reviews

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Medicine in the English Middle Ages

Faye Getz

Princeton University Press,
£21.95, pp 174
ISBN 0 691 08522 6

Rating: ★★★

The term medieval, although available for simple descriptive use, is also open to pejorative employment. How would you like your values, way of life, or indeed your medical practice described as medieval? Such a use is an inheritance of the stigmatisation of the middle ages as superstitious and priest-ridden by our rationalist grandparents, notably Edward Gibbon. Outside this tradition, however, has been another that has sought to understand medieval art and religion in its own terms. The same is true of medicine, and while some have found the middle ages a source of jolly jokes about barbaric medical treatment others have endeavoured to understand medieval healing as part of a whole way of life. Faye Getz is heir to this latter approach and wears the mantle in most distinguished fashion. This is truly a very fine book.

Drawing on the best of modern scholarship and her own extensive researches into such things as legal records, case books, and the works of Geoffrey Chaucer, Getz slowly builds up a picture of the literate medicine of medieval England. For the most part she is not concerned with the healing practices of ordinary folk, and original accounts of these are few anyway. Rather she seeks to display the world in which the ancestors of modern orthodox medicine practised. As might be expected, religion and medicine can scarcely be teased apart in this world; a point wonderfully illustrated by the works of the Franciscan Roger Bacon. For Bacon, the purpose of textual criticism was to restore texts to their original state before Babel, alchemy to return base metals to gold, and medicine to restore the body to its prelapsarian glory. Where medicine ends and philosophy and alchemy begin is far more apparent to us than it was to Bacon.

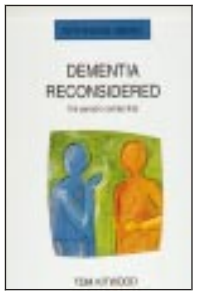
In what is actually more of an extended essay—92 pages of prose plus extensive notes and bibliography—Getz takes the reader through the English practitioner abroad and foreigners in Britain, the founding of the medical faculties of Oxford and Cambridge, the medical text, and much more. Those who seek to preserve the middle ages as a bran tub of anecdotes about bawdiness and drunkenness will find much ammunition in her account of coroners' courts. Walter de Elmeleye, for example, died after a brawl when the drunken Alice Quenbetere engaged in "wordy strife" with two workmen, calling them "tredekeiles."

Written with a deft and confident hand, this book will appeal to amateur and scholar alike as one of the best examples of modern medical history.

Christopher Lawrence, *reader in history of medicine, Wellcome Institute for the History of Medicine, London*

Dementia Reconsidered: the Person Comes First

Tom Kitwood



Open University Press,
£14.95, pp 176
ISBN 0 335 19855 4

Rating: ★

The burden of dementia is borne not only by people with dementia, but by their carers, both informal and professional. The major direct financial costs are managed by the welfare sector, through the provision of community services and residential care, whereas indirect costs are largely attributed to informal carers. Advances in care practices would be of considerable benefit. The health sector has had its main impact in the area of dementia by providing skills and expertise necessary for comprehensive, holistic assessments. Kitwood challenges this medical model, which he labels as the "standard paradigm," and asserts that not only does this paradigm produce bad care practices but that good care practices may slow down or even reverse the deterioration commonly seen in people with dementia by a "psycho-neuro-endocrine systemic relation."

What are these bad care practices? Kitwood calls them "malignant social psychology" and claims they can be observed by a technique called "dementia care mapping." He emphasises the need for continued prolonged intensive personal interactions with people with dementia to overcome these pathological care practices. He then proposes a need for a change in the culture of the services provided if long term improvements are to be made in care practices.

This is clearly a provocative book for the medical profession. The main concern about these hypotheses is the lack of evidence to support them and the author's assertion that there is no requirement for rigorous testing. The background for these hypotheses takes some unusual perspectives from the history of dementia. There is little acknowledgment that some of the recent improvements in the care of people with dementia may be potentially due to the scorned biomedical model validating an organic basis, and that people with dementia had not chosen to go "senile." The major basis for Kitwood's hypothesis is some sketchy case histories and allusion to some small case series in which some individuals with dementia are said not to have deteriorated as quickly as others. Even within these anecdotal cases the process of "medical" assessment seems to have been of benefit to some of the carers.

