

reviews

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Men's Health Journal

Quarterly journal of the Men's Health Forum



Personal subscription: UK
£30; overseas £45.
Institutional subscription: UK
£75, overseas £90
For further details, telephone
01279 714510

Rating: ★★★

Considering the power and influence wielded by men in both medicine and politics it is odd that, unlike women, they have ignored the clear adverse health profiles of their own gender. In the first issue of the *Men's Health Journal*, public health minister Yvette Cooper considers the fact that, on average, men die five years younger than women to be "one of the starkest health inequalities we face." She concedes that traditional health promotion campaigns have not been a great success with men and that NHS services are often perceived as being geared more towards women.

However, it is more complex than that. The "absent male" is a feature of a variety of therapeutic settings and men are unlikely to be the first to seek help when there are marital or child care problems. In general practice, men are more prepared to see a registrar or a locum than women and seem to place less store on the doctor-patient relationship than women. At one accident and emergency department, 57% of attendees were male (*Journal of Accident and Emergency Medicine* 1999;16:425-7). This may well be because they sustain more injuries, but factors like access, availability, and the doctor-patient relationship need to be studied.

Wilson has noted that the impact of general practice on lifestyle is limited, with few practices running effective screening and treatment programmes for hypertension in men (In O'Dowd, T, Jewell, D, *Men's Health*, Oxford University Press, 1998). Preventive services in the workplace seem to have greater acceptability to men than those in conventional primary care, as shown when health visitors offered health promotion from a caravan on two industrial sites (*Health Visitor* 1991;64:265-6).

Healthcare professionals are increasingly interested in men's health but it is not

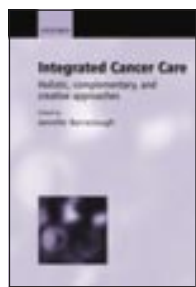
yet clear that men themselves are interested in their own health. Indeed, men's insouciance about their health conflicts with a healthcare system that is determined to improve their health. Most healthcare systems have considerable experience in dealing with women's health and a paternalistic model has evolved that has created a dependence that has extended considerably over the years. In the management of HIV/AIDS men have often developed models of self reliance with medical input being accepted on a technical level only. Men's apparent unwillingness to look after themselves may be partly a resistance to our attempts to make them dependent on the healthcare professions.

The Men's Health Forum, which publishes the *Men's Health Journal* for primary care professionals, is careful to point out that it does not begrudge the achievements of the women's health movement but laments the sparsity of men's health initiatives. Let us hope that the *Men's Health Journal* will be an important vector in reporting on male health.

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Integrated Cancer Care: Holistic, Complementary and Creative Approaches

Ed Jennifer Barraclough



Oxford University Press,
£29.95, pp 312
ISBN 0 19 263095 4

Rating: ★★★★★

Hope, hope, or healing? Complementary and alternative medicine is becoming increasingly popular in the United Kingdom, with a fifth of the population using it. Britons spend £1.6bn a year on complementary medicine (in the United States the figure is £21bn) and there are now 49 000 practitioners.

Complementary medicine adopts a different philosophy to conventional medicine. The idea is that a healthy body is a system in

balance and treating imbalance can help disease. Many sceptics state that it is the placebo effect—enhanced by the lengthy consultation and the often pleasant treatment—that causes positive results in complementary medicine. However, for most of medical history, compassion, attention, and emotional support—all major contributors to the placebo effect—were all that doctors had to offer. With the advent of modern medicine and the advances in science and technology doctors have to a great extent lost the traditional and historical role of healer.

So does complementary medicine actually work? Which types are the most effective? Is it possible to integrate complementary medicine into mainstream oncology care? Within orthodox oncology care settings complementary medicine approaches are usually provided to relieve physical symptoms and ease emotional reactions to illness. These benefits are well founded, but what of the claims of prolonged survival and cure? This excellent book attempts to make sense and order of an often confused and controversial field. It is a mixture of evidence based, scientific research and personal viewpoint, both from patient and practitioner.

