reviews

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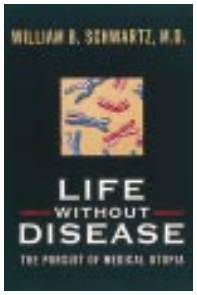
Life Without Disease: The Pursuit of Medical Utopia

William B Schwartz



University of California Press, £17.95, pp 159
ISBN 0 520 21467 6

Rating: ★★

Schwartz provides a framework for understanding how the increasing potential of a disease-free existence can be reconciled with the pressure for containing costs in a US context. To understand where we are and where we may be headed, the book is divided into separate sections focused on the last half of the 20th century, the next 20 years, and the period leading up to 2050. Each section begins with a discussion of actual or prospective developments in what medicine can do, followed by consideration of the challenges these developments have presented or will present for the organisation of health care in the United States. The underlying theme is that cost control requires rationing in one form or another.

The strength of the book lies in the "potted" descriptions of medical advances past, present, and future. The mind boggles at what we can now do and what we might be able to do. The "boggling" is intensified when one recognises that only a small proportion of the US population has access to many of these advances—a rationing mechanism given little attention within the volume.

Rationing in the United Kingdom, France, Germany, and Canada is described. However, the seven pages devoted to this international perspective fail to do justice to an important and well researched topic. Rationing in the United States in the form of "managed care" is dealt with somewhat superficially in 14 pages, though this is sufficient to illustrate that the "programmes" in question have nothing to do with either patient care or population health and much to do with corporate profits. The author's own "proposal" is "Oregon-esque" in the underlying principle of seeking the biggest (health) bang for the healthcare buck. However, the Oregon approach is enhanced by recognition that the outcomes of pairings of treatment and disease will vary according to the severity of the condition. Under Schwartz's approach less severe cases would be less likely to be served (something closely resembling the NHS approach that Schwartz has previously condemned). Emerging evidence shows that healthcare outcomes may be systematically related to other determinants of health, such as the social, cultural, economic, or environmental conditions to which individuals are exposed. The proposed approach would then produce widening disparities in health within societies. Moreover, the approach assumes that the opportunity cost of better health is the same for all—yet the trade-offs underlying "choices for health" may be very different between social groups.

Schwartz considers that "exploding knowledge" begins to make possible the once impossible dream of a disease-free existence and an average life expectancy at birth of 130 years. Whether that knowledge can be turned into wisdom to provide improvements in health expectancy for all our fellow citizens remains to be seen.

Stephen Birch, *professor, Centre for Health Economics and Policy Analysis, McMaster University, Ontario, Canada*

Sports Medicine: Practical Guidelines for General Practice

Domhnall MacAuley

Butterworth-Heinemann, £23.50, pp 280
ISBN 0 7506 3730 7

Rating: ★★

While the demand for education about sport and exercise medicine steadily increases, there is still a considerable reluctance among doctors to acknowledge it as a specialty, despite the provisional recognition shown recently by the Academy of the Royal Colleges. Doubters may be persuaded by the illuminating review of the history of medicine in sport that introduces this book—from the earliest records in ancient China of 2500 BC through to the Framingham study of the relation between inactivity and cardiovascular disease, which laid the basis for the scientific understanding of the effects of exercise.

The author, Domhnall MacAuley, is primarily a general practitioner who has added sport and exercise medicine to his skills, and the book successfully reflects his experience. He discusses at length the benefits and risks of exercise to young and old, with a supporting chapter outlining the physiological effects and how they are measured. Sports medicine is inevitably associated with the diagnosis and treatment of injury, minor injuries and emergency care being the currency of primary care. The outline of initial management is a useful guide for less experienced doctors.

MacAuley rightly emphasises the importance of a treatment plan, so often neglected, allied to an understanding of and sympathy for an athlete's aims, with attention to prevention through appropriate training and preparation for sport. The sections on problems in various parts of the body are necessarily painted with a fairly broad brush and deal more with recognising and treating problems than with understanding their causes. Reflecting the rapidly developing interest in the role of exercise in the management of various chronic illnesses, the book discusses how doctors may influence the progress of disease by appropriate advice as well as the risks of exercise in acute illness, particularly when viruses are involved. The needs of the many general practitioners who are club or team doctors are not neglected, although the importance of their role within the medical support team—with physiotherapists, coaches, and other specialists—is not sufficiently emphasised.

