34

THE HISTORY OF THE DOCTOR–PATIENT RELATIONSHIP

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The history of the doctor–patient relationship since the eighteenth century may be divided into three phases: traditional, modern, and post-modern. Each is characterized by a distinctive level of scientific accomplishment on the doctor's part, and a distinctive psychological attitude toward the doctor on the patient's part. Much of the modern social history of medicine may be understood as what happens to these two actors in the psychodrama, doctor and patient, as these three phases unfold.

THE TRADITIONAL PERIOD

From the viewpoint of the history of medical theories, it would be incorrect to talk about a single 'traditional' period, for over the centuries many modifications had been carved into the basic trunk of Galenic humoralism. (➤ Ch. 14 Humoralism) Indeed in the eighteenth century, several rival 'schools' threw humoralism overboard. Yet over this long haul the structure of the consultation itself remained relatively unchanged. Thus, while we would not be entitled to talk about 'traditional' theories of patho-physiology, we take only a few liberties in speaking of the constant nature of the doctor–patient relationship before the nineteenth century: hence the term 'traditional', or that which existed before the infusion of science into medical practice.

These 'traditional' physicians may in most countries be divided into two groups: the élite consultant physicians of the cities, and the great mass of starveling practitioners elsewhere. This distinction cleaved traditional physicians into those of high or low social standing, the bearers of the 'gold-headed canes' and the country apothecaries. In England, the fellows of the

Royal College of Physicians stood out clearly against the surgeon-apothecaries who were the forebears of the nineteenth-century 'general practitioner'. On the continent of Europe, the professors of medicine in the university towns contrasted starkly with the second- and third-class barber-surgeons and *Wundärzte* of the countryside, though there were gradations in between. In the United States, the majority of health-care providers to the people were 'frontier doctors' whose formal medical training might have been limited to a brief apprenticeship. While all of these second-class medical attendants dispensed 'physic', so did a variety of other paramedical practitioners, such as midwives, apothecaries, corn-removers, and the like. What we therefore understand by 'doctor' before the early nineteenth century had little to do with university-trained physicians, implicating instead a wide variety of professions whose essential preparation had been the apprenticeship. (➤ Ch. 47 History of the medical profession; Ch. 55 The emergence of para-medical professions)

What characterized the structure of the traditional consultation? If we break a consultation into its component parts – history-taking, observation and examination, drawing up a differential diagnosis with accompanying prognosis, and treatment – we may claim that traditional physicians:

1 did fairly well in history-taking;
2 virtually omitted any kind of clinical investigation, in the sense of observing and examining the patient;
3 had almost no sense of differential diagnosis; and
4 did – by their own lights – spectacularly at treatment. (➤ Ch. 4 Medical care)

It is clear from eighteenth- and early nineteenth-century case histories that these doctors spent considerable time upon the past medical history of the patient and the history of the present illness; they hoped thereby to cast some light upon the patient's 'constitution'. As for the perfunctoriness of the clinical investigation, a still quite traditional physician, Bernhard Liehrsch of Dresden, advised colleagues in 1842 on the physical examination: 'You should never omit feeling the pulse, and looking at the urine and the tongue. These are the three matters to which every patient attaches value.' Do it even if unnecessary, he urged, so that you will not be accused of forgetting anything.[1] (➤ Ch. 35 The art of diagnosis: medicine and the five senses) The very nature of traditional medical nosology, which offered diagnoses in the form of descriptions of symptoms ('putrid malignant fever' and the like) meant that little differential diagnosis was occurring. (➤ Ch. 17 Nosology) There was no 'differential' list of competing diagnoses to be got through. Finally, the overwhelming therapeutic confidence of the traditional doctor rested upon endless lists of syrups, spirits, infusions, and extracts in a traditional pharmacopoeia, each with its own indications. The *Pharmacopoeia* of the Royal College of Physicians

of London of 1824, for example, mentions forty different tinctures, twenty-three spirits, and fourteen syrups, all based upon different plants.[2] These physicians believed they had tremendous therapeutic power at their disposal.

Familiar with plant parts though they may have been, traditional doctors enjoyed little social status in the eyes of their patients. An English surgeon-apothecary named Popjay had this sign in front of his house, 'I Popjay, Surgeon Apotecary [*sic*] and Midwife etc; draws teeth and bleeds on lowest terms. Confectionary Tobacco Snuff Tea Coffee Sugar and all sorts of perfumery sold here. NB New laid eggs every morning by Mrs. Popjay.'[3] These surgeon-apothecaries in Britain and their equivalents on the European continent were not seen as 'gentlemen', that is to say, they did not have Latin, the mark of the qualified physician. Looking back over a lifetime of medical practice, the German surgeon Georg Stromeyer (1804–76) wrote in 1875:

> The rights and privileges of a Doctor of Medicine were more fancy than fact in those days. It was hard to succeed even to the pretension of being considered as a man of good breeding, although Latin did help out some. My colleague [Adolph] Henke in Erlangen used to say, Latin was the only means of telling us apart from the barbers.[4] (➤ Ch. 48 Medical education)

