Letter from . . . Chicago

Christmas letter

GEORGE DUNEA

The ways of publishing being as they are, letters written in May are likely to be published in December—and vice versa. Generally speaking, this makes no difference, because some Christmas issues may not reach Nagpur until the summer; may not be read in Tunbridge Wells until September—if at all; and may not end up in a pile in a Durban garage until the December heat of the next Christmas. Should then the termites not bore their way through the wrapping until the following July, you could argue that as the seasons are reversed it could still be Christmas. So there is no way of telling if this letter will be read in the summer, in the winter, on the Greek calends, or at the Burmese new year.

Time thus being of no consequence, I turn to the week of the Scottish new year, long enough ago to exceed the statute of limitations. In Carlylean parlance, I had arrived at Waverleybanhof, turned off Prinzenstrasse, and spent the night in a pension on what may have been Henriettagasse. Extreme cold indeed; snow everywhere. Heat, none. Not unless you drop pennies in the radiator meter all night. To study, also impossible. Unhappily, no Bath is to be obtained either—not on a weekday at least. O thou foolish ambitious young man. Why doest thou thus brave the elements for a mere diploma? Are four letters after thy name worth all that grief? But now comes the moment of truth: "How do you treat pulmonary oedema?" asks Herr Geheimrat-Professor. "Well Sir, some use tourniquets, but others prefer diuretics or venesection." "No," thunders Geheimrat, "I don't care what others do—I want to know what *you* do." In fact what you do at that juncture is to go "gulp, gulp," rather like one of the comic strips. And then comes Prakticum at Ostkrankenhaus or Nordkrankenhaus, I cannot recall which.

The patient that I had to examine was an ex-army officer who had fought in Italy during the second world war. After the war he had settled in Scotland and taken up the Sisyphean job of bridge painting. His main complaint was that he would sway perilously on the bridge whenever he closed his eyes; and his pupils were small, unequal, irregular, and reacted poorly to light—so much for la dolce vita. But he also had some pyramidal tract signs and displayed a certain irascibility or shiftlessness in that he had walked off the job recently, suggesting the possibility of taboparesis. But then it turned out that he had married an atypical Edinburgh lady who would spend all his money at Christmas to buy presents for her relatives. Last year he had threatened to quit his job if she ever did it again—which accounted for his being unemployed this year. His behaviour seemed normal enough to change the diagnosis to tabes with a component of meningovascular syphilis. But his action was in violation of a great Chicagoan medicopolitical Machiavellian genius, whose foremost maxim was "never resign, never write a letter, never send a memo." And you could reasonably argue that all angry letters should be permanently filed away in a desk drawer, and that writing memos is usually a waste of time, a sign of weakness or pomposity, or the consequence of an undue preoccupation with trivial details. Our officer, likewise, had gained nothing by resigning his post on the bridge: next year his wife will buy more gifts, which he will be even less able to afford, what with his problematic fasciculi gracilis and cuneatus. Yet I think kindly of him, usually at Christmas, while trying to survive in the midst of a jostling crowd shopping for presents, or sitting with a pile of bills in my study and fighting off black thoughts about joining as a partner in the prestigious firm of Marley, Scrooge, and associates.

Dangerous time to be ill

Christmas has traditionally been a dangerous time to get sick, even under "socialised medicine." Imagine a nice seaside resort with plenty of tourists in the summer. An old villa converted into a hospital annex—a patient vomits blood; the nurses all eating chocolate and nuts; sister perched on a ladder fiddling with the decorations; the consultant surgeon gone hunting in the New Forest. At last four pole bearers turn up with a stretcher and negotiate a perilous passage down the winding staircase of the hospital annex. At the big hospital the hunting surgeon arrives and opens the abdomen: he is taken aback by what he sees; mutters "cirrhosis"—promptly closes abdomen—and patient miraculously recovers. Then comes Boxing Day, a young boy has severe laryngotracheobronchitis. There is much telephoning. Surgeon gone hunting again. At last he comes but makes the tracheostomy hole too big—and is gone again. All through the night the tube keeps slipping out. It needs to be reinserted several times by the young registrar, who at last decides that he might as well sleep in the empty bed next to the patient. At dawn the wretched tube comes out once more, the patient turns blue. This time the tube will not fit back, there is a little bleeding, it becomes hard to see because there is a fine spray of blood with each breath. At last—one more try—the tube is back—the operator, exhausted, feels that he must lie down or will faint from the strain.

