reviews

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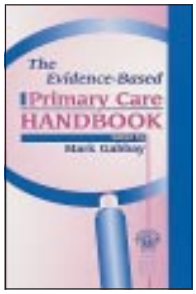
The Evidence-Based Primary Care Handbook

Ed Mark Gabbay



Royal Society of Medicine Press, £19.50
ISBN 1 85315 415 6

Rating: ★★★

Evidence based medicine is fashionable and, at face value, a simple concept that should be self evidently desirable. In practice, it is a rapidly changing and complex field driven by information technology. This handbook attempts to bridge the gap between the sunny uplands of what is desirable and the realities of trying to provide evidence based primary care at the coal face of general practice.

The introductory section provides a helpful overview of the evidence based approach and sensibly extends the definition of evidence based medicine to evidence based health, which incorporates public health and health economics. There are useful chapters on critical reading, basic statistics, and literature sources; indeed, one of the main strengths of this book is the wealth of references to sources of information.

The second section focuses on issues concerned with planning services such as commissioning, health economics, prescribing, and the role of pharmacists. EBM could mean evidence based management as well as evidence based medicine. The skills required are similar and include those of public health medicine, which are particularly important for primary care groups. This is especially so because previous reforms of primary care, such as fundholding, were driven by ideologies of competition rather than evidence. The Audit Commission found that only a third of fundholders said their purchasing plans had been influenced by literature on evidence based health, and there is a lack of evidence both for improvements in the quality of care and for the relative efficiency of fundholding in terms of costs and benefits.

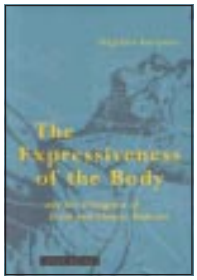
The last part of the book returns to the coal face of evidence based medicine, with practical examples of common clinical problems in general practice. The writing is anecdotal from a variety of contributors. The results are both enlightening and salutary, ranging from reasonably clear guidelines for the management of sinusitis to the exasperated comment on managing *Helicobacter pylori* that "Many of the trials seem contradictory, and the more we read, the less clear were our conclusions."

The main value of this multiauthored handbook is that it links broad concepts with a mine of information about how to go about searching for the evidence, especially in terms of references to the internet. If you want to get stuck into evidence based health in primary care, this is not a bad place to start.

D R Hannay *professor of general practice, Kirkdale, Carsluith, Wigtownshire*

The Expressiveness of the Body and the Divergence of Greek and Chinese Medicine

Shigehisa Kuriyama



Zone Books, £20.50, pp 340
ISBN 0 942299 88 4

Rating: ★★★★

Have you ever wondered why figures in Chinese medical writings are smooth skinned and plump, whereas Greek sculpture commonly depicted taut muscle men, their biceps and sterno-cleido-mastoids sharply outlined? Why Confucius always sports an ample belly, but the most powerful Versalian image is a lean corpse, its skin stripped away to expose its carefully dissected muscles? Why, in the West, taking the pulse is a shadowy remnant of a once vital diagnostic procedure, and why it remains so in China?

In this brilliant and elegantly written volume, Shigehisa Kuriyama examines why East is East and West is West. Equally at home with the Greek and Chinese medical classics, Kuriyama offers an evocative account of how two disparate cultures viewed the human body and saw completely different things. Where the Greeks saw articulations and sinews, their Chinese counterparts saw hues and contours. Whereas the Greeks turned to animals for hints about the structures and functions of the body, Chinese medicine is suffused with botanical imagery.

Greek and Chinese doctors not only saw a different reality, they felt it as well. Although Galen wrote three separate treatises on the pulse, he was more interested in describing what the pulse is rather than how it feels. By contrast, Chinese pulse lore is a rich and subtle amalgam of quality, and quantity remains a minor side issue. A Chinese doctor can diagnose diseases of the stomach, kidneys, or liver simply by appropriate palpation of the radial artery.