As for aspiring to go to medical school, commerce was often seen as a preferable career choice. Elias Canetti (b. 1905), who grew up in a quite traditional Jewish community in Bulgaria, rememberd the opinions of his Uncle Solomon, whose own world-views had been forged many decades earlier, about the undesirability of medicine as a career. 'What are you going to do?' he asked young Canetti. Canetti's aunt volunteered, 'He wants to go to university.' 'Oh no way,' said Uncle Solomon, 'He's going to be a businessman.' The only member of the family who had gone into medicine, a cousin, had soon regretted it. 'A doctor doesn't earn anything,' said Uncle Solomon. 'He's the errand boy of the rich and has to come for every little thing, and then it turns out there's nothing wrong with the people at all.'[5] The Uncle Solomons of this world reflected the low opinion in which the doctor was traditionally held.

These traditional doctors often lived in a poverty as dire as that of the patients themselves. What were the prospects of becoming rich from medical practice in Germany? In 1804, Johann Rademacher (1772–1850) advised his fellow physicians that any doctors who looked prosperous had probably inherited money:

> But around here, even if you made so much that you could live from it, you still wouldn't be able to save anything. And then what will you live from when you get weak from age, or you get an ulcer on your foot or a hernia, or some

other condition which would keep you from horseback, or from travelling about, or from the privilege of immersing yourself in storm and tempest.

If you ask me how an impoverished physician is supposed to get on in this land and prepare himself for the future, I say, if you don't have any money marry a rich girl. If you're an ugly devil whom no one will have, maybe you can win the lottery a couple of times.

And if that failed, Dr Rademacher advised emigrating to America.[6] Unless one was a member of the medical élite, such as the Royal College of Physicians, and could profit from the consulting fees of the wealthy, the lowly income of the traditional physician corresponded roughly to his reduced status.

Lay people mixed into medical matters with a blithe disregard of 'medical authority'. Medical learning counted for little; for example, at the Julius Hospital in Würzburg early in the nineteenth century, lay administrators summoned the doctors to stand at attention alongside the servants. Anton Müller (1755–1827), the psychiatrist, recalled the obstetrician Professor Elias von Siebold (1775–1826) in full uniform and ceremonial dagger, lined up beside the chambermaids for inspection.

A certain clerical member of the hospital would come into the pharmacy, ask for the prescription books and page through them, indicating approval with a nod of his head or disapproval with a headshake. This individual even dared, after reading [Philippe] Pinel's work on the treatment of the insane, to draft a long set of guidelines about how the insane in our ward were to be treated.[7]

For their modest social standing these doctors paid the therapeutic price of patients' non-compliance. It was, perhaps, just as well anyway that patients often refused the courses of bleeding, vomiting, and purgation that represented the therapeutic armamentarium of traditional medicine. Yet frequent refusal to follow the doctor's orders indicates how little those orders meant in lay eyes. For example, physicians obliged to control the spread of epidemic disease late in the eighteenth century in Brittany deplored the reluctance of peasants to accept medical authority. In 1786, one rural physician, attempting to cope with malarial fevers in some provincial nest said, 'It happened often that patients omitted to use the prescribed medications nor did they want to use the emetics. Usually a stubborn constipation would ensue, followed by dropsy.'[8] Henry Sutler, who lived towards the middle of the nineteenth century in Pittsfield, Illinois, was one such disobedient patient, in the days when small-town frontier physicians such as Thomas Shastid (1866–1947) had improved but little in status. Shastid's son, a boy at the time accompanying his father on house calls, tells the story. Although Henry Sutler was a kind man and successful in business, his weak point was that 'he never liked

anybody to tell him what to do'. But when he came down with typhoid fever he had to obey his wife and his doctor, up to a certain point:

Then Henry Sutler's condition began to improve. Henry did not understand typhoid fever, but he thought that he did. After the fourth week, when he had no more fever and scarcely any pain, *he* informed *my father* that he was all right now, that he was going to get up shortly, dress himself and set about his work. [Shastid demurred and said Henry risked the danger of haemorrhaging from the bowels if he were to get up.]

Henry persisted. My father resisted. Henry begged his wife to bring him his shoes, his shirt, his trousers. Father told her not to bring them. [Unless Henry promised not to get up, Dr Shastid threatened to] gather up every particle of clothing that you have in the house, take it away home with me and burn it. [Henry promised.]

Father and I then went away happy. Scarcely, however, had we driven half a quarter when we heard behind us a woman's shrill screaming. Turning, we saw Mrs. Sutler standing on her front porch, crying and frantically gesturing to us to come back.

At the house again we arrived just in time to see Henry Sutler faint and fall to the floor. Yes, he was dead, and his trousers were full of blood.[9]

Beneath this non-compliance lay patients' fundamental disbelief in the doctor as a professional who understood the secrets of Nature. Two thousand years of traditional humoral diagnosis and therapeutics, with their consistently poor, counter-therapeutic results, had sapped the willingness of the population to believe implicitly in the enterprise of medicine itself. For the traditional patient, therefore, access to medicine meant really procuring a prescription for some complex purgative the patient could not compound or as a last desperate resort in terminal illness.

