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MEDICINE IN RELATION TO SOCIETY*

BY

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On a famous occasion in the House of Commons in the reign of King George III a certain member, Mr. Dunning, moved that "the power of the Crown has increased, is increasing, and is likely to increase still further." To-day, at the opening of the 218th Session of the Royal Medical Society, I would remind you that "the power of medicine has increased, is increasing, and is likely to increase still further." For what is the position ? We can now prevent birth, terminate pregnancy, relieve pain, keep unconscious for long periods, prevent and treat many infections, suppress and increase instinct, modify the reactions of the mind with drugs, and influence personality with the knife. We can certainly prolong life. One day we may discover a chemotherapy for cancer and how to slow down the degenerative processes of age.

Mr. Dunning went on to move that the power of the Crown "should be reduced." I do not suggest that the power of medicine should, but, while the general public are acutely aware of the problems recently raised by the discovery of intra-atomic energy, they and many members of our profession remain largely unaware of the more personal ones which are being rapidly precipitated by our increasing power over the physico-chemical machinery of the human body, the basis of the individual life and mind. How, when, and to what extent should this increasing power be used ? I am therefore asking you to consider, not medicine as a science (about which I sometimes think we hear too much), not even medicine as an art (about which I think we now hear too little), but the growing problem of the right use of the power of medicine in relation to Society. And how is that to be solved to the best advantage of humanity ? Surely by establishing and maintaining satisfactory relationships between the three chief interested parties: the patient (you are all potential patients); the doctor (you will all soon become doctors); and the State, in which in this democratic country we are all incorporated by virtue of our votes.

The Patient

Let me begin with the patient, or rather with the potential patient, who at any moment may develop his disease, the average man who often knows or thinks he knows a little about medicine. What is his outlook to-day ? Naturally he still expects his doctor to keep him and his family in health, but, as a result of increasing medical knowledge and specialization, his attitude to his doctor has changed considerably of recent years. Further, it has changed at a time when the influence of the Churches has declined (although religion still sometimes complicates a medical problem), most people live in a structureless urban or dormitory society, the State has become responsible for health, and legal aid is available to all. He is aware that his doctor now knows relatively much less about medicine as a whole than he did a few years ago. (Hence his growing faith in specialists and his doctor's declining opportunity to become, as he so often became in the past, his patient's guide, philosopher, and friend.) On the other hand, does he, the average patient, understand that the most responsible and often most difficult diagnosis is still that between the early symptoms of organic disease and those of functional or psychoneurotic origin ? (Whether to investigate or treat symptomatically may be a decision entailing life or death.) Does he realize that health is a relative term in relation to the constitution with which he is endowed ; that avoiding the disease to which he is predisposed may depend on deliberate effort on his own part ; that in seeking the aid of the growing power of medicine to live longer he may merely add to the total suffering which he must endure ? Further, he still expects his doctor to maintain the principle of professional secrecy and protect him from exploitation at the expense of his health by his employer or the State, which, in these days of nationalized industry, is often his employer. And yet it is to the State that he looks to provide him with living conditions compatible with health and to protect him from the risks to which he is exposed in an industrial society. In addition, he now relies mainly on the State, and no longer on Church, charity, or some voluntary organization to which he subscribed, to restore his health when he is ill and look after him in his old age. But does he realize that elimination of risk demands some sacrifice of personal freedom and that State intervention in medicine tends inevitably to cut across the principle of professional secrecy ?