The first section explores the background of holistic health care, which views health and illness as the result of interacting influences of mind, body, spirit, and the environment. It reviews the scientific evidence underpinning such approaches. The second section focuses on specific therapies such as acupuncture, nutrition, homoeopathy, hypnosis, guided imagery, and psychospiritual approaches. These chapters are written by experienced practitioners (including consultants) and comprehensively discuss the historical background, philosophy, scientific evidence base, clinical application, and often patients' experiences of each therapy. The third section, which includes chapters about delivery of therapies within a variety of healthcare disciplines and settings, was slightly repetitive.

This book should be essential reading for all those involved in oncology, both healthcare practitioners and patients alike. Those who are sceptical about complementary medicine, and those who despise and disparage it, should also read this.

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Holding Health Care Accountable: Law and the New Medical Marketplace

E Haavi Morreim



Oxford University Press,
£39.50, pp 320
ISBN 0 19 514132 6

Rating: ★★★

This book provides a most informative guide to how drastic funding cuts have affected healthcare delivery. It looks at how cuts have changed both the ethos behind healthcare delivery and the suitability of the traditional contract and tort doctrines as mechanisms of legal accountability. The book focuses on the legal and practical implications of resource shortages and it highlights the transition from an age of “if it may help, try it” to one of “don’t do it unless it *definitely will* help.” In this sense its interest to British readers is obvious, even though it is written on the basis of the US experience since the 1950s.

However, obvious interest does not mean obvious significance. Some chapters deal with contractual liability in the context of health plans. Such liability is of only

limited practical significance in this country given that most health care is still delivered through the NHS. This is not to say that the contractual rights of the large and growing number of British citizens who now have some form of private healthcare cover are unimportant. Rather it means that, in this country at least, any discussion about effective healthcare accountability must extend beyond the narrow confines of contract and tort actions.

Public law accountability—for example, judicial review of policy decisions concerning area wide healthcare provision—holds far greater potential for ensuring the provision of high quality health care than private law actions against specific individuals ever can. While the occasional litigant may secure an award in damages from a careless individual (or from his employer) in a negligence or malpractice action, such actions alone can do little if anything to ensure sound policy formulation. Morreim recognises this when she concedes that “tort seems inadequately equipped to look beyond the needs and circumstances of individual litigants” (p 43).

On the other hand, it is perhaps understandable that she concerns herself purely with private law given that the context of her study is the United States where there have been two malpractice crises in recent times: one in the early 1970s; another in the mid 1980s. But this is not my central point. Rather, it is that her account is an insufficient one for the purposes of

presenting a picture of healthcare accountability in Britain.

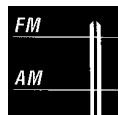
Much more worthwhile is Morreim’s account of how traditional tort doctrines, formulated in an age in which economics was not a major concern, have since lost touch with the economic realities of healthcare provision (on both sides of the Atlantic). She describes how providers commonly try to avert legal action by declaring that an intervention is not medically necessary rather than saying that it “may have some value, but isn’t worth the money.”

Anyone who takes medical malpractice seriously should read Morreim’s arguments about recognising the full potential of negligence law—which is intimately connected with the exercise of skill, knowledge, and care. This is especially so given the way in which the debate about the negligence liability of resource capped public bodies has recently resurfaced so markedly. In particular, Morreim’s suggestion (p 141) that the courts must “invoke a conceptual distinction—expertise versus resources—that is not currently built into the language of adjudication” warrants serious attention.

Although Morreim’s book is narrower in focus than its title suggests, it is nevertheless a welcome addition to the already extensive literature. It is certainly recommended.

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



Signs of Life

BBC Radio 4, Wednesdays at 9 pm,
5 to 19 December

Each of the three programmes in this short series of drama documentaries explores a different medical condition. The voices of patients and their doctors—the documentary part—are interwoven with a radio drama. These voiceovers serve as a commentary on the drama, which in turn serves as a metaphor for the pathology, the symptoms, and their emotional impact. A tall order, for a 30 minute programme. Did it work? The short answer (at least with the first two programmes made available for review) is no. Yet the series still provided moments of dramatic power.

The first programme, “The Drowning,” dealt with cystic fibrosis. In the drama, the sole survivor of a tragic shipwreck mixed memories of the events around the sinking, including a vision he had of a beautiful and mysterious woman. Unfortunately, the drama totally disordered—and distracted from—the

documentary, which was trying to explain the condition and its treatment and tell the story of a real patient, Jo, delicately reported by her father. The main problem was the abstruseness of the dramatic metaphor. Granted, a patient with cystic fibrosis can experience something like drowning, but the hero of this drama spent most of his lines musing on how and why he had not drowned (although, at the end, he did die, but without any obvious explanation). I struggled to see why the drama was about him at all.