THE MODERN PERIOD

What distinguishes the modern from the traditional period is the establishment of patho-physiology in the nineteenth century as a *method* of investigation – in contrast to being yet another doctrine, or 'school'. In the nineteenth century, three crucial events infused the scientific method into the practice of medicine.

First, the clinical investigation started to become both art and science, in the form of percussion, palpation, and auscultation, permitting the physical examination of the patient to go beyond merely looking at the tongue and urine, and feeling the radial pulse. Although the description of percussion technically belongs to the Viennese physician Leopold Auenbrugger (1722–1809) in 1761, the components of the physical examination were really only put into practice early in the nineteenth century by the Parisian clinical school, of which René Laënnec (1781–1826) was the most notable member.

It is interesting to contrast the traditional dismissal of the physical examination with the method of Professor Franz Volhard (1872–1950) of teaching medical students to examine patients in the Frankfurt university clinic in the early 1930s. One young staff-member later recalled that at first in the session students were not permitted to touch the patients at all, merely to say what they observed by looking at them:

> After the students had observed the most minute details, including the pulse of the carotid and the appearance of the nail-bed, and duly described what they had seen, they were allowed to feel the radial pulse. After they had seen asymmetries in the expansion of the chest, they were permitted to feel the circumference of the ribs.... It was quite extraordinary to experience the varieties of tactile sensation. There was, quite aside from the world of sight, an entire world of touch which we had never perceived before. In feeling differences of radial pulse you could train yourself to feel dozens of different waves with their characteristic peaks, blunt and sharp, steep and slanting, and the corresponding valleys. There were so many ways in which the margin of the liver came up towards your palpating finger. There were extraordinary varieties of smell. There was not just pallor but there seemed to be hundreds of hues of yellow and gray.[10]

It was an added benefit that the modern physician, in this kind of observing and examining, also established a close physical rapport with the patient.

A second contribution was the development of the science of pathological anatomy which, in combination with the close clinical observation of patients ante-mortem, would make possible the accurate diagnosis of disease, replacing traditional symptomatic diagnoses. Notable milestones in the unfolding of the science of pathology were the refinement of the microscope in the 1820s, the introduction of the microtome by C. M. Topping in the 1840s, and the discovery of various histological stains, notably haematoxylin from the heartwood of the American *Haematoxylon* tree in 1865 and eosin from aniline dye in 1876.[11] (➤ Ch. 6 The microscopical tradition) Accurate clinical data, together with microscopic pathological findings, resulted in the 'anatomical-clinical method', which was the great motor of progress in clinical medicine during the nineteenth century. Although this great accumulation in knowledge of pathological anatomy caused little improvement in therapy, it did establish the image of the physician as a scientist, able to give patients a reliable diagnosis and prognosis. (➤ Ch. 9 The pathological tradition)

Finally came the germ theory of disease late in the century, putting an end to centuries-old notions about 'miasmas' and 'evil west winds'. (➤ Ch. 15 Environment and miasmata) The diagnostic capabilities of medicine advanced enormously with the science of microbiology. Establishing that symptoms resulted from infection, and then being able to differentiate microscopically and with serum cultures among the varieties of infective organisms, represented a leap towards science comparable to the introduction of the anatomical-clinical method early in the century. (➤ Ch. 11 Clinical research) The discovery by Robert Koch (1843–1910) in 1882 of the bacillus that caused tuberculosis was the main scientific landmark in establishing microbiology. But the demonstration by Louis Pasteur (1822–95) of the therapeutic effectiveness of the rabies vaccine in 1885 and the preparation by Emil von Behring (1854–1917) of the diphtheria antitoxin in 1890 confirmed in the public mind the status of the doctor as a scientist who could actually cure disease. (➤ Ch. 16 Contagion/germ theory/specificity)

The result of these three advances – the clinical examination, pathological anatomy, and microbiology – was to place medical diagnosis upon a scientific footing. By the end of the nineteenth century, the doctor could, for the first time in history, diagnose successfully the most important disease conditions of humankind. Similarly, the doctor was in a position to make reasonably confident prognoses of the disease course, now that tuberculosis had been differentiated from pneumonia, typhus from typhoid fever, and so forth. (➤ Ch. 19 Fevers; Ch. 36 The science of diagnosis: diagnostic technology)

In therapeutics, the gains from infusing science into medicine were modest: a handful of new vaccines; salvarsan for syphilis patented in 1909 by Paul Ehrlich (1854–1915); and a scattering of sedatives and analgesics. Quinine for malaria and digitalis for congestive heart failure were already present in the pre-1850 pharmacopoeia (or rather, the plants from which they were extracted were present). The gains which these few new drugs represented did greatly impress the public, but their limited nature must be emphasized. In view of the vast gamut of bacterial and viral infections that remained untreatable, in view of the array of degenerative diseases such as arthritis, coronary artery disease, and cancer whose palliation was scarcely possible, the 'therapeutic nihilism' of the late nineteenth century was not unjustified. (➤ Ch. 20 Constitutional and hereditary disorders; Ch. 25 Cancer)

How did the structure of the modern medical consultation differ from the traditional? The modern consultation may be characterized as:

