

## Art in Family Medicine

Dr. Koh Eng Kheng M.B., F.R.C.G.P.

This is a true story that needs to be told and I am grateful to the College not only for the honour of letting me deliver the Second Sreenivasan Lecture but also for providing such a distinguished audience to hear me.

Hock San is a nice quiet boy. He is twelve years old and he lies in a ward for adults in the General Hospital. His companions in the ward for some weeks now are either old or very ill patients. Some three weeks before his admission to the ward he had a cough. His parents brought him to see a general practitioner. The cough did not get better, so they took him to another G P. Despite medication the cough got worse. In desperation they took him to a third GP. By this time it was obvious that the boy was in respiratory distress so the GP sent him into the hospital.

An X-Ray picture taken in the hospital showed pleural effusion and a big opaque mass in one of his lungs. He also had enlargement of the liver and spleen. All this now added up to a very grave outlook for the boy. He had a growth in the chest. This condition was very rare, but for Hock San however it was also very real and very sad.

The story of Hock San is not a new one. As doctors we have all seen it before, though fortunately on rare occasions. As doctors too we often think we have an answer for every thing that comes our way. In Hock San's case unfortunately we do not. How did the growth get there? We do not know. Could the outlook have been better if he had been sent into hospital earlier? We do not know. Can radiotherapy or cytotoxic agents help? We do not know. What should we tell the parents? We do not know.

Yes, there are a lot of things we do not know and cannot supply the answers. This is where a clinician like Dr. B.R. Sreenivasan would have been able to help. Besides being a good clinician he was also the complete physician. His experience, his wisdom and knowledge made an art of the practice of medicine.

Is there such a thing as art in medicine? Lord Platt says there are three kinds of clinical scientists. The first group is good clinicians and use all the skills they have been endowed with. The second believe that the whole of medical teaching should be based on clearly demonstrable scientific principles. The last group are the "hard boiled" scientists, "who pale at the very idea that a concept as woolly as the art of medicine should even exist in present day thinking, or, if they concede its existence, they think that what it means is that the scientist should have a human and compassionate approach to his patients."

Art in medicine comprises much more than good bedside manners and a ready to wear dentrified smile. Like all art one is either endowed with it or for those of us who are not so gifted, we have to cultivate it. Is there anything we should cultivate?

We can begin by sharpening our sensory acutities. By hearing more acutely, seeing more sharply, touching more frequently, we will soon learn to immediately recognise patterns. The human brain is a master computer, it quickly learns to recognise and interpret patterns. In clinical practice we call this ability to recognise patterns in a flash, spot diagnosis.

When I was a student making a spot diagnosis was frowned upon and perhaps rightly so because a medical student did not have sufficient clinical experience to be able to make one. But ideas once seeded take a long time to eradicate and there are many doctors who after long years of practice still hesitate to make a spot diagnosis because they have all been taught it was not the proper thing to do.

Not all clinical teachers frowned upon making a spot diagnosis. Sir Gordon Ransome used to tell the story of the street urchins in London who could immediately tell whether a plane was friendly or not during the blitz by listening to the drone of its engines. Lord Platt tells us that many boys can tell you instantly the make of almost any motor car on the highway at a glance.

He goes on to say, "These superb qualities of pattern recognition which man, and all other animals possess, are of the kind which are usually instantaneous in action and correspond with what we know as spot diagnosis, a term derided by a certain kind of clinical scientist who sneers at spot diagnosis in his colleagues and students but exercises these wonderful qualities of the human computer every day in his garden and in his motor car and almost in the whole of his daily life... The cultivation of similar qualities ... in the medical student seems in recent years to be in danger of falling into desuetude. Yet this is the real art in medicine."

This neglect of the art in medicine has come about because of our present day thinking that all medical problems can be resolved by science alone. We try to explain all pathology on an organic and therefore scientific basis. This led almost to a feeling of guilt and uncertainty amongst general practitioners when they found they could not explain most of the illness seen in their clinics in organic terms. In 1958 the Research Committee of the British College of General Practitioners, led by Crombie and Pinsent showed that in only 55 per cent of consultations could doctors make a "firm diagnosis" in pathological terms.

Because we seek an organic cause for illness our doctors these days tend to become too dependent upon medical technology to make a diagnosis. Where results from the laboratory do not shed light our doctors feel uneasy about forming their minds about the case. Clinical experience and observation alone can often provide the answer where biomedical data cannot. Any doctor I am sure can tell whether a patient is angry or frightened by merely looking at him even though the serum corticosteroid levels or the catecholamine assay show both conditions have similar readings. An experienced doctor by looking at the pallor of a patient can also tell whether he is having a colic, is anaemic through blood loss, or is suffering from a chronic renal ailment. It is possible even to detect a case of hepatitis before the appearance of bile pigments in the urine.

