

EDITORIAL

THOUGHTS ON THE ISSUES OF IATROGENESIS

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Hippocrates' first rule of medicine states "Primum, non nocere," or "First, do no harm." To the conscientious practitioner of every healing art it stands as a constant reminder of the weighty responsibilities involved in rendering care to the ill and the injured, and the necessity of evaluating every aspect of what is done in the course of their care for possible adverse as well as beneficial impacts.

When viewed purely in terms of their denotative meanings, the words "iatrogenic" and "iatrogenesis" are relatively neutral, and indicate that something has occurred as the result of a healer's interventions. However, the connotations of these words, which determine their common usage and most widely applied definitions, are largely negative. They conjure up the image of something being done by the healer that is wrong or erroneous, with adverse consequences for the patient.

As an indication of this, neither the emergence of a transference neurosis (which may be encouraged to unfold by a therapist's way of conducting treatment), nor a surgical incision, nor the felicitous outcome of a medical blunder that serendipitously proves helpful, nor the successful cure of a patient are commonly referred to as iatrogenic, although all clearly result from the interventions of a healer. Conversely, the patient's worsening in the course of treatment, complications that ensue in the course of therapy, accidental mishaps and errors, and the untoward outcomes of healer's efforts (be they thoughtful or inappropriate) may well yield outcomes that become described as "iatrogenic."

Working within the context of the usual negative complications of the term "iatrogenic," it is useful to return to the commonplace distinctions made between errors of commission and errors of omission; i.e., errors that stem from steps that are taken and prove to be incorrect, and errors that stem from actions that are withheld, and the failure to act proves to have been incorrect. Concerns about the possibility of the iatrogenic creation or the iatrogenic worsening of multiple personality disorder (MPD) are far from new; they have been an ongoing theme in the modern history of this condition. An interest in the iatrogenic illness and/or complications that follow from the absence of healing efforts in connection with MPD is, in contrast, a relatively new concern.

It is a curious fact that despite the absence of any hard data for the iatrogenesis of MPD, the vocal insistence that MPD is an iatrogenic disorder remains a widely held and "respectable" point of view. Many of our colleagues who freely admit that they have no clinical experience with MPD and have not read the literature of this field nonetheless feel

quite secure in maintaining that the condition is an artifact, or merely a social-psychological phenomenon. It remains commonplace for colleagues to attack the efforts of those who attempt to work with MPD patients, an indication that the disregarding of newer findings and approaches is widely sanctioned.

Conversely, despite a wealth of studies demonstrating that the MPD diagnosis is made on the average only after the patient has spent many years misdiagnosed within the mental health care delivery system, it remains commonplace for both skeptics and scientific investigators within the field to caution against energetic efforts to reach diagnostic clarity, for fear of inducing artefacts. Even many major contributors to the dissociative disorders literature appear rather defensive and apologetic in this respect. Reports that indicate MPD patients as a group can do well in appropriate therapy have not yet resulted in a widespread effort within the mental health community to identify MPD patients as promptly as possible and to offer them or guide them toward appropriate psychotherapy.

The publication of the David Caul Memorial Symposium papers represents a milestone in the study of the dissociative disorders. These contributions represent a conscientious effort to address and explore those unfortunate situations in which the MPD diagnosis is or is thought to be worsened by treatment. Because these papers discuss the issue of iatrogenesis with a focus on situations that generally speak to actual or apparent errors of commission, it seems appropriate to offer in the balance some brief remarks on the iatrogenic aspects of errors of omission.

The phenomenon of nescience with regard to MPD remains a major impetus to iatrogenic misadventure by virtue of omission. Nescience is not a word used in everyday conversations. It means a lack of knowledge, or complete ignorance. While we attempt to study those incidents in which patients suffer as a result of the misapplication of the MPD diagnosis or of treatment interventions that are designed for use with MPD, we must begin to assemble as well systematic documentation of the consequences of the failure to make the diagnosis of MPD because of a lack of skill and knowledge on the part of the healer. Nescience is not without its consequences.

As I note in my own contribution to the David Caul Memorial Symposium, David Caul and I never really discussed the topic about which I wrote. I can only hope that in some serendipitous manner I did justice to his ideas about the iatrogenic creation of new alter personalities. However, over the course of nearly a decade, David and I spent many

hours in conversation about the plight of the MPD patient whose diagnosis is made only after that patient's personal resources have been exhausted, her insurance squandered on ineffectual treatments, the trajectory of her life unalterably distorted by the loss of years and the foreclosure of opportunities, and her most treasured relationships, dreams and talents devastated, if not destroyed. We often discussed how much of this could and should be described as iatrogenic. I would begin to talk about nescience — David would smile indulgently and encourage me to find "a real word that real people could understand."

It is because the iatrogenic consequences of nescience are so crucial to appreciate that the David Caul Memorial Symposium papers and the companion piece by Ross, Norton, and Fraser are joined in this issue by Hall's tragic and thought-provoking case study and by Batson and Stephens' article on integrating a dissociative disorders curriculum into a residency training program. These latter two papers respectively illustrate the problems that may follow in the wake of nescience, and point the way toward their resolution by educators. They are ample food for thought.

Iatrogenic excess morbidity as a sequel to nescience remains a major public health problem with regard to MPD. Before turning my attention to this editorial I attended a case conference in which an MPD patient was being presented. She had been an outstanding student until she began to show signs of mental disturbance. Since then, she had been in state hospitals and residential settings continuously for the last decade. The diagnosis of MPD had been suggested on the basis of very solid clinical evidence early in the course of her treatment, but was disregarded. The patient was treated as paranoid schizophrenic, and several reports in her file disparaged the possibility of an MPD diagnosis. Instead of being given appropriate treatment in her early twenties, she finally will receive it in her mid-thirties. Perhaps some sage will coin a term for the iatrogenic loss of over ten years of young womanhood, perhaps not. Some food for thought digests less well than others. ■