

A VIEW FROM THE RIDGE

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I sometimes long for the simple faith I had as a child, where black was black and white was white. I often reflect on the simple concepts I had of disease when I graduated in Medicine in 1937, and I wish I knew as much, as positively, as I did then. When I was an Interne at the V.G. Hospital in 1936 I knew literally everything: I knew the cause of all but the most unusual diseases; I knew how to treat most of them, and was quite sure that within a few years even the most obscure illness would be thoroughly understood, and would yield before the white flame of therapeutic zeal. I had disease divided into two main categories; (1) real, that is mainly infectious and traumatic and (2) imaginary or neurotic. I knew the cause of almost all of the former, and the latter I more or less considered equivalent to lack of character, and properly the concern of the clergy.

The germ theory in its heyday was a very comfortable philosophy. It resolved itself into believing that dirty little germs were always lurking round to find ingress into the body, and if they did it in sufficient numbers, illness was the result. I had heard of Pasteur's work but not of his axiom which, being interpreted very roughly, is that bacterium is nothing, the infected body all. Gradually experience has taught me that the ground is more important than the seed in the production of an infection, and that many many factors enter into the development of an illness besides the infecting agent. One could start with heredity, with prenatal development, childhood illnesses and affections, the present situation in which the patient finds himself, his needs—both long and short range, his striving and so on.

My reading since has made me well aware that many many people had written on such topics long before I became a physician. Indeed, such philosophy goes back to Hippocrates. How I managed to shield

myself from this knowledge is known only to medical students—who can read, listen, and watch, yet never become aware of material that they are not ready to assimilate.

It is rather humbling to think that the Italian physician Frascatoro in the early sixteenth century developed the thesis that illness was often caused by particulate matter passing from patient to patient, and that clothing could spread the infection, and that the theories of Hippocrates and Galen concerning vapors did not explain the facts. It is humiliating to think that 300 years later Pasteur and Lister had to battle an ingrained prejudice that was completely unprepared for this thesis. Broussais in the early nineteenth century first postulated that disease could be produced by stress—physical to be sure, but by the middle of the nineteenth Claude Bernard launched the idea that health and disease are really differences in degree, and that disease could well be an exaggeration, a disproportion, or a disharmony of normal phenomena—that is disease could result from deviant physiology. The biologists, chemists, and scientists of the nineteenth century fought disease, when they could, with specifics and this tradition has carried right down to the present day, particularly in the field of antibiotics.

Through the latter half of the nineteenth century and up to now, the twentieth, the "scientific" approach to medicine has certainly been uppermost. While giant steps have been taken by outstanding men in their fields, eg. Selye, Wolfe and Wolff, and Masserman, by and large their theories have penetrated the rank and file of medicine as little as did the contributions of Claude Bernard and Cannon in my undergraduate years. We have been dominated by the pseudo-scientific measurements of minutiae of physiology and biochemistry

We have split our patients not only into organs and tissues, yea, even cells; but we have so divorced ourselves from the patient that a diagnostic "workup" in a modern

departmental hospital has to be experienced to be believed. It consists of two or three histories, one a rather detailed history taken by the clinical clerk (which is rarely read), a few addenda by the interne and more by the resident, a great battery of x-rays, tests and consultations, etc., the results of which are scanned by the Chief, who may or may not spend much time with the patient. Finally the Jovian pronouncement of the diagnosis and the treatment is handed down to the patient by one of the above mentioned team. Too often the patient is given a diagnosis instead of a formulation, and prescriptions like "lose weight", "avoid cholesterol", "stop smoking", "stop drinking", etc., with little attempt to understand the total man struggling in a complex field of forces; full of strengths and weaknesses, wisdom and folly, nobility and wickedness. In part this is the reason the North American citizen loves HIS Doctor, but hates and mistrusts the medical profession.

What all this means is that the Doctor, instead of being involved with the patient for a hectic period of acute fever as he was in the last generation is now involved with a great deal of maintenance treatment. While formerly the contact with the patient was often critical at the height of the illness, and was followed by a period of convalescence and resolution, now the physician is concerned with more chronic illnesses, such as arthritis, asthma, ulcers, arteriosclerosis. In these instances, contact with the patient is long, and amelioration rather than cure, is the aim of treatment. This calls for a quite different type of attention and interest on the part of the physician. This different type of practice is often onerous to the Doctor who is geared to the cure turning his efforts to maintenance-type of therapy with little hope of real improvement except in symptoms. It becomes evident that more people are living to an age when they develop neoplastic, degenerative, and the diseases in general that seem to be the results of non-specific or specific stresses acting on a constitutionally vulnerable tissue over a long period of time. With this change in the general pattern of human sickness it is also obvious that Medicine,

which like Law tends to be reactionary, must change more decisively than in merely developing an increasing acuity in reading meanings into borderline physiological and biochemical curia. It becomes more and more apparent that the complete physician must know man as well as the disease processes; in this we are antedated several hundred years by Pope's "The Proper Study of Mankind in Man."

Certainly a Kildare of the twenties or thirties could fight disease without getting involved very much with personality—but how can our modern medicine man ignore the very stuff, the malfunctions of which bring his patient to the consulting room.

