# Insights and Innovations in Community Mental Health

## The Erich Lindemann Memorial Lectures

**organized and edited by**
**The Erich Lindemann Memorial Lecture Committee**

hosted by William James College

William James College

## Foreward

The Erich Lindemann Memorial Lecture is a forum in which to address issues of community mental health, public health, and social policy. It is also a place to give a hearing to those working in these fields, and to encourage students and workers to pursue this perspective, even in times that do not emphasize the social and humane perspective. It's important that social and community psychiatry continue to be presented and encouraged to an audience increasingly unfamiliar with its origins and with Dr. Lindemann as a person. The lecturers and discussants have presented a wide range of clinical, policy, and historical topics that continue to have much to teach.

Here we make available lectures that were presented since 1988. They are still live issues that have not been solved or become less important. This teaches us the historical lesson that societal needs and problems are an existential part of the ongoing life of people, communities, and society. We adapt ways of coping with them that are more effective and more appropriate to changed circumstances—values, technology, and populations. The inisghts and suggested approaches are still appropriate and inspiring.

Another value of the Lectures is the process of addressing problems that they exemplify: A group agrees on the importance of an issue, seeks out those with experience, enthusiasm, and creativity, and brings them together to share their approaches and open themselves to cross-fertilization. This results in new ideas, approaches, and collaborations. It might be argued that this apparoach, characteristic of social psychiatry and community mental health, is more important for societal benefit than are specific new techniques.

We hope that readers will become interested, excited, and broadly educated.
For a listing of all the Erich Lindemann Memorial Lectures, please visit www.williamjames.edu/lindemann.

*The Erich Lindemann Memorial Lecture Committee presents*

THE SIXTH ANNUAL
ERICH LINDEMANN MEMORIAL LECTURE

# Educating the Physician: Which Comes First, The Patient or The Disease?

## Speaker

**Oliver Cope, MD:** Professor of Surgery, Emeritus, Harvard Medical School**,** Senior Surgeon, Massachusetts General Hospital

## Moderator

**David G. Satin, MD, LFAPA**: Assistant Clinical Professor of Psychiatry, Harvard Medical School; Chairman, Erich Lindemann Memorial Lecture Committee

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## Oliver Cope, MD

*Professor of Surgery, Emeritus, Harvard Medical School, Senior Surgeon, Massachusetts General Hospital*

I suppose a lot of us were a little bit puzzled that I, a nonpsychiatrist, was invited to give the Lindemann Lecture. It's a wonderful chance for me to bring my thoughts together and the title, of course, is a hard one but you chose it, "Educating the Physician: Which Comes First, The Patient or the Disease." Having known Dr. Lindemann as I have, I thought I would read a quotation from the Bible. It's from the Epistle of St. Paul, the apostle to the Colossians, "Let your speech be always with grace seasoned with salt that you may know how you ought to answer every man." I picked that out because if there was anything typical of Erich Lindemann it was his grace. He spoke with grace, he thought with grace, his seasoning with salt was very tempered, sometimes just enough salt. I can speak of Lindemann with the grace that was his, and all who knew him understand that. But, when it comes to salt and seasoning I'm a little worried. Those of you who had contact with me know that I sometimes put in not just a little too much salt but even some pepper.

The first contact I had with Erich Lindemann came in the Coconut Grove crisis. You remember that was that disastrous fire in November of 1942. Years before–it was 1928–I happened to be a fourth year student at the time when there was a disastrous explosion at the Beacon Oil Company plant in Everett. Some thirty men, badly burned, were delivered to the Emergency Ward at the MGH and all there was confusion. It was two years after Detroit had recommended tannic acid; and the wounds of the patients were being debrided of the covering of their blisters and efforts were made to tan them. Right there in front of the hospital staff they were dying. Many died within the first hours because the use of fluids wasn't fully understood and of course we were all paying attention to the wound rather than the total disease. We didn't really have time to think of the patient.

