Letter from . . . Chicago

Care and confidence

GEORGE DUNEA

In our caring society available services range from child care to dog care and from hair care to foot care. Caring for health may be plain and without frills, or delivered—as in health care delivery. It is usually deemed to be primary or tertiary, but for some strange reason it is never secondary. Caring is also done by nurses, and may even take the form of primary nursing care.

Primary nursing thrives best in the fashionable teaching hospital that often looks like a new Hyatt hotel. Imagine just having had surgery at Éliteville. You are full of aches and pains and wind, your arms are immobilised by infusions and monitor wires, it hurts to move, let alone to turn over. "Hi, I'm Collette," says your primary care nurse, pretty, well groomed, looking rather like the receptionist at Le Bistro restaurant. She sports an immaculate white uniform and swings a pink stethoscope from which dangles a teddy bear. She takes your vital signs and vanishes. Most likely she is at the nursing station writing you up in her care plan, voluminous biographical reams of it. Ever so superior to the licensed practical nurses, who did nothing but bedside nursing and fortunately were done in during the latest lay off. She "delivers" total professional care. Meanwhile you are left to fend for yourself in your room, uncomfortable, in pain, and out of luck.

But should you be sick enough to "deserve" admission to intensive care your experience will be different. The machinery may not do you much good but the nurses will. They will rub your back, make your bed, monitor your heart, adjust your respirator, and telephone the doctor to remind him that you need more potassium. Nurses also work hard in the financially endangered hospitals where so many staff have been laid off that they have to act as clerks—answering telephones and filing laboratory slips—as dietitians, as nursing aids, even as transportation workers. Some surgical nurses now even push patients in and out of the operating room, or wield the occasional broom. But meanwhile Collette writes her extensive care plans, serenely oblivious of the buzzing intercom call buttons or of the inconsiderate patients who keep activating them.

Yet we should not be too hard on the Collettes. They are beautiful people, as they say here, and they have had a wonderful education. They went to nursing college for four years but may not know how to rub a back if they saw one. Besides, they are up against a lot. The layout of the hospital is against them. How on earth can you do bedside nursing when the patients are scattered in private rooms along a corridor half a mile long? The bureaucrats are against them because every little thing must be documented. Even their age is against them. In the old days the bedside care would have been done by the nursing trainees, strong enthusiastic teenage girls whose backs did not ache and whose heads were not befuddled by all that stuff about potassium and professionalism. In a way even the patients are against them: sick, frightened, regressed, demanding, in pain, too heavy, hard to lift, hard to please.

Traditionally, patients are also hard to please about their doctors—perhaps more so in an age of unlimited expectations. Even doctors, when temporarily assigned to a stint at the other end of the needle or stethoscope, are not always pleased. "Are my colleagues no longer my brothers, is professional courtesy dying, is the Hippocratic Oath outdated?" Thus wondered a prominent professor, unceremoniously rebuffed by a fellow specialist from whom he had requested a second opinion for a complaint that had not been improving. But the specialist announced that he was too busy to see new patients for the next nine months and was not in the habit of making exceptions. Yet he was sorry, he said, if his colleague felt hurt and humiliated.[1]

Seeds of doubt

Thus were sown the seeds of doubt that this was not an isolated incident but reflected a more widespread dehumanisation of our profession. And what better way to tame the human beast and the professional beast than with a journal—hence the appearance last March of *Humane Medicine*.[2] Its statement of purpose is unimpeachable: it affirms the power of the human spirit and of the eternal spirit; it will respect the faith and uniqueness of each person; and it will blend older traditions with modern technical resources. It warns that "the temptations of materialism are greatest where material resources are greatest," and it recalls Voltaire's perception that doctors would be more sensitive if from time to time they became patients. But they also need guidance from philosophers, theologists, and ethicists—because they know nothing about these things.

