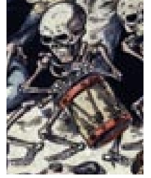
What we don't know about Enza, p 1176



Let us see the medical records of future world leaders

PERSONAL VIEW **David Owen**

Senator John McCain, when up against George W Bush to be the Republican nominee for the 2000 presidential election, revealed medical records that included details of the trauma resulting from his experiences in the Vietnam war. When it came to demonstrating a similar openness over the extensive surgery he underwent for a malignant melanoma on his face he was much less forthcoming. A press conference for medical journalists held in Arizona in May this year was in fact a video conference with his medical specialists elsewhere, and the distinguished medical journalist of the *New York Times*, Lawrence Altman, was not even able to ask a question.

Millions of voters, however, never even registered that he had had a melanoma. What concerned them was McCain's age. At 72 he would have been the oldest person to have been elected president for the first time.

Having just written *In Sickness and In Power*, a study of illness among prime ministers and presidents over the past century, I have come to three interrelated conclusions: many heads of government do not tell the public the truth about their illnesses, if they say anything at all; their personal doctors, when making public statements about their patient, also do not tell the truth; and, as a result of the secrecy concerning their medical treatment, these heads of government receive inferior treatment.

Many heads of government do not tell the public the truth about their illnesses

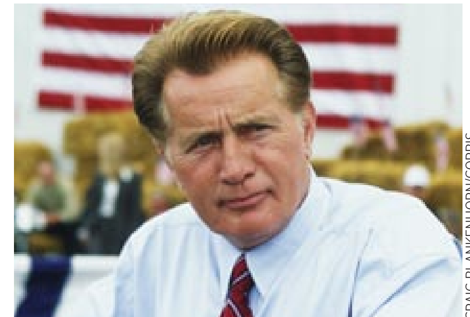
To take a few recent examples, François Mitterrand, as president of France, had for 11 years, in total secrecy, cancer of the prostate with secondary bone cancer. His personal doctor issued communiqués every six months giving no hint to the French public of Mitterrand's true medical condition. Ariel Sharon, former prime minister of Israel, had a severe heart condition while in office and pretended to the press that he was fit and well. Prime Minister Blair denied that he had atrial flutter and pretended to the public that he had only recently had problems with his heart, while telling his Cabinet colleague David Blunkett that he had had the condition for years.

I do not believe it is in the public interest that this situation be allowed to continue. Everyone who wishes to put themselves forward to the electorate as a potential national leader ought to be compelled by party rules to submit to an independent health examination that doesn't involve their personal doctors and that is assessed by people of proven independence. This would not run into conflict with any existing legislation protecting the rights of the individual. If potential candidates knew they faced independent assessment and that they had a health problem then either they would not stand or they would make it public of their own volition. For example, John Kennedy, in 1960, believed that he would never be elected president if he admitted he had severe Addison's disease. Yet there is no reason why someone who has Addison's disease should not be US president if it is well controlled with replacement therapy.

President Kennedy was a genuine war hero, and if he had been open about his illness for some years before he faced Richard Nixon there was arguably a chance that he could still have been elected. Now, however, nearly 50 years later, there is much greater public understanding of illness and less prejudice, and it would undoubtedly be much easier for candidates with Addison's disease to convince their party and the public that they were fit for office.

Furthermore, when in office a president or prime minister should be obliged to have a yearly independent medical check up, and although this would not be made public the independent doctor would be obliged to inform the deputy prime minister or vice president if he or she had any concerns about the head of government's capacity to handle the powers of office.

The medical profession should issue guidance to any doctor treating powerful leaders not to issue public communiqués or to comment on their patient's medical condition—any such comments should be made by the public figure themselves or by independent doctors.



CRAIG BLANKENHORN/CORBIS

***The West Wing*'s President Bartlet (Martin Sheen) kept his multiple sclerosis a secret from voters**

Finally, democratic countries should establish formal procedures for enabling a head of government to step down temporarily or permanently because of illness that affects their capacity to do the job. In August 1998 the prime minister of Norway, Kjell Magne Bondevik, had a severe depressive reaction. His initial decision was to resign, but he discussed the matter with his foreign minister, and together they announced publicly that he had depression. After four weeks of treatment and adapting his working practices he returned to work. His frankness was greatly respected by the Norwegian people and is widely regarded as contributing to the fight against the stigma that mental illness often carries.

