

reviews

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Incontinence

Eds Malcolm Lucas, Simon Emery,
John Beynon



Blackwell Science, £69.50,
pp 384
ISBN 0 632 05003 9

Rating: ★★★★★

The idea that there are boundary walls in the pelvis labelled “urology,” “gynaecology,” and “coloproctology” which surgeons must not cross is a view now losing ground, and this book, which covers urinary and faecal incontinence, supports the modern approach. This has been possible because the three editors are consultant surgeons at Swansea NHS Trust in urology, obstetrics and gynaecology, and

colorectal surgery respectively and seem not to show even minor traits of territorial protectionism.

It is highly unlikely that any single person, however expert, could have the depth of knowledge that the assembled authors have amassed in this book. There will be something in this book for everyone concerned with the treatment of incontinence.

The main meat of the book is in the chapter written by the three surgeons describing their various operations for urinary and faecal incontinence. If ever I need to understand these operations I will turn to this text because they are so clearly described. But there is much more in this book than surgery. There is a chapter on non-surgical interventions—possibly a little uncritical in its enthusiasm but with excellent descriptions of what should be tried before surgery—and an extensive chapter on specialist investigations that is particularly valuable because it includes the authors’ views. Their bold statement about the value of clinical neurophysiology—“sadly ... the benefits ... have been very disappointing”—is one that I fully endorse.

It was inspired to include a chapter on research techniques that describes just the principles of the methods without presenting results: written by experts, it covers a range of techniques and will be informative for anyone who attends meetings at which research papers are presented. If your main interest is clinical an explanation of intracellular recordings and autoradiography will be welcome, and presumably scientists will have a similar view about the clinical sections. The inclusion of a chapter on the economics of incontinence is also unusual, but this aspect of medicine is so important nowadays for justifying expenditure, be it on clinical service or research. The only aspect of this book that I did not like was a few examples of reproduction of others’ figures, however modified, without acknowledgement.

After reviewing a book, I often pass it on, but I intend to keep this one—although that may be difficult when my colleagues find out how valuable it is.

Clare J Fowler *consultant in uro-neurology, department of uro-neurology, National Hospital for Neurology and Neurosurgery, London*

Schizophrenia: Concepts and Clinical Management

Eve C Johnstone, Martin S Humphreys,
Fiona H Lang, Stephen M Lawrie,
Robert Sandler



Cambridge University Press,
£45, pp 271
ISBN 0 521 58084 6

Rating: ★★

Schizophrenia is an exceptionally disabling condition, accounting for a substantial proportion of the 10% of NHS costs that is spent on mental health. It often starts in young adulthood, affects up to about 0.5% of the population, and in many cases leads to a lifelong disability profound enough to prevent paid employment.

Eve Johnstone has been at the forefront of schizophrenia research for over 20 years, for much of that time in collaboration with Tim Crow in a partnership that became as familiar to psychiatrists as Marks and Spencer is to the high street shopper. However, her summary of the past few decades of research makes a sobering read: “The magnitude and intractability of the problems associated with schizophrenia leave an overwhelming impression. Of course there have been advances ... it has been enormously exciting and rewarding, yet at times heartbreakingly sad, because the advances are not really doing anything for the patients.”

Written in conjunction with colleagues from Edinburgh, Eve Johnstone’s book is a useful summary of current knowledge. An overarching aetiological theory is not proposed—indeed, the conclusion that “we have been able to implicate the brain in schizophrenia” seems rather obvious. The suggestion that psychosis can be thought of as along three dimensions—positive, negative, and disorganised—with distinct pathological mechanisms is well argued but probably still falls short of being an accepted theory.

Recent therapeutic advances are also briefly described, though more space would be needed to do them justice. This is one aspect where some lightening of mood might be justified. New atypical antipsy-

chotic drugs are being developed that, despite the hype, may have some advantages. There is also evidence that cognitive-behavioural and family therapy are effective treatments. Much lip service has been paid to a “bio-psycho-social” approach to treatment. We are now increasingly able to support this clinical principle with some hard empirical evidence, although large pragmatic trials are still uncommon.

