

Essay Review

Dr Cabot and Mr Hyde

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Christopher Crenner, *Private practice: in the twentieth-century medical office of Dr Richard Cabot*, Baltimore, Johns Hopkins University Press, 2005, pp. xv, 303, illus. £32.00 (hardback 0-8018-8117-X).

There are many well-crafted vignettes in this book, some excellent big pictures and perhaps also a massive, wide screen production struggling to be set free. For some years I used cases described by Richard Cabot in his *Differential diagnosis* (Philadelphia, 1911) as the basis for student essays. These records are succinct models of clinical investigation in which Cabot employs all the laboratory and bedside tools newly available to the early twentieth-century physician to diagnose and treat his patients. I asked students to compare them with the recorded histories of consultations made by an eighteenth-century doctor, usually the Cumberland physician William Brownrigg.¹ Cabot's cases are perfect for teaching most things an undergraduate might be expected to know about the history of relatively recent clinical medicine. They are hospital-based and scarcely anything can be learned of the patient's way of life save his or her occupation. Physical examination, pathological anatomy, surgical referral, the microscope and the X-ray all appear. The contrast with the case notes made by an eighteenth-century doctor is quite marked. Cabot, to all appearances, was a modern and a principal one at that. The "sick man" has disappeared from his histories in so far as Cabot

never puts in writing how his hospital patients say they feel. In using Cabot in this way I generally kept from the students my guilty secret—that I was being unfair to Cabot—that there was more to Cabot's approach than mechanical medical practice. It is quite well known that in various other writings Cabot was at the forefront of the movement that resisted what was deemed clinical reductionism and that was struggling to restore, in George Canby Robinson's phrase, "the patient as person".² Indeed Cabot's later career saw a retreat from clinical practice and his pursuit of the study of medical ethics.

In Christopher Crenner's *Private practice: in the early twentieth-century office of Dr. Richard Cabot* I expected to meet my nemesis—a Cabot who treated the whole person. Interestingly I'm not sure I did, which is not to say I did not find in here new interpretations of Cabot's medical (and personal) life. In his private practice, patients do emerge much more fully but only because the contingencies of private practice make richer evidence available, not through any change in Cabot's clinical approach (the modern sense of clinical as also meaning "impersonal" or "steely" is important here).

Cabot was born in 1868 into the most illustrious of Boston families. Throughout his life

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¹ Jean E Ward and Joan Yell (eds), *The medical casebook of William Brownrigg, M.D., F.R.S. (1712–*

1800) of the town of Whitehaven in Cumberland, *Medical History*, Supplement no. 13, London, Wellcome Institute for the History of Medicine, 1993.

² See Theodore M Brown, 'George Canby Robinson and "The patient as person"', in Christopher Lawrence and George Weisz (eds), *Greater than the parts: holism in biomedicine 1920–1950*, New York and Oxford, Oxford University Press, 1998, pp. 135–60.

he was associated with Harvard University and the Massachusetts General Hospital. He had a large private practice at his office (it is hard to imagine a British physician of this period having an “office” with its business-like overtones). Between 1897 and 1926, Cabot saw thousands of patients and meticulously recorded his version of the encounters. Previously unexplored, these records are the basis of Crenner’s fascinating book. We do not have only Cabot’s interpretation of the consultations, however. Patients and referring doctors wrote to Cabot in advance of, and after, the meetings, providing alternative evidence of the dialogue that went on and the different languages in use. It is these other sources along with Cabot’s asides that reveal Cabot dealing with disease *and* suffering.

Crenner structures his study under the umbrella of medical authority beneath which a number of delicately linked, polar themes shelter. These include medical art and medical science, bedside and bench, and subjective symptoms and objective signs. Collapsing all these for a moment, a great deal of the book illuminates the issue of how far the work of healing can be said to be a success or failure by assessing patients’ accounts of their feelings in contrast to employing objective measures of health and disease. In what sense has the health of a person, who complains of lethargy, improved when he or she reports feeling “better” at the same time as the doctor, who has diagnosed leukaemia, finds the white cell count has worsened? The extreme opposite case is embodied in the famous quip that the surgeon extirpated the disease but the patient died. Indeed, a young man wrote to Cabot in exactly that vein: “the operation itself was a success” but “I have never recovered from the check to my nervous system” (p. 100).

