Aphorisms

Professor Robert Tattersall

Today's diabetes world is fast-moving and exciting; knowledge is accumulating at an astonishing rate. To help understand the present, however, it sometimes helps to examine the past.

In this final installment of *Tattersall's Tales*, Robert Tattersall reflects on what can be learned from great diabetologists of the past and their experiences treating people with diabetes, focussing specifically on how this knowledge can be applied to diabetes care today.

Professor Robert Tattersall has been a Contributing Editor for *Diabetes Digest* since 2003. Dr David Kerr and the Publisher would like to thank Robert for his valuable contribution to the journal and his interesting, entertaining and thought-provoking comments throughout the years; we wish him well.

In 1983 I read an article by the Belgian diabetologist Jean Pirart (b.1922) entitled "*What I have to say to a young diabetes specialist after 35 years of experience*" (Pirart, 1983). It included such gems as:

- Do not trust schemas and classifications too much. After all, a patient has a right to be himself regardless of the pattern he should fit in accordance with your theories.
- Do not talk in a scholarly way: "High blood sugar" or "low blood pressure" are as good as "hyperglycaemia" and "hypertension". Speak to be understood, not to be admired.
- Listen to your patients. The key of a problem is more often found in their talk than in a laboratory test.
- When you talk, never look at your hospital record (or, I would add, computer screen). Look at the patient. Watch him or her carefully.
- Remain realistic. Do not try to normalise all parameters. Keep in mind a list of priorities in decreasing order.

The more I read over the next 30 years, the more obvious it became that all the greats of diabetology have preached the same messages.

Message 1

Specialising in diabetes is a wonderful job but as Pirart warns: "Be fully conscious that there is often a large gap between what should be done and what is actually achieved. Pessimists claim that the patient will understand 50% of what you taught, and will apply 25% correctly during the first months of his condition. Pessimists are wrong. Anyway, they should never take care of people with diabetes. Epidemiological studies or animal experiments are better jobs for them."

John Malins (1915–1992), who ran the diabetes clinic at Birmingham General Hospital from 1955–1979, suggested that diabetology was the last bastion of the general physician. In the preface to his 1968 textbook he wrote, "The more patients one sees the more difficult it becomes to present the simple picture that so many readers like. Diabetes is a disorder of such infinite variety that it becomes impossible to say that this always occurs or that never happens. We do see thin children with mild diabetes that can be controlled by dieting and fat women who develop severe ketosis…today a diabetes clinic provides the widest clinical range of any speciality in medicine with metabolic, vascular, neurological and psychiatric problems outstanding. In addition there is a chance to enjoy some of the pleasures of general practice, which arise from long acquaintance with many of the patients. The chance, all too frequent, to ease the last years of those whose health is slowly failing calls for all the resources of the general physician."

Message 2

The management of diabetes is theoretically simple, as evidenced in guidelines and algorithms, but the art lies in treating the individual.

As Robert Loeb (1895–1973), the legendary clinician and editor of Cecil and Loeb's textbook of medicine, said: "Diabetes care is most effective when the patient becomes the doctor, and the doctor becomes the consultant."

I Arthur Mirsky (1907–1974), a Canadian physician/physiologist who also trained as a psychoanalyst, wrote: "It should be appreciated that the diabetic patient is not so much a disarranged constellation of enzymes and hormones who is spilling sugar, as he is a human being with feelings, hopes and frustrations. The physician whose goal is merely a diminution of glycosuria treats only the urine, whereas the sympathetic physician whose goal is the prevention of chronic invalidism and the establishment of a normal existence, treats the patient."

Despite Malins' comments about the extraordinary variety of diabetes practice, people sometimes think that diabetes clinics are boring because the patients are stereotypes of one another. It may sometimes seem like this, but the solution is to follow the advice of Frank Davidoff, editor of *The Annals of Internal Medicine*, who wrote: "It is one thing to see 20 different cases of diabetes in the course of a week; it is quite another to see 20 different people as patients, all of whom happen to have diabetes. In every case, the very same biological disease 'lives' in a different person, and the disease expresses itself differently in every one of them. Learning about what makes these individual patients 'tick'

biologically and psychologically; figuring out how best to interact with each of them; deciding how best to negotiate, to develop therapeutic alliances, to use language effectively – all provide potentially endless sources of interest." (Davidoff, 1996).
Or, as Robert Loeb put it: "There is no such thing as a dull patient, only a dull physician."

Message 3

The clinician should not meddle officiously. This has been repeated *ad nauseam* but there are still doctors who rush to put the patient on the latest insulin or fiddle with their regimen.
When you meet a patient who is new to you, Pirart says: "If the insulin regimen or diet seem a bit surprising, do not immediately consider your colleagues ignorant or crazy. Both patient and doctor may have reached a certain regimen after a long way of trials and errors. Be cautious in taking any decision to change something that apparently is running well, however odd a treatment seems to be."

Robin Lawrence (1892–1968) agreed writing: "The good clinician must strive to direct a life of normal efficiency and happiness to suit his patient's habits, desires and temperament…it is no business of his to interfere too much, to change or distort the life of a diabetic in his charge, except to prohibit really harmful habits and factors." (Lawrence, 1949).

Loeb, as always, put it succinctly: "If what you are doing is working, keep doing it."

Message 4

On writing papers the eccentric and provocative physician and endocrinologist Richard Asher (1912–1969) had good advice such as:

- A poor title dulls the clinical appetite, whereas a good one whets it.
- Medical articles today often appear to be written by committees…10 men cannot write an article any more than 10 men can drive a car.
- A diagram should only be used if it makes something easier to understand. The purpose of a diagram is not to crowd as many facts as possible into the smallest space.
- Medical articles should, like after dinner speeches, finish before the audience's attention has begun to wane." (Asher, 1958).

To these I am tempted to add:

- The first draft of a paper is always awful.
- So is the second.
- If your paper is unreadable, people won't read it.
- Direct speech is better than indirect.

I doubt if Asher knew much about statistics, but they are an essential part of modern research. Edwin Gale suggests that one should always get professional help with them. His advice is: "Plan the analysis before you undertake the study, and design the study around the analysis. Always ask for professional advice. If you are lucky enough to find a statistician who can communicate with the non-numerate and is of the opposite sex, you should consider a proposal of marriage. It's that important." (Gale, 2010).

In the real world, what often happens, in the words of the clinical pharmacologist Louis Lasagna (1923–2003), is that: "Too often the statistician is called in at the end of a trial in the hope that the chanting of a few mathematical formulas or Greek symbols over the corpse of an ill-planned experiment will restore the breath of life to the unfortunate victim." (Lasagna, 1955).

Asher R (1958) Why are medical journals so dull? *Br Med J* **2**: 502–3

Davidoff F (1996) The dilemma of the uninteresting patient. In: Davidoff F (eds). *Who Has Seen a Blood Sugar? Reflections on medical education.* American College of Physicians, PA, USA: 65–9

Gale E (2010) *Diabetologia: What does an Editor look for?* EG, Bristol. Avaliable at: www.diabetologia-journal.org/eicadvice.html (accessed 14.11.13).

Lasagna L (1955) The controlled clinical trial: theory and practice *J Chron Dis* **1**: 353–67

Lawrence RD (1949) Insulin therapy: successes and problems. *Lancet* **2**: 401–5

Pirart J (1983) What I have to say to a young diabetes specialist after 35 years of experience. In: Assal J-P, Berger M, Gay N, Canivet J (eds). *Diabetes Education How to improve patient care.* Excerpta Medica Elsevier, Amsterdam, Holland: 272–76