

# reviews

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## Oxford Handbook of Clinical Immunology

Gavin Spickett



Oxford University Press,  
£19.95, pp 714  
ISBN 019262721X

Rating: ★★★

As with many of the biosciences, the exciting developments in immunology reported in the literature often seem slightly divorced from current clinical practice. Moreover, most general textbooks

of immunology are based on teaching and tend to be visual and referenced. Those that are comprehensive tend to be bulky and discursive, but not very convenient for reference. The *Oxford Handbook of Clinical Immunology* fills this “convenience gap” and provides a satisfying source of essential basic information that fits the white coat pocket.

This book will be used frequently by specialist clinical immunologists, medical specialists, and scientists because it is a superb reference source. It covers concisely the information that is relevant to managing a patient with an immunological disease within the diversity of clinical medicine. The clinical information is supported by clear advice on the associated laboratory investigations and their interpretation.

It works by virtue of its excellent layout and indexing. Despite the detail, the sections are written simply, which makes the information, and experience, of the author more

accessible. The section on primary immunodeficiencies is a particular strength. A quick scan for contemporary or contentious issues, such as anaphylaxis or anti-neutrophil cytoplasmic antibody, demonstrates that the text is up to date. A scan also shows that chemical names are correct—a sure guide to editorial and proofreading skills.

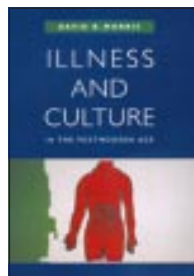
This is done in a comfortable handbook size with small but crisp type. The 714 pages are interspersed with blank pages for making the inevitable notes when assimilating what can be learned from patients into the established wisdom.

Gavin Spickett has bitten the “magic bullet” and has written the book that he, and I, wish had existed during our formative years in immunology.

**Charles McSharry** *principal clinical scientist, clinical immunology, Western Infirmary, Glasgow*

## Illness and Culture in the Postmodern Age

David B Morris



University of California Press,  
£17.50, pp 360  
ISBN 0 520 20869 2

Rating: ★★★★★

The postmodern view of our world is simultaneously terrifying and liberating. By the start of this century, the great explanation of religion, promising perfection in an everlasting life after death, had given way to the big utopian political visions, which promised a perfect society in this life. Through the middle part of the century, these visions were inexorably corrupted into monstrous dystopias, and now, in our postmodern world, the resulting disillusion has fostered a deep distrust of all comprehensive explanations of, and solutions to, the human predicament. The notion of absolute truth has given way to an acceptance of multifaceted truths and the

legitimacy of a range of approaches to the same problem. This challenge to the big explanations enriches our understanding but shakes our security. Patterns dissolve, leaving us bewildered and disorientated but with seemingly endless possibilities of creating new patterns and finding new truths and new ways of relating to the world, each other, and ourselves.

The central thesis of David Morris's fascinating book is that illness is a mental, emotional, and bodily event constructed at the crossroads of biology and culture. He argues that, as our culture changes, so must our view of illness, and that the postmodern gaze introduces both new terrors and new freedoms into the arena of health and health care. Many of the terrors seem to arise from our undiminished yearning for perfection. The focus has simply shifted from society to the individual and from the soul to the body. Our obsession with the utopian body makes anorexia nervosa a quintessentially postmodern illness and, more broadly, fuels a fear of illness and disease that is out of all proportion to the unprecedented health and longevity enjoyed by those in the developed world. Biomedical science clings to the wreckage of an all embracing, essentially modernist explanation of the human experience of illness and disease, while simultaneously promising much more than it can deliver. If the explanation aspires to be comprehensive, it follows that death will come to be seen as a failure of science, and ultimately the desperate excesses

of medical intervention drive the calls for legalised euthanasia.

Biomedical research, with its insistent prioritisation of the methodologies of the randomised controlled trial and frequentist statistics, perpetuates the notion of absolute truth. But in a postmodern world all generalisations, all categories, and all classifications are open to challenge, and slowly this new perspective is infiltrating medicine. The doctor's claim to knowledge of objective fact is challenged by the immediacy of the patient's subjective experience. Insights from anthropology, sociology, philosophy, psychology, and poetry challenge the medical annexation of truth and profoundly alter our understanding. Each discipline uses words in a different way, and so each can contribute to reducing the dimension of suffering and pain that remains beyond language. Healing must always seek to give voice to suffering, and the greater the range of words and meanings we have at our disposal, the clearer the voice becomes.

