A Necessary Inhumanity?

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Abstract

It is argued that the phrase “Necessary Inhumanity” more accurately describes the alienation required of doctors in some circumstances, than do modern sanitised coinages such as ‘clinical detachment’. ‘Detachment’ and ‘objectivity’ imply separation, not engagement: creating distance not only from patients, but from the self: the process may well be required, but when it becomes too extreme or prolonged, it can damage everybody, including patients, family members, doctors themselves, and wider society. An awareness of the history of health care in the context of our society might assist self-reflection—might help keep initiates in touch with the culture they have been induced to leave and might help them remain humane despite the bruising process of training.

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Keywords: Detachment; medical culture; remuneration; presumed consent; specimens; dissection

Introduction

The title of this paper is taken from the teaching of the eighteenth century surgeon-anatomist, William Hunter, who urged his students to gain “a Necessary Inhumanity” by dissecting the dead.1 Hunter knew that trainee doctors could not be too tender, that this inhumanity would stand his students in good stead in dealing with the surgery of the day, which—in the days before anaesthesia, antisepsis or transfusion—needed to be not just accurate but fast if it was to be successful.

Nowadays, we call this necessary inhumanity “clinical detachment” or something similar which sounds less emotive, more scientific. But in a sense Hunter’s words are more honest. They help clarify what he was actually urging—inhumanity—but only to a necessary degree. The phrase has more precision, a suggestion of calibration, even a hint of warning, what this doctor is describing is fundamental to humane medicine.

Lessons from the past

Three episodes from the past, each of which has implications for the present day, illustrate the potential for inhumanity in clinical detachment.

I: DRUGS BUDGETS

To control the national drugs budget, Poor Law contracts of employment ruled that all medicines dispensed to the sick in workhouses were to be paid for out of the doctor’s salary.

In the midsummer of 1872 Dr Joseph Rogers was appointed medical officer at the overcrowded Westminster workhouse. He was conducted around the building by a Mr French, who’d held the post for the previous forty years. In the course of this tour, Rogers discovered that the conditions inside...
the workhouse were atrocious, worse than anything described by Dickens, and Mr French laughingly confided the trade secret that he pocketed all his salary by means of the simple expedient of giving no physic. All patients—whether in mild, severe or even mortal pain—were prescribed coloured peppermint-water.7

The method of remuneration appealed to and benefited the worst motives of unscrupulous doctors—while penalising well motivated and benevolent ones. Rogers perceived it as doubly pernicious: corrupting and brutalising doctors, while exacerbating the suffering of patients in these huge old workhouse infirmaries, congested with sick and dying people.

So what do Mr French and Dr Rogers have to do with us? With the help of the Lancet, Rogers campaigned against the gross abuse of penalising workhouse doctors for prescribing proper treatment. The Poor Law administration was eventually shamed into establishing a system of capitation payment for salary, with a separate dedicated drugs budget. These remain the basis of remuneration for general practitioners in the National Health Service.

A recent report in Pulse, concerning balancing practice remuneration against prescribing costs, quoted a Chelmsford GP, Dr Anne Dyson:

“We have made as many savings as we can without cutting into patient care. The flesh was cut right back to the bone a long time ago. How can we be unbiased in prescribing when you know it might come out of your pocket?”

II: PRESUMING UPON CONSENT

Transplantation is often presented as a phenomenon of the twentieth century. In fact it’s a development in the much longer history of surgery, and rooted in anatomical exploration. Looking back at that history, with a consciousness of the current shortage of organs for transplantation, one cannot help but perceive that problems like those of the past are being played out afresh in our own time.

