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## ORIGINAL ARTICLE

# 'He found me very well; for me, I was still feeling sick': The strange worlds of physicians and patients in the 18th and 21st centuries

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It is commonplace today to deplore the dissatisfaction of patients with the physician-patient relationship. Furthermore, historical investigation shows that this problem is not really new. We investigated an important source of patients' views in the 18th century, namely the letters of patients received by the famous Swiss physician, Samuel Tissot, and noted remarkably similar feelings of frustration. Yet the medical paradigms of today and of Tissot's times are considerably different. We propose that the persisting problems in the physician-patient relationship are due to a basic dissonance between the patient's ordinary modes of perception and the systematic way of perceiving reality characteristic of the physician. In addition, they reflect the unavoidable chasm between the ultimately private and singular nature of the illness experience, and the general and anonymous stance of medical theory. This chasm is therefore a permanent feature of the patient-physician relationship, predating the advent of scientific medicine, even if the latter reinforced it. In line with the current medical humanities movement, we believe that the engagement of physicians and medical students with literature and the arts helps them explore, and to some extent overcome, the existential divide between the patient's experiential self knowledge and the systematic, impersonal knowledge that plays a central role in medicine. We suggest a few examples of contemporary fiction that may be relevant and useful in this respect.

He found me very well; for me, I was still feeling sick.<sup>1</sup> This quotation, which highlights a gap in the interaction between a patient and his physician, comes from an epistolary consultation requested by one Monsieur de La Porte from Dr Tissot on May 27th 1781. Dr Tissot was a very famous Enlightenment physician who received many such consultations (at least 1300) from sick people all around Europe. Monsieur de La Porte was not an exceptional case among Tissot's patients: many of them expressed the same kind of distrust. Thus, Monsieur de Croyer gives us another thoughtful example of the fundamental misunderstanding between physicians and patients. "I haven't asked any doctors to write this consultation: they don't feel as I do the ailments they describe better."<sup>2</sup> He suffered many symptoms over a period of two years: he felt very tired and melancholic, and was afflicted by all sorts of pains. He had consulted several physicians who didn't take him seriously. Disgruntled by their behaviour, he had lost faith in the medical profession and, at that point, wanted to comply only with Tissot's prescriptions. In the same way Monsieur Gualtieu, another patient of Tissot's, writes: "I don't have any trust in our physicians: they swear by systems, to which they bend all facts; they lack the ability to observe, and their fanaticism for systems and hypotheses prevent them from seeing and studying nature".<sup>3</sup>

Consulting by letter was a common practice during the Enlightenment; people resorted to it either because of the lack of physicians in their area, or with a view to obtaining advice from a famous doctor.<sup>4</sup> The archives of Dr Tissot contain more than 1300 documents, sent by more than 1000 different authors and concerning about 1250 patients.<sup>5</sup> The letters come from all over Europe, but mostly from France.<sup>6</sup> Owing to insufficient information, it is not easy to draw a clear cut sociological profile of the patients. However, data on domestic help and housing for example, suggest that at least 160 of them were wealthy, whereas 30 seem to have lived in poverty and in conditions of economic dependence.<sup>7</sup> This is the case for a few servants, about whom their master or mistress had

written to the doctor. It is also the case of an unidentified "very honest man", a 40-year-old father of eight children, who was suffering from epilepsy; he was finally able to afford to come to Lausanne thanks to his village community, which organised a collection for his journey.<sup>8</sup> Indications about profession are also very scattered: craftsmen, workers, or peasants are rare, while churchmen, men in political or administrative positions, and lawyers, are more numerous (more than one hundred).<sup>9</sup> In terms of the therapeutic relationship, the documents show a fairly balanced rapport between the patients and their doctors. While historians and sociologists have described the pattern of patronage established in specific circumstances,<sup>10</sup> the economic dependence of physicians upon their patients is not visible in those consultations. One of the patients' recurrent complaints about their physicians concerns the fact that they are abandoned by them; this suggests that some doctors have few qualms about breaking a therapeutic relationship.<sup>11</sup> Generally speaking, patients and physicians mentioned in these documents seem to belong to the same social world. One also realises that one way of getting in touch with Dr Tissot, was by referring oneself through mutual acquaintances.<sup>12</sup>

