



Des Spence
on cervical
screening,
p 462

Haiti: the emergency is over

PERSONAL VIEW **Nick Rose**

Six months after the earthquake in Haiti the bar at the Plaza Hotel on the Place des Héros de l'Indépendance near the collapsed Palais National is again packed with journalists and photographers. It is a media constructed anniversary. This time round the journalists' checklist includes questions about the unintended damage caused by aid, the stuckness and growing dependency of a million internally displaced people still under canvas, and the slow rate of progress of just about everything. Meanwhile an unremarked watershed has slipped by, symbolised for me by two recent events.

The first was the reopening of the national school of nursing. As a mental health specialist, I was asked to give a seminar to nursing students on their return to studies. Eighty one second year students had died when their teaching block collapsed. The seminar took place in a large marquee erected on the flattened rubble where their classmates had died. I brought a generator to power the fans and projector in what were unbearably hot conditions. The director of education, Madame Nazaire, watched protectively from nearby. Before me sat more than 100 young women, immaculately dressed in starched white and dark blue uniforms. Yet I knew that most still lived in tents. I had also learnt from Madame Nazaire that many had lost family members as well as classmates. Up to that point the meaning of what was happening was poignant but not emotional. Then, quite spontaneously, the girls started to sing. It was a hymn sung in unspoken memory of those not there and a reminder that the notion of "family" in Haiti includes not just the living but also the dead and those yet to be born. For me that moment defined the independence and resourcefulness of Haitians.

The second event was the withdrawal of international doctors and nurses from staffing the emergency room at the central National University Hospital, set up and run by the International Medical Corps within a day or so of the earthquake. This was an acknowledgment that run of the mill gunshot wounds, road crash injuries, fevers, and aches and pains had replaced earthquake related injuries long ago and that continued foreign provision of clinical services risked undermining government and privately run local healthcare systems.

So, with the emergency over, the aid response



THONY BELZAIRE/AFP/GETTY IMAGES

A destroyed health centre in Port-au-Prince. Slowly, Haiti's health service is now rising from the rubble

must become a development one. And in health care this will involve building capacity in a setting where little existed before. Work has already begun to help the government develop a national health strategy, a framework for training community health professionals, and strengthening specialties within medicine.

Yet back on the street the emergency is far from over, of course. Streets of pancaked buildings still swarm with labourers using hammers to chip the concrete from the iron reinforcing rods that so conspicuously failed. The iron is weighed and sold for rebuilding. And men with wheelbarrows are everywhere, working alongside giant excavators and rows of ancient US dumper trucks. It took two days to level the collapsed nursing school of the National University Hospital, including the bones of the dead students. But many large buildings are yet to be disturbed and remain unopened tombs.

In the camps orderly lines of people, mostly mothers and their children, wait to be seen by the medical teams. A Haitian doctor sees a patient who has lost her mother, two of her children, and her home. She fears entering buildings and sleeps with her remaining son under a plastic sheet. The Haitian doctor himself lost family members and his home, so there is an unspoken connection between them. Each day victims of sexual assault arrive, some having been gang raped; this was a problem in Haiti before the earthquake, but locals say it is now much worse. This pattern is perhaps the result of damage

Read blogs from Haiti on doc2doc, BMJ Group's global online clinical community, at doc2doc.bmj.com/haiti



done to protective social networks. One of the most commonly expressed worries mothers have is the safety of their children. With neighbourhoods broken up, who will they be playing with, and how can they be kept safe with so many strangers about?

Gradually the second wave of journalists is departing, public interest is waning, and the floods in Pakistan now preoccupy media attention. But the aid effort is in for the long term. One example: helping people respond to the emotional backlash of the earthquake. Six months on many new patients still attend with headaches and fear, people who wouldn't sleep in a building even if they still had one. And extraordinarily some people are still being brought in who, after the earthquake, simply shut down into dense depression or were thrown into psychosis and have been cared for ever since by their families, the relatives often racking up vast bills from repeated visits to traditional healers. In a country without an effective primary care system emotional problems have largely been the domain of these traditional healers.

