of its longer term objectives will be to ensure that all schoolchildren and students in various types of educational establishments should undertake not less than six to eight hours of physical exercise a week. Furthermore, the document requires an expansion in the number of sports facilities at places of work and the creation of financially self supporting physical culture and health establishments in residential areas. Interestingly, a role has been assigned to work collectives in that their resources will be drawn on—with their agreement—for the construction of health centres which will use “methods of toughening up, physical training, psychological relaxation and other means of strengthening health.”

Recognising the vital importance of an appropriately balanced diet, the document also refers to “measures for improving the quality and rational use of food products.” That touches a notorious pressure point in the Soviet economy and it hardly reflects much credit on the leadership that they have to designate 1991 as the year in which the demand for various types of baby food should be “fully satisfied.”

A broadly comparable failure that is implicitly admitted concerns infectious diseases of the intestines and viral hepatitis. Thus the health service is called on to reduce the incidence of those illnesses “by preventing the contamination of drinking water and food products with microbes and viruses.”

Conclusion

I suggest that there can be no mistaking the sense of urgency now being conveyed by the leadership of Soviet medicine—and especially by the USSR Health Minister, Evgenii Chasov, who will stand or fall according to the success of the perestroika in his area of responsibility. Now that the mortality experience of the recent past has been at least partly revealed and the agenda has been set for reform, it seems imperative for the USSR to demonstrate an ability to improve its health record. Failure to do so would bring in its trail a set of adverse consequences, some of them profoundly embarrassing. One would be the contention that, whatever its military pre-eminence as the second global superpower, in matters of health the Soviet Union could be equated with countries of the Third World.

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Personal Paper

A cautionary tale

STANLEY ALSTEAD

“Feels to me like an earthquake,” growled the languid latissimus dorsi. “I agree,” murmured the angular trapezius, “but at some distance away. Did you feel anything, subscapularis?” “Indeed I did,” replied subscapularis: “I’ve been pushed around with my neighbours more than I like. Perhaps intercostals know what’s going on. I’ll ask viii/ix.” “I’m in a bloody mess—and that’s literally true,” yelled intercostals, “muscles in shreds, nerve endings lying loose, and heaven knows what’s happened to those broken ends of rib.” “Any holes in the pleura?” demanded latissimus dorsi, rousing himself. “Both layers intact,” replied intercostals, “but after that hellish crack, it’s early days; maybe there’s more trouble ahead—perhaps a pneumothorax with its own complications. . . .”

This anatomical fantasy flitted through my mind soon after the accident. But let’s start at the beginning. It was a serene autumn morning. In the west Ben Ledi and Ben Venue smiled benignly on a golden Perthshire—a perfect day for tidying up the garden. My wife beside me, we surveyed the tranquil scene with deep satisfaction.

“The old cherry tree by the gate is marvellous in this golden light,” murmured Janet.

“Just what I was thinking,” I replied, “but that dead branch in the middle of it is an eyesore. We must get it out.”

“A difficult job, surely?” queried Janet.

“No problem,” I declared confidently, “I’ll make it my first job. Firstly, I’ll lash it to the wrought iron gate and keep it under

tension. Then, when I’m ready, I’ll make it fall sideways—and not on my head,” I went on, warming to the prospect of an interesting exercise in dynamics.

“Very scientific, but do take care with that big ladder,” said Janet, adding—as she retreated towards the house—“82 is not 28.”

Man on the flying trapeze

The saw had almost divided the stout branch, some three metres above the ground: this was the penultimate stage. It remained to dismount the ladder and swing the heavy gate, thus—by traction—completing severance. As I descended I realised, not for the first time, that going up is easier than coming down. On the descent I could not see my feet: there was the usual element of guesswork; I took my bearings at eye level and accepted such proprioceptive impulses as penetrated the thick soles of my gardening boots. My guess was wrong: I let go of the ladder and was instantly air borne. For a moment I enjoyed the ecstasy of the man on the flying trapeze who “flew through the air with the greatest of ease.” But all too soon I made intimate acquaintance with the jagged slabs of granite lining the flower border.

I crouched on the ground, immobilised by shock. After a few minutes I stood up slowly, noting with interest bony crepitus in my left flank. The cherry tree branch was also creaking ominously. This was a summons I could not resist. I swung the heavy gate; the nylon rope grew taut and then the massive branch fell with an impressive crash.

Mission accomplished, I retired slowly to the house for coffee and sympathy. I needed both. My broken bones emitted their peculiar

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vibrations like a pair of muted castanets: no need, I mused, for radiology; the clinical features were pathognomonic. Henceforth, I reflected, let no man despise the plumber's mate, his boss's guardian, idle but watchful at the foot of a ladder.

Disability

Doctors' meditations on their own diseases and disabilities are not without value in amplifying their knowledge of therapeutics. Sorry for myself when "the pains of hell gat hold upon me," I nevertheless felt the urge to write my own case sheet. But first my comparatively trivial disability prompted me to imagine the vicissitudes of victims of road accidents who often sustain multiple injuries that may include fractures on both sides of the chest. It were better, I thought, to submit to the torture conceived by Cleopatra—to "be whipped with wire, and stewed in brine, smarting in lingering pickle."

Skilled orthopaedic management they may reasonably expect, but day and night in the gloomy haunts of solitude and despair—lost in the lowest circle of Dante's *Inferno*. There they must bite the bullet and begin the desperate struggle for survival.

My professor of anatomy (God rest his soul) often reminded his junior class that nature will use *any* muscle as an accessory in order to achieve a desired movement of the trunk or limbs. And now, 63 years later, the professor's axiom has come to life: these modest anatomical structures in my left flank have declared their concern with almost every activity of daily routine. But interest in anatomical and pathological niceties has given place to the sheer empiricism of self defence.

