

## DOCTOR'S DILEMMA\*

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THE PUBLIC IMAGE of a doctor is an amalgam of what patients think about doctors, what doctors, as patients, think about themselves, and what both parties believe is the ideal. Patients throughout the ages have grumbled about doctors; Plato, for example, had a double criticism: that doctors treated slaves as carefully as they treated free men or philosophers, and treated patients, including sick philosophers, like slaves. An ambivalent attitude towards doctors was shown in Ecclesiasticus 2,000 years ago: 'Honour a physician with the honour due unto him for the uses you may have of him, for the Lord hath created him. For of the Most High cometh healing' (thus almost deifying doctors and treating them with respect, as an expedient, since they may be needed any time); and a few lines later we are reminded of the dangers of being a patient: 'He that sinneth before his maker, let him fall into the hand of the physician.' (Ecclus. 38: 1-2, 15.)

There is little consensus today about what the doctor-patient relationship is, or should be. Some feel it should be a mystical bond of healing accompanied by exalted human sentiments, whilst others feel that it should be an efficient technical service like calling in the mechanic or the plumber. It is my belief that the doctor-patient relationship has suffered in recent years. Among the many reasons would be rapid changes to which many, particularly the elderly, would have difficulty in adjusting, a failure of communication which has left the patient at a loss to know where he/she fits into the new system, and a social change which demands rights and privileges and brooks no failure or delay.<sup>1</sup>

### DILEMMA

I propose to discuss some of the changes and problems which confront the doctor thus constituting the Doctor's Dilemma. I hope that by drawing attention to these problems the lay public will have a better understanding of the situation and that better doctor-patient relationships may thereby be restored:

1. Should the emphasis be on preventive or curative medicine?
2. Should we rely on a single doctor or on a health team?
3. Is specialization a good or bad development?
4. Should a doctor be predominantly an artist or a scientist?
5. Should a doctor be emotionally involved with his patients?

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<sup>1</sup> H. Osmond, 'God and the doctor', *New England Journal of Medicine* (Jan.-June 1980), CCCII, 555.

6. Should treatment be at home, clinic or hospital? If hospital, what kind of hospital?
7. How do we solve the problems of medical manpower?
8. How do we supply cost-effective treatment to the greatest number of the population?
9. Do we support science or pseudoscience?
10. Are we training committed or committed doctors?

**1. Should the emphasis be on preventive or curative medicine?** With their usual good sense the Greeks believed that Aesculapius (God of Healing) had two daughters called Panacea (Goddess of Healing) and Hygeia (Goddess of Health or Hygiene). Like many fathers, the god hoped that his daughters would live together harmoniously. In fact, however, they often competed rather than co-operated.

Thus, if Hygeia was wholly successful in promoting good health, what would be left for Panacea to heal? On the other hand, if Panacea dominated medical and popular thinking, who would listen to the valuable but trite strictures—'Eat less, drink less, smoke less, fornicate less, avoid excess, exercise prudently; or fall into the hands of my sister Panacea and her physicians'—of Hygeia?

**2. Should we rely on a single doctor or on a health team?** In the past the general practitioner alone would visit the patient at home, spending time talking to the patient and his family, offer a diagnosis, do some simple tests himself, make up a prescription, arrange a follow-up, attend to the social needs of the patient and act as guide and counsellor.

With rapid change and increasing demands it has become difficult for the doctor to make house-calls that waste time in a car. He may try the art of bedside diagnosis, but all too often early disease will only be discovered by fancy tests and x-rays, both of which need expensive equipment manned by skilled personnel. Prescribing has become increasingly complicated and fraught with hazard. With less time available, counselling is apt to be neglected and social problems ignored.

These many facets may require the combined skills of specialists, general practitioners, medical officers of health, hospital nurses, district nurses, radiologists and radiographers, pathologists and laboratory technicians, speech, occupational or physiotherapists, pharmacists, almoners and various social workers. The health team, like a chain, is as strong as its weakest link. Communication between members of the team is essential, but gets difficult with the increasing size of the teams. Thus a busker playing a one-man band outside a station can play simple tunes very well, but the best music comes from a full orchestra controlled and co-ordinated by a good conductor.