Are there any potential negative consequences of this approach? Firstly, by the author's own admission, the style of care proposed is extremely time consuming. This may increase the strain on informal carers and the financial costs to provide services. This approach may allow an opportunity to blame the carers for any deterioration, as suggested by the statement: "We have found that those who are well supported only very rarely suggest that their relative has acquired a different personality." Finally, this may divert time and energy from other approaches that may be more likely to produce benefits—such as tailoring individual care plans to the specific cognitive deficits of patients in order to maximise function and quality of life. It is an unexplained oversight that, in a book addressing the psychology of people with dementia, no mention was made of recent work by several neuropsychologists in this subject.

Leon Flicker, *professor of geriatric medicine, University Department of Medicine, University of Western Australia, Perth, Australia*

CD roms

The Cochrane Library 1998 Issue 4

Update Software, £141 for individual subscription, updated quarterly
ISBN 0 7279 1089 2

Rating: ★★★★

Illness and its treatment are often transforming experiences. It follows that decisions about treatment can be fateful for patients. Such decisions ought to be informed by the best evidence regarding the effectiveness of available interventions. However, timely access to the best evidence is elusive. It requires an organisational and analytical enterprise so prodigious that, until now, it has been beyond the grasp of individual clinicians and the profession as a whole. *The Cochrane Library* represents a formidable attempt to provide a response worthy of the vision of effective and efficient health care articulated decades ago by the project's namesake, the late A L Cochrane. He would be proud of the library that carries his name.

The Cochrane Library consists of (1) the Cochrane Database of Systematic Reviews, currently containing 438 protocols for reviews in progress and 481 completed reviews, including many that address problems commonly seen in general practice; (2) the Database of Abstracts of Reviews of Effectiveness, containing nearly 2000 abstracts of evidence based reviews, some with commentaries about their quality; (3) the Cochrane Controlled Trials Register, with more than 200 000 trials listed; and (4) the Cochrane Review Methodology Database, with 836 citations and abstracts that address methods for unbiased collection and interpretation of evidence. For most users, the completed systematic reviews will be most valuable.

Because medicine's knowledge base is constantly expanding, any useful compendium must be cumulative. This is the fourth issue of 1998, and revised issues are published quarterly. But the library is a work in progress in other ways. Updating is uneven. The coverage of different conditions and of various treatments for the same condition varies. The level of detail is more likely to reflect the interests of those committed to the enterprise than the burden of illness conferred by a condition or other measures of priority. For example, about a third of the completed reviews address evidence regarding care related to pregnancy and childbirth.

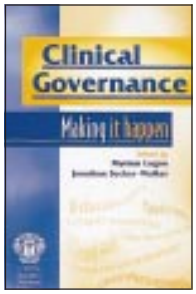
The formats used to present and catalogue reviews reflect more the mindset of a researcher or a librarian than that of a user—doctor, patient, or policy maker—trying to make an evidence based decision. But the search and display functions are well designed and easy to learn. The library will not always inform decisions, however, even if relevant reviews have been completed. It is, after all, a compendium of available evidence, and much of what needs to be known to make a good decision has not been well studied. Moreover, good clinical decisions will often depend on preferences for possible outcomes and attitudes toward risks, which will vary considerably among users of evidence.

These are quibbles, and one would expect these limitations of a work in progress produced by a collaboration convened across national and disciplinary boundaries and sustained by a common view of professional responsibility. Furthermore, to cite limitations of *The Cochrane Library* begs a comparison, and there is none to make. Use today's library despite its gaps. Better yet, find a way to help the Cochrane Collaboration make tomorrow's physicians and patients realise the promise of effectiveness and efficiency in health care.

