VIII

Members of One Body

"The art of medicine in Egypt is thus exercised: one physician is confined to the study and management of one disease; there are of course a great number who practice this art; some attend to the disorders of the eyes, others to those of the head, some take care of the teeth, others are conversant with all diseases of the bowels; whilst many attend to the cure of maladies which are less conspicuous."

—Herodotus, *Euterpe*

1.

Holy Church is indivisible and one, yet it varies in its observances and rituals. The same with medicine. Just as theology's aim is the salvation of souls, so medicine's avowed goals are the prolongation of life and the alleviation of suffering. And medicine, too, has Byzantine rites and special services for special occasions.

Unfortunately no councils, conferences or synods exist in medicine for the guidance of the patient. The honest citizen is left on his own, standing before the directory in the Medical Arts building while he decides on which thaumaturgist he should call on to relieve his headache. Should he see an ophthalmologist, an otolaryngologist, a neurologist, a psychiatrist or (if he's old-fashioned and believes all troubles start in the bowels) a gastroenterologist? Often he pays his money and makes his choice and if he's lucky he makes the right one.

What's a specialist? All physicians are licensed by the states of their residence and are presumably equally competent. The license is acquired after a course of study, a period of apprenticeship and the passing of an examination. A specialist is a doctor who has been further tested by self-constituted superiors in a sharply delimited area of practice. If he survives the ordeal, he is admitted to a College or to a Board or to a Society, and he can charge higher fees for his services. It then follows by circular reasoning that if he charges more money, he is better qualified, money being the criterion of worth in society, and if he is better qualified, he deserves more money. The specialist chooses his field not for the love of science nor for the sake of mental exertion, but because the hours of labor are shorter and the work is easier. This was said as long ago as 1876 by Dr. John Shaw Billings in the *American Journal of Medical Sciences*. The training and initiatory ordeals have become more rigorous since that time, but the postulants' reasons for undergoing them remain the same.

The work doesn't always look easier. Sympathy is readily aroused by the sweat streaming down the tribal dancer's body as he circles around the patient or by the complicated maneuvers he makes with the sacred gourds. The newspapers record and television shows how the specialist manipulates with dexterity the awesome, shining instruments of his trade. And everyone knows of the tremendous advances that have been made in the medical specialties. Only a carping critic, a sour-puss reactionary, would dare to denigrate those Diplomates and Fellows.

Or an innocent child who can't see the emperor's new clothes. Or a tribal malcontent who's seen the wizard's all-too-human nakedness under his feathered robes.

2.

"Anyone who goes to a psychiatrist ought to have his head examined."

—Samuel Goldwyn

Let's start with an easy specialty, one that's been the target of innumerable jokes. But remember Freud's dis-

covery—that the mocker of sacred subjects is showing his fear (and respect) in a distorted fashion. Wits have been shooting barbs into the psychiatrist's couch for so long that the stuffing's coming out. We'll leave wits (but not our wits) aside and look with an unprejudiced eye at the ministers to the mind diseased, the savants whose specialty is omniscience. These hierophants are unique among specialists in that they freely discuss their methods in lay publications, and in spite of that they remain invested with the aura of magic. Why not? Mental aberrations are the closest thing we moderns have to the *possession* of the ancients or the *stolen souls* of aborigines. One who undertakes to treat such aberrations is almost automatically looked on as a mystic, as one who has a key to the secrets of the unknown.

The psychiatrist enjoys being thought so: though he modestly disclaims any knowledge unavailable to the educated man and points to the wide distribution of psychiatric articles in the popular press, he hesitates not to give opinions on the sanity of Presidential candidates, advice to educators, and analyses of the motives of revolters against this best of all possible worlds. Some psychiatrists make no bones about being magicians. On April 24, 1968, Professor Morton L. Kurland, a psychiatrist, gave an address at the Academy of Medicine of New Jersey on "Oneiromancy—A Brief Freudian Study of Dream Interpretation." And on March 22, 1971, at the annual meeting of the American Orthopsychiatric Association a paper was presented entitled "What Western Psychotherapists Can Learn from Witch Doctors," in which the point was made that witch doctors use the same methods and techniques as do Western psychotherapists—and with about the same results!

Psychiatrists have a standard formula for prognosis, the foretelling of the course of a psychic disorder. They say, "This is a complex situation. Time and extensive [and often expensive] treatment will be necessary." They are not being mercenary. The very rich may be treated differently from the very poor, but time and expense remain the same, maybe even more time for the patient and more expense for the taxpayer in the case of those confined to public asylums. (An excellent study, *Social Class and Mental Illness*, by Drs. Hollingshead and Redlich, points this up quite well.)

But it would be supererogatory to confine criticism for the present state of affairs in the treatment of mental illness to the poor (not in the economic sense) psychiatrists, already the butt of night club comedians, ignoramuses and those members of the intelligentsia in search of novelty. The last, because of their vocality, help to set the public image of the psychiatrist. They have decided opinions about psychotherapy, a branch of the medical art, more so than they would dare to have about another branch, such as neurosurgery. Their opinions lean now in one direction and now in another, depending on what the book reviews have to say about the latest "discovery" in the field of mental illness.

The fact remains that psychiatrists are in great demand, an indication either that as a nation we are getting nuttier or that Parkinson's Law has found another application. In New Haven, Connecticut, for instance, in 1940 there were only three psychiatrists; in 1958 there were 24 full-time psychiatrists, 33 part-timers, and 32 residents in training who took care of patients in clinics, Veterans' Administration hospitals and a private psychiatric hospital. During those eighteen years New Haven's population rose by only 5000. In Iowa, part of the supposedly stable Midwest, where the population increased only from 2,621,736 in 1950 to 2,757,537 in 1960, the number of psychiatrists rose from 15 to 95. In ten years the membership of the American Psychiatric Association more than doubled from its 5534 in 1950 and reached 16,000 in 1967.

The increasing supply is the result of the increasing demand. Why? Do the psychiatrists get such good results with their therapies? Are asylums being emptied? Are the couch springs regaining their resilience? Let's see.

Take psychoanalysis, for instance, in any of its orthodox, schismatic or heretic forms, a branch of psychiatry many believe to be fundamental to the treatment of the sick psyche. (Psyche comes from the Greek, meaning *soul* or *butterfly*. Both develop in grubby darkness and both aspire to the heavens.) Very few careful evaluations of the results of psychoanalysis are available. That's not because of negligence or because the analysts are afraid of what the surveys will show. It's because evaluation is so difficult. Is the patient better because he no longer worries about wetting his bed (You've heard that joke before?). Is she better because she no longer argues with a stupid superior at work or an equally stupid husband at home? Is the insomnia or the palpitation or the weepiness gone? The problem of evaluation is one of goals, and too often the goals are as nebulous for the doctor as the patient. Nevertheless, some studies have been made. Dr. Frederick Wertham, a Voice of Authority, a former president of the American Association for the Advancement of Psychotherapy, says that 60% of psychoanalyses are more harmful than

helpful and that four out of five analyses are not indicated in treatment. The most extensive study of the results of psychoanalysis showed that fewer than half of the analyzed patients were cured.[20] More recently, the American Psychoanalytic Association, who might be supposed to be prejudiced in favor of their own specialty, undertook a survey to test the efficacy of psychoanalysis. The results observed were so disappointing that they were withheld from publication.[21] There is a little semantic problem here. *Cure* may not be the correct word (unless used in the religious sense of a *cure of souls*) for a therapy aimed at relieving the anxieties and the discontents caused by upbringing and civilization.

But only one-twentieth of psychiatrists are analysts. Do the other nineteen-twentieths do better? Not so you could notice it, especially in the major psychoses. Forty-seven per cent of the hospital beds in the United States are still occupied by the insane, a percentage that has not varied from 1950. The number of patients confined as "schizophrenic" has risen.[22] Enthusiasm for lobotomies gave way, when the cold statistics were in, to excitement over insulin shock therapy and electric shock therapy, and that in turn subsided in the face of sober examination of their results. Insulin shock therapy is still used in a few hospitals (despite the occasional accompanying fatalities, euphemistically called *irreversible comas*) on the ground that schizophrenia is such a hard condition to treat that anything that ever gave the slightest chance of improvement should be continued. Undismayed by their previous failures, the psychiatrists turned to the marvels of psychotropic drugs, and as the latter multiplied, their beneficial results became less noticeable. An old adage in medicine states that the more remedies there are for a disorder, the less likely any one of them will be of value. That seems to be true in the psychotherapies.

Not that the psychotherapies are worthless. Not at all. The degree of their worth is what's arguable. A recent book (*Human Behavior*, by Berelson and Steiner) states that sober and scientific evaluation of psychotherapy shows it to be no more useful than general medical advice or counseling for neurotics, but still useful. A group of psychiatrists reported that in a follow-up study of psychiatric outpatients, very many were "better" after five years, and of those traceable after ten years most were better; the type of psychotherapy seemed to make no difference.[23] In another critical review of the results of psychotherapy, it was pointed out that fast improvement was the chief virtue of psychotherapy; without it, improvement took place, but very slowly.[24]

Some psychiatrists have a ready explanation for everything. If the patient is late for his appointment, he's resisting treatment; if he's early, he's overanxious; if he's right on time, he's compulsive. Because of it's pretension to a sound comprehension of human motivation, the field of psychiatry is very broad. It even has to do with school problems like under-achievement ("if he's so smart, why doesn't he get all A's?"), over-achievement ("he's too clever for his own good"), aggressiveness ("he's a bully"), submissiveness ("she's always too ready to do what she's told"), showing off and withdrawal, nail-biting and pencil chewing, et cetera, et cetera.[25]

But why do people seek out the psychiatrists? Why are they in such great demand? Because, faced with problems requiring fundamental changes in our society, men find it easier to categorize those problems as "basically psychogenic" than to do the harder work of determining the causes of juvenile delinquency, drug addiction, the rising divorce rate, industrial absenteeism and racial strife. In a secular world where God is either dead or has given us up in disgust, men turn to the gods at hand. They run to those they believe know everything about the workings of the human mind. They cry out like children for Papa to forgive their trespasses, to brush their troubles away, to ease their guilt and excuse their mental laziness by uttering a few charms like Oedipus complex, identity crisis, ambivalence and flight from reality.

Their demands are unreasonable. The chasm between what people think psychiatrists do and what their limited techniques can do is great indeed. But it wouldn't do for a healer of souls to tell them that. People expect so much of the psychiatrist that some doctors forget their mortal limitations and succumb to a

[20] Dr. R. P. Knight, "Evaluation of the Results of Psychoanalytic Therapy," *American Journal of Psychiatry*, 1941, *98*:434–446.

[21] Dr. Anthony Storr, "The Concept of Cure," in *Psychoanalysis Observed*, Baltimore, 1968, p. 57.

[22] Dr. Felix von Mendelssohn, *This is Psychiatry*, New York, 1964, p. 207.

[23] Drs. A. R. Stone *et al.*, "Intensive Five Year Follow-up Study of Treated Psychiatric Outpatients," *Journal of Nervous and Mental Diseases*, *133*:410, 1961.

[24] Dr. Hans J. Eysenck, "Effects of Psychotherapy," *International Journal of Psychiatry*, *1*:99, 1965.

[25] Dr. S. S. Radin, "Mental Health Problems in School Children," *Journal of School Health*, *32*:392, December, 1962.

belief that they are deities. They arrogate to themselves the role of expert on everything from colonialism to cancer prophylaxis. For the former read Dr. Frantz Fanon's book, *The Wretched of the Earth.* The latter was discussed at a conference at the New York Academy of Sciences (May 1968), where three prominent psychiatrists suggested that, on the basis of their findings that cancer patients they studied were people who denied or suppressed emotion after experiencing personal loss or tragedy, cancer might one day be prevented by prophylactic psychotherapy. A reading of their reports is illuminating: they illustrate what is called the logical fallacy of the undistributed middle.

Psychiatrists are not quacks or charlatans. They sincerely believe that what they do has value in the treatment of mental illness. The problem with the practice of psychiatry lies in that very belief. Too many psychiatrists exaggerate their own capacities. Dr. David Cooper, a psychiatrist himself, says of his colleagues, "in fact, many psychiatrists are second-rate doctors—people who could not 'make it' in general medicine, but this fact does not limit the possibilities of pretence. . . . The doctor is invested, and sometimes invests himself, with magical powers of understanding and curing. Whether the formal training of psychiatrists includes qualification in magical omnipotence is perhaps uncertain, but the image is reinforced and perpetuated in many ways."[26] The self-aggrandizement of many psychiatrists often leads people to seek more and more of their opinions and advice, thus encouraging those psychiatrists to assume still greater divine attributes.