The Doctor

Now for ourselves. On the one hand, we have a much clearer idea of the nature of disease than in the recent past, although we are faced with a much more difficult concept. For we no longer think of diseases as entities with characteristic symptoms and signs and definite dividing-lines between them. Rather the phenomenon has become to appear as a continuum like a mountain range in which the textbook diseases stand out like major peaks. (The outlook of the recently qualified doctor is very different from that of one of the older generation.) On the other hand, we

*The inaugural address delivered at the opening meeting of the 218th Session of the Royal Medical Society of Edinburgh

are all painfully conscious (even more so than our patients) that, as medical knowledge marches on relentlessly, we individually know relatively less and less about medicine as a whole. And what are the consequences of that? Some loss of confidence in ourselves and being forced into specialization or, if we attempt to remain general, greater reliance on specialists. (In some countries the general practitioner, as we know him, has almost disappeared.) Further, the growing power of medicine has not simplified practice, as the layman naturally supposes. Rather it has rendered it much more difficult and created many more opportunities for us to make mistakes.

When I first started, there were few diseases for which any radical treatment existed. Early diagnosis was often unimportant. All we could do in so many cases then was to treat symptoms and let the underlying pathological process run its natural course. Now something can be done for so many that early diagnosis is becoming increasingly necessary. For example, until chemotherapy for tuberculosis was discovered, all cases of meningitis of that variety died in a few weeks: the later the diagnosis in many ways the better; the shorter the period of agony for relatives. Now, if the disease is diagnosed early, modern treatment will effect a complete cure: if late, the patient dies or, worse still, is left a derelict for life.

Further, in spite of all our new methods of investigation, "front-line" diagnosis remains clinical. Laboratory tests and *x* rays have not replaced history-taking and physical examination except perhaps in hospital, where the decision whether to investigate or not and what to start investigating has already been made by a general practitioner or in the out-patient department. And clinical diagnosis is still that which is most probable on the evidence immediately available, although there is often a less probable but more serious condition which, if sufficiently probable, must be actively excluded, provided that it is likely to be amenable to treatment. (There is no sense in causing discomfort and wasting public money in excluding some disease which is bound to be incurable.) So the general practitioner and the out-patient physician, unless they are to submit every patient to a whole gamut of expensive investigations, are compelled to take risks. Indeed, they take them every day, clinical diagnosis (although we may be loath to admit it) exemplifying the economic law of diminishing returns.

Let me give you an example. Carcinoma of the stomach and colon are symptomless diseases at first and the patient does not consult a doctor until the compensatory reactions of his body start to fail. Then in 75% of cases, I suppose, symptoms are sufficiently definite to permit a highly probable clinical diagnosis. Further, by exercising extreme care (mainly in history-taking) we can probably "get" the next 20% without investigating too many "functional colons" and "nervous dyspeptics." The remaining 5% are however, I believe, likely to defeat us and must be written off on the balance sheet of human suffering like a bad debt. Indeed, unless we are courageous in diagnosis within reason, we shall cause so much unnecessary anxiety that we shall undo much of the good which we otherwise succeed in doing, quite apart from wasting public money. True that an *x*-ray film of the chest every quarter, for example, might one day become an economic proposition, but routine investigations of the kind which would eliminate diseases such as carcinoma of the stomach and colon must, so far as one can see at present, remain outside the realm of practicability.

Some Moral Problems

In addition, as the power of medicine increases, we are all confronted, and confronted particularly often in hospital practice, by problems of a moral nature. Under what circumstances should birth control be advocated? When should pregnancy be terminated? To what extent should pain be relieved? When is it right to use drugs to suppress or increase instinct? To what extent is it justifiable to alter the reactions of the mind to experience such as the advent of death by means of drugs? When should leucotomy be performed to render a patient socially more manageable and a lesser burden on society at an expense in terms of mind which it is impossible to estimate? When should life be prolonged at the cost of increased suffering by some palliative operation? For example, when should gastrostomy be performed in inoperable carcinoma of the oesophagus or colostomy in inoperable carcinoma of the colon?