Bloodletting offers another telling indicator of the divergence of the two medical traditions. The procedure was less important for the Hippocratics than it became for Galen and his followers. It remained a mainstay in Western medicine until the 19th century, though it largely lost its topographical importance, where blood was let from different sites depending on the disease. (Kuriyama notes some intriguing similarities between traditional bloodletting sites and acupuncture points.) Phlebotomy was not unknown in the East, but it was sparingly used, partly because plethora was viewed as a sign of health, not an indication that the system needed lowering.

In these and numerous other ways doctors in Greece and in China carved up reality differently. But the juxtaposition is not, Kuriyama insists, a dynamic Western medicine counterbalanced by a static, timeless Eastern one. He traces change within both systems, the "divergence" of his book's subtitle. And he remains wonderfully neutral about the relative values of East and West, even while reminding us that there are many ways to conceive health and disease, or to view the world.

W F Bynum *professor, Wellcome Institute for the History of Medicine, London*

Ratings are on a 4 star scale, 4=excellent

The History of the Royal College of Physicians and Surgeons of Glasgow: Physicians and Surgeons in Glasgow, 1599-1858

Johanna Geyer-Kordesch, Fiona Macdonald

Hambledon Press, £30, pp 478
ISBN 1 85285 186 4

The History of the Royal College of Physicians and Surgeons of Glasgow: The Shaping of the Medical Profession, 1858-1999

Andrew Hull, Johanna Geyer-Kordesch

Hambledon Press, £30, pp 288
ISBN 1 85285 187 2

Rating: ★★★

Most of the major royal colleges have commissioned solid scholarly histories. Here is the latest, representing five years' work by three historians of medicine funded by the Wellcome Trust. But the titles are misleading because, rather than merely being an account of the Glasgow Faculty and of the physicians and surgeons of Glasgow, the pair of books are admirably more comprehensive and interesting. They cover the whole history of medicine, in the broadest sense, of Glasgow and western Scotland from the 16th century, and even the medical novels of Smollett and John Moore.

When it was founded in 1599, the Glasgow Faculty included not only physicians and surgeons but also apothecaries and barbers, who were dropped in 1722 as surgeons rose up the social scale. The faculty became royal in 1909 and a college in 1962.

As with most faculties, colleges, and guilds in Europe, the motive was to regulate training, registration, and practice—ostensibly protecting the public from incompetent irregulars and women but also protecting the doctors from competition. In 1714 Glasgow encouraged anatomy courses taught at the university and examined by the faculty, soon followed by clinical teaching. The necessary corpses were robbed from graves by students or shipped from Ireland. The faculty controlled midwives and taught obstetrics from 1802.

By the 1830s, Scotland produced more doctors than could be absorbed into civil society or into the army and navy. This might explain why NHS expenditure per person and the ratio of doctors and nurses per person are both higher in Scotland than in England. Throughout this period, when Glasgow was "the best place to study medicine," the faculty was at odds with the university and its medical school over control of the teaching of fee paying students at the hospitals.

British universities struggled to make medical degrees the sole registrable qualification, but the colleges kept their conjoint diplomas registrable for another century and a half. As in England, Scottish medical schools were forced in the 20th century to create full time clinical chairs in the teaching hospitals on the model of Johns Hopkins University. The many new English medical schools encouraged students to qualify by their degrees rather than by conjoint diplomas so that the latter eventually disappeared.

Colleges then saw their role as providing postgraduate education. They specified curriculums, set examinations, and approved hospital training posts. There were and are interminable arguments about whether college exams should be entry or exit diplomas for consultant posts in NHS, and now European, hospitals. At least cooperation has now produced a common MRCP(UK), with its exams sometimes held overseas.

In 1791 the Glasgow Faculty moved from its 1697 Trongate Building to St Enoch Square and then, in 1862, moved to neoclassical St Vincent Street, with alterations, expansion, women's toilets in the 1950s, and modernisation up to 1999. I noted that Scottish reticence seems to have so faded in the 21st century as to allow an author in the Introduction to thank his wife for her love and to wish his mother better.