The second programme, “Battle Cry” (on Parkinson’s disease), presented a more convincing dramatic metaphor. Two strategists were planning war moves in a secret nerve centre. I understood the metaphorical connection of neural nexus with military machine. In the drama, telephoned military orders were mutinously ignored and a neurologist’s commentary likened this to neurotransmitters not ringing their receptors. However, this programme’s success was partial. For example, the documentary’s real life patient (a middle-aged mother) explained her distress at developing a mask like face and how it reduced her range of possible emotional contact with her children. Crassly, the drama then featured a military commander talking about putting on a brave face when spinning bad news in a propaganda broadcast. The drama had missed the

point of the documentary’s message. It wasn’t about hiding inner feelings; it was about being trapped in a disordered body that could not display them.

What struck me about this series was that powerful drama was, paradoxically, only to be found in the documentary element.

Thus, in the first programme on cystic fibrosis, we heard the father of Jo, the patient, perfectly encapsulate both the pathology and his pain, when he said, “If you kissed her, she tasted salty.” We heard that Jo had had a lung transplant and her doctor then said, “There are days you come off the ward and you could use some really foul language to describe CF . . . it’s a pig of a disease and we hate it.” The father’s simple “Jo died,” spoken in a faltering voice, was the next that we heard. I silently cursed when the actors returned, breaking the spell.

Signs of Life is a bold experiment, which, these days, only radio would dare to broadcast. Unfortunately, it tries to do too much with too little time, and mixes its two genres clumsily, sometimes incomprehensibly. However, its disease is intriguing and the doctor in me can’t resist listening to the last programme (on alcohol dependence syndrome) just in case the metaphor dramatically cures the message.

Iain McClure consultant child and adolescent psychiatrist, Vale of Leven Hospital, Alexandria



Vincent's bandage

The art of selling a drug for bipolar disorder

Over the past few months the *British Journal of Psychiatry* has contained a striking image of Vincent Van Gogh. The *BMJ* has also carried the image. Those who attended the annual general meeting of the Royal College of Psychiatrists in July 2001 encountered the same image in a lofty, softly lit hall, a shrine to the pharmaceutical industry. The image—consisting of renditions of one of Van Gogh's self portraits against psychedelically coloured backgrounds, echoing Andy Warhol's *Marilyn*—formed a devotional icon to the drug valproate semisodium. But this is a Vincent with a difference. A large dressing covers his left ear, held in place by two strips of adhesive dressing. What are we to make of this? What is really being said here?

It is well known that Vincent Van Gogh removed part of his left ear. In October 1888 Paul Gauguin visited him in Arles. The two had previously met in Paris, and had much in common. Van Gogh hoped that together they could start a school of artists in the south, in contrast to "those decadent and rotten Parisian boulevardiers." Things didn't work out. Gauguin was short tempered, and

they quarrelled, sometimes violently, until Gauguin decided that he had had enough and returned to Paris. At this point Van Gogh became agitated, and on Sunday 23 December removed part of his left ear with a razor. He was admitted to the asylum at Saint-Remy. Although he was in and out of hospital after this, the last 18 months of his life were marked by a burst of creative energy, as he painted some of his greatest works, 60 paintings alone between May and July 1889.

The advert for valproate semisodium shows Van Gogh with his left ear bandaged. At least the advertising agency got its facts right, which is more than we can say for poor Vincent. In one of his most famous paintings, the *Self-Portrait with Bandaged Ear* of 1889, he shows himself with his right ear bandaged. He had painted himself from his image reflected in a mirror, which reversed right and left. So the first message is that we can rely on the drug company's facts, in contrast to these temperamental artists.