And again and again I am confronted with this sort of problem. An elderly man is admitted with hemiplegia and aphasia, lies there semi-conscious, and after a few weeks shows little sign of recovery. Then his temperature and pulse start to rise and signs appear at the bases of his lungs. Clearly he is heading for pneumonia, Osler's one-time "master of the men of death." Do I put him on penicillin and prolong his misery, or on morphine and let him depart in peace? "His nearest relative should decide": it is easy to say that, but in situations of this kind can they really be told enough to understand the position sufficiently clearly to arrive at a decision? And how many relatives are capable, under the emotional stress of circumstances such as these, of decisions of this magnitude? In my experience most patients and relatives want decisions taken for them rather than to be left to take them for themselves. Further, if they are forced to take the decision themselves, does not the one which they take depend on the way the situation is explained to them? In practice the doctor is almost always faced with taking the decision himself.

Now, it is always easier to perform a palliative operation or put the patient on deep *x*-ray treatment or chemotherapy; easier, in fact, to do something than to do nothing. Some course of action will probably relieve his immediate symptoms, and often it prolongs his life. It will raise hopes and sometimes clear the bed for the admission of another case for whom more might be done. But what happens to the patient in the end? Looking back, would not analgesics and narcotics often have been better treatment, although the bed might have been blocked for weeks? (The use of drugs to relieve pain, even to the extent of keeping a patient unconscious for a long period, in my experience does not shorten life and is not euthanasia.) The Roman Catholic doctor in dealing with his Roman Catholic patients has firm guidance from his Church in these matters, and some may hold the view that it is always our duty to prolong life so far as is possible, but my experience teaches me that most of the non-Catholic laity would, if they knew the truth, wish doctors to exercise more moral courage than in point of fact is, I think, their practice in these situations. If the patient or his relatives really could be told the facts, they would have their doctor withhold treatment when "the game is up," and let nature take its course. But so often they cannot understand or be brought to face the decision, so that again and again in practice most of us are forced to act on our own sense of what is right in the circumstances of each case. But to that statement I hasten to add this rider. In general we should base our action on what appears to be (and we must always take the trouble to find out) our patient's philosophy of life rather than inflict ours on him when he is ill or dying. (The outlook of a man of 40, be he doctor or patient, may be very different from that of a man of 60.) It is written "Thou shalt not kill." But letting nature take its course when nature cannot be stopped is not killing. Nor in my judgment is a patient committing suicide when he refuses palliative or problematical, as opposed to a reasonably certainly curative, medical or surgical treatment. Never before in the history of medicine has it been so important to remember Clough's oft-quoted rider to the sixth commandment: "But needst not strive officiously to keep alive."

More difficult still is the decision whether to adopt a procedure which *may* arrest a lethal pathological process *possibly* only at the cost of leaving the patient a mutilated relic of his former self: for example, deciding whether to operate for a tumour of the brain. It may be that in a particular case there is a one-in-four chance (so far as

chances can be estimated) of a spectacular success and a one-in-four chance of the patient dying. If the choice lay between those two alternatives alone, there would never be any doubt of what to do. But there may be even chances of leaving him derelict for life. If the patient realized that, would he consent to operation ? Yet it is seldom possible, and it is doubtful if it would be right if it was possible, to explain the position to him. So these decisions remain for us to take, and are most difficult. Further, they must remain individual. It is impossible to generalize. It is no platitude that the doctor should treat his patient and not his disease. Rather that is the first principle of medical practice. The disease, that complicated reaction between the psychosomatic constitution of the individual man and the risks to which he has succumbed, is the abstract concept. The patient is the concrete reality. There can be no disease without a man, woman, or child to suffer from it, any more than there can be a human mind, as we know it, without the physico-chemical machinery of a human body to maintain it. If I really thought that I was either under a moral obligation to keep all my patients alive as long as possible, or under a legal obligation always to apply the textbook treatment for the textbook disease, I would give up medicine to-morrow !

