reviews

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CD roms

Cardiovascular Medicine: Enhanced Multimedia CD-ROM

Ed Eric J Topol

Lippincott Raven, £182.50
ISBN 0 7817 1681 0

Rating: ★★★

As we embrace, with varying enthusiasm, the era of desktop publishing, electronic journals with collaborative online links, and the ubiquity of email and the internet, what role remains for the textbook and, specifically, the electronic mega-text?

This question is echoed in Professor Topol's preface: "Another textbook in Cardiology—why?" Cardiovascular medicine is a rapidly evolving specialty and has witnessed radical changes in the past decade, with a vast expansion in our knowledge base. Given its heavy dependence on the integration of clinical discipline with scientific advance, the constant impetus of data from latest clinical trials, and use of transmitted images, it would seem ideally suited to presentation using the latest advances in multimedia publishing.

This CD Rom is an electronic version of the two volume textbook *Comprehensive Cardiovascular Medicine*, enhanced with video clips of unusual and interesting echocardiograms, angiograms, and nuclear medical investigations, together with 460 supplementary still images, a library of normal and abnormal heart sounds, and copies of recent guidelines from the American College of Cardiology and American Heart Association on the investigation and management of the spectrum of cardiovascular disease.

The textbook itself is superb and awesome in its depth and scope. More than 100 chapters cover the entire spectrum of cardiovascular science from preventive cardiology to the latest advances in molecular biology.

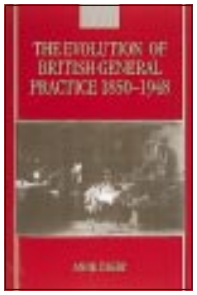
As to be expected from the calibre of the large panel of international authors, the text is authoritative, contemporary, well written, and comprehensively referenced—many citations being electronically linked to their Medline abstract. In contrast, the supplementary features provided by computer technology proved disappointing. The library of heart sounds is neither novel nor useful. Although the video and still images reproduce well and provide good teaching material, they are arranged in rather a haphazard order and add little to the already excellent textbook. Furthermore, I encountered problems in accessing the video images because of incompatibility with IBM software.

In conclusion, other than providing the attractions of portability and speed of reference, electronic technology has failed to substantially enhance an excellent comprehensive textbook. I suspect that many students of cardiovascular medicine will opt for the traditional comforts of their favourite armchair and a solid tome.

Bernard D Prendergast *specialist registrar in cardiology, Royal Infirmary of Edinburgh*

The Evolution of British General Practice 1850-1948

Anne Digby



Oxford University Press, £48, pp 376
ISBN 0 19 820513 9

Rating: ★★★★

Efficient health care requires the careful tuning of medical services to the needs of individual patients. One of the core functions of general practice is to enable this liaison between the lay and the professional system, and from this function follows most of the academic development of general practice in the past decade. It is clear that academic general practice thrives in particular when its position is carved in the laws and regulations of the healthcare system. This is the case in Britain and the Netherlands, which has facilitated exchange of experience between the two countries. A history of British general practice therefore appeals particularly to the Dutch. Both consider the introduction of national law (on the NHS in 1948 and the Dutch law on the sick funds a few years earlier) as the hallmark of modern general practice, a revolution by social engineering.

Anne Digby corrects this view in a fascinating narrative that is based on a painstaking analysis of British general practice in the 100 years preceding the NHS. This period covers the introduction of the Medical Act, which regulated the qualifications of and access to the medical profession, and the development of formal insurance for health care. Both offered threats and challenges for the practitioners of that time. General practice presented itself in these years as a small business, and financial and fiscal aspects dominate clinical information in the many documents that form the basis of this analysis. Two qualitative sources supplement this archival material: oral testimony, in particular for the period around the passage of the NHS, and an examination of general practitioners' obituaries from the *BMJ*.

What results is a testimony, rich in statistics and personal observations, of a profession struggling for its place in the system. The struggle focused on its unique "mission," its niche in a medical environment that valued specialisation rather than the medical generalist. But above all general practitioners struggled to make a decent living from caring for a population that could hardly afford their services. The sore effects of the 19th century free market were alleviated by a variety of friendly societies, poor law unions, and colliery practices—as much a patchwork as the denomination-driven local initiatives that marked health care in the Netherlands at that time. Through Lloyd George's National Health Insurance of 1911, this culminated quite logically in the NHS.