But the development funding gives Haiti an opportunity. There is evidence that the government is responding to the challenge with a plan for developing community health clinics to meet the needs of people with physical and mental healthcare needs. Already a dozen of the camp clinics have a psychiatrist training local Haitian general practitioners to recognise and treat serious mental health problems, a working model that could be replicated in many more camps if resources allowed.

For an outsider like myself it's like having a premonition of the end of the world. Except it isn't, because although 230 000 people are thought to have died, millions live as witnesses to the catastrophe. And in a society where families are at the centre of things, the survivors show an enormous capacity to care for each other. It's rare for someone to attend a clinic alone, for example, especially if they have a mental health problem. And life must go on. As one person said, "It's difficult. You can only take it a day at a time, it's too big to cope with any other way."

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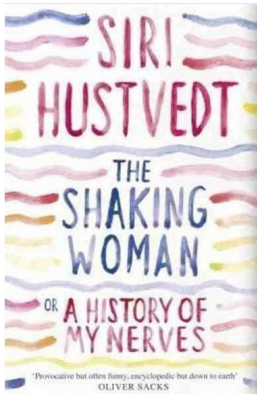
A longer version of this article is available on bmj.com

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REVIEW OF THE WEEK

Shivers down the backbone

Are the US writer Siri Hustvedt's ruminations on her panic attacks likely to enrich the patient literature? **John Quin** reveals what one type of patient might make of it



The Shaking Woman or a History of My Nerves

Siri Hustvedt

Sceptre, £12.99, pp 224

ISBN 978-0340998762

Rating: ★☆☆☆

Dear Doctor,

I know you are a busy man, but I just had to write to you about some recent developments in my condition that I'm sure will interest you.

As you know I have suffered from generalised ill health for a long time now, as detailed in the many symptoms that I have outlined in my previous letters to you (which I hope you have kept on file!). I have tried many treatments, as you know, and have consulted several specialists and have paid a small fortune in fees to iridologists, holistic practitioners, reflexologists—you name it!

The reason I am writing to you again is that I think I have found a cure! Yes! I have found something that has energised me, made me wholly engaged with the world again, and it is this—Siri Hustvedt's discursive new book about her panic attacks with which I identified *completely!!* I share so much with this talented lady!

Like her I am extremely sensitive: I cannot watch horror films, as I feel the victim's torture, and, like her, I too have found the brash colours of our surroundings sometimes unbearable—in her case a lake in Iceland, in mine the shocking pink of the mall at the Elephant and Castle in London. (You know it, surely?) Siri tells me this is called the Stendhal syndrome—why haven't you managed to diagnose this for me despite my many communications? I think you need to do some more reading!

I cannot express how much of a relief it is to realise how she too suffers from mirror-touch synaesthesia—we are just too empathic and imaginative for our own good! We are not your usual run of the mill cases, we are INTERESTING! I read with amazement that, again like me, she has an analyst on her psychiatrist's recommendation *and* is a supporter of monks in Burma *and* takes propranolol!

Amazingly she has also been worried that she had multiple sclerosis, only to be told that she had a "peripheral neuropathy" that "could get better; it could get worse." Incredibly, that happened to me too, exactly like that, and like her I laughed out loud to the doctor—you know who, the one I saw before you!

Both of us are correctly "wary of the doctors in charge of investigating nervous systems" and have had the misfortune to be under neurologists for eight days with GIGANTIC headaches and been asked the name of the prime minister or the president (Obama, it's Obama you

morons!) umpteen times and then pricked with red pins and been asked constantly TELL ME IF YOU FEEL THIS—and who as doctors have then ignored us or seemed irritated that we have not cooperated and gotten well.

And then there are the nurses, those "brusque, indifferent" nurses. I know just who she means. YES, YOU IN CHARGE OF WARD SIX—THAT'S YOU, NURSE OSTER.