**3. Is specialization a good or bad development?** There is no doubt that specialization has been a two-edged sword. Two well-known definitions are that 'A "specialist" is a doctor who knows more and more about less and less until ultimately he knows everything about nothing', and 'A "general practitioner" is a

doctor who knows less and less about more and more until ultimately he knows nothing about everything'.

The good points about specialization include the rapid advance of knowledge and expertise in certain fields. The bad points include the lack of a doctor for the whole family, since the patient is bound to be the wrong age, or the wrong sex, or to have come with the wrong organ. Referral from one specialist to another sets off a very expensive chain reaction, which takes much longer.

Teaching by specialists tends to give students an unbalanced concept of medicine. Specialization is a field in which Parkinson's Law flourishes. Professor Louw, in an oration at the Academic Festival of the Medical Faculty of the University of Cape Town to mark its 150th anniversary, quoted an American educator who likened the modern medical curriculum to a *smörgasbord* or a buffet of educational facilities. The teacher will function as a dietician to help the student select a nutritious diet. The curriculum will thus be *à la carte* rather than *table d'hôte*.<sup>2</sup>

**4. Should a doctor be predominantly an artist or a scientist?** The supreme artist is the charlatan. The extreme scientist is the backroom boffin. The ancient Greeks, besides their gods and goddesses, recognized medical philosophers called dogmatists (clinicians) or empiricists. The dogmatist held that true medicine should be a science resembling geometry derived from known and stated principles. The empiricists treated the sick according to their experience. Some medical scientists today still scorn clinicians and yet when they or their family are ill they call in the practical clinician rather than their fellow scientist.

The decline of the art of medicine is lamented by S. J. Reiser:

In the framework of modern clinical medicine, reverence for objective evidence has led to a continual and serious decline in training physicians to take histories or listen to patients; such data, objective in content, personal biased, is viewed as inferior . . . His skill in physical examination has declined, and his own sense perceptions and clinical judgements have been devalued—in deference to objective data sensed and generated by machines and interpreted by technicians and specialists.<sup>3</sup>

There has been public disenchantment with the poor practical returns of money spent on research. No cure has been found for diseases such as the common cold, coronary artery disease or cancer. Research doctors seem to end up as specialists rather than family doctors and their expensive expertise seems to centre round costly equipment and ever-increasing health costs. The disillusionment shows itself in remarks such as 'medical research is occupational therapy for maladjusted doctors'.

<sup>2</sup> J. J. Louw, 'Whither medical education', *South African Medical Journal* (Jan.-June 1980), LVII, 269.

<sup>3</sup> S. J. Reiser, 'Humanism and fact-finding in medicine', *New England Journal of Medicine* (July-Dec. 1978), CCXCIX, 952.

The public has often chosen to forget the tremendous advances of the past fifty years, resulting from medical research and enabling prevention to replace the need for cure: vaccination for polio, diphtheria, whooping cough, measles, tetanus and smallpox, for example. The advent of the antibiotics and many other discoveries, which have allowed man to live longer, have drawn attention to less curable diseases such as coronaries and cancer. That the science of medicine is waning is pointed out by J. B. Wyngaarden in his Presidential Address to the Association of American Physicians, entitled, 'The clinical investigator as an endangered species'.<sup>4</sup> In America and Britain,<sup>5</sup> it is pointed out that one of the modern shortages is in the field of clinical research investigators.

**5. Should a doctor be emotionally involved with his patients?** The extreme of emotional involvement is the doctor treating his own family. The extreme of unbiased wisdom is the judge with emotionless countenance, framed by a wig, pronouncing a learned judgement. In my introduction I referred to those who like their doctor to be emotionally involved and those who merely want a businesslike service. Emotionalism undoubtedly colours and impairs judgement. Undue coldness seems to give an impression of not caring. On an emotional level the age-old axiom still holds: 'You can make your mistress your patient but beware if you make your patient your mistress.'

**6. Should treatment be at home, clinic or hospital? If hospital, what kind of hospital?** Bed rest is less favoured than in the past. The evils of bed rest were summarized by the late Richard Asher:

Look at a patient lying long in bed. What a pathetic picture he makes! The blood clotting in his veins, the lime draining from his bones, the scybala stacking up in his colon, the flesh rotting from his seat, the urine leaking from his distended bladder, and the spirit evaporating from his soul.<sup>6</sup>

Home-visiting brings the family doctor into contact with the whole family and the patient's environment. The patient is at ease 'playing on the home-ground' and greater privacy is assured.

