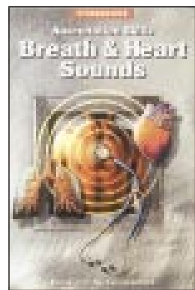
reviews

BOOKS • CD ROMS • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS • MINERVA

Auscultation Skills: Breath and Heart Sounds

Springhouse Publishing



Butterworth-Heinemann, £30, pp 288
ISBN 0 87434 962 1

Rating: ★★

Few physicians would disagree with the opening comments from the foreword of this book: "In today's world of high technique medicine, auscultation is quickly becoming a lost art . . . many medical professionals now rely on tests for diagnosis rather than auscultation and physical diagnosis."

This book and its accompanying audio cassettes, which provide at least 40 various breath sounds and over 50 heart sounds, are an attempt to rectify this by providing a logical approach to learning normal and abnormal cardiorespiratory auscultation. Starting from an oversimplified approach to anatomy and physiology, the book progresses to a complex collection of advanced auscultatory techniques. With its use of pertinent "alerts," raising readers' awareness of dangerous clinical situations, self assessments before and after each chapter, and an appendix listing the features of common disorders, the book design incorporates several effective educational techniques. Readers should find it easy to stop at the relevant points and listen at their leisure to the auscultatory sounds described.

However, this publication is not for the faint hearted, nor for those with little time on their hands. It is not clear which group of learners it is written for, as it passes from the ridiculously simple, A level biology level to the overcomplex, advanced knowledge required by a cardiorespiratory expert. Work slowly through the book and you will learn a lot. If, however, you attempt to scan it, spend no more than 30 minutes learning from it, or use it for reference, it will soon be relegated to the dark recesses of the library. It is not for linguistic purists—the American pronunciation and spelling actively interfere with the learning process.

Although the authors begin by highlighting the need to retain certain clinical skills and not to rely too much on advanced technologies, it is difficult to imagine why this book was not published in a multimedia, computer assisted format which medical staff are increasingly using and which would assist the learning of this complex subject. The book will probably find its way on to the library shelves of departments of cardiorespiratory medicine, but I'm afraid it will spend more time sitting than in use.

Trevor Gibbs *director, Community Studies Unit, Department of Primary Care, University of Liverpool*

What a Blessing She Had Chloroform

Donald Caton

Yale University Press, £20, pp 300
ISBN 0 300 07597 9

Rating: ★★★★

When her eldest daughter gave birth in 1859, Queen Victoria remarked, "What a blessing she had chloroform. Without it I think her strength would have suffered very much." The Queen, an experienced mother, saw no controversy in the use of pain relief in labour. Yet the subject has continually been dogged by controversy (witches were burnt for it). Donald Caton, an eminent chronicler of the history of obstetric analgesia, has written a fascinating account of the social background to its evolution since the introduction of ether, then chloroform, to obstetrics by James Young Simpson in Edinburgh in 1847. The subject is viewed in the wider context of the whole metamorphosis of medicine in the 19th century.

The story began when medicine, religion, and philosophy were intermixed and the balance of earth, air, fire, and water still controlled our bodies, with science a late partner to medicine. Pain had an important role in society: to maintain order and collect information—a purpose still prevalent in some societies today. Its role in childbirth—education, punishment ("She's got to learn"), atonement, redemption, and bonding ("You'll love your baby all the more")—also survives. Writing in the middle of the 19th century, John Stuart Mill pointed out that it was not God but nature that inflicted pain. It was surely permissible to improve on nature. Anaesthesia formed part of a new humanitarian movement that aimed "to eliminate suffering from human experience, a tendency that was not particularly apparent before then."

Writing with grace and humour, Caton traces the progress of obstetric anaesthesia and analgesia through the bombastic overexuberance of Simpson, the opposition from a cautious medical profession, the diligent and innovative perspicacity that enabled Snow to put the technique on its feet and quell the opposition, the ill advised enthusiasm for twilight sleep, the reaction to the overuse of drugs embodied in Grantly Dick Read's natural childbirth campaign, to the more measured and abiding work of the UK National Birthday Trust.