Implicit throughout the book is the reactive nature of the profession to changing circumstances. A number of strong role models, like McKenzie and Pickles, marked their presence, but in the absence of formal organisations for general practice no consistent focused leadership was provided. It can be little surprise that there was great variety in the quality and content of general practice. This statement should probably be reversed: it is amazing how consistent and coherent the discipline of general practice developed in that period, in the absence of any academic leadership—and again the parallels with what happened in the Netherlands in the same period are striking. This fascinating narrative of the development of a discipline is truly outstanding.

Chris van Weel *professor, department of general practice, University of Nijmegen, Nijmegen, Netherlands*

Home Sweet Home? The Impact of Poor Housing on Health

Alex Marsh, David Gordon, Christina Pantazis, Pauline Heslop

Policy Press, £16.99, pp 90
ISBN 1 86 134 176 8

Rating: ★★★

"The impact of multiple housing deprivation would appear to be the same order of magnitude as addressing the issue of smoking and the risk to health posed by multiple housing deprivation seems to be, on average, greater than that posed by excessive alcohol consumption." Furthermore, "housing history matters," as adults who are currently living in good housing circumstances are more likely to be ill if they experienced adverse housing conditions earlier in life. These represent some of the key findings of this study, which are particularly important within the context of the current health policy. They reinforce the need for health and welfare polices to focus on structural as well as behavioural determinants of health, and so lend weight to those initiatives outlined in *Saving Lives* and other recent official documents. They also reinforce the fact that the housing circumstances of children are of paramount importance. Housing deprivation was found to be a highly significant explanatory variable in relation to health, even after controlling for a range of other factors that included standard of living and genetic, social, and behavioural indices.

These general conclusions are based on an extremely thorough study which comprises a secondary analysis of the national child development survey (NCDS), a longitudinal study that involved collecting data on all children born in Great Britain between 3 and 9 March in 1958, 1965, 1969, 1974, 1981, and 1991. One of the great merits of this type of analysis, as opposed to cross sectional studies, is that it allows investigators to ascertain the extent to which factors have long term effects. It has allowed the authors of this book to explore the proposition associated with life course theories—that there could be an accumulation of risks associated with housing deprivation throughout the course of life. No strong evidence was found to support this thesis, but this may well be because of the effect of other related factors which have variable and interactive impacts over time.

A range of indicators were used to measure health status, including those associated with infectious illnesses, respiratory conditions, and overall ill health. More importantly, however, the authors attempted to develop a reliable housing deprivation index. This task proved to be especially challenging, and, although no ideal index was constructed, their contribution to this task is substantial. Herein lies one of the main achievements of this study. Housing deprivation, like poverty, is a relative concept, and those working in this subject must take this into account in their analysis. For example, the authors point to the need in contemporary societies to measure not just the lack of physical amenities but also subjective factors such as satisfaction with dwelling or residential area. This is, of course, more than just a methodological point: policies, too, must address both the material and psychosocial aspects of housing deprivation if they are to improve health and reduce health inequalities.

Sarah Nettleton *senior lecturer in social policy, Department of Social Policy and Social Work, University of York*

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

ART

Exhibiting the mad psychiatrist

Installation "It is only by confining one's neighbour that one is convinced of one's own sanity?" (1995) and film *QM, I think I shall call her QM* (1997, duration 28 minutes) by Ann-Sofi Sidén (film codirected with Tony Gerber)

South London Gallery, 65 Peckham Street, London, until 5 March. Admission free

Swedish artist Ann-Sofi Sidén, exhibiting for the first time in Britain, has based both pieces on the experiences of a psychotic psychiatrist. Sidén was one of several artists given access in 1994 to the home of New York psychiatrist Dr Alice E Fabian after her death.