Morris eschews a conclusion as being incompatible with the open ended nature of the postmodern view, and a summarising book review may be a similarly suspect endeavour. Perhaps all I can say is that my view of the world, and my work within it, is more complex, and my life proportionately richer, for having read this book.

**Iona Heath** *general practitioner, Kentish Town, London*

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

## Patient Power

Sarah Harvey, Ian Wylie



Simon and Schuster, £9.99, pp 310  
ISBN 068484026X

Rating: ★★

Subtitled “Getting the best from your healthcare,” *Patient Power* is meant to put the patient in control, wresting it from the NHS bureaucracy. Armed with this book, patients will be ready for that rude receptionist, uncaring nurse, and disinterested consultant. Knowing exactly what they are entitled to, patients might even have some idea how to get it. And if they don't, they will certainly know to whom and how to complain.

While the book does provide an overview of the roles various professionals play and the services provided, it was not easy to find answers to simple questions such as “Where do I get a wheelchair?” or “How do I get my toenails looked after?” Neither subject was indexed nor readily apparent in the table of contents, and, when eventually found, the answer to both seems to be “Call your GP.” Major dilemmas such as “Who should I get for my bypass?” are dealt with superficially. Readers are provided with questions to ask the surgeon so that they can make an informed decision. One of the strengths of this book is the numerous checklists to

prepare for such things as hospital admission, choosing a rest home, or hospital discharge. The book is written simply to make it accessible to all, but the suggestions for researching an illness might be difficult for some.

While patients' rights are covered in detail, sections on patients' responsibilities are notable for their brevity. Patient abuse of the system is presented as an understandable, if lamentable, foible. Occasional kind words are thrown in health workers' directions, but one is left with the overwhelming impression of an aloof, uncaring system. Much is made of the process of complaint, and even a sample letter is provided. While many complaints serve a useful purpose for keeping us in line, they are not entirely benign. They absorb a substantial amount of administrative time, and if the complaints are frivolous or vexatious have a particularly negative impact on an employee's morale. I would have liked to see some acknowledgment of this. While making complaining easier for those so inclined, this book is unlikely to encourage those who are normally too meek to complain to do so. Unfortunately, I suspect those who will read this book won't need it, and those who need it won't read it.

**Ted Osmon** *family physician, Mount Brydges, Ontario, Canada*

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## WEBSITE OF THE WEEK

**GP websites** General practitioners are independent minded people. They also have to communicate with their patients, mostly as individuals but often as a group. Take these facts together, and it seems obvious that one way of enhancing such communication would be to set up a practice website. In all, 278 British general practice sites are already indexed at [www.internet-gp.com/](http://www.internet-gp.com/). Its author is both a general practitioner and a website designer, and, although its information architecture leaves something to be desired (it would be nice if the sites were indexed in ways other than by name of the surgery), it's a useful first step. The annotations offered add some value, though they seem mainly concerned with the design of the sites rather than the content therein. If you've just designed your own site you can submit its URL to Internet-GP and up it will go.

Browsing through some of the surgeries' sites, I was struck by how little of the web's informational richness they are currently exploiting. On the web “everything is done by someone else,” so the poverty of links from many sites suggests that general practitioners have yet to become fully literate in the medium, if you define literacy as the ability to read and write a web page.

Of course, many things—opening times, statements of mission and ethics, and practice policies—will be unique to your practice, but there is also much that is generic. Say you would like to help patients decide whether to call the practice out of hours: you could either spend a hundred lifetimes trying to write decision support software yourself, or you make a link—such as to NHS Direct ([www.healthcareguide.nhsdirect.nhs.uk](http://www.healthcareguide.nhsdirect.nhs.uk))—on the relevant page on your site. Patients will appreciate being guided to relevant high quality information, and the practice will look modern and efficient. It will be, as the management gurus say, a win-win situation.