Much schizophrenia research has been conducted on either side of an ideological fault line, with biological psychiatrists investigating cerebral ventricular enlargement while social psychiatrists study family dynamics. There are now encouraging signs that the field is gradually evolving a more rounded, multidisciplinary approach. Psychological processes are studied in conjunction with their localisation in the brain by means of functional imaging techniques. Likewise, new psychological therapies have been developed to enhance adherence with both prescribed medication and attendance at outpatient clinics and day care.

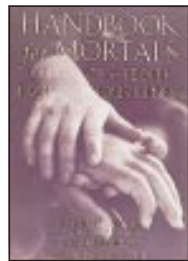
Schizophrenia remains a stigmatised and enigmatic condition. It seems easy to justify the cliché that “further research is needed.”

Glyn Lewis *professor, division of psychological medicine, University of Wales College of Medicine, Cardiff*

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

Handbook for Mortals: Guidance for People Facing Serious Illness

Joanne Lynn, Joan Harrold



Oxford University Press,
£14.99, pp 256
ISBN 0 19 511662 3

Rating: ★★★★★

A hundred years ago most adults died quickly from accidents or infections. Death and serious illness were everyday occurrences, and most people would have had firsthand experience of the death of a loved one early on in their own life. Nowadays most people have little experience of disease and dying, and many of us will have serious illnesses that linger for months or years before we die.

Handbook for Mortals attempts to bridge that gap—the gulf between “living with” and “dying of” that is fraught with fear and

distress, both for the ill person and for loved ones and carers. The authors face the issue of our own mortality head on, and explore in detail a wide range of end of life issues such as finding meaning in the last few weeks or months, helping family members to make decisions and give care, controlling pain, forgoing medical treatment, coping with events near death, and the dying of children.

This is a beautifully laid out book, with the prose interspersed with short poems, quotations, poignant photographs, and practical checklists. Another refreshing feature is that, rather than speaking somewhat abstractly in the third person about other people facing serious illness, the authors have addressed the book to “you”: for example, “It isn’t easy to talk about disease and dying. And talking specifically about your own dying is both harder and more important to do. Sometimes it is hard because you don’t know the words to use.” This technique is particularly powerful as it draws one into the text with a strong sense of the personal, whether from the stance of a carer, an attending professional, or, indeed, the sufferer.

The authors have managed to achieve a genuine mix of practical suggestions—such as how to get help from community services, how to have a successful conversa-

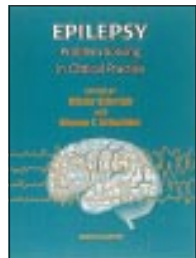
tion with your doctor, how to write a living will or advance directive, and how to plan your funeral—with more esoteric issues around spirituality, having difficult conversations with your family, and how to find meaning in life when there may seem to be none left. There are also a couple of excellent chapters on choosing whether to decline further medical treatment and issues around resuscitation, followed by a thorough explanation of the differences between euthanasia and physician assisted suicide. Sudden death and the death of children is also discussed.

Handbook for Mortals is written by American authors for a US audience, and, therefore, some of the practical information about healthcare providers, health insurance, etc, is not relevant to Britain. Nevertheless, the general truths addressed in the book are extremely relevant to all of us—the patient, the carer, the professional. Talking about death does not make it happen, though many of us are afraid it may. The *Handbook for Mortals* goes a long way in helping to manage and dispel those fears.

Dingle Spence consultant in palliative medicine, St Peter’s Hospice, Bristol

Epilepsy: Problem Solving in Clinical Practice

Dieter Schmidt, Steven C Schachter



Martin Dunitz, £49.95, pp 489
ISBN 1 85317 504 8

Rating: ★★★★★

I enjoyed reading *Epilepsy*. Although we now understand epilepsy and manage it better than we did 10 years ago, some areas remain neglected and new problems have emerged because of recent advances in diagnosis and treatment. Schmidt and Schachter’s book reviews over 30 such problems, and does it well.

The diagnosis and treatment of seizures in elderly people is a neglected area, and this book reminds us that epilepsy is underdiagnosed and undertreated in this age group. Carers are less likely to think of seizures as a cause of episodic abnormal behaviour in elderly people, and they are unlikely to undergo intensive video and electroencephalographic monitoring to make a diagnosis. Moreover, most doctors are likely to extrapolate their knowledge of treating younger adults to this age group—an approach that is fraught with pitfalls.