We both, unlike you, doctor, have read textbooks on neuroscience and the latest *Diagnostic and Statistical Manual of Mental Disorders*. (Shame on you that it remains unread on your shelf!) Siri gets quickly to the point, on page 69, when she asks my own great question: "Who are we, anyway?" And this too: "What do I actually know about myself?" I cannot agree more with her that "tracking my pathology turns out to be an adventure in the history of experience and perception." An adventure! That's certainly how it has felt to me, and I'm grateful that she has guided me to this belated realisation.

She is fantastic too on dreams and how it is imperative that people listen to our dreams, as they have much to tell people like you, doctor! And babies' faces too, how right she is when she illustrates how important it is for mothers to look at their babies' faces.

Doctors like you must read Siri. Listen to what she has to say about your profession: "Many, if not most doctors have little grasp of what came before their own contemporary frames of diagnosis. They are incapable of drawing parallels with the past." That is *soooo* right. You doctors just sit there in your big fancy chairs and take our taxpayers' money and never read anything about medical ideas of the past even if they were on the page of a journal next to the one you are reading!

After buying this book I felt so much better that people like William James

and Wittgenstein and Husserl can all be called in to help explain why I feel so bad. Maybe they felt a bit grim at times too, just like Siri, who I think deserves to be spoken of in the same breath as those venerable names she never tires of citing! Why can't you all be like Oliver Sacks or Patch Adams? I'm not boring you, am I? I do hope not, as I have a number of questions I need to ask, on my next few pages . . . PTO.

[Being page 1 of a 14 page missive recently received by John Quin]

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Fever pitch

Evolutionary theorists have suggested that it is a mistake to lower the temperature of a fever because fever must have survival value, otherwise it wouldn't have evolved as a response to infection in the first place.

Whatever the validity of this roundish, if not completely circular, argument, the author Graham Greene found another virtue in fever: it once persuaded him that life was worth living.

He was on his trek in 1935 through Liberia when he fell ill. The first edition of his book

about it, *Journey without Maps*, had to be pulped because of a threat of a libel action brought by a colonial medical officer in Sierra Leone, Dr P D Oakley, whom Greene portrayed as the drunken vulgarian Pa Oakley (a sheer impossibility in our profession). In the book Greene recounts his illness in a section laconically called "A Touch of Fever": "I remember nothing of the trek to Zigi's Town and very little of the succeeding days."

In fact, his companion on the trek, his cousin Barbara Greene, wrote her own account of the journey, *Land Benighted* (a quotation from a line of the Liberian national anthem). She thought Graham would certainly die from his fever: "I never doubted it for a moment. He looked like a dead man already." Her main concern was how to get candles to light after he died.

Greene was 30 years old but, as everyone knows, he lived to a ripe old age. The fever was, as the contemporary cant phrase has it, a learning experience: "I had discovered in myself a pleasure in living. I had always assumed before, as a matter of course, that death was desirable." Indeed, he had twice tried suicide, or made suicidal gestures, once

BETWEEN THE LINES
Theodore Dalrymple



Greene certainly didn't owe his survival to medicine. He had forgotten to take his medical supplies with him, and they might not have been of much use in any case

by overdose, and the second time, more famously, by playing Russian roulette with a revolver.

The lesson he learnt was a fragile one. He continued: "It seemed that night an important discovery. It was like a conversion... I should have known that conversions don't last, or only as a little sediment at the bottom of the brain... One may be able to strengthen oneself with the intellectual idea that once in Zigi's Town one had been completely convinced of the beauty and desirability of the mere act of living." Am I alone, I wonder, in finding the use of the impersonal pronoun here a symptom of exhibitionist insincerity?

Greene certainly didn't owe his survival to medicine. He had forgotten to take his medical supplies with him, and they might not have been of much use in any case. He had only Epsom salts (which he took in heroic quantities in tea) for internal complaints and boric acid or iodine for external ones.