From the start it became imperative to suppress coughing, sneezing, hiccuping, yawning, and sighing. If a sneeze cannot be totally inhibited by firm digital pressure on the upper lip it must be given full vent with mouth agape. The alternative (dictated by good manners with breath held and thorax rigid) carries the risk of explosive disintegration of the smitten flank. Excess of bronchial secretion was coaxed past the larynx, not by a hearty cough, but by sinuous contortions of the whole body resembling those of a cow with bronchitis. A patient may well pray to be spared the combination of whooping cough and fractured ribs, for in these circumstances his plea for euthanasia would be hard to resist. Sudden movements of the trunk or limbs resulted in paroxysms of pain of such severity that I froze in my tracks. An interesting discovery was that the routine of dressing means much stooping and twisting. The most useful accessory was a wall—to lean on. Garments that fell on the floor were retrieved by means of a walking stick.

The challenges of the bathroom demand a leisurely approach. But the pedestal must not be confused with the old regius chair; it cannot be occupied *ad vitam aut culpam*. The hoisting process can be achieved with minimal discomfort by resorting again to the nylon rope, this time secured to a nearby clothes hook.

Shaving, a douce exercise, and normally a time for drowsy rumination, demanded a new technique. *Platysma myoides*—seemingly created in the course of evolution to make shaving of the neck and chin practicable—can be effectively immobilised only by fixation of the thorax, usually after taking a deep breath. This discovery was painful, and a compromise was time consuming.

From the outset control of bowel function became imperative. The peristaltic rush was at a premium. The patient must aspire to the swift, effortless, and projectile evacuation of the descending colon perfected by our avian ancestors. This "consummation greatly to be wished" is readily achieved by means of a high residue diet (well soaked bran) and the judicious use of the sacred bark.

Some of the disabilities can readily be forecast: they have much in common with those of the painful arthroses and the effects of a prolapsed intervertebral disc. The need to immobilise the vertebrae and limit movement at the costovertebral joints is obvious, but what can be achieved falls short of the ideal. Utter austerity is immediately accepted for freedom from severe pain. The ordinary bed mattress and the luxurious armchair will be rejected after the briefest trial; they are redesignated instruments of torture. A hard

chair with a vertical back is indispensable: and with an improvised extension to support the legs this becomes the patient's bed for a month or more. Such chairs are now hard to find: the search may lead to the attic or to the garden shed. It is easy enough to restrict movement on the affected side by means of a broad band of adhesive strapping or a belt, but any benefit must be weighed against the danger of further diminishing ventilation at the base of the lung. The method doubtless has its place, but prolonged use is not without hazards, especially in old people.

Medication

The old fashioned antipyretic analgesics are useless in combating pain of this quality—severe and stabbing. As for the continuous ache and tenderness, better to thole it than run the risks of prolonged medication, especially during arteriosclerotic senescence. How many aging pharmacologists would submit to a month of high dosage with new analgesics which offer only fleeting relief of pain and the risk of damage to vital tissues in liver, kidney, and alimentary canal? Even the humble aspirin attacks the gastric mucosa, especially when the patient seeks simultaneously the consoling effects of alcohol. But a word or two about this later.

Surely, it may be asserted, there are clear indications for morphine—the sovereign remedy from time immemorial. Generalisations are of limited value: the needs of the individual patient must be studied, and on a time schedule of three or four weeks. The boon of temporary relief of pain cannot be dissociated from the penalty of side effects. Woe betide our morphinised patient whose colon becomes spastic and stacked with scybala. Professional concern and the gentlest of enemata will not save him from pain and distress during such turbulent episodes. Faith in codeine as an alternative to morphine is entirely misplaced. As an analgesic it is almost worthless. The arch enemy of the colon, it causes intense constipation and sometimes persistent nausea.

In the context of recurring lancinating pain, they do but labour in vain who depend on the *materia medica* until the patient has found the posture that eliminates tension in the damaged tissues and prevents pressure on the tender chest wall. And then we do well to recall that the liberal use of alcohol as an analgesic narcotic long preceded the use of laughing gas and of chloroform in surgical operations. Falstaff, of course, said it all—though he spoke of "a good sherris-sack. . . . It ascends into the brain; dries me there all the dull crudy vapours which environ it; makes it forgetive . . . full of delectable shapes. . . ." In the dead of night these "crudy vapours" swirled through my aqueduct of Sylvius to conjure up dreams of a hideous grinning face as big as a pumpkin and pale as a shroud. This nightmare was clearly generated by my recurring fear of surgical emphysema. Only a well timed dose of alcohol could cast out this devil and leave the stage to Sir John's "delectable shapes."

A combination of barbiturates—for example, butobarbitone 200 mg—and alcohol—for example, a generous glass of good port—when the patient is settled will give several hours (up to six) of peaceful sleep.

And now I hear a howl of protest from a great host of doctors whom I advised—from 1932 onwards—never to prescribe barbiturates and alcohol together. In extenuation let me say that I was simply quoting expert opinion. I certainly lacked evidence based on the kind of clinical science that the late Sir Thomas Lewis would have demanded. Nor is that surprising. In the early 1930s an indigent lecturer in pharmacology at Glasgow could hardly embark on a personal study of the adjuvant effects of port on barbiturates.

The virtual disappearance of barbiturates as hypnotics is to be lamented. Their status was suddenly destroyed by the dogmatic writings of the late Sir William Willcox. Instead of these old remedies we now have new synthetics whose name is legion. But how many practitioners retain a useful knowledge of the chemistry and toxicology of these new drugs? How many doctors have personal experience of the practical usefulness of the analgesics and hypnotics they prescribe? The current tendency is not to prescribe a drug but merely to write a name.

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