The light Crenner sheds on this in *Private practice* emerges from his careful unfolding of, and quotations from, the records. At the behavioural level, in Cabot’s consultations, his patients and to some extent Cabot himself ignored the distinction. Doctor and client talked to each other, swapping register as they went. Patients complained about their aches and pains but also, in one example, of an “accumulation

which gathers on the tubes” or in another “something trying to expel itself from my uterus” (p. 86). Sometimes they conflated the two. A Boston tailor wrote to Cabot: “I think that everything is alright now as I don’t feel them pains any more” (p. 115). Cabot for his part recorded rigorous diagnoses such as “angina” but seemingly as a clinical observation also reported the comment of a patient who said his medication “relieves him as a dream” (pp. 86–7). Much of chapters 3 and 4 is taken up with the mutual negotiations conducted through these different languages.

However, and this is the second enlightenment to be found here, it is clear that Cabot often knew that he was bilingual whereas his patients co-opted pathological terminology to give wider expression to their feelings or to coerce, persuade or blackmail their doctor (for example, into prescribing such things as “goat lymph”, p. 116). Cabot seems to have seen with absolute clarity in many diseases a difference between these two languages, one of which could be described as moral and the other technical. Many doctors of the period probably did not see the distinction anywhere nearly so clearly or indeed would have accepted it as a basis for action when it was pointed out to them. Moral languages were integral to pathology. Defining diseases by race, class, aptitude and attribute was central to medicine. Terms like lazy, hardworking, dissolute, irresponsible, backward, bright, dull and so on riddle the texts of the time. To write like this betrayed no intellectual deficit among doctors who had failed to see they had conflated the moral and the natural. Moral languages were constitutive of medicine because moral management was part of the doctor’s job. Helping their patients, encouraging them, ticking them off, putting an arm around their shoulders, scolding their children was what doctors did and what they expected, and were expected, to do. Cabot was seeking to break away from this world. Good doctor though he was in one sense, in another Cabot on occasion leaves me with the feeling that, had he cared to express it, he might have said that the ideal of healing was veterinary medicine: technical skill grounded in biological knowledge.

That doctors who saw their role as embracing the management of every aspect of their patients' lives were not simply acting on the basis of unconsidered assumptions is beautifully brought out by Crenner in his discussion of the Massachusetts physician and professor of hygiene, Alfred Worcester. In 1912 Worcester published an article attacking the ways in which the modern stress on diagnosis was being favoured by doctors at the expense of their traditional "knowledge of human nature". In many cases, Worcester claimed, experience would teach the physician what was beneficial to the patient whereas the "luxury of diagnosis" might bring only further misery to a sufferer who could not be cured (pp. 73–4). One can only imagine Cabot's horrified response.

In line with his rigorous vision of the science-based clinical expert Cabot had no time for placebos or, in theory at least, not telling patients the truth about their disease. Cabot, says Crenner, "tended to be blunt in communicating news to his patients" (p. 113). This may have sat comfortably with his personality but its origins lay in his view that, according to Crenner, "obscuring . . . information, even at the behest of the family, represented a breach of duty" (p. 114). Symptomatic treatments, however, Cabot could cope with when they seemed likely to improve a patient's physiological response to disease (a proviso that permitted huge latitude in prescribing).

Cabot's hospital cases reveal his clinical style to be that of a modern. The contingencies of private practice have allowed evidence to be preserved that shows that Cabot viewed many accepted aspects of practice as throwbacks and in need of reform. This is not an anachronistic judgement. Cabot was quite clear about the limits to be drawn around the physician's job (there is a sense in which he saw medicine as a highly skilled occupation not an avuncular vocation). Yet this big picture is not the only one that can be made from the material. When Crenner paints a very detailed portrait of Cabot drawing on contemporary cognitive and moral resources to deal with conditions that are no longer meaningful to us, we see an early twentieth-

century physician at work. This Crenner does in chapter 5, 'Nervous disease and personal identity'. Cabot recognized that a large number of the patients who came to him had a condition that many would call nervous and which he denoted by a range of terms including "debility" and "nervous exhaustion" and, on occasions, "overwork, loneliness, or high living" (p. 144). Crenner observes that for Cabot "the relevance of the personal and the social features of a medical case might matter most in nervousness, an area of medicine where the legitimate powers of technical medicine seemed least applicable" (p. 142).

