

The art of medicine

What Archie Cochrane learnt from a single case

The 18th-century physician Marcus Herz held that case reports were the means by which doctors “write experience into the world”. In broad terms they record how the diverse phenomena of illness are made sense of medically and which treatments are tried. But the search for explanations can prove elusive and case reports instead may revolve around clinical uncertainty and irresolution. Although today’s case reports often follow standard approaches to medical problems, some feature novel situations that may confound readers’ expectations. Archie Cochrane’s account of a dying man at Elsterhorst, a German World War 2 prisoner of war camp, first appeared in his memoir *One Man’s Medicine*, published posthumously in 1989, and has since entered the medical literature:

“The Germans dumped a young Soviet prisoner in my ward late one night. The ward was full, so I put him in my room as he was moribund and screaming as I did not want to wake the ward. I examined him. He had obvious gross bilateral cavitation and a severe pleural rub. I thought the latter was the cause of the pain and the screaming. I had no morphia, just aspirin, which had no effect. I felt desperate. I knew very little Russian then and there was no one in the ward who did. I finally instinctively sat down on the bed and took him in my arms, and the screaming stopped almost at once. He died peacefully in my arms a few hours later. It was not the pleurisy that caused the screaming but loneliness. It was a wonderful education about the care of the dying. I was ashamed of my misdiagnosis and kept the story secret.”

This recollection, pungently told, recounts a specific turn of events that took place in 1943 in a large camp in Saxony, where Cochrane was the sole medical officer. The clinical scenario—“moribund and screaming” and “gross bilateral cavitation and a severe pleural rub”—is initially taken to support a causal claim: that the soldier’s distress was due to pain, pain caused by tuberculous pleurisy and lung disease for which Cochrane could offer no treatment. But as the case unfolds the facticity of this causal chain is thrown into doubt if not fully retracted, and a quite different claim is made: that it was loneliness (not pain) that was the cause of the man’s distress. The evidence that led Cochrane to this switch in explanatory account became apparent only when he took the soldier in his arms: “almost at once” (he tells us) the screaming stopped, suggesting the embrace transformed the soldier’s mental and emotional world and enabled him to feel calmer and pass away peacefully.

Cochrane’s felt experiences are especially noteworthy because these particular aspects of medical care are often muted in modern case reports. But here they emerge openly, nested in a memoir of the doctor-narrator’s life, in which Cochrane recounts his fortunate circumstances of

birth and education, how he became a prisoner of war, and later a physician-scientist teeming with ideas, questions, activism, and agency, a professor of tuberculosis and chest diseases at the Welsh National School of Medicine, and later director of the UK Medical Research Council’s epidemiology research unit in Cardiff. In his account of the soldier’s dying hours Cochrane is fully present, thinking, caring, resourceful, and unorthodox. Through his thoughts and feelings we sense his sense of urgency and something too of his resourcefulness and capacity to manoeuvre despite the lack of medical means.

Thoughts, feelings, and motives saturate clinical practice, but case reports tend to subordinate these aspects of the hurly burly of clinical experience to the goal of setting out findings, hypotheses, and knowledge claims; and the responsiveness and impulsivity that Cochrane showed in 1943 are often edited out; and where they do creep in it is more likely to be wonder and surprise that become apparent in response to clinical appearances than the raw shame, desperation, and tenderness that we see here. Perhaps publishing this case outside the confines of a specialist field of knowledge, undisciplined by its editorial and peer review practices, allowed Cochrane the space he needed to recall and resolve what had taken place between himself and the dying soldier. Patients who have died leave traces in medical practice. The “work of remembering and the time spent ordering, and living through memories...[of] those who have died” has been conceptualised by Arthur Kleinman as “a continuation of the caregiving...provided when they lived”.

A striking aspect of Cochrane’s account is its didactic closing statement that makes a large yet enigmatic claim that it “was a wonderful education about the care of the dying”. Which aspects of this man’s case did Cochrane find so educative? Had he extracted a useful general lesson from the singularity of these terrible circumstances such as that doctors would do well not to assume screaming is a response to somatic pain even when—as in these circumstances—the patient is suffering from a condition many people find very painful? Could he have concluded that when clinicians cannot communicate verbally the anxiety and loneliness patients feel can much too easily be imputed to pain, and that all three states—pain, anxiety, and loneliness—are eased by human reassurance, reassurance engendered through physical closeness? Did Cochrane conclude that the dramatic alteration in the man’s mental and behavioural state meant he had not been in severe pain in the first place? Cochrane was clearly impressed by how completely the process of dying in this soldier’s case was eased as a result of interpersonal recognition founded on human closeness, on “being with” at the end of life. Was the