No one has to stand for high public office, and it is not credible to argue that the medical condition of leaders is purely a matter for them. The decisions they take can have a major effect on the lives of millions of people, and it is not acceptable for the quality of their decision making to be impaired by physical or mental illness. They have an obligation to those electing them to be their head of government to ensure that their capacity to govern is maintained at the highest level.

David Owen is former foreign secretary, member of House of Lords, and a doctor lordowen@gotadsl.co.uk

Cite this as: *BMJ* 2008;337:a2486

Hold the carrots

FROM THE FRONTLINE
Des Spence

In less politically correct days behavioural therapy was called "sticks and carrots." Now carrots are called "incentives." Financial incentives, such as the quality and outcomes framework (QOF) system of payments, are widely used in medicine to deliver change. But even well intentioned financial incentives have many unintended and far reaching effects that can distort health care. The traditional strength of the NHS has been the absence of incentives: staff do not expect kickbacks, and the only gift is genuine, impartial advice.

Now general practitioners are being offered incentives to reduce the rate of referrals. This is a bad thing. It is not that reducing referrals isn't a good thing, but this is not the way to do it. I have a winged gatekeeper riding a Harley Davidson tattooed on my chest—holding the line is my job. I am proud of not referring. And in these healthy and educated days my surgeries are full of ill informed and well patients. Health anxiety is the scourge of modern medicine. Referral to hospital often serves only to compound health introspection and misery. Consequently I need to protect my patients from hospital colleagues who rightly seek a medical explanation when all too often no such explanation exists. The most important intervention by general practitioners is to do nothing—but to do nothing with style.

Why do referral rates keep rising? The Labour government hosed money into the NHS, destabilising what was an impoverished but essentially sound system. It misguidedly promoted "choice." This set free the devil of consumerism, driving up unrealistic and unreasonable expectations. Stupid disease awareness campaigns just sparked bush fires of health anxiety.

To reduce referral rates we need to re-establish and enforce channels of communication between primary and secondary care, not blunt incentives. More importantly we need to return to the founding values of continuity in general practice: generalism, localness, ordinariness, confident reassurance, and pride in holding that gate, whatever the cost.

Des Spence is a general practitioner, Glasgow destwo@yahoo.co.uk

Cite this as: *BMJ* 2008;337:a2511

See OBSERVATIONS, p 1141

And for my next trick

PAST CARING
Wendy Moore

COLIN CRISFORD

In the history of clinical trials, little has given doctors more pleasure than the demonstration of the placebo effect, particularly when it is used to undermine unorthodox treatments. John Hunter, the tireless 18th century experimenter, could scarcely conceal his delight when conducting a trial on the popular folklore remedy of spider's web. After secretly dosing a patient who had the "ague" with the treatment, he found that it had "not the slightest effect"; yet once his patient had been informed of the intervention, "the effect was produced," he gloated.

Convinced that mercury, the stock treatment for gonorrhoea, was largely ineffectual, Hunter gave several unsuspecting patients pills made of bread. "The patients always got well," he reported, although he added, "but some of them, I believe, not so soon as they would have done, had the artificial methods of cure been employed."

Better known and certainly more systematic were the placebo tests performed on "mesmerism," a form of hypnotism championed by the showman Franz Anton Mesmer, at the behest of Louis XVI in 1784. French scientists blindfolded patients who were subjected to authentic and fake mesmerism in—literally—the first blind placebo trials. To their joy (there was no double blinding) the researchers found no appreciable difference in outcome.

Certain that this placebo effect explained the popularity of alternative therapies in general —although not of course their own useless remedies—doctors next turned controlled trials on metal "tractors," or rods, which a Connecticut practitioner, Elisha Perkins, claimed could relieve pain by conducting "electrode" fluid away from the body.

