RESPONSIBILITY AND ILL HEALTH*

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DOCTORS are occupied and preoccupied consciously and sub-consciously with the assessment of their patients' fitness. On occasions the social, domestic or economic circumstances of their patients, rather than the precise medical diagnosis, demand the issue of a certificate of incapacity. In contrast the amateur sportsman will demand to return to his particular activity long before he is completely fit.

Yet there are many people, and one cannot really call them patients since they tend to avoid medical consultations, who will carry on at their work despite mental or physical disability of a minor or major degree. Among this hardy or foolhardy group must be included the leaders of any field of endeavour who defy or ignore illness or incapacity that would confine many of us to bed. We are all aware of certain characteristics, determined as much by genetics as by training, which are possessed by those who dominate their fellows:

(1) The man with the build of a front row forward and a high threshold to pain, fatigue and hangovers; (2) The hyperconscientious, obsessional personality to whom absence from work or a holiday is a burden rather than a pleasure; (3) The extroverted, aggressive, ambitious man who enjoys the struggle for power and has no intention of allowing his rivals to steal a march on him.

It is not my main intention today to estimate in what way the physical or mental qualities of leaders differ from the average, whether these differences drive them on or finally deny them the highest office, or whether the stress and strain of competition and responsibility exacerbate physical and mental imperfections. What I am concerned with is the association between physical and mental changes and the exercise of command under conditions of stress.

Some years ago I studied certain battles in the two World Wars with relation to the health of the commanders. I used published evidence which inevitably involved major military operations and senior commanders. Casting around for a catchy title I foolishly selected 'Ill-health in Senior Officers'; foolish for two reasons. Firstly, it gave the incorrect impression that senior officers were particularly prone to ill-health, whereas the relatively few examples I found were the meagre reward of a long search. Secondly, it failed to emphasise that the health of any commander—Admiral, Squadron-leader, Sergeant—is a matter for concern.

I have not informed myself about the present system of routine medical examination in the services but I am sure that serious disability would have to be disclosed to superior authority. In contrast politicians can remain in office despite disability. I doubt if any member of the armed forces could conceal or gloss over an adrenal insufficiency as did the late President Kennedy. A discreet silence was maintained although the White House press corps became expert at assessing the amount of 'mooning' of his face due to treatment with steroids. Disease is no respecter of persons and we all know now that, at the time of the Suez crisis in 1956, the Prime Minister of the day had intermittent obstruction of the bile passages causing bouts of fever as high as 105°F. and mental and physical debility which lead him to write later of 'fever attacks so weakening that nobody could suffer from them and do a good day's work.'

* Paper presented at the D.D.M.S., Headquarters Scotland, Study Period (1970).

Minor and even major psychological disorders, moreover, are not uncommon in the 45-55 age group at a period when the efforts of the conscientious and ambitious are being rewarded with supreme responsibility and all its satisfactions and tribulations. Older generations referred to this psychological malaise as neurasthenia, anxiety was a fashionable diagnosis in the Second World War, and nowadays depression seems to be more commonly diagnosed. Little mercy has been shown in times of war to tired, nervous and hesitant commanders, some of whom may have had minor psychiatric disorders which could have responded to simple treatment.

Perhaps senior officers and senior executives have only themselves to blame for this lack of care. They are the survivors of a hard struggle for promotion. They are men with unusual mental and physical qualities who have won battles in the field and in the board room. They must continue to assert their superiority over their business rivals, their nations' enemies and, at times, their own colleagues. If fatigue or illness obtrudes their instinct is to conceal it for the penalty of revelation is the same as that which follows defeat in battle or factory; banishment from office and command. It is neither efficient nor economic to run the human mind and body to avoidable and irremediable destruction. The loss of talented leaders of the type that has been described, often after they have gained priceless experience, cannot and should not be tolerated.