There were other chances to see that the therapy was wrong. A Hartford surgeon found that tannic acid was far from harmless. Everybody had thought it would localize the poisons–tan them into the wound. So by the time of Pearl Harbor there was good reason to believe that the therapy of burns was far from ideal. You remember that at Pearl Harbor the medical people were absolutely buried in the number of civilian and naval air base people who were burned. There were two or three days of caring for the burned by what was found later to be an antiquated method. As a result of that and Dr. Radvin'sview of Pearl Harbor, the Massachusetts General started on a project in order to shorten the care required in a disaster. In the time of Pearl Harbor or the time of the

Beacon Oil explosion it took five people at least to care for one individual. What we needed to do was to reduce it. If we could get one person to take care of ten burned people in disaster conditions we'd have made a big gain. So the General staff went to work from January of 1942 through the year on an investigation of time-saving methods. The simplest method for the burn surface is attention to fluid needs. In the middle of November, 1942, a woman was brought to the hospital with bad burns and by that time our East Surgical Services knew what to do. We thought

that just covering the wounds with vaseline and then taking care of the fluid in take would be the thing.

The very next week, when East Surgical Service was again on duty, the Coconut Grove Fire came. The Resident staff knew what to do. We hoped this would be an advance for pain control. What we did was pay attention to the wound and get it covered quickly, pay attention to the fluids; and the Medical Service came to take care of the toxicity of the smoke in the lungs.

One man had been at the Coconut Grove with his mistress. His mistress was killed, he survived. His wife came in to see him. The Social Service noticed that he was unable to speak and she was unable to speak. There was a former patient of mine at the hospital who recognized my voice. Her husband had been killed. She called, all bound up with her bandages, "Don't I hear Dr. Cope?" I said of course she did. She was doing well, and to pay attention to the fact that her husband had been killed just didn't seem necessary.

The Social Service, of course, noticed that we needed somebody to pay attention and help the patient. There was hardly a patient there, of the 39 who survived the first half hour in the hospital, who had not lost someone in the fire. They called in Erich Lindemann. His experiences with the patients are summarized in a monograph by him and Stanley Cobb.Erich had been experimenting with a method for studying doctor-patient interaction: the interaction chronograph. The essence of this was that an observer sat behind a screen with a moving belt and made a time-line for each question and each answer. If the patient was normal, the patient answered promptly when the doctor finished the question. If the patient was depressed it might be quite a time before the patient managed to answer, and indeed, the doctor might need to repeat the question. Quite the reverse if the patient was manic: the manic patient would anticipate the question and would begin to answer before it was finished. Then the lines would overlap.

When it came to the Coconut Grove fire, everyone thought that the patients who were grieving would be depressed, but Erich Lindemann realized right away that they were suppressing their grief and were manic. The chronograph bore this out; the charts showed the typical picture of true grief based on the loss of a loved one. Just think of how we surgeons missed it. I'm including the pulmonary experts and the Medical

Service too. We were identified with the training in a certain area, and that's what we paid attention to. As for viewing the whole patient–we muffed it.

This is striking, and it is still not paid attention to. Robert Lifton went to Hiroshima very soon after the bomb was dropped, and in his book he describes the confusion of those who survived and were badly hurt. There is a picture of a poor woman crawling on all fours, not knowing what to do. We haven't paid attention to what Erich Lindemann tried to tell us. A disaster needs therapy. Here was that poor woman crawling on all fours. The Coconut Grove victims would have been crawling on all fours if their burns had allowed them.

The Cobb-Lindemann publication was out in June, 1943, six months after the fire. My next encounter with Erich was an indirect one. I don't fully understand it, but I know somehow it's connected. In the month of August, 1943 something happened to me. I did three radical mastectomies in a six-week period and all three women told me what a horrid, dreadful thing I had done and didn't I realize it? I'd been trained to do radical mastectomies. Dr. Churchill made me do it just right, tie the knot, do it without any drainage, a surgical achievement, beautifully done from the technical point of view. I was very proud of my operation on these patients. It hadn't occurred to me what I was doing.