I was mystified that the second book made no mention of Scotland's opposition in the 1930s to English barriers to medical refugees seeking asylum. The Medical Practitioners Union and the BMA did not want German and Austrian doctors to be admitted to practise in the United Kingdom, and the English royal colleges lengthened the time for refugee doctors to re-qualify to three years. The Scottish colleges allowed re-qualification within a year and saved the honour of British medicine by repeatedly rejecting English pressure to be equally restrictive and by reminding the English colleges that "the purpose of the medical licensing bodies was to protect the public and not the medical profession."

Jeremy Hugh Baron *honorary professorial lecturer, Mount Sinai school of medicine, New York*

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WEBSITE OF THE WEEK

Heart transplantation US doctors can be contemptuously dismissive of "wait-list-ology," but when the scarce resource is organs rather than money even highly insured Americans in fee for service settings have to join the queue. And this week the *BMJ* publishes evidence that suggests that, for heart transplantation at least, such waiting lists are far from straightforward. Deng and colleagues stratified candidates for heart transplantation according to their risk of dying on the waiting list: only high risk patients actually had less risk from surgery than being on the waiting list, and it seems possible that they have their chances of receiving an organ diluted by the presence of lower risk patients.

The Cardiothoracic Surgery Network delivers a huge bundle of exemplary content at ctsnet.org/. Its FAQs (frequently asked questions) on heart transplantation pulls no punches, is evidence based, and will be useful for generalists everywhere who would like to understand and explain the risks and benefits of transplantation to their patients. The site is targeted at medics, but there are links to high quality patient information materials at ctsnet.org/doc/2189. Multimedia content is also bundled on the site, but even on a fast internet connection picking up the proprietary RealPlayer multimedia software (a 7 Mb download) before failing to view the video of an innovative operative technique was a chore.

More relevantly, three major journals are freely available in full text through the site, and you can track down colleagues across the world using a highly efficient database of contact details. The European Association for Cardio-thoracic Surgery maintains its committee rosters on line, which should facilitate wider discussion if colleagues feed input by email to their representatives. It's perhaps not surprising that one of the most technical of specialties has a technically adept website; even if you're not a cardiothoracic surgeon there is much to learn from the architecture.

Douglas Carnall
BMJ
dcarnall@bmj.com

ads ads ads

O Liberty! what crimes are committed in thy name!

LANGLAND/AVENTIS

Bare breasts: if suitable for Liberty, why not for breast cancer?

Would bare breasts make you look twice at a drug company's advertisement? If the answer is yes, then the makers of Taxotere (docetaxel), used in the treatment of advanced breast cancer, will probably be very pleased with their advertising agency team.

We doctors are shamelessly manipulated by drug companies in all kinds of ways. Although the methods cover the whole spectrum from subliminal to brazen, from little pens that don't work to pushy reps, the new advert for Taxotere does manage to be both innovative and striking. It is innovative because I've never seen such a display of feminine pulchritude in a medical journal before and striking for the very same reason. Even the adverts for oral contraceptives are usually quite coy, as if they were promoting aerobics rather safe sex.

This advert was not in the *Sun*, or the *Star*, or *Playboy* (though there are many fascinating articles in *Playboy*, on Grand Prix racing, for example, or maybe gardening or fellatio). It has been placed in many leading medical journals, including the *BMJ*. As it is advertising a treatment for breast cancer obviously it can't be reckoned as pornography. Obviously.

Nudity for art's sake is not pornographic; the painting used in the advert is not an original but a reproduction of *Liberty Leading the People*, by Eugène Delacroix, which is currently in the Musée du Louvre. So that's all right then, it's not pornography. Obviously.

I wonder how Delacroix would feel about it if he was with us today. On the one hand, he might be disturbed at his work being hijacked for squalid commercial gain. On the other, he might be delighted to accept the patronage, which is presumably also the motivation for the many medical journals accepting the advert—everything has a price.