Schmidt discusses the 10 most common errors in treating epilepsy. Many of these are predictable, such as adding a second drug

before the first one has failed and using sub-optimal doses of new antiepileptic drugs. “Adding a drop of this or one tablet of that anticonvulsant will do the trick” may not do the trick—better to use the maximum tolerated dose of the first drug before adding this or that. With so many new drugs in the market and no clear guidelines on which one to add, Schmidt’s commonsense advice is that the individual doctor should learn to use two new drugs well rather than experiment with several.

Surgery for epilepsy, especially for seizures originating in the hippocampus, is now an established treatment. Expert opinion tends to favour early rather than late surgery in order to avoid the brain injury that prolonged and recurrent seizures cause. Early surgery could also reduce the social disadvantages and psychological problems associated with chronic epilepsy. But it may mean diagnostic errors in selecting the right candidate for surgery. This dilemma is well highlighted in *Epilepsy*.

In an otherwise excellent publication I found the last chapter (“The team approach to treating epilepsy: when do we need it?”) unnecessary and elementary. Modern medicine is a team effort, and managing epilepsy is no different.

Neurologists should add this book to their “to be read list.” Others who refer to it will be rewarded with easy to use information. The problems might not go away, but, after reading this book, you should be able to deal with them better.

Rajendra Kale assistant professor of neurology, BJ Medical College, Pune, India

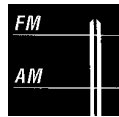
Hit parade



These articles scored the most hits on the BMJ’s website in the week of publication

JANUARY

- ABC of heart failure: Pathophysiology**
2000;320:167-70
57 762 hits
- Science, medicine, and the future: Allergic disorders**
2000;320:231-4
53 932 hits
- ABC of heart failure: Aetiology**
2000;320:104-7
48 286 hits
- ABC of heart failure: Investigation**
2000;320:297-300
37 680 hits
- Regular review: Treatment of *Helicobacter pylori* infection**
2000;320:31-4
33 134 hits
- ABC of heart failure: Clinical features and complications**
2000;320:236-9
30 699 hits
- Recent advances: Nephrology**
2000;320:98-101
30 222 hits
- Extracts from “Clinical Evidence”: Chronic fatigue syndrome**
2000;320:292-6
29 145 hits
- ABC of heart failure: History and epidemiology**
2000;320:39-42
27 704 hits
- A good death**
Editorial 2000;320:129-30
25 127 hits



Let the children do the talking

Tuning Into Children, BBC Radio 4, Wednesdays at 11 am, 26 January to 1 March

Radio 4's daytime programming is a curious mix of arts and sciences: intellectual debate is interspersed with poetry and jazz, information and entertainment go hand in hand. The recipe continues in the second series of *Tuning Into Children*, presented by Kirsty Wark, the ever popular BBC anchorwoman. The first series explored child development from birth to 5 years old, and the current one looks at issues affecting 5 to 9 year olds. Over six programmes, we "tune in" to children talking frankly about their identity, relationships, family, and schooling. Kirsty Wark listens to them in the company of an expert—an academic from the world of child psychiatry, psychology, or education—so that we are guided towards an understanding of what constitutes healthy child development. The mid-morning timing of the programmes targets parents working at home.

The first question is whether we will ever get bored of tape recordings of cute kids. I hope that we never do. These children are both surprisingly knowledgeable and

refreshingly broadminded on everything from interracial marriages to friendship, to homosexuality. There are gems in each programme. We learn that a real friend is "one that you give your phone number to." We meet children who speak Bengali, English, and Welsh, reminding us that, in fact, 70% of the world is multilingual; it is only in England where this seems unusual.

We also learn that Britain and the United States are the only developed countries left that don't have a compulsory programme of sex education in schools. This prudishness may have something to do with the fact that Britain has the highest rate of teenage pregnancies in Europe. Hopefully the policymakers who hear this programme will realise that children, even as young as 6, are more than ready for sex education. The girls again astound with an analysis of the best age to have children. They had all heard about the 13 year old whose pregnancy made news headlines. They conclude that she will not only miss out on school but also get into trouble with



Kirsty Wark asks too many leading questions

her mum. They agree that the best age to have a baby is 20, because "by then you have finished school and you have a driving licence." The boys, as ever, are less mature, commenting that "it's all disgusting." Whether because of nature or nurture, there are massive differences in every programme between the girls and the boys. The little girls seem mature, sensitive, and politically correct, while the boys snigger and tease.