**Douglas Carnall**  
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## NETLINES

● Beyond medicine, there is a world of science on the internet. The web edition of *Scientific American* ([www.sciam.com](http://www.sciam.com)) is a prime example, being much more than a simple archive of the paper journal. Apart from free access to articles from the journal, there is a host of features ranging from questions and answers (including medical topics) to exhibitions of information on science and selected links to other science websites.

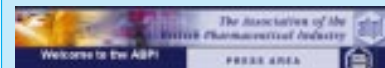


● The British Paediatric Surveillance Unit has an interest in uncommon and new childhood diseases. It seems to be quite active, and its work is highlighted at <http://bpsu.rcpch.ac.uk>. Though the website's design is not flashy, it is easy to peruse, and a site of this calibre should raise the profile of the organisation within the medical community.

● If you fancy an endoscopic tour of the gut then look no further than the Atlas of Gastrointestinal Endoscopy at [www.mindspring.com/~atlsouthgastro/atlas\\_1.html](http://www.mindspring.com/~atlsouthgastro/atlas_1.html). The site has a good selection of pathologies with helpful commentaries and is easy to navigate around. Being laden with graphics, its download times can be slow, but some of the pictures are worth the wait. More information on gastroenterology can be accessed through the links page.



● Discovering good quality websites is not always easy, but [www.signpost.org/](http://www.signpost.org/) could point you in the right direction. This is essentially a catalogue offering a brief description of web resources organised in a style similar to Yahoo! Unsurprisingly, it is a highly selective group and is by no means comprehensive, but the medicine section is well worth a browse and presents a useful launch pad for surfing.



● The Association of the British Pharmaceutical Industry has a glitzy website at [www.abpi.org.uk](http://www.abpi.org.uk), packed with useful information. The site is divided into sectors, which are well signposted, and there is a comprehensive collection of links to drug companies and regulatory bodies. This site has depth, and, although that means clicking around and spending time touring, the end result is worth pursuing.

**Harry Brown** *general practitioner, Leeds*  
[DrHarry@dial.pipex.com](mailto:DrHarry@dial.pipex.com)

We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email.

PERSONAL VIEW

## The sharp end of the dural puncture

As the pain of a sudden onset dural puncture headache was searing and spreading like hot molten metal I forgot what I was there for. The pain of the contractions disappeared into the head pain. Three failed epidurals, two spinal blocks, and a few incisions into a caesarean section the head pain was all consuming, the lights surreal and too bright, and the only sound that I could hear through the ringing woolliness was my own screaming. My head. Please help me. *"Patient not coping. Converted to general anaesthetic. Delivered of female infant."*

Recovering from the anaesthetic I forgot that there had been a baby, only remembering the headache, which seemed to have gone. In morphined confusion I cried a bit and turned away from the baby, and the headache came back. *"Patient lying down. Unable to care for baby. Not coping. Very upset."*

Four days and two painful blood patches later the headache resolved enough to allow me to stand up and let light and life back in. The anaesthetist sat on my bed and stroked my hair. Tears streamed down my face. He held my hand. I was so afraid of him; he reminded me of the pain. *"Not coping."*

Slowly, but painfully, over the next day, the blood clot removed, the headache reappeared, and the light began to hurt behind my eyes. Over the next few days my back hurt where the blood patches had burnt their way in, and my left hand and arm were weak and constantly tingling. *"From an anaesthetics point of view this patient can be discharged."*

From my point of view I was a wreck. Discharged with daily pain, curtains shut, little feeling in left arm and hand, feverish. Having nightmares about the anaesthetist. Painkillers don't touch the pain, so I visit my general practitioner for stronger stuff. Can't because I'm breastfeeding. I am unhappy, so let's try antidepressants. Can't because I'm breastfeeding. Perhaps the problem is psychological? Perhaps. *"Patient not coping with life."*

The psychologist thinks that there is a deep anger towards the anaesthetist. Wants me to apportion blame. I do not feel anger. I do wonder, though, if the long term impact of dural puncture features in the medical curriculum, and sometimes late at night I wonder if the anaesthetist ever thinks about me or what became of me, but it isn't anger. We sort this out. Is it postnatal depression and post-traumatic stress presenting as