Albert G Mulley, *associate professor of medicine, Harvard Medical School, Boston, Massachusetts, USA*

Clinical Governance: Making it Happen

Eds Miriam Lugon, Jonathan Secker-Walker



Royal Society of Medicine Press, £17.50, pp 222
ISBN 1 85315 383 4

Rating: ★★★

This book comprises 13 chapters by various contributors addressing aspects of clinical governance. The chapters cover organisational, legal, educational, informational, and patient perspectives and an extremely useful guide to sources of information. The contributions are of a high standard, notwithstanding the different style and approach of each. To me, however, the book was missing two chapters—on professional self regulation as a critical component of clinical governance, and clinical governance in primary care. To a certain extent, there is a lack of conceptual "thread" through the book. The chapters could even have been structured or grouped into sections around topics such as information, risk, organisational implications, etc.

The book also misses the opportunity to provide a powerful examination and overview of the subject. Clinical governance is potentially the most important stimulus for improving care in the NHS in its 50 year history, and the president of the Royal College of Surgeons has said that hospital consultants are experiencing a "cultural earthquake." Clinical governance has a massive scope—other than the definition in the NHS white paper, its range of inclusions vary according to the observer or participant. The government is extremely serious about clinical governance—it is a central plank of its modernisation of the NHS and of its quality initiatives embodied in *A First Class Service*. Government is also taking action about "serious clinical failure."

Management is interested in clinical governance—it has an important new duty of quality, and clinical and managerial leaders will want to know that systems are in place to ensure that patients are protected and quality is promoted. The public and the media are also interested—in particular in clinical failures and, in its most extreme sense, the perceived betrayal of the public by the medical profession and the NHS. The link between the erosion of the medical profession's autonomy with professional self regulation and other requirements of clinical governance is key. The big opportunity offered by clinical governance is the opportunity to change systems—to pull together different components and strands from the clinical and managerial worlds to improve things for patients.

This book should have begun with such a pulling together of antecedents and implications of clinical governance—where it came from, what it means, and what tensions lie in its implementation. Nonetheless, *Clinical Governance* will be a useful handbook for practitioners in the field who are charged with implementing this important new system.

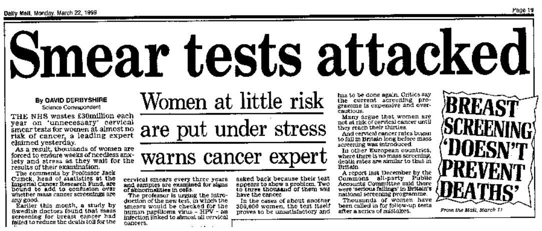
Pam Garside, *Judge Institute of Management Studies, University of Cambridge, Cambridge*

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

Screening stories

Jack Cuzick's colleagues were surprised last weekend to see a story in the *Sunday Times* with the headline "Cancer expert attacks 'waste' of smear tests." The story claimed that Cuzick, head of statistics at the Imperial Cancer Research Fund, was expected to warn a BMA conference on screening in London that "the NHS is spending as much as £30m a year on unnecessary tests." No one, however, was more surprised at the story than Cuzick. He had not spoken to Lois Rogers, the medical correspondent of the *Sunday Times*. "I was very surprised that she was discussing what I was going to say at the conference when I haven't even decided yet," said Cuzick. Rogers had asked Cuzick's secretary to get hold of him, but he had not returned her call.

Cuzick published a paper in 1995 in the *Lancet* suggesting that testing for human papillomavirus (HPV) is more sensitive than the current screening programme in detecting cervical cancer and its use could extend the period between screenings. He also gave a costings paper at a World Health Organisation meeting in 1996 in which he estimated that cervical smear tests cost £10 each. He presumes that the £30m in the news story comes from piecing these two bits of information together. In the news story he was quoted as saying, "What we need now is a large UK trial involving about 300 000 women to demonstrate that HPV testing is better than the current cervical screening programme." Cuzick wouldn't disagree with that statement, but he is unhappy that Rogers made it sound as though he had spoken directly to her. He suspects that the quote was lifted from a press release from a conference in Chamonix a month ago, issued by Digene, the manufacturers of the human papillomavirus test.


