"The diagnosis is increasingly subjective, and based on soft clinical signs." Des Spence on bad medicine and rheumatoid arthritis, p 750

An elected government should fix Libya's health system

PERSONAL VIEW **Issam M Hajjaji**

"There are tanks on the streets. Get up! Get up!" cried my mother on 1 September 1969. So started Lieutenant Muammar Gaddafi's *coup d'etat*. I was 10 years old and attending an English school in Tripoli. Within two years the ruling military council closed foreign language schools, and I was rushed to a boarding school in Kent because the school year was starting two weeks later. Libya, then with a population of three million, became wealthy in the 1970s as the price of oil shot up. Modern hospitals were built, foreign staff were employed, and the first medical schools were opened in Benghazi and then Tripoli. Doctors were sent abroad for postgraduate training.

Matters began to take a different path in the 1980s. Public executions, imprisonment, and forced military conscription became widespread. Though healthcare was free, there was a noticeable decline in standards. The "revolutionary committees"—groups of zealots who were often violent—were present in hospitals, clinics, and universities.

I went to medical school at Trinity College, Dublin and then returned to the UK to do senior house officer and registrar rotations, attaining membership of the Royal College of Physicians in 1989. When I returned to Libya in 1990 my first impression was that it had undergone a civil war. The health sector was in disarray. Those with the means went to Tunisia or Egypt for medical care—or to Europe if they could afford it. Directors of hospitals were appointed for their loyalty rather than for their ability. Gaddafi travelled with a surgeon, a physician, and an anaesthetist. I was put on this rota in 1995. The first time I met him, he asked about my education and then asked, "Why did you come back?" I was asking myself the same question.

Those around him feared him. Gaddafi did, however, show respect for doctors. I repeatedly asked to be excused this duty, and two years later my request was granted. I taught Gaddafi's son, Moatassem, and adopted daughter, Hanna, in the medical school. Moatassem was later appointed head of national security and played a key part in the atrocities of the subsequent revolution. I kept the final examination papers for his class's bachelor of medicine degree at home and took them to the exam hall with a friend in the police, fearing theft by his cronies.

The Arab spring fever caught on in Libya on 17 February this year. Demonstrations started in Benghazi and quickly spread to Tripoli and other cities. We all thought the regime would fall within days. However, Gaddafi had a mercenary army in Tripoli. They quickly quelled demonstrations there and in Zawiya (the third largest city) by firing directly at crowds. People taken to hospitals or private clinics were arrested if their injuries were firearms related. Relatives started to treat injured people at home. I set up a secret clinic at home for first aid, shock, and suturing. Casualties would be sent by members of my extended family, using simple code words on the telephone. The towns of Zintan, in the Nafusa mountains, and Misurata were under siege. I managed, through gun runners, to smuggle insulin, intravenous fluids, and antibiotics to Nafusa but not to Misurata. This smuggling was widespread, I later learnt.

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ANDREW MEDICHINI/AP/PRESS ASSOCIATION IMAGES

Gaddafi: respected doctors

Libyans abroad, both doctors and business people, organised large relief groups. These groups treated Libyans who fled to Tunisia. Libyan doctors in other countries came to clinics in Tunisia to treat injured and sick people. Libyan doctors even left families in the United States, Canada, and the UK to help the rebels. Some were caught and paraded on state television. The International Red Cross, Médecins Sans Frontières, Qatar, and the United Arab Emirates also set up camps on the Tunisian side of the border.

My cousins in law, a family originally from Misurata, played a big part in the covert medical relief in Libya. They founded two charities in the UK to buy medicines, including controlled drugs. They sent these to Benghazi and other eastern towns through the porous Egyptian border, then smuggled drugs inside car tyres to the Nafusa mountain towns through Tunisia. Misurata was besieged for months and fired on haphazardly by Gaddafi's forces using long range artillery rockets. The main teaching hospital was destroyed, and a private clinic had to be used for injured people. Once its seaport was secured, drugs and medical equipment were brought in on fishing trawlers from Benghazi. Many severely injured people were shipped out to Benghazi and Qatar.

Rebels assumed control of Tripoli and most other western towns on 20 August. Gaddafi's forces left mass graves and bodies in the main trauma hospital. One of these patients was found to be alive but had dared not move while Gaddafi's forces were around. The death toll for the conflict so far is estimated to be at least 30 000 for a country of 5.5 million. The extent of injuries and psychological trauma is as yet unknown.

The healthcare sector is still in disarray: drugs and medical equipment are available, but distribution is disorganised. I am optimistic that once an elected government assumes power—and elections are promised in eight months—reorganisation of health services will be a priority.

