A FEW ANOMALIES AND STUPIDITIES IN MEDICAL PRACTICE*

RANDOM THOUGHTS WITH GLEANINGS FROM MEDICAL LITERATURE—OLD AND NEW

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There is a tendency to look back at our predecessors with an amused tolerance and say with Rudyard Kipling:

'Wonderful little, when all is said,
Wonderful little our fathers knew;
Half of their remedies cured you dead,
Most of their teaching was quite untrue.'

Have we, in fact, improved in our conduct of medical practice to the extent that we have improved scientifically? Is our first concern always for the patient, or do we disguise the truth with a lot of mumbo-jumbo? As Sykes remarks: 'The value of history lies in the fact that we learn by it from the mistakes of others. Learning from our own is a slow process.' As students, after we had examined an old lady, ex-professor of Medicine, Don Craib, would say: 'Now this patient is your mother. What do you advise?' The mainspring of all good medicine is sympathy towards human suffering. William Osler believed that it was more important to know what sort of patient had the disease, than what sort of disease the patient had.

One of the world's greatest cardiologists, Sir James Mackenzie, was for 28 years a general practitioner in Burnley, an industrial town in the North of England. By following-up his patients for many years he revolutionized the study of heart disease. In 1913 he was made a Fellow of the Royal College of Physicians. His statement that, 'no matter what the organic lesion may be, the guide should always be the state of the heart muscle and its efficiency in response to effort', is equally true today. Can the patient walk upstairs? The patient himself is in no way interested in the efficiency of his heart valves, in fact, he is not even concerned that his T-wave is inverted! All he wants to know is 'how serious is my illness and how soon can I resume normal life?'

What is the meaning behind that rather high-sounding phrase, 'doctor-patient relationship'? Simply this—does the patient trust us, or is he becoming more suspicious and more demanding? Is free choice of doctor a euphemism for professional jealousy? Some years ago I had the humiliating experience of realizing that, as a general practitioner, when I became seriously ill, my faithful patients felt I had failed them since they had the inconvenience of looking for another doctor. I may add that within an extremely short time they were all perfectly happy!

As most patients are apprehensive, few can behave with the determination of Queen Victoria before the birth of Prince Leopold on 7 April 1873, when John Snow administered chloroform to her Majesty. Five weeks later Thomas Wakley, editor and founder of the *Lancet* (that 'fearless, implacable and incorruptible watchdog of medicine, whom no money could bribe and no power on earth silence when he thought speech was necessary') wrote:

'A very extraordinary report has obtained general circulation connected with the recent accouchement of her gracious Majesty Queen Victoria.' He remarks that the Queen always had normal confinements, then continues: 'Intense astonishment, therefore, has been excited throughout the profession by the rumour that her Majesty, during her labour, was placed under the influence of chloroform, an agent which has unquestionably caused instantaneous death in a considerable number of cases. In several fatal examples persons in their usual health expired while the process of inhalation was proceeding.'

It was not until 1911 that Goodman Levy, in the *Journal of Physiology*, experimentally showed that excess adrenaline (produced by fear) and chloroform resulted in fatal ventricular fibrillation explaining these sudden fatalities in young healthy people undergoing trivial operations. It explained the immunity of women in labour, they did not fear the anaesthetic, they welcomed it.

Mr. Wakley continues: 'These facts being perfectly well known in the medical world, we cannot imagine that anyone had incurred the awful responsibility of advising the administration of chloroform to her Majesty during a perfectly normal labour.'

One can imagine the Queen's doctors trying to dissuade her from having chloroform, as they were well aware of the possible dangers and were, no doubt, rather apprehensive of what the formidable Mr. Wakley might say. Sykes suggests that the Queen replied: 'Thank you gentlemen for your opinions, but we are having this baby, and we are having chloroform.'

Dr. Locock, the chief accoucheur for this and a later confinement, for which Dr. Snow again administered chloroform, was rewarded with a baronetcy. Dr. Snow, being an anaesthetist, naturally got nothing out of it at all.