### An angel of mercy comes along in the form of a health visitor

neurological damage? Interesting theory. We even get into my childhood, but somehow the pain persists and the light is too bright and I have had enough. Psychotherapy is not helping the shortage of cerebrospinal fluid. *"Not coping."*

Then an angel of mercy comes along in the form of a health visitor. She believes me, and she listens. She gets me to send for my notes, and we pick through them together. The hospital is worried. Why do we want my notes? I am invited for "an informal chat," and five people appear. I am placed face down as an exhibit on a bed while they patronise above me. "Well, you are difficult, aren't you?" "Hello, I'm Dr X. I'm the only anaesthetist in this hospital that you haven't seen." If I have seen them all why can't they come up with some answers? I feel humiliated and let down by the world. One of them sees my despair and takes some time to explain what he thinks is wrong. He is kinder and gentler than his colleagues and confirms that I had a "terrible experience."

While much has been written about postsurgical pain, postanaesthetic pain seems largely ignored. Eventually a long term low grade cerebrospinal fluid leak is diagnosed. The hole has been a big one and my back is ripped to pieces from damage and mending. My health visitor is jubilant. I am relieved. It is not in my head, it is in my back. The pain is still there but less bitter when it has a name. Most dural puncture headaches resolve within a few days, but some don't. Mine didn't. The seven month threshold released me, but the tingling and numbness persist along with the relentless and annoying warm, tight sensation in my back that feels as though the blood patch is still being administered. The residuals I can cope with and have now learnt to live with. Bonding with the baby? No, it didn't happen. I was too sore to cope with that.

Flippancy, lack of interest, and arrogance may be common coping strategies among healthcare professionals faced with the non-coping patient. Not coping implies that coping is expected and is the sole responsibility of the patient. It is only now that I can look back and see how close I was to the edge that many others have slipped or jumped over. Good pain management begins with believing the patient and continues by providing an unthreatening forum in which to share the reality of the pain experience. These things, along with simple caring and explanation, were largely denied to me. I am, and will always remain, a different and damaged person because of it.

Evelyn C Weir, lecturer, Edinburgh

SOUNDINGS

## What crisis?

Here in Auchendreich we take pride in being prepared. We believe our emergency planning systems are second to none: a happy legacy of our frontline role in the cold war, when a top secret bunker, 200 feet beneath a local pig farm, offered shelter to key members of the Scottish civil and military establishment for as long as the nuclear holocaust might necessitate it.

Recent years have not blunted our preparedness for whatever may befall. As usual, the planning group for the annual winter bed crisis held its first meeting in June, just as the impact of last year's crisis was beginning to recede.

July and August meetings are traditionally devoted to analysis of the previous crisis and full discussion of the lessons learnt. In the event both had to be cancelled.

As usual, the September meeting was reasonably well attended, but as a result of a major trust reconfiguration exercise there was a distressing lack of continuity among the various representatives. And, sadly, the main business of the meeting—a controversial proposal from the board to merge the functions of the Twenty Fifth Annual Winter Bed Crisis Planning Group with that of the Millennium Planning Group—led to an acrimonious and inconclusive debate which significantly depleted the rather limited reserves of goodwill towards our three directors of planning.

Eventually, a chairman for the amalgamated planning group was identified; work began in earnest with the usual flurry of faxes in late December.

Then it occurred to someone that much needed extra beds might be found by reopening two wards of the old Royal Dreich Asylum, so just before Christmas a dozen people—from personnel, catering, patient transport, laundry, portering, and pest control—were summoned to a meeting.

A plan was agreed with remarkable speed and a commendable effort by all concerned ensured that within four days about 40 bewildered elderly patients could be whisked from our hard pressed acute beds to the comparative safety of a spacious old asylum.

Already the operation has been acclaimed as a triumph, mainly because not so much as a whisper of any crisis has reached either local or national media. And already our delighted trust chief executives are seeking out potential members of the Twenty Sixth Annual Winter Bed Crisis Planning Group.

Colin Douglas doctor and novelist, Edinburgh

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](mailto:editor@bmj.com)