reviews

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Whiplash and Other Useful Illnesses

Andrew Malleson

McGill-Queen's University Press, £26.95, pp 544
ISBN 0 7735 2333 2
www.mqup.ca

Rating: ★★★★★

Andrew Malleson observes that "victimhood can bring much gratification." As he indicates, the high social status currently accorded to the victim is an important factor in the rise of "dissimulating disorders," in which patients present chronic physical symptoms for which no organic cause can be found.

American psychiatry recognises three categories of these disorders: malingering, factitious disorders, and somatoform disorders. Malingering is where symptoms are intentionally produced with the aim of

securing tangible benefits. The problem is the difficulty of distinguishing malingering from factitious disorders, in which symptoms are intentionally produced but where there is no apparent external incentive and the motivation seems to be unconscious. These conditions are in turn difficult to distinguish from somatoform disorders, in which both symptoms and motivation appear to arise from unconscious processes. As Malleson observes, perhaps the essential difference depends upon the effectiveness with which the victim can "deceive himself and therefore others."

Malleson, a Canadian psychiatrist, discusses the "dissimulating disorders"—by any criterion one of the most important issues in contemporary medical practice—by focusing on the epidemic of whiplash neck injuries following minor car crashes. Through a comprehensive survey of the literature he exposes how doctors, alternative practitioners, scientists, lawyers, and patients have colluded in promoting a disorder that now afflicts millions and costs billions. While patients who sustain serious neck injuries have a good prognosis, minor collisions producing no demonstrable tissue damage now result in lifelong disability in around 10% of cases.

Malleson regards whiplash as a modern combination of the 19th century conditions of "railway spine" and hysteria. He locates it as one of a family of fashionable conditions, including fibromyalgia, repetitive strain injury, chronic fatigue syndrome, occupational back pain, chronic pain syndrome, and post-traumatic stress disorder, which the medical profession has offered patients who are, either consciously or unconsciously, seeking an escape from the pressures of modern life into the roles of sickness and victimhood. As he shows in this elegantly written and profound book, these conditions risk degrading medicine and bankrupting health services; they elevate junk science and corrupt the law; worst of all, they condemn patients to disorders from which there is little hope of recovery.

In one of his many aphorisms, Malleson captures the real menace of whiplash: "In perceiving a small auto collision as a cause of a persistent and disabling psychiatric disorder we diminish the calibre of our souls. We dissipate our human heritage of courage."

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Time out of Mind

Jane Lapotaire

Virago, £16.99, pp 320
ISBN 1 86049 977 5

Rating: ★★★★★

I confess a certain dread before settling down to read this book. Another celebrity falls foul of an illness and charts her decline or recovery. Almost always doctors come out of these accounts less favourably than we like to see ourselves.

But *Time out of Mind* is in a league of its own. Jane Lapotaire, an eminent film and television actor and a member of the Royal Shakespeare Company, uses skills and tech-

niques acquired in her job to dramatise her life since just after the start of the new millennium, when she collapsed in Paris with a subarachnoid haemorrhage. The bulk of the book, starting with a chapter entitled "Nearly Dying is the Easy Bit," plots her convoluted journey back to a partial recovery.

Lapotaire writes without sparing anyone's feelings. While it is true that she is probably harder on herself than anyone else, hardly any of her friends, family, or doctors come out of this account without criticism. Dr Vinikoff, a French neurosurgeon "who saved my life," is chastised for sitting on her bed: "Doctors aren't supposed to do that, are they?" Nurses tie her to the bed in intensive care: "I was never told it was bad for me to move." A British neurosurgeon, referred to by Lapotaire as "Mr H for Hell," has "all the Rolls Royce attributes of the brain surgeon: softly spoken, luxurious office, Mont Blanc pen." He is also patronising, condescending, and rude. He implies she is wrong about her second aneurysm: "statistically unlikely." When she is upset and angry he accuses her of "over-reacting." When Mr H sees her second aneurysm on a magnetic resonance image, he tells her triumphantly that breast cancer will probably kill her first.

The chapter "At the Doctor's" left me squirming. Lapotaire's general practitioner, who had been a friend, dismisses clinical depression with "Well, you are an actress." When she asks her doctor why her attitude has changed, she is told: "I realised I was treating you differently from my other patients. I was losing my grip."