Such psychiatrists have good precedent for their arrogance. Freud wrote a monograph on Leonardo da Vinci based entirely on a bad translation of his writings. He wrote another, *Moses and Monotheism*, that displayed his imperfect acquaintance with Egyptology and comparative religion. (I won't even mention *Totem and Taboo*, that masterpiece of *Schund-Anthropologie.*)

There is a dialectic relationship in the ballyhoo about psychiatry and its overrating. Both the witch doctor and his patient are at fault.

But no one denies the existence of psychic disorders that make the sufferer therefrom miserable, that distress his family, that may be a danger to the community. We can't dispense with psychiatrists. But we can divest them of their priestly clothes and remove them from the pedestals we have erected for them. We can recognize that they are human beings using experimental tools to deal with illnesses of uncertain etiology. We can demand from them a clear statement of their goals when they start to treat a patient. We can insist that their results be visible to others. We can ask for interim reports on progress or the lack of it. One thing we cannot afford to do and that is to be brainwashed by torrents of mystical phrases so that we forget what the purpose of psychiatry is—the treatment of a sick man or woman.

3.
A CYNICAL FABLE

Once upon a time there was a young man whose family wanted him to be a physician. The young man, who was a dutiful son and anxious to avoid the draft, therefore entered a premedical course at a university.

After five years, he received a Bachelor of Science degree; he had taken a year off for cultural study in Europe. The young man then entered medical school. Because of the shortage of physicians and the faculty's resultant need to pass everyone, he did not find the course of study terribly onerous. In due time, five years later, the young man was graduated with the degree of M.D. The extra year, to widen his horizons, he had spent with various peace missions in those benighted foreign countries just emerging into the dawn of Western civilization and its concomitant diseases. The year further broadened his knowledge of non-American cultures. He learned that being poor is worse than being rich, that English is more widely understood than Xhosa, and that flush toilets are not a necessity.

The young man then entered upon an internship that was to prepare him for the exigencies of actual medical practice. He learned that emergency-room service means the treatment of the common cold, that illegible handwriting prevents callings-down for errors in charts and that laboratory tests save wear and tear on brains.

On the completion of his internship, the young man, being very patriotic and having no other recourse, undertook his military duties. Because he was highly trained and was an officer, he spent two years at a military post, at which he okayed treatment given by the master sergeant of his detachment, gave lectures on the dangers of venereal (as opposed to martial) combat,

[26] Dr. David Cooper, *Psychiatry and Anti-Psychiatry*, London, 1967, pp. 24, 93.

and learned the extraordinary serviceability of the third person, passive voice and subjunctive mood in writing reports.

He was then ready for a residency. Not fond of blood and bored by physical examinations, the young man decided to become a psychiatrist, psychiatry also being a branch of medicine that requires no great outlay for equipment. He took up a residency in an ultramodern psychiatric hospital complete with computers for fudging statistics, a pharmacy full of psychotropic drugs of unknown menace, and beautifully decorated open wards with the most cleverly disguised restraints. The hospital had a steady inflow of the mentally weak and halt. It also had an equally steady outflow of the same, in order to maintain its reputation as an up-to-date institution with neither back wards nor simple custodial care, a place that specialized in active therapy. The young man was taught that cold baths, colectomies, lobotomies and shock treatments were antiquated and harmful. He was so well indoctrinated with psychopharmacological propaganda that, on the completion of his residency, he was unprepared for the news that in order to be a successful psychiatrist he needed a thorough analysis of his own psyche.

Having during this time married and, therefore, being in need of money, the man (young now only by courtesy) entered practice while he underwent analysis. Of course, aware of his limitations, he treated only psychotics and neurotics. He spent most of his free time giving lectures (unbolstered by such trivia as facts) to lay groups on the great advances made in the field of psychiatry. These lectures, he was told by his older and presumably wiser colleagues, were ethical means of publicizing his name and qualifications and thus of increasing his practice. His advisers were correct. The man was soon able to provide his family with the necessaries of daily living commensurate with his status: a large house, several cars, private schools for his children, expensive jewelry for his wife, and a country-club membership for himself.

Meanwhile, the man went on with his analysis. Faced with the range from orthodox to radical—from the phylacteries of the Freudians to the nudity of the neo-existentialists—the man (an educated consumer) made the "best buy," an analysis of moderate length and of little cost.

The analysis resulted, first, in his developing insights into his character, and, second, in making strong defenses against the defects he uncovered. He learned humility by finding he was not so smart as he thought he was; he coped with that by boasting, in papers read before medical associations, of his therapeutic successes. He learned that his goals were as limited as his capabilities; he surmounted that knowledge by raising his fees, to prove his worth and the value of his ambitions. He recognized his egocentricity; he overcame it by mock-modest disclaimers of credit for his increased activities in community affairs.

Because of his professional attainments and his civic activities, by the time the man had reached the end of middle age, he was frequently called on to give his opinion on subjects which affected the lives of his fellow citizens: the mental capacities of Presidential nominees, the prophylaxis of teen-age drug use, and the relative values of varying educational theories. He became known as an expert, appearing before Congressional committees, testifying in court cases and being a TV panelist.

At the dinner given him on the twenty-fifth anniversary of his starting practice, the man responded to the toasts by a statesmanlike speech critical of the rising generation, who were departing from the basic virtues of integrity, honesty and self-discipline, who forsook peaceful reform for riot in the cause of revolution, and who refused to benefit from the painfully acquired (through experience) wisdom of their elders.

MORAL: There's always a market for skim milk masquerading as cream.

American attitude toward medical doctors as viewed in (MORE), the magazine of journalism.

4.

"A fashionable surgeon, like a pelican, can be recognized by the size of his bill."

J. C. Da Costa, *The Trials and Triumphs of a Surgeon*

At first glance no specialty would seem to be more removed from the pseudo-religiosity of psychiatry than surgery. Surgeons are not concerned with what was and when; they deal with here and now. The objects of their attentions are not such stuff as dreams are made of, but concrete matters like stones and tumors. They treat their patients not by exorcism but by the laying on of hands. (*Surgeon* is derived from *chirurgeon*, from the Greek *cheir* = hand and *ergon* = work.)

And yet what more resembles an esoteric religious ritual than an operation? It's done behind closed doors, with the anxious relatives waiting in an anteroom until the surgeon, still wearing his robes of office, comes out and shakes his head sadly or beams wisely before he says, "Well, we've done what we could. Now everything depends on his recuperative powers." That's an overt admission, if I ever heard one, that the mystical forces of nature will do the rest, the surgeon having complied with the placatory rituals. It is also a variant of covering-up (*q.v. sup.*)

(Incidentally, have you ever noticed how doctors of all description dote on the regal *we*? "*We'll* do some tests," and "*We'll* decide today." It's as though standing by his side is an invisible man almost as competent as he is.)

What actually goes on behind the closed doors is not entirely a mystery; you've seen the spectacle dozens of times in the movies or on TV. Clad in white pajamas, masked, head covered, the surgeon solemnly scrubs and scrubs and scrubs his hands. (You've never seen the bulge in the sock underneath one of the legs of those pajamas. That's where the surgeon stows away his billfold. And in the movies the plot advances during the scrubbing. In real life the time is spent conversing about golf, politics, the student revolt and so forth.) The surgeon walks, arms up, elbows dripping, into the operating room and is assisted into a covering garment and helped with the putting on of rubber gloves. Then he takes his place at the operating table under an inverted bowl of lights. The patient lies there unconscious, tubes attached to his outstretched arms, a balloon on his face; he is covered with drapes and surrounded by the surgeon's assistants, nurses and onlookers. The rest you don't see. You only hear the slap of hemostats, the sharp requests for gauze, scalpel, scissors, the whisperings of the attendants wheeling in strange and cumbersome apparatus. Occasionally the surgeon, without removing his arm plunged into the patient's innards, turns his head to have a nurse mop his sweating brow. The scene is dramatic, yet calm, like the part where Charlton Heston strikes the rock.

And afterwards, when the surgeon describes what he's done, the drama remains. As in Greek tragedies, the very language is elevated in keeping with the solemnity of the occasion. The abdomen is *incised*, not *cut*; the tissues are *divulsed*, not *spread apart*; the wound is *sutured*, not *sewed*. Oliver Wendell Holmes (still not the jurist) once dryly remarked, "Some men ligate bleeding vessels; others tie them. Hemorrhage stops in either case."

The awe and respect with which surgeons are held can be judged by the size of their fees and by their pomposity. They are so surrounded by apprehensive patients, reverent families and subservient nurses that they brook criticism neither by laymen nor by their peers (if they admit they have the latter). It took man years of nagging, haggling, and politely applied *force majeure* before surgeons permitted tissue committees in their hospitals. The sole purpose of such committees was to establish the justification for surgery; they set up standards and applied sanctions against those men doing unnecessary or bad surgery. They proved their value. In one hospital 262 appendectomies for acute appendicitis were performed in 1953; in 1954, when a tissue committee was organized, only 178 were done, but the pathologist reported that 36% of the appendices removed were not inflamed; by 1957, only 62 "acute" appendices were operated on, and the percentage of normal appendices removed in those cases dropped to 16%.[27] In another hospital, 593 appendectomies were done in 1952; after the organization of a tissue committee in 1956, only 184 appendectomies were performed. Operations for the separation of abdominal adhesions declined in the same period from 133 to 60; cholecystectomies (removal of gall bladders) dropped from 173 to 117, but more thorough operations (exploration of the common biliary duct) rose from 16 to 38 in those cases.[28]

[27] Dr. Harvey R. Sharpe, Jr., "The Effect of a Tissue Committee on Appendectomy in a General Hospital," *Wisconsin Medical Journal*, 59:135, 1960.

[28] Reported from the Missouri Baptist Hospital (St. Louis) in the *Bulletin of the American College of Surgeons*, 43:449, 1958.

I don't want to imply that surgeons as a class are unethical or incompetent. They are not, and far less so than many of their colleagues in other specialties. They may be unthinking, they may be carried away by their very competence into doing operations they shouldn't be doing, and some of them may even be stupid, but why should the public expect more of them than of officials chosen by the electorate?

Let's return to the operating room and see what you've missed at the first showing. Remember that rigidly aseptic atmosphere where germs are scrubbed and washed away? The patient has been wheeled into the operating room on a trolley-cart and lifted onto the operating table. Stop and think. Where has that cart been? Its wheels have traversed hospital corridors where the shoes of visitors have brought in dirt, where doctors attending infected cases have trod, and now it comes into that nice clean operating room. And look at the patient. Everyone else is capped and masked. If the patient wears a cap or turban, it has been displaced by his journey from his room to the operating suite or it will soon be displaced by the anesthetist. The patient doesn't wear a mask; he can be talking nervously and spraying millions of bacteria from his mouth until he is put to sleep (temporarily, of course, since that euphemism does not apply to humans). Nine times out of ten he is wearing leggings, draw-stringed bags covering both legs to the midcalves. Why? If he's so dirty, why not clean him up first in his room, and if he's not, why does he wear the leggings? I called several hospitals to ask why the leggings were worn. The operating room supervisors unanimously answered, "It's traditional." How much more is traditional?

Many things. Start with the scrubbing. A recent study by Dr. Ralph C. Richards, professor of surgery at the University of Utah Medical Center, showed that prolonged scrubbing was unnecessary, that 70% ethyl alcohol removed more bacteria from the hands in one minute than were removed in ten minutes of scrubbing with soap. Prolonged scrubbing is a carry-over from the days when surgeons first stopped operating in frock coats.

The drapes, too, are traditional—those drapes under which the patient's temperature steadily rises. Multiple layers of sterile cloth drapes were devised to keep the entire operative field free of external contamination and to insure that blood and pus would be quickly absorbed by the fibers of the drapes. But now there are lightweight plastic coverings that can be taped around the field and disposable light sterile paper drapes for the rest of the corpus (not corpse). Use of both obviates washing and sterilizing linens, and saves time in the operating room.

Asepsis, the prevention of bacterial infection, is the reason for the scrubbing, the rubber gloves, the drapes, the sterilized instruments. Some hospitals have operating suites, access to which is by special elevators; all require that the surgeon cover his street shoes with cloth boots or wear shoes reserved for the operating room. Such regulations are comprehensible until you consider: what about the orderlies and nurses who bring the patients to be operated on? Are their shoes permanently shielded from infectious bacteria outside the operating room? I would think that if breaks in aseptic technique must be so zealously guarded against, then *all* personnel working in the operating rooms should be subject to the same rules.

