Doctor-Detectives in the Mystery Novel

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By

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PREFACE:
SPOILER ALERT

The author of this sort of book faces a dilemma. I could attempt to discuss and describe the works without revealing the ultimate solution to the mysteries that they contain. Or I could analyze the writing and plot development without worrying whether or not I was "spoiling" the story for the reader. While how much I will want to say about the solution to any mystery depends on the details of that work, please assume a GENERAL SPOILER ALERT throughout this book. If you don't want to find out beforehand about the solution to the mystery, then don't read about any author or volume that you plan to read but have not yet read.

CHAPTER ONE

INTRODUCTION

I

It's the 1970s in Britain. An older physician, Dr. X, leads the weekly meeting of British general practitioners at which the younger physicians are invited to present interesting or difficult cases from their practices, usually ones that involve complicated psychosocial and emotional problems. At this week's meeting, Dr. X irritates the others by demanding that each present to the others only the very start of the interview with the patient. Dr. A objects, "How can we come to any conclusions without all the available data?"

Dr. X replies, "The point I'm trying to make is that we often fail to listen really carefully to the first few moments of the patient consultation. You'd be surprised how often, if you use your eyes and ears well, the first 20 seconds gives you the entire patient's problem in microcosm."

The others remain skeptical, but Dr. K is willing to give it a shot. "Last week I saw one of my patients, Babs, she's been in my practice for maybe 15 years, she wanted to know whether I thought she should be taking hormone therapy for menopause…"

Dr. X interrupts: "Wait a minute, what did she say, exactly? Can you describe her actual words and her actual tone of voice?"

Dr. K searches his memory: "Well, she said she'd read an article in a magazine…"

Dr. X repeats: "But just what did she say?"

After they go back and forth a few times, Dr. X establishes that during the office's evening consultation hours, Dr. K had greeted his patient with, "Evening, Babs," using her first name as he was wont to do with his old established patients. The patient then replied, in a quiet tone of voice, "Hallo, doctor, I hope I'm not wasting your time, I've been reading this piece in the waiting room while I was waiting that says you can get something nowadays for hot flushes and that."

The group goes around and offers their speculations on what might have been Babs's actual problem, making such guesses as frigidity,

abnormal uterine bleeding, and simple hypochondria. Dr. X then says, "It's my guess that the patient had just found out her husband is having an affair."

"How could you possibly know that?" demands Dr. K. "It took me more than 20 minutes to dig the full story out of her."

Dr. X then lays out his reasoning:

- Babs was unsure how to talk about her problem with Dr. K, because she was still getting her story put together while she was in the waiting room.
- "I hope I'm not wasting your time" usually means, "I'm not sure you can help me."
- Asking about hot flashes *and that* hints that the problem has to do with her sexuality. Her downcast, quiet tone of voice hints at a feeling of inadequacy in this area.
- Babs starts off by talking, not about herself, but about the magazine article—she wants to keep the personal aspect out of it at the start.
- While Dr. K calls her by her first name, she responds with "doctor," maintaining greater professional distance. How she deals with male figures that she knows well seems to be an issue for her; she's not sure she should be talking with another man about this problem.
- Babs chooses the evening hours for this visit, a time when she'd usually be at home with her husband. She will probably have to explain to him where she was, and perhaps what led her to go.

As Dr. X wraps up for the group, "So you see, all the clues were there in the first few sentences at the very start of the consultation."[1]

II

The middle-aged woman, from a small town in Oklahoma, obviously had hyponatremia (low level of sodium in the blood). That much was evident from the laboratory studies when she was admitted to the university hospital the previous evening; and the lab finding explained her weakness and her other symptoms. The resident physician who had admitted her, however, had no idea what was causing the low sodium. His attempts to get a detailed medical history were frustrated by her short, sketchy, and occasionally hostile answers. Mostly she lay buried in the bedclothes, her expressionless face not making eye contact. Her family had left earlier,

[1] Roger Neighbour, *The Inner Consultation* (Newbury, Berkshire, UK, Librapharm Limited, 1996), pp. 113-115.

saying that her thinking was "messed up," so they were not available to talk with either. The physical exam was unremarkable. A common cause of low sodium is medication, especially the diuretic pills commonly taken for hypertension, but the patient explicitly told the resident she was not taking any medicines.

Now, on morning rounds with the attending physician, the resident complained about the patient being a "poor historian," the standard complaint whenever physicians cannot get the information out of the patient that they are looking for. "Let's see," replied the attending. He turned to the patient and asked, "Are you taking medications? Is there anything you want to add to what you told the doctors during the night?" "Why do you keep asking me all these questions?" she replied, glancing at her nightstand, then down at the foot of the bed.

The attending took the resident out into the corridor and said, "Her purse is in the nightstand, and if we look inside we'll find the bottle of the chlorthalidone (diuretic) that she's been taking." They returned to the room and the attending told the patient, who was again buried under covers, "Please get out your purse so that I can look at the pills in it." She emerged from the covers, pointed to the bedside stand, and told the resident that he could get her purse out. The attending opened the purse to find four bottles—chlorthalidone, a thyroid medicine, a tranquillizer, and a pain medicine. "Do you take these every day?" he asked. "Most days," she replied, "but I didn't take any yesterday because I felt bad." She then buried herself again.

