Personal View

When we tell a doctor that we have been having pains—in what cases is it useful for him to imagine pain?

When Wittgenstein put this question to himself he was teasing an old philosophical puzzle; whether, and in what ways, we can understand the pain of others. Philosophers have always wondered how you could be sure that someone else was in pain. The rather silly paradox "I have a pain in your leg" illustrates the difficulty; not a proposition that a doctor would have much time for. Although he is expected to have compassion, his preoccupation is not with the verification of the symptom but with the discovery of its cause, and to try and imagine a pain is to waste precious time better devoted to detached thought about why it is there—in short—about the diagnosis.

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This is undoubtedly a good thing. From the doctor's point of view a patient without a diagnosis is worse than one with the wrong diagnosis. This is because a diagnosis gives you an immediate plan of action: bed rest, penicillin, surgery, no treatment, hypnosis, or whatever it is. The primary clinical urge is gratified even if little is known about the disease or if the available treatment is unsatisfactory or non-existent.

A disadvantage of the diagnostic process is that it leaves out an awful lot about the patient. It is bound to, because what you are doing is putting a label on someone, not writing their biography. But if a doctor thinks that his only duty is to administer the treatment that the diagnosis dictates he is mistaken. He has to consider other things that the patient needs from him —for example information and guidance. This is not such a problem if you are ready to make more than one diagnosis. Working in a geriatric unit I was struck by the fact that not many patients were admitted with fewer than three. It is a fine ideal to try and fit all the symptoms to one disease process but it must not be compulsory. Instead, the rule should be: have the minimum number of diagnoses, and they need not refer strictly to a lesion. A typical heading on the geriatric case sheet would be (1) multiple cerebrovascular accidents, (2) social admission, and (3) faecal impaction. The fact that each of these is regarded as a diagnosis has some novel consequences. It means that we can go straight ahead with an enema to get things moving and not get too excited about the precise neurological lesion causing the patient's disability. We are bound to think about where the patient comes from and about where he is going. Where I worked the medical social worker frequently arranged the admission of an old person who had just been bereaved or whose devoted children needed a holiday. Social admission is a compassionate diagnosis, if you like, but it is based on a thoughtful assessment of facts not of feelings.

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But to get back to Wittgenstein; here then is a situation (that is, making a diagnosis) in which it is not very useful to imagine a symptom, because there is some cool thinking to be done. Just the opposite applies when we are in danger of not making a cool appraisal of a patient, namely in a case of hysteria. There is something very irritating about hysterical symptoms; indeed it is just this reaction that can arouse suspicion of that peculiar condition. I recently saw a man sent to hospital by his general practitioner, allegedly suffering from an acute paraplegia, having previously been in good health. The picture was certainly not convincing. In the first place he said it had happened before, and certainly he did not look very surprised. Secondly, he smelt of beer. Before examining him I asked him to get out of bed and sure enough he got up and walked, in a rather wobbly fashion. I was furious and rushed out of the ward saying the man was drunk and, furthermore, not paralysed. I was speaking to a colleague, but rather loudly, and the man's relatives were unfortunately standing behind.

The point about this is that I was being unsympathetic. Freud, lecturing in Massachusetts in 1909, said "But all his [the doctor's] knowledge, his training in anatomy, in physiology and in pathology—leaves him in the lurch when he is confronted by the details of hysterical phenomena. He cannot understand hysteria, and in the face of it he is himself a layman. This is not a pleasant situation for anyone who as a rule sets so much store by his knowledge. So it comes about the hysterical patients forfeit his sympathy." I cannot think of a more pressing indication for a doctor to imagine his patient's symptoms than in a case of hysteria because he will otherwise not believe them, even though to the patient they are quite real. In this case the patient was not drunk, and really had been paralysed when the G.P. saw him. In hospital, however, there were no abnormal physical signs to be found. The patient told me with great deliberation how, after an explosion in 1944, he had sustained fractures of his "first, third, and fourth lumbar vertebrae." He was receiving a war pension for this and his wife indicated that it was not nearly enough anyway and that it was going to be reduced in February, 1971. This was apparently not so, as the daughter-in-law explained to me. The old couple had been informed of the change of the pension to decimal money and had assumed that the new figure represented a reduction of the amount. I made a tentative diagnosis of decimalization paraparesis—perhaps the only case ever recorded.

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The doctor's ability to sympathize might impress his patients above all else, but his own priorities are different. Motivation to succeed in medicine seems to come from a desire not to make a fool of yourself in the eyes of other doctors. The mark of a good doctor is that "he doesn't miss a thing." This means making all the right diagnoses, irrespective of whether the conditions so discovered are treatable or not. Of course, he is not to be blamed for the diseases he treats (at least not for all of them) but it is a pity that curing patients, or even pleasing them, earns so little applause. Another criterion of excellence is knowledge; again, the object is not to impress the *patient* with your grasp of the latest information from the journals but to introduce the matter within his hearing and discuss it loudly across the bed. It is essential to be brief and to number items of evidence. Use of the fingers in doing so adds emphasis. It is easy to impress colleagues with knowledge that they do not possess, but the great pitfall is to misquote an article that someone else has read correctly.

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If some of these seem cynical comments it is because they are based on only a few months' experience in hospital medicine after years of high-minded theorizing as a student. They are not really so unfair. I do not think that a complete altruist would succeed in professional medicine because too much of the individual's work is other-doctor related rather than patient-related, and without ambitions one might easily give the whole thing up as too hopelessly difficult. I suppose doctors need to compete for the same reason that people adrift on a lifeboat need to sing.

SEBASTIAN KRAEMER
House Officer

Glasgow