Responsibility for Major Decisions

Now, in actual fact by whom are these major medical decisions usually taken ? Almost always, I think, by the physician or surgeon under whom the patient has been admitted to hospital, and who, although he is often a specialist in some particular branch of medicine or surgery, seldom knows much (because in his position he cannot) about the background of the patient's life. Further, they are usually taken without reference to his general practitioner. Indeed, to-day he seldom "comes into the picture," except in so far as the medical fate of a patient may depend on the specialist (Dr. X or Y or Mr. A or B) to whom he is referred in the first instance. A duty of every general practitioner is to "know" his specialists and choose that one most suitable to advise his individual patient. But the gulf of loss of contact between specialist and general practitioner has grown wider and wider of recent years, and, as things stand at present, the responsibility of the latter for any major decision ends completely in most cases as soon as his patient is admitted to hospital. Nor am I altogether happy about responsibility in a large hospital. For a patient may be attending several departments simultaneously. His G.P. has been "cut out" and no one doctor is now primarily responsible for him. Further, we seem to be developing a race of laboratory middle-men who now sometimes dominate the investigation of a patient, and therefore come to influence his treatment, and yet must know less than anyone else of the background of his life. As I see it, all major decisions in respect of a hospital patient, whether to investigate, how to treat, and above all the vital decision whether to treat, should be taken by one physician or surgeon who should be responsible for ascertaining the background of his life by getting in touch with his general practitioner.

Divided Loyalties

The problem of divided loyalties also bothers me. By the tradition in which our profession has developed, and we ourselves have grown up, our allegiance is still primarily to our patients. I say primarily deliberately, because we have two other allegiances. On the one hand, we have an inclination always to get as near the truth as possible, the scientific approach determining the pattern of medical education to-day. On the other, we have a feeling of duty to the State. True that the latter is not very strong in our minds, anyhow as yet, but duty sometimes calls awkwardly in that direction. For practically all doctors are now full- or part-time servants of the State, or, if you prefer it, of the public embodied in this democratic country in the State. Further, we are now entrusted, both in domiciliary and in hospital practice, with the expenditure of public money. Now, at one time there were no expensive methods of diagnosis (sometimes to be proved or disproved on the post-mortem table), so that these three loyalties seldom came into collision, and, when modern methods of investigation started, we spent the patient's money, or money subscribed by the charitable or contributed voluntarily by him to a society. To-day, not only are investigations far more numerous and expensive, but they can be used to paint a much more complete picture of a disease. Sometimes this must be painted in all its details. But how often do we order investigations (apart from planned research) merely to paint more completely the picture of a disease for which nothing can be done; or, to state it crudely, how often do we spend public money merely to satisfy our own intellectual curiosity ? Nevertheless, curiosity is necessary if medicine is to feel its way and each of us individually is to continue learning. The conflict of interests exists, and it is better to realize it. The only solution lies in compromise.

The State

Now for the State, the latest comer on the scene. Indeed, it is a very recent comer. It is less than 200 years since the importance of environment in the pathogenesis of disease began to be understood, and only in the memory of living man did the cost of treatment become so great that Church, charity, and voluntary organizations could no longer cope. Lloyd George's National Insurance Act was introduced just before the first world war, and Mr. Bevan's National Health Service Act just after the second. Further, in the modern world, every State has begun to take a positive interest in health for two reasons. In peace the labour force must be maintained. In war the Services must be kept up to strength. The State can no longer sit back and look on. It must intervene, and intervene with the maximum economy compatible with efficiency. So medical administrators, with financial considerations always "treading on their tails," would gain complete control of medical certification and expenditure if they could. Further, State medicine is impersonal. It thinks in terms of numbers and percentages, not in terms of individuals, dislikes professional secrecy, and would have all the information about the incidence of disease which it can get.

The State has three main functions in relation to health. First it must reduce to a minimum those risks which are prejudicial to human existence. It must therefore take responsibility for housing, water, and sanitation and enforce regulations to minimize the traumatic and chemical risks to which people are exposed in an industrial society. As to these functions of government there can be no controversy.