Among the articles in the first issue we find one on the philosophy of medicine. We learn that even Galen thought that "the best physician is a philosopher," and that physicians are in error when they try to make a distinction between the soul from the body. For, as Spinoza wrote, "they are not two processes, and they are not two entities; there is but one process . . . mind and body do not act upon each other, because they are not other, they are one." All this and more we learn from philosophy, and we hope at least some of it will trickle down to help in everyday life. That is unless we should be like the essayist who always agreed with the philosophers while reading them but remained untouched by their precepts as soon as he put the book down. "Though I held the same opinions for purposes of theory, I could not entertain them for a moment for purposes of conduct. Death, pain, and poverty are to me very real evils, except when I am in an armchair reading a book by a philosopher."[3]

There also remains the classical problem of the preacher who directs his sermon at the wrong audience, scolding the people present in church for the negligence of those who stayed away. For neither the brutal surgeon who treats his patients like so many cattle, nor the specialist too busy to see his colleague for the next nine months are likely to ever read *Humane Medicine*. But those who do may find their sensitivity enhanced. They will learn about the process of grieving and about the need to redefine life in the face of tragedy. To achieve this patients need support from relatives, nurses, and doctors, and sensitive attention to physical and psychological needs. We fail the incurable patient if we leave him in despair, for we must help him achieve the peace of mind that comes from a realistic adjustment to his condition.

Cook County Hospital, Chicago, Illinois
GEORGE DUNEA, FRCP, FRCPED, attending physician

Experiential disease

We must also understand the concept of experiential disease. It is explained that each illness has two components: one universal, consisting of the symptoms and signs that are more or less the same for everybody; the other, more personal, the experiential disease, the sum of all that is experienced by the patient. This includes not only the physical changes but also possible feelings of guilt, shame, grief, a sense of loss, a failure to understand. Sometimes the experiential disease persists after the physical illness has been cured. A failure to comprehend the experiential aspect of disease may well be the greatest fault of our healing profession and the most frequent cause of dissatisfaction among patients.

The solution, we are told, is by no means easy in a teaching hospital with its large "team of anonymous health care specialists—none of whom takes the opportunity to interact for any length of time in a private, personal setting." The secret is to listen, to listen creatively, then to rearrange the patient's concepts—in what is the traditional medical as well as the psychotherapeutic approach: "Being a healer may often involve sharing deep and painful feelings with the patient."[2]

And is this not the common cry of patients, that the doctor does not listen, does not care, does not spend enough time? Some years ago the mayor of Chicago, addressing a group of specialists, told a story that perhaps few understood. Her father had suffered a stroke, she said, and for several weeks the family had received no satisfaction from the neurologist. Eventually they took the patient to a university hospital; and here at last was a young doctor who took time, spoke to the family, explained what a stroke was, talked about the prognosis and the prospects of rehabilitation. The intern had clearly succeeded where the specialist had failed: he had treated the patient's and the family's "experiential disease." He had allayed their fears and their uncertainties. He had gained their confidence.

Secret of inspiring confidence

In *The Story of San Michele* Axel Munthe discussed this issue of inspiring confidence. He viewed it as the secret of success in clinical medicine, even more so than hard work and competence. He also thought that it was a magic gift, "not acquired by book reading, nor by the bedside of our patients. It is a magic gift granted by birth right to one man and denied to another. The doctor who possesses this gift can almost raise the dead."[4]

This may well be so, even though some will disagree. But an ophthalmologist recently described how he referred a patient to an internist after finding signs of retinopathy. The patient came back dissatisfied, with a list of 12 diagnoses, including hypertension, diabetes, and hypercholesterolaemia. "You know," he said, "you made the diagnosis in a minute by looking at my eyes, but it took Dr L two weeks of tests to come up with the answer." Everybody knows of medical students gaining a patient's everlasting confidence by the thoroughness of what may well have been their first physical examination. "I have seen many doctors," said one patient, "but I have never been examined like this before." And a French professor once wrote an inspirational piece called *La Médecine Lente*, slow medicine.

Yet "slow medicine" does not always work. A young consultant recently saw a patient with a chronic illness, spent an hour examining her, and then took her into a side room for another hour to explain what the treatment would entail. It was done in the best tradition of "slow medicine," but the patient was so frightened that she signed herself out of the hospital and went home that very night.