Furthermore, anyone who has ever been in the emergency room of a busy hospital has seen how such a place functions. Wounds are sewed, with sterile instruments and sutures, of course, but all around is a hubbub: police officers wander in and out; relatives weep, wail, and blow their noses; nurses come from taking the temperature of a child with a sore throat into the room where a laceration is being repaired; masks and caps are conspicuously absent. And yet torn skin heals and no infection supervenes. Well, you say, rigid asepsis is impossible under emergency conditions. A nagging thought—maybe it is also unnecessary under others? One medical center has broken with tradition by doing what it calls a mini-prep (in presumably already infected cases—a sort of what-the-hell attitude): the area is washed well with soap and water, and only three towels are used as drapes. "In the year that we have been using this approach we have been impressed [with it] . . .[29]

What about war surgery done, as you've seen on the screen, under tents, in the open air, in a manner at which any self-respecting operating room supervisor would hold up her hands in horror? The statistics are amazingly good. Take my word for it, the results of battlefield surgery (in relation to infection) are almost as good as civilian surgery done with full ceremony. (On second thought, don't take my word for it. Write to your congressman for full details. It will do him good to know that his constituents are on their toes and that they expect him to be, also.)

[29] Described by Dr. William J. Ledger, of the University of Michigan Medical Center, in *Hospital Practice*, July, 1968, p. 34.

Tradition extends to surgical technique itself. Laborious hand work is still used when advanced machinery is available. I recall the furor aroused at a medical convention when surgeons from the Soviet Union demonstrated their stitching machines for the sewing together of blood vessels; practically none are used to this day in the United States. A stapling machine useful in stomach surgery is in routine use in Japan, but in only a few hospitals in this country. (In one of those hospitals, the surgeons wear belts *and* suspenders—they suture the same area after the stapling is completed.) In 1955 a Dutch surgeon, Dr. Iete Boerema, introduced a snap-together plastic button for gastrointestinal operations; it saved time and, better yet, could be applied in areas where ordinary sewing was extremely difficult, if not impossible. The device was reported on in the *Annals of Surgery*; it was no secret. Fifteen years later it was first used in this country.

But conservative and traditional as surgeons are, they are simultaneously innovators and radicals. Patients used to be kept in bed for a week after an operation; it took a world war with its concomitant shortage of doctors, nurses and hospital beds to bring about acceptance of the idea of early ambulation. Then the race started to see how soon patients could get up postoperatively; it is now agreed that he may (not *can*) walk as soon as he recovers from the effects of the anesthetic. Formerly surgeons refused to operate on cases where cancer had spread through viscera, pelvic bones and spine; now, with improved techniques, they delightedly report additions to the pelvic exenteration operation (in which parts of the bowel and bladder and all pelvic tissue are removed) by doing translumbar amputations which leave the patients in a worse condition than the illusionist's half-woman, the cancer presumably having been eliminated, but the life left not worth living. Dr. Michel Garbay, reporting on a case (with horror-inducing illustrations) in which he performed this operation (*La Presse Médicale*, 1967, *76*: 559) acknowledges his debt to American surgery by citing five cases done in the United States, dating from 1962. The total number of cases is now seventeen.

Another illustration of bold surgical technique was the recent separation of Siamese twins joined at the midline, with three legs (one with two feet) jutting out from the sides of the body. In an operation requiring six surgeons and lasting twelve hours, the twins were separated and remained alive. But not exactly well. To quote one of the surgeons (name on request), "No one should look at the separation as leaving two normal children either anatomically or physiologically. They will need orthopedic surgery to bring down their good legs, and a prosthesis will have to be fitted to the other side. They have permanent colostomies, and the urethral function remains to be determined. . . ."

The greatest surgical achievements have been in the field of cardiovascular surgery leading up to the sanguinary orgy of cardiac transplants. The drama of transplanting a heart from one individual to another (or perhaps the publicity attendant on Dr. Barnard's initial success) spurred surgeons to such unreasoning levels that the Board of Medicine of the National Academy of Sciences felt constrained to set up comprehensive guidelines for the procedure. (One guideline was to make sure that the donor was dead!) It warned that cardiac transplantation was not an accepted form of therapy but a scientific experiment. Furthermore, although there may be some uncertainty about when the donor will die or has died, there is even more uncertainty about the ultimate fate of the recipient. The heart transplant is not the same as a kidney transplant; if the latter fails, the technique known as dialysis is still available for the prolongation of life; but if the cardiac transplant fails, woe!

To be fair to the medical profession, I must say that from the very beginnings of cardiac transplantation, physicians have voiced their doubts about the procedure. As time goes on and the public becomes more informed about the uncertainties of the operation, the voices become louder. Dr. George E. Burch, president of the American College of Cardiology, says, ". . . At what point can the medical man, in good conscience and given the wide range of drug and surgical therapies available, tell his patient that medicine has nothing to offer him except an experimental and hazardous procedure? . . . To compound the problem, the patient may already have been persuaded by publicity in the mass media that transplantation is his real salvation . . . 40,000 patients could be restored to a useful life at far less cost and without the immunologic problems of transplantation." And Dr. John J. Hanlon, past president of the American Public Health Association, wryly comments that the $60,000 over-all cost of one heart transplant with dubious chance of success could be better used to train four physicians who could treat thousands of patients; he suggested it was time to stop the narrow thinking typified by such surgery and apply the money to preventive medicine.

The arguments about cardiac transplants brought out some interesting statistics. A study of congenital

(present from birth) heart disease in adults (237 cases) showed that only 37 had died at the time of the survey and 19 of those had died from surgery done to correct the defect. Another study, of the causes of death of 109 patients with cerebrovascular disease from narrowed carotid arteries, showed that 57 had died while under medical treatment and 52 after surgical treatment, no great statistical difference. Dr. Barnard, defending himself at a surgical congress, pointed out that surgeons operate on children with atrial septal defects although life up to fifty or sixty years is very possible in such cases. Another speaker commented that it was often smarter to leave well enough alone rather than tamper with the anatomical peculiarities a patient had, because the cost of attempting correction might far exceed the price of a judicious do-nothing approach. Among those costs (other than the hazard of immediate death on the operating table or shortly after the operation) is permanent brain damage from anoxia or fat embolism. (Fat embolism is a condition in which globules of fat lodge like clots in an artery.) Dr. J. Donald Hill of the Pacific Medical Center in San Francisco says flatly, ". . . The vast majority of patients leaving the hospital after open heart surgery have varying degrees of fat embolism in their brains."

About cardiac transplants for themselves, doctors answered a poll in no uncertain terms. Fifty-three per cent of respondent cardiologists (218 in all) would not consent to heart transplant surgery if they had advanced heart disease with a poor prognosis; an additional 20% were undecided.[30]

The problem of transplants is not one of technique. No one can deny that the surgical feats are amazing. What is too bad is that they are so good that surgeons, in their zeal to show their skill, go ahead before all the problems of tissue-matching and tissue-rejection have been solved. Even after the death of Dr. Blaiberg, overoptimistic comments appear in the surgical literature, to the point where such science-fiction stories as brain transplants are discussed. One doctor in Texas not too long ago performed what he called an eye transplant. If he did what the press claims he did, only charity can excuse him for his ignorance of physiology. Experiments with drugs are usually so carefully circumscribed and controlled since the thalidomide fiasco that one is puzzled by the freedom with which surgeons experiment and by the equal nonchalance with which patients submit to the operations.

Let's forget about cardiac transplants. Here's a better example of surgeons rushing in where angels fear to tread. There is a psychiatric (yes, sir—*psychiatric*) condition in which the patient feels he/she would be happier were he/she to belong to the opposite sex. I do not refer to true hermaphroditism (often curable and actually cured by operation) but to transsexualism. Reputable surgeons do not hesitate to offer their services to men (not women—because constructing an erectile penis is an impossibility) who want to have their genital organs removed and an artificial vagina constructed. Christine Jorgensen (real) and Myra Breckenridge (fictional) are examples of what can be done. What *can* be done—but should it?

Should it? Suppose you were a doctor with an obese patient (fat, very fat, around 350 pounds). You could hospitalize the patient, put him on a restricted diet, and assure him that more than 100 pounds would be lost. Or—you could hook up the beginning of the small intestine to the large bowel, thus bypassing the area where food absorption takes place. The patient could then eat whatever he pleased—hot fudge sundaes, whipped cream cakes, home fried potatoes—and lose weight anyway. Who needs to diet if such a marvelous procedure is available? But don't run yet to the nearest surgeon. First remember that the operation is physiologically unsound and then read about the damage it can do to the liver.[31]

Which brings us to the difference between surgical achievements and progress. Dr. Eddy D. Palmer (another Voice of Authority) castigated a meeting of surgeons for their lack of distinction between the two. It would be difficult to show, said he, that a patient with cancer of the stomach in 1966 would fare better than a patient with the same disease in 1866. He also pointed out that the surgical treatment of duodenal ulcer reflected not only the failure to add much to our knowledge of gastroduodenal physiology but also showed technical regression from time to time. New operations were continually being put forward, hailed as the final answer and then quietly discarded as disillusioning evaluations poured in. Just as in cardiac transplantation, the techniques outstripped the knowledge of physiology.

[30] Reported in the *Journal of the Medical Society of New Jersey*, May, 1968, p. 223.

[31] Drs. E. J. Drenick, F. Simmons, and J. F. Murphy, reporting in the *New England Journal of Medicine*, 282:829, 1970.

I get the feeling that maybe there are new dance steps, but the rhythm and results are the same.

But don't blame the surgeons alone! They're just keeping up with the public demand for brilliance and breakthroughs. People are impressed by surgery because actions speak louder than words. Manual dexterity, like prestidigitation, is more spectacular than the mental processes needed to arrive at an accurate diagnosis or sound surgery. In medical school I had a professor who said, "Truth is revealed and mystery dispelled by the use of the aseptic scalpel." One of his medical colleagues laughed when the aphorism was repeated to him and asked, "What about a hot, tender, swollen shoulder joint? Would he operate first and think later?"

The medical man did not consider that people want a definitive solution to problems, not long, drawn-out treatments, and what's more definitive than transplants, excision or amputation?

Think twice—maybe three times—when a doctor recommends a surgical procedure for you. Ask what are the possible complications, what are the chances of dying from the operation, and most important, how much longer will you live comfortably if you're not operated on. That's what I did.

5.

A SIMPLE SOLUTION

A man had a fungus infection of the toes (athlete's foot), especially between the webs of the third and fourth toes on each foot. Three weeks of treatment cleared the infection temporarily. When it recurred, the fifth toe on the right foot was amputated and the third and fourth toes sewed together, eliminating the web. The patient was so pleased with the result that he wanted the same operation done on the left foot, but by this time more conservative therapy had controlled the infection and the surgeons did not operate.

The surgeons learned from that first case. What? Not that conservative therapy might help, but that in their next case they'd better do both sides at once. They did. They removed all except the great toe on each foot. End of disease.

The above is true. It was reported in the *Achives of Dermatology*, 99:6.

By analogy, recurrent headaches can be permanently eliminated by the use of the guillotine.

6.

"Better a snotty child than his nose wiped off."

George Herbert, *Outlandish Proverbs*

Serenely pursuing the mysteries of their craft, the otolaryngologists (nose, throat and ear men) pay no attention to the crude television pictures of sinus cavities and blocked-unblocked nasal passages. They used to be eye, ear, nose and throat specialists, as though proximity of structure had relation to diagnosis and therapy. Imagine them treating brain tumors by the same reasoning! Common sense finally prevailed. The specialty underwent fission into ophthalmologists and otolaryngologists. The ENT men feel secure in their profession; they have no need to unbend to the fickle public. They know that as long as women talk and men blow their noses and children have sore throats their services will be called for.

They don't resist change. Not at all. When optical engineers developed an operating microscope, the otolaryngologists gladly used that instrument for science-fiction types of manipulation of the tiny auditory ossicles in the treatment of otosclerosis, a form of deafness. When other engineers improved audiometers, the otolaryngologists took over to improve their diagnostic techniques.

Such an ecumenical spirit can only be commended—until one looks carefully at the practice and discovers that the addition of the new and helpful has not necessarily meant the discarding of the old and harmful.