The surgeon-anatomist John Hunter (brother of William—he of the “Necessary Inhumanity”) performed successful autotransplants on cockerels, moving the spur from a bird’s heel to its own head, where it proliferated. It was only a short step to the practical application of such ideas to human subjects. In the 1770s, he recommended the transplantation of teeth, which was rapidly adopted by high-class dentists, first using teeth supplied by plantation of teeth, which was rapidly adopted by high-class dentists, first using teeth supplied by

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The most spectacular specimen in the Royal College of Surgeons’ Museum in London is the skeleton of Charles O’Brien, or Byrne, otherwise known as the Irish Giant, almost eight feet tall. In the 1780s he was a living human exhibit—rather like the Elephant Man. His fear of dissection was so intense that before his death in 1783 he had accumulated a large sum of money (said to be £500) to have his body buried at sea in a lead coffin. His undertaker, however, was heavily bribed (apparently to the same amount) to deliver the corpse instead to John Hunter’s dissection rooms. O’Brien’s skeleton continues to serve as a monument to the morality of the medical museum, to theft, to medical acquisitiveness, and to a historic injustice.

It was from the basement of this institution that the artist Anthony Noel Kelly took the body parts which recently landed him in jail for theft. The irony of his prosecution cannot be lost on anyone who contemplates the sources of the college’s specimen collection.10

Pathology as a discipline—and its customary manner of specimen-taking, too—has preserved many of the attitudes of its forbears. Many hundreds, possibly thousands of parents in Bristol, Liverpool, Southampton, Leeds, London and elsewhere have suffered profound distress because their children’s organs have been “retained” after postmortem examination (and in many cases disposed of) without consent. The attempt to maximise yield by deception has caused terrible anguish and damage to bereaved relatives, and has brought the entire medical profession into disrepute.11

III: SPECIMEN TAKING

By far the great majority of the human specimens in UK medical museums were obtained without consent.

The problem of obtaining human materials has been largely resolved since the National Health Service. Donation supplies all UK dissection rooms, blood donors keep the blood banks going, and over eight million British citizens have currently registered themselves on the UK organ donor register, established less than a decade. Obtaining body parts by theft, purchase, coercion or trickery, as in the past, is quite unnecessary, and rightly perceived as unethical. Nevertheless the current policy of the British Medical Association is to promote “presumed consent”, or, taking without asking.
I’m a rationalist. I have no problem with the idea that medical science needs body parts, that bodies need to be dissected, that students need to train, that surgeons need to understand fetal and other abnormalities, that postmortem findings are important. But I also believe that human beings have feelings, and it is the job of a caring profession to respect them. We all also have rights, and one of the most fundamental of human rights is the right to freedom of self determination.

An inhuman attitude of mind has pervaded medical dealings with a too trusting public. The attitude is inhumane because it denies our common humanity. I suspect it may derive from the fact that many doctors learn in the process of becoming doctors to deny aspects of their own humanity.

**The humane doctor**

As we’ve seen it’s quite possible for doctors to behave inhumanely: Mr French laughed as he described the coloured water he’d meted out to the dying for forty years. John Hunter extracted healthy teeth from the mouths of poor children, and paid the undertaker to deny the Irish Giant his rightful burial.

These doctors were without pity, able to ignore, deny, overlook or even despise their patients’ humanity. Their motives were fundamentally acquisitive. Their activities thrived in closed institutions—the workhouse, the anatomy school. In each of these stories, too, government had a hand—failing to protect children, administering a heartless Poor Law, choosing neither to oversee nor adequately to regulate the conduct of the anatomy school, the dentist’s surgery, the workhouse. Dissection rooms remain immune to public scrutiny, as do operating theatres, coroners’ mortuaries, research laboratories and medical museums.

Each of these stories also has its humane professional, who nudged matters towards change—Dr Rogers, serving his workhouse patients even to the extent of losing his job; Sir William Watson, lifting the lid on a corrupt and highly lucrative surgical and medical museums.

Each of these stories also has its humane professional, who nudged matters towards change—Dr Rogers, serving his workhouse patients even to the extent of losing his job; Sir William Watson, lifting the lid on a corrupt and highly lucrative surgical and medical museums.

**A Necessary Inhumanity?**

A “Necessary Inhumanity” is in my view greatly preferable to ‘clinical objectivity’ for describing the necessary distance from the patient which the trainee doctor must attain, in order to become a good clinician. It more honestly and precisely describes an aspect of the doctor/patient relationship. Were we to resurrect the phrase, to return consciously to using it, knowing what we know, and with the science we now have, it might become evident that clinical detachment is not a simple acquisition, but a spectrum of sensibility which can range from extreme cruelty to conscious empathy.