During the course of the book Lapotaire makes a paradigm switch. Before her collapse she is a bit of a martyr, responsible for everything. By page 300 she has changed role to a fully fledged victim. She learns to censor outspoken rudeness and intolerance of others, but the feelings are still there. She has learnt not to blame herself, but her expectation that carers, friends, and even total strangers should show understanding, empathy, and selflessness is breathtaking.

This remarkable book—disturbing and hateful but also humbling—is one I am grateful to have read. I started by admiring the author's powers of description and style and finished with a new insight, seeing the shortcomings of our profession through patients' eyes.

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Items reviewed are rated on a 4 star scale (4=excellent)

Is this journalism that makes a difference?

Some media campaigns, such as the *Sunday Times*' on thalidomide, have been more successful than others. Where does *Panorama* on paroxetine stand?

Whenever its topic is medico-scientific, BBC Television's *Panorama* can induce the odd feeling of having slipped back in time. Back to a period before the advent of evidence based medicine; before, indeed, the advent of science itself. Back to a world where basic concepts such as risk, probability, coincidence, biological variation, and the nature of cause and effect seem unaccountably to have vanished—and left behind only anecdote, suspicion, and inference. I had that feeling last October when watching *Panorama* on "The Secrets of Seroxat" (*BMJ* 2002;325:910).

Last weekend's follow up, "Seroxat: E-mails from the Edge" (BBC 1, 11 May at 10 15 pm), was prompted by the unprecedented response to its predecessor: a record 1400 emails and 67 000 phone calls. The earlier programme told of a shifty, rapacious drug company pursuing profit at the expense of patient welfare: a charge that even the tightest of regulations will never completely defuse if the industry is to operate commercially. The new programme was the one that *Panorama* should have made first time round. It concentrated on something less dramatic but no less important: the inability of drug companies, doctors, and patients to communicate with one another.

One of the issues was Seroxat or paroxetine's capacity to induce addiction, which is alleged by many patients but denied by manufacturer GlaxoSmithKline. As the company's psychiatrist, Dr Alastair Benbow, slugged it out with *Panorama*'s Shelley Jofre in the first programme it was clear that they were using the same word in different ways. A strict medical definition of addiction is much tighter than its everyday meaning. It took the second programme to explore the obvious potential for confusion, and the

consequent inadequacy of the information given to patients.

Some of the second round confrontations were as fruitless as those of the first. Paroxetine is accused of provoking suicide or outbursts of violence. But the game of charge and countercharge got nowhere; when talking of particular cases, those making the allegations are no more able to prove the link than the company is to deny it. What this further programme did underline were the inadequacies of the yellow card system, and the inability of patients to get a hearing when their suspicions about adverse effects are disbelieved, or their doctors don't pass them on. Unwisely, the Medicines Control Agency (as was) declined to take part.

Panorama is no stranger to controversy when tackling medical issues. Its 1980 programme "Are Transplant Donors Really Dead?" challenged the code of practice used to certify brain death. But the patients whose unexpected recovery featured in the programme were American and, so it was claimed by British experts, wouldn't have satisfied the criteria used on this side of the Pond. British surgeons were infuriated. One such was Roy Calne. But he went on to suggest that television could be used as a facilitator. Which is why, four years later, the BBC's *That's Life* was persuaded to campaign on behalf of a liver transplant for the infant Ben Hardwick.

Written journalism too has notched up some triumphs. Until the *Sunday Times* Insight team under the inspired editorship of Harold Evans took on the Distillers Company, the children damaged by thalidomide were not going to receive adequate compensation. One of the paper's articles was blocked by a high court injunction: a ruling that took Evans to the European Court and, eventually, to victory. Newspapers have campaigned often—but seldom so successfully.

In the 1950s, when deference was more in vogue, the last thing on the minds of medical soap producers was to foster dissent. As one of them told Anne Karpf when she was collecting evidence for her 1988 book *Doctoring the Media*, "We wanted to overcome the pre-war attitude of the British public to hospitals as institutions, as places to be feared at all cost. We wanted people to respond to new research in medicine." The programme was *Emergency Ward 10*—and if praise from the BMA is anything to go by, it succeeded.