Written consultation is a particular mode of therapeutical relationship which excludes non-verbal communication. Meanwhile, the kind of discourse contained in these letters evokes a mistrust of sick persons towards physicians which sounds quite familiar to us, at the beginning of the 21st century. Indeed, many today are dissatisfied with the quality of the patient-doctor relationship, for different reasons, (overspecialisation, technologising of medicine, discrepancy between lay and medical discourse) which lead to a similar breakdown of the relationship. The many commentaries, scholarly or popular, on this dissatisfaction, the more frequent recourse to litigation in some countries, and the increasing number of people consulting healers who use complementary medicine are all testimonies to this fact. This resonance across the centuries is by no means trivial. How is it that 250 years apart

patients express similar feelings of frustration with the patient-physician relationship, while being confronted with two very different medical paradigms? To oversimplify these two paradigms, it is commonly thought that the 18th century patient was generally considered as a whole individual whose health and illness was interpreted in terms of humoral medicine. In that holistic view, and especially considering the ineffectiveness of the available treatments, the patient's discourse was central to the patient-doctor relationship. The number of written consultations testifies to the importance of illness narratives and of the spontaneous self reporting of symptoms in the actual words of the sick person. As medicine became, over the course of two centuries, more scientific, the holistic emphasis on the sick individual gradually disappeared. Disease became increasingly a matter of organs, cells, and finally genes and molecules, at least in the eyes of doctors.<sup>13</sup> At the same time, many therapeutic discoveries established a new kind of medicine based on effective treatments. As a result, one may well ask how it is that patients from two utterly different worlds of medical theory and practice come to have similar complaints.

### DO DOCTORS LISTEN?

Today, one of the main grievances patients have against doctors is that physicians look at them piecemeal as organs or cells, and that they don't really listen. Indeed, one study in the nineteen-eighties revealed that doctors interrupt their patients' presentations of their main complaint after 18 seconds on average.<sup>14</sup> This is in sharp contrast with the increasing number of medical publications underlining the importance of narratives and promoting the legitimisation of the patient's discourse.<sup>15</sup> Yet in the 18th century, narratives were at the very root of the patient-doctor relationship. The then widespread practice of written consultation is especially illustrative of this fact. Letters, of more than ten pages sometimes, testify to the importance given to patients' own words. They contain many details about the every day life of the writer, and about the course of the disease through the perception of his or her symptoms; the author feels free to express all kinds of emotions, which are perhaps easier to tell the doctor by letter rather than face to face. In that situation, the patient is obviously not interrupted and the interview is not directed by the physician. In such a context, the narrative is not "abstracted from the patient's control and the context of its original telling".<sup>16</sup> And yet patients of the Enlightenment complain about the "deafness" of physicians just as much as they do today. Madame Turmeau (second half of the 18th century), who suspected she was suffering from an "engorgement of the spleen", writes: "I have consulted several doctors, who have imagined that I was joking, saying that when one is suffering and when there is engorgement, one doesn't walk as easily as I do, and that the cheerfulness wouldn't be so evident if I were as sick as I pretended".<sup>17</sup> Voicing a similar complaint, the chevalier de Bellefontaine writes: "All my complaints have resulted only in my being seen as a hypochondriac by physicians, and obtaining virtually no relief".<sup>18</sup> About another physician, an anonymous writer says: "He wasn't listening to anybody and remained silent".<sup>19</sup> These examples show that, contrary to the conventional wisdom of today, the lack of satisfactory patient-physician communication is not confined to the technical coldness of contemporary medicine alone.

### TWO DIFFERENT WORLDS

As regards patient-physician communication, there are indeed two different worlds, not so much between the ancien régime and today, but between the sufferer and the healer. Sickness can often be an individual non-shareable reality; as pointed out by David Le Breton, "pain immerses us in a universe inaccessible to anyone else".<sup>20</sup> The conflict between those two worlds has already been highlighted by Katz and Shotter, who

experimented with the presence of a "cultural go-between" during the patient-doctor interview to "open a new space between patient and doctor".<sup>21</sup> The quotations above clearly express the gap between the perception of the illness by the sick and the perception of the same illness by the physicians. By perception, we mean the "preconscious level [which gives us the] structure of our reality".<sup>22</sup> Living the pain in one's own body constitutes one perception; analysing it is another matter altogether. Therefore, there is a split between the bodily experience and the intellectual explanation of that experience by somebody else. Furthermore, this difference lies in the question of the perception of reality, as noticed by Hick.<sup>22</sup> According to him "the classification of diseases must be seen as a mutilation of what is perceivable in the individual patient—a 'loss of reality'". It can lead to a difference in understandings of the disease, and the gap between these two perceptions is not at all new, as evidenced by our historical investigation. One could argue that this difference of perception is explained by the growing distance between medical and lay discourses about disease. Indeed it is true that many patients today blame physicians for using incomprehensible words. This semantic distance doesn't, however, give a satisfactory explanation when we consider the 18th century. During the Enlightenment, the elite of society (to which the majority of Tissot's patients belonged) was able to understand medical discourse fairly well and to make the medical knowledge of the day their own. Consequently, the sharing of discourse does not entail the sharing of perception.

