reviews

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Flu: A Medical Mystery

BBC Radio 4, 2 February at 8 pm

Rating: ★★★

A spate of high-profile infectious threats has gripped the public psyche over the past few years. Coming amid reports of a rise in avian flu and a year after the outbreak of severe acute respiratory syndrome (SARS), this programme, which looked at the influenza pandemic of 1918, was timely.

The 1918 flu was one of the most devastating disease outbreaks of all time, killing 50 million people worldwide. Witnesses reported the effects on family and society, as well as providing descriptions of the signs and symptoms—including heliotrope cyanosis, a grey to lavender hue over patients' faces and ears. The ages of those affected—people in their 20s and 30s—made the accounts seem all the more chilling.

Rather remarkably this outbreak, which cost more lives than the first world war, has been largely ignored. Hence the programme dubbed it "the forgotten epidemic." In the United Kingdom 250 000 people died from this strain in 1918, compared with a current figure of 4000 deaths a year from flu.

But why did this flu cause more deaths than any other? What were the origins of this particular pandemic? The virus is traced back to a military camp in France. It is likely that the mêlée of animals and, more importantly, birds, combined with the cramped conditions of the soldiers to foment a perfect breeding ground. As with SARS, it is believed that the virus originally came from a bird.

Despite the huge death toll, most of the 70% of people affected recovered. So why did previously healthy young people die? Scientists have been attempting to isolate the virus and understand why some people died and others did not. By looking at archived specimens and exhuming bodies in Alaska (and elsewhere), a hypothesis has been developed. Maybe an exaggerated immune response, resulting in a cytokine storm, could have been responsible for the fluid that flooded the lungs of those afflicted. The work continues.

And what of the future? "Is there another virus out there somewhere that will one day mutate and take against us with drastic consequences?" asked the voice-over.

The next pandemic?

The answer seemed to be yes. However, the scientists interviewed hoped that, by understanding past outbreaks, future epidemics might be prevented or contained.

This account of pestilence on a large scale retained a human dimension with witness accounts used to good effect. But the programme's focus on the future threat to mankind seemed somewhat scaremongering. While it is right to highlight the threat of pandemics, it is not right to exaggerate that threat.

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Grand Rounds

Published by e-med

(www.e-med.org.uk)

www.grandrounds-e-med.com/

Rating: ★★

This online journal aims to collect case reports from surgical and medical specialties in a unique database, providing information and education on new diseases, unusual features, and complications of treatment. *Grand Rounds* presents cases in a concise but clear manner.

The editors, who claim that the medical literature undervalues the importance of case reports, plan to link presentations to evidence based data already available, but this feature is not fully up and running.

Although *Grand Rounds* is free to readers, authors are expected to pay a nominal sum to cover the publication costs. It would seem that this is no barrier to authors as there is a good spread of papers already published on subjects from anaesthesia to vascular disease.

Most medical journals commonly publish case reports, but it is this journal's ambition to be comprehensive, collecting cases from all medical and surgical specialties in a single site.

Simply but well designed and user friendly, *Grand Rounds* has a useful search engine. Articles are easily accessible from a click on list, and they are collected according to field of interest. Some of the

references have a URL link, but on some that I tried this feature did not appear to be up to speed. Instead I was taken to an old and no longer functioning web page of the National Center for Biotechnology Information.

These are early days for the journal, and I would expect the archive to grow steadily over the next few months. The site receives more than 45 000 hits from 50 countries every month; the more popular articles are viewed more than 1000 times a month, and all articles are viewed at least 100 times a month, say the editors.

Although entirely web based this is a proper journal, with a two referee peer review system for each article and an ISSN.

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The Oath: A Surgeon Under Fire

Khassan Baiev (with Ruth and Nicholas Daniloff)

Simon & Schuster, £17.99,
pp 354
ISBN 0 7432 2011 0

Rating: ★★★

Have you ever wondered, after a hard week at work, why you decided to become a doctor? If so, you might want to read this book. It should make any woes you might have pale into insignificance. It might also lead you to reflect on the continuing significance of the Hippocratic oath. In this gripping true story Khassan Baiev, a surgeon from Chechnya, has provided his own interpretation of Hippocrates' ancient touchstone of medical ethics. Part autobiography, part history lesson, part

drama, the book is a page turner not because of its literary style (Baiev cannot speak English, and his translators have, whether by accident or design, left his somewhat naive style undoctored) but because of the horrific reality of its content.

To the great Russian bear the republic of Chechnya is a troublesome tick of a nation of a million mostly Muslim people stuck in its Caucasian underbelly—a politically volatile, oil rich interface between the Muslim and Christian worlds. Chechnya's struggle for independence goes back to the 16th century, and the consequent cycle of Chechnyan resistance and Russian repression has led to some of the worst (but largely under-reported) atrocities of recent times. By 1994 political instability and consequent lawlessness in Chechnya gave the Russian president, Boris Yeltsin, the excuse he needed to invade. The attacks in the United States on 11 September 2001 provided further political cover for Yeltsin's successor, Vladimir Putin, to order a second Russian invasion in 2000, this time with overwhelming force, resulting in the levelling of the once beautiful capital, Grozny.