The resident later asked the attending how he knew. "Diuretic abuse is one of the most common causes of hyponatremia, as you know. It seemed clear that she did not want us to know something that she was embarrassed about. When I asked about the medicines, she immediately looked over to the nightstand. And in the small town where she comes from, chlorthalidone is the favorite diuretic of all the local practitioners."[2]

Medicine and Detection

These true anecdotes are a reminder of how close everyday medical practice is to the contents of a detective story. Neither author who recounted these anecdotes did so with the idea of "writing a detective story." Both accounts appeared in books intended primarily for other

[2] Modified from: Ronald Schleifer and Jerry B. Vannatta, *The Chief Concern of Medicine: The Integration of the Medical Humanities and Narrative Knowledge into Medical Practice* (Ann Arbor: University of Michigan Press, 2013), pp. 125-6.

physicians, to instruct them on the finer points of improving their medical skills.

If these moments that can only be described as brilliant detective work pop up naturally in everyday medicine, we start to see what a short journey it is from medical practice to a type of detective story that relies particularly on the use of medical science to assemble the clues that will unravel a mystery. Medical investigations on both the living and the dead regularly feature, after all, in routine police work. Laboratory tests measure drug and alcohol levels, psychiatrists assess the mental health and competence of prisoners, homicide victims give up their secrets on the autopsy table. It is a relatively small move in the detective novel for these medical investigations to move from the periphery to the center of attention.

There are many ways that physicians and other health professionals can figure in detective stories. They can be the victims of crimes. They can be incidental characters, perhaps suspects. They can be the criminals—their crimes committed by subtle medical means, or by ordinary, old-fashioned weapons such as guns. They can assist the "real" detective character—the most famous physician in detective fiction, Dr. John Watson, assists Sherlock Holmes in ways that very seldom cause him to call on any specifically medical knowledge or skill. Or they can be the actual detective characters themselves.

My focus in this (nonfiction) volume will be *physicians (or equivalent practitioners) as the central detective characters in detective fiction*. I will, however, offer a couple of side trips into bodies of literature that seem to me to be closely associated. One such side trip will be nonfiction accounts of medical detection, somewhat similar to the two anecdotes above. The other will be selected psychologists as detectives, since in this regard psychiatry and psychology can be overlapping.

I will admit to being old-fashioned and committed to stories printed on paper. (I will reluctantly admit Kindle.) I will therefore exclude mention of mysteries that have appeared solely on radio and television.

But first, let's discuss the relationships among medicine, mystery, and the novel in more detail.

CHAPTER TWO

MEDICINE, MYSTERY, AND THE NOVEL

In 1909, Richard C. Cabot, a prominent Boston physician, began a series of medical detective exercises at the Massachusetts General Hospital. These exercises, held weekly, were so popular that several years later Cabot began to circulate printed accounts of them, and in 1924 the *Boston Medical and Surgical Journal* (today, the *New England Journal of Medicine*) began to publish these accounts, titled "Case Records of the Massachusetts General Hospital."

Cabot, appropriately, never called these exercises medical detective stories. Instead, they were more formally titled Clinicopathological Conferences (CPC for short).

In a CPC, a medical case was described in detail with the arrival of the patient at the hospital, all the symptoms the patient complained of, the results of the physical examination of the patient's body, any laboratory tests or x-rays, and how the patient progressed thereafter. In early days, the outcome was usually death, or sometimes major surgery. In more recent CPCs the patient often survives and the case story ceases with the performance of what's considered to be a definitive diagnostic test, such as a biopsy of tissue. As there would be little mystery in a case of mumps or pneumonia, the patient's diagnosis is obscure; or if the patient suffers from what turns out to be a common complaint, the way that it shows itself in the case is unusual.

Next, a physician who does not yet know the actual outcome of the case takes the stage and offers his (or in later years, her) reasoning as to what the diagnosis must be based on the signs, symptoms, and preliminary tests. The physician is expected to give as long as possible a list of different possibilities that might explain this constellation of findings—the differential diagnosis. The physician then has to say which of this list of possibilities he or she favors as the correct answer.