The television drama best known for having influenced social policy is still *Cathy Come Home*. Screened by the BBC in 1966, it put homelessness on the political agenda and led to the creation of the charity Shelter. Something less spectacular but otherwise similar happened in medicine following a 1980 BBC play, *Minor Complications*, by Peter Ransley. It recounted the misfortunes of a woman who underwent sterilisation, but ended up with peritonitis and gangrene. The play featured the trouble she had in seeking compensation for negligence; it helped to launch the charity Action for Victims of Medical Negligence.

Dawn Owen: her husband tried to stab her after taking paroxetine

Whether *Panorama*'s latest intervention will have a measurable impact on adverse event detection and reporting remains to be seen. Possibly not; the programme no longer punches at quite the weight it used to. But Charles Medawar of Social Audit and pharmacologist Andrew Herxheimer have analysed and written up the viewers' calls and emails for peer reviewed publication. The viewers' anguish will not be completely ignored.

Geoff Watts *freelance medical journalist*

Hit parade

bmj.com

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

APRIL

- Editorial: Severe acute respiratory syndrome revisited**
2003;326:831-2
7562 hits
- ABC of diabetes: Cardiovascular disease, hypertension, and lipids**
2003;326:874-6
7025 hits
- News: SARS virus identified, but the disease is still spreading**
2003;326:897
5311 hits
- Editorial: Treatment of pulmonary hypertension**
2003;326:835-6
5260 hits
- Interactive case report: A 42 year old man with acute chest pain**
2003;326:920
4575 hits
- Clinical review: altitude illness**
2003;326:915-9
4158 hits
- Clinical review: Treatment of herpes zoster and postherpetic neuralgia**
2003;326:748-50
3538 hits
- Editor's choice: The screening industry**
2003;326 (26 April)
3424 hits
- Editorial: Emergency contraception**
2003;326:775-6
3319 hits
- News: Hong Kong and US scientists believe illness is a coronavirus**
2003;326:727
3141 hits

Graham Aldred: his wife committed suicide after taking paroxetine

Blurring the boundaries

Are sponsored news programmes a new form of paid fronts for the pharmaceutical industry?

In the field of medicine, finding the line between education and promotion is often a daunting task, as industry sponsored events and materials dominate so many of doctors' postgraduate learning experiences.

If recent developments in the United States media are any indication, a whole new blurring of boundaries is also happening within the world of medical news.

Take the innovative New York based Healthology, founded by former advertising executive Dr Steven Haimowitz. Boasting 40 staff, the company makes highly accessible videos about medical conditions and treatments featuring leading physicians. These are available as "webcasts" on more than 4000 websites around the world, including the sites of news organisations such as America's ABC News and disease groups such as the International Multiple Sclerosis Support Foundation.

Haimowitz told the *BMJ* earlier this week that his video programmes used the latest technology to give ordinary people access to top experts in the field. "It's the next best thing to having a visit with a thought leader." So should this be called news? "Absolutely not," Haimowitz emphasised. "We are not a news service... We are a health content company, we distribute content across the web."

Yet despite these claims by the president and chief executive officer, Healthology's medical programmes are made to look an awful lot like they are news. The company's own publicity says, "Most programmes are produced in a newsmagazine style." Moreover the company hires well known news journalists to present its short magazine pieces, and its programmes are widely available on the websites of highly respected news media.

What many viewers of these "news-magazine" style programmes may not realise is that healthcare companies, including pharmaceutical and biotechnology companies, are directly paying for Healthology's videos and suggesting the topics to be covered, according to a report in the *New York Times* last week. That article named a number of senior American broadcasters, including the famous former CBS anchor Walter Cronkite and *Sixty Minutes* presenter Morley Safer, as having worked for another company called WJMK, which like Healthology is funded by pharmaceutical giants to make video material. The celebrity journalists were reportedly paid up to \$100 000 for one day's work recording segments for WJMK, which were then broadcast as news on public television stations across the country. WJMK did not respond to *BMJ* requests for an interview.

Healthology argues strongly that its sponsors don't control content, and its material is not promotional. However, one of its respected "thought leaders" has told the *BMJ* that the Healthology programme in which he appears has a lot to do with drug company marketing strategies.

Professor James Miller, a doctor from the Columbia Presbyterian Medical Center

in New York, is featured in a Healthology webcast being interviewed about the pros and cons of three drugs for multiple sclerosis (www.healthology.com). The programme is presented by a WNBC medical reporter, who tells the audience the sponsor is a group called "MS Active Support," but fails to inform them that "MS Active Support" is funded by Biogen, the biotechnology company that manufactures one of the three interferon drugs being discussed. As it happens the Biogen drug emerges favourably from the programme in which Miller appears, although a company spokesperson told the *BMJ* that it had no influence over the topic or the content.