The first patient was a friend. I came in to see her the morning after the mastectomy. I said how nice it was to see her doing so well after the operation. She said, "Sit down. Do you realize what you've done to me? I'm 61, I've had my one child. My husband is dead. I can have no other child. I have no need for my breasts. But it's done. The loss of my breast has done something to me."

The next patient was a hospital volunteer whom I had known for years. She was 51, unmarried, caring for her mother, looking forward to a future life perhaps married, and she too said to me, "Don't you realize what you've done to me?"

And then there was the pediatrician on our staff that I operated on. She had two children, but she wanted another child. Why did she want another child? This came out six months later. Because with the loss of her breast she no longer felt like a woman; the child would be proof that she was still a woman.

The message that had somehow reached me after Erich's experience with the Coconut Grove patients was simply, "Sit down and listen." It's the result of his influence that I have changed. I learned to distinguish between education and training. I received a medical school education: I went through physiology, all the courses in anatomy. I learned them very well. I won a student research scholarship. In the second year I started research with Joseph Aub and Walter Bauer at theMassachusetts General Hospital. I did adrenalectomies on cats, searching for the adrenal hormone. I did the things that were expected of me. Cecil Drinker came in to coach me on how to take the

adrenals out of cats and do it well. The older surgeons, E.P. Richardson, Daniel Fisk-Jones, said, "Look, here, young fellow, you've been through medical school and been told a lot of different ways of doing things. Now you're here in the hospital, and you're caring for people, and you don't know enough yet to change a routine and try something new. What you do is Step One, and then you go to Step Two, and then you do Step Three, not forgetting a, b, c. Then you go on to Four, and when you're finished you'll have done it well and there'll be no harm to the patient." Now with those mastectomies I did from the time I was on the staff in 1934 until the Coconut Grove experiences and meeting Erich Lindemann, I did what I was trained to do. The education somehow disappeared and the training governed my actions. How do you abort that? That's an educational problem.

The fact that I could change shows that education did come in handy. The most important thing in relation to breast cancer now is to help the woman with breast cancer. In 1943, when these three patients questioned the reasons for doing a radical mastectomy, I started studying again. I was disappointed tofind how pretty lousy radical mastectomy was; but when it came into being, there wasn't anything else. Europe had more experience. In 1954, as we went along, we found that the surgeons in Finland had been doing lumpectomies and radiation since 1940. Doctors in Paris had reported in the early 1950's and again in the 1960's their success with limited procedures, and again we didn't pay attention because we didn't quite believe they were as good as Americans. This, too, is an educational problem.

Gradually, a lot of people here became interested. In 1946 C.C. Wang came from the Lawrence Laboratory after being tutored in radiation therapy in Berkeley. Benjamin Castleman, bless his soul, assigned him to treat with radiation large breast tumors in patients who already had liver metastases and other metastases. Ben measured them before and after the radiation. In eight years, by the end of 1955, they had done 97 patients, and to their amazement, a few of the tumors had just dissolved. Not all breast cancers are alike. Castleman, our pathologist, was interested in identifying the different kinds. To the surgeon, it didn't matter which kind, as there was only one treatment. If it was cancer you took the breast off, and if it wasn't you sewed up the wound. Ben Castleman knew better.

The first time a woman patient at the General refused to have her breast removed was in January, 1956. She had been a patient in the hospital before, and had heard of our alternative therapy. She said she wasn't afraid of an operation, but she told us to find a different way. So, in January, 1956, we introduced what we thought would be a more considerate method, with the help of Benjamin Castleman and the people in radiation therapy. I felt all the time we were doing this that Lindemann was approving. I know he was; and this was enormously important to us.

The next lesson I learned from psychiatry had to do with hyperthyroidism. Soon after the Coconut Grove fire, in the summer of '43, some colleagues had me to luncheon in the doctor's cafeteria, and pointed a finger at me–I wasn't paying attention to the psychiatrist sitting across the table, and they noticed it, and said, "By the way, Cope, it's high time you fellows in the Thyroid Clinic paid attention to what we psychiatrists know about the genesis of hyperthyroidism."