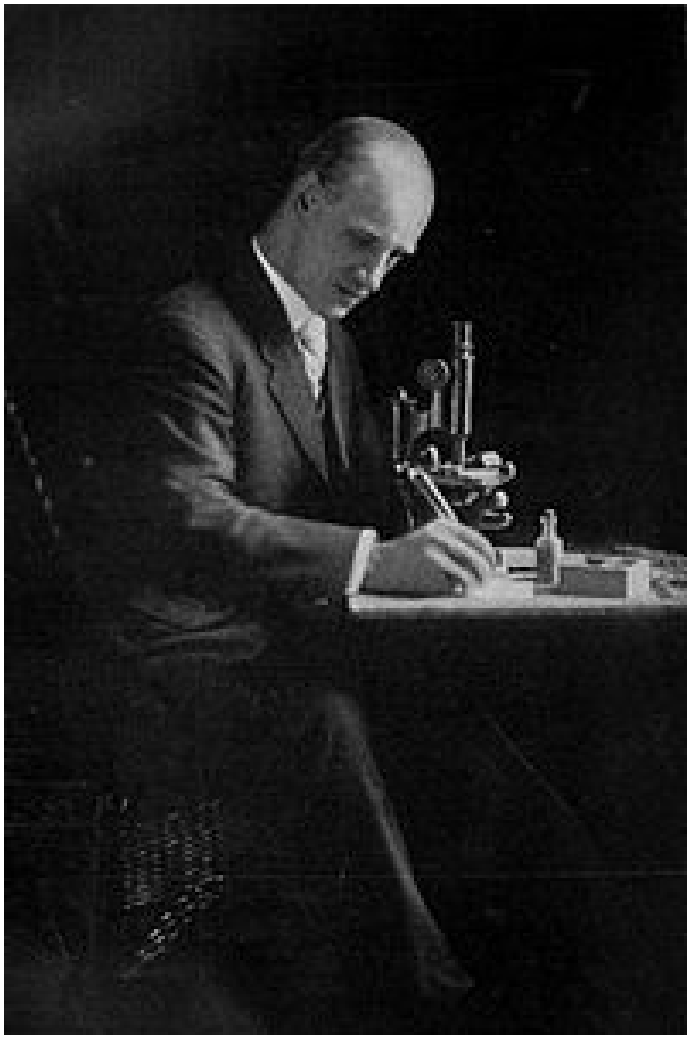

Figure 2-1. Richard C. Cabot (1868-1939)

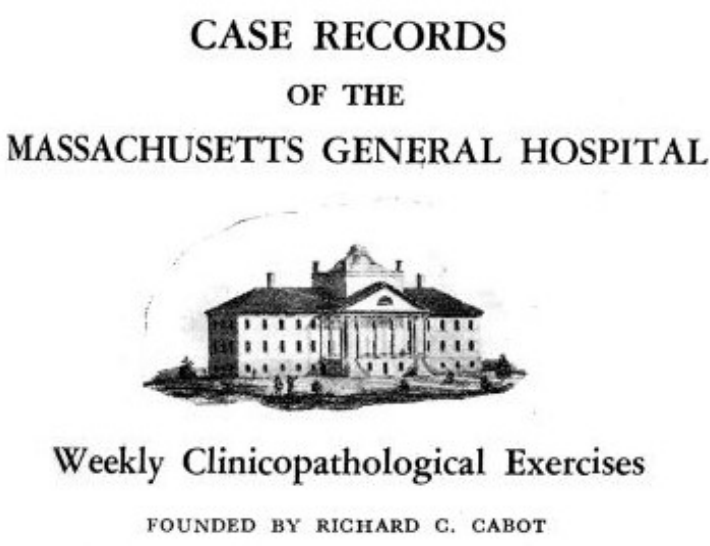

Figure 2-2. Case Records of the Massachusetts General Hospital: Logo in the *New England Journal of Medicine*

The final speaker at the conference is the pathologist, or perhaps more recently, a physician capable of interpreting the imaging or other definitive study. When the patient had died, this speaker reports the autopsy findings. This speaker reveals the answer of what the patient actually suffered from. The dramatic tension is now relieved—was the expert physician who offered the differential diagnosis, and who guessed at the best answer, right or wrong? The physician achieves a perfect score if his answer was correct, or gets some points if the real diagnosis was at least on his list of differential diagnoses. The physician feels most foolish if the true diagnosis turns out to be something he had not even considered.

The CPC illustrates both the close alliance between the medical "case" and the "case" of a detective story, as well as some of the presuppositions that underlie the very idea of a detective story. The surface appearances—the patient's symptoms and physical exam findings—were as likely to be misleading as informative. They were judged insufficient to provide a conclusively satisfying answer to the puzzle. The question, "what disease does this patient have?" nevertheless is considered fully answerable, objectively answerable, and answerable (if the right procedures are followed) with 100 percent certainty. The final, conclusive answer is to be found in looking beneath the surface—inside the body, via the autopsy,

surgery, or imaging. Whatever is found there is reliable; whatever the patient said or felt was inherently unreliable.[1]

The expert physician (who might be shown up at the end for a fool) and the pathologist (who according to the CPC protocol could never be mistaken) represent two different approaches to detection. The physician is Hercule Poirot. He uses his little grey cells and tries to approach the case holistically, assembling all the pieces of the puzzle into a grand synthesis. He seeks an overall pattern that will explain what happened. The pathologist is Sherlock Holmes. He is looking for the previously hidden clue—the bit of cigar ash or which bicycle tire made the deeper track. It is by taking things apart and looking at the component elements, one at a time, that he finds out what's hidden below the surface, what really is the solution to the puzzle.