Daily Mail, Monday, March 22, 1999 Page 19

Smear tests attacked

Women at little risk are put under stress warns cancer expert

By DAVID DERBYSHIRE
Science Correspondent

THE NHS wastes £30million each year on 'unnecessary' cervical smear tests for women at almost no risk of cancer, a leading expert claimed yesterday.

As a result, thousands of women are forced to endure weeks of needless anxiety and stress as they wait for the results of their examination.

The comments by Professor Jack Cuzick, head of statistics at the Imperial Cancer Research Fund, are bound to add to confusion over whether mass cancer screenings are any good.

Earlier this month, a study by Swedish doctors found that mass screening for breast cancer had failed to reduce the death toll for the

cervical smears every three years and samples are examined for signs of abnormalities in cells.

The professor is urging the introduction of the new test, in which the smears would be checked for the human papilloma virus – HPV – an infection linked to almost all cervical cancers.

asked back because their test appears to show a problem. Two to three thousand of them will have the cancer.

In the cases of about another 300,000 women, the test itself proves to be unsatisfactory and has to be done again. Critics say the current screening programme is expensive and over-cautious.

Many argue that women are not at risk of cervical cancer until they reach their thirties.

And cervical cancer rates began to fall in Britain long before mass screening was introduced.

In other European countries, where there is no mass screening, death rates are similar to that in Britain.

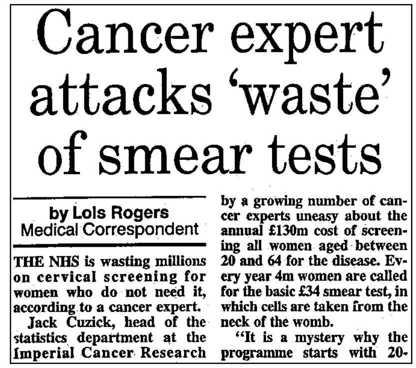
A report last December by the Commons all-party Public Accounts Committee said there were 'serious failings' in Britain's national screening programme.

Thousands of women have been called in for follow-up tests after a series of mistakes.

BREAST SCREENING 'DOESN'T PREVENT DEATHS'

From the Mail, March 11

The impression Rogers's story gives is of an expert attacking the cost of cervical screening, the weekend before a major screening conference. The conference was last Tuesday (23 March). Rogers could not have written it up for the following Sunday as it would have been old news. Like many Sunday news stories, it was a speculative piece dressed up to look hard hitting and contemporary. Generally, news pages are harder to fill at the weekend. The broadsheet Sunday newspapers often have health pieces because they are less time sensitive than other stories. They are still happy to make a story out of "an expert says"—often with little research or context to back it up.


Cancer expert attacks 'waste' of smear tests

by Lois Rogers
Medical Correspondent

THE NHS is wasting millions on cervical screening for women who do not need it, according to a cancer expert.

Jack Cuzick, head of the statistics department at the Imperial Cancer Research

by a growing number of cancer experts uneasy about the annual £130m cost of screening all women aged between 20 and 64 for the disease. Every year 4m women are called for the basic £34 smear test, in which cells are taken from the neck of the womb.

"It is a mystery why the programme starts with 20-

The "expert says" story is particularly useful if there is a health debate already in the media. The media backlash against screening started earlier this month with a front page story in the *Daily Mail* by Jenny Hope. The story cited a Swedish study "published in the *BMJ*," which reported that breast screening did not reduce mortality. The paper was not published in the *BMJ*, rather its findings were reported in the news section, with quotes from two doctors criticising the study's findings.

Journalists, especially Sunday newspaper journalists, like it if other reporters follow up on their stories. Rogers's story was followed up by the *Daily Mail* on Monday. The *Daily Mail*'s headline echoed the *Sunday Times* with "Smear tests attacked." The journalist, David Derbyshire, had obviously fallen for Rogers's story, starting his story with: "The NHS wastes £30 million each year on unnecessary cervical smear tests for women at almost no risk of cancer, a leading expert claimed yesterday." Cuzick, of course, had not been claiming anything to anyone. "I've had everyone calling me up saying I'm going to call for the abolition of the screening programme," he said. "What I do think is that the cervical screening programme is successful and that HPV is a substantial way of improving it and should be evaluated properly by the NHS."