This guide is a good introduction to the practice of sport and exercise medicine in primary care and is extensively referenced for those who wish to read further. It has the sort of practical information that general practitioners can immediately relate to their practice. The layout is conventional but clear, set out in small, easily digested sections with helpful, but rather too infrequent, illustrations, check lists, and summaries.

Malcolm B Bottomley, *director of studies, sports medicine teaching course, University of Bath*

Reviews are rated on a 4 star scale (4=excellent)

Mount Misery

Samuel Shem

Black Swan, £7.99, pp 480
ISBN 0 5529 9813 3

This is an edited extract from Samuel Shem's new book, his sequel to House of God

"After lunch, Errol let me sit in on his private practice. His office was on the top floor with a fantastic view unrolling to the north, where the line of white smudges on the horizon was maybe snow on the mountaintops, maybe clouds. The office was a kind of museum of the drug trade: everything "Courtesy of" somebody. From the leather couch and chairs courtesy of Ciba-Geigy/Brazil; through the immense rosewood desk courtesy of Smith-Kline/Thailand; to a tiny working model of the blood supply to the human brain, bubbling bright red cartoon blood through the arteries and draining sludgy blue venous blood out through the veins, with a flashing sign that said, "Zoloft Keeps You Aloft."

A series of well-heeled patients marched in. Errol spent at most ten minutes with each and treated each exactly the same way: asking about their drugs—usually they were on three to six drugs—and then adding or subtracting drugs before saying good-bye. He asked a question or two about their symptoms. He asked nothing about their psychological state. The patients were treated with a courteous benevolence, like good dogs.

It was astonishing to see how, being treated with total authoritarian objectivity, they responded with total submissive gratitude. Errol gave the impression of being absolutely *sure*. While he was sure about everything, he addressed but one thing: drugs. If his patients wanted to talk diagnosis, he talked drugs. If they wanted to talk symptoms, he talked drugs. Stress? Drugs. Suffering? Drugs. Family problems? Drugs. Job? Drugs. The love his patients felt for Errol was palpable. How could they love him? They could love him because not only did he convey to them that he was sure about their drugs, and by implication about all the other things they mentioned, but in addition he always said to each patient at the end of the ten-minute interview: "This will make you feel wonderful and make you *better*."

Most patients loved hearing this and thanked him. A rare patient might ask "Are you sure?"

"Absolutely. This will make you feel wonderful and make you *better*."

Finished with his private practice, Errol shot to his feet and bolted for the parking lot. Trying to keep up with him, I screamed out, "But a lot of them come back from their last visit with you *not* better."

"And then I give 'em a new drug and it makes 'em feel wonderful and *better*."

"But what if it doesn't make them better?"

"I try a newer drug. Let's go!"

"Don't you ever run out of drugs?"

"You never run out of *mixtures*. Principle of 'the Drug Cocktail' - *c'mon*!"

The gull wings of his red Ferrari spread up and out as if just dying to catch the alluring spring breeze. A bumper sticker read:

RESEARCH TAKES BRAINS,
DONATE YOURS. CALL
1-900-BRAINBANK

"Nice car," I said.

"Ferrari Mondial. Sterling/Italia cut me a deal. Only 197 K."

"Still a lot."

"Not if you maximise your billability. Everything you saw, I bill for. Ten minutes, a hundred bucks. Ten bucks a billable minute."

"It's mind boggling."

"No, it's modern psychiatry." ❞

CD roms

Current Medical Diagnosis and Treatment 1998

Stephen J McPhee,
Lawrence M Tierney Jr,
Maxine A Papadakis,
Ralph Gonzales

Appleton and Lange, £67
ISBN 0 8385 1480 4

Rating: ★★★

Can a reference source really meet the needs of "a student, resident or clinician," as the user's guide for this CD claims? To do so, the information it provides would need to be readily accessible, up to date, and capable of answering the questions that members of each of these groups might pose.

It is certainly quick. The questions I asked it in a week seeing patients, preparing for teaching sessions, and reviewing grant applications convinced me of that. Whether I wanted to know about drugs, diseases, or diagnostic tests that were unfamiliar to me, the search engine usually found what I was looking for within 2 seconds (you don't even need to understand its Boolean search operators).