The need for analgesia in labour was thought to result from the decadent lifestyle (or heightened sensibilities) of modern civilised woman. Read resurrected this 19th century belief in asserting, apparently from a personal series of two, that "primitive" people had painless, trouble-free labours but that educated women need feel no pain if fear were eliminated. Would that either of these assertions were true.

Both medical and non-medical readers will enjoy this book but may find the blanket term "anesthesia" confusing. It is used to refer to inhalational analgesia as developed by Snow, true anaesthesia (throughout labour) as advocated by Simpson, deep sedation as in twilight sleep, regional (epidural) anaesthesia as once used for labour and now reserved for surgery, and the milder regional analgesia. Caton does not mention, perhaps because it still eludes most of humanity, that effective analgesia with mobility and an alert mother and baby can now be provided for labour. Historically, women have demanded analgesia in labour when the medical profession approached it with caution, yet now that it has become vastly safer many women reject it as dangerous.

Felicity Reynolds *emeritus professor of obstetric anaesthesia, St Thomas's Hospital, London*

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

WIT

By Margaret Edson

Now showing Union Square Theatre, New York, USA. Coming to London this year

She is unlovely, unloved, and unloving, a middle aged professor of 17th century poetry (her specialty the fiendishly difficult Holy Sonnets of the metaphysical poet John Donne) at a US university. Vivian Bearing, the heroine of Margaret Edson's Pulitzer prize-winning play, is also dying of advanced (stage IV) metastatic ovarian cancer.

When we first see her she is dressed in a hospital gown, trails an intravenous drip, and, beneath a bright red baseball cap (the only spot of colour throughout), is completely bald. At this stage, she is also spirited, aggressive, and bold, ready to tackle her illness with the same incisiveness and inquisitiveness with which she has learnt and taught her subject. And with the same sardonic wit.

But, it is Vivian's added misfortune that she is being treated at a major teaching hospital, where she is instantly perceived by Dr Harvey Kelekian, chief of medical oncology, to be a prime candidate for his programme of experimental chemotherapy. He deduces that this is one helluva tough lady, both physically and psychologically; and another advantage must be her very aloneness, her convenient lack of concerned, possibly nosy, family and friends.

Edson's gruelling first play is not for the squeamish, but, powered by Judith Light's magisterial performance in the lead role, it is so intellectually and emotionally challenging that it is worth going through the ordeal. At one level, it is a deeply sympathetic study of a not very sympathetic character in a state of crisis. Watching the intensely proud and private Vivian trying to hang on to her dignity and cling to her defences in the face of appalling discomfort and insufferable pain forces our respect, and ultimately our affection. But it is Edson's chilling indictment of the medical profession that has the most devastating effect. An elementary school teacher who worked in the cancer and AIDS unit of a research hospital between studying for degrees in history and literature, she clearly speaks from experience.