1. excellent in history-taking, for the anatomical-clinical method attached great importance to the chart, the course of the illness;
2. excellent in clinical investigation, especially in the physical examination of the patient;
3. excellent in diagnosis, genuine differential diagnoses organized about elucidating a 'chief complaint' appearing now for the first time;
4. terrible in therapeutics, there being few effective medications. (➤ Ch. 67 Pain and suffering)

The new scientific basis of medicine lent enormous prestige to the physician in the eyes of the patient. First, the physical examination encouraged a laying-

on of hands, a gesture with ritual as well as practical import, suggesting to the patient that he or she was being cared for. Establishing this kind of physical rapport became almost a code of honour with the physicians of a certain generation. Michael Lepore (b. 1910), a New York internist, looked back at this clinical style as taught before the Second World War at the College of Physicians and Surgeons at Columbia University: 'Who will ever forget having witnessed the aristocratic and fastidious Hugh Auchincloss Sr (1878–1947), Professor of Surgery at Columbia Presbyterian, clearing a patient's "intestinal obstruction" on rounds by rolling up his gold cuff-linked shirtsleeves and digging out by hand, a large fecal impaction!'[12] The men of his generation – there were as yet few women – attached great importance to communicating to the patient a physical sense of care.

Second, pathological anatomy, whose source of knowledge is the laboratory and the autopsy suite, may not greatly have affected the psychodrama of the doctor–patient relationship. But it did generate a public image of the doctor as a scientist poring at all hours over his heavy tomes. This image was used to great effect by the drug companies in the 1920s and 1930s in advertisements featuring, not various prescription drugs ('ethical specialties'), but clean-shaven, lantern-jawed physicians reading the latest pathology journals at a time of night when the rest of the population was at play.[13]

Third, the science of microbiology had a great effect upon opinion. After the drama of the rabies vaccine in 1885, Louis Pasteur (1822–95) started to become a household name. The work of Paul de Kruif (1890–1971) published in 1926, *Microbe Hunters*, inspired a whole generation with the nobility of microbiology as a calling. On its title-page stood the quotation, 'The gods are frankly human, sharing in the weaknesses of mankind, yet not untouched with a halo of divine Romance.' The 'gods' were the physicians![14] As for 'germs' themselves, their impact upon public consciousness is evident in the neurotic vogue of the 1920s for opening door-handles with pieces of tissue and indulging in compulsive hand-washing. Without the prestige of 'medical science' in the background, the neuroses driving these deformed precautions would have taken other forms.

The image of the physician as a demi-god possessed of boundless authority over patients dates from the late nineteenth century. Female patients, for example, became willing to submit to pelvic examinations and to give birth in the lithotomy position mainly because they had acquired an implicit belief in the doctor as a scientist. (➔ Ch. 38 Women and medicine) As Worthington Hooker (1806–67), a physician in Norwich, Connecticut, and later a professor at Yale, said in 1849, the doctor acted not merely as clinician but as a 'confidential friend'.

> If he has been the physician of the family for any length of time . . . this feeling

> of affectionate reliance is deep and ardent; so much so that it is a severe trial to the sensitive mind to be obliged to consult a stranger. . . . Especially this is so when the patient is a female.[15]

Similarly, doctors in the modern period often involved themselves in counselling patients in intimate problems, indeed presuming to advise society as a whole in a wholly unfamiliar extension of this new medical authority.

The great irony of the modern phase of the doctor–patient relationship is that the prestige of the doctor rested not upon his improved ability to cure, but rather to understand disease and to establish an accurate prognosis. Nineteenth-century physicians cast their therapeutic helplessness in the Viennese doctrine of 'therapeutic nihilism', the view of both Joseph Skoda (1805–81) and Carl Rokitansky (1804–78) that doctors did far better in investigating basic disease mechanisms than in curing. Psychoanalyst Fritz Wittels (1880–1950), reflecting about his medical training in late nineteenth-century Vienna, wrote:

> In contradistinction to the naive faith of the romantic epoch, the medical school in Vienna fostered a notorious nihilism in therapeutics. . . . The order of the day was to cleanse the temple of science of superstitions, some of them thousands of years old. Such a cleansing had to precede any scientific therapy of the future.[16]

But the lecturers did ignore therapeutics. 'They frequently seemed to forget that sick people want to regain their health.[17]

Because therapeutic horizons were so limited, these modern physicians needed everything they had going for them, and that meant relying therapeutically upon the psychological dimension of the doctor–patient relationship, trying with the force of the doctor's personality, and the quality and closeness of concern, to 'suggest' the patient into a cure. This is why modern doctors were so mindful of the notion of the 'great physician', the commanding personality whose bedside manner worked in and of itself, in the words of Michael Balint, 'as a pill'.[18] One thinks of such well-known internists and neurologists as Hermann Nothnagel (1841–1905) and Carl von Noorden (1858–1944) in Vienna, Jean-Martin Charcot (1825–93) in Paris, Hermann Weber (1823–1918) and his son Frederick Parkes Weber (1863–1962) in London, and Silas Weir Mitchell (1829–1914) the inventor of the 'rest cure', in Philadelphia. None of these physicians could do much for patients but prescribe placebos and send them off to spas, yet all possessed powerful personalities and were acknowledged in their day to be great healers.