When I checked how current it was I was even more impressed. Every reference untilthe end of 1997 that I knew about was there with abstracts and hypertext links. I was unable to discover any omitted references without extending my searches beyond Medline.

Of course, the kinds of questions its three target groups ask vary considerably. Students and residents will like the accessible, authoritative text, and they will love the audio and video multimedia features. Cardiovascular and respiratory systems are well represented in these features, with less detail on other systems.

The system's functionality goes beyond the limitations of other CD Roms by providing facilities for updating and personalising the material it contains. The database may be continuously updated via links to 200 internet addresses. Individuals can tag and bookmark the material that is relevant to them.

Many students, residents, and even clinicians don't yet have uninterrupted access to a computer with a CD Rom. Perhaps the availability of reference material like this will encourage more information technology managers to invest in giving their students and clinicians the rapid, relevant access they need to practise evidence based medicine.

Frank Sullivan, *professor of research and development in general practice and primary care, Tayside Centre for General Practice, Dundee University*

Emergency soaps

Casualty, BBC1, Saturdays
ER, Channel 4, Wednesdays

If there's one thing we all want from television programmes these days, it is authenticity. With the advent of Jerry Springer, the revelation that award winning documentaries were faked, and the disclosure that even Vanessa Feltz (whose husband, in case you had missed it, is a gynaecologist) was duped by agency actors, it's a confusing time.

We need more shows that don't pretend to be something they are not. More shows that are so obviously theatre that no one in their right mind could possibly mistake them for real life. More shows like *Casualty* and *ER*. Many emergency specialists long to live in a city like Holby, where BBC1's *Casualty* is set. It's not a big place, but it has a railway station, an airport, a harbour, a motorway, all night rave venues, a flourishing drugs scene, and an endless supply of dangerous chemical factories. It is also surrounded by farmland, providing ample opportunity for ghastly agricultural accidents involving heavy machinery and severed limbs. It's every trauma junkie's fantasy town.

This week, they had a bank robbery that went horribly wrong and, as a result, stretched over two episodes. It looks as if the department's registrar is going to meet a sticky end, having been held hostage by the villains. (You can't miss the villains; they're the ones with the evil ski masks and carrying the bag marked "swag.") Her loss will be a particularly heavy blow for Holby's accident and emergency department, which has only three doctors to start with, one of whom, the consultant, is currently having an affair with a bottle of vodka. This was presumably why he was to be seen listening to a patient's chest having forgotten to put the stethoscope earpieces in his ears. The senior house officer will be the only one left in the place in a couple of weeks, and he's too busy smouldering to see any patients.

It would be nice to think that a show watched by millions might have some effect on the way people behave as patients, but if there is an effect it's a subtle one. No matter how loudly people tut-tut at the drunken, abusive, or malingering patients that regularly feature on the show, exactly the same number of them keep on turning up. Maybe they think the portrayals cannot possibly apply to them, or that telling the sister to piss off is the correct and proper response when not seen and treated within 30 seconds. Or maybe they just don't watch it.

BBC

Where's George Clooney when you need him?

Casualty's American cousin, *ER* (that's "Emergency Room" to the uninitiated), has had one noticeable effect at Holby. Now, as soon as they get someone in the resuscitation room, the doctor barks out a whole list of commands—blood tests, *x* rays, IV fluids. The difference is that in *ER* someone does something about it; in *Casualty* everyone just carries on staring at the patient. *ER* is set in Chicago and makes the Holby department look like Disneyland without the drive-by shootings.

US emergency centres have achieved almost mythical status over here, with staff as well as patients. The image has been bolstered by the arrival of the advanced trauma life support (ATLS) course, which originated in the United States (the manual is full of references to roentgenograms, celiotomies, and diaphoresis). Having your ATLS certificate is de rigueur these days, and things are done very much "by the book" when it comes to trauma. US imperialism takes many forms. It is easy to imagine that every US hospital has a department like that featured in *ER*, staffed by George Clooney lookalikes, where lives seemingly lost can be saved, and everyone has perfect teeth. The reality is that there are just as many ugly, smelly doctors over there as over here and just as many silly, basic mistakes made every day.

Perhaps as a concession to the huge British appetite for the show, the producers recently included a token Brit on the cast. It might be just me, but the actress in question, Alex Kingston, seems strikingly reminiscent, in the nicest possible way, of the Queen or Princess Anne from certain angles—surely a complete coincidence and nothing at all to do with the other interpretation of "ER."