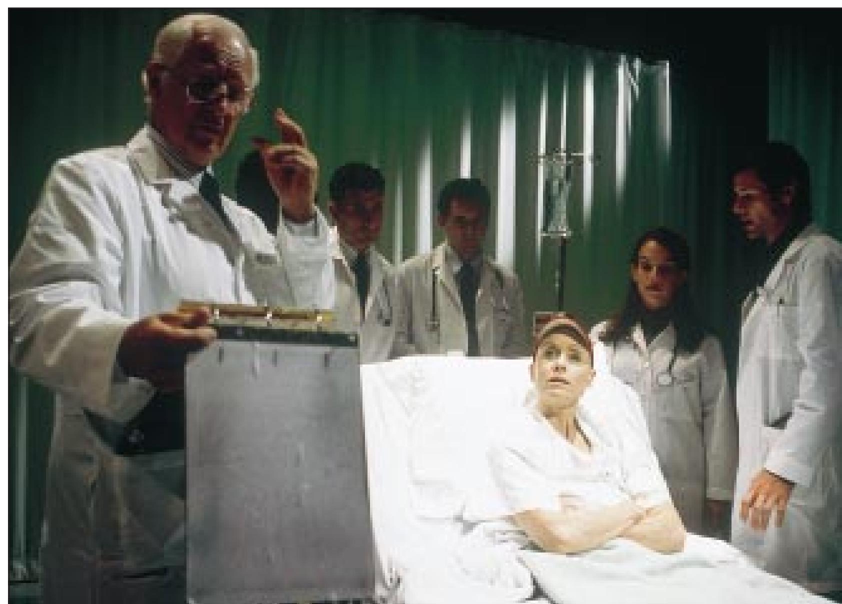
JOAN MARCUS

Judith Light plays cancer patient Vivian Bearing

In the interests of accumulating data for their research, Kelekian and his eager young research assistant Jason Posner coldly and calculatedly subject Vivian to "the impossible"—eight cycles at full dose of "hex and vin" (hexamethophosphacil and vinplatin)—giving her hope while knowing she is doomed. They do not even dispense their "death drugs" with grace. Kelekian is a bald deliverer of bad news ("You've got cancer") who proceeds to blind his patient with jargon. Posner regards the obligatory course in "bedside manner" as "a colossal waste of time." Only primary nurse Susie Monahan, dim but compassionate, is capable of seeing her patient as a human being as opposed to a specimen.

Lay members of the audience, like me, emerged from the theatre shocked and shaken, if not entirely surprised. It is our fervent hope that for any doctor among us the play (which should be compulsory viewing for the entire medical profession) will be a lesson well learnt.

Madeleine Harmsworth *freelance arts critic*



JOAN MARCUS

How easy is it to retain dignity in a teaching hospital setting?

December bestsellers

1. **British National Formulary No 38 (September 1999)**
   BMA/Royal Pharmaceutical Society,
   £15.95, ISBN 0 85369 438 9
2. **How to Read a Paper: The Basics of Evidence-Based Medicine**
   T Greenhalgh
   BMJ Books, £15.95, ISBN 0 7279 1139 2
3. **Withholding and Withdrawing Life-Prolonging Medical Treatment: Guidance for Decision Making**
   BMA Medical Ethics Committee
   BMJ Books, £9.95, ISBN 0 7279 14561
4. **The Insider's Guide to Medical Schools 2nd ed**
   L Corps, I Urmston
   BMJ Books, £14.95, ISBN 0 7279 1428 6
5. **ABC of Asthma 4th ed**
   J Rees, D Kanabar
   BMJ Books, £14.95, ISBN 0 7279 1261 5
6. **ABC of Sports Medicine 2nd ed**
   M Harries, G McLatchie, C Williams, J King
   BMJ Books, £18.95, ISBN 0 7279 1366 2
7. **Anaesthesia and Intensive Care A-Z 2nd ed**
   S M Yentis, N P Hirsey, G B Smith
   Butterworth-Heinemann, £45, ISBN 0 7506 3249 6
8. **Emergency Triage**
   Manchester Triage Group
   BMJ Books, £13.95, ISBN 0 7279 1126 0
9. **Evidence Based Gastroenterology and Hepatology**
   J McDonald, A Burroughs, B Feagan
   BMJ Books, £85 (£65 until end of March),
   ISBN 0 7279 1182 1
10. **ABC of Major Trauma 3rd ed**
    P Driscoll, D Skinner, R Earlam
    BMJ Books, £18.95, ISBN 0 7279 1378 6

BMJ Bookshop

The BMJ Bookshop will endeavour to obtain any books reviewed here. To order contact the BMJ Bookshop, BMA House, Tavistock Square, London WC1H 9JR.
Tel: 0171 383 6244, Fax: 0171 383 6455
email: orders@bmjbookshop.com
Online: www.bmjbookshop.com
(Prices and availability subject to change by publishers.)