But there is more. We are presented with four identical images of Vincent, each with a different coloured background, scarlet red,



If only Van Gogh had been on valproate semisodium ...

blue, green, and purple. Does this mean that Vincent was a fragmented human being? Perhaps he had multiple personality disorder. But no, the message becomes clear if we examine the text that accompanies these images in the medical journals: "First Line Mood Stabiliser" above the images and "Proven across a spectrum of today's bipolar patients" below. So the truth is that Vincent suffered from bipolar disorder; his extremes of mood implied by the violently clashing colour backgrounds out of which his mutilated face emerges. The adverts also have helpful little coloured bullets to guide our interpretation of this revelation, each annotated and linked to reliable drug company references, scarlet red for mania, blue for rapidly cycling bipolar disorder, purple for mixed mania (*sic*), green for lithium non-responders.

Surely, then, there can be no doubt about the facts. Valproate semisodium is the best thing for fast, consistent mood stabilisation. If only Vincent had taken this he wouldn't have needed the bandage. With mood suitably stabilised he would not have hacked away at his left ear to still his tormenting voices. He would never have found his way into Saint-Remy, and the world would never have had its breath taken away by *Starry Night*, or any of those other great canvases in his last 18 months.

And it can work for us too, in an age that has no use for anxiety, in which we lie etherised like Prufrock, sedated, becalmed, and tranquil, neither high nor low. No suffering, no soul, no art. Yes, if Vincent had been on valproate he might still have painted. If he were alive today and on valproate Vincent would be driving around in a white transit van, painting houses battleship grey. But then at least the bandage wouldn't be necessary. Madness is okay, as long as it's kept in its place, on the canvas, in the asylum but, either way, under drugs.

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WEBSITE OF THE WEEK

The information gap www.scidev.net was launched last week to bridge the divide between knowledge rich developed countries and the knowledge poor developing world. Sponsored by the journals *Nature* and *Science*, the site was created on the premise that "those who stand to benefit most from modern science and technology tend to be those who have least access to information."

Over the past few years there has been increasing recognition of impact of the knowledge gap on developing countries. To this end free access to medical research published by the *BMJ* has been possible via bmj.com since 1995. All 23 specialist journals published by the BMJ Publishing Group are currently available free of charge to 44 low income nations and there are plans to extend this access to 34 lower middle income countries. Earlier this year six of the world's leading medical publishers signed a "statement of intent" to provide free access to scientific information for more than 100 of the poorest countries in the world (*BMJ* 2001;323:65).

Against this background, scidev.net is now the first website dedicated to the needs of the developing world. It reports and discusses aspects of science and technology that are relevant to sustainable development and specific to the needs of developing countries. Each week up to four full length research articles from each of the journals *Science* and *Nature* are posted on the site. There is also a news section on development related scientific and policy issues, and in depth dossiers are being created on topics such as gene cloning, climate change, and malaria.

The site—funded by UK, Swedish, and Canadian development agencies—also advertises job opportunities and international meetings. Links are available to funding agencies, and other development agencies. Overall the site gives the feel of being a forum where connections are made, ideas exchanged, and information shared. Together with the changes in publishing, it shows how the electronic revolution could help to abolish the information gap.

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PERSONAL VIEW

In praise of books

Occupied as we are with electronic databases, information on the internet, and full text journals on the web, do we not sometimes overlook the value of information in current textbooks?

I have gone through my file of reference inquiries over the past six months and looked at those questions where clients insisted on a search on Medline, other electronic databases, or the internet. I would think that more than 60% of the questions were actually so general and unspecific that relevant information could have been found with ease in a current textbook or other printed source.

I refer to questions such as "Where do I find everything [sometimes the word "something" is used] on: diabetes in pregnancy? sectioning under the Mental Health Act? how to write a research paper? crisis intervention? screening for prostate cancer? hepatitis C? the principles of evidence based medicine? preceptorship? priority setting in the NHS?"

In each case the attempt to get more information from the reader in order to develop a specific, focused question (only those can generally be searched on, for instance, Medline or the internet) has failed. Sometimes clients react with remarks suggesting that I am prevaricating and condescendingly preventing access to current information. Sometimes people say: "My tutor/lecturer has said that I should do a search on the web."

I am aware of the dictum that "half of what we learn in medical school will be outdated by the time you start practising; we just don't know which half." I also know of studies that indicate that it takes five or more years for new research findings to filter through into medical textbooks (*JAMA* 1992;268:240-8).