The control of infection is a more difficult problem. Vaccination against smallpox and inoculation against diphtheria are not compulsory, because some people have conscientious scruples against them. The State accepts these scruples (in the same way as it accepts conscientious objection in time of war), although both are actively discouraged. If, however, a patient develops smallpox or diphtheria he has no choice in the matter. He is bundled off to a fever hospital. Tuberculosis we handle differently. The patient must be notified, and is then kept under observation and encouraged to undergo treatment, but he cannot be compelled to enter a hospital or sanatorium. Public opinion would not stand for treating people with chronic tuberculosis as lepers were treated in the Middle Ages, although patients with open lesions must be almost as dangerous. Venereal disease is not even notifiable, but the State sees that facilities for treatment are easily available. Thus we compromise between eliminating risk and sacrificing freedom.

The third function of the Government is now the organization of the medical services, and as the result of the National Health Service Act doctors are becoming distributed more equitably in relation to population, the standard of medical care has been raised in many areas, and special centres are growing up where previously they did not exist.

The best medicine has not become available to everybody (there is never enough of the best to go the whole way round), but the National Health Service has brought good medicine within the reach of all. It is a great advance in social legislation, but there are difficulties and dangers inherent in the new system which it would be folly to ignore.

The State looks to the doctor not to spend public money unnecessarily. It does not expect him to waste it either in the satisfaction of his own intellectual curiosity or in acquiescing to his patients' unreasonable requests. In most cases expenditure is justified, but there are difficult cases. For example, when is an *x*-ray examination justified merely to convince a patient who doubts a purely clinical opinion? When is the more expensive drug justified which might do the patient just a little more good? When is physiotherapy really worth the cost of repeated visits to a hospital? But I am not suggesting that problems of this kind are new, still less that they are the result of the National Health Service. (That started at a time of economic stress and rapid progress in methods of diagnosis and treatment. Medicine was becoming so complex that the State was compelled to take over.) Rather, they have assumed larger proportions and become more difficult because, now that they are servants of the public, it is not as easy for doctors to be firm as when they gave their services to hospitals in an honorary capacity and were paid fees which they could refuse or remit. The man in the street, whatever his politics, held charity and, whatever his religion, the Church, and naturally the society to which he voluntarily subscribed, in some respect. But the State is often fair game, and he may claim the right to be investigated or treated in a certain way or given a certificate to get him this or protect him from that. The unpalatable truth is that the hospital doctor who did his work unpaid, and the consultant or general practitioner who worked for fees, have both to some extent lost the throne of freedom of action on which they used to sit.

Further, there is this added danger. If a doctor makes a mistake (we must all make mistakes sometimes), a patient is much more likely to sue him or his hospital now than in the recent past. As paid servants of the public, we are a tempting target for that dangerous few who have a "down" on the profession and enjoy publicity. Nevertheless, I am not suggesting that the recent spate of litigation against hospitals and doctors is due to the National Health Service, or that in general our patients are any less grateful than they were before it started. Rather, it is the consequence of the general public thinking that they now know so much more about medicine (when in reality they know much less), our much greater opportunity to make mistakes, and legal aid becoming (if a reasonable case for it exists) accessible to people with small incomes. True that we are probably passing through a transient spate of it, but there has been enough to tend to make doctors play for safety to a greater extent than safety should be played for. And what are the likely consequences of that? To the patient, unnecessary discomfort and loss of working time. To the State, loss of output and additional cost to the Health Service.

A further danger to the happiness of the doctor–patient relationship (on which successful medicine so much depends) is the inevitable tendency of the National Health Service to undermine the traditional principle of professional secrecy. For these are the days of reports to employers (often the State) and copious records. Hospital notes are bandied about from hospital to hospital by lay secretaries and must be produced in court if demanded. The patient's record card changes hands through a central office whenever he changes his doctor. Can that too be demanded in court? Has the patient the right to insist that it or his hospital notes be destroyed? I do not know the answer to these questions.