There is a similar story told by Sir Clive Fitts in his 1967 Tudor Edwards Memorial Lecture to the Royal College of Physicians. Many years earlier a young physician made a house call on a man suffering from severe laryngeal infection. He tried to have the patient admitted, but the casualty officer at the hospital gave him the third degree and condescendingly told him to send him over, "I'll take a look at him." Returning from the public telephone, the young doctor found the patient had taken a turn for the worse, blue, face engorged, and eyes staring. An instant later he fell on the floor over a bucket of lysol. Then, as the relatives all fled in terror, the young man knelt on the floor, got hold of a razor, and cut a hole below the larynx. As the blood and froth gushed out and air rushed in, the patient went through that stage of mania, which Haldane had described in people recovering from anoxia, and began to crawl on all fours. The doctor himself found himself riding on the patient's back, one finger in the trachea, the bloody razor in his other hand—remaining in that position throughout the ambulance ride to the hospital, but elated at having saved a life. In the casualty department this odd bloody couple attracted no attention whatsoever. At last a house officer came and looked. "Tracheostomy," he

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said, "but you have made your incision too high"—thus bringing the young physician well down to earth.

Platitudes on ward rounds

There was another Christmas, in the days when the devils who later invented utilisation review and quality assurance programmes were still placidly singing hymns around the celestial throne. A then wide eyed medical student remembers reading the *BMJ*, with wonderful stories about the physician with "sense of smell and mental acuity undimmed by tobacco," who recognised uraemia when the patient had only haematemesis; and about the aortic thrill missed because the examiner had cervical tabes.[1] There was a reminder about fatigue unrecognised, causing our quote of mistakes to expand or leading us into uttering platitudes on ward rounds. And there was a section about the importance of taking a detailed history, "a process that cannot be taught but must be achieved afresh by each succeeding generation," also about paying attention to the initial symptom and not scamping the history.[1]

There was nothing new in all this, it was just rather well put. As was Dr Balint's "if you ask questions you will get answers, but preciously little else"; Osler's "listen to the patient, he is telling you the diagnosis"; or Sir Thomas Lewis's insistence that housemen had to carry out a good physical examination but could not as yet be expected to have the experience to take a good history. But as this process must be learnt by each generation we note Dr Coulehan's rendition of a scene that is re-enacted at least 10 times a day in every teaching hospital in this country. "The patient is a 52 year old male," the intern begins reciting as he is presenting the case. He is a "known case" of diabetes, which usually means "unknown," so that nobody has the faintest idea when the illness began, or how or what has happened since. Then the patient is referred to as a "poor historian," which usually means, as Dr Coulehan points out, not that the patient is an impoverished professor of history, nor that he is a failed history student, but that most likely it is the doctor who is the poor historian, having neither the time, the inclination, or the patience to pull up a chair, listen, and establish rapport rather than fire a barrage of questions.

Yet in at least one medical school, according to an indignant instructor, the medical students have enough time, on account of an arrangement that though outlawed has been impossible to stamp out. It seems that whenever a new patient is admitted one of the students takes the history while at the same time another one does the physical examination. My only thought was that at a time of doctor excess such a system may provide extra jobs, one doctor perhaps specialising in listening and one in firing questions, one examining above the diaphragm and one below. Strict coordination would be needed, to avoid having the patient go through the difficult process of remembering the dates of his childhood illnesses while one doctor looks at the tonsils and another at the hernial orifices.

Manna from heaven?