At the start of the first invasion in 1994 Baiev had a choice: to join the medical exodus (and pursue a lucrative career in plas-

tic surgery in Moscow) or to remain in Grozny as a general surgeon and help the civilian population. He remained out of loyalty to his Hippocratic oath. By the peak of the second war in 2000 Baiev was the only doctor working in his home town of Alkhan Kala, which had been absorbing the devastated human exodus from Grozny. In one 48 hour period Baiev performed 74 operations (67 amputations and seven brain operations) using a blunt carpenter's saw and ordinary sewing thread. He describes shattered children and heroic pensioners. Baiev's perspective on the combatants is particularly telling. He is not partisan and dealt equally with the callousness of the Chechen fighters and that of the Russians. He was almost executed by soldiers from both sides, on several occasions. His subsequent mental health problems and his escape as a political refugee to the United States provide a further dramatic twist.

This book is a testimony to Baiev's fortitude and to the potential uniqueness of the doctor's role. As Baiev says: "War reveals a person's true character."

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Constructing RSI: Belief and Desire

Yolande Lucire

University of New South
Wales Press, \$AS49.95,
pp 216
ISBN 0 86840 778 X
www.unswpress.com.au/

Rating: ★★

ADallas taxi driver once helpfully informed me that 90% of Americans were sick. He explained that it was all down to liver disease and that the medicine in the boot of his car was going to cure the nation. His statistics were not outrageous. Physical symptoms are certainly common in the general population, but their persistence, the distress that they cause, and their significance to the individual are not necessarily explained by underlying disease.

Psychological factors afford one level of explanation, either because they may cause physical symptoms directly (anxiety's effect on the heart, for example) or because psychological distress may be felt and expressed as physical symptoms (somatisation). A further explanation comes at the level of society and culture in the notion that

the significance and meaning, to an individual, of commonly experienced symptoms may be influenced by what is going on in the world at large.

An example of this last level of explanation lies at the core of this book, an account of the sudden appearance and dramatic rise of a new syndrome, repetitive strain injury (RSI), in Australia in the 1980s. The author argues that this diagnosis was established by an alliance of doctors and union officials in the context of concern about working conditions and the new technology of the computer keyboard, but in the absence of any scientific basis for the existence of the disease itself. The syndrome was well publicised and the result, Lucire claims, was the equivalent of an epidemic, as workers presented their symptoms for scrutiny and compensation under the new label.

The story presents a depressingly familiar litany of reasons for the confrontations that ensued: doctors too willing to apply spurious pathological labels to symptoms; the law fixated with the notion that medical diagnoses are an arbiter of truth about the severity of people's symptoms and disability; and the persisting belief that managing a workplace symptom such as arm pain as a disease, independent of social and psychological circumstances, will make the problem go away. The confrontations between Lucire the psychiatrist and claimants with arm symptoms also illustrate how, just at the point where biology is uncovering the mechanisms of how social and mental events cause bodily symptoms, we are far from having a common language that pulls body and mind together and communicates to patients that symptoms such as pain do

not somehow become trivial or pejorative in the absence of a physical diagnosis.

But the main message of the book is that cultural change has the capacity to influence the experience and presentation of symptoms. Symptoms are not simple reflections of the prevalence of a disease in a population. Their expression and significance depend on such things as how we as a society define ill health, approach disability in the workplace, or compensate for symptoms—all matters that are as much moral, political, and economic, as medical. This is a tricky issue. The encouragement to seek compensation for injury may produce justice for ill people, but it may also turn symptoms into illness, and make ill people more ill. Lawyers may be bad for your health. And what the RSI epidemic reminds us above all is that the traditional biomedical model still dominates much legal, medical, and popular culture.

Lucire's book provoked me to think it provides a route to interesting historical literature, and to much detail, anecdote, and reference about this intriguing epidemic. But there is a lack of logic, consistency, and objectivity in the author's analysis, and her own study of litigants seems to have no stronger basis to it than many of the studies she condemns. Perhaps this is the result of distilling a dissertation into a book, but it seems likely that the author's own position and role in the affair—only revealed late on—has influenced this informed but partial view.

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

PERSONAL VIEW

The strange world of private medicine

To build a flourishing private practice is the dream of most hospital consultants, but to achieve this they are almost totally reliant on the goodwill of general practitioner colleagues. There is nothing new in this, except that increasingly I hear GPs complaining about being the poor relation in this lucrative business. To put it bluntly, Mrs Smith may be worth several hundred or even several thousand pounds as she trots up to a private consulting suite underwritten by her health insurance company, but to her GP she can never be worth more than £20.05 per year. GPs know that this is the way of the world, although many are not happy about it. What price ethical purity in an increasingly market driven health service? However, if GPs cannot reap financial benefit from private referrals, they do at least have the ability to decide which of their consultant colleagues will benefit, and some are enjoying the power that this gives them.

