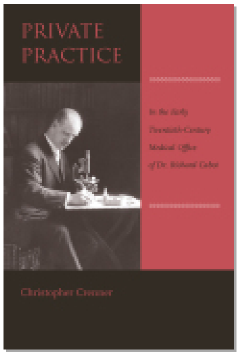
Chapter 4: Treatment



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CHAPTER 4

TREATMENT

How to Know What Works

What kinds of agreement could early twentieth-century physicians reach with their patients concerning treatment? And what inducements could they provide for patients to accept increasingly potent and risky therapies? Doctors long before Cabot had been accustomed to seek trust and support for their therapeutic plans in many sources, including local reputation, agreement on therapeutic mechanisms, established relationships with patients and families, and sustained attention over the course of an illness. But risky and potent treatment like aseptic surgery or chemotherapeutics more routinely raised the stakes in therapy. The patient who came to Cabot seeking the new treatment called Salvarsan, or 606 (chapter 3), was frustrated by her inability to find anyone to administer it to her. Cabot tried to explain that she did not need the medication, since she did not test positive for syphilis. But she continued her search. She went to another physician, who wrote to Cabot in exasperation after his first meeting with her, noting that "somehow the desire for 606 has fastened itself upon her and I fear that she will not be happy till she gets it."[1] Salvarsan was moderately toxic, and he feared that she might have the misfortune to find another physician who would indeed prescribe it. This patient's struggle over access to the medication pointed to certain anxieties about therapeutics that were becoming more familiar to Cabot and his colleagues in the early twentieth century. Patients might eagerly seek special new treatments, but what basis did they have for judging their appropriateness or their effects? Since medicines like 606 were potentially dangerous, the doctor's influence over their use might entail heavier responsibilities and more stringent criteria for treatment.

Physicians increasingly sought to confirm the effects of therapy through specialized techniques of physiological monitoring, making the patient's immediate experience of treatment seem more incidental. As doctors adopted powerful new disease-modifying treatments, they took to gently criticizing traditional treatments that they felt were "merely symptomatic"—as the writer on "Therapeutics" in the 11th edition of the *Encyclopedia Britannica* put it. How would physicians conscript patients into treatment that was assessed and adjusted, not according to symptoms, but according to hidden markers for disease? Such physiologically guided therapeutics seemed to demand new reassurances from the treating doctor. One hope among the innovative physicians like Cabot who urged these changes was that the demonstrable power of these treatments would bolster the authority to guide them. Sustained cures would mean happy and compliant patients. In many cases, however, these medications made only transient or partial improvements in how the patient felt. Cabot and many of his peers began to offer the evidence of therapeutic monitoring itself as a reassurance and confirmation about the value of treatment. Testing to monitor and assess the course of a disease under treatment became one means of demonstrating to the patient the effectiveness of medications or procedures whose therapeutic benefits might otherwise seem ambiguous or slow to arrive.

Among Cabot's patients, a parallel set of concerns was emerging. What did it mean to get better from a treatment? With growing public information about miraculous treatments like diphtheria antitoxin and 606, how did a person know which treatment was the right one? There were so many new therapies and therapists to choose from in a growing health-care marketplace. What constituted adequate evidence that a treatment indeed worked? Just feeling better seemed at times inadequate proof of effective treatment, just as feeling worse was judged compatible, at least at first, with therapeutic success. As one young man wrote to Cabot describing the outcome of his surgery, "the operation itself was a success," he reported, "but I have never recovered from the check to my nervous system."[2] He identified a significant difference between the medical success of the "operation itself" and his mixed experience of treatment and recovery. Rather than discounting his acceptance of a medical definition of success as simple pandering, we might inquire further how he, and others, used medical definitions of success—even as they registered the incompleteness of these medical answers to the challenges of getting better.

Symptomatic and Physiologic Therapy

Therapeutics in the late nineteenth and early twentieth century began to seek a strange forbearance from patients. It was not that medical treatments were becoming more unpleasant or noxious, although Cabot's patients did describe some difficult experiences of care. Nineteenth-century physicians had similarly asked patients to endure some very taxing treatments on occasion, especially when the medical condition was itself severe. But a gap opened toward the end of the nineteenth century between a patient's experience of medical treatment and the treatment's intended effects. The targets sought out by newer twentieth-century therapeutics often had little connection to their immediately perceptible effects. Cabot wrote of a patient with pernicious anemia in 1912 (chapter 1) that "when his red [blood] cells begin to fall, that fall can be retarded by giving Fowler's Solution beginning with two drops after each meal and increasing up to the limit of toleration, that is until nausea and diarrhea . . . are produced."[3] Fowler's Solution aimed to retard the fall in the count of red blood cells and only incidentally had the effect of making this man feel nauseous. The ultimate goal, of course, was to treat his illness, the pernicious anemia. Yet Cabot and the physician to whom he wrote were willing to relegate the patient's immediate experience of the treatment to the role of an unpleasant but medically incidental nuisance. The perceptible effect of nausea was unrelated to the drug's true therapeutic action. In contrast, a delay in the predicted fall in the count of red blood cells was almost by definition undetectable for the patient. Patients and doctors earlier in the nineteenth century had indeed dealt with some troublesome effects from therapies. Quinine, a mainstay of nineteenth-century therapeutics among Cabot's predecessors, was known to cause a disturbing ringing in the ears in doses large enough to suppress fever, for example.[4] The twentieth century, however, marked the deployment of a therapeutic rationale in which perceptible effects were sharply distinguished from therapeutic actions, and where therapeutic effects might only be evident through specialized physiological monitoring.

Medical therapy had chosen targets deep within the body that were suddenly made visible by technical means. The idea of guiding treatment according to the medical understanding of bodily function had ancient roots in medical theory. What changed late in the nineteenth century was the availability of routine methods for extracting information about physiological effects: with blood counts and hemoglobinometry, chemical urinalysis, microscopy, serology, and x-rays. One attraction of physiological monitoring may have been a kind of hermeneutics that it provided—by revealing in laboratory results the otherwise hidden significance of a medical treatment. But physiological therapeutics also had a compelling simplicity to their rationale. Count the number of red blood cells and determine if it rose or fell with treatment. Any subtleties or difficulties with this effort could be attributed to the monitoring practice: gathering an adequate sample of blood, identifying red cells, and partitioning and counting them. The application of the information to treatment then seemed obvious, at least in general outline. It was a rationale that appealed not only to Cabot and his peers but to some of their patients as well.

Many of Cabot's treatments were medicinal; he gave pills and tonics. But his therapeutics was likely influenced by the success of his surgical colleagues. In surgery, the commonsense justifications for therapy often had to overwhelm a patient's immediate cautions and speculations about the nature of therapeutic effects. Removing the diseased part made sense at some basic level, despite the accompanying terrors of cutting and sewing. Abdominal surgery was a particularly decisive case, in which the internal defect was both made visible and corrected through a single dramatic procedure. Chapter 1 noted how, in 1910, Hugh Cabot showed a mother her son's appendix, which he had just excised in an adjacent room, on a napkin.[5] Physicians might need only share such surgical evidences rarely before developing a sturdy confidence in their ability to gain approval for treatment. This confidence in the evidence of therapeutic assessment and monitoring was neatly evident in the correspondence among Cabot's peers relating to both medicinal treatments and surgery.

Drug therapy increasingly sought to produce interior changes in a patient's body that were as concrete as surgical effects. Dr. Sarah Bond in 1915 summed up to Cabot her treatment of a patient's anemia in a brief letter. This patient's hemoglobin, she indicated, measured "about 50% and it has not improved under iron and arsenic which she [her patient] has been taking for several weeks."[6] Dr. Bond communicated nothing more to Cabot about the state of her patient beyond the measurements of the hemoglobin, a constituent of the blood visualized with a tool called a hemoglobinometer. She was not alone in placing such weight on a simple technical measure of therapeutic progress. Another physician wrote to Cabot saying of his patient that "his symptoms have all been objective" and describing those symptoms—the disordered microscopic and chemical characteristics of the man's urine—in detail. This doctor went on to describe various medical treatments that he had tried, concluding with the report that the treatments had "acted favorably on the renal lesion," as evidenced by the improving microscopic quality of the urine.[7] Testing and assessment of red cells, hemoglobin, or urinary constituents provided a persuasive material reality for the internal targets of therapy, at least among physicians. This form of professional agreement about markers of therapeutic success was a distinct change from the concerns of mid-nineteenth-century medicine.