As a result of a study of many historical figures I have found that they suffer from a wide variety of illnesses and that so-called stress disorders are by no means common. Even if one accepts the concept of stress as a cause of disease one has to admit that stress is, more often than not, accompanied by overeating at irregular intervals, excessive drinking and smoking, and lack of exercise and sleep; factors in themselves which may lead to physiological and pathological change. Stress disorders as judged by coronary thrombosis and peptic ulceration are the exception rather than the rule. The two Presidents, Eisenhower and Lyndon Johnson are, of course, distinguished exceptions; perhaps the Americans are more tolerant of coronary thrombosis which they may regard as a badge of success and it is of interest that General H. H. Arnold, who commanded the United States Air Force from 1943 to 1946, had such a thrombosis in 1944.

Such a liberal policy carries a risk however. Eisenhower has written that for the first few weeks after his coronary thrombosis the weighing of pros and cons in decision making would have created a burden that his doctors would have found unacceptable. But somewhat alarmingly he was confident that he could have made a rapid decision after forty-eight hours. The example that he gave of a rapid and presumably easy decision has frightening implications; a decision to retaliate against incoming bombers.

The illnesses that are suffered by leaders present the doctor with a dilemma which may have serious consequences for the patient and the community.

This dilemma is compounded by advances in medicine and surgery. Forty years ago a surgical operation was a more hazardous process involving weeks or months of convalescence, recovery from pulmonary infection was a lottery and many diseases could not be successfully treated. Modern advances in surgical technique, anaesthesia, transfusion and resuscitation enable a patient to sit up in bed and talk with friends and colleagues a few days after a major operation. The natural history of surgical healing, and recovery from traumatic shock, apparently are dramatically shortened. But has intellectual judgement and ability kept pace with the physical recovery? Within

a few days of a prostatectomy Harold Macmillan took a decision which affected the future of the Conservative Party. Was he fit to take another decision that might have affected the future of the country?

These illnesses are also complicated by therapeutic advances. Psychostimulants—or could they have been placebos?—apparently enabled Churchill and Eden to withstand the unremitting demands of office. What we do not know, what we cannot know, is whether efficiency and judgement were improved or altered to any degree.

Consideration of such illnesses leads me on to the controversial subject of routine medical examinations and, looking on the negative side, they have limitations.

One physician at least has reservations:

“At first glance, a multichannel automatic-analyser seems an admirable way of detecting disease. In reality, all it does is to stop the patient’s physician thinking. Why listen to the patient’s history and weigh the significance of each symptom in turn when ‘the answer’ is going to be spewed from a machine? It has been repeatedly shown that around 40 per cent of abnormal results detected by routine screening are ignored by the physician in attendance, sometimes because he does not know the normal values.

“If a comparable effort were to be put into persuading modern man to stop smoking, to take some form of regular exercise, and to cease his gluttony, something tangible would result. As it is, we continue to lull ourselves into a sense of false security with the annual fiasco.”

Routine sigmoidoscopies and other elaborate tests are used in many executive examinations in America and the same physician writes of ‘a series of steel bars and contrast media [being] rammed into [the patient’s] several orifices’, although a series of over 1,000 sigmoidoscopies on symptomatic subjects did not reveal a single cancer of the large bowel in another study.

Lengthy and expensive routine medical examinations may only reveal minor abnormalities.

There is a lesson here for the Services, nevertheless; these minor abnormalities are compatible with civilian life or home service, but such weaknesses will be ruthlessly exposed on service overseas due to changes in climate, diet and activity. Faulty teeth, skin disease, piles, varicose veins and foot deformities, the type of defect that needs treatment which we invariably defer or avoid, should be dealt with promptly, and in a service setting justifies routine examination.

Apparently serious conditions, however, require far more skilled and judicious assessment because X-ray and electrocardiographic changes may be equivocal. One cardiologist has studied the subject of what he calls ‘coronary mimicry’, and has found 100 situations where the e.c.g. pattern can be confused with that of coronary disease.

Preoccupation with physical disability may mean that subtle and more important mental changes are ignored. An impressive list of X-rays, electrocardiogram, electroencephalogram and biochemical and laboratory readings may tell us nothing about certain attributes essential for command; vitality, mood, rationality and intellectual capacity.

It is likely that a psychiatrist or a psychologist can assess these qualities in a short interview, or that a general practitioner who knows the patient can do the same. Regular

re-examinations however, have other limitations for previous knowledge of the patient may blunt the sharpness of that first clinical impression which is so often the most valuable.