Clinics improve the turnover and efficiency of the doctor and it can be argued that any patient sick enough not to be at the clinic should be in hospital. However: if a hospital is required, do you envisage a cottage hospital such as Tannoch Brae with attention from Doctors Cameron and Finlay, or do you see yourself in Blair General Hospital with Doctors Gillespie and Kildare?

**7. How do we solve the problems of medical manpower?** These problems include:

<sup>4</sup> J. B. Wyngaarden, 'The clinical investigator as an endangered species', *New England Journal of Medicine* (July-Dec. 1979), CCCI, 1254-9.

<sup>5</sup> Editorial, 'MDs or PhDs in medical research', *British Medical Journal* (Jan.-June 1980), CCLXXX, 274.

<sup>6</sup> R. A. J. Asher, 'The dangers of going to bed', *British Medical Journal* (1947), ii, 967.

- (i) *The unequal distribution of doctors.* Doctors throughout the world tend to gravitate towards the cities. Specialists tend to need big cities and big hospitals for their survival. Yet the majority of the population does not live in urban areas. How then can health care be provided for the rural areas?
- (ii) *Who should be the primary care provider.* Is this best done by a doctor or by paramedical personnel? If paramedical personnel, what kind? For example, by medical assistants, advanced clinical nurses, pharmacists, or others?
- (iii) *The distribution of facilities.* Should care be spread widely or should there be improved transport facilities to move patients to central units?

**8. How do we supply cost-effective treatment?** Should the doctor have unlimited money for research and be allowed to prescribe whatever drug he likes? Should there be some system of rationing? For example, there can be 'implicit rationing' whereby districts or institutions are given a sum of money to spend as they think fit, or 'explicit rationing' whereby dictatorial instructions, subject to public and political pressures, exclude certain drugs or procedures with low benefits and stipulate what proportion of the budget is to be spent on preventive and curative services or on primary, secondary and tertiary care respectively.

**9. Do we support science or pseudoscience?** A move from orthodox to alternative medicine is shown by the following editorial in *The British Medical Journal* entitled, 'The flight from science':

Nowadays most G.P.s—certainly those in the bigger cities—have a few patients who are being treated by alternative medicine: meditation, yoga, acupuncture, moxibustion, ginseng, and a whole galaxy of diets . . .

Outside medicine, the public mood has swung away from unquestioning admiration of science and technology that reached its peak at the time of the NASA flights to the moon. Nuclear power is now seen as a threat, not a hope for the future. The motor car is evil; jet aircraft are noisy, polluting and unsafe. Science fiction illustrates the trend: authors such as Arthur Clarke and Isaac Asimov, whose inventiveness was firmly based on orthodox physics, have been overtaken by writers and film makers primarily concerned with doom, disaster, and the paranormal. Astrology is taken more seriously now than at any time this century.<sup>1</sup>

An American book, *Wholistic Dimensions in Healing*,<sup>2</sup> suggests that people are looking for alternatives to what some perceive to be a dinosaur (the modern medical system). The subject matter of the book includes homeopathy, naturopathy, chiropractic, applied kinesiology, nutrition and herbs, oriental medicine and

<sup>1</sup> Editorial, 'The flight from science', *British Medical Journal* (Jan.–June 1980), CCLXXX, 1.

<sup>2</sup> L. J. Kaslof (ed.), *Wholistic Dimensions in Healing: A Resource Guide* (New York, Doubleday, 1978).

acupuncture, whole-plant substances, aerion-therapy, radiesthesia, psionic medicine, astrology, iridology, psychic and spiritual healing, psychophysical approaches (*shiatsu*, polarity therapy and rolfing). Also, various mystical cults and witchcraft seem to have been revived.

**10. Are we training committed or committed doctors?** Doctors have not been immune to a modern disease. Already too busy to be able to spend time talking to their patients, they are called upon to serve on a plethora of committees. In all walks of life individuals are no longer allowed to make decisions. Consensus has to be obtained from committees, which proliferate into subcommittees whenever difficult decisions arise, all in the name of democracy. Committees have been defined as 'bodies of people who take minutes and waste hours'. 'The best committee is one composed of two members when one is absent.'