Attention to the criteria of physiological therapy displaced the nineteenth-century reliance on the experiences of patients in assessing treatment. The change was evident to physicians who lived through it. Writing about physiological therapeutics in 1902, the prominent American physician Nathan Davis recalled how in the nineteenth century, "the effects of remedial agents were determined by their visible influences on the various evacuations and on the sensations of the patient."[8] He contrasted this older mode of treatment with more modern efforts to monitor and assess treatments through their measured physiologic effects. Nineteenth-century therapy with mercury, belladonna, skin plasters, alcohol, morphine, lobelia, or bloodletting was intended to alter the pulse, trigger purging or vomiting, calm the nerves and pain, draw blood to the skin, dry up or augment the saliva, or increase urination. These obvious changes in "the various evacuations and . . . sensations of the patient" were the sought-after healing effects of the treatments. The ability to adjust medications to create these desired bodily effects in a patient was the essence of treatment.[9]

Therapeutic Monitoring and the Patient-Doctor Relationship

Physiological therapeutics established, and required, a greater asymmetry between the twentieth-century therapist and patient. Nineteenth-century treatment gave the patient greater control over therapeutic evidence, because a doctor had to seek any confirmation in the report of sensations and bodily responses. Feeling better was never the sole prescribed route to getting better, of course; but how a patient felt still mattered first and foremost. Patients in the nineteenth century sometimes endured long courses of bloodletting and dosing with mercury that were fully as vexing as anything recommended by the twentieth-century physician. Nor were nineteenth-century therapeutics lacking in the theoretical complexities that obscured the rationale of the physician's craft. Nineteenth-century treatment relied on theoretical knowledge about disease processes and bodily reactions wholly as subtle and variegated as anything cited in physiological therapeutics. Control over the levels and flux of urine, saliva, blood, bowel movements, or bile through the body aimed to reestablish the obscure internal balance of flows and pressures that was upset by different diseases. Nineteenth-century physicians claimed a special expertise in recognizing and correcting these imbalances. Yet the arduous path of nineteenth-century treatment remained more overtly intelligible and perceptible to the patient who traveled it.

By contrast, new criteria for physiological testing posed obvious challenges for the prescribing physician. Early twentieth-century supporters of physiological therapy expressed concern about the implications for their therapeutic relationships with patients. Powerful new medicines that struck effectively at disease might draw patients to the physician's side. But since feeling better was not necessarily or immediately related to real therapeutic effects, the negotiation of ongoing treatment could be problematic. Consider again the treatment of syphilis with the powerful medication 606, or Salvarsan, which Cabot's patient had unsuccessfully sought from him. Charles Whitney, a medical colleague of Cabot's in Boston, speculated in an essay in 1916 that the effectiveness of a drug like 606 for syphilis undermined the doctor's control over treatment, rather than enhancing it.[10] In the early stages of syphilis, the initial dose of 606 sometimes produced rapid, superficial improvements in a patient's syphilitic sores and swellings. These improvements were, however, deceptive. The microscopic syphilitic organisms advanced more quietly after a single, partial treatment, and physicians found that they were "not always able to convince the patient that he needs further treatment and he drifts away feeling assured that he is as well as ever."[11] Before the discovery of Salvarsan, Whitney recalled, a typical patient being treated with established medications like mercury and antimony more readily offered "diligent and faithful cooperation," understanding that "a cure required a long course of treatment faithfully followed." Salvarsan provided falsely reassuring results that undermined the ability to guide patients through a complete treatment.[12] Feeling better was not accurate evidence of therapeutic effect. Whitney cited his own practical experience to argue that such treatments offered no easy leverage to the doctor seeking to influence a patient's acceptance of a course of treatment.

Other physicians of the time spied a solution to this problem within the process of physiological monitoring itself. Assessment and monitoring of disease could become part of the process of securing ongoing cooperation with treatment. Promoting such new therapeutic norms in 1912, George Dock advised that patients had to be "taught that the remedy prescribed is only part of the treatment, [and] that trained intelligence must accompany them until well."[13] Physiological monitoring represented to Dock an ideal means to control the process of therapy through continued "observation and examination under treatment." Since the physician could now, for example, "see the pathologic changes in the blood being treated," it was no longer acceptable, he warned, to send a patient off with a medicine and the simple advice "to return if he does not get better."[14] Trained intelligence, as Dock put it, must accompany them through the process. Control of treatment required control also over the assessment of its effects. A doctor who left the patient to decide independently about the results had failed in an important professional duty, since there was, Dock contended, "no real difference between this and the self-medication based on newspaper advertisements or druggist's posters."[15] A patient could not easily be stopped from purchasing one or another fashionable remedy from the local druggist to see if it worked; but someone who came to the physician for care should expect to be tested as a way of following and confirming the treatments. Seeming to take Dock's lead, Charles Whitney held out a similar solution to the problem of controlling treatments with Salvarsan. The blood test for syphilis, Whitney argued, "is of the greatest value to us in verifying the results of our treatment, and especially in showing the patients . . . that the disease is still present" when they resisted further treatment.[16] A blood test, like an appendix on a napkin, showed both the hidden target of the treatment and its demonstrable therapeutic effects.

Physicians in the early twentieth century were beginning to gain the ability to control a patients' access to medications through their individual prescribing practices. But with few exceptions, any identifiable medicine that was available from the doctor was available elsewhere, as well as a wide array of substitutes. Physicians faced competition from many sides, from alternate purveyors of conventional treatments, from alternate purveyors of unconventional medicines, and from their own inability to enforce the distinctions between them. The question of who got medicine, and how, had practical significance for every physician in private practice. It was not surprising then that the early twentieth-century medical literature tended to characterize patients who came seeking treatment as rather crude consumers in need of careful professional oversight. In essays and editorials about therapeutics, Cabot's colleagues tended to present a consistent image of the typically fickle customer for treatment. Writing about practice, they noted the challenge of a public that "was anxious for a quick, sure, and easy cure."[17] Patients were seen as liable to make shallowly informed choices about their care. They searched indiscriminately for cures, valued treatments only according to their immediate effects, and offered no loyalty to anything that failed these tests. The pressure to treat the immediate symptoms of the disease, Dr. Albert Geyser complained in 1916, came from the patient, who "expects results cheaply and quickly and if it is not forthcoming from one doctor then the patient tries another . . . [since] nothing but visible, immediate results count."[18] In contrast, as Whitney had noted in regard to syphilis, patients who saw quick, superficial results were then wont to drop all treatment, since "seeing nothing they fear nothing and are therefore unwilling to be called sick."[19] They needed to learn that the physician's monitoring of treatment provided the only sure answers about effect.

Patients as Fickle Consumers

The shortcomings of the average patient had long been a theme in medicine's professional orations and essays. Airing these concerns obviously served solidarity among doctors, emphasizing a shared challenge in applying their expertise, rather than their disparate obligations to their many clients.[20] But this critique of the fickle patient held special relevance for Cabot and other physicians concerned about the management of physiological therapy.

A marvelous heterogeneity of therapeutic practices and products greeted the person who was looking for care around New England in the first decades of the twentieth century. Patients who wrote to Cabot recounted their experiences with a great variety of resources and only rarely expressed any frustration in getting specific therapies that they sought. In this respect, the woman who was seeking 606 was a rare exception. Patients described many treatments offered to them by Cabot's conventional medical peers and their competitors. Although they reported on occasion no more than that they had received "Medicine" or a vague "treatment," they also named specific therapies, ranging from "the use of x-ray" to "forty tablets of 'Erythrol tetranitrate' " to "an operation (laparotomy) at the Boston City Hospital."[21] In addition, patients told of finding their way to mind-cure treatment, "an osteopathic treatment every week," homeopathists, an "herb doctor," and Christian Science healers.[22] They also described their own experiments with static electricity, "an electrical instrument called the 'Neurotone,' " Warner's Self-Cure, and yogurt capsules.[23] Many things were available in this market for treatment. Patients faced complicated choices, and those who had the requisite resources could move from treatment to treatment in search of a durable fix. The man who wrote saying that he was taking yogurt capsules also told Cabot that he had gotten a prescription for a medicine from one of his neighbors, presumably another Back Bay practitioner. In addition, he wanted to know if there was "anything new under the sun" that Cabot could prescribe, and requested further whether there was likely to be "any virtue in Goat lymph?"[24] It was difficult to know whether the next treatment offered the key to lasting relief.

Popular demand for treatment, of course, offered a reasonable means of recruiting patients to an office like Cabot's, but only if the patient's quest could be captured and channeled onto conventional paths. According to the professional ideals of the day, physicians would undertake to provide stable, ongoing exchanges and responsibilities in treatment, rather than the simple remittance of a box of pills on request—although this kind of reflex prescribing seems to have been sufficiently common to warrant frequent parody in the medical literature of the day. The literature was as critical of the physician who merely prescribed on request as it was of the patient who merely requested. The notion that treatments like goat lymph, the Neurotone, or erythrol tetranitrate might be available simply for the asking chafed against the values of professional control. Physicians' complaints about their restless consumers asserted a desire to control therapy and a parallel concern about an open market for treatment that could undermine this control. We can see the American medical profession's struggles against this market being played out in the early twentieth-century campaigns against commercial, proprietary medications.[25] Physicians pressed their colleagues and the public to empower them to establish sharp distinctions between Salvarsan and Warner's Self-Cure, or between the mail-order "Neurotone" and the surgical laparotomy, and to control access to the therapies that they endorsed more tightly.