“The notion of a “Necessary Inhumanity” could be valuable because the questions it prompts might help serve as an effective calibrator: how necessary in these circumstances? For how long? And with what effect? Resurrecting and knowingly re-embracing the term “inhumanity” could mark an increased awareness of its dangerous potential, which in turn might mean there’d be less of it about.

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**Acknowledgement**

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1. Hunter W. Introductory lecture to students [circa 1780]. St Thomas’s Hospital Manuscript 55: 182. Dr Marion Bowman kindly brought this manuscript to my attention when I was researching my book Death, dissection and the destitute. Chicago: University of Chicago Press, new edition currently in press.


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Unhealthy Societies—the Afflictions of Inequality

Why read this book? Read it if you are interested—professionally or otherwise—in the current state of society and the effects this has on our health. And in this case read it even if the complexities of epidemiological research, of anthropology, of social psychology, economics, history or politics are not your home-ground: for though the book draws on all these areas it can and should be read from cover to cover.

Wilkinson’s thesis concerns the relationship between relative income and mortality. He shows this relationship to hold very strongly within a given society or social grouping, ie it is the distribution of income rather than its absolute level which seems the more important, particularly so in developed countries. Wilkinson shows early on how relative deprivation becomes a major determinant of health once a society has passed through the so-called “epidemiological transition”—where predominantly infectious causes of death give way to predominantly degenerative causes (cancer, cardiovascular disease, stroke etc), and where the stark relationship between life-expectancy and per capita income declines as absolute incomes rise. (Interestingly, this also seems to mark a pivotal point in the direction of related research. Its methodology runs counter to the fashion for sub-disciplines guarding ever-smaller areas of exclusive expertise, and because it deals with complex issues straddling several disciplines. The value of conceptual thinking is outstandingly demonstrated, as “evidence” takes on new meanings from different viewpoints. Moreover it refocuses attention on the subjective quality of life as crucial for assessments of social vitality, making material and economic aspects of secondary and indirect importance.)

Finally the text is accessible, it assumes no specialist knowledge, and it manages to evoke genuine excitement at the “first views of the landscape ahead”. Read on!

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Clinical Judgement—Evidence in Practice

The authors define the aims of this book as being: (1) to make a case for the centrality and irreplaceability of clinical judgment; (2) to identify the elements of good clinical judgment, and (3) to suggest how these might be developed by using the humanities in medical education.

The book’s message could be summarised as “evidence based practice is not enough”. The case is made by looking at four elements of judgment. Science is not merely a question of facts but also of their interpretation and the construction of theories, matters of judgment. Clinical judgment is needed to apply the general principles of scientific medicine to the individual, who is never identical with the average patient. The two chapters which discuss these topics, although worthy, are...
in the traditional rather ponderous style of British philosophy, and might have least appeal for those who most need to read them.

The chapter on humane judgment is easier reading and more interesting, exploring the relationship between autonomy, consumerism and professional judgment. A brief chapter on judgment in public health is followed, by perhaps the best chapter, a clear account of both the facts and values of rationing. This would be an excellent text to give on an introductory course on this important issue, and I have little doubt that I shall use it as such. The final chapter rehearses the arguments in favour of the medical humanities, which are likely to be well known to readers of this journal.

Paradoxically, perhaps because of my background in experimental psychology, I couldn't help feeling that many of the chapters could themselves have benefited from a bit more evidence—particularly those on clinical judgment and the benefits of teaching the humanities, where empirical research has as much to teach us as philosophy.

The book certainly makes the case for clinical judgment, although not always in a very accessible way. Whilst it includes some interesting insights into the nature of clinical judgment, and into the place of medical humanities in its development, I did not feel that the authors really achieved their second and third aims. As a whole I found it hard to see for whom the book was written. Those committed to the view that medicine is both a humanity and an art will find little new here, whilst those still locked in a positivist time-warp (and sadly there are still many such souls in purgatory) might find the style too discursive and philosophical to stick with it.

