Conclusion

Diphtheria is a rare disease at the moment, but positive laboratory reports are still common. Treatment depends primarily on the signs and symptoms, and no laboratory report should create a clinical emergency. The fever hospital clinician or the medical officer of health should be consulted when swabs are reported positive. Patients should not be rushed into hospital because something has grown in a laboratory.

Next article on Emergencies in General Practice.—
"Acute Rheumatic Fever," by Dr. Stanley Graham.

REASSURANCE*

BY

A. BARHAM CARTER, M.D., M.R.C.P., D.P.M.
*Consulting Physician, Ashford Hospital, Middlesex ;
Adviser in Neurology, The War Office*

It will generally be agreed that reassurance has some part to play in the treatment of ill people, and that, like all forms of treatment, it can be helpful or harmful. It is one of the major therapeutic measures in helping those who are suffering from psychoneurosis. What may not be realized, and what I want to suggest, is that in the treatment of organic illness reassurance is important and necessary, but is often neglected. This neglect, shared equally by general practitioner and consultant, not only implies the withholding of confidence and encouragement from a patient, but has a positive, harmful effect in the inference that he is so ill that reassurance is impossible.

Needs of the Patient

To give a patient reassurance it is necessary to implant into his mind the idea that everything possible has been, is being, and will be done to help and speed his recovery. Implicit in this is the belief that recovery is possible, and there must be few patients who really believe that death will terminate their illness. These few need a different type of reassurance, probably better administered by the clergy.

How is this implantation of confidence in treatment and in the outcome of the illness to be achieved? I think the first thing is to realize the points on which the patient requires reassurance.

Firstly, the obvious—he wants to believe that he is going to get better, that his illness is not life-shortening, and that it will leave no permanent disability. This reassurance is not quite as easy as it seems, even in benign illness, because the timing of it is important. If a doctor, early on in a case of, say, pneumonia, tells the patient he is not likely to die the response may be disappointing. The patient may well say, "Of course I'm not; nobody ever dies of pneumonia these days," and imply that the doctor does not know his job. What the patient really thinks may be more important still: he may think, "Perhaps the doctor does know his job and I have got something more serious after all." Thus this attempt at reassurance may produce added anxiety and unnecessary alarm, which I believe occurs only because we do not realize that reassurance is not necessarily spoken. In fact, I think that a doctor's air of authority, efficiency, and unspoken optimism is the best type of reassurance possible, and this may well be enough for the serious but not fatal illness, unless the illness is unduly prolonged or complicated. Then spoken reassurance is required, and is often enhanced by repetition and should be the last thing said by the doctor before he leaves the bedside.

In this first and obvious type of reassurance I include reassurance that the patient is getting on as quickly as is possible and as well as other people with similar illnesses.

*A talk given to general practitioners of the West Middlesex region on May 10, 1955.

This fondness for comparison with others is a human trait that doctors do not use enough. We laugh at the women comparing notes about their operations, but neglect to turn this to our own advantage, and such advantages are very necessary in these litigious days.

The second need of the patient is less obvious, perhaps. I find that many need to be reassured that they are really ill. These people are not always psychoneurotic, and are genuinely anxious lest the doctor think they are imagining their complaints; and I believe that when a patient comes for help with some disability it is always a mistake to say, "There is nothing wrong with you." This is one of the abuses of reassurance that are dealt with later. I always do my best to reassure patients of the genuineness and reality of their complaints, and especially so in the psychoneurotic type of illness.

The third need the patient has regarding his illness arises in the case of such fatal conditions as carcinomatosis, leukaemia, chronic nephritis, etc. Here no rules can be laid down, and each of us must follow his conscience in whether any particular patient is to be told "the truth, the whole truth, and nothing but the truth." Up to the present I have found that this difficulty tends to solve itself one way or another, and I think it would be impertinent for me to offer any advice in this matter. What I can suggest is that these patients are always helped by simple statements that everything has been done and that pain and suffering can be relieved. I find that fears have changed in the last 20 years—fear of cancer and tuberculosis has receded, fear of paralysis and blindness has increased, but fear of insanity and death remains unaltered. Some reassurance against any of these is necessary and some softening of the blow if the doctor is asked. I am not so certain of the value of unasked reassurance in these cases, and indeed this type of encouragement may be misleading and arouse false hopes.