These anxieties played out with special fervor in the debates of the day over physiological therapy, and monitoring seemed at least a partial solution. Albert Geyser, in his warning about the patient "who expects results quickly and cheaply," contrasted the quick relief that patients sought with the "physiologic treatment" that physicians should properly apply. The opposite of physiological treatment in Geyser's account was "symptomatic treatment," the unreflective remediation of symptoms.[26] The establishment of physiological parameters like measured hemoglobin or urinary chemical constituents as proper criteria for therapy left doctors with an uncomfortable question: "[W]hat is a symptom and to what extent is symptomatic treatment rational or permissible?"[27] Treating symptoms might be necessary for a humane practice or to cultivate the cooperation of patients, but the stronger professional endorsement of physiological goals sometimes lent an apologetic tone to this discussion. One physician said that he was "compelled to rely largely upon what for want of a better name we term symptomatic treatment; and up to a certain point and within certain limits this is an essential factor in successful practice."[28] Practice required the ability to provide treatment and the largest part of the traditional pharmacopoeia of the early twentieth century still offered medications like soporifics, anodynes, and stimulants that were known, as the categories themselves implied, primarily for their effects on perceptible bodily function. A reliance on the treatment of symptoms was part of the well-established legacy of nineteenth-century practice, and while this reliance could be displaced, it could not be casually ignored.

What the twentieth-century physician needed in part was a new justification for symptomatic therapeutics. One such defense aimed curiously to free it from the suspicion that it simply appeased demanding patients—the fickle consumers of medical services. Occasionally, doctors defended "the immediate relief conferred" in treating symptoms as simple compassion.[29]

After all, a practically minded editorialist in the journal *American Medicine* noted in 1903, "the patient does not come to us to pay for our theories and diagnoses, but to be made well."[30] Yet such accommodation risked pandering to the unexamined requests of patients. Other physicians pointed to a deeper rationale for symptomatic treatment, emphasizing that the fundamental aim was not merely to palliate disturbing symptoms. Cabot added a minor voice to this chorus, arguing that treating symptoms was warranted, because it was likely to improve a patient's own physiological responses to disease.[31] Physicians need not feel defensive about treating symptoms, since they were actually "supporting, opposing, imitating or altering the natural bodily responses to disease"[32]—although in practice they ended up simply dealing with the most obvious bodily responses, that is, the symptoms. So a cough, Cabot explained, should be suppressed well enough to keep it from interfering with recuperative rest and nutrition, but not so much that it ceased to expel diseased material from the lung. Palliating a symptom was acceptable, but not as an end in itself. A similarly apologetic tone also intruded on the discussion of placebo medications in this period, a debate that involved Cabot as a central figure, as I shall describe later. The literature on placebos similarly portrayed patients as crude consumers challenging the doctor's ability to exert appropriate control over therapeutics.

A change in the contents of the doctor's black bag seemed to call for new norms to guide treatment. Physiological therapeutics picked out interior targets for medical therapy in a manner that made a previous reliance on the patient's perception of therapy seem less legitimate. Hobart Hare in his 1898 textbook on practical therapeutics described the campaign for therapeutic progress in colorful terms, advising that "the old-fashioned 'shot-gun' prescription containing many ingredients . . . should be supplanted by the small-calibre rifle-ball sent with directness at the condition." This metaphor was compelling enough to find wide use, being repeated almost word for word in Wallace Abbot's article "Plea for a Truer Therapy" in 1903.[33] The metaphor served simultaneously in several capacities. New medical treatments seemed to these observers more exact and more potent. No longer would doctors spray mixtures of medications at a problem, judging their results by the obvious changes that they made in a patient's bodily evacuations or sensations. Modern medical treatments, like the rifle bullet, were precisely aimed and deadly, although their targets were not always superficially evident to the patient. What should a doctor expect of patients in targeting obscure internal processes and diseases? Physicians schooled in medicine's ancient literate traditions could quote from their Hippocrates the ideal that "the patient ought to side with the doctor against the disease."[34] In a new twist, however, twentieth-century physicians seemed to be asking that the patient should just hold very still to let the doctor get off a better shot at the disease. Physicians had to consider how to cultivate this kind of cooperation among the people who came to them seeking treatment.

Prognosis as a Means to Cooperation

Many of the existing means for gaining therapeutic influence over patients were unrelated to physiological monitoring, although not necessarily incompatible with it. For a purist like Cabot, however, certain common means for encouraging cooperation with treatment seemed to undermine a reliance on monitoring. He graciously documented common practices of therapeutic persuasion among his colleagues, even as he rejected them. One widespread means for gaining influence was through prognostication about the course of a disease. The art of medical prognosis had a long history as a valuable service of the physician.[35] Yet physicians did not draw sharp distinctions between the goals of prognosis and the goals of treatment. Physicians used their statements about prognosis as support for therapeutic plans. The prognosis could, for example, be given in different versions to patient and to family, as a means of creating alliances to support treatment plans. Doctors, in fact, portrayed the use of prognostic statements as itself a form of treatment. These uses of prognosis as a support for, and an extension of, therapy are evident in the correspondence among Cabot's peers.

Writing confidentially to Cabot in 1912, a physician from Maine endorsed the idea that statements about his patient's condition were a crucial tool in managing treatment. In a letter referring the patient to Cabot's office, he filled in the background on what he had already said concerning prognosis: "I have simply told him that he had some trouble with his heart and kidneys." The doctor had softened his description of a condition that he actually thought was very grave. His patient was growing sicker, and it might be appropriate for Cabot to give him some additional warnings during his visit, he explained. The Maine doctor advised tact in this process, however. “I think it is just as well to let him down just as easy as we can,” he continued to Cabot, “but tell what you think best in order that he may be better able to follow your instructions.”[36] The goal was not to lay out the most accurate prognosis, but to phrase the medical opinion in a way that would enhance cooperation. Conveying just the right impression about the course of the disease might enable Cabot to gain compliance with his “instructions,” and so greater therapeutic influence. Prognosis and therapy were mutually dependent actions.

It required a nuanced touch to achieve the right balance of prognostic impressions. While a sufficiently threatening condition might motivate a patient’s careful attention to advice, too overwhelming a threat would inspire only resignation and retreat. Cabot’s colleagues sometimes sought his assistance in achieving this desired balance. Dr. G. S. Foster wrote from Manchester, New Hampshire, in 1914 about his patient, a banker in his fifties, who suffered from the late stages of pernicious anemia. Foster was concerned that the banker was still hard at work, “settling some important estates etc,” while his condition really required “to have him fully at rest both morally and physically.” He was sending his patient down to Cabot’s office for further advice. Perhaps, he suggested, Cabot could better convey to the man the seriousness of his problems in order “to make him feel that he cannot longer attend to these duties in any way.” A proper warning might prompt the desired therapeutic change in behavior. Still, Dr. Foster worried that his patient was “failing very rapidly. “ It would be important, he also advised, not to rob this man of the hope necessary to inspire continued attention to his health, so “we must withhold the hard truth.”[37] A properly balanced prognosis about the disease would encourage the patient to make a therapeutic withdrawal from his business without abandoning further effort at appropriate care. The prognosis itself might in this way provide a therapeutic benefit.

These strategies for representing the disease to the patient were not a professional secret wielded unilaterally by physicians. The family of a patient often became allies and even accomplices in this process. The dynamics of disclosure about disease were evident to people who wrote to Cabot about the problem of cooperation with treatment. The relative or spouse who wished to inspire a sick person’s commitment to therapy sometimes suggested collaboration with the doctor. Seeking to encourage his wife's willingness to treat her diabetes, one husband wrote asking Cabot to be prudent in discussing her prognosis. He explained that she had already been cautioned that she was "*threatened* with it [diabetes] and that she must be very careful of her diet." He was sure that by neglecting her diabetes, she was "acting in a way that will cause serious results." So cooperation with treatment was vital. However, she certainly should *not* know that she already had diabetes, because "if she had been told this it would have been fatal—it was hope that encouraged her to make an attempt to get strong."[38] This man also sought that delicate balance of a prognosis serious enough to inspire effort but not so grave as to instill despair.

Prognosis and Family Allies

Physicians in private practice had been accustomed to draw patients into treatment in part through the creation of such strategic alliances, not only against the disease, but also with the family and caretakers. The ability to influence adherence to treatment was the foundation of private practice. Most of the doctor's therapies in domestic settings were, after all, no more than injunctions to be carried out by others, to take an elixir, to alter the diet, or to monitor and respond with appropriate treatments. Doctors found their strongest allies in a patient's home, among the family who provided care and stayed with the person who was sick. This cooperation of the family might even serve better in some instances than the cooperation of the patient. "Better to leave your directions about medicine, food, etc., with the nurse, or whoever may be in charge, rather than the patient," advised one nineteenth-century physician discussing the management of the home visit.[39]

Cabot's colleagues tended to create complex alliances with family members around prognosis, giving differently weighted reports to patients and to their kin. A letter from a physician to a patient's brother, who forwarded it to Cabot, reported "a well established kidney degeneration I am sorry to say," while at the same time assuring the brother that the physician had not alarmed the patient himself "by laying too much stress on the kidney condition."[40] Physician and family should cooperate in controlling the patient's impressions about the disease. There seems to have been no one standard practice for disclosing dismaying opinions, and many of these communications display signs of improvisation. One of Cabot's patients reported having openly discussed the fact "that my trouble was positively fatal" with her physician, for example.[41] But an alliance with the family to protect the patient from bad news seems in general to have been desired, if not assumed. One woman wrote in 1914 asking whether Cabot suspected cancer in her husband, saying, "naturally we much rather he would not know."[42]