Ingeniously constructing a sham pair of tractors from painted wood, the English physician John Haygarth tested the instrument on five patients with rheumatism in 1799. Four of the five reported a remarkable improvement, including one who could walk much more easily, prompting Haygarth to proclaim: "Such is the force of Imagination!"

Doctors next fixed homoeopathy in their sights. In a large trial in St Petersburg beginning in 1829, physicians divided army patients into three groups to receive conventional treatment, homoeopathic remedies, and placebo bread pills. Unsurprisingly the patients who received the placebos did the best. Equally unsurprisingly they did little to diminish confidence in the routine bloodletting and toxic concoctions touted by orthodox physicians.

Finally, in a landmark article in 1955, Henry Beecher described the power of the placebo effect in conventional and unconventional medicine alike. But as far back as 1689 the London physician Gideon Harvey had already given a passable description. Berating his orthodox colleagues, Harvey proclaimed, "It is to the Art of Expectation Physicians are indebted for their Reputation, that occasions an ignorant world to continue the use of them."

Wendy Moore is a journalist, London
wendymoore@ntlworld.com

Cite this as: *BMJ* 2008;337:a2492

Murder most ordinary

BETWEEN THE LINES
Theodore Dalrymple

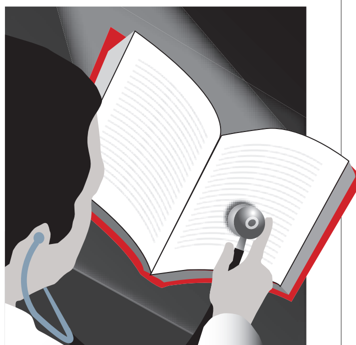
Perhaps it is only my nostalgia for the good old days, but I can't help believing that coroner's courts used to be less hostile to—or merely less searching of—doctors than they are now.

The first time I ever attended a coroner's court is etched on my memory. For some reason, the flat and monotonous voice of a pathologist, reading out the findings from his postmortem examination of a murder victim over the public address system in the lobby of the court, was more soothing than, say, pop music.

I realised I had nothing to fear when the coroner assured the family of the deceased in the case before mine, a man who died as a result of the most lamentable medical incompetence, that everything that could have been done to save him had been done. Now, of course, it's the other way round: when everything that could have been done has been done, the relatives are still left with an impression of malfeasance. Which kind of misapprehension is better?

Another thing that has changed about coroner's courts is their location: in A A Milne's *The Red House Mystery*, his only detective novel, which he wrote in 1922, before Pooh, Tigger, Roo, and Eeyore made him really famous, the inquest on the deceased took place in the local pub, The Lamb. (In Victorian times they went one better: the postmortem examination of John Parsons Cook, the racing friend of Dr William Palmer, whom he allegedly poisoned with strychnine, took place in the saloon of the Talbot Arms, in which establishment Cook had met his untimely end.)

Also different today is the speed of inquests after death. The inquest on the deceased in Milne's story takes place three days after he is killed. That wouldn't happen today—now an inquest can take place three years after a death. The few that I had to attend in the latter part of my career concerned cases so old that I no longer had any direct recollection of them and had to rely for my evidence entirely on the notes. If the deceased person had come back to life and walked into the court I should not have been surprised, for the simple reason that I wouldn't have recognised him or her.



If the deceased person had come back to life and walked into the court I should not have been surprised

Considering that Milne's dead man was murdered, it is strange how, at the inquest, the medical evidence was so perfunctory. Sometimes it seems to me that we have gone straight from being slipshod to being pedantic without passing through being reasonable.

One little episode at the fictional inquest reminded me of something that happened long ago in my own family. In the story a man called John Borden gives evidence that he recognised the man who is the prime suspect at a railway station (he couldn't have done so, because by then he was dead).

"There's always a John Borden at every murder case," the amateur detective who eventually solves the case says to himself.

I had a great uncle whose maid was brutally done to death in his flat. The murderer was seen leaving my uncle's flat in his grey Homburg hat, and a neighbour swore that it was my uncle, who became the prime suspect and narrowly missed arrest and trial as a result. The murderer, of course, turned out to be the young man with whom she was walking out.

Denouncers and calumniators there are aplenty, whistleblowers very few, the penalties for the second category being so much greater.