The installation is an interpretation of Fabian's apartment, and her story is recounted through written material, audiotapes (excerpts from her diaries), some Polaroid photographs, surveillance screens, a wall of psychiatric texts, and, in the great tradition of contemporary art, an unmade bed. It is a catalogue of Fabian's paranoia—of laser beams, electricity, and passers by interfering with her thoughts—a desperate voice articulating bewilderment and trying to regain control. We observe and evaluate a woman who became deluded that she was being observed and evaluated. Although the mad psychiatrist is somewhat clichéd, Fabian's concerns are articulated in the psychiatric jargon she uses to rationalise her paranoia. The psychiatrist counters concerns about surveillance with surveillance, and the artist is the inquisitor/editor/voyeur who presents these. It is voyeurism that glories in its voyeuristic means.

The film, comprising a classical narrative in conventional form, develops these themes, fictionalising the psychiatrist (as Dr Ruth Fielding) and introducing a second character into the story. During the 1980s, Sidén had developed the character of a mute mud-clad creature (played by herself) called QM, the Queen of Mud. The film begins with Fielding's discovery of QM in her home, and records how she treats her as prisoner, pet (feeding and mating), patient (she injects her), and even estranged daughter. Clearly psychiatry will not "explain" QM—a combination of prehistory and science fiction. Equally, QM cannot cure the doctor. Kubrick and Scorsese have explored psychosis as metaphor within their films, each making wider points about the nature of society and humanity.

GALERIE NORDENHAKE

Fabian's unmade bed, less cluttered than some

I left with uncertainty as to what insights Sidén has gained from these preoccupations. Psychiatry as social control is old hat, and its colonisation of women has been covered in, for example, Janet Walker's *Couching Resistance* (University of Minnesota Press, 1993). My initial concerns, given the reality of Dr Fabian's illness, were that this could be paranoia as art/entertainment, but this is not the case. The exhibition may raise even more questions in those who have been lucky enough to be free from the constraints of psychiatric training.

Peter Byrne *senior lecturer in psychiatry, University of Kent at Canterbury*

ads ads ads

The new NHS smoking campaign

The UK government's 1998 white paper on tobacco promised that £60m would be spent over three years to set up smoking cessation services in the NHS and that these services would be backed up by an advertising campaign. The campaign—"Don't give up giving up"—was launched in December 1999. This initial £5m media campaign comprises posters and six weeks of television advertising; it offers tips on giving up, testimonials from people with smoking related diseases, and a video diary of nicotine addicts trying to quit. All the advertisements feature genuine smokers: there is not an actor in sight.

The testimonials are particularly powerful. It would be surprising if the story of a 43 year old woman who died of lung cancer three weeks after filming didn't prompt many smokers to think again. The video diaries provide a day by day account of smokers' efforts to quit. They seem partly to be designed to remind smokers that they are not alone in trying to quit at the beginning of a new year and to convince them that they can succeed.

One unusual feature of the campaign is its explicit message that "relapsing is a natural part of the process … lapses are OK." This message is reinforced by one of the main characters in the video diaries. This aspect of the campaign was presumably designed to demonstrate an understanding of and empathy with smokers and to avoid finger wagging. Unfortunately the evidence from trials of smoking cessation consistently suggests that a lapse during the first weeks of trying to quit is predictive of a full relapse over the next year. The media campaign, however, is targeting a different population from that of clinical trials. And the hope must be that the advantages of supportive encouragement outweigh the hazards of reassuring smokers that an occasional cigarette is permissible when trying to give up.

A new freephone number replaced the Department of Health's old Quitline number just before the campaign was launched. A private call centre is now used to screen calls to decide whether to provide brief information or to transfer the caller to a Quitline counsellor. Another change from previous years is the prominence of NHS branding taking the place of the logos of the Health Education Authority and Quitline. These changes reflect a desire by the Department of Health for greater control of the campaign.

The most objective measure of the campaign's impact is the number and nature of calls made to the helpline compared with previous years. A press release from the Department of Health issued on 7 January quoted Yvette Cooper, public health minister, as stating that the number of calls was up 250% on last year. However, the Department of Health's analysis of the data for January shows that only 9% of callers were transferred to counsellors, and 82% were dealt with as simple requests for literature; the service provides a brief pamphlet about stopping smoking. Part of the reason might be that up until the end of January more than half of the calls were answered by an answering machine. In contrast, last year a trained counsellor answered 80% of calls.