The biggest mystery on the show is the inexplicable single crutch which Dr Kerry Weaver (attending ER physician) always uses to get around. A walking stick, maybe, but why a crutch? Although easy to poke fun at, it's compulsive viewing for millions and is a fabulous show, mainly because the characters, despite the annoyance of their near perfection, are all likeable and very watchable.

Casualty, in its own British way, is also watchable telly and consistently tops the Saturday night ratings. There was talk last year of it going thrice weekly, but instead they have gone for a "first"—the first soap within a soap. *Holby City* revolves around life in the hospital where *Casualty* is set; like running *Weatherfield Town* alongside *Coronation Street*. The programme exploits every media cliche about medicine you've ever heard of, and a few you haven't. It's *Eastenders* meets *999 Lifesavers* with a dash of *Barrymore* and then dumbed down.

At the end of the last episode, two lads broke into the ward pharmacy to steal drugs. These days, what really happens is that a small, valuable piece of medical equipment gets stolen and is sold on to buy a larger quantity of better quality drugs than you'll ever find in any ward's drug cupboard. A pretty nurse gave chase and cornered the two in a room full of sharp, pointed surgical instruments. You can probably predict what happened next. If you can't you'll probably really enjoy the show.

Ed Walker, *staff grade practitioner in accident and emergency medicine, Dewsbury, Yorkshire*

WEBSITE OF THE WEEK

www.open.gov.uk/royal-commission-elderly/index.htm Last week, the royal commission studying long term care for elderly people recommended that taxpayers should meet at least part of the cost of caring for infirm elderly people, and you can read the full report, and the evidence that led to that conclusion, on the internet. It is unusual for the words "elderly" and "internet" to inhabit the same sentence, but in many ways the internet is an ideal resource for elderly people, combining the stay at home convenience of television and radio with the interactivity that could previously be supplied only by a large circle of family and friends.

Older people's familiarity with the internet seems to be increasing: more than 11 million British people accessed the internet in 1998, and the fastest growing groups were the socioeconomic groups C2, D, and E and older people (www.nop.co.uk/news/Ticker_Tape/internet.htm). Of course, being on line won't negate the need for physical care, but it's nice to imagine your online chums alerting the emergency services when you don't reply to your email as promptly as expected.

Older people in America are, as ever, ahead in forming virtual communities: the ones that I looked at advertise Viagra on their home pages and have chat forums, where elderly people log on for advice on many subjects from professionals and their peers. The website www.seniors-site.com is typical, although the weakness of the hypertext mail is readily apparent, with an unwieldy number of messages. Such sites could scale up and use a search engine or scale down and concentrate on promoting their information to a more limited community (either by geography or by interest) because the big guys, in this case the American Association of Retired Persons, have already created an excellent overview at www.aarp.org/cyber/guide1.htm

Douglas Carnall
BMJ

PERSONAL VIEW

In memory of Annie

When Annie was first diagnosed we started using the word "Yo" as a symbol of hope for the future. Annie was a whirlwind of energy, enthusiasm, and humour. She was an idealist, truly believing that the world could be a better place. Her conviction that individuals really can change things carried many people with her, producing real improvements both locally and further afield. "Yo" summed up Annie's approach to her life—and to her death.

For Annie died. Eighteen months ago she was diagnosed as having Hodgkin's lymphoma. Her apparently rapid physical decline came as a shock to her friends. We did not know of her repeated visits to her general practitioner complaining of tiredness. We did not know it took her two days to recover from a simple walk. We did not know of her tears of frustration when her tiredness and breathlessness were attributed to "depression" and "asthma." It was hard to understand her relief when her tumour was finally diagnosed. But for Annie this affirmed her belief in herself—she had known that there was something wrong. Her self belief fortified her through the long months of chemotherapy, bone marrow transplant, and radiotherapy, but in the end "Yo" was not enough and Annie lost her struggle for life. We, her husband, her brother, and her friend, try to come to terms with this.

The twin desires—to blame and to learn—now produce their own struggle for us. We know that blame leads to its own damaging cycle of hurt and learning leads to healing. But questions burn that make the healing route a difficult one to follow. Why was there a two year delay to diagnose her Hodgkin's lymphoma, usually the most treatable of cancers, and why did general practitioner after general practitioner fail to see the significance of her low haemoglobin?