From these turn-of-the century internists and neurologists we first encounter admonitions to 'treat the patient as a person', meaning to consider the patient's personal history and social situation in diagnosing and treating organic disease. Valentin Holst (1839–1904), a neurologist with forty years of experience, said in 1897, that one had to treat the whole person:

> And the patient must be able to feel this. He should approach the physician with a feeling of trust, he should have the confident feeling of being entirely understood by his doctor. It is precisely these patients who suffer most from the feeling that [no one understands them].[19] (➔ Ch. 43 Psychotherapy)

What gave doctors of this modern period their distinctive therapeutic skill was the ability, based on the patients' implicit confidence in 'science', to inspire them into a cure. Although increasing the patient's morale plays a role in treating all disease conditions, the inspirational aspects of the doctor–patient relationship were especially important in the treatment of the psychogenic physical symptoms associated with 'hysteria' and 'neurasthenia'. Somatizing patients often benefited from the opportunity to experience a 'catharsis' in the presence of a respected figure. And the modern doctor's newly acquired social status had resulted in such respect.

There is much evidence that somatizing patients obtained relief from the sheer opportunity to tell the doctor their stories at their own pace (rather than responding to a series of 'yes–no'-style questions). Already at the end of the eighteenth century, this was clear to forward-looking physicians such as Jacob Isenflamm (1726–93), Professor of Medicine at Erlangen:

> Not without reason does one give patients full reign to tell their stories. It is the more important for patients [with psychological problems] that precisely this manner of letting them ramble on about their histories and leaving nothing out – sometimes even putting the whole affair down on paper then reading it aloud to the doctor – be allowed, for in doing so they believe they receive marked relief.[20]

Although not unknown in traditional medicine, this cathartic benefit of the consultation was more commonly obtained in the modern style of medical practice. John Horder (b. 1919) recalled in 1967, 'My partner, Dr M. Modell, had a classic example of a quick consultation: a woman came for the first time, sat down, began to cry, did so for four minutes, said "Thank you, doctor, you have helped me a lot" – and left.'[21] This kind of confidence is conferred only upon physicians whom patients regard as healers.

THE POST-MODERN PERIOD

The post-modern period is characterized by an overweening confidence on the physician's part in medications which, for the first time in history, really do heal or ameliorate a vast range of disease conditions. It is this confidence that makes the psychological benefits that flow from the consultation seem secondary. But post-modern patients respond to what they perceive as the physician's lack of interest with anger and withdrawal, ultimately with malpractice suits and recourse to alternative healers.

The advent of drugs that could cure a wide range of disorders began in 1935 with Prontosil, or benzenesulphonamide. The first of the sulpha drugs, it gave way to a cascade of medications for bacterial infections. Penicillin, for example, became available to the civilian population in 1945. These new drugs enabled physicians to treat successfully such nightmares of previous medical practice as post-partum sepsis, and vastly reduced the mortality from bacterial disease. (➔ Ch. 39 Drug therapies)

The success of these 'wonder drugs' prompted research into biochemical and pharmacological mechanisms, as opposed to pathological anatomy, which had dominated the previous period. A whole new line of scientific investigation, beginning with biochemistry and terminating in clinical applications in the field of internal medicine, thus opened up. (➔ Ch. 8 The biochemical tradition) The post-modern period therefore may be said to have begun as this new line of biochemistry/internal medicine started to be taught in medical schools in the years after the Second World War. For only via the medical schools would it truly be introduced into medical practice. The dominant approach to medical education in the 1950s was to treat medical students as mini-scientists rather than as physicians-to-be. This tilt towards science in the curriculum was rationalized on the grounds that the physician must understand the scientific mechanisms underlying the drugs prescribed. (This apparently sensible rationale ignored the realities that, first, it is not at all necessary to understand basic metabolic pathways in order to prescribe successfully; and second, most doctors forget this information anyway after they leave medical school.) The impression thus arose in medical education that 'legitimate' symptoms stemmed only from organic diseases, the mechanisms of whose biochemistry and whose pharmacological treatment may be understood and memorized. Other kinds of symptoms were deemed to come mainly from 'crocks', and were really most suitable for the psychiatrist to treat. (➔ Ch. 56 Psychiatry)

Thus, in the 1950s, a new generation of ultra-scientifically trained physicians, truly prepared to take on the classic killers of humankind, burst into the doctor–patient relationship. For this generation, most of that 'psychological stuff' had been dismissed. The great internist of Columbia University, Robert Loeb (1895–1973), coolly pronounced its last rites in 1953, when he complained to the administration that he had heard enough about training pre-meds in 'social sciences' and experimental 'home care programs in which medical students would participate even during their first year'. From now on at Columbia, only standards of 'the highest possible scientific level' would prevail.[22]

How did this new emphasis upon disease mechanisms affect the consultation? For one thing, it precipitated a loss of interest in the whole 'patient-as-a-person' approach, which had hallmarked much of medicine before the

Second World War. The doctor did not now have to exhibit interest in the patient's overall life, given drugs that really cured disease. It must be emphasized that it was the *appearance* of caring that tended to be withdrawn. It would be ridiculous to argue that doctors actually became somehow less caring or less humane, since the character attributes of physicians have probably not changed over thousands of years. Merely the show of concern, the stage presence of a trained physician, came to seem less therapeutically important, simply because the doctor now handed out effective medications.