## ANSWERS

**1. Should the emphasis be on preventive or curative medicine?** Undoubtedly prevention is better than cure. Prevention can usually be undertaken by paramedical personnel and is thus relatively cheap. An example of the stage of expensive half-truth to the cheap state of whole truth is as follows:

### *Polio*

Half Truth:	Faith	: Respirator (Iron Lung)
	Hope	: Physiotherapy
	Charity	: Tendon transplants; Gadgets (calipers; wheelchairs; special cars)
Whole Truth:		Polio vaccine

However, until Hygeia is wholly successful there will still be a need for Panacea. Also, preventive medicine improves survival, so family planning becomes increasingly important as a form of preventive medicine.

**2. Should we rely on a single doctor or on a health team?** For most simple health needs one can still depend on the local medical assistant or advanced clinical nurse, in the case of the districts, or on the local G.P., in the case of the towns and cities. With complex problems it becomes increasingly important to make full use of the diverse talents and facilities available, which one practitioner alone is unable to provide. Doctors form a relatively small proportion of the health team, but since they usually lead the team they must remain of high calibre.

**3. Is specialization a good or bad development?** Specialists have been misused at the expense of the G.P. who is himself a specialist of sorts. Specialization in itself is admirable and desirable if used at the right time, in the right place and in the right proportions. The main need in developing countries and in fact all countries, is for generalists rather than specialists. Specialists are

required in a small percentage of cases. 'G.P.s are the backbone of the profession and must be brought to the front.'

**4. *Should a doctor be predominantly an artist or a scientist?*** Desparaux might well be describing the back-room boffin in his poem written in 1711:

Brimful of learning  
See that pedant stride,  
Bristling with horrid Greek  
And puffed with pride.  
A thousand authors  
He in vain has read  
And with their maxims  
Stuffed his empty head  
And thinks that  
Without Aristotle's rule  
Reason is blind  
And common sense a fool.

Or, as Bertrand Russell puts it, we are faced with the paradoxical fact that education has become one of the chief obstacles to intelligence and freedom of thought.

A good doctor is both artist and scientist, using his experience to improve his art and keeping up to date with the science of medicine by reading, by postgraduate education and by research. Not all research has to be expensive. Practical, low-technology research is cheap and will answer many problems, improve efficiency and ultimately save lives and money.

**5. *Should a doctor be emotionally involved with his patients?*** Here again the ideal doctor manages to strike the golden mean. He must show the patient that he really cares and yet he must not let emotions colour his decisions.

**6. *Should treatment be at home, clinic or hospital? If hospital, what kind of hospital?*** Ambulant treatment should be used wherever possible. Clinics provide a useful stepping stone for the Health Team. When hospital is required, the personal touch of the family doctor in a small hospital or G.P. unit is preferred in the majority of cases, providing that the G.P. has clearcut guidelines as to when referral to specialists is necessary. For the small percentage of cases requiring high technology services, such as neurosurgery, thoracic surgery or plastic surgery, complicated obstetrics, renal failure, or coronary thrombosis, a large modern hospital with advanced facilities, intensive care units, and junior staff available at a moment's notice becomes essential.

However much faith one has in Dr Cameron or Dr Finlay, it would be a mistake to ask them to do some cardiac surgery at Tannoch Brae. Far rather Drs Gillespie, Kildare and the team at Blair General Hospital.

**7. How do we solve the problems of medical manpower?** Where practical we should use paramedical personnel in primary care and preventive medicine. For example, medical assistants, advanced clinical nurses and health assistants. Pharmacists will have some role to play in primary care, but an even greater role in educating patients and doctors in how to take medicine and in indicating which medicines may interact.

Where doctors are necessary in rural areas a scheme of National Service could be introduced, initially for Government Cadets bonded to Government for four years and then possibly for all newly qualified doctors. With two years' postgraduate training for the job and two years in the district, I believe we will have a new breed of doctor (or more accurately the rebirth of an old breed). I believe our training in Zimbabwe should be *table d'hôte* rather than *à la carte* or a messy *smörgåsbord*. Our young doctors should be good all-rounders who can cope with work in a district, and may hopefully decide to become country G.P.s. Some will decide to specialize, and since two years in general practice is needed for registration in most countries, these requirements will have been met, the doctor will have found in which fields his strength lies, and he will make a better and more understanding specialist.