Keen observation thus forms one of the cornerstones in the art of medicine. One should not only look closely at the patient but also those who accompany him into the clinic. In this way a lot of valuable information may be gleaned even without one word having been spoken. Dr. B.G. Dudley has this observation to make. "A boy of 11 or 12 coming on his own alerts one to the danger of neglect. On the other hand, the appearance of mother with a young man of 18 - 20 seems to indicate over-protection or over-dependence. The sight of a teenage girl, appearing with a friend of either sex, always set alarm bells ringing in my mind; the story of a missed period and the possibility of pregnancy is frequently heard." I am sure we can all readily attest to the truth of Dr Dudley's observations.

Dr. Dudley goes on to say that one of the diagnostic pointers usually ignored by books, is the voice. The changes of voice in people with depression he feels is the commonest voice abnormality in general practice. Some patients too have changes in their voice with upper respiratory tract infection like influenza or in asthma. The change is often quite out of proportion to the severity of their illness.

Voice changes are not the only things to listen for amongst the patients. A good G.P should learn to pick up pare-language as well. This is the language within a language. Often what is spoken is mere verbalisation and the innuendoes have to be looked for if the message is to be properly understood. In English for example, "good evening" is a normal form of salutation. "Good day" however can carry a different meaning altogether. A person who says curtly "And a good day to you Sir" shows that he wants to terminate the conversation immediately. To give another example. If your wife for instance requests you to accompany her to the supermarket and if she notices you are dragging your feet, she may turn round to you and say, "Oh! Don't bother. You needn't have to go." You may have to read the pare-language here. It isn't that she does not want you to go. "Don't bother" reads that you had better bother. "You needn't have to go", means you had better go along, or else. Doubtless similar examples can be found in the context of local dialects. A lot is lost if a patient speaks in a language he is not completely at home in.

Our pre-occupation with science has also meant that the art in medicine in many instances is being transformed into social sciences. I think enough controversy has been made about social science in the local press lately and I do not wish to add to this. What many experienced GPs take for granted as experience and skill are now dished up in many teaching universities as social science subjects like behavioural studies, communication with patients, management of the sick and many others. I suppose words like psycho-cybernetics, micromomentaries, spatial kinesics lend authority to old ideas in this new age of the sciences. I really do not know whether making a science out of an art is really improving matters. The important thing however is at long last someone is taking a hard look at things which we doctors have long neglected.

Now we can be sure, I hope, that more people are awakening to the fact that computer readouts alone are not going to solve all our medical problems in the future. Hock San lying quietly in the ward is not merely an unfortunate member of the species Homo Sapiens. He is a young boy with a medical problem. He has a family who love him and he loves them too. So the medical problem is compounded with a social problem, an emotional problem, an economic problem and so on. Science alone will not be able to solve all these problems.

Osler once said, "Medicine is a science of uncertainty and an art of probability." No one seems to heed this very much these days. The fact that science alone does not hold all the answers seems to escape many medical schools who still insist that those who intend to take up medicine must produce first grades in the sciences, physics, biology, chemistry or mathematics. No one bothers to ask whether a student is proficient or interested in any of the liberal arts like music, art or drama, or any of the humanistic subjects. Is it important?

Dr. Sreenivasan thought so. In the First College address which he delivered in 1972 he said that as early as 1224 the medical school at Salerno insisted that medical students undergo three years of general studies as a preparation for the medical course which lasted another 4 years. Even at that time a general education was considered not only desirable but necessary. A well educated man must be versed in the classic languages as well. In England the physicians knew Latin and therefore considered themselves one rung above the barber-surgeons who did not.

General practice has once been cynically described as "the ability to be therapeutically effective in the absence of scientific data." Whoever made that statement obviously did not think much of the GP as a scientific man. Does it matter all that much? The Chinese Vice-premier Deng Xiao-peng said, "It does not matter whether it is a white cat or a black cat so long as it catches mice." I think we should not be put off by critics who say we are unscientific in our approach to medicine. The important thing is to cure, or if that is not possible, at least care for the patients in our charge.

Let us not forget the Litany of Sir Robert Hutchinson.

"From putting knowledge before wisdom, science before art, and cleverness before common sense, From treating patients as cases and from making the cure of a disease more grievous than its endurance, Good Lord deliver us. "

That is why our little boy who lies quietly in the ward has a name, and does not carry merely an anthropological tag. And his name is Hock San.

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## REFERENCES

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