"All the drug companies are doing it, God knows," says Miller, who has been a paid speaker for Biogen. "The battling is purely a marketing issue. Companies like Healthology get caught up. Every one of the drug companies has these organisations that front for them." Soon after *The New York Times* revelations last

week the WNBC reporter ended his contract with Healthology, just as others have reportedly severed ties with WJMK.

"Video news releases"—television versions of press releases—and "advertorials"—newspaper advertising designed to look like editorial articles—have been around for a long time, but Haimowitz's brainchild is really something new, and it is part of a growing entanglement between the pharmaceutical industry and the mainstream media. Apart from the "educational" activities such as sponsored videos, drug company spending on direct-to-consumer (DTC) advertising rose by almost 150% between 1997 and 2001, and drug advertisements now add \$3bn a year to media company turnover. For countries without DTC, other forms of financial ties exist, raising serious concerns about conflicts of interest for media organisations and their journalists.

In Australia senior broadcast journalists with major national networks have worked as paid consultants producing materials sponsored by drug companies, at the same time as covering issues and products in which those companies have a direct interest. Senior wire service journalists have taken gifts of international travel to cover medical conferences from companies whose products were showcased at those very same conferences.

Health reporter Melissa Sweet has written of accepting company-funded trips in the past to visit Germany and Scandinavia. "But no more," she wrote two years ago in these pages. "With compelling evidence to show that close ties with industry can influence doctors' behaviour, there's no reason to expect journalists would be any different" (*BMJ* 2001;323:1258).

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WEBSITE
OF THE
WEEK

Passive smoking While the connection between active smoking and disease has been widely documented, the jury is still out on the dangers of passive smoking, which is the subject of a paper and an editorial in this week's *BMJ* (p 1048 and p 1057).

The internet has much to say about the dangers of passive smoking. For a general review on the topic visit the website of Action on Smoking and Health (www.ash.org.uk/html/passive/html/passive.html), which presents a summary of the evidence. The site discusses links between passive smoking and pulmonary and cardiovascular diseases, and visitors can also find information about the impact of passive smoking on children and about local policies.

The US Centers for Disease Control and Prevention (CDC) has launched a web page (www.cdc.gov/tobacco/ets.htm) full of information and links about environmental tobacco smoke. Here you can find information about the prevention of exposure and links to papers and reports.

The effects of passive smoking on children is a recurring concern (www.ash.org.uk/html/passive/html/who-ets.html). Those looking for brief information for their patients might want to recommend a short review from the American Academy of Paediatrics (www.medem.com/MedLB/article_detailb.cfm?article_ID=ZZZ1UBHWQ7C&sub_cat=29).

The CDC can also help in giving advice: its page "Taking Action on Second Hand Smoking. An Online Toolkit" is a well done, interactive educational resource with much information and many links (www.cdc.gov/tobacco/ETS_Toolkit/index.htm).

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PERSONAL VIEW

China in the grip of SARS

At a press conference on 20 April the Chinese minister of health admitted that there had been failings over the SARS (severe acute respiratory syndrome) epidemic: the situation was more serious than had been admitted previously. Along with the mayor of Beijing he was promptly fired. But the speech had had the desired effect: public health action had finally been galvanised.

I live in Zhejiang, a coastal province halfway between the two Chinese epicentres of the disease, Guangdong and Beijing. Here following the press conference, the government immediately held an emergency meeting. By the next morning a whole raft of measures was in place. All cinemas, theatres, and karaoke bars were closed. All public training courses and meetings and all school outings were cancelled. All buses, trains, taxis, train stations, bus stations, airports were to be disinfected. The May Day holiday was cancelled.

But there was much more: at 7 am we were handed a leaflet about SARS prevention at the gate of our compound. This included advice about regular hand washing, warnings about crowded places, and the dangers of nose picking. It advised that masks should be 16 layers thick and changed every four hours. At our sons' school chaos ensued as 600 children were having their temperatures taken before being allowed into class. They would have their temperatures taken twice daily until further notice. Any recording over 38°C would result in the child's immediate removal to hospital.