There is nothing much factually wrong with Rogers's piece, but the tone is misleading. Cuzick is not saying (and certainly not to the *Sunday Times*) that the NHS is wasting money, he just wants the evaluation of another screening test. The backlash against screening is not unexpected, given that both the media and public may have expected more than is being delivered from screening programmes and have not been prepared for the false positive rates, which are so distressing, or the scandal at Kent and Canterbury Hospital, where women died after their cervical smears were misread.

The pros and cons of screening are fairly complicated, but responsible media reporting should try to take a balanced view of current expert thinking and scientific evidence. The stories in both the *Daily Mail* and the *Sunday Times* say that Cuzick's claims will confuse women. Perhaps they would like to take some of the credit for that.

Luisa Dillner, *BMJ*

WEBSITE OF THE WEEK

www.worldbank.org The World Bank is the one way that the rich countries of the world have of channelling money to the poor countries, and it offers the prospect at least of providing cheaper funds in a manner independent from national government self interest. Its website is one of the most extensive I have yet reviewed, containing great stacks of information about the political and economic situation in each country. The site is well designed—I suspect that its staff use it every day—and has a text only version for the information poor—those using dodgy analogue lines in sub-Saharan Africa or the network at University College London on a Monday lunchtime.

Much of the content is available, not as generic HTML files, but in proprietary formats like Microsoft Word and Excel. Although this is a pragmatic short term solution for corporate communication, there are several reasons to deprecate this sort of behaviour for the web: it is not an open standard (like HTML), you have to buy the latest version of the Microsoft product to read it, and sharing Word files can transmit macro viruses, which are generally pretty harmless but can be a pain.

Organisations like the World Bank are founded on assumptions that people who "subsist" are "poor" and in need of "development." The great strength of the web is that such conventional views can be sidestepped with the click of a mouse. For critiques of the inappropriate development (remember the Pergau Dam?) try www.oneworld.org/actionaid/cause/coca1/briefing.html.

Douglas Carnall
www.carnall.demon.co.uk

PERSONAL VIEW

Where there's will, there's a way

Randomised controlled trials (RCTs) are often considered an expensive way to gain knowledge. Frequently, that criticism leads researchers to use less expensive and less reliable procedures to address clinical questions. It is also sometimes suggested that major trials should be limited to research centres in countries that are economically well endowed. I think it is important to challenge these views, partly because the needs of developing countries do not always coincide with those of developed countries, and partly because not all RCTs need be expensive.

The history of the Argentine episiotomy trial provides an example to illustrate this alternative view. The trial started life in 1990 at a research unit in perinatal care in Rosario, Argentina, where I was a tutor. It emerged as part of the annual training course in clinical epidemiology in perinatology, supported by the International Development Research Centre in Ottawa and the World Health Organisation's special programme of research, development, and research training in human reproduction. The recent publication of the book *Effective Care in Pregnancy and Childbirth* had introduced us to the concept of evidence based care and provided inspiration for our work, and we proposed a learning exercise consisting of reviewing the scientific evidence relevant to the routine use of episiotomy for the care of women at low risk of problems in childbirth.

Given the limited evidence available, we decided to design—as a teaching exercise—an RCT to assess whether routine episiotomy actually does reduce the rate of severe perineal tears in childbirth, an obstetric practice that was widely accepted among our colleagues but whose alleged efficacy was not based on solid evidence.

Accordingly, we set out to contact maternity services run by obstetricians known to us in other Argentinian cities. We managed to interest them in our project and we agreed to conduct a survey of current practice. This showed that episiotomy was performed in as many as 80% of vaginal deliveries in nulliparous and primiparous women in childbirth.