The flu news epidemic

In the end we weren't prepared for it. Sidney A, the real millennium bug—not a computer glitch but an influenza virus—was at the centre of a furore over its true extent and its impact on the NHS. The media generously fanned the flames. But once again New Labour's spin kings were thought to be behind the headlines.

Two key questions arise from the past fortnight's exhaustive media coverage. Was it really a flu epidemic? And, whether it was or not, why was the NHS unable to cope?

Before the millennium holiday the government had said that it was prepared for a surge in emergency admissions. As it turned out, the holiday period was not exceptionally busy for hospitals.

On 4 January, however, there were signs that the lull was about to end. "Britain's Y2K flu bug is due to peak this week as the country heads for its worst epidemic since 1989 when 29,000 died," observed Jill Palmer in the *Mirror*. "Calls to NHS Direct, the national nurse-led helpline, have soared from 4,000 to 14,000 a day. Meanwhile, pharmacists have reported a fourfold increase in the number of customers asking for cold and flu remedies and painkillers."

Figures for calls to NHS Direct varied: other newspapers put it closer to 20,000 a day. But none of the early reports suggested the figures were of epidemic proportions. The only outstanding statistic, noted the *Daily Telegraph*, was that "family doctors dealt with a record number of calls over the holiday, with an estimated 2 per cent of the population contacting a GP."

By 6 January the *Daily Telegraph* was indignant ("Flu outbreak leaves only 11 beds free for intensive care") and claimed that almost every family was affected by the flu virus. NHS horror stories gathered apace. Northwick Park Hospital hired a St John Ambulance bus "to ease the backlog of accident and emergency patients" (*Mirror,* 6 January). Eastbourne Hospital had to store 60 dead bodies in a refrigerated lorry (*Daily Telegraph,* 7 January). A 74 year old man died after an emergency aortic aneurysm repair and a subsequent 200 mile drive in search of an intensive care bed (*Independent*, 8 January). And, *sacré bleu*: "NHS ask France to take our flu victims" (*Sun*, 7 January). No! How could it be?

But the government was, as yet, unfazed. "Officials played down the use of lorries [for storing bodies] and said it was not 'an emergency reaction. It was part of our unprecedented long-term winter planning exercise, given the circumstances of the extended millennium holiday,' said a Department of Health spokesman," reported the *Independent* (8 January).

The *Guardian* (8 January) whiffed the hysteria and argued that the government's reforms should be given more time: "Crises in the NHS have become as much part of the post-Christmas New Year season as the moulting Christmas tree and the left-over turkey soup. We are currently being bombarded with NHS disaster stories . . . All this is grist to the mill for various interested parties, keen to prove a point."

On 8 January, the flu outbreak was not an epidemic; demand on primary care and hospital services was heavy, but officially the NHS was coping. And the media, wanting to stay occupied after the damp squib of the millennium bug, had found an easy target in the NHS. Overnight, however, everything mysteriously changed.

"Britain is in the grip of a serious flu epidemic, the government has declared. The outbreak is forcing hospitals to cancel thousands of urgent operations and is leading to an overcrowding crisis amid scenes of chaos in wards," revealed the *Observer* (9 January). The source of this claim was said to be Professor Liam Donaldson, England's chief medical officer. The official figures, he argued, were an underestimate because thousands of flu victims were calling NHS Direct and not going to see their GPs or attending casualty departments.

Alan Milburn, the health secretary, hummed the same tune in the *Daily Telegraph* (11 January): "Unless present levels of influenza activity peak soon, we would be heading for the worst epidemic in the last decade." If the figures didn't support the government line, what was his evidence? "That chimes with most people's experiences. There can hardly be a family in the land that has not been affected by the flu." Really? And what does that actually mean for the NHS?

But on this occasion the medical experts weren't falling for New Labour's spin; the official figures fell well short of an epidemic, and newspaper columnists reacted quickly. Charles Arthur asked: "If the NHS is coping so well, why are all those extra beds needed, why has an epidemic-that-is-not-an epidemic been declared, and why are routine operations being cancelled all over the country?" (*Independent*, 11 January).