It used to be much simpler. When I joined general practice nearly 30 years ago, my senior partner coaxed me to refer private patients to his friends. They were golfing partners and were part of the same social circle, perhaps even the same masonic lodge. I obliged at first, but gradually began to make my own decisions. This, after all, is a significant feature of my practice. For the past 10 years I have been keeping figures relating to my private referrals and they are averaging 29% of the total. Admittedly my geographical area is above the national average in terms of wealth and private health cover, but this figure still represents a substantial tranche of private work.

So nowadays, without the possibility of any rewards, what makes me decide to choose Mr A or Dr B when Mr C or Dr D could do the work equally well? I should be lying if I gave competence as the reason. There are still, unfortunately, some countries in which people are appointed to consultant posts on the basis of their relationship to the minister of health or their membership of ruling tribes or families. Thankfully, in this country no one is going to be appointed as a consultant if they don't have the necessary competence. So, although there are a few cases where referrals genuinely require a rare expertise, in most cases any consultant could do the job.

Like most GPs, I have a small group of consultants to whom I refer patients regularly. The best explanation is that the "chemistry" between us is good. When I meet someone for the first time, I decide in the first few minutes whether I am going to

like them or not, and whether this is someone with whom I can "do business." Not for me that slow growth of rewarding relationships. It is all or nothing. You've either got it or you haven't. A consultant without the chemistry will not get my patients, however experienced, qualified, or charming he or she is.

Then I choose those who expedite events to my patients' satisfaction and to mine. I listen carefully when private patients tell me what they thought of the service they received. There is no point in courting trouble by continuing to refer patients to a consultant who fails to please. Equally important, I take into account how a consultant deals with my requests on behalf of my NHS patients. I know my patients well, and I like to think that if I make a special case on behalf of one of them, this will be taken seriously. If my special pleading is ignored, then I don't see why the consultant should be rewarded with more private income.

Why should I risk sending a patient to a consultant who regularly upsets my colleagues?

Those who are willing to help me with special problems of NHS patients are the ones who tend to sweep the board when it comes to private referrals.

Even so, the situation is not static. GPs talk to each other a great deal now, and exchange gossip and information at a level that might surprise some hospital colleagues. Our working life is far more meeting-driven than before, and every coffee break provides an opportunity to give any complaint a good airing. Why should I risk sending a patient to a consultant who regularly upsets my colleagues? Sometimes the smallest thing can tip the balance. Recently, a colleague grumbled about a certain consultant whose Christmas cards bore his stamp but no personal signature. Such lack of respect for his GP colleagues was not well received, and he may experience an unexpected reduction in referrals no matter how expert he is at his job.

In this strange world of private referrals, while no money changes hands, all sorts of other factors will determine who gets the profitable private patients. We are constantly reminded about patient choice, but this is one of the few areas in which GPs are free to make their own decisions. So, when it comes to my decision as to why I should make Mr A richer than Mr B when they are both competent at tying haemorrhoids, they should never forget that I have a choice.

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SOUNDINGS

Dear diary

Here in Auchendreich our response to the challenge of change combines in judicious measure both the positive and the practical; and we find that open discussion allows us to test arguments and conclusions, thus ensuring that well managed change brings maximum benefit throughout our newly created unitary healthcare system, NHS Auchendreich.

So it was that, late in the evening of last week's Burns supper in the Dreichmuir Station Hotel, a broadly representative group of senior clinicians made substantial progress with the implementation of the new consultant contract, or at least with the sensitive issues arising from the diaries we are now urged to keep to define our workloads.

The orthopedist who had addressed the haggis was sceptical. He thought a 40-hour week divided into 30-minute slots and 24 possible categories of work simply did not take account of day to day reality in Auchendreich. His average week was 60 hours at least, and at 7.30 that morning he had been at his desk dictating operation notes, viewing x rays, reviewing a registrar audit proposal, and teaching three students—all while awaiting a response from the still problematical switchboard of our flagship new PFI hospital.

Other surgeons nodded in support, and a pleasant new consultant psychotherapist—whose response to the toast "the lassies" had astonished the company both by its length and its emphatic feminism—agreed strongly. If she did not spend at least half an hour reflecting on the previous hour's interaction, then both patient and therapist would have wasted their time.

A forceful and garrulous paediatrician proposed to claim extra sessions for her routine 45-minute meetings with parents, then was badly let down by a terse colleague who pointed out that 15 or even 10 minutes was usually plenty, provided you remembered to let the parents talk too. But by the time the final round of single malts appeared there was broad agreement: even if we worked in different ways, we all worked hard and should all be paid far better for it. Fittingly, the last word came from Burns, as quoted by the chaplain afterwards, though quietly and between ourselves in the car park: "O would some power the giftie gie us, to see ourselves as others see us."

Colin Douglas *doctor and novelist, Edinburgh*