These practices in managing prognostic information imply certain assumptions about therapeutic influence, which are highlighted by Cabot's own opposition to them. Although he made important exceptions in his private practice, Cabot vigorously protested in general against withholding or manipulating diagnostic and prognostic information, and he actively undermined this practice among his peers on occasion.[43] His concerns about the legitimate basis of medical influence may have made him wary of manipulating information about disease. He often responded in a guarded way to the suggestion by other physicians that prognosis be used for therapeutic ends. The personal physician of one patient on whom Cabot had been consulted wrote hoping to inspire Cabot to make further efforts to stop this man's drinking. He asked Cabot "to bring upon [the patient] your influence in an endeavor to stop him from using alcoholic drink" by, for example, "explain[ing] the possibility of cirrhosis of the liver in cases addicted to alcoholic stimulation with a tendency to gout," and so forth. Cabot immediately penned a letter to this man about his drinking, ignoring the suggestion about cirrhosis and gout, since he had not diagnosed and did not prognosticate these diseases in this particular patient. Cabot also carefully disclosed in his letter that he was writing at the encouragement of the man's personal physician. After outlining some recurrent troubles with the pancreas that he thought might actually be a result of drinking, he explained that total abstention from alcohol was part of the treatment. Yet he allowed that "you may well think that the cure is worse than the disease. That's your business not mine. My only duty is to state the facts as clearly & honestly as I can."[44] Cabot felt a responsibility for the accuracy of information about disease that ruled out certain indirect therapeutic uses. He tended to be blunt in communicating news to his patients. Writing to a woman whom he diagnosed with circulatory problems, he reported, "I fear that it may trouble you somewhat for a good many years and I fear that medicine can give only partial relief."[45] His bluntness in diagnosis and prognosis was a source of harsh collegial criticism for Cabot, as he seemed to reject the valuable use of such information as a means of gaining the patient's cooperation.

For Cabot, the doctor's ability to identify and control disease was the primary justification for medical influence. Distorting or obscuring this information, even at the behest of the family, represented a breach of duty. While Cabot's call for physicians to be scrupulously honest in disclosing medical opinions still draws regular notice in present-day discussions, his efforts seem not to have affected actual contemporary practice much, although he did find a few medical allies in his day.[46] Despite the general opposition, his main argument seems incontrovertible, namely, that such deceptions would naturally become evident to the public, especially since they often relied on the collaboration of family members. A reputation for deception, Cabot sensibly maintained, tended to undermine the profession's broader credibility and authority. In essence, he argued that when doctors gave blatantly differing information to patients and to their families, they precluded recruiting the family as wholly trusting patients in the future.

Despite its pat logic, this argument found little support among Cabot's peers, who were reluctant to give up a practice that brought them valuable allies. They were, on the contrary, diligent in tallying up the bad effects that Cabot's policy of candid disclosure had on the patients exposed to it. The eminent cardiologist Paul Dudley White, who later became Cabot's own doctor, recalled the distress that Cabot's frank reports created among the patients whom they jointly cared for in the hospital, recounting how he had often had to return to calm and reassure patients whom his colleague had left alarmed by freely dispensed bad news.[47] Cabot's own brother Hugh was the source of a widely known story seeming to expose the foolishness of the former's frankness. Cabot, as Hugh told it, had found a suspicious growth on the cervix of a patient who consulted him and gave his patient to understand that she likely had a fatal cervical cancer. The woman reportedly left his office to quit her high-level job in order to prepare for her imminent death. She went next, however, to Hugh who was able to demonstrate through a surgical biopsy that the growth was actually harmless. Hugh reportedly never let his brother forget this, not so much for having been wrong, as for having been so painfully honest about his mistaken diagnosis.[48]

Tailoring a medical prognosis to support therapeutic advice was one means of gaining influence over patients, whose families were often willing partners in an effort to influence them through the careful management of prognostic information. In an office clinic like Cabot's, however, the traditional allies among family members might suddenly be absent. Inside the hospital, it was clearly the nurses who took over as allies of the physician's therapeutic control. The reorganization of the twentieth-century hospital and the creation of professional nursing only made these alliances stronger. A patient was likely to come to a medical office alone, however, without a companion or caretaker. An agreement about treatment had traditionally been struck with the patient, of course, but in the office, the patient became a more exclusive negotiator. Cabot's patients demonstrated an involvement with new forms of therapeutic influence based more on assessing and monitoring disease than on managing prognoses.

How to Know What Works

From the perspective of the person who was sick, the task of getting better could be perplexing. What evidence did one necessarily have either of the progress of health or of the effects of therapy? It was possible, of course, to reason based on how one felt and the nature of one's symptoms, especially in negotiating with one's physician. "I think that every thing is alright now as I don't feel them pains anymore," a Boston tailor wrote to Cabot in 1908, for example.[49] Another man sent a letter noting that he was coughing less, with less expectoration, and found that he was gaining weight; and so, he asked: "Question No. 1. Am I making progress?"[50] Some changes wrought by a therapy were conveniently evident to the eyes of the independent observer. One woman wrote that another doctor had recently "given me a remedy that has benefited me greatly and completely changed my color."[51] A change in complexion was the kind of evidence that other people could witness and confirm. A man who took Cabot's prescription for nitroglycerine reported that although he still had the same pains in his chest, "people that meet me say that I am looking a great deal better now" and that must count for something.[52] All sorts of evidence might confirm the benefits yielded by medical treatment. Yet patients still expressed apprehension about the gaps that arose between their physical appearance, what they felt, and the deeper alterations in health that they should perhaps be aiming for.

In the quest for therapy, such ambiguities made for difficult choices. The effort to get the right care could, for example, create difficult spirals, requiring people to continually adjust their treatments and assess the results. "[H]ow long should I take these drops?" an elderly man wanted to know. "I continue taking the 10 drops of medicine you prescribed for me three times a day." Although some of his troubles had subsided, he noticed that a new, disturbing symptom had arisen. Was this a sign of a new ailment, a new manifestation of the old condition, or simply "owing to the drops?"[53] It seemed difficult to be sure whether the medicine was slowly making him better or just substituting one trouble for another. Having received an apparently helpful remedy from Cabot, another man wrote back, still with some hesitancy, stating that after the treatment, "I was apparently as well as ever and do not know that I have ever felt any of the old symptoms." He seemed to be better but he expressed some uncertainty about the accuracy of his judgment on this matter. "I have just finished the 45 drops in the medicine which I have been taking," a stenographer wrote in 1912. "On the whole I think I am feeling somewhat better as I do not have the pain or pressure around my heart all of the time but after I work a little while it seems to come back."[54] Perhaps these patients were simply deferring to their physician by not overstepping their right to assess their own state of health. But they may also have been unsure about their ability to discern true improvement under medical treatments, or about what in fact constituted the best criteria for such progress.

Some patients, like the man who wrote to inquire about goat lymph and the woman who wanted to be treated with 606, hinted that their physicians should merely supply whatever it was that they deemed useful. Others adopted the passive role implied in a physiological therapeutics that relied exclusively on objective, measurable effects to guide treatment, in essence saying, "I shall do as you recommend."[55] Most people, however, seemed to accept a subtler and more involved relationship with their doctor. Even a gesture of unquestioning cooperation might serve more as a bargaining chip than a binding commitment. "I eagerly wait your prescribed regimen, which I suppose you will plan for me," one woman wrote. "I shall try to be faithful in carrying it out."[56] Her offer, which on the face of it looks like a promise of simple compliance, was in fact part of more extended negotiations in contracting for medical advice. The offer to carry out medical advice was an effort in soliciting sustained therapeutic counsel that she seems to have made before. She arrived in Cabot's office having already seen another physician, Dr. Agnes Victor, for the same set of problems. Dr. Victor had written to Cabot about her to complain that she "did not follow instructions for any length of time and after two weeks she did not return until December when she reported that she felt much worse in every way."[57] So her offer to follow the regimen Cabot prescribed was likely contingent on what happened next in this new therapeutic relationship.

The treatments that were available to these patients had both attractions and hazards that were vividly apparent from the very first days of Cabot's practice. After treating a young woman who came to him in 1898 with pain during urination, Cabot was able to celebrate in his office chart what he called a "brilliant therapeutic result." Prescribing ten grains of a chemical called urotrophine for her to take three times a day, he noted in her chart on a next visit that her problems had "gradually decreased" and the "urine (in about 5 days) cleared," with confirmation obtained by the repeated microscopic examination of her urine.[58] Similar therapeutic satisfactions were evident to another physician who wrote to Cabot in 1919 pleased about results for a man that he had treated for "streptococci [bacteria] growing in his blood." "I gave him mercury bichloride intravenously and he promptly fully recovered," the doctor announced, concluding with the definitive evidence that "his blood was sterile on culture."[59] In these brief success stories, Cabot and his peers sketched the outline of a powerful therapeutics. People with clearly defined disturbances in the blood or urine received exact chemical treatments followed by physiological testing to confirm the effects. If Cabot and his colleagues hoped to deploy this simple logic to recruit the support of their patients in daily practice, however, they faced several significant obstacles. Uncomplicated cures and immediate relief were rare. The same woman whom he had cured of urinary troubles returned to Cabot's office the next year with the same troubles. She was treated again with urotrophine, and the result noted in the chart this time was: "miscarriage and transfer to Camb[ridge] MD."[60] A treatment that seemed demonstrably effective against disease might have other distressing consequences.