Theodore Dalrymple is a writer and retired doctor

Cite this as: *BMJ* 2008;337:a2490

MEDICAL CLASSICS

The Surgeons By Jean-Édouard Vuillard

Painted 1912-14; reworked 1925, 1937

Being a patron of the arts might seem beyond the means of most doctors now, but this was not the case for Antonin Gosset, who was the top Parisian urologist when he commissioned a portrait (now in a private collection) of himself performing an operation in 1912 (www.nga.gov/exhibitions/2003/slideshow/slide-171-12.shtm). The artist was Jean-Édouard Vuillard, a Parisian post-impressionist who also turned his hand to printing and the emerging art of photography. He painted interior scenes of ordinary life, including of workers at their daily tasks, and designed sets for theatre productions; and while the "theatre" in this painting would not be familiar to the general public, it is a good example of his typical use of subdued colour schemes. The painting is almost entirely composed of varying shades of white—and with a few changes to the anaesthetics shown, it could have been painted recently.

It is considered one of Vuillard's masterpieces of the period. Completed by 1914, it was reworked in 1925 and again in 1937. The artist made detailed preparatory sketches on many visits to the operating theatre, but the final overall effect is somewhat blurred, perhaps in keeping with the dynamism of the theatre—although details such as the patient's lithotomy position and Trendelenburg tilt are perfect. Just as preoperative tests and examinations are carried out before a knife is committed to skin, the artist made a considered assessment of the task before committing oil to canvas.

Vuillard: not shy about depicting disease

COLLECTION ANNETTE VAILLANT/ARCHIVES CHARMET/BAL

Vuillard was not shy about depicting disease and its treatment. He also painted a dentist friend at work, and one of his best loved portraits is that of a woman with mumps. This "fly on the wall" depiction of subjects became known as intimism; the exposure of a person's viscera on the operating table can certainly be considered intimate. Surgery, an art in itself, is not an obvious subject matter for a painting, but this work has much in common with Rembrandt's 1632 painting *The Anatomy Lesson of Dr Nicolaes Tulp* (*BMJ* 2008;336:1075, doi:10.1136/bmj.39559.677708.3A), and its influence was perhaps later reflected in Christian Schad's 1929 painting *The Operation*. It is a good reflection on artist and on patron that this snapshot view was chosen rather than a staid portrait. In fact, all we can see of Dr Gosset is the back of his neck.

The walls of the theatre are tiled and the floor bloodstained. Perspective draws the eye towards Dr Gosset along the line of medical students and a trolley strewn with soiled swabs. This was the new post-Lister era of safe surgery under anaesthesia, and surgical specialties such as urology were beginning to emerge. The doctors are all men, and they are wearing street clothes under their gowns, but the painting shows that the surgeon's outer garb has changed little over the years.

Hugh Byrne, specialist registrar in obstetrics and gynaecology, North West Thames deanery hughbyrne@hotmail.com

Cite this as: *BMJ* 2008;337:a2496

REVIEW OF THE WEEK

Darkness falls

We don't know where the great flu of 1918 came from, or whether it will come again, finds **Tom Jefferson**

One of my earliest memories is hearing the words "Stai buono, altrimenti viene a prenderti la spagnola" ("Be good or the Spanish lady will come and get you"). Such was the folk memory of the devastation of Spanish flu that my nanny from Abruzzo used it as a threat to keep me docile. The dark and menacing image that the threat still evokes in me finds an echo in Mark Honigsbaum's book *Living with Enza*, whose title is inspired by a gruesome contemporary skipping rhyme: "I had a little bird, its name was Enza, I opened the window, and in-flu-enza."

Honigsbaum's story takes us through the three waves of Spanish flu, in the spring, late summer, and winter of 1918-19. The book aims to redress the scant attention paid to the pandemic in many biographies of those who witnessed its effects by giving us a picture of what it must have been like to live with "Enza" in Britain, through the memories of the rich and powerful but also through the eyes of the common people and the efforts of public health officials.