The cost of the Health Service is, as everyone knows, steadily increasing (it is doubtful if there can be any natural limit to expenditure on health), but this is in no way due to the Service itself. Rather, as I have already emphasized, it is due to present-day economic conditions and recent advances in expensive methods of diagnosis and treatment (which together rendered the Service necessary), and, I should add, the increasing age of the population (one of the results of modern medicine) and the higher cost of keeping old people alive (as the power of medicine increases). Economy is clearly necessary. There are already directives intended to reduce the cost of prescribing in domiciliary practice, and we are repeatedly implored to cut down *x* rays, expensive investigations, and the use of costly drugs in hospital. Further, it would certainly be more economical to run hospitals with a smaller number of full-time consultants than on the present half-time system. Indeed, if we let medicine get too expensive—and that rests to some extent with doctors—the National Health Service, which retains at present most that was best and has eliminated most that was worst in the old system, might be forced into the pattern of a full-time salaried medical service. And what could that be like? The allegiance of the doctor might become primarily to the State. Promotion might become based mainly on service to it rather than to the patient for which the service was intended. In the interests of economy some forms of treatment might become standardized and the progress of medicine thereby hindered.

Further, a State medical service might lead to an orthodox State medicine. But even under the National Health Service as at present organized I sometimes think that we are nearer to it than is generally realized. There is a movement to limit prescribing and reduce expensive investigations already. True that there have been no directives regarding treatment as yet, but no patient can get free homoeopathy, osteopathy, or faith healing under the Act except from a legally qualified practitioner. True, also, that at present we are free to act as we believe to be right in the circumstances of the individual life, and that Common Law holds that a doctor cannot be found negligent if he has exercised all reasonable care in diagnosis and treatment. But suppose a doctor takes the view that it is right in certain circumstances to withhold treatment and let a patient die, and is then sued by his relatives. What then? I do not think that a case of this kind has been taken to court, but, unless inaction of this kind in certain circumstances is upheld, if a case does come to court, doctors will be afraid to let nature take its course in certain circumstances, adding vastly to the sum of human misery. The rising expense of the Health Service and the growth of Common Law might between them force the orthodox medicine which we have at present into a dangerously rigid system.

Basic Principles

Three principles stand out to keep us straight.

1. The patient must remain free to choose his doctor and change him when he feels inclined. That principle has long been conceded, and is an integral part of the Act of Parliament on which the National Health Service is founded. It is Statute Law.

2. The doctor must be free to treat his patient as he thinks right, and feel confident that he will be upheld in court if, after all due consideration, he decides to withhold the textbook treatment for the textbook disease, thinking that under the circumstances it would serve no useful purpose or merely prolong suffering. This principle has not yet been established.

3. The nature of medical practice is such that the State must continue to control medical education indirectly through the General Medical Council and the medical schools of the universities, but they must not have direct power over methods of medical treatment. It must achieve economy by suasion rather than directives. It must continue to organize the medical services, but it must never command individual doctors. Under no circumstances must the growing power of medicine be handed over to committees or vested unfettered in the State.

Conclusion

After thirty-five years in medical practice I have attempted (I am afraid in a very muddled way) to paint a picture of a peculiarly difficult problem in human relationships—namely, the triangular one between the patient, the doctor, and the State. A perfect solution depends upon an agreed philosophy of life, but unfortunately that does not exist. Compromise is therefore essential. Now I must have said much with which you will not agree. I may have made statements which you positively dislike. You may think that I have painted the darker corners of medical practice in too sombre colours. But I have raised questions which must be faced. True that I have given you no answers to any of them, but I venture to hope that I have helped you toward a better understanding of the problems being raised by the power of medicine which, to adapt again Mr. Dunning's famous motion in the Commons, " has increased, is increasing and is likely to increase still further.