HEA

The government has spent £5m on this year's campaign

When I first called the helpline I was greeted by a 64 second message asking me to leave my details. On another occasion my call was answered and dealt with efficiently by an operator. Inevitably services of this kind will be patchy when demand is heavy but it is troublesome that the proportion of calls being answered by a machine increased so markedly. In its wisdom, the Department of Health asked all organisations interested in bidding for next year's contract to run the helpline to submit bids by the first week of January 2000—right in the middle of its busiest period and immediately after the millennium celebrations.

Overall, the media campaign appears to have struck the right note with smokers and produced a rise in calls to the helpline which is roughly in line with what was expected with the increase in expenditure. However, there are doubts about the quality of the service provided by those screening the calls, the timing of the change in the helpline's number, and the timing of the tendering process for the next contract. Fortunately, now that the new year's rush has passed, over 90% of calls are being answered by a human. Perhaps the campaign's message should really be: "Don't give up on ringing up."

Jonathan Foulds *senior lecturer in clinical psychology, University of Surrey, Guildford*

@ www

WEBSITE OF THE WEEK

Consumers' health You wait months for a UK consumer health website, and then three come at once. Last week saw the launch of three such sites, all complete with television celebrity and all predicated on a portal strategy—that is, acting as a gateway to direct users to content at other sites. I tested each site by playing a smoker who wants further information about stopping.

The search facility of HealthInFocus (www.healthinfocus.co.uk) was slow but seemed worth the wait, pulling an impressive range of categorised links. Sadly, the content behind these was not so impressive. SurgeryDoor (www.surgerydoor.co.uk/) loads quickly, but indexes only its own content; much of which was irrelevant. If you're willing to go with the frames based navigation, the Healthy Living link pops down to reveal a link to smoking and good content prepared by a counsellor for stopping smoking. NetDoctor's (www.NetDoctor.co.uk) search was fast, and among the links pulled was an interactive page that calculates a score for "How addicted you are to smoking," although the evidence that the scoring system is a reliable way of judging which smokers would benefit from nicotine replacement therapy is not linked. All three sites publish clear statements about their ethics: the way that they plan to make money is, for example, by putting banner ads for Beconase before the eyeballs of hay fever sufferers—linking niche consumers to niche advertisers.

Will they succeed? Better than any of them was the BBC's "Kick the habit" page (www.bbc.co.uk/health/kth). Although the BBC has spent millions on its site, it needed only to generate a single page of in-house content with links to two high quality external sites—the Health Education Authority's www.givingupsmoking.co.uk/ and No Smoking Day's www.no-smoking-day.org.uk/—to outperform the three portals' in-house content. Richer even than those is www.quitnet.org/, and there lies the problem with the portal strategy—the competition is but a merciless mouse click away, so content must either be focused and unique or of the very highest quality. These portals are neither and will suffer as a result.

Douglas Carnall
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PERSONAL VIEW

It could be you

Last Saturday the envelope containing my decree absolute landed on the mat. Two and a half years ago, after 19 years of marriage and the production of three children, my partner, a doctor, thought that he could do better elsewhere and left. But the pill which has at times been harder to swallow than the divorce wrangling is the elegant disdain with which I have been cast aside by some of his colleagues.

I had been around for a long time—not in any stunningly important capacity, but always available to take telephone messages, entertain colleagues, attend functions, soothe irate private patients. Yet within an amazingly brief period the new partner was introduced on to the scene and to certain people I automatically became yesterday's news, an Orwellian unperson.

These are people with whom we socialised as a couple for years. People who came regularly—over eight, 10, 12 years—to our home to receive our hospitality, which generally entailed my spending Friday evening and most of Saturday in the kitchen producing fussy food or clearing up. More fool me, perhaps. But then we in turn were entertained in the colleagues' homes—presumably after the same mad behind the scenes activity. Tickets to balls were bought and lifts shared; sherry and mince pies were consumed; and bored children entertained in the hospital boardroom on Christmas morning.

So the circles turned. Nothing new, this is how the wheels of professional society are oiled, and you don't have to be bosom pals with everyone to enjoy these things on a superficial level. Many of these were not particularly close friends, some no doubt don't care much for either or both of us, but others were great fun and I thought we had some good times. Yet here is the puzzle: what turns intelligent members of a profession into blank eyed strangers overnight?