The association between doctors and drug companies may have brought many benefits, but the price we pay is our independence. The drug companies finance our medical press, support our postgraduate education, shower us with useless little freebies, and stroke us and make us feel important. Their raison d'être is to make a profit, and, as the free lunch palpably does not exist, why shouldn't they also call the tune and act as arbiters of good taste?

The overall ambience of the advert is of revolutionary France, and all the political and social ferment that this implies. Against a background of barricades and muskets and gunpowder smoke and men in pantaloons there are a few jaunty urchins running around with flags; it feels like *Les Miserables*, with maybe a soupçon of Molière as well. It implies progress, action, a sweeping away of the old order, a new era of vigorous and virile therapy.

But this background is all just window dressing, nothing but an artful veneer of pseudo-cultural sophistication, for there is no mistaking the main attraction—a woman, the eponymous Liberty, curiously not unlike Xena the warrior princess, with big bare breasts bang on centre stage. I almost expected a caption below something like: "Linda is 19, is interested in football, and wants to work for world peace."

The fact that the drug promoted is for the treatment of breast cancer does not really excuse the indiscretion. Are we being urged to talk more openly about breasts? Is it time breasts came out of the closet? Should adverts for Viagra show a huge phallus? Other famous advertising campaigns have employed the same aggressive and penetrative strategy: Barnardo's and the baby preparing to inject heroin in a dirty backstreet, Benetton and the cachectic patient with AIDS. To shock is to be noticed, and sensitivity is a secondary consideration; to be showered with outrage is more desirable than to be flogged with indifference.

The breasts are put there to make an impact. It is a clinical and calculated action, and by writing about it I'm reacting just as the advertisers want me to: the strings are yanked, and the puppets dance and jerk; the bell rings, and both Pavlov's dog and I drool and slobber. I'm not so much turned on or even offended as I am surprised; I can handle breasts, I like having them around me, I feel comfortable in their presence, I enjoy hanging out with them, but they do seem less appropriate in some situations than in others.

BRIDGEMAN ART LIBRARY/LOUVRE

Detail from *Liberty Leading the People* (1830) by Eugène Delacroix

Liam Farrell *general practitioner, Crossmaglen, County Armagh*

bmj.com Should the *BMJ* have published this advert? Vote on bmj.com

PERSONAL VIEW

Abortion—a hell of a decision

Ignoring the issue could last only a short time—for inside my body the truth was living. Each day was just another hurdle to get through while waiting for the termination appointment to arrive. More time to contemplate and anguish over one of the most difficult decisions a person ever has to make. I remember the final moments before the operation so clearly that they will go with me to my grave.

I lay in a hospital bed, having once more gone over the details of the procedure with a nurse. I couldn't see the ceiling for the tears. I just felt so miserable, but I kept saying to myself that I had made the right decision. Another child would either finish me off or finish the marriage. I was just about coping with my two young children, who were already suffering the disasters of a loveless marriage and a husband who preferred his hobbies to sharing in family life. However, I constantly needed to justify my presence in that ward. To this day I do not know whether anyone has ever backed out at the last minute.

Finally, they came for me. I was in a terrible state, quietly, silently hysterical. As I was wheeled along the corridor it felt as though I was heading into an unknown destiny of misery. Indeed, that is exactly how it turned out.

Strangely, a calm came over me as I regained consciousness—a feeling that a great weight had been lifted from my chest. I was taken aback at my calmness. Numbness had replaced the pain. The hospital had provided me with care, but I was desperate to leave so that I could wipe away the memory of that place. If counselling was offered I was not in a state to either accept or reject it

Returning to work my mind was busy and it surprised me how well I seemed to be coping. I had kept my hospital confinement a secret. How do you tell someone that you have just destroyed a life? My husband, who was against the abortion, refused to talk to me about it, and so I kept that tragic fact bottled up, not daring to confide in anyone. Within weeks my husband seemed to have forgotten about the abortion and was demanding his marital rights. Sex to me had become the route of pain and evil, and I froze at the thought of it, but I was powerless against him. Now I know that his behaviour constituted rape within a marriage but, since he had threatened to tell our friends that I was frigid, and our two young children lay fast asleep next door, I was too scared to cry for help.

