes me with his Ancient Mariner eye and says: "Do you know exactly what a virus *is*?" I reply at once: "Any of numerous kinds of very simple organisms smaller than bacteria, mainly of nucleic acid in a protein coat, existing only in living cells and able to cause disease." *That* shuts them up, even though I would not know a nucleic acid if it were served to me chilled with an olive in a stem glass.

But if Americans do not actually know more, they want to. And their curiosity is fed daily at high and low levels. At the lowest it is fed by the preposterous magical cures propounded by weekly junk magazines that litter the display shelves of junk food stores. At the highest level it is fed by television documentaries and by the excellent and wide-ranging articles on health and disease that appear in the best of the American press. In how many other countries, I wonder, is a weekly scientific supplement enclosed in the daily newspaper, as it is every Tuesday in the *New York Times*?

Television

As for television, it is at once a curse and a blessing. The curse is television commercials, from which viewers pick up, subliminally, in the moment of ridicule, quick fixes for indigestion, headaches, haemorrhoids, lower backache, insomnia, and what is guardedly called "minor arthritis." The blessing, not unmixed, lies in the frequent television documentaries on how the body works and how it doesn't. Here again, it is the nature of the medium to be most engrossing when it is most visually dramatic. Few inquisitive people can resist the marvellous world revealed to us by microphotography, and the most memorable medical documentaries I have seen have been of performances of microsurgery. Inevitably, these deal with impaired function which, without the intervention of the skilled surgeon, would kill the patient. Before television, something of the sort was done by documentary film makers. I remember how enthusiastically, before the last war, the Roosevelt administration discovered the virtues, or rather the propaganda uses, of documentary film. One of the ablest of the directors hired by the government did a film called "The Birth of a Baby." It was quite brilliant and received ecstatic reviews from everybody but—I should guess—expectant mothers. Throughout the film the heartbeat was amplified on the sound track and provided a bass rhythm as relentless as the drumbeats that throb through Eugene O'Neill's drama about the life of the Emperor Jones. And, indeed, the effect of it—as it pounded at a gallop and then perilously slowed—was no less ominous. For what the director was filming was not the normal birth of a baby but a terrifying case of eclampsia. It was, in other words, a film about disease. I should think it contributed powerfully to the abortion rate of the time—which was not its original purpose.

But the effects of television in general—its dramas, soap

operas, its fictional life—go much further than most of us had guessed in implanting in the general public new attitudes towards the doctor. We have just learnt this from a study conducted over the past 10 years by the University of Pennsylvania. It is serious enough to merit its being published in full, later this year, by the United States Public Health Service. Its conclusions are at once flattering to the doctor and a threat to his honesty and patience. Here are the main ones:

Characters on evening prime-time serials are shown as healthy "despite all the mayhem, eating, and drinking" and are relatively sober, safe from accidents, and slim at all ages.

The image of mentally ill people presented by television fits erroneously into stereotypes and popular prejudice.

There are five times as many doctors, nurses, and other health professionals on television as there are in real life.

Daytime soap operas rely for their cliff-hanging tension on so much illness, major and minor, that "they could well be the largest source of medical advice in the United States."

These characteristics alone, by reinforcing the preconception that doctors are available in all places at all hours, could well make the patient who suddenly falls ill all the more outraged by the reality of the unreachable doctor and the tedium and trauma of the emergency clinic; they may have done much to stimulate what is called "roadside medicine" and the mushrooming growth of free standing emergency centres, or walk-in clinics, with a promised limit of 15 minutes' waiting time.

The most sombre and threatening—threatening to you—sentence in the report is this one, which starts out as a seeming compliment: "Television contributes to a syndrome in which high levels of confidence in the medical profession seem to justify live-for-today attitudes. . . . This cultivation of complacency, coupled with an unrealistic belief in the 'magic of medicine,' is likely to perpetuate unhealthy life styles and to leave both patients and doctors vulnerable to disappointment, frustration—and litigation."

False expectations

Litigation! The dread word reminds us of the enormous increase in this country, in the past 20 years or so, of suits for malpractice, and a corresponding increase in protective premiums, so stiff in some States that there are skilful surgeons who have quit their practices and turned to more dependable ways of providing for their families. It is taken, by many newspapers and other media, as a grisly reflection of rampant malpractice. And it may be that as people come to expect more from doctors, more doctors take bigger risks to accommodate them. But many of these suits reflect rather the bitter disillusion of a generation lulled by the popular education we have been talking about into believing that doctors can cure any disease, and that almost any organ of the body can be replaced as readily as a punctured tyre or a shock absorber.