In the language of the academic theorist, the CPC is an exercise in modernism, while today we live in a postmodern age. Today, for example, we realize that there's a given probability, which can be empirically measured, that if two pathologists look at the same microscope slide of autopsy tissue, they will reach two different diagnoses. The possibility of this occurring is simply not taken into account in the traditional CPC. Similarly, the classic detective story is a modernist exercise as well, which partly explains why the detective story in its traditional form seems so out of fashion amongst writers today. (The model of the postmodernist detective story is Umberto Eco's *The Name of the Rose*, where what we learn at the end of the novel is not the answer to the puzzle, but the arrogant fallacy of assuming that such a puzzle could have an answer that we could find.[2])

The fact that the "Case Records of the Massachusetts General Hospital" still appear today in the *New England Journal of Medicine* testifies to the staying power of the modernist medical detective story. But where did these stories come from? What, exactly, is the relationship among medicine, mysteries, and novels?

During the century between roughly 1740 and 1840, three things emerged. First, the modern novel took its place in literature. Second, the medical case study arose as a distinct form. Finally, the mystery or detective story appeared. These developments were more closely linked than is usually appreciated. Let's look at each in turn.

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[1] Christopher Crenner, "Diagnosis and Authority in the Early Twentieth-Century Medical Practice of Richard C. Cabot," *Bulletin of the History of Medicine* 76:30-55, 2002.

[2] Umberto Eco, *The Name of the Rose* (New York: Warner, 1984).

The modern novel

The modern novel is by its very nature a type of mystery novel. Mystery novels, that is, are different only in degree and not in kind from the "standard" novel. There are good and bad standard novels and good and bad mystery novels; merely being of the mystery genre does not make a novel second-class.

Why are all modern novels mystery novels?

1. The reader is not supposed to discern, immediately, how a novel will end. One is not supposed to read that all happy families resemble one another, but that each unhappy family is unhappy in its own way, and say to oneself, "I bet at the end of this novel the woman will throw herself under a train." The relative degree of surprise at the ending of the novel is a part of the form.
2. That said, once one has read the end of the novel, the novel is considered a relative failure if the reader does not say, "Now that I know how it all turned out, I see how you could sort of have seen it coming all along." In other words, the author is expected to have left clues throughout the novel that make the conclusion understandable and reasonably expectable.
3. Finally, the novel has proceeded all along at two levels. There is the outward level of the behavior and dialog of all the characters, and the deeper level of the inner thoughts of the main characters. It is often the case, and this gives the novel much of its dramatic tension, that there's a disconnect between the two levels. People commonly behave one way and inside think something different. The reader is challenged to connect the dots, to discern in the outward signs further clues to what might actually be happening beneath the surface. In short the reader is invited to become a detective.

The third point reminds us of one aspect of the CPC—the distinction between outer, possibly false appearances and the inner, "real" process of disease. The rise of the novel in literature in the 1700s and 1800s coincided with this emerging view of human reality.

The medical case

Pediatrician Philip Rosoff writes:

> The basic composition of a [medical] case report has remained remarkably stable over the centuries: a patient's story is told in a manner that steadily reveals ever more information, much in the manner of modern detective stories, which maintain the reader's interest with a slow but steady trickle of

> clues. Indeed, well-written case reports bear a close resemblance to classic 'whodunits.' The reader is encouraged to think along with the case presenter and test her diagnostic wits to see if she can come up with the answer before the big 'reveal' at the end.[3]

In a similar vein, Dr. Faith Fitzgerald, a prominent internist, described for Dr. Lisa Sanders the conference she presents at the annual meeting of the American College of Physicians which is a sort of CPC: "It's a form of entertainment. A lot of the appeal of internal medicine is Sherlockian—solving the case from the clues. We are detectives; we revel in the process of figuring it all out. It's what doctors most love to do."[4]

While the medical case report has indeed remained stable over centuries, the outer/inner distinction did play a major role in medicine during roughly the period we have been considering. In the early to mid-1700s, most medical thinking followed the pattern of humoral medicine, the dominant theory of medicine since Hippocrates and Galen. The outer and inner worlds were thought to be in harmony. A person was healthy when all the humors were in balance. When an imbalance occurred, changes appeared which could readily be discerned upon the surface of the body. Humoral treatments, such as bleeding and purging, involved changes equally well seen on the surface.

The philosopher Michel Foucault, in *Birth of the Clinic*, wrote of the revolution in medical thinking that occurred roughly between 1780 and 1830 under the title, "clinical gaze."[5] Nikolas Rose summarizes Foucault's view: "The clinical gaze, trained at the bedside, shaped by anatomical atlases and the experience of pathological anatomy, must read beneath the appearance, distribution, and progression of visible symptoms to the vital living interior of the patient, to identify the underlying pathology that gave rise to them and is the key to their intelligibility."[6] The stethoscope, invented around 1820, illustrates this new view. With the physical exam of the day, the physician could get a rough idea of the heart's function. With the stethoscope, the physician could discern much more precisely how the heart was beating and how its component parts were working. The physician used his hands, for the most part, to examine the "outer" heart. His ears applied

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[3] Philip M. Rosoff, "Can the Case Report Withstand Ethical Scrutiny?" *Hastings Center Report* 49(6): 17-21, 2019, quote p. 17, endnotes omitted.