Take such a well-known instrument as the otoscope, for example. You know that cute little searchlight device with the small earpiece that the doctor uses to examine the ears. With that device the doctor can see the eardrum and can tell whether it's inflamed. But if it isn't—well, he's doing his best to inflame it. I quote: "The study showed beyond a reasonable doubt that it is possible to induce purulent otitis media (pussy inflammation of the middle ear) through excessive manipulation in the ear canal. It is little wonder, then, that there are many who consider the use of the direct otoscope a curse rather than a blessing.[32] Poking at the delicate tissues of a child's ear canal (and who can prevent poking when the little darling is squirming and fighting?) irritates those tissues; if the earpiece is not scrupulously

[32] Dr. H. Bakwin, "Pseudodoxia Pediatrica," *New England Journal of Medicine*, 232:691, 1945.

clean, infection supervenes. But doctors learn, even if it does take them a long time. In 1969 disposable earpieces came into fairly general use.

The otolaryngologist has a special place in the social maturation of children. Long before any of the other rites of passage (like wearing a training bra or getting a driver's license) are undertaken, he initiates the child into painful health-consciousness, one of the desiderata of our society. He removes the tonsils and adenoids.

Tonsillectomy, with its concurrent adenoidectomy and its equally concurrent morbidity (illness) and unfortunate mortality, is the operation most frequently performed (except for those procedures associated with childbirth) in the United States today. It accounts for 100 to 300 deaths annually in this country. Those figures are not mere statistics—they're made up of the wailing of mothers for their lost children, children who died as the result of an "elective" operation. Who elected to do it? The parents? The doctor? That's mortality. Morbidity includes the 42.8% of children losing 10% of their blood volume and the 3% losing more than 25%, leading to, in some cases, tying off of the external carotid artery in the neck (a formidable operation with potential serious aftereffects) and, in others, to more than five transfusions. Furthermore, the operation has profound and bad psychological effects. Consider—a child is separated from his parents, put in a strange bed, stuck with a needle and then terrorized by having a mask clamped over his face so that he must breathe a suffocating gas. No wonder the psychiatric literature is full of evidence that childhood tonsillectomy may cause night terrors, abnormal dependency on parents and deep hostility toward doctors.

Why is the operation done? Ask the doctor who advises it or the one who performs it, and the answer will be double-talk, if he bothers to answer at all. More likely you'll be looked at as an anarchist radical who carries a Molotov cocktail in one hand and a copy of Chairman Mao's teachings in the other, one of those wise guys who dares to question the eternal verities.

Actually, doctors themselves (including a few, a very few otolaryngologists) have long been doubtful of the value of tonsillectomy. The consensus is that tonsils are being removed merely because they're there. After all, no one knows their function; therefore, no one can say with assurance that their removal is harmful. "Enlarged tonsils" is a statement, not a disease; it is in the category of a retroussé nose or a receding chin. Doctors agree that tonsillectomies can be done for any condition except acute tonsillitis; in that case it is contraindicated. In other words, tonsillectomy should be done in the absence of tonsillar infection; the operation is safest when done on perfectly healthy individuals. Dr. Bakwin (quoted previously) reported that no correlation existed between a child's health status and recommendation for the operation; how the physician felt about it was the decisive factor.

Ah! I hear you say, but tonsillectomy is a prophylactic measure, not a therapeutic one. Removing those lymphoid blobs from the throat will prevent colds, rheumatic fever, sore throats and a dozen other ailments. Not at all. Survey after survey, study after study, year after year, all have demonstrated that children whose tonsils have been removed are no better off in health than before the operation, that rheumatic fever is not prevented, that indeed no determinable value adheres to the operation.

One of the first controlled community studies on tonsillectomy (in Rochester, New York, in 1922) showed it had no effect on the recurrence of otitis, bronchitis, laryngitis, pneumonia or rheumatic fever; yet this past year one-third to one-fifth of all children hospitalized in that same area were admitted for tonsillectomies!

A more recent survey (1968) says the indications for the operation should be severely limited to children between the ages of five and seven who have persistent nonallergic nasal obstruction from very large adenoids or who have tonsils so big that they cannot swallow. The operation is worthless "for repeated colds, chronic cough and other respiratory diseases, or anorexia [loss of appetite]. With antibiotics, there is little need for the operation in patients with a history of rheumatic fever or nephritis . . ."[33]

And a professor of otolaryngology at Johns Hopkins University, Dr. Donald F. Proctor, says, "We now know that recurrent tonsillitis is generally a benign disease to be expected during one or two years of the average child's life. We believe that the presence of tonsils and adenoids during early childhood may play a role in the development of normal [immune] defense mechanisms . . . if each child is treated more considerately, fewer psychoneurotic complaints will complicate the lives of adults."

To illustrate the unthinking acceptance of tonsillectomy as a procedure of value, first consider that in

[33] Dr. Robert J. Haggerty, of the University of Rochester, N.Y., in an article in *Pediatrics, 41*:815.

12% of the patients operated on, the complication of post-operative bleeding occurs and then ask why the operation is performed on hemophiliac patients who are almost guaranteed to bleed. Yet it is done. And ingenious doctors resort to novel methods (cryosurgery, for instance, done by Dr. Hans von Leden of the University of Southern California at Los Angeles) to obviate hemorrhage. A thinking person might say—why do it at all?

Really, why are tonsillectomies done? The obvious, but incorrect, answer is venality. Again I hasten to rise to the defense of my colleagues. The same studies I have mentioned also show that economic considerations play no part in recommendations for the operation; clinic and welfare patients have proportionately as many tonsillectomies as those able to pay for that dubious service.

Tonsillectomy is done because of mental inertia, because a break with established ritual is emotionally painful, and because (*very* important) parents feel that they would be depriving their children of the benefits of good medical care were they not to offer them up to the tonsillar guillotine as to Moloch. (*Guillotine* is not used metaphorically; it is the name of an instrument.) "Ritualistic surgery" is what one eminent pediatrician calls tonsillectomy. He puts it in the same category as sacrificial castration or the pubertal knocking out of teeth.

But what if your doctor recommends tonsillectomy for your child? Immediately you can come to the conclusion that he is either stupid or mentally lazy. Time to change doctors.

7.

A STUFFY NOSE

Don't get the idea that otolaryngology is a needless specialty. It is not. The operative cures for several types of deafness have been nothing short of marvelous, and the recent results in the treatment of cancer of the larynx equally so.

Even in such a mundane case as a chronically running nose, the ENT man can often effect a cure by removing what shouldn't be there. People have strange habits.

Here is a list of what I have removed from the nasal passages—of adults as well as children:

Bits of rubber eraser	Paper clips
Cotton swabs	Lima beans (uncooked)
A shoelace	Newspaper
Crayons	Toothpaste caps
Tin foil	A piece of frankfurter
Bolts and screws	Assorted nuts (metal and edible

An ENT friend of mine added to the above. He removed a beetle, watermelon seeds (ungerminated), cigarette butts, popcorn and a jack (playing, not automobile).

8.

"Birth, and copulation, and death—
That's all the facts when you come down to brass tacks."
—T. S. Eliot, "Sweeney Agonistes"

Unlike the EENT men, who split off the first E, the obstetricians and the gynecologists have amalgamated. (Pronounce *gynecologists* as you please. Authorities differ. Classicists say *Guy*; modernists can't make up their minds between *Gin* and *Jine*.) The two groups have united not because they deal with the same anatomical parts but because of the falling birth rate. It stands to reason that in the nine-month interval between conception and delivery the obstetrician should do more than sit and twiddle his thumbs while waiting. He might just as well be doing something useful like repairing the tissues damaged in a previous delivery or like making fertile women infertile or the other way around. (I say *he* not because I am a male chauvinist, but because the number of women practicing medicine in this country is negligible, deplorably so. I can be smug in my deploring—one of my daughters is a physician.)

The OB-GYN man is surrounded by a mystic aura compounded of fear, male hostility, female adulation and a peculiar glamour. The fear is mixed with awe. It is understandable. It is a primitive, almost reflex, response to one who seems to bring forth life "between corruption and corruption," as St. Augustine said. It is the mouth-open wonder at one who touches with impunity the secret parts, at the magician who disregards the lightning of parental and societal disapproval, at the fearless prober of the mysteries of the Bona Dea. The hostility of the male is derived from envy of privileged voyeurism, from his feeling of exclusion from an area in which he has a vital interest, and from a mistrust of the doctor, a mistrust fostered by the lurid imaginations of the doctor-novel writers. The adulation of the female is also comprehensible. On the

surface, it occurs because the doctor actually helps women in trouble and pain. Analysts have said it is a socially acceptable surrendering to incest fantasies; more skeptical observers consider it a barely disguised lubricity, for with whom else could women indulge in conversation that would make the Wife of Bath blush?

Glamour attends the picture of the frantic racer with the stork, the weary, haggard doctor patiently comforting the woman in travail, the sympathetic listener to the woes of womankind. Besides being a healer, the doctor is used as a father-confessor, a confidant, and an advice-giver.

Small wonder then that the heads of so many OB-GYN men are turned. They undertake to merit the confidence placed in them. They forget the limitations of human knowledge in their field. They assume the mantle of divinity. They proceed to interfere with nature in the name of science and by virtue of the authority vested in them by the states in which they practice.

First, they tried to get rid of the curse of Eve. "No more pain!" became the slogan. Under their expert ministrations the woman in labor was to expect no more than slight discomfort and was to awaken refreshed and chipper after her delivery, with her baby at her side. Chloroform, ether, "twilight sleep," newer and newer synthetic drugs for inhalation and injection were introduced and acclaimed but not discarded as their danger for mother and infant became known. In the century since Sir James Simpson gave Queen Victoria chloroform for her accouchement, obstetricians came to the conclusion (which a little forethought and attention to the facts of physiology would have shown) that anything that put a woman to sleep would also have the same effect on the baby in her womb and would tend to prolong her labor by diminishing the strength of her uterine contractions.

Spinal anesthesia, so useful in surgical operations, was then tried but found to be too dangerous for the mother. In 1941 caudal anesthesia, a variant of spinal anesthesia, was introduced and for years was held to be the ideal agent. Unfortunately, the technique for its use was complicated and equally unfortunately, it carried with it a small but definite mortality in the mothers (and a small—if 10.6% is small—problem of resuscitation in the newborn child).[34] The obstetricians met the challenge directly. They announced that natural childbirth was the best method and rejoiced to see the new generation of mothers doing breathing and relaxing exercises in anticipation of the grand event.

Some doctors kept right on trying, however. Back to unconsciousness they went. (A catty person might say *consciencelessness.*) Bigger and bigger doses of sedatives were used. Then in 1968 it was reported that large doses of barbiturates given intravenously not only do not have a good sedative effect on the mother but they depress the breathing of the newborn infant. So—the dose was reduced and a phenothiazine compound was added; that was a little better for the baby but provided less sedation for the mother. You'd think now the method would be discarded, wouldn't you? "No," said the well-meaning doctor, wiping his sweating brow, "we gotta do something." So—back he went to the heavy sedation, making the mother unconscious by intravenous doses of the narcotic, meperidine, plus scopolamine, and then a few minutes before delivery he injects nalorphine (a pharmacologic antagonist to the drugs he's used). Result: less depression for the baby but an increased incidence of acidosis. Conclusion—"The normal healthy infant born under this type of medication can withstand the pharmacologic insult; however, the child who is compromised in any way seems better off delivered by less injurious methods."[35]

Hypnosis and suggestion are also used. Old women in primitive societies practice witchcraft in difficult deliveries. Lest that last be interpreted as a snide remark, let me hasten to say that in my own practice I used suggestion with good results. I even wrote a paper on it, to which I shall modestly give no reference.

So now natural childbirth is fashionable. But the American version of that process is not exactly like Eve's parturition. It presumes a little help from the obstetrician. The patient is no longer numb from the navel down, but Baby's entrance into this vale of tears is speeded by cutting Mother's perineum and applying extractive apparatus to Baby's head.

Since the doctors couldn't stop the pain of labor, they tried their hand at shortening its duration. That had advantages for the doctor, more so than for the patient. He didn't have to sit around waiting until the goddess Lucina settled down to her job. He used quinine, astor oil, hot enemas, pituitary snuff, enzymases, forceps, and vacuum extractors. Of course, presumably delivery should not take place until the maternal tissues and the delicate fetal head have had time to adjust to each other. But progress is progress and if art can improve

[35] Doctors R. B. Clark *et al.*, in *Obstetrics and Gynecology, 153*:30, January, 1969.

[34] Drs. A. O. Lurie and J. B. Weiss, reporting in the *American Journal of Obstetrics and Gynecology, 103*:850, 1970.

on nature, why not? Furthermore, if, as says the American College of Obstetricians and Gynecologists, "obstetrical care, including delivery, is a surgical procedure," why not schedule a delivery just as surgeons schedule an operation?