We are left with the notion that there is a genuine gap between the perception of the illness, becoming increasingly "closed" in the medical profession, and the perception of the same illness by the patient, which is by essence individual, and needs an "open perception" from the doctor to be understood. Indeed, Hick distinguishes the "open" ordinary pattern of perception, with its mixture of knowledge and ignorance, and the "closed", scientific way of perceiving reality, constituting "absolute knowledge"; he adds that the interaction between both is necessary. By absolute knowledge, according to Hick and Foucault, one must understand the "scientific way of perceiving reality", built through the new paradigm adopted at the beginning of the 19th century, when the development of anatomopathology provided a new basis for understanding illness. In other words, one should understand "absolute knowledge" as a kind of universal knowledge, only loosely connected to the singular perception of the suffering body.<sup>23</sup> According to these authors, with the work of the School of Paris, in the first decade of the 19th century, "the simple perceptual reality" became "the truth of the pathological lesion".<sup>24</sup>

This, however, is only part of the story. Granted, it is certainly true that the adoption of a new paradigm reinforced the gap between the two perceptions of the illness. But the previous quotations show that the gap actually existed before. Indeed, whatever the advancement of medical science, and whatever the prevailing medical theories, there is a suffering body, and a "scientific" system which tries to explain it. There is pain, sometimes difficult to express in words, and there is a translation of these words in order to interpret them. The question is how we can reduce the gap between those two perceptions. Dr Tissot gives a kind of answer, when he writes to one Monsieur Ferber, who was complaining about doctors: "If physicians were generally more observant and less systematic, you would not be, Sir, in this uncertainty . . .".<sup>25</sup> The term "systematic" is crucial here: each medical paradigm means a system, and the open perception depends on the way of each physician is able to get out of this system, when necessary.

### BEING CONSCIOUS OF THE SYSTEM

"They swear by systems, to which they bend all facts", in the words of Monsieur Gualtien quoted earlier.<sup>3</sup> The criticism

bears not so much on the very existence of a system, but rather on the fact that physicians did not realise that they were bending everything to it. In other words, they were not aware that their adherence to often bookish medical systems conditioned their way of selecting and interpreting observations. If this was true at the time of the Enlightenment, it is even more relevant today. Indeed, nowadays the adherence of physicians to a specifically medical way of thinking is reinforced by the social status of doctors in contemporary society. In short, since the early 19th century, the professional identity of the physician has been strengthened in the community, while other healers have been increasingly pushed aside. Physicians have taken on more and more political functions, and this newly won prestige is inversely related to the loss in influence by clerics: "One doesn't appeal to the priest, but to the physician to obtain salvation. For salvation has become the synonym of health", as stated provocatively by the philosopher Alain Finkielkraut.<sup>26</sup> The result is that at the beginning of the 21st century, the doctor is a key figure in a deeply medicalised society, wielding considerable power. This situation fosters contrasted societal attitudes that swing between positivist exaltation and antiscientific denigration, as noted by the anthropologist François Laplantine.<sup>27</sup> A doctor whose attitudes and behaviour adhere too strictly to these socially expected patterns will have more difficulties in interacting with his or her patients. He may not have the necessary distance to develop the open perception required for a successful communication with the suffering person. In Hick's terms, there is a failing in interpersonal relations "where the other no longer is perceived by what he is doing . . . but by what he is supposed to be".<sup>22</sup> In that situation, communication is doomed to failure because it is attempted between socially constructed images rather than real persons.

### PATIENT HISTORIES, PATIENT STORIES

To overcome the prevailing representation of the medical profession and its consequences, one possibility would be for the physician to appeal to his own mode of feeling and thinking, as he does in ordinary life. We believe literary fiction can play an important helping role in this process, and wish to give a few, rather unsystematic, examples. *La maladie de Sachs*, a novel by the French general practitioner and writer Martin Winckler is a beautiful example of this process, and makes useful reading for medical students.<sup>28</sup> In a very sensitive and subtle way, it tells of the everyday life of a doctor in a small provincial city, and squarely describes the doubt, weariness, burnout, but also the satisfaction, and all the rich range of emotions of a medical practitioner. Generally speaking, reading the experiences of others is important to gain "the capacity for critical examination of oneself and one's other tradition", and "the ability to think what it might be like to be in the shoes of a person different from oneself, to be an intelligent reader of that person's story, and to understand the emotions and wishes and desires that someone so placed might have".<sup>29</sup> In fact, we believe that the literary narrative has a specific function in helping to bridge the chasm between the "closed" perception of medical knowledge and the "open" perception inherent in experiential patient knowledge. As Northrop Frye points out, literature promotes tolerance.<sup>30</sup> This is, in our view, one of the main justifications for the medical humanities.