So one big social question that the modern doctor has to face is: Who will help him adjust to these rosy expectations and regain the realistic confidence of his patients? Well, there is good news. The answer is—the sociologists, whose main job, after all, is to tell us how society works and, by the disinterestedness of their findings, point the way to its behaving better. In the past 10 years the sociologists have turned their expertise to the doctor-patient relationship. The studies I have seen² are based on the premise, which seems to me a sensible one, that the root of a trusting relationship or a suspicious one lies in the first interview. Consequently, they went out with microphones and tape recorders, in Southern and Northern California, in Washington, DC, in Massachusetts, and in West Germany, to tape the dialogues between doctors and their new patients.

Sociologists' field day

The reports I have looked over should not raise your hopes

for enlightenment too high. They appear to me to share two initial flaws. The first is almost inevitable in a procedure that requires both the doctor and the patient to be told that they are going to be recorded. The happy injunction to "just be yourself" is one with which naive radio and television producers hope to comfort beginning broadcasters. The truth is that to 99 human beings in 100, however emotionally secure or blithe they may be in life, a microphone is a sword of Damocles that instantly heightens self-consciousness and produces a tune (what the phoneticians call an "intonation pattern") which is not the natural tune of a person talking to one or two friends in a room—and that, to me, is the ideal condition for all successful broadcasting. It takes years to forget the microphone and any awareness of an outside audience.

So, in the transcripts of the interviews I have read there is an unnatural strain on both sides, which is in itself a seedbed of suspicion. Many doctors seem to overcome this better than their patients, however, and this leads the recording angels—the sociologists—into their second flaw: the presumption, reported as an observation, that doctors tend, especially with less educated patients, to be intimidating, to be exercising power, and to use medical jargon that does not provide the patient with helpful information. No one could be more sympathetic than I to the patient who is not allowed to discover that his tibia is his shin bone, that a thrombosis is a clot, and that therapy means no more than treatment. But apart from this culpable habit, surely the first meeting between a patient and a doctor, between the learner and the teacher, between the anxious ignoramus and the one who knows, cannot possibly be an equal emotional and psychological exchange.

Whatever else the sociologists can usefully tell us is befogged by their own appalling jargon. Let me recite—not for long—some of the discoveries which they seem to offer as being most relevant, if not profound.

They notice that patients develop an "attitude" to the doctor: "Specific aspects of the doctor's talk obviously contribute to this notion of attitude." The only comment I can make on that is: obviously. Some investigators, we are told, "use a scale of 1 to 6 to score . . . the least to the most technical remarks . . . [and] the same scale is used to decide the globality or specificity of the patient's questions and the doctor's responses . . . additional scoring is used about the causal or non-causal nature of the explanation and its probabilistic or non-probabilistic nature." Well, fancy that!

One original study "involved longitudinal observations of doctor-patient interaction between six internists and 36 patients over a nine-month period." What they were doing discussing longitude I have no idea, unless—as I can well imagine—the patients were so disoriented after nine months that they had to be told where they were at.

I am afraid there is no succour for us from the sociologists. I should like some doctors—neuropsychiatrists preferably—to do a study on the problems of communication that are peculiar to sociologists: why they fail to get anything at all across to poor us, their abject subjects.

Arrogance and authority

Any of you frightened by these strictures may take decent consolation from the wiser words of Franz Ingelfinger, who four years ago, meeting the charge that doctors are more arrogant than most professionals, had this to say: "Physicians as a class are, I suspect, no more vain or insolent than any other people. Some are presumptuous and condescending, others self-effacing and sympathetic . . . [but] if the physician is to be effective in alleviating the patient's complaints, it follows that the patient has to believe . . . that his physician not only can be trusted but has also some special knowledge that the patient does not possess. He needs, if the treatment is to succeed, a physician whom he invests with authoritative experience and competence. He needs a physician from whom he will accept some domination.

If I am going to give up eating eggs for the rest of my life, I must be convinced, as an ovophile, that a higher authority than I will influence my eating habits. I do not want to be in the position of the shopper at the casbah who negotiates and haggles with the physician about what is best. . . . In fact, if you agree that the physician's primary function is to make the patient feel better, a certain amount of authoritarianism, paternalism, and domination are the essence of the physician's effectiveness."³

This must be so, though we have only to look around at any dozen, and apparently happy, marriages we know to see that for some people authority does not reside in domination but rather in the partner's serene temperament, or in humour, or in simply a pair of beautiful brown eyes. For me, medical authority is most acceptable in the sceptical doctor.