By 16 January, the government was reeling from the media and public backlash, including an attack on its handling of the NHS by its own high profile peer Lord Winston. In response, Prime Minister Tony Blair could do little more than promise further investment in the NHS.

The government's attempt to mask the problems of the NHS had clearly failed. The *Observer* (16 January) offered an insight: "The reason the government was talking up a flu epidemic was simple. Reports to the NHS executive suggested elective surgery was grinding to a halt and the number of spare beds was close to zero." Government officials, said the newspaper, had "made discreet calls to Sunday newspapers." And the reason for this media manipulation? "Health Secretary Alan Milburn," revealed the *Observer*, "one of the most media-savvy Cabinet Ministers, knew that the NHS was about to go on to the political front line."

So, it wasn't an epidemic. No different from most other years, and the NHS had coped poorly. But, at least on this occasion, New Labour's spin had been publicly unravelled.

Kamran Abbasi *BMJ*

WEBSITE OF THE WEEK

Competing interests One of the many ways in which the web differs from conventional media is the potential difficulty of assessing the financial interests of those who promote a site. This week the *BMJ* reports how a manufacturer of interferon beta is trying to encourage patients with multiple sclerosis to lobby the National Institute for Clinical Excellence (NICE) before its ruling on the drug in May. The site itself (www.msvoice.co.uk) is a classic, frames based piece of "brochureware" exhibiting no signs of human habitation. Users do not get feedback on how others have completed the online questionnaire nor, indeed, any clue as to its sponsor's interests. It would be easy to get indignant about such sites, but a search on "link:www.msvoice.org.uk" on Altavista (www.av.com/) revealed that the site has no external links, and so it is probably irrelevant since its traffic is not likely to be great.

This is hardly a new phenomenon on the web: last year, the US healthcare portal DrKoop.com raised eyebrows with its forthright acceptance of sponsorship from a wide range of "ebusinesses," including www.vitaminshoppe.com (http://techdeals.findlaw.com/agreements/drkoop/vitaminsponsorship.html). Now, providing such relationships are transparent, people can judge for themselves whether there is a conflict of interest. The logo of vitaminshoppe is clearly displayed on DrKoop's home page, though how sponsorship affects editorial policy remains unclear (www.drkoop.com/aboutus/koop/).

Reputable organisations will have to be increasingly careful about sponsorship. The reputable Multiple Sclerosis Society website (www.mssociety.org.uk) generates plenty of hits from a search on "interferon," but I had to ring the society's press office to confirm that, although the society has accepted educational grants from companies that make interferon beta, the website is editorially independent of any pharmaceutical company.

Douglas Carnall
BMJ
dcarnall@bmj.com

PERSONAL VIEW

Surfacing after burnout

Chris Johnstone's Career Focus article on burnout (*BMJ*, 1 May 1999) struck a chord with me as I had recently downshifted from the chaos of trauma surgery.

Unlike Dr Johnstone, it was not a respiratory tract infection which took me out of the fast lane; it was the discovery from a long overdue medical check up that I was hypertensive. Sadly, I am unlikely the first or the last professional person who has demanded a nice, unequivocal diagnosis before accepting that physical and emotional resources were buckling under the prevailing demands.

> Did anyone realise that my coping mechanisms were exhausted?

For 12 years I headed a paediatric trauma unit. The profile of trauma care in South Africa is well known, and the substantial cohort of British students who visit our hospitals no doubt return home well equipped with ripping yarns of rivers of blood and guns hidden under hospital gowns. When local trauma surgeons gather at conferences or advance trauma life support courses, the fishing stories are no less melodramatic.

Sadly, all this guff serves primarily to shut out the cumulative emotional strain which we all feel. Trauma surgeons are the epitome of medical warriors, and would sooner drink hot chocolate down the pub than admit that their emotional resources had been tested once too often by gruesome scenarios, working routines which are no routine at all, or being overwhelmed by the enormity of the societal ills which feed our resuscitation areas night after night.