[4] Lisa Sanders, *Every Patient Tells a Story* (New York: Broadway Books, 2009), p. 27.

[5] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York: Vintage Books, 1975).

[6] Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton, NJ: Princeton University Press, 2007), p. 43.

to the stethoscope revealed the function of the "inner" heart. Small wonder that physician came to view the inner heart as *more real* than its outer manifestations. As Dr. Lisa Sanders summarizes: "Using his eyes, his ears, his stethoscope, the doctor becomes a detective—deducing the pathology within from the observations made from without. Using the clues provided by symptoms described by the patient and the signs elicited and observed by the physician, the doctor-detective was able to track down the villain—the morbid process within the body."[7] The CPC is the more recent embodiment of the clinical gaze.

In 1981, philosophers K. Danner Clouser and Bernard Gert and physician Charles Culver offered a definition of "malady," the general state of being sick, injured, etc. They said that to have a malady is to suffer, or be at risk of suffering, a bad state of affairs such as death, pain, the inability to carry out basic bodily functions, and so forth. They had to add a key modifying phrase to their definition: "in the absence of a distinct sustaining cause." That is, if one suffered from pain, but one was also at the same time lying beneath a heavy iron safe that had fallen on one, then one did not have a "malady," though once the safe was removed, the resulting injuries could constitute a malady.[8]

The implication seems to be that in general, if you are sick, you need to consult a physician, and the physician cannot rely on surface appearances to know what's the matter with you. Following Foucault's thinking, these other philosophers of medicine suggest that the physician may well need to peer beneath the surface and cannot rely on outer appearances to get to the bottom of the situation. In medicine, what's real, what's the answer, is not to be found by relying on surface appearances only. In short, there's always something mysterious about medicine.

The mystery story

There is debate among mystery experts as to what counts as the first true, published detective story. The various candidates tend to have been written during the first few decades of the nineteenth century. Everyone agrees, however, that with Edgar Allan Poe's stories, "The Murders in the Rue Morgue" and "The Purloined Letter," the mystery story came of age.

Why did the mystery story not emerge as a distinct literary genre until the early nineteenth century? The germ of the detective story can be found

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[7] Sanders, *Every Patient Tells a Story*, p. 138.

[8] K. Danner Clouser, Charles M. Culver, and Bernard Gert. "Malady: A New Treatment of Disease." *Hastings Center Report* 11(3): 29-37, 1981.

in the Bible and in Aesop's fables. Voltaire similarly glimpsed the contrast between his own age of enlightenment and earlier centuries, when his proto-detective Zadig, in correct Sherlock Holmes style, describes a horse and a dog accurately based solely on the footprints and other physical traces left behind, and the immediate reaction of some authorities is that he should be burned as a sorcerer.

In his classic essay "Crime and Detection" (1926), historian and critic E. M. Wrong argued that two key ingredients were missing throughout medieval and Renaissance times. First, readers could not possibly have a modern idea of what a detective was supposed to do, in a world where the way you "solved" a crime was to find the most likely suspect and then torture him until he confessed. Second, to enjoy a modern detective novel, readers have to be on the side of the authorities against the criminal, but for much of that period of history, the common folk were much more likely to sympathize with the highwayman.[9]

Michael Ryan, an Irish physician working in London, quoted a passage in his *Manual of Medical Jurisprudence* (2nd ed., 1836), to show how far the field had advanced since previous centuries.[10] His source, apparently, is *A Complete Collection of State-Trials…* with a preface by Francis Hargrave, published in 11 volumes between 1776 and 1781; the murder trial referred to in this passage apparently occurred sometime during the reign of Charles II, that is, the later seventeenth century, showing how long beliefs that we might consider typical of the medieval period persisted.

The passage describes a courtroom scene. Testimony is taken regarding the body of the deceased person being taken from the grave thirty days after death. According to the testimony of the minister of the parish, the four defendants in the case were each ordered to touch the dead body. One of them "did touch the dead body, whereupon the brow of the dead, which before was of a livid and carrion colour…, began to have a dew, or gentle sweat arise on it, which increased by degrees, till the sweat ran down in drops on the face; the brow turned to a lively and fresh colour; and the deceased opened one of her eyes, and shut it again; and this opening of the eye was done three several times. She likewise thrust out the ring or

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[9] E.M. Wrong, "Crime and Detection," in *The Art of the Mystery Story*, ed. Howard Haycraft, (New York: Carroll & Graf, 1974), pp. 18-32. His views were readily seconded by another classic author on the genre, Dorothy L. Sayers, in her introduction to *Great Short Stories of Detection, Mystery, and Horror* (1928-29), reprinted in *The Art of the Mystery Story*, ed. Howard Haycraft, (New York: Carroll & Graf, 1974), pp.71-109.