These treatments were often highly potent and alluring in their promise, but equally dangerous and difficult to apply. Many novel treatments were emerging from the pharmaceutical laboratory and the surgical theater that, in the words of the New York physician Samuel Meltzer, "enabled us in some instances to grapple with the disease itself,"[61] a struggle that the patient at least might consider with a certain ambivalence. The example that Meltzer found close at hand in 1911 would become a familiar one for Cabot's patients. That year marked the announcement of the miraculous drug 606, "an efficient, specific, synthetic drug scientifically developed" for the treatment of syphilis.[62] Salvarsan carried great promise, but also imposed tough choices on those who would employ it. Surveying the results from its early use in the pages of *Popular Science Monthly,* Dr. Fielding Garrison warned that twelve deaths among the first thousands of cases, along with a course of treatment that was "exceedingly painful in the first stages," had led the inventor of the drug himself to "compare it with operative surgery in that it can never be given without certain risks."[63] Salvarsan "marks an epoch in medicine," said Meltzer, suggesting that it figured as part of a general change under way in the doctor's therapeutic armament.[64]

The Value of One Patient's Treatment

Some patients seemed surprisingly appreciative of their doctor's control over physiological manifestations of disease, even when it served their expressed interests only indirectly. Physiological therapy, at least in Cabot's clinic, offered them often weak and partial solutions to their troubles. Yet patients sometimes endured long trials with such treatment. The individual medical practice was a good site for recruiting and educating patients, so that a regimen of physiological monitoring could be established as the form of care. One thing that this care offered was protection, or at least support, in the patient's perplexing choices about treatment. While physiological treatment rarely offered the cheap, sure, and rapid benefits demanded by the crude consumers parodied in the medical literature, it displayed an impressive control over the entities that it defined. For the patients who accepted the premises, physiological treatments did offer a proof of control that could be perceived as a service in its own right. One example helps to demonstrate how patients could accept the physician's markers of progress as their own. Some patients not only identified an independent value in the doctor's control over disease, but seemed capable of sharing it vicariously.

In May 1902 a middle-aged woman, whom I shall call Ella Watson, came to Cabot with a complicated story about many ailments and treatments. She had "pain with urination" and severe pain at the waist when she bent to sit, as though, she said, she were being folded up "like an accordion." Cabot reported that she had been "purging and vomiting," which likely meant taking medications to produce these effects. She had tried "rectal injections" and had "had bladder washings done." Some of the therapy seemed to help. Previous treatments, he noted in the chart, "have made her able to sit." Reflecting back on the months before her visit, she herself noted, "I am better now than I was . . . I can walk now it hurts me much less." She was still suffering, however, and looking for further guidance. She had come to Cabot's office, she reflected in a subsequent letter, because "I believe . . . if any one can assist me to health you can."[65]

Assisting to health might involve many things. If it meant medical treatment, then Cabot insisted on naming the disease to be treated. During their first meeting, in addition to the usual detailed interviewing and examination, he subjected Watson's urine to several chemical and microscopic tests, which made evident certain worrisome abnormalities there. Perhaps he discussed the finding with Watson. Following this visit, she and Cabot both fixed their attention more determinedly on the urine. Watson went home and returned for a next visit with dutiful notes detailing her experiences with urination over a couple of days. She charted observations on when it occurred, how much, and how it felt to urinate after rising from different positions. On a separate sheet of paper she recorded the times of urination over the course of an entire night and carefully described some solid material that she had passed, including a small sketch of it in the margin of her notes.[66] She returned with this evidence and thirteen separate samples of urine that she had collected. Cabot reciprocated by analyzing the samples and confirming that there was indeed a problem in the urine; and he offered some new advice.[67]

With their mutual concern about the urine secured, Cabot recommended that Watson next see a surgical colleague who specialized in the treatment of the bladder and kidney. The surgeon, Dr. Edward Reynolds, could employ a special lighted tube called a cystoscope to examine the inside of her bladder and possibly treat the problems there directly. But this recommendation did not at first win Watson's support. "I dread an instrument examination," she wrote back to Cabot after their second meeting.

She had good cause, as she explained in the letter: "a Somerville lady was dilated by Dr. Morris Richardson [a surgical colleague of Reynolds's]" she wrote, "and could not hold her urine afterward." She worried about the treatments that a surgeon might apply, writing that "those physicians who have instruments and the knife I am afraid of."[68] Perhaps it made some sense, however, to pursue the trouble where it seemed to reside, in the urine and bladder. A short time after writing about her anxieties over surgeons, she did go to visit Reynolds in his office just down the block from Cabot on Marlborough Street.

Over the next three years, in a series of letters from his office, Reynolds reported back to Cabot about Watson's ongoing treatment. He used the cystoscope, as anticipated, to examine the interior of her bladder and found a specific source for the continuing troubles. Testing her urine on a guinea pig, he confirmed what his examination had suggested, that she had a tubercular infection of the urinary system. With this diagnosis established, Reynolds persuaded Watson next to come to the Deaconess Hospital, located at this time in a couple of adjacent row houses on Massachusetts Avenue, not far from Reynolds's office.[69] There, Reynolds used a more involved technique with the cystoscope again to sample the urine separately from each kidney through the two ureters that emptied into the bladder. No surgery took place; but with the tuberculosis effectively localized to only one kidney a surgical solution presented itself. One kidney was infected while the other kidney tested as normal during this sampling procedure. Reynolds managed to have Watson enter Deaconess Hospital again. In a subsequent publication outlining this lengthy case, Reynolds described a lengthy surgery that he performed on Watson at the Deaconess, where he removed her infected kidney, leaving the healthy kidney intact.[70] Following the surgery, Reynolds wrote back to Cabot that Watson had gained back much of her weight. Her original urinary symptoms persisted, he confided, but were certainly attributable to localized areas of continued infection now in the bladder; and went on to report that these lesions were, in fact, visible on a repeat examination with the cystoscope.[71]

For another year, Reynolds continued his efforts to eradicate from Watson's bladder any testable evidence of tuberculosis reporting his progress in an ongoing correspondence with Cabot. He performed repeated examinations with the cystoscope, applying silver nitrate and heat to suspicious areas in Watson's bladder, followed by confirmatory testing for tuberculosis. After a long course of treatment and monitoring Reynolds was able to boast finally in 1905 of two successive negative tests on Watson's urine. It was an excellent example, he wrote to Cabot, of what could be accomplished through "determination to see the case through on the part of both patient and attendant."[72] In his published account of this surgery, Reynolds made it clear that the primary accomplishment of his work with Watson lay in the eradication of the testable evidence of tuberculosis. He concluded his published account of the case by noting incidentally that "this patient still suffers somewhat from a contracted bladder, due undoubtedly to long-continued inflammation."[73] The urine, however, remained entirely clear of tuberculosis.

We might wonder at Watson's own impressions about the utility of a treatment whose primary outcome was normal tests. The sources of her determination to see through several years' treatments with "instruments and the knife" remain obscure. Watson did, however, manage to leave behind a personal summary of her long experience under Reynolds's care. Enclosed in her office chart is a final letter to Cabot dated 1908. Trying to sum up the three years of surgical treatments, she remained tentative. "I think I am a well woman," she wrote. She had, she ventured, some "little trouble with bladder now . . . Dr. Reynolds says I will have trouble with that as long as I live in extremes of heat or cold weather as I have thus far."[74] She and Reynolds agreed on the incomplete resolution of her urinary symptoms. She did "still suffer somewhat," as he had reported in the article, but it was after all a difficult world, full of inclement weather.

In this final letter, Watson was able to point to one certifiable benefit of her determination to see her treatments through to their conclusion. Dr. Reynolds had claimed that his treatments corrected an abnormality in her urine, eliminating all traces of tuberculosis. Such monitoring of the urine had been part of Watson's first exchanges with Cabot when she originally sought his assistance. So in concluding, Watson recalled for Cabot a last report on the urine that she had received from Reynolds following the completion of her treatments. He had analyzed a final sample of urine and written a reply that she now cited back to Cabot. "The specimen of urine which you left me," she quoted from Reynolds's note, "appears to me to be about as normal as anything could well be—I know that will please you." She ended her own assessment of the treatments with this same material assurance that had begun it. Reporting to Cabot about her health, she turned again to the evidence of the urine, which had been a basis for their mutual planning. The problem with her urine had been corrected. She would be pleased about the demonstrably normal tests, Reynolds had asserted. And perhaps she was. She closed her letter, "I am very gratefully yours, Ella A. Watson."[75]

Cautious Consumers of Treatment

The patients who wrote to Cabot did not in general protest that they needed something fast, cheap, or sure from him or his colleagues. They did deliberate a great deal about their acceptance of their doctor's advice and prescriptions. Some patients characterized their acceptance of treatment as a cautious step, for which they took responsibility. Watson had written to Cabot soon after her second visit, questioning his recommendation of surgery. Weighing her choices, she reminded him that "I want to do what is best for me"—as though admitting that she might finally have to be the judge of that.[76] When patients felt that they had chosen correctly, such a responsibility seemed easier to bear. Another patient, an office clerk from a nearby town, wrote to say that he had decided not to go on with Cabot's prescribed therapy, stating, "I have discontinued the treatment allowing [the rheumatism] to takes its own course." "The result," the clerk informed his doctor, "is that it has left me entirely."[77] He had evidently made a good choice.