My job takes me regularly into the teaching hospitals, where unsurprisingly I have run into several of these faces from the recent past. The dodging down corridors or sudden interest in the floor patterning seem amusing now but initially they hurt. Away from work my altered status was thrown into even sharper relief when I met one man—my husband's close colleague from the same department, and certainly a familiar face—as we reached for trolleys in the supermarket. He managed a look of recognition and half a smile before escaping into the store.

I could go on but too much of the same smacks of paranoia, and though there may be an element of catharsis here I am not seeking revenge. Thankfully, as a working wife and mother of three the medical social circle was by no means my only one. I have kind and decent children who are gradually recovering, a supportive father, an understanding GP, a new partner, and friends who have been such towers of strength that I run out of superlatives to describe them. To these I would add my job, which provided not only income but also much needed traction to my first weeks and months alone. I have recanted utterly my cynical view of counselling, a service which turned out to be beneficial both for the children and for me. My cup, though not quite at capacity, is refilling. Perhaps these positive things allow me to make my point now, nearly three years down the line, in a relatively calm and reasoned manner. Medical social circles are fragile, impermanent things, and it would be self deluding to imagine the numerous relationships within them are the same as solid friendships. This does not mean that their vaporisation overnight is painless, and I would urge those still on the inside to remember that. Bear in mind the abandoned spouse next time you hear of the breakup of a medical marriage. While you will continue to work with the colleagues, and clearly need to maintain relationships, spare the odd thought for the outcast non-medical partner.

What turns intelligent members of a profession into blank eyed strangers?

We are not asking for undue attention or any hypocritical continuation of a relationship which was of minimal importance. What would be nice would be an acknowledgment if you recognise us in the hospital corridor or in the local supermarket, or a smile instead of an embarrassed shuffle when we find ourselves picking up children at school at the same time or watching the kids playing rugby.

Relax—we abandoned wives won't ask dolefully what you think of our replacement, or weep unnervingly on your shoulder. Those things will be left until we get back in the car or climb into bed alone later that night. The trick includes deep breathing and a lot of waterproof eye makeup.

Life changes immeasurably during and after divorce. Rejection by a partner involves a quite spectacular shattering of constructs: perceived rejection by his or her colleagues adds to the damage. Acknowledge an ex-spouse today and you will promote his or her self esteem immensely. The marriages of doctors are notoriously prone to breakdown—remember, one day it could be you.

Joan Maclean *university lecturer, Leeds*

SOUNDINGS

This tablet may save your life

A good way to sell a dubious product is to slap a label on it saying, "this could save your life." If you surf the internet for long enough you can find such claims made for anything from megavitamins for the over 50s to gulp sized oxygen cylinders for stressed executives. What is extraordinary is that the claim is rarely made for drugs that could and do save lives.

A friend of mine recently telephoned in a panic on a Sunday morning. His mother had collapsed with central chest pain. The ambulance was on its way, but what could they do while waiting?

I asked some brief questions to confirm a likely heart attack, and gave some first aid advice, to which my friend was very receptive. Instructions to reposition the patient and loosen tight clothing were exactly what you might expect from a doctor in an emergency. I next quizzed him about contraindications to aspirin. He was surprised at these questions and needed to be told twice to seek the relevant information from his mother. There was a bottle in the bathroom cupboard, and I advised him to give her a single tablet.

"Look," he said, "I don't think you understand what kind of pain she's in. Even two or three aspirin are not going to touch it. In any case it's probably better to wait till we get to hospital. I don't want to do anything until she's seen the doctor."

The point of this story is that when the life of his nearest and dearest was hanging in the balance my friend was in no state to accommodate a lesson on the thrombolytic efficacy of low dose aspirin—a drug he still categorised as an old fashioned and rather dangerous painkiller.

My suggestion is simple: pharmaceutical companies should be encouraged to produce brightly packaged single dose aspirin tablets emblazoned with a red cross or other first aid symbol and the evidence based slogan, "This tablet could save your life if taken as soon as possible during a heart attack" along with a tick list of important contraindications.With a focused advertising campaign, the "miracle cure" will soon find its place next to the triangular sling in every family first aid kit. More importantly, patients and doctors can debate the potential benefits of such treatment at a time when their decision making faculties are appropriately tuned.

Trisha Greenhalgh *general practitioner, London*