In one sense it is easy to see how it happened. We, your brother and friend, both general practitioners, know that it is common to be confronted by someone who is "tired all the time." And iron deficiency is a common explanation. But we need to remember that a microcytic anaemia is a sign, not a diagnosis. If we write "scanty periods, eats well, supportive husband," we should not accept iron deficiency or depression as an explanation without other evidence. And when 12 months go by and the promised repeat haemoglobin is finally done and it has dropped even further, surely it is now time to do something other than prescribe more iron. When, 18 months later, someone finally tested the erythrocyte sedimentation rate and C-reactive protein they were both abnormal. Did it have to take so long?

When a person comes back again and again saying that they know that something is wrong the listening general practitioner should take seriously what the person is saying; it is, after all, their body and they may well know a bit about it. When we write "breathless, reduced air entry left base," the reflective practitioner will not assume that this is asthma and perhaps do the chest *x* ray examination that would have shown the tumour that had taken the place of the left lung. And then there is continuity of care. You see, Annie saw different doctors, both partners and general practitioner registrars, in different practices, but no one explored things deeply enough. Mistakes were made. But they were made by different people in different places. In this age of frantic general practice development and high patient mobility, the personal relationship and follow up are under threat. Yet these, together with the arts of listening and diagnostic alertness are surely at the heart of good general practice.

> The personal relationship and follow up are under threat

> No one explored things deeply enough

So we, your brother and friend, promise you Annie that we will pause whenever we see someone come into the surgery full of "Yo" and listen when they say that something is wrong. We will pause and we might just say, "It's usually nothing, but do you mind if I keep an eye on you—it's just that I remember someone a bit like you."

And I, your husband, am greedy. I want more. I want all doctors who read this to remember you Annie and learn from you. However busy, however tired, however distracted doctors are, if they lose the ability to learn from their mistakes, then they lose the art of medicine. I and our two small children have to live with the knowledge that a delay in diagnosis may well have cost you your life. Perhaps this article will prevent the death of someone else.

Written with love.

Graz, *your husband;* **Paul**, *your brother; and* **Clare**, *your friend*

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SOUNDINGS

Church parade

I quite enjoy church parades—in moderation of course. In agnostic middle age there are complex pleasures in revisiting our national religion perhaps once or twice a year, singing its hymns, listening to the kind of scholarly, liberal sermon still sometimes heard in Scotland, and doing so in the company of agreeable and like minded colleagues.

We gather early, to stroll and gossip in the great hall where the procession is marshalled for the short walk across a cobbled square and into the cathedral. Everyone who should be here is here: variously robed, gowned, capped, and preened, representatives of the colleges, ancient and learned societies, the universities, the professions, and the armed forces—successful contented bourgeois Scotland, dressed to pray.

"Are you the physicians?" a politely agitated middle aged lady inquires. We are. "I'm sorry to bother you, but it looks as though someone's collapsed.... Quite poorly.... So I wondered...." The two of us nearest to her, actually a physician and a surgeon, head off up the hall.

At first glance the collapse victim is worse than just poorly: pulseless, but pupils not quite dilated. My surgical colleague, by happy chance also my instructor a few years ago on a trauma life support course, does the decent surgical thing and opts for the mouth to mouth role.

Like riding a bike, thumping a chest is a skill of your youth it is hard to forget. The urgency, the rhythm, the resistance—unlike that of any model—and the underlying purpose are all once more instantly familiar and in this case effective. My colleague bravely breathes. I thump. Our patient's pupils stay down. Time passes.

Other colleagues kindly relieve us. Eventually ambulance people arrive. An electrocardiograph shows ventricular fibrillation. Defibrillation helps. Soon a mobile intensive care team shows up too. Apart from the victim and his various helpers, the hall is now empty. In due course a second, less tidy procession, including a stretcher, straggles down the great stairway.

In church my surgical colleague reads the first lesson as though butter would not melt in her mouth. On Monday afternoon when I ring the coronary care unit the news is good: the recently condemned man is pink, cheerful, talkative, though still a little forgetful, and has just finished a three course lunch.

Colin Douglas, *doctor and novelist, Edinburgh*