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BETWEEN THE LINES **Theodore Dalrymple**

Successful failures

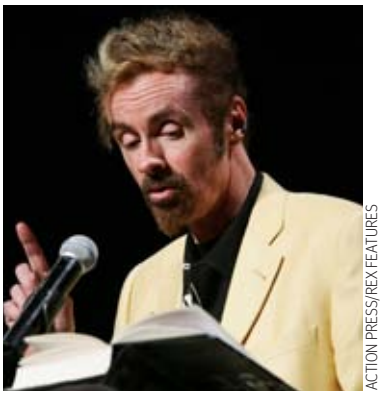
Failure is the dark underbelly of success; for every outstanding case of the latter, there are many cases of the former. Perhaps that is why the US author and philosophical anarchist Henry David Thoreau wrote that most men lead lives of quiet desperation (and go to the grave with the song, if any, still in them). The necessity of failure for there ever to be success also explains why, in so optimistic a land as the United States, so much of the literature is tragic; the land of opportunity is also the land of missed opportunity. The study of failure is in any case a more fertile subject for literature than success; failure is both more various and attractive than success.

T Coraghessan (or T C) Boyle is a contemporary novelist and short story writer whose characters are often the failures who smoke, drink, take drugs, and rarely have satisfactory careers or marital relationships. They search but they do not find; they drift from disaster to disaster; a deep vein of self destruction lies in their character.

In the short story "Killing Babies" the protagonist and narrator is a man who left school to join a rock group that broke up within a year, after which he drifted from job to job without ever finding a vocation. He drifted into a life of drink, drugs, and dishonesty; at the start of the story, he has just come out of drug rehabilitation (for the second time) and is going to stay with his older brother, the success of the family, a doctor in Detroit, who has given him a menial job in the laboratory of his clinic. It is hoped that this will keep him out of harm's way, on the straight and narrow path that leads from addiction.

He doesn't like his brother, who, at 38, is 10 years older than he. Greeting him at the airport after not having seen him for years, he says, "You look like shit, Philip. You look like Dad just before he died—or maybe after he died."

"He has a gun and, irritated by the aggressive and even violent self righteousness of the anti-abortion protesters, he starts shooting them"



ACTION PRESS/REX FEATURES

Boyle: drink, drugs, and baby killing

It turns out that his brother's clinic performs abortions and has attracted the attention of anti-abortion activists who picket it daily, singing hymns, shouting insults and slogans, and uttering menaces. Their self proclaimed love of human life does not preclude them from hating the staff of the clinic.

Life in a quiet Detroit suburb (this was before the city imploded) is not for the protagonist. He searches for, and soon finds, drugs: "I can see now that the Desoxyn [methamphetamine] was a mistake. It was exactly the kind of thing that they'd warned us about. But it wasn't coke and I just needed a lift, a buzz to work behind, and if he [the brother] did not want me to be tempted, then why had he left the key to the drug cabinet right there in the conch-shell ashtray on the corner of his desk?"

This is a shrewd illustration of the tendency of addicts to blame others, or circumstances, for their conduct. He has a gun and, irritated by the aggressive and even violent self-righteousness of the anti-abortion protesters, he starts shooting them: "It was easy. It was nothing. Just like killing babies. It is a regrettable fact that we often behave like, or worse than, those whom we most despise."

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

The National Health Service Act 1946

Some good things come in small packages: and this compact document changed the world. Its proposals opened up the possibility of modern medicine, sweeping away economic barriers to healthcare that had excluded up to half the population.

There is also a beauty in simplicity, and even in the dry parliamentary language of a bill that in its first few paragraphs sets up the first ever universal and comprehensive tax-funded healthcare system, free to all at point of use.

This is more poignant in light of the current debate over attempts to reword the first few paragraphs in a new Health and Social Care Act. The architect of the 1946 act, Aneurin Bevan, makes it absolutely clear in the very first paragraph that it is the "duty of the Minister" to "provide or secure the effective provision of services" that "shall be free of charge." Paragraph 3 also states simply that it is the minister's duty to provide hospital accommodation, medical, nursing, and other services, and the services of specialists.

Bevan's solution to the problems of a broken and bankrupt network of teaching, charitable, and municipal hospitals was also beautifully simple. Instead of subsidies to prop up flagging structures one by one, in one step he nationalised the whole network, (paragraph 6). This was to be a publicly provided service, as well as publicly funded.

The nationalisation made it possible for the first time to ensure that the various hospitals—many of them very small—could begin to work together, to share expertise, and develop clinical teams, and to plan the allocation of health resources according to needs. These later developments were not spelled out in the bill, but emerged as it was implemented.

The bill reflected aspirations of the postwar electorate that had thrown out the backward looking wartime leadership and given Labour a massive mandate for radical change. It won the support of junior doctors who saw the chance of a career structure and a national training scheme.

But it also reflects the backwardness of sections of the medical profession, who clung tenaciously to their private practice and their right to offer superior services to those with money to pay. Bevan's compromise—conceding pay beds in NHS hospitals—is set out in paragraph 5. His later 11th hour compromise, allowing GPs to remain independent contractors is not here: it was not agreed until 1948.

The new NHS was incomplete, lacking mental health, preventive, community health, maternity, and ambulance services, which were all controlled at first by county councils. Some of its language— "lunacy" and "mental defectives"—has long ago been dropped. But it was a seed boldly planted, that grew and bore fruit. It's history in the making.