Trying to share the same perception of reality means for the healer to leave, when indicated, the world of "absolute knowledge" provided by medical science to move towards the "open perception" that allows a deeper understanding of the patient's discourse. Literature and the visual arts, among others, can pave the way towards shaping that kind of understanding. "The arts can also extend our imagination and deepen our sympathies by allowing us a vicarious participation in situations that we have not experienced ourselves, and perhaps never will experience".<sup>31</sup> For instance, the beginning

of the film, *All about my Mother*, by film director Pedro Almodóvar is an impressive portrayal of the suffering of a mother around the time of her son's death and the decision to donate his kidneys.<sup>32</sup> The film shows the troubling contrast experienced by the mother, who works in an organ procurement team, when she is suddenly confronted by the same reality but this time in the role of the mother of her dead son. It shows both sides of this reality, and suggests that these two faces can live together, without nullifying each other. Almodóvar's intention is not to argue for or against organ donation, but to describe different perceptions of the same reality and to show the irreducible heterogeneity of the human being that was emphasised by Mikhail Bakhtin.<sup>33</sup> The message, if there is one, is that the human person is a powerful creator of meanings, able to integrate experiences that appear hopelessly contradictory to the purely rational mind.

Faith McLellan observes that literary texts are able to surpass the singularity of a given situation without suppressing it in the way medical knowledge nullifies the single cases in constructing general knowledge.<sup>34</sup> Thus, reading a book such as *The Diving Bell and the Butterfly* brings to light a perception of the everyday life of a man with locked-in syndrome, not only through the description of his life but above all through the clear-minded analysis, by the author, of his emotions, his own situation, and his relationship with others, especially his family and his carers.<sup>35</sup> This kind of book shows us the fundamental changes arising from a break in ordinary life, caused by sudden sickness or accident. In short, it introduces the reader to a truth that might otherwise remain unavailable. Similarly, reading testimonies by sufferers from depression provides a unique way of perceiving their distress, and a direct insight into the permeable border between madness and health. William Styron's *Darkness visible – A memoir of madness* is a good illustration.<sup>36</sup> Through Styron's writing, one realises the difficulty of choosing a hospital treatment, when that choice entails accepting one's mental illness.

Reading literary texts will induce physicians to resort to their imagination, something rarely required of them during their studies. Frye suggests three different modes of dealing with the world we live in: consciousness, social participation and imagination. This last is transmitted through the medium of literary language. Referring to Aristotle, he writes: "The poet's job is not to tell you what happened, but what happens: not what did take place, but the kind of thing that always does take place . . . In literature you don't just read one poem or novel after another, but enter into a complete world of which every work of literature forms part."<sup>37</sup> In the words of J Rancière, "reality must be fictionalised to be thought out".<sup>38</sup>

Besides exploring experiences, literature is also a way to discover different meanings of illness. One of the possible gaps between patients and physicians resides not only in the perception of the patient's illness, but also in the various meanings patients given to illness in general. As highlighted by Mead and Bower: "In order to understand illness and alleviate suffering, medicine must first understand the personal meaning of illness for the patient".<sup>39</sup> This meaning can be dependent on the religious beliefs of the sufferer, as was generally the case until the end of the Enlightenment, and as is still true now for many people. An example can be found in the book, *La Présence Pure*, written by the French writer Christian Bobin, whose father is suffering from Alzheimer's disease.<sup>40</sup> Furthermore, it is important to be aware of the different possible meanings of disease, and this is expressed in several works. A book by the Swiss writer, Fritz Zorn, is a particularly brilliant example.<sup>41</sup> The author is a young man, dying of cancer at the age of 32. It opens thus: "I am young and rich and well-educated; and I am unhappy, neurotic and alone". The whole book is a reflection on the link between Zorn's background and his disease. He tries to give meaning to his suffering, which for him lies in a conflict between his individuality and the petty and repressive middle-class



outlook of his milieu. Such writings “help teach students ‘to read in the fullest sense’, a skill that helps prepare them for the clinical work of listening to and interpreting patients’ stories”.<sup>42</sup> Stories of personal experiences, regardless of when they were written, are one of the ways to open perception and to broaden the range of emotions that can be made comprehensible and meaningful to aspiring doctors.