That can be done and it is done, especially when the doctor is busy. On or about the calculated date that the baby is due to arrive, the patient goes into the hospital. She is prepared to be rid of her burden. Drugs are given to induce labor; the membranes around the baby are punctured instead of waiting for their inevitable rupture; instruments are used and surgical incisions made to facilitate the delivery of the future President. A nice clean procedure. The hospital is happy, the patient is happy, and best of all, the doctor is happy.

Maybe all the happiness makes up for the disgraceful position the United States has in maternal and newborn mortality lists. In 1950, eight out of every 10,000 deaths were of women in childbirth; in 1966, the number dropped to three. Good, huh? Not on your life! "The low prevailing maternal mortality rates have led to a philosophy that an irreducible minimum has been reached and that the few remaining deaths must be inevitable . . . Three-quarters of the remaining obstetric deaths are preventable . . ."[36] The authors of that statement charge that overuse of uterine stimulants during labor and the too-frequent resort to Caesarean section are the major causes of this morality. With all this country's wealth and far-flung medical services we stand eleventh on the international maternal mortality list, just below Belgium. Sweden is first, with exactly half our maternal mortality.

One of the most sensitive indices is the neonatal mortality rate, deaths under 28 days of age per 1000 live births. In 1966, Sweden was first, with a rate of 10.3; we were tied with Czechoslovakia for twentieth place, preceded by Singapore, Jamaica, Bulgaria, Romania, etc.

Some things are worse than death. Consider what happens as a consequence of interfering with normal childbirth. As long ago as 1861 it was noted that cutting off or down on the oxygen supply to the baby in the process of being born resulted in neurologic and mental disorders. That observation kept being confirmed and disregarded. The disregard came from skeptical and scientific doctors who said, "Prove it." So finally it was proved by Dr. (Ph.D., not M.D.) Windle of the New York University Medical Center. He concluded a popularization in the *Scientific American* of his findings thus, "there is reason to believe that the number of human beings in the U.S. with minimal brain damage due to asphyxia at birth is much larger than has been thought. Must this continue to be so? Perhaps it is time to re-examine current practices of childbirth with a view to avoiding conditions that give rise to asphyxia and brain damage."

Anything that slows the placental circulation reduces the blood supply (and hence oxygen supply) to the baby's brain. Very strong uterine contractions will do that. Drugs that depress the mother's circulation will do the same. Pain-relieving drugs that pass through the placenta to the baby, especially drugs related to morphine, have an inhibitory effect on the baby's respiration, so that spontaneous breathing after birth may be delayed or so shallow that insufficient oxygen gets into the baby's lungs. Pressure applied directly to the baby's head may also depress circulation by a reflex as well as by a direct action. If the neck of the womb (the cervix) is excessively rigid and the protective bag of waters is not present, the baby's head acts as a battering ram with every uterine contraction. If forceps are applied, pressure is obvious and vigorous. Vacuum extractors almost always cause subcutaneous bleeding under the scalp; why should one not expect tiny bleedings in the brain under the yielding bony structures of the baby's skull? Unassisted (and unimpeded) childbirth has its own problems—those of maternal discomfort and unavoidable pressure on the baby's head. Why add to them?

Expectant mothers should remember that babies were born before the advent of obstetricians, that pregnancy and childbirth are not diseases, and that therefore the more natural the labor, the better the result for mother and newborn infant. Beware the doctor who promises a scheduled delivery and a painless labor! And be equally wary of the doctor who freely prescribes drugs to alleviate the minor discomforts and tensions of pregnancy.

They may make you feel better but may damage your baby. It has been demonstrated that barbiturates and tranquilizers may cause changes in the fetus that show up in later life as learning and behavior problems;[37] tetracyclines cause discoloration of the child's teeth; some steroids affect the sex organs, etc., etc.

In Israel obstetricial nurses deliver 90% of the

[36] Drs. Otto C. Phillips and Jaroslav F. Hulka, "Obstetric Mortality," in *Anesthesiology*, *26*:435, 1965.

[37] Dr. Conan Kornetsky, of Boston University, in a paper delivered at the American Medical Association meeting of December 1, 1970

women in labor. "Our doctors are reluctant," says Dr. Wolfe Z. Polishuk of Hadassah University Hospital in Jerusalem, "to have our mothers unconscious during delivery. We use natural childbirth and avoid anesthesia in normal deliveries . . . Only 2% of our [vaginal] deliveries are with forceps. . . ."

Swedish doctors say that their enviable position arises from the fact that nurse-midwives do all normal deliveries. They stay with the patient from the time she enters the hospital until she is delivered; they are not permitted to use anesthesia; they are not allowed to rupture membranes (the bag of waters), induce or hasten labor, or make use of any operative techniques.

Then why don't American women use trained midwives? Because when they want a priest, they're not satisfied with a deaconess. They feel it's beneath their dignity to have a motherly midwife rather than an abstracted obstetrician in a hurry to get on with his second job.

That other job is primarily, to judge from the volume of reports and publications on the subject, to guard the female sex from two presumptive evils: the menopause and reproduction. The menopause, with its accompanying fearsome old-wives' tales and its actual physiologic changes, is a bogeyman that must be conjured away. The prevention of conception is not only the inborn right of women, but it has also now become a patriotic duty.

Menstruation, "the curse," would gladly be given up by women were it not that its disappearance signals to them that they have reached the final milestone of their lives. From that point on everything goes downgrade. But suppose some sorcerer held out to them the promise of eternal youth, or at least permanent middle age? Would they not flock to his cave for that wonderful elixir? Would they not take it without thought of the aftertaste? A sorcerer would sell it to them without any warning, but should a gynecologist?

The female sex hormone, estrogen, originally used as replacement therapy in more or less pathologic postmenopausal states, such as senile vaginitis and excessive flushing, has recently been touted in the women's magazines and widely prescribed by doctors in response to the demand by women for protection against the changes that occur in them as the years go on. Enthusiasts claim it can prevent wrinkled skin, gray hair, loss of libido, constipation, "liver spots," osteoarthritis, depression, irritability and a dozen other complaints. Those claims are not substantiated by carefully controlled studies. The manufacturers of estrogens, wary of the Food and Drug Administration, are more cautious in their advertisements; for example, one says, "In view of the accumulating evidence that estrogens are protective against *premature* [my emphasis] degenerative metabolic changes, within recent years the continuous use of estrogen in the aging female has been looked upon with more favor than in the past." The quotation is from a package insert for information of physicians (Estinyl, manufactured by Schering).

The informational inserts in the packages also warn, however, that prolonged use of estrogen may inhibit the secretion of certain hormones of the anterior pituitary gland. That should give you pause. Scientific observation has demonstrated how fearfully and wonderfully the human body is made and how delicate is its physiologic balance. Interfering at any single point with its mechanism or its dynamics may cause changes far distant from the original point of interference. For example, if an endocrine substance naturally produced in the body is given artificially, the gland making that hormone shuts itself down. In the case of estrogen, the anterior pituitary gland stops secreting its ovarian-stimulating hormone. Once that internal governor controlling estrogen secretion is not working, who can judge what is the right dose to give? An excessive use of estrogenic hormones may produce oversecretion of mucus at the neck of the womb and thus a secondary inflammation of that area. Furthermore, so well documented are the findings that estrogens cause stimulation of breast tissue and of the tissue lining the uterus that the package inserts must carry the warning to physicians that estrogens should not be used in women with a personal or familial history of mammary or genital cancer.

Dread word! Is there any basis for worrying that estrogens can cause cancer? Yes, there is. Dr. Roy Hertz, Chief of the Reproductive Research Board of one of the National Institutes of Health at Bethesda, Maryland, says so quite bluntly.[38] After discussing the experimental data on the carcinogenic action of estrogens, when asked whether the prolonged use of estrogens in women before the menopause could eventually cause cancer, he answered, ". . . We are ill advised to ignore the mass of observations clearly relating . . .

[38] Interview reported in *Ca—A Cancer Journal for Clinicians*, (published by the American Cancer Society), March, 1968.

estrogen to the pathogenesis of breast cancer in both man and animals." In response to the question of why estrogens were so extensively prescribed by the medical profession, he gave an evasive answer, one implying willful ignorance on the part of the doctors. He also commented that cancer of the uterus was a possible delayed aftereffect. There is much more evidence than that interview for the danger in using estrogen; you can find plenty of references in any text book on gynecology or in the book; *The Pill,* by Morton Mintz, published in Boston in 1970.

The Pill has dangers. Why shouldn't it have? The Pill has a profound effect on the endocrine system. It prevents ovulation by inhibiting the output of gonadotropins (ovary-stimulating hormones) from the pituitary gland. It also affects the skin, the adrenal glands, the liver, the uterus and who knows what else. It may be (and has been) the cause of jaundice and other liver disturbances, the enlargement of fibroid tumors, abnormal increase of facial hair, the retention of fluid in the body leading to a gain in weight, sometimes kidney or heart strain, swelling of brain tissue (aggravation of epilepsy, migraine, possibly mental changes), thyroid disturbances, excessive clotting of blood, stunting of growth in teen-agers, and—why go on? The longer the Pill is used and the more its action on the female organism is investigated, the more horrendous does it appear. And if you think that I made up that list of perils of the Pill, you're mistaken. I *shortened* it from the one the Food and Drug Administration requires in the package inserts. Every advertisement to doctors about the Pill carries a full page of fine-print warnings about adverse reactions, contraindications and side effects.

Why all the side effects? Because prolonged treatment with ovulation inhibitors interferes with a woman's normal hormonal balance. Because inhibiting the action of the pituitary gland in one direction inhibits it in others. The result in some cases is actually a permanent suppression of ovarian activity even after the use of the Pill is discontinued. The woman no longer menstruates and becomes sterile. In other cases, while fertility is unimpaired, the ability to secrete milk after delivery is reduced so that the mother cannot breastfeed her baby. In still other cases, the Pill, being a steroid hormone having an effect on the liver, results in a folic acid deficiency type of severe anemia.

Three studies of the effects of the Pill are still going on. The latest, by Dr. Herbert Gershberg of the New York University Medical Center, warns that the Pill may cause high concentrations of cholesterol in the blood, presumably a forerunner of hardening of the arteries. Another report agrees with that of a previous survey conducted by the National Institutes of Health, which in turn supported that of a British team. Since the Pill has been in use there has been a significant increase in the number of deaths in women between the ages of 20 and 44 from venous and pulmonary embolism secondary to thrombophlebitis. That is, abnormal clotting takes place in veins; portions of the clot break off and are carried to the pulmonary arteries, where they lodge and obstruct the circulation in the lung. The annual increases in the death rate have averaged between three and twelve per cent. Embolism also occurs in the cerebral arteries; women have had strokes after taking the Pill. When you consider that strokes in the age period when women are fertile are rare, you realize that the fancy package contains a bunch of tiny lethal weapons. Confirmation comes from Doctors Hobell and Mishell, who found that in seven of their eight cases of pulmonary embolism in women, the women had been taking oral contraceptives. The Food and Drug Administration now requires that the manufacturers of the Pill caution doctors about the dangers of thrombophlebitis and embolism when it is used.

The most controversial aspect of the Pill comes from its direct effect on the uterus. A Sloan-Kettering research team found significantly more cervical cancer *in situ* (localized cellular cancer of the neck of the womb) in pill takers than in diaphragm users. Dr. Wied of the University of Chicago reported a sixfold increase in positive Pap smears among women who had taken oral contraceptives. The proponents of the Pill say it is safe, that the above studies are inconclusive, and that more study is needed. They all concede, however, that the Pill does induce changes in the surface lining of the uterus.

I'm not a stick-in-the-mud reactionary nor the only opponent of the Pill. Dr. Hugh J. Davis, assistant professor of obstetrics and gynecology at Johns Hopkins University School of Medicine, says, "It is medically unsound to administer such powerful synthetic hormones in order to achieve birth control objectives which can be reached by simple means of greater safety," and "The widespread use of oral contraceptives . . . has given rise to health hazards on a scale previously unknown to medicine . . ." and "It is extremely unwise to officially license, sponsor, and encourage a long-range experiment, such as we now have in progress." But, as Dr. Ralph Benson said at a recent meeting, "Women make superb guinea pigs [for testing oral

contraceptives]. They don't cost anything, they clean their own cages, they pay for their own pills, and they even remunerate the clinical observer."

The dangers of the Pill were finally recognized by the manufacturers of pharmaceuticals. They didn't take the Pill off the market. Oh, no! They reduced the amount of hormone in each pill so that the side effects would be less obvious. But—in order to stop the egg-producing function, there must still be a dose large enough to interfere with the body's natural hormone balance!