It is clear that from one perspective this invasion of the biological realm by the human condition troubled Cabot. Yet, from another, he was a man immersed in contemporary moral assumptions about disease. Crenner illustrates this extremely well with Cabot's utterly unreflexive management of Jewish patients. The latter were found by him to suffer from "Hebraic debility" and "jew-neurasthenia" (p. 164). Jews were not exceptional. Cabot's management of nervous diseases was riddled with assumptions about the causal role of race, sex, culture, class and occupation. I particularly liked his idiosyncratic observation that "work in a rubber factory often produces a stubborn type of general debility" (p. 169). But there is something of the Jekyll and Hyde about Cabot. For even in nervous disease he strove throughout his career to bring objective data to reign over subjective chaos. Dr Jekyll, who began treating people with debility, ended up as Mr Hyde, treating patients with psychoneurosis. Psychic forces clearly seemed to him much more like biological determinants of disease than ennui.

As might be predicted, Cabot also held strong views about the positive value of euthanasia. There is, however, a twist here, for euthanasia was also deeply entwined in his personal life. This is a strange and powerful tale and it only seems fair not to give away the ending, since Crenner has carefully reconstructed and told a moving story. On balance, however, the guess must be that Cabot would have held the views he did even without the personal, emotional engagement with the question. With dying,

Cabot was not so good; ending biological life where an incurable disease had set in was more in his line. “Cabot’s observations on his own final illness nearly swallow up his reflections on his mortality”, writes Crenner (p. 213).

There are a couple of oddities in this book, neither of which detract substantially from a thought-provoking volume. Pages 9–11 are given over to early twentieth-century discussion of organic and functional disease. Crenner uses functional to mean diseases that were “changeable and contingent, only subjectively defined”. They were defined by “exclusion” (p. 10) Two things are being confused here. Crenner is quite right to say that this, the older use of functional, was still in use in the early twentieth century. Its synonyms were, neurotic, unimportant, imaginary, not fatal and a source of regular income in private practice. Strangely, however, Crenner cites the “new cardiology”, as it was called, as an example of the move from structural to functional in this period (p. 257 n.24). But functional in this and other specialities meant something entirely different to “subjectively defined”. It derived from German medicine and meant a physiological (usually laboratory based) correlate of a symptom. Thus cardiac arrhythmia traceable on an electrocardiograph (and ultimately, therefore, referable to an experimental animal) was a functional change at the basis of heart failure; so was acidosis, a biochemical parameter, measurable in air hunger; so was hyperchlorhydria in gastric ulcer and hyperglycaemia in diabetes. When American physicians (including David Edsall, Dean of Harvard Medical School—Cabot’s own—no less) came to London in the 1920s they were appalled, they said, by the lack of functional or dynamic or physiological thinking among British clinicians. It seems likely Cabot would have used functional in the same sense as his Harvard colleague although possibly also as a term of abuse for an older way of describing disease.

This minor blemish is in no way as puzzling as Chapter 7 ‘From Cabot’s day to ours. Ideals of the Medical Relationship’. This is not a blemish; there is nothing wrong with it, but much the latter part of it was surely an afterthought. The chapter

begins with a sophisticated and challenging analysis of the late twentieth-century rise in demand for informed choice for patients. Crenner convincingly argues, and my summary will not do him justice, that this is a consequence of a rather more naked commodity-exchange mechanism at work in modern medicine manifested notably in specialization and the circulation of patients among many doctors. In reality, Crenner suggests, patients now have no more or less informed choice than they did in Cabot’s day, but at that time, when a single physician often ministered to patients’ ills over a lifetime, their powers of choice and consent operated in other ways. Crenner then offers the view, with which I concur, that after Cabot’s era and before our own age of consumerism in medicine, physicians “wielded a rather unalloyed authority over their patients” and “promoted a paternalistic model of medical decision-making” (pp. 233–4). So far so very good but then Crenner, quite rightly I think too, tries to theorize the shift from Cabot’s world to our own. The last ten pages of the book describe the gift exchange and commodity exchange models of economic relationships famously originated by Marcel Mauss. Crenner suggests that using this “interpretive framework . . . we can examine the dynamics of the doctor–patient relationships in different periods from Cabot’s day to our own” (pp. 247–9). Good idea, it must be said, but with three pages of the book to go and these devoted to a summing up of ‘Cabot in Context’, the theory is never used. Introduced at the beginning of the volume and employed to illuminate the rich detail that graces this book, it would have been interesting but as a vestigial appendage it is, to say the least, curious.