A Neglected Point

So much for reassuring the patient about his illness. Now for an important but neglected reassurance—about his doctor. The patient needs no reassurance that his doctor is clever—this astonishing belief is held by all laymen, and occasionally the adjective is used in a deprecatory way. However, he needs reassuring that the doctor is interested, that the doctor understands his case, and that the doctor has seen many like it before. Reassurance on the first two points must obviously be unspoken, and be given by actions and manner; but it is sometimes useful to mention familiarity with the illness and its effects.

There is a salutary form of reassurance about the doctor which often involves disagreement with a patient. Some patients argue about the cause of their illness and know better than the doctor: occasionally they must be put right, although I am opposed in any way to scoring off a patient. The following story illustrates my point. An American expert on obesity was telling a woman patient that it was food that made her fat. She said, "Surely not, doctor; that's impossible—I only eat like a bird." "Yes, madam," said the doctor, "like a vulture."

Abuses of Reassurance

Firstly, reassurance without examination is criminal, and has a place only in the hands of quacks and charlatans. I need say no more than that.

Secondly, reassurance that is hesitating, uncertain, and artificial is of little use; and it is important to realize that, although sincerity is one of the emotions that can be detected and appreciated very easily, insincerity is even more apparent. This does not mean that any attempt to prevaricate for the patient's benefit can be easily perceived—in fact, a lie told sincerely to help a sick person has a considerable ring of truth about it.

Thirdly, the right type of patient must be chosen for this form of therapy. Reassuring depressive or paranoid patients is not only a waste of time but makes them worse; they believe so much in the reality of their tortures that,

unfortunately, any such attempt at lightening their load fails. In the same way, telling patients who visit you that nothing is wrong with them is of no help unless you are sure they are malingering or they have come for a routine examination without symptoms. What you can do is to add one very important word. If you think they are not very ill you can and must say, "There is nothing seriously wrong with you," which will be accepted by most patients and which will do them good.

Another abuse of reassurance is to use it instead of more adequate treatment. This is the result of ignorance rather than deliberate malpraxis in most cases, and only knowledge and experience can put it right. I have reassured patients with angina of effort that their pain is of little importance, and patients with a cerebral tumour that attention to their domestic worries will relieve their headache.

The last abuse of reassurance that I shall mention is not really an abuse but an unfortunate association of reassurance and disaster. This may occur in two forms, one common and the other rare. In the first an apprehensive patient or relative asks about the progress of an illness or the risks of an operation. As sure as you say, "Nothing can go wrong now," or, "There is nothing more at all to worry about," something will go wrong. I remember a difficult case, in 1938, in which, after a successful colectomy, ileus developed, followed by a pulmonary embolism. This left a haemorrhagic pleural effusion, which became infected and required drainage. Later an abscess was drained from the right frontal lobe. The patient recovered remarkably well, and we all congratulated him, telling him how fortunate he had been. Next day, at the celebration party given for him on the ward, he slipped and fractured his femur. This is an admittedly unusual combination of events, but it is not uncommon to find things going wrong when you have said with reasonable evidence that they will go right.

The second—and fortunately rare—type of misfortune I encountered not very long ago when a nervous, quaking woman came to me and said she was sure her heart was wrong, although cardiologists had advised her otherwise. I asked when this trouble had started. "Oh," she said, "when my dear old doctor died." I said I quite understood how a friend's death could have upset her, especially someone who had helped. "It's not so much that," she said, "but when I went to see him for an examination he examined me and said, 'Your heart's as good as mine, my dear,' and dropped down dead."