Some ten years ago I failed a patient with rheumatoid arthritis who had been treated in a hospital with 60 mg of prednisone and phenylbutazone. The symptoms had subsided promptly, recurring as soon as the patient was sent home without medicine. On being consulted I spent a long time examining every joint and noting the degree of inflammation and deformity. Then I prescribed indomethacin, explaining that it works well but should be taken after meals to avoid gastric upset or bleeding. I did everything by the book, yet within an hour an angry husband telephoned to ask how I dared prescribe a drug that would make his wife bleed from the stomach. Before I could open my mouth he screamed that he would certainly not pay my bill and slammed down the receiver.

Somehow I failed that patient. Perhaps I asked too many questions. Perhaps I spent too much time examining her joints instead of listening. I failed to treat her experiential disease, and I certainly did not gain her confidence. She probably went back to the doctor who had given her 60 mg of prednisone a day.

References

1 Oreopoulos DG. Is professional courtesy dying. *Can Med Assoc J* 1983;**128**:506.
2 *Humane Medicine* 1985;**1**:2-44.
3 Lynd R. On not being a philosopher. In: Williams WE, ed. *Book of English essays*. Harmondsworth: Penguin English Library, 1980:280-1.
4 Munthe A. *The story of San Michele*. New York: Carroll and Graf Publishers Inc, 1929:37.

Why are some people more "attractive" to insect predators, such as mosquitoes and bed bugs, than others?

A major factor in the differences in the amount that individuals notice and complain about being bitten by insects is variation in the strength of their allergic reaction to bites.[1] When the numbers of approaches, landings, and bitings by mosquitoes affecting different individuals are directly observed, however, significant variations are found.[2 3] Sometimes, but not always, individuals retain high or low attractiveness from day to day. In laboratory experiments men tended to be more attractive than women to *Aedes aegypti*,[2] but no such sex differences was found in field observations on biting by *Anopheles gambiae*.[4] Adults receive more bites than babies or children—an observation of importance in malaria epidemiology in view of the great differences between young children and adults in malaria immune state and gametocytaemia in endemic areas.[4] Adults of different age groups show little difference in average attractiveness,[3] but Wood claimed that blood group affected attractiveness,[5] though Thornton *et al* subsequently refuted this decisively.[1] There is abundant evidence that mosquitoes are attracted by body warmth, human breath and sweat, and some individual components of breath and sweat such as carbon dioxide, moisture, and lactic acid. When a sample of 100 subjects was studied there was an important correlation between the extent of attractiveness to mosquitoes and skin temperature.[2] There is evidence that individuals with exceptionally low sweat production have a low attractiveness to mosquitoes.[2 3] Little progress seems to have been made on possible relations between attractiveness and individual variation in chemical emission rates; and little work has been done with bed bugs.—C F CURTIS, senior research fellow and honorary senior lecturer in entomology, London.

1 Thornton C, Dore CJ, Willson JOC, Hubbard JL. Effects of human blood group, sweating and other factors on individual host selection by species A of the Anopheles gambiae complex. *Bull Entomol Res* 1976;**66**:651-63.
2 Gilbert IH, Gouck HK, Smith N. Attractiveness of men and women to Aedes aegypti and relative protection time obtained with deet. *Florida Entomologist* 1966;**49**:53-66.
3 Maibach HI, Skinner WA, Strauss WG, Khan AA. Factors that attract and repel mosquitoes in human skin. *JAMA* 1966;**196**:173-6.
4 Carnevale P, Frezil JL, Bosseno MF, Le Pont F, Lancien J. Etude de l'agressivité d'Anopheles gambiae en fonction de l'âge et du sexe des sujets humains. *Bull WHO* 1978;**56**:147-54.
5 Wood CS. Preferential feeding of Anopheles gambiae mosquitoes on human subjects of blood group O: a relation between the ABO polymorphism and malaria vectors. *Hum Biol* 1974;**46**:385-404.

Correction

Medicolegal: First successful court challenge to GMC charges

In this medicolegal article by Clare Dyer (16 November, p 1415) Dr Sidney Gee was described as a general practitioner "who treats obese patients privately." Dr Gee has asked us to point out that he sees all his patients privately irrespective of their clinical condition. He also points out that Dr B K Atlee, described in the article as "another patient's general practitioner," is in fact an assistant and locum.