Nonetheless, villagers *en route* asked him for treatment, assuming he had powerful medicines with him. (In return, Greene believed that Liberian witches really could call down lightning to eliminate their enemies.) For example, he treated a leper with boric acid, for which the latter was very grateful.

I couldn't help remembering the time I persuaded an obstructive West African port officer to allow me to join a ship by giving him some luminescent, luridly pink erythromycin pills. He then became helpfulness itself. My destination? Liberia.

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

Barney's Version By Mordecai Richler

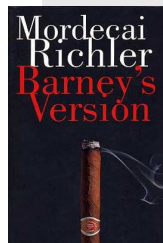
First published 1997

One of the great challenges of teaching modern dementia care is to assert the vitality of life and life experience in illnesses such as dementia. Artists are often the storm troopers of consciousness, and the last novel of the great Canadian author Mordecai Richler gifts us with unique insights into life with dementia that could enhance any teaching programme related to the illness.

Barney's Version is the story of the eponymous Barney Panofsky, a colourful character who has led an equally colourful life. Barney is a Jewish self-made millionaire who wishes to write his memoirs while he can still remember the details. He gives his version of events in a humorous, rambling, and at times combative style. The story is in three segments representing each of his three wives and is narrated in the first person.

From an early stage we notice that Barney has difficulty recalling certain words, names, and literary works. His son corrects these mistakes by way of footnotes in the book. Although the alcohol doesn't help Barney's memory, he frequents his local tavern every day and continues to live life to the full despite his family's disapproval that he does not conform to their visions as to how an "old" man should behave. As his dementia progresses, he insists on going to work, dictating often comical and nonsensical letters to his long suffering secretary and demanding they be sent regardless of the content or the insults extended to the unfortunate recipient.

The short scene where Barney is finally persuaded to see a doctor and undergoes the mini-mental state examination provokes humour and discomfort and is a medical classic in its own right. It is not only entertaining but a reminder of the need for better training for people carrying out even simple cognitive screening. Barney admonishes the doctor for patronising him with ridiculous questions and counters each question with one of his own, all the while puffing on a cigar and uttering expletives in an attempt to mask what he knows are deficits in his memory. After his consultation he reads up about Alzheimer's disease, then promptly calls a friend who is a doctor and asks him how long he has before he "goes gaga" and to set up an enduring power of attorney.



Barney copes with the diagnosis of his dementia with the humour, candour, and irreverent manner we have become accustomed to, but his family's emotions are different. Barney's daughter constantly pleads with him to come and live with her because she feels he is not capable of living alone.

The challenges to dignity in dementia are palpable in the description of a meal Barney has with his third ex-wife Miriam, where he has difficulty choosing from the menu and coordinating his cutlery and even forgets that they were no longer husband and wife. When it is decided that he should enter a nursing home, there is a huge sense of guilt, grief, and also relief.

Overall the book affirms how fullness of life can be enjoyed in the face of dementia and allows us to reflect on how we need to nuance and develop our own understanding of dementia and reconsider how we portray this condition to our patients and their families.

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We welcome submissions for medical classics. These should be no more than 450 words long and should focus on a book, film, play, artwork, or piece of music that sheds light on the practice of medicine or the role of doctors in society. The work under review should be at least 10 years old. Please email ideas to Richard Hurley (rhurley@bmj.com).

Cervical screening: a smear campaign

FROM THE
FRONTLINE
Des Spence



I once worked in Norfolk; but when my wife fell pregnant she choked, “I want to go home.” Concrete tower blocks, Irish tricolours, Union Jacks, and red hair flashed through my mind. “To Glasgow!” I said. But Scotland has enduring qualities: humour, respectful irreverence, directness, pragmatism, swearing, and a national mantra, “Life is for living.” We may have some of the worst health statistics in the Western world, but we are a country of the unworried unwell. It is odd that there is a current anomaly in screening policy in the UK countries. Cervical screening in Scotland (and Wales and Northern Ireland) starts at the age of 20, not 25 as in England. Last year after the death of Jade Goody there were emotional calls to lower the screening age in England to 20 in line with rest of the UK. These calls came not merely from the tabloid press, which unquestioningly considers all screening a good thing, but also from many in the BMA.