If regular medical check-ups are to be considered seriously nevertheless, some attention must be paid to the psyche as well as to the soma. When Eisenhower heard that one of his generals might be downgraded because of arthritis of the knee, he said he preferred a general with arthritis of the knee than arthritis of the head.

Doctors are not unique among professional men in having a duty to their patient and a duty to the community. The possibilities of such a clash in loyalties are probably greater in theory than in practice. Incapacity in an airline pilot is usually quoted but, in the changing world in which we live, patient relationship and community responsibility may well be strained if a patient reports with a knife wound or traffic injury of uncertain etiology.

A third duty is imposed on a service doctor—a duty to his branch of the armed forces, and in general most doctors adjust to these occasionally conflicting demands. The spectrum of activity and adjustment is broad, and the edges of the spectrum are dangerous; exemplified by the American army doctor who was court-martialled for refusing to give first-aid lectures to troops on their way to Vietnam, and the Nazi concentration camp doctors who confused their medical role and authority with the administrative and authoritative role of the party and military machine. Should a doctor ever breach the confidentiality of his relationship with his patient in the contemporary national interest?

This implies, first of all, a far greater skill and certainty in diagnosis and prognosis than many of us possess; and an even greater skill and certainty in analysing the political situation and the national interest. It also forces one to admit, albeit reluctantly, that a doctor, depending on the circumstances, may have to adopt a slightly different attitude to his patients and even a different interpretation of confidentiality, a term that in itself is difficult to define with precision. There can be no doubt that a doctor in the armed forces, civil service, occupational health or university health services, who has accepted the appointment with the attendant responsibilities, must be prepared to render an unprejudiced opinion on the subject's fitness or unfitness for service, promotion or transfer. In rendering such an opinion he is not by any means bound to pass on personal or domestic details that he has learned in the course of a routine examination.

Service doctors, even those of junior rank, and little experience, are vested at times with the collective medical authority of the whole profession, though the exercise of this power may be painful and embarrassing.

Many years ago on the North-West Frontier of India according to Major Reginald Hargreaves, the battalion commanders decided that the brigade commander was mentally disturbed and no longer responsible for his actions. Turning to a young Medical Corps captain standing, it is noted 'modestly in the background' they asked for his opinion.

'To a young man on the threshold of his career, the demand to come to so momentous a decision must have been appalling but he did not flinch from it.'

'He afforded the senior officers the necessary authorisation which justified them in suspending the unhappy man from command and putting him under restraint.'

As private practitioners, without responsibility to a bureaucratic system, our only duty is to the patient, to help him to work as efficiently as possible, and to dissuade him from activities that may be harmful to him. But we are not infallible, we are not judges, however senior we are not elder statesmen. Although a breach of confidentiality might conceivably have a successful national outcome, despite an unhappy outcome for the patient, resort to such tactics at all frequently would remove any trust between doctor and patient.

Although such action can be justified, as it was with Winston Churchill, on the grounds that premature removal from office would weaken the will to live, one must never forget the haunting words of James Roosevelt. Shocked by his father's appearance at the Inauguration in January 1945 he was not shocked by his death in April, but wrote later:

"I never have been reconciled to the fact that [his doctors] did not flatly forbid him to run."

A study of the pathology of leadership can perhaps be justified as a subject of practical importance rather than an armchair study of military history. In 1935 Wavell wrote to Liddell Hart:

"If I had time and anything like your ability and industry to study war, I think I should concentrate entirely on the 'actualities' of war—the effects of tiredness, hunger, fear, lack of sleep, weather, inaccurate information, the time factor and 'so forth.'"

Wavell did not mention illness but some of his actualities—tiredness, hunger, fear, lack of sleep, weather—can lead to illness and incapacity or can be the result of illness. Wavell went on to write, with all the effortless superiority of the Winchester scholar:

"The principles of strategy and tactics, and the logistics of war are really absurdly simple, it is the actualities that makes war so complicated and so difficult, and are usually so neglected by historians."

It is very evident that the actualities to which he referred—tiredness, hunger, fear, lack of sleep, weather—are very much the responsibility of members of the medical services of the armed forces. Furthermore, they are inextricably bound up with the pathology of leadership which I hope you will regard as worthy of further consideration and study.