There was much fuss last Christmas about reports of people going hungry in this land of plenty. This was especially so when presidential aide, Edward Meese, another prospective for Mr Marley's firm, threw fat in the fire by offending the "hunger lobby" when he said that people standing in soup lines were freeloaders and too lazy to get jobs. Then a presidential commission spent four months and $320 000 looking for widespread hunger but found only "pockets" of it, often among people who were also mentally ill or had other problems. In the extensive dialogue that followed it was noted that the $19 billion available each year to feed hungry people should be enough, if only local people were allowed to develop innovative programmes instead of much of the money being spent on red tape and bureaucracy. Some thought that the problem was more one of malnutrition, from empty calories, junk food, and Pepsi. It was agreed that some groups were at risk, mainly the new homeless, the addicts and street people, the unemployed and the unemployable, the mentally ill, some elderly, the single women with dependent children—but that often food was only one part of a more complex problem. There were also questions about the federal farm subsidy policies—paying for food being destroyed or not grown in the first place—to keep farming prices artificially high.

Finally, Christmas being a time for miracles, we read about a man who went hunting on a mountain and shot an enormous turkey, big as a stagecoach.[3] The turkey, felled by the bullet, seemed dead, but then suddenly gave one big gasp, heaved himself in the air, fell off the mountain, and was never seen again. Then the story goes on that several months later this man met a couple who told him about a wonderful thing that had happened the previous Christmas. They said that they were wandering in a valley, and that at least the wife had prayed to be delivered from that state that Mr Meese thinks is so rare. All of a sudden a huge turkey appeared in the air from nowhere and crashed down right in front of the couple. It seemed that their prayers must indeed have been answered, especially as the hunter did not have the heart to ever tell them the true story.

References

1 Douthwaite AH. Pitfalls in medicine. *Br Med J* 1956;ii:895-900.
2 Coulehan JL. Who is the poor historian? *JAMA* 1984;252:221.
3 Hardison JE. Do you believe in miracles? *JAMA* 1983;250:3293.

MATERIA NON MEDICA

Aesculapius invoked

Coming out of the Franciscan church in Salvador I was drenched by a Brazilian tropical storm before I had time to ponder what St Francis would have thought of the church dedicated to him but lined with gold. I sheltered in a nearby coffin shop and found the staff epitomes of jollity even by the standards of Salvador, unique in my travels as a city of smiles. There is a limit to pretending to choose a coffin even from the variety and splendour surrounding me, so I ran through the rain back to the Terreiro de Jesus where I had seen next to a cathedral a tantalising sign: "Antigua Faculdade de Medicina."

The ground floor housed a new Afro-Brazilian museum where I dried off among the syncretism of the gods of the old and new worlds. Upstairs was an unadvertised Memorial de Medicina lovingly preserved and displaying the history of the medical school. Without a catalogue, and with the captions in Portuguese, I deduced that this was the site of the Jesuit College of Medicine of 1808, which became a faculty in 1826. It burnt down in 1905 and these grand buildings of 1909 were in use until the faculty became part of the Federal University of Bahia in 1982. Room after room displayed portraits of the teachers of old, some head and shoulders, others proudly full length in cap and gown. The archives, theses, and old instruments were displayed together with historical medical books (almost all in French, but I found one in English: not surprisingly, Patrick Manson's 1898 *Tropical Diseases*).The dean's office and the solemn faculty committee room had been preserved with all their furniture, as well as the medical school's banner for the centenary in 1923 of Brazil's independence. A vast new mural summarised the history of medicine in Salvador, and one room enshrined Aesculapius with a beautiful neovorticist aluminium statue of our god, together with the working drawings of the sculptor, Mario Cravo.

The other buildings have been left to crumble. The old library entrance still has its flanking statues of Hippocrates (confidently dated 468-377) and Galen (113-200), but the great amphitheatre—which from the photographs must have been as ornate, gilt corniced, and ceiling painted as any baroque church—is a crumbling hulk with the tropical garden inexorably creeping over, rather like a John Piper bomb site ruin. On the outside wall nine busts stand in a semicircle: Hippocrates with four eminent Bahian doctors on either side. One of them has sadly lost his head.—J H BARON, consultant physician, London.