The incidence of cervical cancer in women younger than 25 is low: perhaps some 40 cases a year in the UK. Some people argue that screening could prevent half of these. But, as ever, theory is not the same as practice. A recent review of screening in women under 25 showed little or no benefit on rates of invasive cancer up the age of 30, so these cases may not be preventable by screening (*BMJ* 2009;339:b2968). Screening is also associated with harm. Some 40% of

women will have a false positive result of cervical smear testing, representing non-progressive and reversible changes, during their lifetime (*BMJ* 2003;326:901). These false positives don’t just cause considerable psychological angst but also lead to referral for colposcopy and treatments that remove part of the cervix—treatments associated with real and lasting harm. With even the least problematic treatment, large loop diathermy, the numbers needed to harm are 250 for preterm labour before 28 weeks and 500 for perinatal mortality (*BMJ* 2008;337:a1284).

Even in the land of the far-from-free, irrational, unregulated, and financially driven screening, the United States, it has been recommended to raise the age at which screening starts to 21. This is at long last a recognition of the harms of overtreatment when screening young people. Also, the recent introduction of vaccination against human papillomavirus will see a decline in cervical dysplasia, so soon the absolute benefit of screening will be reduced greatly. Generally the cervical screening programme is a success story, but we should recognise its limitations. So, rather than England changing its policy, it is the devolved health departments in the rest of the UK that should raise the screening age to 25. For this is the pragmatic and simply the Celtic thing to do.

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Who on earth cares?

DRUG TALES AND
OTHER STORIES
Ike Iheanacho



In the end, numbers alone aren’t enough. That one in every 300 of the world’s people have had their lives or wellbeing ruined by a stunning natural catastrophe seems to have provoked little more than a shrug of indifference from the other 299. The underwhelming global reaction to the flooding in Pakistan should be food for sobering thought for those wishing to bring health and social problems to the attention of an otherwise uncommitted audience.

If minds aren’t engaged by the plight of 20 million, what hope is there for a mere 90 000 facing a real but comparatively minor trial (albeit closer to home)? This is the estimated number of people with diabetes in the United Kingdom who currently use Mixtard 30, a biphasic human insulin sold by Novo Nordisk. Not for much longer, though, as the company intends to withdraw the drug from the UK market at the end of this year (*BMJ* 2010;341:c4210).

It would be easy to focus on the commercial reasons for this decision, in particular, the company’s desire to promote the use of newer, insulin analogue products rather than older drugs such as Mixtard 30. But in some ways, that’s the most predictable and least interesting bit of the story. What’s more surprising is the muted public reaction to the impending change—the prompt for *Drug and Therapeutics Bulletin’s* recently launched campaign (2010;48:85) and online petition against withdrawal of the drug (www.thepetitionsite.com/1/withdrawal-of-mixtard-30-from-the-uk-market).

On the face of it the situation has enough ingredients to disturb anyone who supports best practice in health care. Firstly there’s the anxiety and disruption that the enforced termination of established treatment will cause for people with diabetes and their families. And it’s not as if they can be reassured that

the change is clinically necessary or advantageous, given the lack of evidence that the alternative biphasic analogue insulins are any safer or more effective than Mixtard 30. Also, these alternatives tend to be more expensive. And that’s not the only source of added pressure for the NHS: somehow resources will have to be found for the individual patient reviews and follow-up needed to ensure that tens of thousands of patients are switched to and settle on substitute insulin treatment.

But in the end you could be forgiven for concluding that none of this matters much, such is the lack of obvious protest from some of the patients’ groups and professional bodies with an interest in diabetes. Maybe the fact that these dogs haven’t barked much is the most intriguing feature of all.

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