Doctors' despair: a paradox of progress

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THE story goes that the great advances of medicine have made the modern clinician a more powerful doctor than his forbears. However, when one considers each individual consultation—the actual experience that a doctor has with each patient—he can usually do little to affect his patient's illness. The Emperor has no clothes. In an age of supposed medical potency, doctors are surprisingly dissatisfied, demanding, and lacking in self-respect, while their suicide rate is higher than most other professions'.

There are many reasons for medical discontent. First, and most obviously, there is the social revolution with disturbing changes in the pecking order and the material dispossession of the medical middle classes. There is also our displacement from the male medical preserve; where are the nurses of yesteryear? Second, many more psychological problems are brought to the doctor, who is rarely trained to deal with them, and even in the best hands psychological treatments are seldom dramatically effective. Psychotherapists learn to accept restricted aims and slow changes but the different expectations derived from medical training lie heavily on the souls of most doctors with each patient who complains of unhappiness.

We are interested in the modern medical myth as a third specific factor in medical discontent. It is not our wish to belittle the huge achievements made in the last hundred years, but rather to examine the way these advances tend to recede like a mirage in the face of much actual clinical work. The modern doctor learns the myth of medical efficacy at medical school, and his expectation to cure people leads to confusion in the clinical encounter. The problem is usually not consciously recognized and leads to bewilderment, disenchantment, gloom, anger, and a sense of personal failure as a doctor. These feelings are fairly common and arise particularly in general medical practitioners.

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Significance of therapy

The enormous pleasure derived from therapeutic success keeps us professionally alive. Nevertheless, the modern therapeutic success is often achieved with such speed and anonymity as to provide a fleeting *frisson* of magic and an unexpected aftermath of disillusion. The very speed of such cures can diminish some of our pleasure in achieving them—a case of easy come, easy go. The old treatments that did not work held associations with joint struggle and shared suffering that could ennoble the doctor's work, even though there were dangers of idealization, paternalism, and ritualism. Now, when treatments are supposed to work, the doctor is liable to feel ashamed for what he takes to be his impotence in many of his consultations.

The relative anonymity and sameness of drugs that work diminish the joy of prescribing them. One general practitioner described an elderly patient who used to point to the large coloured bottle on the mantelpiece and say, 'That's you doctor. I've got you there and while I can see that bottle I feel I shall be all right.' In spite of the idealization and the whimsy, it is possible to feel at ease with that vignette; whereas, a comparable relationship to a box of pills (probably poisonous) would surely produce medical shudders.

Treatments that work swiftly remove the beneficiaries from our vision and the doctor is left with the patients who suffer the crippling and killing diseases. Cancer, arthritis and degenerative arterial disease are barely touched by modern treatments, but the modern medical myth makes these failures even more painful for the doctor than they ever used to be. Moreover, the intractable diseases of today are of an overwhelmingly endogenous flavour, and we believe that this fact is charged with unexpected psychological force.

Paranoid and depressive positions

It is an unhappy truth that the human organism is often most comfortable when embattled against external threats. In wartime we all pull together against the enemy and share a sense of usefulness, however illusory this may be. The suicide rate falls sharply. Psychoanalysts recognize paranoid fantasies as ubiquitous primitive defence mechanisms against anxiety, sometimes predominating in a paranoid stance or position found periodically in normal people under stress. Bad feelings and destructive urges are imputed to real or imaginary objects in the outside world, giving rise to persecutory anxiety. With the development of more mature mental functioning and with reasonably good experience these processes subside and we are exposed to a greater feeling of responsibility and regret for our own faults while we discover the pleasures and pains of richer ambivalent relationships with the world around us. Psychoanalysts call this gloomier but richer state of mind the 'depressive position,' in which depressive anxieties (a mixture of yearning and regret, concern and remorse) are associated with a firmer grasp of reality.

We believe that doctors, as a profession, are now unconsciously struggling somewhere between these two positions, the paranoid and the depressive. The most momentous achievements of hygiene, immunology, and chemotherapy have been in the prevention and treatment of infectious diseases, the eradication of the enemy without. By contrast, the diseases we appear to generate from inside ourselves are almost untouched by our advances, and we seem to destroy ourselves from within. Cancer proliferates each year, and degenerative arterial diseases have advanced relentlessly from old age into middle life. It is true that certain advances have transformed the lives of many individuals who may formerly have died from such endogenous disorders as thyrotoxicosis, diabetes, and pernicious anaemia; but these achievements become almost insignificant as the death rate from the internal killers multiplies relentlessly. There appears to be some real basis for the suspicion that we bring these disasters upon ourselves by our way of life, but in any case, endogenous disease is always liable to be experienced in that way. Actually, people also brought syphilis upon themselves by their transgressions, and dirty habits of living could have been inculpated in other infectious diseases. We are not pointing towards a supposed need for moral regeneration. It is simply that medicine has achieved great victories over the external killers, whereas the endogenous nature of the remaining intractable diseases creates special psychological difficulties: we feel more responsibility for internal events than external ones.