For another thing, advances in clinical investigation since the Second World War entailed the downgrading of careful history-taking and physical examination. Patients once experienced a catharsis in being able to tell their stories at their own pace, and felt a thorough physical examination to be an expression of the doctor's concern for them. With the advent of such post-modern techniques of investigation as computerized blood tests, computerized tomography scans, magnetic resonance imaging, and ultrasonography, old-fashioned percussing, palpating, and auscultating seemed increasingly irrelevant, for the new techniques yielded far more information. The 'history' too became downplayed, and letting the patient talk was perceived as a waste of the busy physician's time. (➔ Ch. 68 Medical technologies: social contexts and consequences)

The structure of the post-modern consultation may accordingly be classed as:

1 limited to an impatient and abbreviated style of history-taking;
2 cursory attention to physical examination while giving painstaking attention to laboratory data and diagnostic imaging;
3 concern with differential diagnosis unchanged;
4 enormous therapeutic power by the standards of double-blind controlled studies.

One of the great ironies of the social history of medicine is that, at the supreme moment of achieving this therapeutic power, the crown of glory was snatched from the doctor's head. In the last quarter of the twentieth century, as an ever-broader stream of antibacterial, anti-inflammatory and antineoplastic medications became available, patients became increasingly alienated from the former 'demigods in white'. Recent statistics illustrate these changes. For example, rising numbers of malpractice suits point to growing alienation: one half of all surgeons in Florida had been sued for malpractice within the period 1975–80, and the better trained the surgeons were, the greater the number of suits.[23] Between 1975 and 1985, claims per 100 physicians in the United States as a whole more than doubled. Some specialities were exceedingly vulnerable: over the five-year period 1976–81, claims against obstetricians tripled. The average claim itself climbed from $18,000 in 1975 to

almost $100,000 in 1988.[24] (➔ Ch. 69 Medicine and the law; Ch. 37 History of medical ethics)

Second, patients responded to their perception of physicians' coolness and lack of interest with a lack of loyalty. Several different American polls commissioned in the mid-1980s found that two-thirds of all patients would be willing to 'change their provider in an attempt to find more satisfactory medical care'.[25] One contrasts this high volatility with patients in the days before the Second World War who, with their families, would often develop lifelong attachments to the same family doctor.

The whole persona of the 'family doctor', the elderly pipe-puffing figure present both at birth and death, is now disappearing, both in fact and in the minds of patients. In the United States in 1988, only slightly more than one doctor in ten was in 'general family practice'.[26] Nor were American patients particularly interested in the advice of their physicians: the percentage of patients willing to use the family doctor as a source of 'local health care information' declined from 46 per cent in 1984 to 21 per cent in 1989.[27] How did families select which hospital to attend? More than 50 per cent of patients polled in 1989 said that 'they or their family have the most influence in selection of a hospital' – as opposed to listening to the doctor – up from 40 per cent in previous years.[28] (Non-American readers will recall that private American hospitals compete for patients.)

This alienation from the doctor–patient relationship has diminished the public's former hero-worship of the doctor. According to a Gallup poll in 1989, 26 per cent of patients said they respected doctors less now than ten years ago (14 per cent said more). And of those who respected doctors less, 26 per cent said, 'they [the doctors] are in it for the money'. Seventeen per cent claimed that doctors 'lack rapport and concern'.[29]

Alienation is also apparent in a flight to alternative therapies such as naturopathy, iridology, reflexology, and the like. Lacking any scientific basis, these represent a return to the eighteenth century, when all therapies, medical and non-medical alike, were based upon anecdotal results rather than quantitative demonstrations of efficacy. For example, in the United Kingdom: in 1981, alternative practitioners were 27 per cent as numerous as the total number of general practitioners; the number of acupuncturists doubled between 1978 and 1981; and the consultation of such non-orthodox practitioners increased by 42 per cent from 1981 to 1985.[30] (➔ Ch. 28 Unorthodox medical theories)

Post-modern physicians, wounded and estranged by this lack of patient trust, often respond with a similar emotional withdrawal from the doctor–patient relationship. In a nationwide American survey in 1989, 63 per cent of the physicians polled said they felt their control over patient treatment decisions had decreased (up from 54 per cent in 1987). In the same poll,

four doctors in ten said they would be unlikely to go to medical school if they had their lives over again, and only one in four said that he or she would definitely go.[31] A decline of 23 per cent in the number of applicants to American medical schools between 1978 and 1987 suggests that fewer young people look forward to being doctors.[32]