So when diaphragms and jellies and foams and condoms are available, why do so many women play a variety of Russian roulette? Because they (or their husbands) are lazy. Because they have been brainwashed by the vested interests of the proponents and makers of the Pill. Poor things! They are children playing with matches, matches supplied by the indulgent doctors who give them what they ask for.

(I insert here a political note. In Cuba, "The pill is not considered safe enough for distribution and, because health is not a commodity in Cuba, it is not distributed."[39] In the Soviet Union the Pill is neither manufactured nor imported, according to the *Medical World News* of January 10, 1970. "The Western world is their guinea pig for The Pill.")

What about the surgical qualifications of the gynecologists? I quote: "The requirements of the Board of Obstetrics and Gynecology are inadequate . . . for the handling of many of the surgical conditions in the pelvis which may be encountered in the course of gynecologic surgery."[40]

Why go on? The glamour surrounding the OB-GYN man would be tarnished were the adoring women around him to remove their self-imposed suspension of reason.

8.

A PAINLESS LABOR

I once delivered a woman of a fine baby boy. It was during wartime, when there was a shortage of anesthetists and nurses, so that she was unable to have all the benefits of modern medicine. When the delivery was over, she said to me, "Why did everybody tell me labor was so hard? It's no worse than having a hard bowel movement."

Now here's a true record, copied from a hospital chart. The attending obstetrician was a busy man who'd built his reputation on his success at quick, painless deliveries. Calculated date of delivery: October 5.

(Admittedly this date is only an approximation, being calculated from the date of the last menstrual period.)

Admitted to hospital: October 7 for elective induction of labor. The indications for such induction were listed as

(1) Patient's choice.

(All those years of the doctor's training for naught? He lets the patient decide when she wants to have the baby?)

(2) Past due date for delivery

(A touching proof of the doctor's belief in his infallibility. When he says the baby's due on October 5, it's due then and that's that.)

(3) Favorable cervix

(Meaning that the neck of the womb is already partially dilated and that normal labor would start soon anyway.)

8:50 A.M. Examination showed that the baby's head was in good position and the cervical opening was two inches wide. The doctor then ruptured the membranes.

(The elastic bag of waters protects the baby's head, but it is not so effective a dilater of the cervix as the baby's skull. The hard pressure of the head will speed up the process of dilation. And bang the head.)

9:00 A.M. Intravenous infusion of pitocin in glucose solution was started.

(Pitocin is a powerful uterine stimulant; it causes strong contractions of the uterine muscles, thus propelling the baby onward and outward.)

9:05 A.M. Uterine contractions started fairly strong, coming every one or two minutes.

(The baby's head is pounded against the cervix with each contraction.)

9:30 A.M. Pains are much stronger and last longer.

(With each contraction the placenta is squeezed upon and less blood goes to the baby.)

Intravenous meperidine given.

(Similar in action to morphine, the drug was given directly into the bloodstream of the mother to insure

[39] Chris Camarano, "On Cuban Women," in *Science and Society*, 35:53, Spring, 1971.

[40] Drs. A. M. Kiselow, H. R. Butcher, Jr., and E. M. Bricker, "Results of the Radical Surgical Treatment of Advanced Pelvic Cancer: A Fifteen-Year Study," *Annals of Surgery*, 166:430–434, 1967.

prompt relief of pain without slowing up the uterine contractions. Some of the drug necessarily passes through the placenta into the bloodstream of the baby.)

Intramuscular promethazine given.

Another sedative, to enhance the action of the meperidine.)

10:05 A.M. Examination showed the cervix was almost fully dilated and the head was coming down fast.

10:15 A.M. Caudal anesthesia started.

(The doctor promised the mother a painless delivery and he will keep his promise.)

10:28 A.M. The head of the baby was visible at the outlet of the birth canal.

(The doctor barely had time to finish the anesthesia!)

10:32 A.M. Delivery of a 5½-pound female child that cried after a few good spanks.

(A wonderful delivery! Fast and painless!)

When the baby was a year old, the mother became concerned because of its slow development. Her pediatrician informed her that the baby was somewhat mentally retarded.

When the baby was two, she could not stand without support, she could not hold toys well, she could not even say "Da-da," and she was excessively placid. A thorough study showed "delayed neurologic maturation and definite mental retardation."

Write your own moral.

10.

"The best of doctors is destined for Gehenna."

Mishna, *Kiddushin 4*:14

Internists, the epitome of specialists, are what the public ordinarily thinks of as doctors: men who use stethoscopes, fluoroscopes and electrocardiograph machines. They take histories, they listen to the chest, they palpate abdomens. Never, never confuse them with interns. The latter are important only in their own eyes. An intern is a fledgling doctor who lives in the hospital, there to complete his education by a little practical experience under supervision of those older (not necessarily wiser) than he. Internists are so called because they specialize in treating diseases of the internal organs. Not quite. They exclude from their purview the contents of the skull: the brain, the eyes, the paranasal sinuses. They also are not concerned with the bones, the male and female generative organs, and the rectum. What's left? Plenty. So much in fact that there are specialists in disorders of the bronchial tubes and lungs (except for tuberculosis—that has its own specialty), the blood, the heart and major blood vessels, the peripheral vascular system, the liver, the stomach and intestines, and the kidneys; in addition, there are those who treat conditions like diabetes, arthritis, allergies, endocrine disturbances, tropical diseases, obesity, and that hodgepodge called psychosomatic ailments. The newest subdivision is geriatrics, a branch which undertakes to repair the irreparable ravages of time.

The internist is consulted for a pain in the chest, for heartburn, for palpitations, for a cough, for swollen ankles, but not for a fever, for a sore throat, for a cold, for a headache or for a stomach-ache. He can't be bothered with such trivia. His mind is on more complicated problems: are the swollen ankles due to kidney disease, hardening of the blood vessels, tight garters or the heat? Is the heartburn caused by an ulcer or by too much liquor or by bad cooking? Does the cough result from heart failure or chronic bronchitis or overheated rooms or an allergy to the spouse? Why bother him with acute illnesses? He's got enough to do with the other kinds.

An internist differs from a general practitioner in that he does not deliver babies, open boils, sew up cuts, set broken fingers, or vaccinate for smallpox. In exchange for not performing these services, he charges more money for what he does do in the field of diagnosis and treatment. The line between the general practitioner and the internist is so tenuous that the size of the fee is often the only feature distinguishing the two. Not always, however. The internist, in keeping with his exalted position, holds himself aloof from the mundane cares of the patient. He examines dispassionately, gives his opinion flatly and makes recommendations appropriate to his diagnosis. "Take a sea voyage," he may say, or "Do more exercise," or "Don't work so hard." The recommendation may be impossible to follow, but that's not the internist's worry. He has danced the sacred dance, heard the ghostly voice and spelled out the sufferer's fate. He has done his duty.

He is proud of his results. Typhoid fever is a thing of the past; tuberculosis has almost disappeared; scurvy is found in text books only. Of course, a captious critic could point out that improved nutrition, better sanitation and housing, and above all, enlightened public health measures have played a greater part than medical practitioners in bringing about such wonderful results. Maybe so. Pasteur was not a physician, nor was

organized medicine the initiator of mass immunizations.

Nevertheless, advances in medicine have come about, and today medical doctors are the agents of those advances. Every organ has been investigated in detail; every bodily function has been examined. Medical journals bulge with learned papers on all the ills man is heir to (and some, like radiation sickness, he inflicts upon himself).

Reading the medical journals is fascinating. Doctors like to report on what they're doing and why. You never realize what a thorough job the internists do until you read the complicated mental maneuvers they go through to establish a diagnosis and the elaborate justifications they give for their treatment. They're not always serious. They kid themselves about their antics; they're not all taken in by the magic. In the April 1, 1968, issue of the august *Journal of the American Medical Association* appears a "Letter from Copenhagen," by Dr. Myron C. Greengold, in which he describes the diagnosis and treatment of the princess who had the pea under the mattress (familial thrombocytopenic purpura). The article is well worth reading *in toto*. (Contrary to antimedical propagandists, *The Journal of the American Medical Association* is a lively, literate magazine, much better than many sold on the newsstands.)

The very thoroughness with which the internist works makes one wonder. Is he doing all those fancy tests because he needs the information from them? Or because he fears being criticized by his colleagues as heterodox were he to omit any one of them? Or because there is danger that a disgruntled patient will accuse him of scanting the ceremonies?

The last is ever-present in his mind. Lawsuits for malpractice increase yearly in this country not because doctors are mistreating more patients but because patients and their families demand a surety of cure that they would not think of demanding in answer to a prayer. Doctors are human; they make mistakes. They should be forgiven. But they are not. Why aren't they? The answer lies in anticlericalism. Where the Church is strong and an arm of the state, the rebels and the frustrated and the *philosophes* see in that institution the cause of the ills of society. Where (as in the United States) the churches are respectfully ignored as Musical Banks, a sort of secular anticlericalism takes over. One of its forms is anger and a desire to get even with the practitioners of the mystic art of healing. When charms fail, when unpredicted disaster strikes, when the well-fed augur misreads the omens, then resentment flares, not against the gods, the authors of calamity, but against the intercessors and mediators between Olympus and Earth. A man walks out of a doctor's office after a routine check-up and drops dead. Who's to blame? The doctor. A constipated woman develops an intestinal obstruction. Who's to blame? The doctor. Who else? *Post hoc, ergo propter hoc* has always been popular.

So—the doctors become overcautious. Like scribes inditing a Scroll of the Law, they are circumspect with every jot and tittle. They take electrocardiograms, needed or not, lest they be accused of neglect; they prescribe potions for every symptom lest they be charged with indifference to the needs of the patient; they check and recheck their findings and hedge their prognostications lest they be denounced for overweening confidence in their own abilities.

Somebody has to pay for all that extra effort. Guess who?

Internists are big on periodic health examinations. What they say sounds rational and very scientific. Get a check-up every six months or every year and you'll nip in the bud any incipient disease. Would that were true! It isn't. Dr. Gordon S. Siegal of the United States Public Health Service says sadly that periodic health examinations have been greatly overrated. Even strong advocates of those examinations (in a survey conducted in 1970) say they seldom find unexpected disease in presumably healthy adults. When they do, the disease most frequently found is diabetes, a disease detectable by a simple urine test. Dr. W.K.C. Morgan, Associate Professor of Medicine at the West Virginia University School of Medicine, wrote a stinging article entitled "The Annual Physical Examination: Factitious Farce or Futile Fetish," in the *Medical Tribune* for March 17, 1971. In that article he calls the annual physical examination a sacrosanct fetish with little objective evidence to show it does any good. He backs up his argument with an extensive bibliography, and concludes thus: "Let us resolve to be a little less susceptible to meaningless cliches; let us recognize that a 'biochemical profile' is in reality a series of unnecessary investigations, that 'multiphasic screening' is just a euphemism for biochemical bingo, that the 'base-line ECG' is often a cause of cardiac neurosis, and that the 'annual physical' is virtually always an annual fiasco."

In the last fifty years of periodic health examinations no statistics have emerged showing that those who faithfully go for regular check-ups live longer or have

healthier lives than those who shy away from doctors. They may be happier, however. Hypochondriacs are always happier after an examination.

Prevention of illness being obviously more desirable than finding it in its earliest stages, internists are also advocates of a variety of prophylactic regimes. But being human and having developed in an age of fad and fashion, they are also enthusiasts for whatever is new and of good report. To prevent coronary artery disease, for example, they have endorsed low cholesterol diets, no smoking, no mental or physical stress, female sex hormones and a host of other supposed preventatives. As one medical wag put it, the best way not to have a heart attack is to be an impotent bookkeeper addicted to bicycle riding and a vegetarian diet.

The low cholesterol diet was based on a logical sorites: Myocardial infarction (the acute heart attack of the layman) is a result of coronary thrombosis, which is a result of hardening of the arteries of the coronary arteries that feed the heart muscle; cholesterol deposits are found in arteriosclerotic coronary arteries; cholesterol is a major component of ingested dietary fat; therefore, cut down on those fats and you reduce the incidence of heart attacks. Alas! A twenty-year study just completed in Framingham, Massachusetts, showed that there was "no discernible association between reported diet intake and serum cholesterol level"—thus breaking one link in the sorites—and that "there was no suggestion of any relation between diet and the subsequent development of coronary heart disease in the study group"—effectively knocking out the premise on which so many food products are sold.