[10] Michael Ryan, *A Manual of Medical Jurisprudence and State Medicine*…, 2nd ed. (London: Sherwood, Gilbert, and Piper, 1836), pp. xxi-xxii.

marriage finger three times, and pulled it in again, and the finger dropped blood from it on the grass." This witness was followed by the minister of the adjacent parish, who testified that he had also been present and that events took place exactly as described. The passage devotes approximately equal space to the strange events involving the dead body, and to the attention paid in court to the testimony of the witnesses and precautions taken to assure that what they had said was trustworthy.

In the passage quoted by Ryan, the people involved in the trial appear to believe that they are actively solving a puzzle of who committed the crime. But just as obviously, today's reader cannot sympathize at all with their conclusions.

Now, fast forward to the early years of the nineteenth century—the "modern" era according to Michael Ryan. In February, 1832, in Doylestown, Pennsylvania, Lucretia Chapman was placed on trial for the murder of her husband William. Dr. Phillips, the local physician, had originally diagnosed "cholera morbus" but later testified that William died of arsenic poisoning. The postmortem exam had been performed hurriedly after the body had been buried for three months, by two physicians who had never previously examined a corpse under those circumstances. The physicians ignored the rectum, though the opinion of that era held that an inflamed rectum was an invariable guide to arsenic poisoning as opposed to cholera morbus. They instead removed the stomach and sent it to a chemist. The chemist cooked and dissolved the tissue without any clear results, save for an instant when a beaker holding some tissue accidentally cracked and the chemist thought that he smelled a garlicky odor associated with a form of arsenic.[11] To summarize, as late as the early years of the nineteenth century, the medical evidence likely to be presented in a court of law was far too flimsy to serve as a valid basis for a "mystery."

Slightly earlier, in 1829, the Metropolitan Police of London had been established by Home Secretary (later Prime Minister) Robert Peel. The mid-nineteenth century saw the development of legitimate and ultimately powerful police forces which eventually featured detective sections. Alfred Swaine Taylor (1806-1880) published the first of many works on medical jurisprudence in 1843, ushering in the modern era in the scientific study of the crime scene. By the later decades of the nineteenth century, all elements were in place to create the modern idea of the detective or mystery story.

The emergence of the medical "case" in its modern form, the detective or criminal "case" in its present form, and the modern novel at roughly the

[11] Ann Jones, *Women Who Kill* (New York: Fawcett Columbine, 1981), pp. 82-3.

same period in history, are therefore intertwined more closely than one might first imagine.

When authors came to write mystery stories or novels, they found that they had to deal with some recurring issues. In the next chapter we'll look at some of the features of detective novels that we'll have to pay special attention to as we turn to medical mysteries.

CHAPTER THREE

GENERAL FEATURES OF MYSTERY PLOTS

Mystery stories, including medical mystery stories, tend to have several recurring features. In many instances, how well or how poorly they handle these features determines the overall quality of the story. Let's look at some of them.

Two major plot types

Most mystery stories are variants on a few basic plot types. For our purposes, two of these plot types are of special interest-- the Rue Morgue Murder and the English Country House Murder.

Edgar Allan Poe was clearly the most influential among the early experimenters in the mystery genre. His classic tale, "The Murders in the Rue Morgue," can be taken as the template for one basic type of plot. The detective arrives at the scene of a murder and investigates various clues. Based on these clues he reconstructs the personality and physical characteristics of an as-yet-unknown murderer. The remainder of the story consists of the detective's search, across the city, for a person matching these characteristics. One plot possibility is to lay a trap into which a person with these specific characteristics might walk. (In two Rue Morgue murder stories, Poe's original and Conan Doyle's "The Adventure of Black Peter," the trap is a carefully worded newspaper advertisement.)

Arthur Conan Doyle was a great admirer of Poe, even though he covered this up by putting anti-Poe comments in the mouth of his main character. So it is not surprising that the first two Sherlock Holmes long stories, *A Study in Scarlet* and *The Sign of Four*, mimicked the basic Rue Morgue formula. In both cases there were obvious suspects near the scene of the crime, upon whom the police immediately fasten, but Holmes is convinced that the police are blundering as usual and that these people have nothing to do with the murders. Instead he goes farther afield to find the individual that matches the clues left at the crime scene. Doyle returned to this formula in later short stories such as "The Dancing Men," "Black Peter," and "Abbey Grange."

As early as "The Boscombe Valley Mystery," in his first set of Holmes short stories, Doyle tried a different type of plot. A murder is committed in an isolated setting, so that only a limited number of people would have had access to the site and therefore the opportunity to commit the crime. Solving the mystery means going down this list of possible suspects and eventually identifying the actual murderer among them. Often the mystery lies in the motive for the crime, since opportunity has already been established, so that discovering who had the strongest motive is the key to solving the puzzle.