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Just a Head: Stories in a Body

"I was no longer an academic, a runner, a skier or a traveller. Essentially I became just a head. My body was gone. I was no longer a physical being." This is how M R Gallagher, previously a diabetes researcher and triathlete from Tasmania, begins this account of her five-year experience of illness, written with friend and nursing lecturer Denise Fassett. After an asthma attack and ten days in intensive care she found she was unable to move her arms and legs, had difficulty swallowing and continuing problems breathing. Tests did not reveal a cause and as she becomes more and more disabled, M R finds herself in the "medical wilderness of the psychosomatic". There is no cure. Five years later she remains in a nursing home, wheelchair-bound, with poor vision and generalised pain. She is surrounded with the paraphernalia of disability: a catheter, a feeding tube, and a voice-activated computer. The reader is ultimately left uncertain about whether there is a physical diagnosis. M R's experience of her illness has led her to campaign for her own and others' assisted suicide and she plans a PhD to explore the doctor-patient relationship.

At the heart of the book is M R's struggle for a physical diagnosis. Her faith in science, the hospital's apparent narrow-mindedness, her disempowerment through the experience of hospitalisation and lack of diagnosis become a potent barrier to recovery. When the doctors finally give up and she becomes a "psych consult", her condition deteriorates dramatically. She herself, her co-author, Fassett, and perhaps some of the hospital staff, equate this label with blame, stigma and a disease that is no longer "genuine". She is happy to receive psychotherapy and antidepressants for her depression but not to treat her physical symptoms.

Fassett is explicit in her aim as co-author to tell M R's story as an "ill person", using narrative as a "research technology", not to find out why she has become ill. In doing so she narrows the scope of the book but provides a rarely performed service of documenting the distressing situation in which patients with severe unexplained symptoms in a medicalised setting can find themselves. M R's inability to obtain a label to legitimise her symptoms only seems to make her more ill and angry. Doctors, nurses and other professionals emerge murkyly from the narrative. They are largely distant, unsympathetic figures who are portrayed emphasising M R's objectification of her body.

At one point M R reminds us of Smyth's adage: "ask not what disease the person has but what person has the disease". Paradoxically, this book, conceived as the story of a personal journey through illness, fails to answer this central question. Behind Fassett's consistent intellectualisation, I felt I learnt very little of M R's everyday life, her relationships, her family and her prior history. I was disappointed that the book didn't tackle some of the crucial issues. How can a person end up in such a disabled state if there is no apparent cause? Has the medical system colluded to make her ill? Would a label early in her illness have helped her to get better? Why does she think she will never get better? In M R's case, like many others, a complex mixture of organic disease, iatrogenesis, psychological, social and cultural factors are probably at work.

M R's story will be sadly familiar to anyone working in neurology, liaison psychiatry or rehabilitation medicine. She is one of the "undiagnosed": the most severe end of the spectrum of medically unexplained symptoms that make up one third of hospital outpatients and an even greater proportion of general practice work. Patients like M R are not rare—up to ten per cent of patients in young disabled units in the UK may fall into a similar category.

Health professionals often find patients like M R difficult to help. Discriminating psychosocial factors that may be important in the genesis or maintenance of illness, and the performing of tests that are negative, can alienate patients, yet a failure to do so would be negligent. This dilemma, found every day in most medical practice, reflects the poor schemata and linguistics that we have for dealing with human somatic distress.

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Correction
In the December 2000 issue of Medical Humanities the following acknowledgements were inadvertently omitted: Barker P, Metaphors of life and death and Richardson R, A necessary inhumanity.

The original versions of the papers on which these articles are based were first presented at a conference, The Healing Arts: the Role of the Humanities in Medical Education, held at the Royal Society of Arts on 30th March 2000. The papers are reproduced in their original form, complete with illustrations, in D Kirklin and R Richardson, eds. Medical Humanities: an Introduction. London: Royal College of Physicians, 2001.