**8. How do we supply cost-effective treatment to the greatest number of the population?** As far as drugs are concerned, I prefer control by implicit rather than explicit rationing. One can control prescription by limiting drugs to those in a National Formulary. Alternatively one can circulate schemes of practical cost-effective treatment for common disorders to doctors and paramedical personnel in Government service, suggesting possible therapy. This would mean that therapy started in central hospitals could be continued in the smaller hospitals and clinics to which patients are discharged.

As for hospitals, it is cheaper to treat as many patients as possible in the districts and keep the number of patients referred to expensive central hospitals to a minimum. This requires the re-establishment of an efficient peripheral service.

In regard to primary care, re-admissions should be avoided by an efficient handing over of care to the original primary-care centre or doctor, whether this be the specialist handing back a case to his G.P. or the hospital handing the patient back to a primary-care clinic. A discharge clinic and chronic disease register may well help in this respect.

**9. Do we support science or pseudoscience?** Orthodox medicine must not despise alternative forms of medicine, but subject these alternatives to the same controlled trials and experiments on which orthodox medicine has been built. Until these alternatives have been subjected to the fire and crucible, I believe that Government and Medical Aid Societies should recognize only orthodox medicine. In my personal opinion it was a retrograde step when Medical Aid Societies accepted the payment of chiropractors' bills. Whilst I have a healthy respect for the manipulative skills of chiropractors, I find dangerous the concept that disease,

whether it be meningitis, diabetes or cancer, is due to displaced vertebrae.

Once alternative forms of medicine, or pseudoscience, gain a foothold it will be impossible to draw the line between which should be recognized and which should not. It is hard enough to decide about the acceptability of the training in different schools of orthodox medicine, without introducing further imponderables such as faith healers, herbalists and astrologists.

**10. Are we training committed or committed doctors?** I could not help getting a dig at my pet hate, namely committees. Communication is becoming increasingly necessary and may well need to take the form of committee meetings. Committees are often used as stalling devices or as the means of postponing awkward decisions. Under such circumstances family planning to avoid the propagation of numerous subcommittees is desirable!

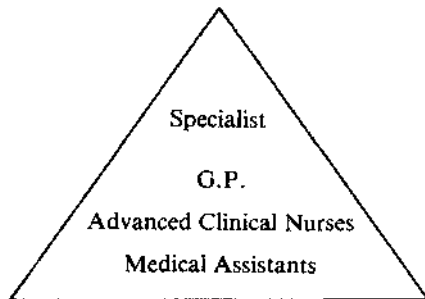
### CONCLUSION

The dogmatists held that medicine should be a science resembling geometry. Let me conclude by putting my concepts of medicine into geometric form:

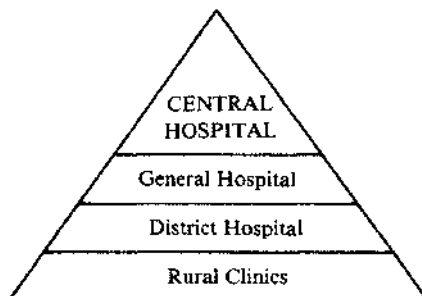
PREVENTIVE SERVICE



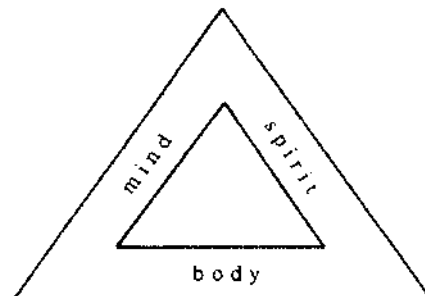
CURATIVE SERVICE



HOSPITALS



TOTAL HEALTH



At present the body and mind are catered for by orthodox medicine. The spiritual beliefs of the patient are very important, but difficult to cater for when they differ so widely; it is debatable whether those catering for the spiritual needs of the patient should be financed by the taxpayer. If body, mind and spirit are working harmoniously with each other and with the environment one is at *ease*; but if any facet is disordered or out of step with the others there is a state of *disease*.