Conclusion

Finally, and a little more seriously, I would say this: that, although ignorant reassurance is cruel, creating as it does a fool's paradise for patient and doctor alike, informed reassurance, and perhaps even in some cases knowingly untrue reassurance, is one of the few unchanging forms of treatment neither outworn nor outmoded that we can all use with benefit. It is always greatly needed and usually gratefully received, and I sometimes think that we can have no greater satisfaction than to know that, whatever the illness, our patient feels better for our visit.

BRITISH ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE

[FROM A SPECIAL CORRESPONDENT]

The 117th annual meeting of the British Association was held at Bristol from August 31 to September 7 under the presidency of Sir ROBERT ROBINSON, O.M., F.R.S. As well as his doubts about the safety of hydrogen bombs—he wanted to be assured that every possibility of their explosion setting fire to the lighter elements had quite certainly been excluded—Sir Robert referred in his address to the recent determination of the complete structure of vitamin B₁₂* by Mrs. Dorothy Hodgkin, F.R.S., the same x-ray

crystallographer who earlier played a large part in determining the structure of penicillin.

The Nucleic Acids

In his presidential address to the section of chemistry, Sir ALEXANDER TODD, F.R.S. (Cambridge University), discussed the structure and function of the nucleic acids. He reviewed recent evidence that structurally the deoxyribonucleic acids are composed of two coaxial spiral chains, as postulated by Watson and Crick, and the plausible but still speculative suggestion that in a medium where polynucleotides are being synthesized each strand, if separated from its partner, may have the power of building on itself a second strand so constituted as to duplicate the original double spiral. There was much circumstantial evidence for the view that ribonucleic acids were intimately concerned with protein synthesis in living organisms, and that this was probably one of their main functions. How this might come about had been the subject of much speculation, largely mathematical, whereas the chemistry of the process needed also to be fully considered. The present stage was exciting. In the popular mind the proteins were often thought to be the central substances in living matter, but the nucleic acids must rank as at least the equal of the proteins, and their further study by combined disciplines might open new chapters in our knowledge of life and heredity and in the conquest of disease.

Immunity and Susceptibility

Professor F. W. R. BRAMBELL, F.R.S. (University College, Bangor), in his presidential address to the section of zoology, referred to the "tolerance" which might be established in an embryo to cells transplanted from another organism, with the result that the antigen/antibody defence mechanism might be permanently incapacitated. Professor P. B. MEDAWAR, F.R.S. (University College, London), who spoke next, said that it was at least conceivable that a "family history" of susceptibility to infectious diseases was not always due to hereditary predisposition in the usual sense but to a weakening of defences caused by the exposure of the unborn child to bacterial or viral substances before birth. Dr. N. A. MITCHISON (Edinburgh University) saw the promise of remarkable results from the application of techniques developed in work on iso-immunization—that is, the immunization of animals against the cells of another individual of the same species to auto-immunization. Such results, it was suggested, might include the control or elimination from the body of particular organs or cell types. Highly specific reactions, not amenable to the procedures of classical serology, had recently been demonstrated against central nervous system tissues, peripheral nerve, uveal tract, and testis.

Pharmacology in Jamaica

A discussion on the chemistry of colonial products, introduced in the section of chemistry by Dr. R. A. E. GALLEY (Colonial Products Council), included a contribution by Professor C. H. HASSALL (University College of the West Indies) on medicinal products from tropical plants. He is engaged on a programme of research directed to the identification and synthesis of such products and their modification by chemical means. He described the recent demonstration that the disease known in Jamaica as "vomiting sickness" was caused by the ackee apple, a richly coloured, segmented fruit which was a favourite article of diet in the island. Two active substances had been isolated and had proved to be "pharmacologically and chemically interesting." Dr. GALLEY stated that plans had been made for enlarging the Colonial Microbiological Research Institute.

Man's Social Future

In the section of education Mr. H. REE (Watford Grammar School) discussed automation from a point of view which may later be of concern to general practitioners. While there would be fewer repetitive jobs in factories and offices, there would also be a decrease in the variety of manufacturing jobs available. Watching dials and coloured

*See *British Medical Journal*, September 3, p. 610.