A recent rage is exercise in the form of jogging. The reasoning goes thus: the heart is a muscle; muscles are toned up by exercise; *ergo*, exercise will help the heart to function better. No proof exists for that assumption. On the contrary, no one has data from any controlled series to prove that life is prolonged as a result of exercise. "Whether or not the cardiovascular effects induced by physical training will play an important role in the prevention and treatment of coronary disease remains to be established," says Dr. Jere H. Mitchell of the University of Texas Southwestern Medical School at Dallas. It is also well known that members of the laboring class die at a younger age than the idle rich and that death from heart disease occurs more often and sooner in men than in women. Think on that. Who gets more exercise?

Internists wear fancy headdresses and shake imposing rattles, but when the trappings are discarded, underneath are only men, not representatives of divinity.

11.

DETECTIVES

Priests they are not, but good internists outshine any fictional detectives. They *are* the diagnosticians par excellence. They are not mere technicians. They actually try to discover the cause of an illness as well as to treat it. Sometimes all they do is think (*All?* Isn't that enough?) and they come up with the right answer.

A severe anemia caused by the fish tapeworm is not uncommon among the descendants of the Finns who settled along the shores of Lake Superior and Lake Michigan. They enjoy a dish made of chopped raw fish. *Ergo,* they are more likely to get the anemia than their fellow Americans who eat only cooked or cured fish. But in Brooklyn the same disease occurred in adult Jewish females (not in Jewish males) and in Jewish boys and girls under the age of five. Guess why. Give up? In the preparation of *gefilte fish,* a Jewish delicacy, the chopped raw fish is seasoned and tasted before it is boiled. That accounts for the women, but what about the kids? Here's the picture as described by a group of brilliant doctors: Mama is making the fish; the children not old enough to go to school (aha! under five!) are watching her; she tastes the fish and gives them a little to taste. I think that's as good a bit of detection as any of Sherlock Holmes's.

Detective story number two. A man moved into a house in the suburbs on a tree-lined street. Thereafter, almost every evening he came home with a headache that sometimes was so severe that he had to vomit. He attributed the headaches to his intense dislike of his new neighbors. His doctor elicited the surprising fact that the man had no headaches on rainy or cloudy days. The doctor had an electroencephalogram taken; it confirmed his intuitive diagnosis of a migrainous type of epilepsy brought on by the flicker of the setting sun's rays through the trees. Pretty good, huh?

One more, one that has already passed into modern folklore. A previous healthy man began to have fainting spells unrelated to emotion or exercise. The only significant finding in his medical history was a slow and steady gain in weight over the preceding two years The spells came on Sunday mornings in church but not when he didn't go to church; they never came on Sunday afternoons. They came when he sat alongside his wife on a wall banquette in a restaurant, but never

when he faced her. They also appeared when he turned his head suddenly, the doctor discovered. The doctor did one simple pressure test and announced, "Your shirt collars are too tight. You are getting too fat. You have carotid syncope." That's a fainting spell induced by pressure on the carotid sinus of the neck. All right, so you've heard that one before, but it's true nevertheless.

Not all detectives are Ellery Queens, however. A construction worker named Joseph Snow moved from Brooklyn to Indianapolis. He had to have a pre-employment physical examination before starting a new job. The doctor (careful, but of limited horizons) noted the peculiar bronzing of the skin, the scanty body hair, and the smooth unrazored face despite normally-sized genitalia. The doctor told Snow that he had an endocrine disturbance, probably in the adrenal glands, that it was retarding the development of masculine hirsuteness, and that he should get male sex hormone injections. Snow, the father of four children, blinked. "No Mohawk Indians have to shave," he told the doctor. And that's a true story too.

There's a lesson in these four tales. A good internist is a humanist. He knows about religion as well as arrhythmias, arts and letters as well as asthma and lead poisoning, sociology as well as sarcoidosis, men's occupations as well as their response to oxygen therapy, and how people live as well as what they're sick with.

12.

"A dermatologist has the best kind of practice. He has no emergency calls. His patients never die and they never get well."

"A pediatrician has the best patients. They're frequently ill and they seldom die."

"People who consult a proctologist must have confidence in him. They can't see what he is doing."

"Orthopedists don't have to worry. They always give a guarded prognosis and on that basis can treat a patient indefinitely."

"The fear of blindness is so great that no one objects to paying the eye doctor."

The above aphorisms, (presumably witty remarks of their professors) culled from medical students' notebooks, are examples of how some of the other specialists view their fields of practice. The "in" humor barely conceals the realities. Concern for the patient is present, of course, not for his sake alone but also for the sake of the doctor's reputation.

The dermatologist treats chronic skin disorders. Naturally, for acute eruptions are gone by the time the patient gets an appointment. Hives, poison ivy dermatitis and sunburn are treated by mothers, grandmothers, friends and patent medicines. The American Academy of Dermatology estimates that fewer than 30% of all skin problems come to the attention of the dermatologist. Dermatologists belong to two schools: one relies only on inspection of the skin to make a diagnosis; the other, on a full history plus inspection. The latter may seem more rational, but the additional information may merely add confusion when inspection of the skin is not conclusive. Example: A married woman developed a peculiar itching eruption on her body after each time she met her paramour in a cheap hotel; one dermatologist demonstrated her case as a skin manifestation of a guilt reaction; another looked at the rash more closely and said, "Bedbug bites."

Regardless of the diagnostic technique and often regardless of the diagnosis, the dermatologist follows a standard procedure in treatment: stop all previously applied medications, clean the skin, use a steroid locally for itching plus antibiotics as indicated, use tar ointments for more chronic conditions, use peeling agents for still more chronic troubles, have the patient return for frequent check-ups on his progress.

Some skin ailments are self-limited; that is, they last a few weeks and go away regardless of the treatment used. Fortunately for the dermatologist, there are few of such unrewarding diseases. Acne is great for him; he has willing and desperate patients made more desperate by TV commercials and advertisements in teen-age magazines. Psoriasis is just as good. So is athlete's foot.

The only trouble a dermatologist has is in making an impression on his patient. If he merely looks, makes a diagnosis and prescribes, where's the glamour that should attend a visit to him and the payment of a fee? The dermatologist, therefore, must do more. He cannot don a mask nor do a dance, but he can subject the skin to a variety of direct treatments: carbon dioxide slush, X-rays, ultraviolet rays and so forth. (The medical term for such techniques is *modalities. Modalities* is pure jargon, an elaborate way of saying methods. Even the medical dictionaries are shamefaced about defining it.) Of course, the treatments may be of questionable worth, but dermatologists are honest men and like to give value for the money they get. I once asked a dermatologist why he was giving weekly ultraviolet

treatments to a patient I had sent him. His reply: "I have to see her once a week to check on her progress. She'd be unhappy if she just walked in and I looked at her and said, 'You're doing fine.' So a little ultraviolet won't hurt."

Ultraviolet may not, but X-ray treatment is undoubtedly dangerous. For almost fifty years, epilation (artificial baldness induced by X-rays) was a standard treatment for ringworm of the scalp. The procedure was abandoned in 1958 (thirteen years after Hiroshima) not because of concern over possible bad effects, but because a new drug, griseofulvin, was more potent and much simpler to use. Now a study by Dr. Roy Albert of the New York University Medical Center has shown that in the patients treated by X-ray epilation there has been ten times as much cancer and leukemia as in an unradiated population, and what is more surprising, three times as much mental illness.

Don't you get the feeling that a specialist in skin diseases should not try to do too much? Shouldn't you be willing to pay him just to hear him say, "This condition is trivial and will require correspondingly trivial treatment?" And never use the ointment or lotion or medication he's prescribed without having asked him, "Are there any dangers in this treatment?"

Most pediatricians, unlike dermatologists, have no qualms about dismissing ailments as trivial. They take pride in being the big pooh-poohers in medical practice. A pediatrician has undergone rigorous training in the care of sick infants and children; he knows that the delicate physiologic balance in the young is easily upset by disease, especially by acute illnesses; he recognizes and preaches that children are not little adults and should not be treated as such.

So what does he do? He spends 90% of his time caring for well babies and examining healthy school children at regular intervals. Don't get me wrong. That's not bad. But that type of preventive medicine (measuring and weighing, giving antidiphtheria toxoid, vaccinating) can be done by public health nurses or by general practitioners. Why let the pediatrician's good training get lost in so much banality that he has no time to use it when it's needed? You've heard the joke: "Doctor, my baby just swallowed a bottle of aspirin." "Don't worry. Give him an aspirin and bring him to the office tomorrow." When a child gets sick outside of the normal visiting hours, the child is seen by a general practitioner or is taken to the emergency room of a hospital. Certainly, if he has a contagious disease like measles, German measles, chicken pox or a streptococcic sore throat, he doesn't belong anyway in a doctor's office where there are well children tearing the place apart.

To justify his existence as a specialist, the pediatrician is an educator and an indoctrinator. He teaches young mothers important things like how to dress baby, when to ignore baby's cries, when to start bowel and bladder training, why pacifiers are better than thumb-sucking, and when to start solid foods. His indoctrination is of the mother. He is an expert at instilling mother-guilt. Baby gets up too often at night? Mother doesn't give it enough attention during the day. Baby rejects the strained spinach? That's because mother makes a face when she spoons it out and babies are ultrasensitive to parental attitudes. Baby has no teeth at twelve months. Mother, don't be so competitive. Baby screams when he moves his bowels? Too much emphasis on defecation. Sometimes—often—the poor mothers get the impression that everything they do is wrong. That's the idea of the visits to the pediatrician, his *raison d'être*. He's there to correct her mistakes.

Not only by his airy dismissal of complaints is the pediatrician distinguished from his medical colleagues, but also by the time-limited nature of his practice. His patients can last only from birth to rebellion, when they leave him for other medicine men. He must, therefore, run constantly in order to stay in the same place financially. He must attract to himself new patients via their mothers. He must make himself remarkable over his fellow pediatricians.

That he does by being an innovator. He adds cereal to the infant's diet when the infant is six weeks old. His competitor raises him by adding it at four weeks. He counters by adding it at two weeks. He introduces the hapless child to strained spinach a week earlier than was customary, and another pediatrician answers by starting yogurt even earlier. One man "hardens" his infant patients by counseling against the wearing of hats: another puts the baby outside clad only in diapers. One encourages crawling; another advocates baby-walkers. One advises small toys because they're easy to grasp, thus hastening small-muscle control; another warn[illegible] against them because they may be swallowed. On[illegible] pushes for cuddly plush animal toys; another take[illegible] them away because they're allergenic dust collectors.

Divided as they are in their techniques, pedia[illegible] cians present a united front against parents. Pedia[illegible] cians (childless ones not excluded) say they k[illegible] what's best for the child. Doing what comes natural[illegible] for the birds, not humans. And so, within the mem[illegible]

of man, the pendulum has swung from rigidity in feeding schedules to permissiveness and back again, from bare feet to corrective shoes, from enforced naps for greater vitality to delayed bedtime for more socialization.

Meanwhile, lost in the competitive struggle and overwhelmed by the authoritarian approach is the poor child, supposedly the subject of tender ministrations.

The proctologist's field of activity is very limited, but he's very busy there, nevertheless. Anal worries left over from childhood, supplemented by a strong campaign against cancer, send thousands of patients every year to proctologists. The willingness of the proctologist to mess around in that usually filthy area (because not all patients wash themselves before going to the doctor) gains him the devotion of his patient, who will submit to the passage of proctoscope and sigmoidoscope without demur and without pondering on the fate of Edward II. (Perhaps apocryphal. The poor king was supposed to have been done in by the passage of a hot iron bar up his rectum. The sigmoidoscope is hollow and shiny but probably of the same dimension as the bar.) The patient wants to be told he doesn't have cancer; the campaign literature says that no physical examination is complete without a proctosigmoidoscopy.

And now I quote: "It is not popular . . . to do anything to thwart the efforts of the cancer society groups that make a career of instilling in all of us the fear of a horrible cancer death . . . The fact is that none of the reported series of large-scale routine sigmoidoscopic surveys of apparently healthy people has turned up very much information that could be used to help the patient."[41] Further data: A series of 1000 consecutive patients at the Lahey Clinic on whom sigmoidoscopy was done was evaluated.[42] Of them, 637 had minor rectal conditions, most of which benefited from advice about diet, local hygiene, and medication. Only *six* cancers were found, and in every one of these the patients had complaints of rectal bleeding. In a 1966 survey at the Mayo Clinic in a series of 1000 sigmoidoscopies on patients without symptoms, not one cancer was found[43]

I get the distinct impression that a patient would do better to turn his thoughts away from his fundament up to the spacious firmament on high.