Thus, at the very moment of triumph, the post-modern doctor is rewarded with snarls of rage rather than praise from the patient. What lies behind this paradoxical reaction? Most important, in my opinion, has been the effect of the media on patients' knowledge of medicine and medical practice. In former times, patients acquired their medical knowledge from the experience of their families and communities. Within this rather folkloric knowledge base, the image of the doctor as kindly general practitioner, with an office piled high with books of learning, loomed prominently. The knowledge base of the post-modern patient, by contrast, is heavily informed by the media. Family and community sources of information recede. The world-view of medicine that patients receive from the media is a highly Manichean one, in which the miracle of virtually eternal life through Medical progress is extended on the one hand, horror stories of malpractice brandished on the other. Unlike family or village knowledge, medical knowledge disseminated in the post-modern world is assessed by editors primarily by its sensational value. It is this sensationalizing of all medical stories that creates a climate in which any unfavourable outcome is seen as the incompetent denial of the hope proffered in the press. Thus a flood of malpractice suits, eroding the goodwill between doctor and patient, is the result.

One may read this larger chronicle of changes in the relationship between doctor and patient in two ways. One group of scholars has been inclined to see these changes as evidence of 'medicalization', arguing that the autonomous attitude of traditional patients towards their bodies and their healthy collaboration with non-professional healers became replaced by a toxic kind of hero-worship in which patients sacrificed their own judgement to place themselves in the thrall of the experts. This disdainful assessment of the physician's increasing role in patients' lives thus sees them as ever more passive objects of professionalization. The account offered in this chapter is flavoured, of course, by quite different value judgements, interpreting the doctors' growing influence upon the patients as positive, and celebrating the scientific basis of modern medicine. I would modify the received wisdom on medicalization in two ways.

First, one forgets how much power the patient has in the doctor–patient relationship when choice among physicians prevails. Rather than being a passive recipient of authoritarian medical commands, the patient has beliefs that set limits on the range of procedures and medications available to the doctor. The post-modern triumph of the consumers' movement in obstetrics

offers an example, forcing doctors to admit husbands to the delivery suite and to desist from automatically administering analgesia and anaesthesia.[33] A historic example was the shift in psychiatric terminology from 'mental disease' to 'nervous disease' at the end of the nineteenth century, as wealthy patients, dreading the familial stigma of insanity, insisted on their symptoms being seen as an organic affection of the nevous system.[34] (➔ Ch. 21 Mental diseases)

The rapport of forces in the doctor–patient relationship is the result, in other words, of the play between medical supply and patient demand. Science-driven changes in technology, pharmacology, and concepts of pathophysiology affect the supply, or what doctors wish to offer. Larger cultural and social trends affect the demand, or what patients are willing to accept. As George Bernard Shaw said in his preface to *The Doctor's Dilemma* in 1911:

> [Doctors] must believe, on the whole, what their patients believe, just as they must wear the sort of hat their patients wear. The doctor may lay down the law despotically enough to the patient at points where the patient's mind is simply blank; but when the patient has a prejudice the doctor must either keep it in countenance or lose his patient. If people are persuaded that night air is dangerous to health and that fresh air makes them catch cold, it will not be possible for a doctor to make his living in private practice if he prescribes ventilation.[35] (➔ Ch. 65 Medicine and literature):

Second, the modern style of medical practice may be said to have offered some therapeutic benefits for the patient. The distinctive accomplishment of the modern doctor was the ability to relieve psychogenic conditions, or somatization. Lacking an organic basis, such complaints responded to the informal kind of psychotherapy conferred by the doctor–patient relationship itself. Such somatoform problems represent at least 30 per cent of all complaints seen in primary care today.[36] Only one person in ten in the general population does not experience symptoms in a given two-week period, and the average adult has fully four symptoms of illness on one out of every four days.[37] Stripping the doctor–patient relationship of its intrinsic healing qualities in the post-modern period cannot be said to represent a therapeutic advance in the management of such complaints.

NOTES

1 Bernard Liehrsch, *Bilder des ärztlichen Lebens, oder: die wahre Lebenspolitik des Arztes für alle Verhältnisse*, Berlin, 1842, p. 148.