The third wave, which manifested itself at the very end of the first world war and continued into the late spring of 1919, was the most deadly. But all three waves brought misery to a world emerging from four years of bitter war. The flu's body count was mind boggling, though it was democratic, taking the lives of famous poets (such as Guillaume Apollinaire), rich young men, Arthur Conan Doyle's son Kingsley, and war heroes such as Captain William Leefe-Robinson, the first British pilot to shoot down a German airship over Britain, as well as tens of thousands of mostly young men and women, leaving widows, widowers, and orphans everywhere.

The book is at its most powerful when it links the events at home in Britain to those on the war front that formed the backdrop to the three waves of the pandemic: the German Kaiserschlacht offensive of the spring of 1918; the subsequent offensive by the Allied forces in the summer, leading to the breach of the Hindenburg line; and the subsequent collapse of the German and Austrian will to carry on fighting and, finally, the armistice.

In an interesting postscript to the main story, one of the flu's most illustrious victims was the US president Woodrow Wilson, who was visited by Enza while at the peace conference at Versailles in April 1919. Observers speculated at the time that, although he recovered, Wilson was never the same man again, and his will not to impose punitive terms on Germany at the peace table may have been fatally undermined by his experiences.

Historical caricature of the 1918 pandemic

CCI ARCHIVES/SPL

The last part of the book is devoted to the present day spread of what is considered the most likely candidate to replace the 1918-19 virus in the gallery of rogues: the now infamous H5N1. Honigsbaum imagines a scenario in which the 2012 Olympic Games are the epicentre of a pandemic imported into Britain by the Chinese team.

But the part of the book I liked best—perhaps for the wrong reasons—is the epilogue. In it we are given a summary of the exceptional features of the Spanish Lady. It starts by giving us a glimpse of the type of callous logic that recently brought the world financial market to its knees. The money men of the Prudential Assurance Company, then the main life insurance company in England, expressed shock at the huge sum they had to fork out for victims of the flu, £650 000, whereas in comparison it paid out £275 000 to war widows and orphans. Of course, a notable feature was that Enza largely took those in their prime, who were more likely to be insured, not the uninsurable.

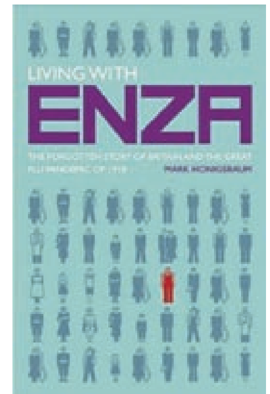
The very high mortality rate of the second and third waves is one unexplained fact, as are the peculiar perilabial cyanosis of the victims (heliotrope cyanosis) and the extreme severity of the disease, which quickly led to respiratory failure. Explanations offered at the time (and since) for the death rate include massive troop movements, stress among combatants, undernourishment, and cumulated grief on the home front. However, such factors do not explain the virtual devastation of remote or isolated communities (such as the Inuit of Alaska) or the toll among nations that had not taken part in the war. Social position, as we have seen, was no protection against flu either.

However, in his summary Honigsbaum omits perhaps the most important characteristic of the pandemic: the very well documented near synchronous appearance of outbreaks in places thousand of miles apart. This aspect cannot be explained by jet travel (in an era of planes made of wood and canvas), nor by human or bird migration. As Honigsbaum does point out, contemporary travelling times were incompatible with the documented spread of the pandemic.

Honigsbaum's main conclusion is supported by the most impressive of the experts he interviewed, Jeffery Taubenberger, the leading researcher in the team that sequenced the genome of the Spanish flu virus: despite all the scientific progress made since the first world war we still do not know where Enza came from, where it went, or indeed if and in what guise it will fly in again.

Tom Jefferson is at the Cochrane Acute Respiratory Infections Group
Jefferson.tom@gmail.com

Cite this as: *BMJ* 2008;337:a2501



Living with Enza: The Forgotten Story of Britain and the Great Flu Pandemic of 1918
Mark Honigsbaum
Macmillan Science, £16.99, pp 227
ISBN: 978-0230217744
Rating: ★★☆☆

Honigsbaum imagines a scenario in which the 2012 Olympic Games are the epicentre of a pandemic imported into Britain by the Chinese team