In 1894 Leonard Guthrie published reports in the *Lancet* of 14 cases of delayed chloroform poisoning (acute yellow atrophy of the liver) at a Children's Hospital, which took him 16 years to collect.

In spite of all this Ralph Waters, in 1951, published 'Chloroform. A study after 100 years'. He and a team of about forty people, including anaesthetists, cardiologists, chemists, biochemists, pharmacologists and electrocardiographers started in 1947 a study of chloroform as a new anaesthetic. In their conclusions they appeared to advocate the revival of chloroform. Possibly patients, or chloroform, or both, had not changed for Siebert and Orth reported on only 7 chloroform cases for thoracic operations in 1956, of which 4 had severe hepatitis, 2 of which were fatal.

But how could patients today die of old-fashioned chloroform poisoning, just as Guthrie's children died in the 1880s? The implications are patently obvious.

May I quote one further example from the February 1960 editorial of the *British Journal of Anaesthesia*:

'Years ago, when a surgeon was doubtful of the advisability of operating on a patient, he frequently asked a physician to see the patient and express his opinion, presumably to obtain moral support. "Mr. X would be pleased if Dr. Y would tell us if this patient is fit to stand an anaesthetic". The operation itself was a mere trifle, and if the patient was so foolish as to die after it, that was his own fault. All that modern surgery could do had been done and it could not be blamed for such an unfortunate result. The absurdity of this proceeding never seemed to strike the surgeon or the physician concerned. Years before the physician had grown to his present eminence, as an undergraduate he was signed up as having given the required number of anaesthetics—the number eventually became twenty! A well-known professor of anaesthesia was signed up when he had only given one anaesthetic, and though this particular gentleman has made ample amends for his early delinquency, had he become a physician that anaesthetic would, in all probability have been not only his first, but his last. It is to such a man that the surgeon used to enquire as to the fitness of his patient to receive an anaesthetic. Authority, in the shape of this physician, did not hesitate to pronounce the patient fit only for light gas and oxygen, with plenty of oxygen.'

But there are several ways in which the physician can be of the utmost help to both the surgeon and the anaesthetist. With all due deference to my surgical colleagues, the diagnosis may require confirmation, or the severity of the disease assessed. Further medical treatment may be required before the operation is carried out—or medical treatment alone may be adequate. This is perhaps an illustration of the way a group of specialists can bungle the treatment of a patient. Treatment by the specialist, who is becoming more of a technician as medicine becomes increasingly complicated, is only an episode in the life of a patient.

The family physician, friend and counsellor, who cares for his patients throughout their lives, must not be allowed to disappear. Unfortunately today he is frequently far too over-

*Valedictory address.

worked. Also it is obviously impossible for one single person to keep abreast of and understand all the new medical techniques. But what his function should be is to give sympathy and help to the sick patient and guide him through the maze of modern diagnosis and treatment, and perhaps protect him from the over-zealous specialist who is often more interested in the disease than the patient.

Students should be attracted to general practice by more interesting and practical courses on its implications and potentials, these to be given by senior general practitioners and not by specialists with their essentially narrower outlook. Why should there not be a Professor of General Practice? This is not a new concept, but practically no serious attempt has been made to implement this. Postgraduate courses in general practice should be readily available—these not being so technical as to be unintelligible, boring, and of little practical value.

But let the family doctor stick to his last. Let him not subject his patients to procedures for which he is often inadequately trained. Let him refer his patients to the technicians who are trained. These patients will benefit. But let him retain his function of being the overseer of the treatment, the friend and protector of his patient.

As the old lady remarked: 'I always feel that the young doctors are only too anxious to experiment. After they have whipped out all our teeth and administered quantities of very peculiar and very expensive glands, and removed bits of our insides, they then confess that nothing can be done for us. I really prefer the old-fashioned remedy of big bottles of medicine—one can always pour those down the sink!'