Drugs

I should like to end by considering briefly the special temptation that is offered by the present great age of bacteriology—the temptation to become what the late Dr Haven Emerson called "the PhD": the pharmacopoeia doctor, who listened to a recital of the symptoms, retired to the back room, matched the most distressing symptom with the latest drug, and prescribed it. The layman does not know that about a half of today's prescriptions are for drugs that did not exist 10 years ago. With his preconceived trust in the doctor as a sainted healer, he is not disposed to discover that, according to a survey done almost 20 years ago,⁴ one in three prescriptions handed out by general practitioners is based on the information folders that come with the drug company's sample. Luckily for doctors the time it takes for each succeeding wonder drug to be discredited, or restricted to its rare and proper use, is so long or so masked by gradual disuse that the disappointment or damage in the old drug is forgotten in the glowing promise of the new. I am thinking of those drugs which are seized on as godsent solutions to ancient or particular problems and which, in time, reveal not so much that they have bad side effects but that the effect on the ailments they are prescribed for may be the side effect, the main effect being the damage done to some organ that was not considered in the original research or manufacture.

The example of thalidomide is too gross to mention, although for a year or two its potential merit was seriously weighed and attested by some very competent physicians in the Western world. Those in active practice in the 1950s will recall chloramphenicol, a wonder drug indeed until it was seen to shut down the bone marrow. Those of us with any interest in athletics vividly recall the miracle we saw with our very eyes, when some football player received a brutal injury, limped or was carried off the field, and within 10 minutes or so was trotting happily back into combat after a massive shot of hydrocortisone. We never noticed how many of these heroes went off into early retirement. Then for several years there was the blessing of dextropropoxyphene hydrochloride, an analgesic more powerful than three double martinis and probably more dangerous. And to this day, it takes courage for the good doctor to refuse to pump penicillin into patients with self-limiting ailments such as the common cold. The belief in fashionable magic has come so far in the United States that there are rich people, from Palm Beach to Beverly Hills, who at the onset of a headache demand a computed axial tomography scan.

As for the vitamins—apart from the weekly shots of vitamin B₁₂ for patients who feel out of sorts but could not possibly have pernicious anaemia—all but the most cynical doctors can be excused from blame, since vitamins constitute the most flourishing branch of the self-medication industry. First it was C, then the B complex, and now—in the United States—the magical E. I once tried to tell a devoted addict of vitamin E how Evans and Emerson, so long ago as 1936, laboured to find for rats a diet deficient in vitamin E; how difficult this effort was; how the thing seemed to exist in cardboard, ground glass, and dust; how in the end those two pioneers isolated such a diet, so deficient in

everything that the rats grew lackadaisical and some developed muscular dystrophy. Moreover, Mr Rat was no longer interested in Mrs Rat. That was the detail that excited the industry and the laggard lover. If you took lots of vitamin E surely your potency would be enhanced. It followed, did it not? It did not. But it was useless to suggest to my addict that the logic in this inference was about as sensible as deducing that if Neville Chamberlain had gone to Munich *without his umbrella* he would not have appeased Hitler. In fact, I believe that nothing at all can be done for patients, or non-patients, who believe that with vitamins—more is better.

Bedazzled by a small halo

But, as I travel from place to place and country to country, I am constantly struck by finding that this friend in London, and that one in Dallas, another in Paris, and yet another in Glasgow are all getting the same, the latest, antibiotic though their ailments seem to be different. My conclusion is that, because this is an era of intensifying specialisation and widespread biochemical experiment, there never was a time when the ordinary doctor, the general practitioner, needed to do more homework, to exercise more patience, and to direct his own and his patients' attention to the human body's subtle, and, indeed, preponderant capacity for health. Lewis Thomas has said it as well as anyone: "It is a distortion . . . to picture the human being as a teetering, fallible contraption, always needing watching and patching, always on the verge of flapping to pieces; this is the doctrine that people hear most often, and most eloquently, on all our information media. We ought to be developing a much better system of general education about human health, with more curricular time for acknowledgment, and even some celebration, of the absolute marvel of good health that is the real lot of most of us, most of the time."⁵

Well, I seem to be asking of doctors inhumanly high standards of skill, intelligence, imagination, patience, and honour. This is unfair, but it is only because of an illusion that doctors have

fostered as much as anybody: the illusion of modest infallibility. I noticed as a student, first at my own English university and then at two others in the United States, that medical students were notable for high spirits, coarse humour, and general affability, but not particularly for intellectual brilliance. This cruel reputation must have been planted long ago because practitioners of medicine were regarded for hundreds of years as journeymen, on a level with butchers, carpenters, and barbers, and were denied the term "doctor" for two centuries after it had been bestowed on theologians and lawyers.