The problems in this programme begin, as always, when the adults interfere. Kirsty Wark has difficulty treading a path between keeping the children on topic and being too directive and overinterpretive. All too often she tries to "help" the child with, "Oh, so what you mean is that ..." It is also disappointing that the studio professors seemed to be so marginal. There is no doubt that they are eminently qualified and could have gone into much more depth on their subjects. There were missed opportunities to go into many fascinating and relevant areas of research. During the episode on peer relationships, for example, I was hoping to hear about the research evidence showing that children who receive negative social ratings from peers are more likely to experience mental health problems in adulthood. Why not use some of the children's insights to discuss the evolving concept of "emotional intelligence"? The Bengali, English, and Welsh speaking children were great to listen to, but couldn't there have been a discussion about the remarkable early developmental window when children can learn many languages without recourse to the grammar or structure that plagues older children and adults?

I'm sure the programme's producers and not the contributors set these limitations. Although the series was not intended for a clinical audience, I found it helpful to be reminded of milestones reached in normal child development. The children in this programme were great to listen to, and perhaps the best strategy would have been for the interviewer to really tune in and simply let them do all the talking.

Paul Gringras consultant paediatrician, Harper House Children's Service and Queen Charlotte's Hospital, London



WEBSITE OF THE WEEK

Disease management Those of us who look on in bewilderment at the US ability to commercialise anything will find such brash commercial solutions for human suffering as disease management distasteful. This week's *BMJ* carries a critique of the US "health" marketplace, in which "disease management" is the next big thing.

In any such development there will be good and bad, and these are to be discussed at the disease management congress later this year (www.nmhcc.org/events.disease.html). Unsurprisingly, this will feature "insightful keynote discussions by leading industry visionaries ... for timely information to put your institution at the helm of the industry—and ahead of your competitors."

The Disease Management Purchasing Consortium and Advisory Council advertises its wares at www.dismgmt.com/. It advises health maintenance organisations, which purchase care for populations, on how best to deal with disease management organisations, which specialise in dealing with populations with particular diseases. Its home page conjoins the jargon of software with that of healthcare management in a singularly unfortunate way: "CLICK HERE to learn about the Consortium's newest killer app, total population management."

But the site's depths make for some very interesting reading. At www.dismgmt.com/frame11.htm is a remarkable essay modelling urban poverty as if it were a disease, with a coincidental upbeat view of the concept of disease management. This, the site claims, will save health maintenance organisations money by relying on the self interest of corporations which are paid only if they save money on hospitalisations and other costs. It is also claimed to be in the best interests of those with chronic diseases, who do best when their self management skills are boosted while living within their own homes.

"Self management" is also claimed by the anarcho-syndicalist libertarians for their own—see <http://members.xoom.com/autogestion/>. Can they and corporate America really be saying the same thing?

Douglas Carnall
BMJ
dcarnall@bmj.com

PERSONAL VIEW

Facing the challenges of long term care

I grew up in the United States thinking that Britain was the most caring country in the world because the NHS provided free health care to everyone regardless of race, creed, age, or financial circumstances. I worked in the finest hospitals in the United States for almost 20 years, and the inequality of care provided for the "have nots" was distressing.

I married the Englishman who encouraged the NHS to deliver services more effectively by using information systems. In 1991 he developed a rare disease that took eight months to diagnose and was physically and mentally debilitating. Since then I have witnessed an appalling lack of accountability and waste of resources.

Professionals opened sterile trays to obtain a single lumbar puncture needle or sterile dressing. Patients received meals that resulted in surgery being postponed. Patients were admitted to hospital for tests and treatments that could have been performed in the outpatient department.

Rather than promote accountability and reward efficient use of resources to cut costs, the administration was increasing the workload of professional care providers without increasing their support or income. Behind closed doors with no witnesses, two consultants and a physiotherapist have told me on separate occasions that they could no longer spend their budget on my husband's care because others could achieve greater benefit from their limited resources.