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5 Elias Canetti, *Die gerettete Zunge: Geschichte einer Jugend*, Frankfurt, Fischer, 1977, pp. 234–5.
6 Johann Gottfried Rademacher, *Briefe für Ärzte und Nichtärzte über die Aftermedizin und deren Nothwendigkeit im Staate*, Cologne, [1804], pp. 89–90.
7 Anton Müller, *Die Irren-Anstalt in dem königlichen Julius-Hospitale zu Würzburg*, Würzburg, 1824, p. 61.
8 Quoted in Jean-Pierre Goubert, *Malades et Médecins en Bretagne, 1770–90*, Rennes, Université de Haute-Bretagne, 1974, p. 232.
9 Thomas H. Shastid, *My Second Life*, Ann Arbor, MI, G. Wahr, 1944, pp. 226–7.
10 Karl Stern, *The Pillar of Fire*, New York, Harcourt, Brace, 1951, pp. 102–3.
11 W. D. Foster, *A Short History of Clinical Pathology*, Edinburgh, Livingstone, 1961, p. 20, *passim*.
12 Michael J. Lepore, *Death of the Clinician: Requiem or Reveille?* Springfield, IL, C. C. Thomas, 1982, p. 272.
13 Such drug companies as Merck and Parke-Davis ran numerous such advertisements in the American Medical Association's popular magazine *Hygeia* in the 1920s and 1930s.
14 Paul de Kruif, *Microbe Hunters*, New York, 1926. The chapter on Walter Reed was subtitled, 'In the interest of science – and for humanity!' (p. 311).
15 Worthington Hooker, *Physician and Patient*, New York, 1849, p. 384.
16 Fritz Wittels, 'Freud's scientific cradle', *American Journal of Psychiatry*, 1943–4, 100: 521–8, quote on p. 522.
17 Ibid.
18 Michael Balint, *The Doctor, his Patient and the Illness*, rev. edn, New York, International Universities Press, 1972; orig. pub. 1957.
19 Valentin Holst, *Erfahrungen aus einer vierzigjährigen neurologischen Praxis*, Stuttgart, 1903, p. 24; reprint of a lecture given in 1897. See also George Canby Robinson, *The Patient as a Person: a Study of the Social Aspects of Illness*, New York, 1939; Francis Weld Peabody, *The Care of the Patient*, Cambridge, MA, 1927.
20 Jacob Friedrich Isenflamm, *Versuch einiger praktischen Anmerkungen über die Nerven zur Erläuterung . . . hypochondrisch- und hysterischer Zufälle*, Erlangen, 1774, p. 182.
21 John Horder, 'The role of the general practitioner in psychological medicine', *Royal Society of Medicine, London, Proceedings*, 1967, 60: 261–70, quote on pp. 267–8.
22 Robert Loeb and Dana W. Atchley, letter, *Journal of Medical Education*, 1953, 28: 87–8.
23 Frank A. Sloan *et al.*, 'Medical malpractice experience of physicians: predictable or haphazard?', *Journal of the American Medical Association*, 1989, 262: 3291–7, quote on p. 3291. Some of these statistics are also cited in the new preface of Edward Shorter, *Doctors and Patients in Historical Perspective*, New Brunswick, NJ, Transaction Books, 1991.
24 Peter Jacobson, 'Medical malpractice and the tort system', *Journal of the American Medical Association*, 1989, 262:, 3320–7.
25 Cited in Alan H. Rosenstein, 'Consumerism and health care: will the traditional

patient–physician relationship survive?, *Postgraduate Medicine*, 1986, 79: 13–18, quote on p. 16.
26 *New York Times*, 18 February 1990, p. 20.
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28 Ibid., p. 42.
29 American Medical Association, *Surveys of Physicians and Public Opinion*, Chicago, IL, American Medical Association, 1989; Commissioned Gallup pol. These data represent a continuation of trends that had begun at least as soon as the early 1980s. See George D. Lundberg, 'Medicine – a profession in trouble?', *Journal of the American Medical Association*, 1985, 253: 2879–80; on survey data for the years 1982–5 showing declines in the percentage of the public who believe that 'physicians explain things well', and that 'physicians' fees are reasonable'.
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31 op. cit. (n. 29). American Medical Association, Doctors were asked 'whether they would go to medical school if they were in college now, knowing what they now know about medicine'. Fourteen per cent said they would definitely not go, and 25 per cent said they would probably not go.
32 Victor R. Neufeld *et al.*, 'Optimal outcomes of clinical education', in Barbara Gastel *et al.*, (eds), *Clinical Education and the Doctor of Tomorrow*, New York, New York Academy of Medicine, 1989, p. 13.
33 As evidence of this change see Iain Chalmers, Murray Enkin and Marc J. N. C. Keirse (eds), *Effective Care in Pregnancy and Childbirth*, 2 vols, Oxford, Oxford University Press, 1989.
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THE ART OF DIAGNOSIS: MEDICINE AND THE FIVE SENSES

Malcolm Nicolson

> . . . having entered the sick room the physician should view the body of the patient, palpate it with his hands, and enquire about his complaint . . . the five sense organs of hearing, touch, sight, smell and taste, as well as oral inquiry, materially contribute to a better diagnosis.
>
> (*Súsruta Saṃhitā*)

The term 'diagnosis' may refer to the identification of the specific disease from which an individual is suffering. Or it may have a more general meaning, as in the above quotation, referring to the overall process of consultation and inquiry whereby the problems which the patient presents to his or her medical attendant are elucidated.[1] It is a truism to say that, in the latter sense, diagnosis has always been a central element of the practice of medicine. However, the particular means by which medical attendants address the problems of their patients have varied from culture to culture and from one historical era to another. In one society, the identification of disease may be accomplished by a formal interrogation of the spirit world;[2] (➔ Ch. 60 Medicine and anthropology) in another, by the sending of samples of tissue to a diagnostic laboratory. Even within the mainstream of Western medicine there has been much temporal and geographical variation in how the challenge posed by the need to diagnose has been addressed. Moreover, what the doctor does at the bedside of the patient tells us a great deal about the status and power of the practitioner and about the social context within which medical knowledge is produced.[3] The history of diagnosis is thus an important aspect of the wider history of patient–practitioner relationships. The purpose of this essay is to provide a broad overview of the changing character of diagnostic practice,