By 9 am our residential compound had been disinfected, and we had been offered free disinfection of our apartment. Masks and thermometers were sold out by mid-morning. Supermarkets were busy with people stocking up to batten down for the duration. Usually jam packed buses had plenty of spare seats as people took to bikes as a safer option.

The next day I was scheduled to go to Yunnan province in the south west of the country. The trip necessitated six flights in a week. On the outward journey around 20% of passengers were wearing masks, and a health declaration had to be completed

before boarding each flight. At two hotels I had to take my temperature before being allowed to check in. On the return journey mask wearing had increased to over 80%, health declaration forms were required before departure, on arrival, and in one case during the flight as well. In addition, passengers' temperatures were taken in-flight. At the local airport in Zhejiang infrared imaging was in use. But with just one camera for all domestic flights, the crush of passengers probably just increased the potential for SARS transmission.

The China SARS story is instructive in a number of ways. Firstly, as many commentators in China and elsewhere have pointed out, the failure to acknowledge the problem earlier has almost certainly resulted in a more widespread epidemic. The government is painfully aware of this, and the high profile sackings (almost unknown in China, except in cases of corruption) demonstrate just how seriously the mistakes are regarded. Though there have been significant moves towards greater transparency over the past decade in areas regarded as sensitive by the Chinese, the SARS secrecy debacle is certain to accelerate this process.

Secondly, it demonstrates that once China has decided to mount a campaign it can do it with speed and aggression over a vast area, in a way that must be the envy of many other countries. The public health network allows for rapid dissemination of information down to the grassroots. Provincial level health bureau staff have been dispatched in great numbers to the countryside to ensure that all appropriate preventive measures are being taken and to ensure that identified cases are managed correctly. Even in remote rural Yunnan, health workers I spoke to knew about SARS. In a township hospital a doctor told me he wasn't afraid of SARS, because he had ribavirin (at a cost of 5 US cents per tablet) to treat it. He would isolate any case immediately, and treat free of charge.

While many of the preventive measures are of dubious effectiveness—all that disinfection, and all those schoolchildren taking their temperatures, for example—frightened people find all the activity reassuring.

Finally, China needs to change the name of this disease. Currently SARS is called *fei dian xing fei yan*, which translates as atypical pneumonia. I believe that at least some of the earlier under-reporting, which has proved so damaging, was related to failure to realise that this was a new form of pneumonia, and not just a more severe form of atypical pneumonia, for which the causative organism is frequently not isolated. This new disease needs a proper Chinese christening.

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A dubious measure?

SOUNDINGS

There is no evidence that ...

I was in a medical meeting discussing the extent to which mental attitude influences the natural history of disease. In an interesting debate the mantra "there is no evidence that ..." was repeated at diverse moments by several colleagues. Although I am an enthusiast of evidence based medicine I must admit that I have begun to find it irritating that the phrase is used like some sort of runic spell to negate all opposition. Surely it encompasses two totally different situations. The first context (and overwhelmingly the commonest) is that there is no evidence because no one has looked. The second is that someone has done the relevant study and found a negative result. The first is merely noteworthy and the latter persuasive, but neither is the word of God.

Recently I have been hobbling around, in a mildly depressed state, on a rather damaged knee. I have surreptitiously asked a colleague to prescribe some anti-inflammatory gel and slipped away to distant, anonymous chemists to obtain the nefarious unguent. The stuff is much loathed by prescribing leads and the *Drug and Therapeutics Bulletin*. It is definitely a "there is no evidence ..." treatment. In this case some studies have been done and have shown limited or no effect overall. But again the bland "no effect" assertion conceals two possible situations: no one benefited at all (a narrow spread of effect) or overall no one benefited but there was large spread in biological response and some did benefit. I'm certainly going to continue to use the stuff (with the slightest frisson of guilt).

The difficulty, I suppose, is the disparity between the subtlety of the questions required to manage individual patients, and the inevitable crudity of methods that must aggregate large numbers of cases to answer relatively one dimensional questions. The tricky thing about answers is knowing what they mean and, just as importantly, what they don't mean.

One of my permanent regrets is that I didn't buy a book I saw in a second hand bookshop when I was a student. I have no idea what the subject matter of the book was, but I feel sure it would have helped me through life. Its title was *Right Answers—A Short Guide to Obtaining Them*. I particularly like the fact that it was a *Short Guide*.

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