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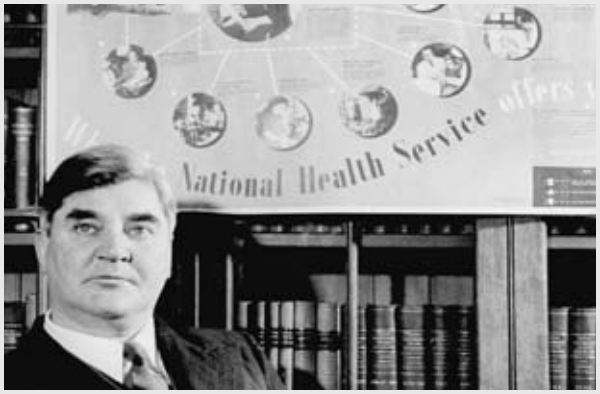

Bevan: a simple plan for healthcare for all

Bad medicine: rheumatoid arthritis

FROM THE FRONTLINE

Des Spence

In my experience there has been a dramatic decline in the severity of rheumatoid arthritis. Once common clinical signs such as ulna deviation are now rare, even on medical wards. Evidence supports my experience, with a halving of rheumatoid arthritis rates from 1955, and major declines in the rate of orthopaedic interventions.This reflects a change in the epidemiology and improvements in medical care.

But following decades of declining incidence, rheumatoid arthritis started to increase with the introduction in 1987 of new diagnostic criteria—the American College of Rheumatology criteria—and oddly only in women. There was no need for a positive rheumatoid factor nor elevated inflammatory indices to make a diagnosis of rheumatoid arthritis. Subjective features such as stiffness, pain, and synovitis became key. Recent guidelines from the National Institute for Health and Clinical Excellence (NICE) have gone further, suggesting that diagnosis should not be "constrained" by these criteria. NICE presses for early and urgent referral from general practice, even with normal investigations and limited symptoms. There is scant evidence to support this policy, and those on the development group (a group of 23, only two of whom were GPs) seem to have had little appreciation of the implications of such advice when 1 in 7 GP consultations are for musculoskeletal problems.

The early use of disease modifying anti-rheumatic drugs (DMARDs) and in combination is also recommended. Since 2005 the number of drug prescriptions for DMARDs and new biological agents has doubled with a near tripling in costs to £40m annually. A profitable business. The 2012 British rheumatology conference is currently seeking £400 000 in company sponsorship. But immunosuppressive treatments require regular monitoring and are associated with serious harms, including death.

In my experience, the diagnosis of RA is increasingly subjective, and based on soft clinical signs. Rheumatology also seems dependent on the use of "validated" questionnaire scoring systems. This approach relies on self reporting, but rheumatology need look no further than problems this has caused in pain management. These clinical scoring systems are intellectually bankrupt. Even within NICE guidelines there is an admission that there is "no evidence to support this approach . . . in mild synovitis," raising the spectre of widespread overtreatment.

A rising incidence following a background of decline, a rise seen only in women, and declining complications would strongly suggest that we are overdiagnosing rheumatoid arthritis. Even within the literature there is recognition that 10-20% of rheumatoid arthritis has a fibromyalgic variant. Worse still, new criteria may potentially double rates of rheumatoid arthritis diagnosis in the coming years. Experience and evidence suggest that we are overdiagnosing and overtreating RA. Burdening patients and the well with a life long diagnosis and polypharmacy is just bad medicine.

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Walkabout

OUTSIDE THE BOX

Trisha Greenhalgh

You will probably know (perhaps from the film *Crocodile Dundee*) that the Australian likes to go walkabout. He (or, less commonly, she) wakes up one morning, pulls on a pair of cowboy boots and a wide-brimmed hat, pockets a mean looking knife, and wanders off into the bush. Months later he will return, mud streaked and reflective, and be immediately reintegrated into family and work as if nothing had happened.

There is an academic equivalent. The Aussie wakes up and pens off 30 or 40 emails of the format, "Dear Prof, I have obtained a government grant to visit Europe/North America. I am especially interested in topic A and this links well with your own interest in topic B. The dates of my trip are . . . I will be passing through your town on . . . Please could you let me know when it would be convenient to meet up. No worries etc. "

Not wishing to appear unapproachable—but mindful of an occasion when the visitor scared the students when he arrived unshaven with cowboy boots, wide brimmed hat, mean looking knife, and bagloads of souvenirs from Harrods—I usually offer to meet immediately after work in a bar in Camden Town.

There generally follow a congenial few hours in which I apologise for British beer and s/he gives entertaining accounts of how my work has been misinterpreted and/or over-rated in Alice Springs. We find some acquaintances in common and exchange light gossip about them. At some point, I ask the Aussie to send me their paper on X and they promise to buy my latest book.

Occasionally this journey into the academic dreamtime bears unanticipated fruit. The Aussie and I find that we really do have much in common and end up writing a paper together. I once made a return trip, funded by two Australian universities under the euphemism of a "knowledge transfer fellowship," and came home six weeks later greatly refreshed and with a fine pair of cowboy boots of my own.

More commonly, I just have a laid back evening keeping a wanderer company. Apart from exchanging the promised publications and chance meetings at conferences years later, I rarely hear from them again. But as night follows day, a month after the encounter I will start getting emails beginning, "I am a friend of X and have obtained a government grant . . ."

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