While primary care providers have intimate awareness of our needs, they may be unaware of services that local authorities, healthcare trusts, and independent and voluntary organisations provide to enable people to remain in their homes. A social services care manager delighted us with handrails; adaptations to furniture; and incontinence, shopping, and home help services that she arranged to keep my husband at home.

Challenges with home help services provided by private agencies were overwhelming at times. Training new carers included how to help a person with severe physical disabilities get up and down the stairs; how to push the wheelchair over kerbs; and how to manage double incontinence.

We were unaware of local and health authorities' procedures when they transferred my husband from hospital in 1996 to a jointly funded nursing home placement. A two month placement extended to 18 months with no response to my calls or correspondence. I unexpectedly received an invoice from social services for almost £36 000. Four months later, they acknowledged they were seeking only to recover

local authority funding and sent a revised invoice for £17 500.

Research unearthed little known policies and procedures, including eligibility criteria for NHS continuing care; hospital discharge procedures; social services priorities; charging policies; and the responsibilities of local and health authorities to perform assessments and to provide information about their services. Some care managers are unaware that these procedures exist.

Consultation papers to review the social services complaints procedures are being reviewed independently of the NHS complaint procedures, although primary care groups and joint funding represent "joined up government." One hospital discharge leaves us facing three, and possibly four, separate complaints procedures four years after the event.

Continuously changing eligibility criteria and unknown procedures and policies leave vulnerable people and their carers even more vulnerable. People who have relied on health and local authority support for more than 40 years suffer from indeterminate health and social care policy transitions.

Perhaps the government should consider encouraging people who are just beginning to earn a living to take out private insurance, rather than people who have relied on public service provision for years.

The quality of NHS care has been truly exceptional and I hold care providers in the highest esteem. The government has the opportunity to continue and enhance the comprehensive and caring service of the NHS. Rewarding best practice in effective and efficient service delivery can improve NHS staff morale and reduce cost. Developing identical complaints procedures for the NHS and social services, both within the Department of Health, can enhance working across departmental boundaries. Encouraging and facilitating communication across professional boundaries can support "joined up government." By proactively marketing the results of service user consultations in the community, vulnerable people will be helped to know which way to turn when they need support or help.

We have founded a charity, Caring Matters, to empower and inform people facing the challenges and complexities of long term care and to help them to become aware of their rights and responsibilities. People need to know where to obtain the right information—at the right time.

Ruth Windsor *Caring Matters, London*
(caringmatters@dial.pipex.com)

SOUNDINGS

And how is sir today?

A long time ago, when I was a lean young surgeon lieutenant drifting agreeably on locum duties through a series of naval ships and establishments, the calm of the sickbay would be ruffled from time to time by the arrival of a patient of the lofty rank of commander or captain. In one naval air station I learnt to my surprise that even admirals got ill sometimes.

In sickbays these great beasts of the naval jungle (so to speak) created certain problems. Petty officers would feel compelled to straighten their shoulders and glower at sailors inclined to slouch around the place as usual. Time would be found, paths smoothed, and the wearers of brass hats—the peaks of the caps of commanders and above are indeed richly blazoned with gold braid—would be ushered tactfully through the amiable muddle of the morning, so that suddenly I would find one sitting opposite me.

No one had told me how to deal with them. The easy bit was the medicine. Their seniority, however, was a problem for both of us. I did my best, perhaps like a zoo keeper faced with a large, nervous, and possibly dangerous new resident. I would let them settle down, more or less on their own terms, giving them time to accommodate to the possibility that a lowly lieutenant—and a reservist at that—might be usefully placed to advise and even help them. Some were easy, some skittish and oddly jocular, a few difficult, none impossible.

I emerged not only reassured but impressed too

I thought of them again the other day. No longer as lean and junior as once I was, I had occasion after a long interval to see a GP. A greying, teaching hospital consultant now, I sat opposite a pleasant and poised young man who seemed not markedly older than the medical students I had just been taking through the basics of my specialty.

I tried not to be nervous. If he did too it did not show. He took time and let me settle down, and offered just enough in the way of not visibly ironic respect to put me at my ease. When we got down to the medicine he was concise and competent. I emerged not only reassured but impressed too by his zoo keeping skills. And as with my brass hats of long ago, the medicine was the easy bit.

Colin Douglas *doctor and novelist, Edinburgh*