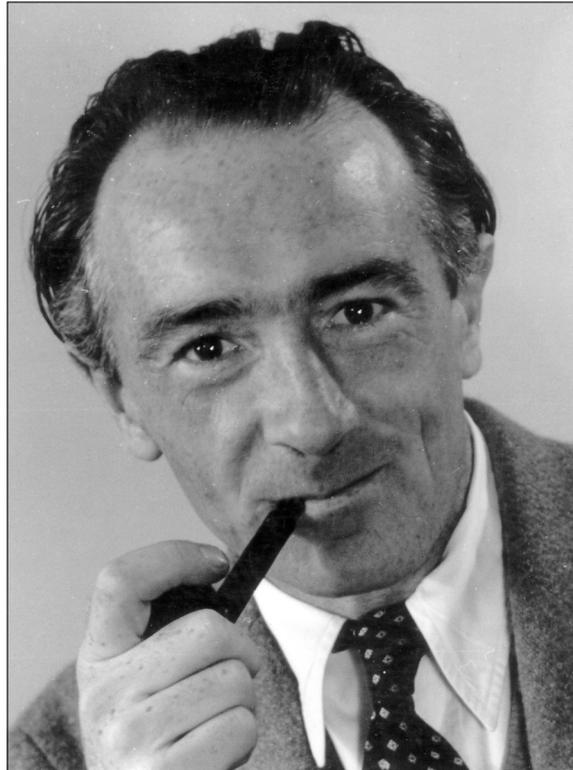
main lesson for Cochrane that instinctive responses, which here took the form of an embrace lasting hours, have a place in clinical practice?

The confessional quality of Cochrane's account is evident and goes beyond accepting responsibility for a delay in diagnosis. Cochrane referred (perhaps too severely) to having misdiagnosed the man and of feeling ashamed about this, which might have led him to suppress this encounter at the time. In 1945, he published a paper in the *BMJ* that reflectively and rigorously set out his experiences as the only doctor responsible for the medical care of thousands of prisoners of war, many of whom had tuberculosis and were severely malnourished, but made no reference to the death of the Soviet soldier. The appearance of the case 45 years later suggests Cochrane continued to ponder its meaning, recalling that "the... event...had a marked effect on me". The memoir provided him the opportunity to offer homage to the soldier, a form of reparation for his suffering, and Cochrane might have hoped publication would release him from the shame he seems to have harboured about the case.

But what was it that Cochrane felt ashamed about? Was it the "misdiagnosis"? Was it the fact that he had achieved the correct diagnosis not by a process of reasoning or by a recognised clinical method, but through a sense of his own desperation, which led him to his instinctive gesture towards the soldier; was his shame engendered by what Cochrane thought a misreading of another person's agony? Was it the sheer serendipity of this clinical epiphany that affronted this physician-scientist in the making? Or did Cochrane feel discomfort at the prospect of admitting that instinct and impulse had driven him into the arms of a patient—to a bodily closeness—at a time when this could have been interpreted as improper and a breach of professional etiquette and ethics?

We cannot be sure what the answers to these questions are, but their plurality alerts us to how much can be at stake in written accounts of clinical cases, how relationally and epistemologically entwined case reports can turn out to be, and how much of what they recount may be left unresolved. As Arthur Frank has shown, there is much more involved in the experience of illness than the medically told account of it. In his own illness memoir Frank writes of the commotion facing caregivers who are "confronted not with an ordered sequence of illness experiences, but with a stew of panic, uncertainty, fear, denial, and disorientation".

Cochrane's case has entered the medical literature as a spur to better pain relief in palliative care, but it is more than this; it brings to the fore uncertainties, ambiguities, and unexpected occurrences that can unfold in clinical work that give rise to feelings that are often muffled in official accounts. Case reports today offer accounts of clinical situations that feature dominant ostensive descriptions of what happened. But Cochrane's case provides a



Photograph by Albert Rinsler, from James Lind Library

Archie Cochrane (1909–88)

story containing another message resonant of human relationships: it asserts that some cases go beyond specific, scientific claims or counterclaims, paths not taken, riddles solved, and elegant solutions. His is an act of memory and reconstruction, an account of a dying soldier undertaken without the benefit of clinical notes, by someone unusually meticulous and rigorous in defining and thinking about medical problems. We have no reason to think it is not an accurate, textual embodiment of what happened and how it happened, which sets out the findings, thoughts, instinctive reactions, imperfect understanding, and the partial state of knowledge of a clinician caught unawares in circumstances of war. It can be read as a memorial text, as an act of reparation, an attempt at gaining some release from self-criticism, and as a small contribution to ethical witnessing and the cultural memory of suffering, recounted by a man whose subsequent professional achievements inspired critical scepticism towards the value of case reports. Cochrane's case records an act of brotherhood to another person. Not medical, just human.

Brian Hurwitz

Centre for the Humanities and Health, Department of English Language and Literature, King's College London, London WC2B 6LE, UK
brian.hurwitz@kcl.ac.uk

Further reading

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