Patients sometimes regretted having forgone treatment, however, especially when the untreated condition did not improve. "[I]f I could follow your advice of a change of climate and associations of two to three years I might gain in strength—I cannot tell," one man wrote Cabot.[78] "If I could have acted upon your advice I would not have much trouble," a second patient similarly wrote. However, a third reported: "I followed your advice . . . and took the pills and digestive biscuits," but without getting much better.[79] If patients sought and considered therapy, when should they then reject it, and on what grounds?

One young man, whom Cabot described only as a "baggage recorder," wrote reporting that he had not had much relief since his last visit, and in fact felt worse after taking the doctor's treatments. He was not giving up on the treatments yet, however. "I shall continue a little longer," he conceded, "with medicine and 'rules' as near as possible . . . and may yet get [the] 'desired result.' "[80] It was sometimes hard to know what to expect of a treatment or medication. Patients expressed complex understandings of the desired effects. A young man wrote about his medication, for example: "I think the first two or three days after taking [it] I had more distress in my stomach . . . and I was somewhat pleased for I thought it was going to have a different effect after the newness of the change was over for a great many times a medicine that helps often upsets one at first."[81] Symptoms were changeable and difficult to convey to others. They might seem an insufficient basis for tough choices about a lengthy, risky, or discomforting treatment, especially when the ultimate goal was the eradication of a disease.

The concrete facts of physiologic monitoring offered a shared territory lying between the patient's unimpeachable, if inaccessible, claims about symptoms and the physician's assumed expertise. Perhaps Ella Watson had difficulty assessing how her bladder problems in 1908 differed from her problems in 1902, after years of treatments. She could in any case offer the evidence of her physician's confirmatory testing of the urine. Such evidence also provided a reasonable leverage in the process of understanding and negotiating treatment. This use proved attractive to a stenographer in her fifties who wrote in 1915 about the strict dietary recommendations that Cabot had made for controlling her diabetes. Body weight provided one important piece of information about the course of her disease: "[T]he fact that my weight is now 184 1/4 pounds on bathroom scales (no encumbrances) may not be of thrilling interest to you, but I tell you this because I want some fruit," she wrote.[82] If part of the authority over eating fruit did lie with her doctor, it was at least an authority responsive to petition. Measured weight was a criterion more equally accessible to doctor and patient than were either the symptoms or the process of disease. Such shared criteria could prove useful in negotiating plans about treatment. "I feel good," on the other hand, might seem as much a pleasantry as it did a basis for seeking to influence the physician's advice.

Patients were sensitive to some odd discrepancies in the results of medical treatment. If symptoms posed a challenge to the physician, then they might also pose a challenge to the patient hoping to gain the advantages of specific therapies. "I think the Treatments help[ed?] me a great deal," wrote one perplexed patient, "but I came home in just about as much pain as ever but I gave up all medicine and keep Cheerful."[83] Perhaps this man was merely confused about the purposes of his treatment, but he may also have acknowledged an imperfect relationship between how he felt and what his treatments aimed to accomplish. Similarly, the statement cited earlier that "the operation itself was a success, but I have never recovered from the check to my nervous system,"[84] might have come from a patient who recognized the paradox involved. It seems an earnest attempt to note the evident tensions between therapeutic goals and subjective good health.

Cabot's patients sometimes demonstrated an appreciation of physiological monitoring of therapies, when it was available. One middle-aged man, a minister, developed explicit criteria for his disease and medical care using specialized testing. He came to Cabot in July 1903. Evidence from their interview, a physical examination, and microscopic examination of his blood yielded the unfortunate diagnosis of pernicious anemia. The disease had a difficult reputation at that time. Although potentially fatal, its course could be unpredictably mild and prolonged. It might leave a person on his feet for years or quickly create devastating troubles.[85] The minister wrote to Cabot over the next year in ongoing efforts to track the treatment and control of this shifty malady. Physiological monitoring of his blood played a central role.

A couple of months after his first visit, he wrote back from New Bedford, where he had met with another physician. Another blood examination by this second physician had found red cell counts slightly different from Cabot's. The New Bedford physician, Dr. Connor, had prescribed a new medicine for him, he reported. It raised for him an important question: "Do *you* think I should take the medicine?" In providing Cabot for a basis on which to make his recommendation, he noted, "I find that in three months [since our visit] I have gained in number of red cells from 1,000,000 to 3,480,000."[86] He also noted that he was feeling better, evidence well supported in the rising number of red blood cells. Did he really need a change in medication as Connor recommended? The question as it was posed in the minister's correspondence seems as much directed to the minister himself as to his physicians.

In February of the next year, he wrote to Cabot asking further advice about treatment, this time less sanguine about the results of monitoring. He had been back to Dr. Connor earlier in December for further monitoring. "I found that I had gone back to 2,546,000," he reported. "I fear the month of January has taken me down still more." He described weakness and malaise, which seemed to confirm the information from the blood counts. He inquired about other possible therapies that he might pursue, asking: "I have an electric battery, continuous current, but do not use it. Could it be made to do me any good?"[87] He drew his physicians into the deliberations over treatments using the information of blood counts as their shared evidence about the disease. He last checked in again about seven months later, writing from Nebraska to say that he hoped to be in Omaha soon, where he believed he could obtain another blood count, which he would forward on to Cabot.[88]

Falsifying the Value of Treatment

Both the minister and Ella Watson had in their own ways turned to the evidence of laboratory testing to judge and communicate the results of their medical care. Protracted illnesses like those associated with urinary tuberculosis or pernicious anemia might wax and wane under a great variety of influences, including treatment. The blood count or the urinary bacteria seemed to represent acceptable targets for therapy that might be drawn out over years. If improvements in the tests did not always correlate with a marked sense of improvement in health, at least they served as a reasonable means of communicating with their physicians about matters of mutual concern.

Physiological monitoring provide one means to confirm the value of a medical treatment when the way it made you feel seemed insufficiently persuasive evidence. Monitoring might also serve to expose a physician who tried to foist an inadequate treatment on a patient when the latter's testimony alone could not indict him, as in the following example. The husband of a fifty-year-old woman who had been a patient of Cabot's wrote to the doctor in 1915 to inform him of her recent death and of her mishandling by another of her physicians. She had first come to Cabot's office in 1912 suffering from weakness, weight loss, and stomach pains. Cabot examined her blood during this visit and confirmed the diagnosis of pernicious anemia that she had received from her doctor at home. Although this agreement on the condition by independent doctors in different states may not have been especially reassuring at the time, it seemed to the husband worthy of note in light of what followed. After the visit to the Marlborough Street office in Boston, she had returned to her doctor at home, Dr. Fulton, where she continued with a conventional line of treatment that he had begun. Over the next year, several laboratory reports on her blood reached Cabot from Fulton's office and were dutifully filed away, diagramming her ongoing struggle with the disease. Then in 1914, Fulton wrote about an important development. His patient had heard of a new treatment with the radioactive element thorium being used in Berlin and, being eager to try it, she was traveling to Germany to put herself under the care of an expert at the university there, Dr. Bickel.

Her husband then took up the account in his subsequent letter, reporting to Cabot that "Dr. Bickel acted the part of a faker." Bickel had provided his wife with the thorium treatments and claimed to demonstrate their powerful effectiveness against her disease through a series of gradually improving blood tests that he showed to her. In fact, after a short time these tests seemed to display remarkably normal results for her blood. Apparently skeptical, however, his wife had sought out a second opinion from another physician in a nearby city. Her husband continued the story, "within a few hours after leaving Berlin she had a thorough examination by Dr. Von Noorden and he found her blood count nothing at all like Bickel had reported it." In fact, her blood tests still demonstrated exactly the signs of the pernicious anemia that had plagued her all along.[89] The whole sad tale of these false treatments was spelled out in the physiological monitoring of her blood, which also allowed her husband to provide creditable evidence of how she was misled by this one physician. He concluded the story to Cabot, noting that his wife had died shortly after her return home from Germany. The results of blood tests remained her husband's best evidence for what had happened.

Placebos and the Authority to Treat

The use of physiological monitoring of treatment with blood counts or urine tests offered independent support for the patient's trust and cooperation; but such use did not supplant other, more personal forms of medical influence. Early twentieth-century physicians continued to weave therapeutic intentions into their discussions of diagnosis and prognosis, as we saw earlier. They did not in general abandon their claim that the authority to treat derived as much from a privileged understanding of the individual patient's circumstances as from an objective knowledge of the disease.