Unrealistic therapeutic ideals

The paradoxical effect of medical advances in producing medical discontent, from unrealistic ideals and actual clinical ineffectiveness, is a prime aetiological factor in the present epidemic of iatrogenic disease consequent upon over-investigation and over-treatment. Anxiety and unrealistic therapeutic ideals in the doctor lead to compulsive over-investigation and over-medication, seemingly impossible to resist in spite of much persuasion. The age of lethal bloodletting is surpassed a thousandfold in the age of the FP10, iatrogenic invalidism, and epidemic self-poisoning (one in six medical admissions to hospital).

Ivan Illich (1974) writes interestingly, but we think that his view of escalating greed and grandiosity misses the sense of its driven defensive nature against irrational fears and guilt.

Malleson (1973) examines related problems, highlighting the commercial pressure towards over-use of pharmaceutical products, but all this is supplementary to the primary susceptibility of modern doctors to anxious over-activity.

Whereas in former times diagnostic skill was the doctor's *raison d'être* and a basis for his self-respect, it can now easily become an involuntary defence against guilt-ridden therapeutic helplessness. The most wholesome feature in doctoring may still be the ability to diagnose, whereas the ability to treat may be a more dubious affair, contaminated with omnipotent and narcissistic aspirations in the doctor. The highest human achievements may have more to do with the pursuit of truth and a passionate concern with the nature of the universe than with zeal to change things. In this sense, the attempted distinction between art and science is often foolish and shallow. It may be a significant observation that the most trusted and admired physicians are those who are also regularly to be seen in the post-mortem room, reflecting their willingness or determination to follow truth to the bitter end, not in a spirit of mere insatiable curiosity but rather in the sense of commitment to see something through. The inordinate prestige that neurologists have tended to command among doctors may be related to the extraordinarily precise diagnostic feats of which they are capable even though their therapeutic impotence is usually obvious. Neurologists are almost innocent of the zeal to cure.

Unfortunately, in the modern climate of high therapeutic expectation, investigatory procedures become more and more complicated and dangerous. As psychoanalysts, we are in no position to point at other doctors who may engage in expensive investigatory procedures of uncertain therapeutic result, and our purpose is only to examine the process of investigatory furore in which doctors may be caught up as a result of the burden of modern scientific medicine. Of course, some doctors may also proliferate investigations owing to deficiencies in their own personalities, but that has always applied and it is not what we are writing about.

All this is less true of the work-experience of surgeons. They have always had a more robust response to their failures owing, possibly, to the satisfaction they

can draw from the conscious and visible exercise of manual skill and precise anatomical knowledge. The gratifications and frustrations of surgery are obvious, and have the same essential nature that they always have had. Apart from the glamour and the money, this may be a prime reason for the popularity of a surgical career. The readiness of surgeons to 'have a go', irrespective of results, has always been worrying to the physician's temperament; but perhaps there is now a backlash in the physician's over-concern with effectiveness. Useless operations may now be overtaken by the astounding over-medication disclosed in each new batch of statistics for prescribing costs and pharmaceutical profits. Physicians have a very long history as a profession with negligible genuine therapeutic power, and are still disorientated by the relatively recent heritage of some treatments that work—like a sudden substantial bequest from an unknown great-uncle, easily over estimated and overspent.

References

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Childhood antecedents of adult obesity

It was investigated whether obese infants tend to become obese adults. Records of subjects born between 1945 and 1955 were reviewed to select three cohorts based on weight in the first six months of age, which exceeded the 90th percentile at least once, ranged between the 25th and 75th percentiles, or was below the tenth percentile at least once. Three hundred and sixty-six subjects, now between 20 and 30 years of age, were located and their present height and weight determined.

Thirty-six per cent of those exceeding the 90th percentile as infants were overweight adults, as compared with 14 per cent of the average and lightweight infants. A significant increase (chi square = 17·2; $p < 0{\cdot}001$) in adult obesity was evident when the infant exceeded the 75th percentile that was independent of his height. Social class, educational level, and parental weight all correlated with adult weight ($p < 0{\cdot}001$). Sex and ordinal position of birth did not.

The data suggest that infant weight correlates strongly with adult weight independent of other factors considered.

Reference

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