Letter from Mumbai

IATROGENIC AGGRAVATION OF ANXIETY AND NEUROSIS

Before I come to the subject itself, please permit me a diversion. An attempt at determining the origin of the term *iatros* (physician) led to a fascinating trail. Most dictionaries end up in Greece, telling us that the word is derived from ιατρός in Attic Greek—the dialect used in ancient Athens.

Dr Elliott Martin (2009) of Connecticut, then a first-year resident in psychiatry but a scholar in Middle Eastern languages, takes us further back in time and shows us how the term actually originated in Sumer—the earliest known civilization in southern Mesopotamia (now southern Iraq) that emerged during the Chalcolithic and early Bronze Ages between the sixth and fifth millennium BC. (You will recall that Abraham of the Bible was born in Sumer and the tower of Babel was located there.) I warmly commend this paper[1] for your study.

Returning to anxiety and neurosis precipitated or aggravated by physicians, my thoughts were turned to it when I saw a patient who was mortally frightened by fluctuations in serum cholesterol in his blood and checked it almost every week although he had no cardiac symptoms whatsoever. Worse off is the patient to whom every twinge in the upper chest heralds a heart attack even after a diagnosis of the syndrome named after the German surgeon Alexander Tietze (1864–1927) was made and it was shown that the heart and its blood vessels showed no abnormality.

Life is, indeed, miserable for such persons. While the treatment of the underlying neurosis is best left to psychiatrists, can we help by ensuring that we would not, inadvertently, set off triggers that end up aggravating the situation?

It is important that every member of the clinical team chooses words carefully when talking to patients and their families. This is especially important in agitated and tense persons. When possible, optimism should be emphasized and unjustified unfavourable statements avoided.

Where the illness is grave, stress on what can and will be done to attempt cure, relieve symptoms and ensure comfort must supplement bad news. Providing facts and figures of successful outcomes in similar patients will also help. Most of all, providing evidence of care and concern by frequent visits by senior consultants in the immediate postoperative period and during critical stages and unhurried discussions at intervals with the patient and family boost their morale.

Beware, though, of being in a haste to hustle off a patient to the psychiatrist ere you have carried out a thorough clinical examination and, where required, relevant tests.

I shall never forget an incident narrated by the eminent neurosurgeon, Dr R.P. Sengupta, in Newcastle-upon-Tyne. Known especially for his expertise in dealing with intracranial aneurysms, he was approached hesitantly by his operation theatre nurse. She apologized for taking up time with what might be insignificant but sought his help as she was at her wit's end. Her family had recently lost a member from fatal rupture of an intracranial aneurysm. There was no opportunity for rushing him to a hospital. Since then, her brother kept telling her that he too had such an aneurysm and wanted her to get it treated by Dr Sengupta. Well aware that he had neither symptom not sign of such an aneurysm she had kept reassuring him, but this had not worked. Would Dr Sengupta examine him? Dr Sengupta met the patient for a consultation and found him extremely nervous at the thought of imminent rupture of his imagined aneurysm. He insisted that an angiogram be done as soon as possible. Reluctant to perform an invasive test in a patient free from symptom or sign, Dr Sengupta suggested a computerized tomographic (CT) study instead. If it showed an aneurysm, they could proceed to catheter angiography. To his surprise, the CT demonstrated an aneurysm on the anterior communicating artery. At surgery, Dr Sengupta remarked on the thin wall, through which he could see blood swirling within it. Truly, left untreated, it would have ruptured in the near future. To this day he cannot explain how the patient had made his diagnosis but is grateful that he acted on it!

MUMMIES—USED AS MEDICINE

A recent experience watching children and adults marvelling at the over 2000 years old mummy at Mumbai's Chhatrapati Shivaji Maharaj Vastu Sangrahalaya (earlier the Prince of Wales Museum) prompted rumination on their role in medical therapy.

We rightly associate mummies with Egypt and many of us have been able to marvel at the human bodies preserved over thousands of years. Such mummies, imported from Egypt, can also be studied at the Hyderabad State Museum (4500 years old mummy), Indian Museum in Kolkata (4000 years old mummy), State Museum in Lucknow (3000 years old mummy), the Albert Hall Museum in Jaipur (2300 years old mummy) and, perhaps, in other museums in the country.

We have learnt that the embalmers in ancient Egypt evolved sophisticated techniques for removing organs that could putrefy, preservation of the heart in the body and other organs in canopic jars. These embalmers discarded the brain (removed through the cribriform plates of the ethmoid bone) in keeping with the concept that the heart was of paramount interest since it would be weighed against feathers to determine the balance of good to evil done during the person's life.

There is, however, one mummy on record, in Montreal, where the heart is missing and the brain is in place.

All this is preamble to the saga of how mummies were used by Arabian and Europeans physicians as therapy. Mummies were eaten, ground into powder that was prescribed to patients and incorporated into balsams to be applied to wounds, sores and other lesions (*https://aeon.co/essays/when-we-lived-with-death-mummies-were-medicine-and-paint*). We learn that in the 15th and 16th centuries there was a thriving trade in mummies for medicinal purposes. In 1586, John Sanderson, an English merchant, bought 600 pounds of mummy and sold it to apothecaries in London. Other contemporary remedies at which we would shudder today included moss growing on skulls, 'man's grease' or cadaveric human fat, bull's fat, hearts of lizards and boiled corpses sold as oily preparations.