Besides Doyle, another author who we will consider in depth later, the physician R. Austin Freeman, made much use of this general plot subtype. But I suspect that the most powerful influence on later writers in Britain and the U.S. was Agatha Christie whose fondness for the "English country house murder" was legendary (and whose use of this plot template no doubt inspired the board game "Clue," which itself helped to influence later authors). Indeed, a number of Christie's novels appear to have arisen from the logical exercise of trying to list every possible variation on the basic country-house, limited-list-of-suspects motif:

- Two of the suspects did it together, these being the two who outwardly appeared least likely to collaborate in anything (*The Mysterious Affair at Styles*; *Death on the Nile*)
- None of the suspects did it, since all are found dead in the end, under circumstances where no outsider could have been responsible (*And Then There Were None*)
- All the suspects did it (*Murder on the Orient Express*)
- The policeman did it (*The Mousetrap*)
- The Watson character did it (*The Murder of Roger Ackroyd*)
- The detective character did it (*Curtain*)

The least likely culprit

Of the two plot types, the Country House appears to have been much more widely imitated than the Rue Morgue. This is unfortunate for medical detection, in my view, for two reasons. First, I believe that the Rue Morgue formula can be used to great advantage in a story that depends on medical clues. But perhaps more important is how easily the Country House formula deteriorates in hands less skilled than Christie's.

The English Country House type of plot has a damned-if-you-do, damned-if-you-don't feature. If the author features just a few characters, it's quite difficult to conceal the main clues well enough to continue to hide the criminal's identity till the end. If the author creates a large cast of

characters, the readers lose interest because they cannot keep the whole mess straight in their minds.

Anyone who peruses "fair play" mystery novels published roughly between 1930-1960 knows the formula where the front of the book features a list of the characters, and the reader therefore is immediately tipped off that the criminal is to be found among that list. This approach becomes a race to the bottom in which the author tries, not to construct the most ingenious plot, but instead to hide the identity of the actual criminal by making that character seem the least likely to have committed the crime ("the butler did it"). Thus, the English Country House Murder plotline is subject to one of the most important recurring weaknesses in the detective-story genre, which I'll call the Least Likely Culprit ploy. The novel becomes a game between the reader and the author where the reader looks not for real clues to the criminals' identity, but rather signs that the author wants us to think that so-and-so couldn't possibly be guilty. Unfortunately, the better the author plays this game, the less convincing is the final working out of the plot.

Later we'll see that Helen McCloy's Dr. Basil Willing deserves a spot as one of the most satisfactory physician-detective characters. But that did not save McCloy from the pitfalls of the Least Likely Culprit template in her first Willing novel, *Dance of Death* (1938). Here is her description of one of the characters who was present at the party where the crime was committed: "[Detective] Foyle liked Mrs. Jowett the moment he saw her. But then he had a weakness for large, placid, smiling women who made him think of sunlit farm kitchens and freshly baked bread. His own mother used to give him a slice of such bread with butter and brown sugar, and he could imagine Mrs. Jowett giving the same thing to [her daughter] in the photograph when she was a few years younger." It seems obvious that this character is being set up to prove to be the murderer. When the astute reader notices that it is the police detective Foyle, and not the hero Dr. Willing, who has this impression of Mrs. Jowett, that further clinches the identification.

Superficially, the Least Likely Culprit ploy looks a lot like a truly excellent mystery plot of the classic "fair play" school. The master at this type of story presents us with a series of clues, but through expert misdirection, much like the way a skilled magician performs on stage, the author gets us not to recognize the true significance of the clues when they are first presented. When we learn the culprit, we slap our heads and exclaim, "I should have known!" But there is a big difference between not recognizing the answer early on because the author has so cleverly concealed the significance of the clues, and not recognizing because the

author has deliberately tried to make that character the Least Likely Culprit. In the excellent-plot case, it is not merely that we are unable to guess the culprit in advance, but also, once we know the identity, it all makes perfect sense. It is the "making perfect sense" part, and not the "couldn't guess" part, that marks the true master of the genre. In the Least Likely Culprit type of novel, the author is stuck. All the work he has done to make this person seem least likely to be the criminal means that in the end, when that person is discovered to be the criminal, the author has to quickly make up an explanation as to why he previously seemed so unlikely when he was actually guilty as sin. The average author can't do this in any convincing way, and the entire house of cards collapses. Apparently, given the sales of B-grade mysteries over the decades, a lot of undiscerning readers didn't care.

Another variant on the Country House/Least Likely Culprit theme that has been worked into the ground is to have suspicion first fasten on one character, then another, and so on, with each chief suspect then being eliminated by becoming the next murder victim.