But some time during the nineteenth century—perhaps after surgery turned from amputation to repair—a medical degree descended like a small halo, and ever since the ordinary citizen has secretly resented it or been dazzled by it. The retention of the serpent as a logo has certainly helped to keep alive the notion of the doctor as the possessor of a strange and subtle wisdom. Cherish and protect this illusion. It has not yet occurred to the layman that doctors—like cab drivers, schoolmasters, politicians, and television repair men—can be very good, good, indifferent, bad, or downright stupid. Do not let the word get out!

In the meantime, let the conscientious doctor, harried by an excess of sick patients and by his usual large allotment of hypochondriacs, make the most of the peculiar boon offered today by the increasingly numerous varieties of antibiotics and steroids: when you are baffled by the patient's primary affliction, give him another disease and cure that.

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ONE HUNDRED YEARS AGO Enoch B, aged 56, was admitted on August 11th, 1880. The patient, who was troubled with seat-worms, was in the habit of introducing butter into the rectum with his finger, as a means of destroying them. On the afternoon of the day of admission, in order to pass the butter further up the bowel, he placed it on a piece of paper on the mouth of a hock-bottle, which he put on a stool, and then, sitting on this, gradually introduced the bottle entirely within the rectum. He attempted to remove the bottle himself, and did not call in assistance until about 10 o'clock at night, when a medical man attempted to remove it, but failed.

He was brought to the hospital about 1.40 on Wednesday morning. The base of a bottle could be felt within the rectum. After several attempts had been made to lay hold of it by the hands and other instruments, he was put under chloroform, but with no result. The hands of the resident medical officers were too large to pass between the bottle and the pelvis, but one of the nurses could grasp it, and withdrew it over an inch. The mouth of the bottle could be detected on the left side of the abdomen near the short ribs; and, by applying pressure on that part, great assistance could be obtained.

Mr Spanton came about 3.15 am, and, under chloroform, an incision was made backwards between the coccyx and tuber ischii. This allowed more room, but still the bottle could not be removed. Various forceps were used, and a cord passed over it, but to no purpose. About 5.45 am, he was taken to bed, being too much exhausted to undergo any further operation. About 8 am, the urine was withdrawn with a catheter; he was found to have rallied considerably; vomiting was very severe. At one o'clock on August 12th, at the patient's urgent request, operation was undertaken. An incision being made through the abdominal wall in the left linea semilunaris, the bottle was grasped through the bowel, and an attempt made to push it out *per anum*, but this failed, although every assistance was given through the anus. The bowel was then opened in the descending colon, and the bottle drawn out. A morphia suppository having been introduced into the bowel, the wound was brought together by a continuous catgut suture, and

the abdominal cavity closed with deep and superficial sutures. He recovered rapidly from the operation; but, about 7 pm, he complained of great pain; this was reduced by means of morphia, but he gradually sank, and died at 7 am, August 13th.

At the *post mortem* examination, the abdominal cavity was found to be distended, and, on examining the bowel, the wound in the middle third of the descending colon was found to have united; there had been no oozing of faeces into the peritoneal cavity. The mesentery was adherent by a thin layer of recent lymph to the wound in the bowel, and to the parietes of the abdomen. The rectum, sigmoid flexure, and colon were not lacerated, but on the lower part of the rectum there were several ecchymosed patches about three inches in length and half an inch in breadth, running round the bowel. The bottle was eleven inches long, having a diameter of two inches and a half at its bottom, gradually tapering towards the summit.

Remarks by Mr Spanton.—The smoothness of the bottle, which rendered its introduction so easy, was the main source of difficulty in its removal. Its edge lay firmly against the concavity of the sacrum, and any attempt to extract it in the axis of the pelvic outlet caused the mouth of the bottle to impinge on the promontory of the lumbar vertebrae; and, although the bottle could be grasped with the hand through the anus, it was, for the reason just stated, impossible to extract it. There remained, therefore, no alternative but to remove it through an abdominal incision. This was accomplished without any difficulty by opening the colon, and withdrawing the bottle upwards; and, if we could have known at first the impracticability of its extraction in any other way, it is just possible the case might have terminated differently, inasmuch as the bowel would have sustained less injury from the manipulations which were unsuccessfully employed previously. The fatal result was, I think, due to the prolonged anaesthetic influence in a greater measure than to the final operation itself; that occupied a very few minutes, and caused far less additional shock than I was prepared to expect. (*British Medical Journal*, 1881.)