Slowly I began to notice little babies, and grief started to eat into my calm exterior. Pain such as I had never felt before worked its way into my vulnerable mind, and I realised that I was crumbling. The numb feeling that had protected me for so long was ebbing away, and I didn't know what to do. The reality of the termination had hit me in the form of grief and despair and above all guilt. I tried to reason with myself that I had no option, but that grief was being translated into anger. I was angry because, using a coil, I had made every effort to prevent a pregnancy. I was angry with God because I knew that there were many women desperate to conceive, but above all I was building up anger towards my husband.

> My message to anyone contemplating an abortion is to accept counselling

When misery consumes your body, it becomes very difficult to seek help. I was acutely aware that I was heading for depression but kept hoping that somehow the situation would resolve itself. I was scared to visit my GP for fear of criticism. I couldn't sleep at night and during the day I alternated between self pity and pain. Worst of all were the frequent moments when tears just poured uncontrollably down my face. I desperately wanted to talk to those close to me and to unload that agony I was carrying alone but something always stopped me. I needed help to face and accept the truth.

> My husband, unable to cope with the difficult situation at home, left

As I look back over those sad years, my message to anyone contemplating an abortion is to accept counselling. Everyone copes with pain differently but having an understanding, professional counsellor to talk to may help prevent years of silent misery. Ideally, this counselling should start before the termination so that a link is already forged.

My husband, unable to cope with the difficult situation at home, left. I thought this would finish me off, but in fact it turned out to be my salvation. I owe this to my mother who, in her wisdom, took me and my children under her wing and helped me recover. She sat for hours listening to me pouring out my heart. She didn't condemn me as callous and wicked which I feared she would. She was just there for me and I will always remember that.

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email **editor@bmj.com**

SOUNDINGS

The turning sky

Some years ago, in an age when I felt younger than I do now, I built myself an observatory. It stands there tonight, some 50 yards up the garden, a dark, domed, lonely place, throwing a circular shadow on to the moonlit grass. I built it in a spirit of optimism and rather, I think, of innocence. Time passes, and my responsibilities to those around me have grown, and with that the place stands empty, a haven for those insects that crave hidden, still air.

Tonight, unable to sleep, I walked around the place. I haven't used it for some time now. The large, unwieldy telescope is dismantled and the perfect parabolic mirror lies under my bed. But the dome sits there silently in the garden, reminding me of a less cluttered time. It is like the stack of vinyl Pink Floyd records to be found somewhere on the shelves of most middle aged oncologists—a talisman of youth.

> That's the trouble these days, you just can't trust your senses

But I realised tonight that, in fact, the telescope is no longer necessary to the place. The observatory has become a shrine—a place of worship rather than of study. As I sat in the shadowed stillness and watched the stars slip past the open shutters, I realised that I am, in fact, the centre of the universe—the still point in a turning world. This is an epiphany which, working in the NHS, I suspect will not survive the daylight. Nevertheless, tonight it is clear. Copernicus was absolutely wrong. I will publish immediately.

Back in the study, sitting in front of this glowing screen, the idea seems delusional. I have been told since I was a child that the movement of the sky is an illusion, caused by the spinning of the earth. Trust the model, not your senses. Every sense may be screaming at you that you are at rest and the universe moving, that all motion is relative to you, but you mustn't actually believe that. After all we think that we are conscious beings with a will and a purpose, when in fact, so I am told, this is an illusion caused by serotonin (among other things).

That's the trouble these days, you just can't trust your senses. Tomorrow I'll listen to Professor Susan Greenfield, and she'll put me right. Or perhaps I'll just take some chlorpromazine.

Kevin Barraclough *general practitioner, Painswick, Gloucestershire*