I believe such statements and research findings are instances of hard cases leading to bad laws and I offer the following observations:

- In everyday practice, it is possible to find in current textbooks valid answers to questions such as those above. Textbooks put the subject in context, investigate background, describe current practice, and highlight problems. Typically, articles on Medline deal with specialised aspects of a problem.
- It is worrying that during facilitated searches (a search conducted with the help of the librarian) clients are unwilling to scan, say, 40 references to pick five that are directly

relevant. Even the minor effort to scan is considered too time consuming.

- Focusing a database search to retrieve general overviews is difficult. Scanning a table of contents or the index of a printed source is easy. One doesn't even have to scan a table of contents or indices: in my experience you can find the introduction to the subject on pages 1-18, with pages I-IV or the dedication note giving background on the enthusiasm, dedication, and sometimes human costs involved in producing the book. It is here that authors mention instances of spouse and child neglect, and also, sometimes, the help of a librarian.
- It appears to me that results of Medline searches tend to confirm the prejudice that scientific medicine deals only with body parts

while books tend to give a holistic view of the disease and patients affected by it.

- I suspect that among reasons for this decontextualised approach to medical information—this reluctance to use books—is evidence based medicine's stance that only the most current and validated information should be used. This is true only for focused questions derived from clinical settings where valid information may age quickly.

- Taking this point a bit further, I would suggest that "electronic information" is to "information in context in books" what "evidence based medicine" is to "narrative medicine." As the patient's narrative forms part of good clinical practice, so should a book or printed source be part of the information gathering process for finding the external evidence.

- Medicine, an art based on science (sorry), thrives on more than just "valid information." It depends on "knowing," which is characterised "by the fact that we know more than we can impart" (*Lancet* 2001;358:397-400). I would claim "that what cannot be imparted" is more easily found in a book than a number of articles found on Medline or a site on the web.

I promise myself to exercise at least once every week a policy of benign refusal to launch a full Medline or internet search and insist on consulting a relevant printed source first. If the client then uses that source to reframe and focus a question, so much the better. My subsequent facilitated search or search tutorial on Medline will be more enthusiastically executed, generate more benefit for the client, and still highlight the valuable, albeit old fashioned, source of medical knowledge: the printed book.

Reinhard Wentz *Imperial College Library Service, Chelsea and Westminster Hospital, London*

Typically, articles on Medline deal with specialised aspects of a problem

Books tend to give a holistic view of the disease and patients affected by it

SOUNDINGS

Clients on diets

So we worry about frightful epidemics, on television and in the newspapers, about the Black Death coming back or variola major rising from the dead, forgetting, in the midst of our recent preoccupations, about the deadliest scourge of all, more lethal than handguns and automobiles and anthrax all put together. It is food, food, the stuff that in the Hindu Kush we drop from planes in yellow packages but that here is a pathogen, causing this terrible epidemic of obesity, of coronary heart disease, of type 2 diabetes.

And so it came about, some 10 or 15 years ago (according to notes I found in an old file, and that I had made for a "Letter from . . . Chicago" that was never written) that the phone rang while I was in the middle of a busy outpatient clinic.

"It's about my client for whom you prescribed an 800 calorie diet."

"You mean my patient," I interjected.

"Well, we call them clients," the voice said. "I think 800 calories is too little for my client."

Defensively I suggested that 1000 calories might be sufficient to keep this 270 pound woman in metabolic balance.

"No," said the voice, "at 1000 calories she will still need supplements; 1500 calories would be better."

"Would you please do as I asked you?" I ventured.

"Oh no," she said, "you do your doctoring, and I do the diet counselling."

By now I could have hit her, had she not been at a safe distance. Instead I asked for her name, saying I would speak to her supervisor, whereupon she slammed the phone in my ear, and I let the matter go.

My feelings, moreover, were compounded by a certain amount of guilt, because somewhere in the dim past I was taught that it was the doctor's job to counsel patients about their diet. But things being as they are, I must also add that I have always felt sorry for dietitians because, despite their best efforts, most patients will still eat whatever they please.

I also find that many dietitians imagine indeed that we are in the Hindu Kush, and are more worried about starvation and deficiencies than about obesity. But I have stopped arguing with them. I now tell my overweight patients to listen politely, but then to eat half of what the dietitian prescribed.

George Dunea *attending physician, Cook County Hospital, Chicago, USA*