It is now clear, and will be increasingly so in the next two decades, that the bulk of man's ills owe their genesis to many factors. Longitudinal life studies make it plain that the end result in 1960 began with conception in 1900, and that the multitude of stresses, some short, some long term, some bacterial, some chemical, some interpersonal, some social, that have been operative over the past sixty years have all played a part in the production of the clinical picture that we now see. Furthermore, the cardiac insult in 1960 did not happen to the coronary artery of a department store dummy, but it happened in a real flesh and blood person, a personality whose doubts, fears, hopes, and aspirations are at least as individual as his fingerprints. One can reflect on the ten thousand excursions and alarms of the past sixty years—how his faithful little vessels reacted manfully without consideration of the wear and tear on the media and intima, no thought for the point of no return, no heed to the parable of the "pitcher that goeth too often to the well."

Doctor Jacques May in his book "The Ecology of Human Disease" expresses this very succinctly and defines disease in the following terms: "That alteration of the living tissues that jeopardizes survival in their environment." Thus he makes disease more or less synonymous with maladjustment. Doctor May conceives disease as a convergence in time and space within

the person of the patient, various environmental stimuli: organic, inorganic and socio-cultural. These stimuli are a challenge which produce the response from the organism which we call disease (communicable, degenerative or behavioral.) This, in its turn, results in an ecological adaptation and survival, or in partial maladjustment, or in total maladjustment and death. More and more will cultural factors of disease, that is to say, concepts of the techniques of which man avails himself in the different environments in order to survive come to the fore. Inter-relationships existing between culture and disease offer several possible approaches for the mastery of disease: (1) To erect a protective wall between the human being and the pathogenic agent, be it bacteria, be it noxious physical conditions, or noxious emotional condition. (2) To change the disease producing environment in which man lives; again this could apply either to the physical or to the mental and emotional environment.

(3) To change man's response to the pathogenic stimulus and to render him less vulnerable to its impact.

These changing patterns and the shift in philosophy necessary to work with them, have thrown great stress on the medical profession as a whole. Changing patterns of practise, new demands for service, have left the rigid among our guild less and less able to cope, and many have taken refuge in various mechanisms of denial or escape.

The spectre of a Government sponsored medical practise which has been hanging over us for the past fifteen years seems to be increasingly imminent. This has also increased the pressure under which we collectively labor. Since organized medicine, in spite of loud protestations to the contrary, has really failed to provide adequate medical care to the people as a whole, it is inevitable that sooner or later the people, through the Government, will insist on more complete care. While no doctor likes his profession to be considered as a public utility, yet the parallel is there; people must have medical care in increas-

ing amounts as medicine becomes more expert. Attempts to pass legislations which would cause doctors to practise in a different way are doomed to of our profession, which has practised so many many years under sometimes extremely adverse conditions, and yet has managed to continue improving itself and to continue providing more complete care. Let us hope that Government and governing medical bodies will seduce rather than command us.

The spectacle of our brothers floundering in an unworthy squabble of politicking in the recent Saskatchewan pre-election festivities is humiliating. How painful are the follies of blind good men? Let us not waste our argument in foolish attempts to stay the inevitable tide of socialization, but let us now use our best offices to prepare, both as a group and as individuals, for the inevitable.

Indubitably this will mean the greatest change that has taken place in the history of medical practice. It will mean as well the loss of independence, and unless we are alert, it will also mean an increasing trend in the emasculation of the general physician. He could be considered more and more as a diagnostic filter—a triage expert—who could channel specific organ distress to the appropriate specialist—thus furthering the splitting of the patient into even finer atomic splinters. He could be relegated to becoming expert in signing absence excuses for the patients who have missed work, school, etc. from innumerable causes. He could well be pre-occupied during his precious forty hours a week deciding whether or not false teeth, glasses, or scalp prosthesis demanded by John and Jane Doe are necessary Ego-building functions are properly a public charge; or are they mere cosmetic artistry and therefore justifiable as a charge to the Does themselves? You smile? Ask the general practitioner from the United Kingdom.

On the other hand, what price independence in our increasingly complex field, where more and more it is impossible to

"keep up" in all areas? Where even if one could keep up, the social trend to specialization, which has not yet reached its zenith (or nadir depending on the point of view) provides an increasing temptation to the physician to limit his practise to manageable limits. Thus, if these limited practitioners are given more kudos and more money than the general physicians, the ebb of members from general practice becomes increasingly swift. What new stresses are just around the corner for the medical man—how will his overworked alarm system stand up—when will his obituary grace the columns of the C.M.A.J.?

Let us not, like Sisyphus, roll our stone

laboriously up the hill each day, only to find it at the bottom again tomorrow. Let us not like Don Quixote tilt against the windmills along the Rideau Canal. Let us not like our misguided brothers and sisters of Saskatchewan engage in a profitless and face-losing fight with "the people." Let us rather pull up our socks and use our influence here and now to make our best possible bargain with our present clients, who will be our future employers. Let us so improve our public relations that as well as being the best loved professionals.



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