Cabot himself argued that new physiologically guided treatment remained, like all good therapeutics, "based on the individual's manner of reacting to the disease . . . [accounting for] the whole individual so far as it [therapeutics] can discover him."[90] Such claims, however, took on changed significance in the context of new medications and treatments. Treatments that targeted specific diseases, like 606, abdominal surgery, and thorium, promised a future filled with cures that were quick, sure, and easy. In actual use, however, they required patience, sacrifice, and compromise. The emerging tension between the promises of modern therapy and its applications pushed physicians to reconfigure certain traditional bases of authority. Debate about placebo treatment among Cabot and his peers, although a minor skirmish, reflected and sharpened these concerns over the sources and justification of therapeutic influence.

Placebo medications such as a vial of colored water or a sugar pill had no defined therapeutic action that could be monitored or assessed. The doctor who offered a placebo was making the gesture of treatment without its expected content. Placebo treatment thus exposed questions about the basis of medical authority in a stark form. Cabot was an especially opinionated party in the debate over placebos. His arguments still find frequent reference in present-day discussions of the ethics of placebo use, but are equally valuable perhaps as an insight into the issues of his day.[91] The placebo, Cabot claimed, was nothing more than a lie about therapy, and it was thus unacceptable in practice.[92] As a treatment devoid of specific effects, the placebo placed the doctor's control over treatment at stake without its usual justification in technical knowledge about the diseased body.

It is important to recognize that the use and significance of the placebo were simpler for Cabot and his peers than they would become subsequently. By the mid twentieth century, placebos had developed into valuable tools of medical research, serving as a baseline or a control against which researchers could measure the effects of other treatments. By the late twentieth century, medical researchers were increasingly being pressured to draw sharp distinctions between conventional and experimental therapy, and between experimental therapy and placebo-controlled experimentation. The use of placebos as a control in medical research became emblematic of the fundamental conflict of interest between researchers and research subjects. The intention to treat differed crucially from the intention to experiment. The use of placebos in experiment seemed to make this fact abundantly clear. For physicians like Cabot in the early twentieth century, however, placebos remained just a particular form of treatment. The concept of a well-defined "placebo effect" of importance to the clinical evaluation of novel treatments still lay several decades in the future. Yet placebos raised equally pressing questions for Cabot and his peers about the nature of medical authority over treatment.[93]

Cabot warned that the use of placebos imperiled the reputation of physicians broadly. Although his criticisms of placebo treatment seemed an application of his concern about separating medical authority from its technical justifications in the management of disease, they also spoke also to broader issues. In attacking placebos, he mirrored the pragmatic argument that he had made against the conscious manipulation of prognostic or diagnostic information. A patient who found that a physician was dispensing placebos might well ask, "What other tricks will he think it best to play on me for my own good in future?"[94] People might come to doubt or challenge the doctor's therapeutic advice, just as they would doubt prognostic statements once having found out that they might be altered to suit ulterior purposes. Rational persuasion was a cornerstone in Cabot's conception of the doctor's authority. To recruit a patient into treatment, Cabot advised, the first steps were to "take the patient into our confidence. . . . tell him the truth, explain his malady, and the means of its cure. "[95] Placebos might limit medicine's ability to draw upon public trust and credence in such dealings. In addition, the use of placebos would risk separating individual therapeutic influence over patients from its material justification. If therapeutic authority was grounded in special technical knowledge about the diseased body, then the use of placebos seemed a willful misrepresentation of this authority.

That the use of placebos would require professional discretion was evident to physicians long before Cabot's critique. Until the mid twentieth century, when they took on a central role as research tools, placebos were seldom discussed in the medical literature.[96] The use of placebos required an element of secrecy almost by definition; and its mention was often accompanied by advice to be circumspect. An early nineteenth-century description of the placebo in a *Medical Lexicon* called it a substance "intended rather to please a patient than to cure a disease."[97] But what was pleasing about a treatment with an ordinary, inert substance like sugar unless its true nature remained hidden? It would be paradoxical to champion placebos publicly, as open discussion tended almost necessarily to undermine their use. Discussion of the tacit use of inert therapies was thus buried in medical communications intended for professional audiences.[98] To speak publicly about placebos was to eschew them.

Although this secrecy has made them difficult to track, placebos were by all evidence widely used in medical practice throughout the nineteenth century and into the twentieth.[99] Cabot documented his own explicit use of placebos in his private practice before he came to reject them around 1903.[100] The placebo was one application of a general tenet of therapeutics that long predated the introduction of this specific term into medical parlance. In eighteenth-century medicine, a positive influence over the patient's understandings and beliefs figured as an indispensable part of practice. Enlightenment physicians argued that the patient's imagination was a valuable avenue for exerting a physician's therapeutic influence. By the end of the long eighteenth century, physicians were linking such influence directly to the intentional use of placebos to create favorable and hopeful impressions. By the end of the nineteenth century, a similar rationale had developed for the use of the placebo as an adjunct to mental suggestion. The placebo looked like the concrete form of a therapeutic suggestion: the suggestion that effective treatment was being provided. Placebos found relatively uncontroversial use in the nineteenth century as a therapeutic tool not too different in practice from the physician's established and accepted resources of reassurance, support, and encouragement.[101]

Placebos and the Lazy Patient

Long familiarity with the use of inert treatments in this tradition perhaps buffered Cabot's contemporaries against his dire warnings. Few at the time went as far as he did in renouncing the placebo as illegitimate or dangerous to medical reputation. Instead, those who criticized the placebo echoed familiar concerns about giving in to the weaknesses of patients. Placebos, they cautioned, pandered to the patient's desire for an easy solution. Francis Peabody made light of the physician who indulged a patient's anxieties through "cheerful reassurance combined with a placebo."[102] In 1938, William Houston, a Texas internist and member of the prestigious American College of Physicians, aired a fascinating and extended argument about placebos and the legitimate therapeutic influence of the physician. In his account, placebos endangered the doctor's efforts "to educate his public to demand something different, something far better," such as full explanations and truthful advice.[103] The principal harm done by the placebo was inspiring medical laziness, Houston said. Physicians tended to reach for placebos to treat minor symptoms in the absence of severe diseases. Placebos thus both substituted for the physician's earnest efforts to explain why no medical treatments were indicated and indulged patients by teaching them "to expect a medicine for every symptom."[104] Physicians should fight against the temptation to take the easy route in prescribing placebos. It might also undermine their ability to pursue more complex and taxing therapeutics when they were required. Patients who grew accustomed to the relatively easy task of taking an (inert) pill for every ache would balk before the difficulties of applying a more taxing treatment to address the fundamental cause of a disease.

Other physicians, who identified a similar risk in indulging patients with placebos, continued to affirm a noncontroversial role for them as an element of treatment compatible with medical authority. For George Roland, writing in 1908, placebos were minor aids to the doctor's therapeutic influence over a patient. Affirming the traditional idea of the therapeutic potential to be found in all interactions with patients, Roland argued that prescribing pills of any kind in fact distracted from more fundamental therapeutic obligations. Pills were also the easier path, since "patients will always take medicine when they will not take advice." So it was "the physician whose force of character makes his advice sought after and followed . . . who accomplishes the most good," rather than the doctor who gave out pills, placebos or otherwise. Physicians achieved their greatest gains by influencing "the correction of the habits and customs of the patient," enforcing moderate diet, outdoor activity, regular routines and schedule, as well as the proper use of medications. However, since patients often sought out the doctor primarily to get a prescription, it was reasonable and sometimes helpful in Roland's thinking to give placebos. He argued that in some cases "a teaspoonful of colored sweetened water every two hours will come as near meeting all the requirements as any of all the multiplicity of medicines recommended."[105] If an inert placebo treatment supported the doctor's beneficial therapeutic influence, then it counted as legitimate.

To Roland, a placebo medication threatened no special compromise or betrayal of professional duty. Placebos were just another tool in the doctor's black bag, valuable to the degree that they helped to encourage much-needed attention to personal habits and hygiene. Like his nineteenth-century predecessors, Roland sought to identify therapeutic purpose in all interactions with his patients. Anything that supported a patient's attention to a healthy way of life counted as a valid medical treatment. Once again the fickleness of patients seemed to present the greatest challenge to the doctor's ability to recruit to treatment. The major task facing the early twentieth-century physician, to Roland's way of thinking, was in asserting a strong therapeutic influence— rather than in attempting to justify such influence, as Cabot would argue.

The Placebo as Psychological Influence

Despite the willingness of physicians like Roland and Houston to minimize the problems of placebo use, there were rifts opening during this period in professional agreement about placebos over and above the controversies outlined by Cabot. Unusual or controversial placebo treatments sometimes touched off intense dispute and debate. Physicians who followed the medical literature in 1918 would have been struck by the remarkable case of Dr. Hildred Carlill in the pages of the British medical journal *Lancet*. Carlill provoked a spirited debate by publishing a defense of his placebo treatment of a patient who suffered from sudden debilitating attacks of sleepiness. He reported a complete cure of this ailing young man through an elaborately contrived, and risky, sham surgical procedure that involved removing a small section of skull bone. He reported that although there was no defined, physiological rationale for this procedure, it had produced favorable results by creating the psychological impression that it was a beneficial intervention. The treatment represented the successful use of a placebo surgery to cure a patient of a hazardous condition, Carlill argued. He attempted to justify his treatment as a valid medical action, intended only to benefit his patient. He understood his individual patient well, he explained, and had researched his disorder carefully; he had a duty to act upon this potentially remediable problem when he felt that he had a probable solution to offer. The sham surgical procedure was his best attempt to remedy his patient's difficulty.