The decision to slow down followed quickly if not painlessly on the shock of my first three figure diastolic pressure reading. That evening, the urgent need to alter my lifestyle seemed as clear as it was daunting. I slumped on a couch for hours, unable to hold back tears divined out of relief, anger, grief, and recrimination.

Twelve years of tension foamed out, only to be interrupted sometime after 11 pm by a telephone call from my registrar on duty, calling for assistance. I composed myself quickly, and drove off to fight the dragons once more. Whenever I reflect on that night, I am frightened by the ease with which the call to duty could evoke the brittle persona that I had unwittingly adopted in the quest for career satisfaction. I handed in my notice the following day.

It was not easy to bow out of the workplace. I imagined that every face, every innocent comment, screamed "Judas" at me. After all, I was deserting an institution already strained by the double whammy of staff cuts and a steadily increasing workload. Self recrimination often resurfaced, sweeping personal needs like dander under the perceived demands of the greater good. I simply retreated to the relative safety of my office, and did my best to sabotage farewell functions in my honour. As in a bad dream, I was vainly trying to escape my own demons, my feet glued to the ground.

It has been two months since I finally walked out of the hospital. I still grieve for the loss of a professional lifestyle which ran amok, the void now filled by a non-clinical job with regular hours and a much slower pace. My life is less exciting, but there is more of it now, and it is still worth living—perhaps more so. It has been a major adjustment learning to do less without feeling unfulfilled. I often have to remind myself that kudos carries a price that I can clearly not afford.

> My life is less exciting, but there is more of it now, and it is still worth living

I sometimes reflect on the way that I have seemed to my ex-colleagues on the many occasions when stress got the better of me and I began to bounce off the wall like a Tasmanian devil on amphetamines. Did anyone ever realise that my coping mechanisms were exhausted, a potential danger to my patients? If so, did they hold their counsel out of tact, embarrassment, or the time honoured resolution not to interfere?

I reflect on these things not because I am seeking scapegoats. After all, it was I alone who made myself indispensable, snapping up any additional obligation which could have been delegated elsewhere. It was my idea to provide senior cover almost every day, night, and weekend, ostensibly "to ensure continuity," but in fact such apparent largesse was just another symptom of an insatiable and obsessive need to feel needed. It was me who fooled myself every step of the way. I shall have to be very careful that it does not happen again.

David Bass, *former trauma surgeon, Cape Town*

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

Changes

Last year I grew a beard—after 13 years with a small goatee that, as I used to say, was my "true" face and would not change.

Last year I learnt to ride a bicycle—after years of trying, after quitting at my 19th birthday, sure that I wouldn't change.

Last year I resigned my job at the hospital—after almost two years of hard working with many new friends, and believing that this couldn't change. But after one of my friends was fired there wasn't another way to express our vehement opposition. So 20 of us, almost half of the internal medicine staff, signed our resignation letters and sent them, along with our manifesto against the whole affair, to all competent powers in the university, explained our position to them, and waited.

I must say that it wasn't a decision made serenely. I hate changes. I favour stability and order, and anything that endangers my peaceful private corner of the world is a personal threat to me and it's dealt with as such. But we had to take the action. If we couldn't risk everything for a friend's sake, who could we risk it for?

And then, one week after the start of the crisis, everything changed. One of the administrators resigned in a most unexpected way, ending 11 years of inflexible rule.

The atmosphere at the hospital is so different now. People laugh more, talk in the corridors and restrooms more freely. And we have started to meet for breakfast in the dining hall every Friday morning, just as we did until it was forbidden, months ago.

As doctors we should welcome changes, shouldn't we? If we didn't believe that a state of illness could change into a state of health we couldn't cure anyone. If we didn't know that a state of health could change into a state of illness we couldn't prevent any disease, could we?

Small and big, simple and near miraculous—changes can happen, once in a while.

Ricardo S Silva *psychiatrist, São Paulo, Brazil*