There is no need to go into detail about the other specialties. What goes for one goes for all. The doctors trip their magic round, bemuse their patients and themselves, and push aside the nagging gnats of doubt. The patients watch the wondrous dance, applaud the priests and cry for more. Two make a team—doctor and patient. One skeptic on either side destroys illusion. But perhaps illusion is more comfortable than reality. One thing is sure—it's not healthier.

13.
FRAGMENTATION

A forty-year-old woman trying to recapture her youth began to wear very short skirts. She noticed that her right thigh was quite a bit smaller than her left. She went to an orthopedist, who measured both thighs and found she was correct. The circumference of the left thigh was three inches more than that of the right.

The orthopedist put her through a series of exercises. He found that there was no muscle or joint weakness. The woman could stand and walk without trouble. He was puzzled by what he considered an atrophy of the right thigh. He sent the woman into the hospital for a thorough check-up.

The intern took a complete history and did a physical examination on the woman lying in bed. Because atrophy of the thigh may have resulted from a neurologic disorder and because he was going to be an ophthalmologist, the intern paid particular attention to the eye grounds, a valuable indicator in multiple sclerosis, brain tumors and related disorders. The eye grounds were normal.

The resident went over the intern's history and physical. Because he planned to be a gynecologist, the resident did a careful vaginal examination and found nothing of moment. He made a note on the chart to that effect and ordered a laboratory work-up.

After $450 worth of laboratory tests (that cost the hospital less than $50 to do) came back negative, a neurologist examined the patient in consultation. He found no nerve disorder that would account for the right thigh being smaller than the left.

After the tests were finished with and while the doctors were making up their minds what the diagnosis was, they ordered physiotherapy to be given to the

[41] Dr. Eddy D. Palmer, "Diagnostic Endoscopy," *Current Medical Digest*, March, 1968.
[42] Reported in *Ca—A Cancer Journal for Clinicians*, March, 1968.
[43] Drs. C. Q. Moertel *et al.*, in *Mayo Clinic Proceedings*, *41*:368, 1966.

thigh (heat, massage, muscle stimulation). The physiotherapist by error started massaging the left thigh while the patient lay on her abdomen. "What's this?" she asked. "What's what?" asked the patient. "You're on the wrong side." The physiotherapist made a note on the chart: "Lump at back of left thigh."

The attending doctor read the note and went over the left thigh. He found a flat fatty tumor, apparently under the posterior muscle of the left thigh. It was an ordinary lipoma, a benign growth that needed no treatment except for cosmetic reasons.

The doctors all realized that the right thigh had nothing wrong with it. The difference in circumference from the left was due to the presence of the tumor on the left.

14.

"Grammarian, orator, geometrician, painter, gymnastics teacher, fortune teller, rope dancer, physician, conjuror—he knows everything."

Juvenal, *Satire, III*

And now we arrive at the great nonspecialist, at the family doctor, or the general practitioner, as you may call him. He's not happy with either name. (He's happy with his fees, though. Recently surveys show that the general practitioner is right up there at the top of the money-makers. Probably because of his rarity, like chinchilla and uranium, he commands a high price. In a late issue of an advertising service for physicians, general practitioners are being sought at a starting minimum of $25,000 to $35,000 a year.) In a desperate attempt to build up his own ego the family doctor has begun to call himself a *generalist* vis-à-vis the specialist. He seems to think that the name gives him a cachet, that it implies that he knows everything about everything in medicine, that he is really the captain of the ship, with the specialists subordinate to him.

Giving himself that name plus a little political pressure properly applied in some hospitals has led to the setting up of divisions of general practice in those hospitals. Theoretically, then, the family doctor is on a par with the surgeons, the internists, the pediatricians and all the other specialists. Actually, he finds that for the most part he is not allowed to do operations more complicated than circumcisions or the removal of an ingrown toenail nor permitted to read electrocardiograms nor treat a child in convulsions. If a patient is sick enough to be hospitalized, the reasoning goes, he's sick enough to require the services of a specialist.

When it comes to knowing everything about everything, alas, too often the general practitioner knows too little about not much. He's kept busy taking care of the everyday illnesses of the flesh, like tonsillitis, acute bronchitis, bellyaches and diarrhea, not to mention migraine, inflamed eyes, nervous indigestion and infected scratches. He works very hard all day and many nights giving the medical care that specialists feel it is beneath their dignity to provide. He has little time to wade through the self-serving puff articles in the medical journals so that he can separate the rare nugget of information from the dross. It follows then that he goes on doing what he was taught in medical school with the addition of what he gleans from an occasional lecture or the mountains of pharmaceutical company advertising matter that come in every mail. He has a smattering, it is true, of every branch of medicine, but that smattering is spread thinner than a blood smear on a microscope slide.

The situation is not entirely due to the general practitioner's stick-in-the-mud attitude. It is perpetuated—indeed, the process of deterioration is accelerated—by the education doctors get, particularly in the clinical aspects and in the internship. How can you expect them to learn when residents (one notch higher on the totem pole) take care of all the minor and much major surgery, do the deliveries and tend the very sick medical cases? About all the intern who's going to be a general practitioner can do is look on, take orders and run errands. Some general practitioners complain that they never get a chance to utilize the skills for which they were trained; more likely, they were never trained for the skills they need.

They are conscious of their incompetence. (That's a harsh word. But when the doctor gets sick, does he go to a fellow general practitioner or to a specialist? What do *you* think?) They also resent their medicosocially inferior position. Family doctors, therefore, have sought out various approaches for restoring their status in the hierarchy and for improving their image in the public eye, to use Madison Avenue lingo. First they formed an Academy of General Practice, membership in which required a definite number of hours spent in attending lectures, conventions and classes. A good idea, fallen amongst vacationers on cruise ships, at Las Vegas and on combined golf-and-learning trips. All one had to do was register to denote attendance, after which credit could be claimed, and then the tired doctor could refresh himself in more entertaining surroundings than a sleep-inducing darkened lecture hall. That method of self-improvement and status-seeking having shown

self to be innocuous and equally meaningless, other proposals were made. One group wanted family doctors to have frequently repeated examinations to make sure that they're up to date in their diagnostic and therapeutic techniques. Most of the general practitioners were in violent opposition to that suggestion. They objected, not without merit, to being singled out to take such examinations when specialists don't have to.

Another group wanted to create a specialty board so that general practitioners would be able to call themselves specialists. Naturally, the specialists were against such a board because it would dilute the value of their own boards. Some family doctors, too, were not wholeheartedly in favor of it because, in a rare burst of honesty, they recognized that naming, like thinking, would not change reality.

A specialty board for family physicians was finally created, however. Are the general practitioners happy now? Not so you could notice it. Some of them see further restrictions on them in the offing. They fear that the bona fide specialists will say, "Yours is a nonsurgical board. Good. No surgery for you," and then the G.P. will have even fewer hospital privileges than he has now. Others warn that the board will discourage medical students from going into general practice because of the periodic recertification requirement, which is not required in the other specialties. A cynical few applaud the board because now "specialist" general practitioners will be able to charge more for their services. Discontent is vocal: only 20% of California's general practitioners said they would consider taking the board examinations.

Still another group, with much support from medical schools, medical reformers and medical philosophers, ignores the board entirely. That group says that general practitioners should be transformed into *primary physicians*. Their function will be to make the first tentative diagnosis, to treat all trivial ailments, to direct more serious cases to the proper specialists, to co-ordinate the findings of the specialists and to supervise treatment in the sense that they will be alerted to untoward effects. In other words, the primary physician will act like a sorting station, or a battle aid station, separating the gravely hurt from the walking wounded.

The family doctors holler that then they'll be merely the equivalent of superior grade hospital corpsmen or European-type *Feldshers*. They don't want to accept a permanently inferior status, no matter what fancy name it's given. They enlist the public on their side. They object that such a system will deprive patients of the compassion and human sympathy doctors are noted for in song and story, and often in real life.

That warm interpersonal relationship is supposed to have a great therapeutic effect in the healing process. You've heard people say, "My doctor absolutely insists that I . . ." and "My doctor strictly forbids me to . . ." and "My doctor was pleased that I . . ." You can just see the doctor beaming and cluck-clucking.

Tender Loving Care. *That's* the real specialty of the family doctor. He is the consoler, the adviser, the lay father-confessor, the bringer of hope, the shoulder-patter. His art transforms cold science into warm understanding. He stands, a fearless knight in rumpled clothes, between the Angel of Death and the frightened family.

A glowing picture. You've seen it in the movies; you've read about it in the novels. (Even the scurrilous antidoctor novels have one nature's nobleman arrayed against the licentiousness and lucre-grabbing of his confreres.) Maybe you think your own doctor is like that. I hope he isn't. Tender Loving Care is no substitute for common sense; sympathy can't take the place of antibiotics; kindness may be a cover for ignorance. What you need is a doctor who knows what he is doing and why. If his bedside manner is soothing, if his presence spreads comfort, so much the better. That's lagniappe, but the prime consideration is the application of a scientific attitude toward the diagnosis and treatment of disease. Otherwise the doctor could dispense with his stethoscope and prescription pad; he could don a biretta and swing a censer.

Popular magazine writers bewail the passing of the old-style family doctor. They advise their readers to try anyway to establish a meaningful relationship with a personal physician. Doctors nod approval of such fostering of nostalgia for the "good old days." What's looked for is rapidly becoming a historical curiosity. A good thing, too, that it is. The bumbling but sympathetic doctor, so busy paving the road to hell with his intentions, belongs in a museum, not at a patient's bedside.

Dr. LaSagna says in *Life, Death, and the Doctor*, "The man whose life is threatened by a complicated infection . . . demands technical expertness, from a misanthrope, if need be." Then the doctor hedges with, "But there still remains an enormous range of human illness . . . where 'magic bullets' are lacking" and manual skill or special training is not needed, and for these ailments the doctor must dispense the milk of human kindness. I ask you—why the doctor? Why not Mama?

Or Madame Zodiac, the spiritualist? Or the bartender? from hemorrhage from his ruptured spleen right at the door of the emergency room. They never forgot how he stayed all night with the Hammer woman in her labor, bustling around the kitchen, telling the three little children funny stories to keep their attention away from the shrieks from the bedroom, giving the suffering woman needle after needle to ease her pain, and then having the miserable job of delivering a dead baby by high forceps. In the four terrible days of delirium before Mrs. Hammer died of sepsis, he was with her day and night, standing by her bedside, adjusting the tube that slowly dripped the serum into her veins. People never tired of telling how Old Doc broke down and wept the night Mrs. Hammer was laid out and how Mr. Hammer had to drive him home.

Old Doc had a social conscience too. He gave lectures to the Boy Scouts on what they should know about health and hygiene, explaining to them the horrible consequences of masturbation and evil living. He was a generous contributor of cash to the Dorcas Home for Unwed Mothers, besides giving his services gratis and shouting at those patients who cried out during labor so that the girls would learn a lesson they'd never forget. He was a vigorous advocate of compulsory immunizations and other preventive health measures such as tonsillectomy. He was not a stick-in-the-mud. He gave birth control information to married women. He treated venereal diseases by the latest methods, making sure that his nurse immediately phoned in the name of the patient to the Board of Health as required by law,

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Young and old alike adored the Doc. "When you come in the door, I'm halfway better already," was a common remark. His colleagues in the Lenape County Medical Society held him up to incoming physicians as a shining example of what a real doctor should be.

The Old Doc began to have pains in his stomach and lost much weight. He went to the Medical Center fifty miles away. The doctors there marveled at the constant stream of flowers and get-well cards that poured into his room. "If we had more men like him," growled the professor of surgery, "there'd be none of this nonsensical talk about socialized medicine."

Old Doc never came back from the Medical Center. His cancer was too far gone. His funeral was magnificent.

A young whippersnapper took over his practice, to the dissatisfaction of the townspeople. They missed Old Doc. Mrs. Smith, who'd been bedridden for a year with "kidney dropsy," grudgingly admitted when she began going back to church and choir meetings that the new doctor's treatment was good, but he just didn't have the touch Old Doc had. Mr. Jones, whose "chronic rheumatism" disappeared on the diet and tablets the new man gave him for his gout, complained that he now had no chance for gabbing with the doctor about state politics. Miss Robinson, the schoolteacher, no longer looked forward to the badinage of the Saturday afternoons when she used to get her weekly liver shots for anemia; the new fellow removed her cervical polyp and the bleeding stopped.

Old Doc's memory lingers on. Five years after his death, the Baby Health Station was named after him in gratitude for his long and arduous service to the people of the town.

MORAL: The milk of human kindness may not be as effective as the proper medicine for an illness, but it tastes better.