But what of my initial dilemma: the fact that Cabot was, in one respect, a biologically-informed technocrat as evidenced by his hospital case histories, and the fact that, in another, he is often remembered as being at the forefront of those promoting a more person-oriented or individual patient-centred approach in the increasingly reductionist, disease-specific world of academic medicine? That there was a pronounced holist strand in the medicine of the inter-war years seems clear. One of its most

obvious features was reverence for the healing power of nature which was considered by many physicians to be a process far more powerful than their own science and art. This force—for so it seemed to be—was valued highly by Cabot's Harvard colleague, Walter Bradford Cannon, who embedded it in his theory of homeostasis.³ In 1936 Cabot jointly published a volume with Russell L Dicks, *The art of ministering to the sick*. In it, the authors cite Cannon's work approvingly, but whereas Cannon attributed the wisdom of homeostasis to nature, they state that they "believe" it originates from God.⁴ (Cabot of course would have very good reason to hold this belief since, famously, among the Boston élite, the Cabots "talk only to God"). I have read few authors who extolled the healing power of nature to quite the extent of Cabot and Dicks, and, although their view was substantiated by reference to the most modern physiology, their admiration for the force bordered on the natural theological. "The work of the kidney", they wrote, "seems to us one of the most wonderful things to be found anywhere on earth."⁵

Like the holism of a number of British clinicians, the organicism of Cabot and Dicks was closely tied to their vision of the doctor as moral and medical generalist. They wrote: "We who write this book believe so little in specialism that we would rather see doctors treat *all* their patients' ills, instead of turning some of them over to the nurse, some to the social worker, and some to the minister." They lamented the disappearance of "that almost mythological being now extinct in many places" whom they termed the "old-fashioned country practitioner".⁶ Yet to equate the holism of British

consultants and the Boston physician is a crude generalization which misses the point as much as it hits. British doctors looked to the past and, although they embraced the new medical sciences, many of them sought to stop the hands, turn back even, the clock of the social relations of academic medicine.⁷ Cabot's position seems more complex. Whereas the British romantics fled the shock of the new, Cabot accepted it and embraced it. Like them, Cabot held that besides disease narrowly construed, a patient's whole life needs to be addressed in order for a satisfactory resolution of sickness to be effected. But for Cabot the dimensions beyond ordinary pathology had in the modern world to be in the hands of "the medical team".⁸ This phrase suggests a corps of scientifically-trained experts and is in harmony with the "office" as the place of medical work and the whole business-like turn of American medicine. To many in Britain the idea of a medical team or group practice was an alien one. In respect of these things Cabot can be called modern with some historical precision. Any nostalgia for a mythologized medical past on Cabot's part was a private sentiment not a call to conservative political action. Cabot, writes Crenner, "saw himself as a reformer in an era of progressive reform". In a world of weakening "social links of neighborhood, kinship, and personal association" reformers "sought new sources of organizational power in professional expertise and technically derived knowledge" (p. 29). This insight is never fully used. Perhaps in the light of it, and in a book which does so much to enhance our understanding of the clinical encounter, Crenner should have turned to Marx not Mauss for the really big picture.

³ See W R Albury and Steven J Cross, 'Walter B. Cannon, L. J. Henderson, and the organic analogy', *Osiris*, 2nd ser., 1987, 3: 165–92.

⁴ Richard C Cabot and Russell L Dicks, *The art of ministering to the sick*, New York, The Macmillan Company, 1936, p. 119.

⁵ *Ibid.*, p. 123.

⁶ *Ibid.*, p. 7.

⁷ Christopher Lawrence, 'Edward Jenner's Jockey Boots and the great tradition in English medicine 1918–1939', in Christopher Lawrence and Anna-K Mayer (eds), *Regenerating England: science, medicine and culture in inter-war Britain*, Amsterdam, Rodopi, 2000, pp. 45–66.

⁸ Cabot and Dicks, *op. cit.*, note 4 above, p. 5.