Agents in Egypt and Syria kept European physicians supplied with mummy products in a trade that was extensive and highly profitable. To augment profit, European merchants adulterated mummy matter with pitch—a black or dark viscous substance obtained as a residue in the distillation of organic materials and

tars. These remedies were classified on the basis of their origin—Egypt, Babylonia, the region of the Dead Sea and so on. Ancient works of medicine tell us that the Babylonian kind was good for diseases of the eye and skin (including leprosy). The medium in which it was administered was important. Respiratory ailments responded to mummy taken with wine. Rheumatoid symptoms were relieved by mummy taken with vinegar.

Avicenna (AD 980–1027) used mummy products to treat paralysis, diseases of the throat, lungs, heart and stomach and disorders of the liver and spleen. It was also used as an antidote to poisons. Paracelsus (Theophrastus Bombast von Hohenheim 1493–1541) offered his patients balsam of mummy and treacle of mummy. Guy de la Fontaine, physician to the King of Navarre, visited Alexandria in 1564 to learn the medical uses of mummy. John Parkinson (1567–1650), famed for his eponymic disease (paralysis agitans), was full of praise for 'the very body of a man or woman brought chiefly from Egypt or Syria (no other part of the world so good).'

The use of mummy as medicine was referred to in several lay writings. Shakespeare described 'witches' mummy' in *Macbeth* and again in *The merry wives of Windsor* and in *Othello*.

Ambroise Paré (1509–1590) was an exception to the list of those favouring mummy in therapy. 'This wicked kind of drugge doth nothing to help the diseased … as I have tryed an hundred times, and as Thevet witnesses, he tried it himself when as hee tooke some thereof by the advice of a certaine Jewish physition in Egypt, from whence it is brought; but it also inferres many troublesome symptomes, as the paine of the heart or stomacke, vomiting and stinke of the mouth...' (The final observation is not at all surprising!)

The physicist Robert Boyle (1627–1691) praised it as 'one of the useful medicines commended and given by our physicians for falls and bruises, and in other cases too'.

It was only in the late 18th century that such usage went out of fashion but mummy parts from Egypt were used as medicine until the early 20th century. As late as 1924, a kilogram of mummy powder cost 12 gold marks, according to the price list of Firma E. Merck Darmstadt.

FAMILY PHYSICIANS

There is a growing and urgent need for family doctors. The medical profession is imbalanced in favour of specialists who are experts in fields that grow narrower with the passage of time and are at risk of knowing more and more about less and less.

The dangers to patients are obvious. In many instances, the patient is viewed as a diseased organ, the rest of his anatomy and physiology receiving only passing attention.

Lacking general practitioners who treated the patient as a whole—and often cared for the entire family—patients now seek specialist attention for relatively trifling complaints.

While the large number of paying patients is viewed favourably by specialists, limitations imposed by time ensure that history-taking and examinations are perfunctory. Individuals and families that remain discontented even after paying considerable sums to their consultant physicians and surgeons then seek second, third and fourth opinions, ending up with a collection of reports, X-ray films, sonography, CT and MR scans that require hours for evaluation. Notes made by consultants are often brief to the point of being uninformative, many patients being provided just prescriptions or referral notes.

Confusion is further confounded when an invasive test or surgery is proposed. Is the test or operation justified? What are the options? What if something goes wrong? Who is the best person for performing the procedure?

Websites are replete with lists of 'top 16 neurosurgery hospitals in Mumbai', 'best cardiologist in Mumbai', 'top gynaecologists in Mumbai' and so on. This is true also of all the major cities and towns. The lists, when opened, resemble advertisements and provide boxes for making appointments to see each consultant. Patients cannot be blamed for being bewildered. Who, amongst these, is the best choice? What if the advertised claim is false and the patient lands up with a poorly qualified and inexperienced consultant?

Most lay persons are well aware of the wide discrepancies in the capabilities of doctors trained in our various states and in teaching institutions in each state. They have no way of determining whether the consultant emerged from a reputed public sector teaching institution or a for-profit capitation-fee college. We have no reputed, transparent, honest system for evaluation of our medical teaching institutes and of practising consultants that everyone can consult.

In times gone by, the family physician could and would resolve most of these doubts and fears. In several instances, they treated the illness successfully without recourse to any other physician. Their ready access and proximity to the patient's home provided comfort to the family.

When a consultant was needed, the family physician could filter out the competent from the others and advise the patient who was best suited to their needs. This was possible because of feedback from colleagues and patients and personal experiences while listening to and interacting with eminent physicians and surgeons at seminars and conferences.

On most occasions, the family physician accompanied the patient to the consultant and discussed medical aspects with the latter. This, in turn, ensured that the patient and family obtained detailed information that the consultant had not provided.

The family physician was also present at the procedure or operation and, once again, discussed findings and further care with the consultant. The benefits to the patient and family are obvious.

The dwindling numbers of family physicians followed poor remuneration. Customarily, they were paid only the cost of the medication provided or for minor procedures such as injections and dressing of wounds. It is high time family physicians were paid consultation fees for their knowledge, expertise, clinical examination and recommendations.

The Academy of Family Physicians of India and its members have started off on an excellent foundation. Their website *www.afpionline.com/index.php* and publication—*Journal of Family Medicine and Primary Care* are worth studying.

It is possible for our young graduates to obtain qualifications in family medical practice: DNB Family Medicine, MD Family Medicine (Calicut), Masters in Medicine–Family Medicine (Christian Medical College, Vellore) and MRCGP (London) and MRGCP (International).

In time, rectification of the skewed balance between family physicians and consultants will greatly benefit patients and lay folk.

REFERENCE

1 Martin Jr. EB. The Greeks may have the last word, but who has the first? *Historia Medicinae*2009;**2:**1–6.

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