## CONCLUSION

Our historical investigation, based on hundreds of letter consultations written during the 18th century, helped us refine and reorient questions about communication difficulties in the contemporary patient-doctor relationship. It suggests that these difficulties are not to be accounted for merely by contextual explanations, such as, for example, the hyper-specialisation or technologising of contemporary medicine. These consultations took place in a totally different medical paradigm, which viewed patients as whole persons rather than as collections of organs, cells, and molecules, and where social elites were well acquainted with the prevailing medical theories. It turns out, however, that there were similar criticisms of the medical establishment then as compared with now. This finding, added to the fact that those letters were mostly written by sick people or family members and not by physicians, led us to think that the failure of communication lies in a difference of perception of reality, above all the reality of the body, between physician and patient. This difference arises for two basic reasons. The first is that the very practice of doctoring entails the interpretation of a singular case and the individual experience of a sick person *in terms of* some form of generalised medical knowledge which is necessarily universal, abstract and anonymous: in short “absolute”, in the words of Hick.<sup>23</sup> The second is the fact that no doctor, however empathetic and concerned, can truly be in the patient’s shoes and feel the patient’s feelings. Moreover, expressing one’s *own* feelings and discomfort is very difficult. In fact, then as now, some patients are well aware that their insider’s view of their own disease is unique. Explaining why she chose to tell of her pains herself, Madame Bordenave de Disse wrote to Tissot: “because I thought that a man skilled in the art (= a doctor) would have told you his ideas; for myself, I have told you my pains”.<sup>43</sup> This quotation is reminiscent of Puustinen’s comment that, “the doctor’s response to the patient’s expression is modified by the ideas acquired through a long process of medical training and the accumulated clinical experience . . . [but it is] . . . also shaped by the doctor’s personal life in all of its dimensions and relations”.<sup>44</sup> The personal life of physicians must be valued again, as well as being enriched by the experiences of others. We believe that literary narratives and other works of art can be among these “other” experiences, and can provide useful routes towards a deeper understanding of the lived experiences of patients. Medical humanities should contribute to increasing the proficiency of physicians in mastering the dual perception of illness, “absolute” and “open”, scientific and experiential, both of which are essential if medical practice is to be humane as well as competent.

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- As a result of funding by the Swiss National Fund for scientific research, Séverine Pilloud and Micheline Louis-Courvoisier have developed a database integrating as much information as possible from these written consultations. This database will be put on the web. This project (FNRS no 11–56771.99) has been conducted under the direction of Professor Vincent Barras (Institut Universitaire d’Histoire de la Médecine et de la Santé Publique, Lausanne, Switzerland). From 1997 to 1999, we studied the documents and elaborated the database. This research is to be continued until 2002 by Séverine Pilloud; a publication presenting our results in a more analytical way is planned. The issues we will address are the therapeutic relationship, lay representations of health and sickness, self treatment and healing practices at large, the medical market, etc. There are more patients than authors because some authors wrote simultaneously on behalf of several sick people. On the other hand, some documents are not related to consultations but to personal or scientific subjects. A little more than a third of the authors are women, while around half of patients are women.
- The other countries are: the Low Countries, Austria, Switzerland, Germany, England, Ireland, Scotland, Denmark, Greece, Portugal, Spain, Luxemburg, Russia, Croatia.
- We cannot draw any clear conclusions for the others. However, fees for letters were high enough to suggest that most of the correspondents were not really poor. See Dauphin C, Lebrun-Pezzerat P, Poublan D, avec la collaboration de Demonet M. L’enquête postale de 1847. In: Chartier R, ed. *La correspondance. Les usages de la lettre au XIXe siècle*. Paris: Fayard, 1991: 49. Furthermore, most of the correspondence still found in the archives comes from middle or upper class people.
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  - 19 **Lausanne BCU**, IS3784/II/149.01.01.03, 7.8.1769. “Il n’écoutoit personne et se taisoit.”
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  - 24 On this question, see Ackerknecht E. *Medicine at the Paris Hospital, 1794–1848*. Baltimore: John Hopkins, 1967, who described the beginning of modern medicine grounded on physical examination, the notion of lesion, the growth of anatomical pathology and the introduction of statistics; Foucault M. *La naissance de la clinique*. Paris: Presses Universitaires de France, 1994. However, this assertion is now challenged by authors such as Othmar Keel. L’essor de l’anatomie pathologique et de la clinique en Europe de 1750 à 1800: nouveau bilan. In Barras V, Louis-Courvoisier M, eds. *La médecine des lumières: tout autour de Samuel-Auguste Tissot*. Genève: Georg (Bibliothèque d’Histoire des Sciences), 2001. See also Hannaway C, La Berge A, eds. *Constructing Paris Medicine*. Atlanta, GA: Rodopi, 1998.
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