The soap opera complex

Another weakness that we encounter especially in more recent medical detective stories is what I'll call the Soap Opera Complex. Again this weakness is the more extreme form of a tension that's built into the very idea of a detective novel. Ellery Queen, writing about the detective story in 1942, took a dim view of novels:

> Modern readers tend to think of "detective stories" as novels, and admittedly the novels are numberless. But the original, the "legitimate" form was the short story. The detective novel is a short story inflated by characterization and description and romantic nonsense, too often for purposes of padding, and adds only one innovation to the short story form: the byplot, or red herring, which when badly used serves only to irritate when it is meant to confuse.[1]

A novel, to be a detective novel, has to have an intellectual puzzle, but to be a novel at all, it has to tell an interesting story about interesting characters. The medical-mystery master himself, R. Austin Freeman, admitted to the difficulties he had with this tension. His version of the

[1] Ellery Queen, "The Detective Story: The First Hundred Years," in *The Art of the Mystery Story*, ed, Howard Haycraft (New York: Carroll and Graf, 1992), pp. 476-491, quote p. 477.

Soap Opera Complex (Queen's "romantic nonsense") was what he called the "Love Interest," which he both dreaded and sought in many of his novels. One character has to fall in love with another and the novel has to end with the likelihood of their living happily ever after. Ideally, one of the lovers either has to be an intended victim of the murderer, or else unfairly suspected of the murder, to further heighten suspense. With Freeman in control, the medical-mystery plot was so strong that there was no danger of the Soap Opera Complex, or Love Interest, unduly dominating the story. Sadly that cannot be said of many of his successors.

Perhaps the most successful author in history at controlling the soap-opera element of the detective story was the most successful mystery author around, Arthur Conan Doyle. Doyle had the least need for any soap-opera business to keep his narrative moving because he worked mostly in the short story mode, where character development and non-mystery plot elements are of necessity kept to a minimum. Yet today, more than a century after he introduced his characters, Sherlockians attend meetings and read magazine articles devoted entirely to sorting out the offhand remarks he threw out about where Holmes attended college, or what exactly happened to Watson during his service in the Second Afghan War. While appearing not to be telling us anything important at all about Holmes, Watson, and their personal relationship, Doyle over the course of a series of 60 tales managed to paint a picture of such a compelling pair of individuals as to have his readers always clamoring for more Holmes and Watson, even after the cleverness of the mystery plots had slipped. Maybe the soap-opera part of detective fiction ultimately works most successfully when it seems to be absent.

The Soap Opera Complex seems especially strong today when the commercial elements of mystery novels tend to dominate even more than they did in the past (not that any authors of note ever gave away their books for free or failed to care about profits). Successful series like the Kay Scarpetta novels by Patricia Cornwell and the Temperance Brennan novels by Kathy Reichs appear to have had a stranglehold on how both publishers and authors now think about their goals. To launch a commercially successful detective series, you need to have a cluster of characters that have complicated personal lives and romantic entanglements. The reader has to get to be interested in what is going to happen in the next episode of the soap opera, to keep on buying books. The author also has to churn out the books on a tight schedule, so that the next novel in the series is nearly ready to go by the time the earlier novel is being printed. Working on this sort of assembly-line schedule, it's nearly impossible to keep coming up with great medical or scientific plot ideas.

And as far as the publisher is concerned, that's not what keeps the readers coming back anyway, once they get hooked on the characters' escapades.

The end result is a series of novels with the Soap Opera Complex riding high and the medical theme hardly present at all. From my old-fashioned point of view, that's a perversion of the whole idea of the medical mystery story, no matter how many copies get sold. As we get to later chapters, sadly, we'll see many examples of the Soap Opera Complex taking over and eclipsing the medical-mystery part of the plot.

Attack the impregnable detective

Nick Carter, who appeared first in 1884 and then for a half-century afterward, was a dime-novel detective character whose adventures characterized the difference between the "thriller" and the true detective story. Carter, noted detective historian A.E. Murch, on the one hand seemed to have "superhuman powers of mind and body."[2] Yet in virtually every story Carter found himself trapped and in danger of death from the criminal he was pursuing, and required his faithful assistant to rescue him.

We may term this plot device "Attack the Impregnable Detective." It has two features that place it in the "potboiler" category. First, the detective is supposed to be too smart to fall for these tricks, so it often requires a dubious plot twist to make the hero of the novel susceptible to the attack. Second, in all cases that I am aware of at least, the attempt of the villain to kill the detective fails. So the reader is supposed to be thrilled by the attack, yet at the same time really knows that it cannot possibly be successful.

The most accomplished classic mystery writers, Doyle and Christie, were quite secure in the narrative interest of the more cerebral aspects of their plots and characters. We do not expect to encounter "Attack the Impregnable Detective" incidents aimed at Sherlock Holmes or Poirot or Miss Marple. When such an attack does occur, as in Doyle's "The Illustrious Client," it's truly a big deal (and all the more effective as a plot twist) because it's such a deviation from the normal.

R. Austin Freeman, whom I'm holding up as the all-time dean of medical mystery writers, was not similarly confident. The first published Thorndyke novel, *The Red Thumb Mark* (1907), features no fewer than three attempts by the villain to eliminate Thorndyke. Admittedly, Freeman handles these episodes with typical Victorian-Edwardian restraint. First of

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[2] A[lma] E[lizabeth] Murch, *The Development of the Detective Novel* (New York: Greenwood Press, 1968), pp. 138-141, quote p. 139.