THE CANCER PATIENT: DELAY IN SEEKING ADVICE

BY

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Cancer of the breast, cervix uteri, skin, or mouth usually presents symptoms which a patient can recognize and for which early successful treatment is a practical possibility. Yet of 2,700 patients attending this hospital with cancer in these sites 45% had delayed consulting their doctor for three months or more, and 17% for a year or more, after the onset of symptoms. This article describes a study of factors which influence people with these cancers to delay seeking advice. The study is based on the interviewing of a series of 75 men and 239 women patients and their relatives, resident in Manchester, Salford, and Stockport, and attending this hospital. All the interviewing was carried out by one person (J.A.-S.).

Interpretation of facts obtained by these means is inevitably subjective. Sometimes more can be learned in a few minutes from a relative than from several interviews with the patient. Conclusions are not based, therefore, on the patient's statement alone, but on all the evidence available. In addition, 63 patients were tested by the Wechsler–Bellevue method of intelligence testing to ascertain the relationship between individual I.Q. and delay.

Early in the study it appeared evident that there were two clear-cut groups of patients: (1) those who " knew " they might have cancer, and (2) those who were genuinely ignorant of the possible significance of their symptoms. The mental processes of these two groups are entirely distinct. Nevertheless, it was sometimes far from easy to place individuals into the correct category, especially as those in the first group often tried to hide the truth. The degree of awareness of a symptom, and the extent to which people will consciously accept what they suspect to be the truth, are dependent on personal factors. Shands *et al.* (1951), describing three levels of knowing, say : " (1) A person may be in the possession of a number of facts that are not related to each other ; he may know, for instance, that ' a lump may be a cancer,' and ' I have a lump,' without arriving at the conclusion, ' I may have a cancer.' (2) He may have taken the initial step of the relationship but stops short of translating the insight into action. . . . (3) A third level of knowing is that characterized by the integration of the pertinent information into the behavioural patterns of the individual."

In the present study a patient is considered to have known if there is evidence that at any level she thought of cancer in relation to her symptoms before consulting a doctor. Patients who " knew " can be subdivided according to a characteristic positive or negative response—those in whom fear is the dominating factor, and those who fatalistically accept the situation and mean to do nothing. The former group may offer a series of superficial reasons for their delay, and some of these are discussed later. Basically, these patients are motivated by fear, and their actions, wise or unwise, represent response to fear. As will be seen, fear may result in immediate action, as it ought to, but more often it leads to an only half-conscious policy of concealment and appropriate rationalization. The latter group, usually older people, are well adjusted to the situation which they do not deny.

Where there is genuine ignorance clearly no such factors operate, and delay, if it occurs, represents a normal response to the problems of health and illness which would take place regardless of the type of disease. At this point it may be noted that if education masters ignorance it may only result in a transfer to the other category.

It appeared later that the fraction falling into the two categories of " knowing " and " not knowing " varied greatly with the type of cancer, category 1 being dominant for breast cancer and category 2 for cancer of the cervix, skin, and mouth. This is, of course, an important finding in regard to the placing of emphasis in any educational campaign.

The average length of delay and numbers delaying three months or more are significantly higher among patients who knew than among those who did not know. This is not to say that they necessarily all delayed because they knew. Naturally, delay is also influenced by the degree of inconvenience suffered. The figures may therefore also reflect the fact that, generally, cancer of the cervix and mouth present troublesome symptoms earlier than cancer of the breast or skin.

Table I sets out an analysis of the whole material divided with as great accuracy as possible on these lines for the four diseases under review. In 19 cases it was impossible to determine on the evidence available whether the patient " knew " or not.

Action Related to Ignorance

Where the first symptom was not a lump in the breast women with breast cancer were apt to mistake the possible significance of their symptoms. Enlargement or swelling of the breast, a lump in the axilla, or retraction of the nipple was genuinely attributed to old lactation difficulties, menopausal disturbances, or recurrence of previous complaints. Even where the first symptom was a lump, in some cases the history was long and the lump unchanging. In addition, some put off through apparent indifference about their symptoms. They did not think the condition important, and allowed it to drag on owing to pressure of other events, and possibly low health standards and a low level of intelligence.