Once it had been decided to carry out the project, we tried to obtain funding to cover the expenses of doing the trial. These were not excessive by First World standards: we estimated that US$30 000 (£18 750) would cover materials, communications, travelling, and financial incentives for the local collaborators at participating hospitals. We approached foundations, and international and national institutions—but all to no avail.

Undaunted, and because we were convinced that our project addressed an important question and that it had to be undertaken, we decided to cover the cost of the trial ourselves in various ways. We succeeded in securing invitations to give lectures in the places we were supposed to visit so as to implement or audit the project, and we appealed to the good will, enthusiasm, and commitment of the staff of the maternity services at participating hospitals to incorporate the trial as part of their regular clinical practice. As a result, we obtained their agreement to collaborate in the trial.

> Investing in RCTs that address important questions can pay dividends

A little over two years later, this RCT was successfully completed and a report of it was published in the *Lancet* (1993;342: 1517). It is the largest such trial ever published and we concluded that there was no evidence to justify the very extensive routine use of episiotomy in Argentina, or elsewhere for that matter. A Cochrane review of all the trials shows that our evidence is consistent with that derived from trials done elsewhere.

It has been estimated that in a country like Argentina, with over 650 000 deliveries a year and a high incidence of episiotomies, at an average cost of $10 each, $1m a year could be saved by abandoning the routine use of episiotomy. This suggests that applying financial resources to clinical investigation need not be considered an expense, but that it can be a highly profitable investment.

It is not my intention to suggest that clinical research can always be carried out by appealing to the good will and individual effort of clinicians. On the contrary, although their willing participation is essential, resources are needed to support research. However, despite the capacity of RCTs to give sound answers to important questions about the effects of health care, only a small proportion of the total investment in biomedical research (5-10%) is used to support controlled trials. And large amounts of resources are sometimes used in delivering ineffective and sometimes harmful forms of care—like the one we challenged in our trial. It should be more widely recognised that investment in RCTs addressing important questions can pay dividends, even in a developing country like Argentina.

Roberto Lede, *Argentinian Institute for Evidence Based Medicine, Buenos Aires*

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email **editor@bmj.com**

SOUNDINGS

Spin doctor

I used to enjoy firing off letters to newspapers. If they were published they produced no discernible results apart from occasional postcards from long lost relatives. Nevertheless, I felt that the papers were trying to help.

Now, recently installed as press officer to a royal college, how do I feel about the media? Uncomfortable when they focus on medicine's shortcomings. Stimulated when journalists ask incisive questions. Paranoid? No, surprisingly. The media rarely seem to be out to get us for no reason.

In a era of government by focus group, even the most altruistic college needs to work on public opinion if it wants to improve care. But it is hard to influence the media's agenda. They are today's control freaks.

Should we become a pressure group? Last week, when launching recommendations for safer labour ward care, should we have suggested that at present things are really dangerous? Or wheeled out a couple who have lost a baby? Certainly not, I thought, but part of me mourned the lost opportunity.

Next day, it was easy to persuade myself that I could do more for womankind by broadcasting on national radio than by attending my antenatal clinic. When I reached our local studios an apologetic receptionist told me that my interview had been cancelled because America's leading femme fatale—Monica Lewinsky—had turned up at the BBC.

Such setbacks are understandable, but occasionally I get the feeling that the media are being devious. Take this month's number one obstetrical issue—the millennium baby. The first questions were factual. When should a couple make love to schedule delivery on 1 January 2000? The reporters did not want to hear about odds or biological variation. They wanted understandable physiology.

The next questions were on the advisability of elective caesarean section at 00 01 on a public holiday. That would be unwise, said I, because of possible staff shortages, unpredictable emergencies, and the millennium bug.

The third wave was trickier. Would the college regard such an operation as unethical? Say the woman had enough money to pay privately for all the staff that she could possibly need? I began to suspect that my questioner's ethical stance would depend on whether it is his paper or a rival which is financing the stunt. I think that I am losing my innocence.

James Owen Drife, *professor of obstetrics and gynaecology, Leeds*