You know how we treat hyperthyroidism–the surgeon diminishes the size of the goiter. If you cut out enough of the goiter, hyperthyroidism soon disappears. When radioactive iodine came along there was the radiation iodectomy, and if you didn't need to do that you gave the patient special drugs.

Let me give you three examples of women whose disease onset could only be understood in relation to stress experiences, a la Lindemann: The first patient had come here in the early days of radioactive iodine. She had a goiter and received the iodine. She had an exophthalmus on the left side and the neurosurgeons operated on her, opening up the bony space for the eyeball so it set back in, relieving her left eye. Her right eye at that time was normal. She also received radioactive iodine for her overactive thyroid, which slowed it and diminished the size of her goiter to normal. She came back four years later. She now had no overactivity of the thyroid, but the right eye started in May to get bigger and began suppurating in the middle of June. Knowing of our thyroid interest, it was suggested that I go up to see her. So I did. I sat down with her in her room and told her I had come to see her, hoping we could find out why this has happened. I asked her if she knew how her disease had come about. She was a social worker from Detroit, and said she had seen a lot of doctors there, but I was the first one, in Michigan or in Boston, to ask what she thought about herself and the disease. Once she was sure of my interest, she told the following story:

She had married a man who proved to be an alcoholic. She found him impossible, but they had a daughter and the daughter was devoted to the husband. She thought she would put off getting a divorce until the daughter was eighteen. As the eighteenth birthday approached the mother became increasingly anxious. The morning of the daughter's birthday she went to the lawyer and started the divorce. That very evening she noted her left eye had enlarged. Then the toxicosis came. This was the occasion of her first MGH admission. The current trouble began when the daughter, now twenty-two, decided to marry against her mother's advice–a man who, like her father, was an alcoholic. Arguments were useless. It was at this point that the right eye became involved.

The next patient had a problem with her mother. The onset of her hyperthyroidism came when she was to go away on a questionable trip for three months to South America and she realized her 80-year old mother was sick and might die while she was away.

While she was worrying about whether she should leave or not, she first noticed her eyes were hurting. Her goiter didn't appear until she decided to go. She went and, sure enough, her mother did die while she was in South America. When she came back there was trouble with her two brothers trying to settle family affairs. Suddenly her problem reappeared. It came in two stages–in March the eyes had bulged and the doctor who cared for her in New York said it was typical Graves' disease, but no goiter had come until the summer. She then went to see a woman psychiatrist who had helped her previously with a problem of amenorrhea. This doctor enabled her to understand what was going on in her life, and the symptoms and this goiter disappeared.

The third patient came here with a unilateral exophthalmus. Her father and mother were divorced when she was five. She had only seen her father on rare occasions. The last time was shortly before the admission, when she met him on the street. He looked at her and sort of sniffed and went on by. In the meantime she had terminated an unsuccessful marriage and gone back to live with her mother and a stepfather, to whom she became greatly attached. The onset of the eye condition coincided with her father's sudden death and her guilt for not having been with him when he died. In the western part of the state, where she lived, her doctor began taking x-rays, looking for a tumor, until a friend suggested the MGH Thyroid Clinic. After telling her story here, by golly, the exophthalmus disappeared.

So this is another area where Lindemann taught us, started us reflecting, made us listen, pay attention to the other aspects, the ones that he described to us so well. When we came into Harvard Medical School we were busy with enzymes and chemical reactions and hormones, and we continued this preoccupation as doctors in the hospital. It wasn't bad; it wasn't anything that shouldn't have been done. There is nothing wrong about it. It's just not enough!

I am reminded of a famous trial lawyer in England who was defending a very complicated case. He brought every single detail into the account, one after the other, not missing a single point. When he sat down, the judge said: "I've listened to this long recitation, I've heard every detail, and I find myself none the wiser." The lawyer jumped up and said: "Perhaps not wiser, my lord, but certainly better informed." I would like to think that some words of wisdom have come out, that you get my reaction to Lindemann and what it has meant to know him and his sense of the social side of disease; what it has meant to me as I have tried to understand it.