Other physicians wrote to the *Lancet* joining in on his side. "Dr. Carlill," argued one supporter, "was actuated solely by the desire to benefit a patient, who, as long as he remained uncured, was in danger."[106] In replying to the first raft of criticisms, Carlill himself went so far as to claim that any form of treatment administered by a physician was acceptable, "so long as there is a remote chance that it will benefit the patient."[107] After all, Carlill asserted, the patient "prefers a cure, however produced."[108] Carlill suggested that the placebo was simply another version of what the patient sought from him and what he had the duty to provide, a potentially helpful treatment.

Carlill's opponents too seemed to accept the premise that a placebo treatment was one way that a doctor could respond to the patient's uncomplicated request for help. None of the respondents in the *Lancet* attacked placebos simply on the basis that they were deceptive, as Cabot had. Instead, they raised questions about the implications of placebo treatments for more general therapeutic influence. Adopting a familiar tone of wariness about the average patient's appreciation of the challenges of therapeutic compliance, Carlill's opponents warned that placebos were yet another form of medical pandering. One opponent, Dr. Ready, took up a line of criticism similar to that of Peabody, Roland, and Houston, suggesting that placebo treatments indulged the patient with the promise of simple solutions and easy relief. Dr. Ready asked whether even successful placebo treatments "are good or justified when no effort is made by the patient and nothing is given to dethrone his egoism."[109] Placebos gave in to laziness on the part of both physicians and patients in reaching agreement about more difficult and complex therapeutic plans.

We can also hear in Dr. Ready's reply in 1918 the hint of emerging ideas about a vigorous new branch of therapeutics. His suggestion to "dethrone egoism" reflected a psychodynamic understanding of interactions with patients being pursued most concertedly in the growing medical literature on Freudian psychoanalysis.[110] Perhaps the doctor's personal relationship with patients should be distinguished sharply from conventional medical therapeutics, so that advising about prognosis had no legitimate independent role as a form of treatment. Nonetheless, there might be purposeful, therapeutic uses for the medical relationship. Houston, in his 1938 article "The Doctor Himself as a Therapeutic Agent," and in a longer prior monograph, explored this notion in greater detail.[111] Houston asked whether physicians could anticipate and control the therapeutic effects of the doctor's personal connection to the patient. He reiterated Francis

Peabody's notion that there were healing bonds formed in the relationship between physicians and patients, validating the therapeutic nature of personal interactions. Drawing in part from psychodynamic teachings of the day, Houston asked, "[H]ow can the doctor himself, as a therapeutic agent, be refined and polished to make of him a more potent agent?"[112] Placebos were to Houston no significant threat to therapeutic authority, as was shown earlier. They were only distractions from a more thoughtful application of related modes of influence.[113] Freudian psychodynamics aspired to affect mental aberration through the medium of the therapist's relationship to the patient, using the relationship as a tool for detection and treatment. Houston, and to a lesser extent Peabody too, assumed the existence of such therapeutic relationships. With their focus on physicians in general medical practice, however, they took as their goal, not the treatment of mental pathology, but the creation of general medical therapeutic influence. They took an instrumental view of the medical relationship that paralleled the new psychodynamic model and reconfigured the doctor's traditional therapeutic interpretation of efforts at reassurance, support, and encouragement.[114]

Cabot and others who debated the use of placebos often characterized the sugar pill as a simple entity; for Cabot, it was nothing but a deception. But placebos were more potent and complex mixtures than was allowed in these critiques, as the psychodynamic interpretations of Houston and others would suggest. Isolating the placebo so cleanly from its manifold meanings and associations was not easy. Cabot himself had organized and tucked away evidence about the extended significance of placebos that might have given him pause. One person who wrote asking him to soften his opposition to the sugar pill brought a complicated personal history to bear on the issue. She had never been a patient of Cabot's but knew him socially and maintained a curious association over several years. Her first two letters, which Cabot filed away with his personal correspondence, sought out his company at an evening social engagement and then subsequently extended another invitation, with the reassurance that his previous abbreviated attendance had not been misconstrued.

In a series of personal letters over the following year, she continued what seems like a determined flirtation in the face of a lukewarm reception. She wrote to marvel that Cabot's companionship was to her "more like that of a brother's than any I ever expected to have" and described her embarrassment at finding missing buttons on the front of her coat after an evening out together. She inquired in detail about his understanding of the commandment to love thy neighbor and wrote again to excuse him from his absence at another event, where she had been anxious to see him. Then she wrote to mention that she would be taking a walk to a particular bridge at a certain time and day and said she would be glad if he happened to be free to meet her there.[115] She assured him that this was her planned itinerary and should he not be able to make it, he would be excused in advance for his absence. Following this letter, there was a long break in the correspondence.

Her final letter in the collection turned to the subject of placebos. She had just read Cabot's denunciation of the medical use of placebos and wrote to ask whether they might not in fact be a good thing sometimes. Honesty on the doctor's part was important, she agreed. But could he not allow "that in highly nervous cases and in unbalanced minds where reasoning is practically impossible, a placebo may be necessary?"[116] How could withholding care in such cases be better? She concluded by requesting copies of his paper for two physicians of her acquaintance. Perhaps in this way she might be able to gain some concession from the good doctor, who proposed to give not even the semblance of treatment to certain patients. A placebo was at least a substantive response to the request for assistance and must have seemed better to her in some ways than the honest response that there was nothing to give.

PLACEBOS SEEMED TO CABOT to present a peril to the physician's ability to guide treatment. He joined a larger debate among his contemporaries that explored the changing basis of therapeutic authority. Placebos were a minor concern but pointed to larger tensions developing between the doctor's therapeutic influence and its basis in the verifiable control of disease, at a time when doctors increasingly aspired to such control. By the mid twentieth century, placebo effects would become a common baseline serving to define and measure treatments. Valid medical treatments became by one definition interventions that were better than the placebo. But in Cabot's time, placebo treatments still squared nicely with the use of prognostic reassurance, admonishment, or encouragement, and other well-established means of supporting and enforcing therapy. Physicians had long claimed that their power to treat derived from a general obligation to help the sick, from a privileged understanding of the individual patient's constitution and needs, and from a willingness to put the patient's interests foremost. But in the isolated realm of the office clinic, in the face of increasingly high-stakes therapies, would such justifications continue to suffice? Physicians like Houston responded in part by trying to redefine a therapeutic role for the medical relationship in psychodynamic terms, independent of the technical services delivered in the treatment of disease, but potentially supportive of them.

The challenges facing the doctor's therapeutic influence had also changed. Cabot and his peers expressed concern that patients would not tolerate the demands of physiological treatment. They aired their concerns in professional communications that parodied the impatient consumer of medical services searching for a quick and easy fix. Similar discussions spilled over into the debate on placebos. Placebos indulged the patient's desire for a pill for each and every ill, Cabot warned. In contrast, careful, physiologically guided therapeutics required patients to accept treatments that sometimes sought obscure targets, like red-cell counts, and created results that were not immediately evident, except through technical methods. Physicians inspired by these efforts asserted the need to control treatment in a way that was independent of the reports of symptoms and effects by patients. Physiological monitoring of therapy could both confirm the effects of treatments and create the framework for the ongoing supervision of treatment. Paradoxically, treatment that was quick and simple also seemed to some doctors to be the most detrimental to the physician's authority. The professional literature of the early twentieth century warned against the hazards of a market filled with easily obtained patent medicines, panaceas, and quack cures.

The actual give-and-take of negotiations over treatment in Cabot's clinic reveals a much greater variety and complexity of interaction than was imputed by the medical literature. People writing to Cabot rarely articulated an interest in treatments that were quick, cheap, and certain, however desirable they might be in the abstract. Perhaps they understood that it was better to seek such services elsewhere, despite the apparent promise of modern medical science. Patients proved flexible in petitioning for Cabot's services and demonstrate concerns in their correspondence that differ strikingly from what the medical literature attributed to them. If their physicians seemed wary of the subjectivity of symptoms, patients replicated this concern, often noting in their correspondence that their symptoms gave them difficult and sometimes conflicting evidence. What did it mean to get better from treatment? Illnesses waxed and waned and followed their own unpredictable courses. The response to therapy might be ambiguous and impossible to distinguish from the natural changes that typically accompanied illness. Patients accepted medical reassurance about the validity of medical therapy through physiological monitoring to the extent even of discounting their direct experience. Physicians like Fulton, Von Noorden, Reynolds, and Cabot attempted to make their clinical value demonstrable in the physiological monitoring of disease. One patient, Ella Watson, even suggested subtly that her physician's ability to chart and document control over a disease had its own vicarious value for someone who was vexed with a chronic illness.