VIEWS & REVIEWS

A medical classic written for the bass viol, p 305

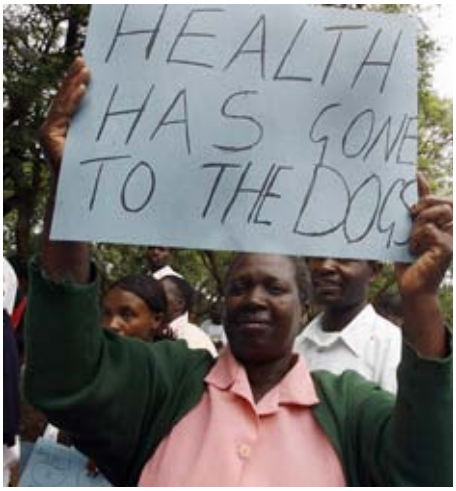
Zimbabwe's health system is starting to function again

PERSONAL VIEW **Kate Adams**

I was apprehensive as I returned to Zimbabwe in May this year. I had last visited in November 2008, a low point in Zimbabwe's recent history, and wrote a personal view about my visit (*BMJ* 2008;337:a2637). At that time the country had hyperinflation, there was no food in the shops, people were hungry and depressed, and the health system was in a near state of collapse.

The Government of National Unity, a coalition between Robert Mugabe's ZANU-PF party and Morgan Tsvangirai's Movement for Democratic Change, was formed in February 2009. Soon after, the Zimbabwean dollar was suspended after a period of hyperinflation, which became so out of control that at one point one South African rand was worth 50 trillion Zimbabwean dollars. No one could continue to trade under these extreme conditions, so adoption of the US dollar eased the crisis.

Arriving in Bulawayo I immediately noticed more vehicles. Petrol is now available, and more trading is taking place. Communication is much easier now that Econet, a telecommunications company, has expanded. The shops have food, which has made life much easier for people who have money, although the prices of most commodities and utilities put them out of reach of most people, many of whom continue to depend on the



DESMOND KWANDE/AFP/GETTY IMAGES

That was then . . . but now there is some optimism

Some healthcare professionals are beginning to return, though people remain anxious about the country's stability and their own prospects

World Food Programme. The average monthly wage is $150 (£95; €110), 90% of adults are unemployed, and 70% of children can't afford the fees to attend school. Power cuts continue.

At last the health system is beginning to function. I visited one of the public hospitals in Bulawayo. When I last visited, the nursing staff had gone on strike, most patients were malnourished, there was no soap, and very few drugs and tests were available. Now the hospital is well staffed with nurses, and morale has improved; the Global Fund to Fight AIDS, Tuberculosis and Malaria tops up staff members' salaries, so at last they now receive an income they can live on. The wards were almost full, though conditions in certain areas remain basic. Some of the ward windows were broken, and the weather was uncharacteristically cold. User fees continue to act as a barrier to access to care.

HIV related disease pervades almost every clinical encounter, and I wonder what the hospital would be like without it. Eighty per cent of the adult patients have advanced HIV disease, many also with tuberculosis. Patients continue to present with pellagra. Around the country outbreaks of measles occur, as immunisation rates have fallen. Shortages of drugs persist, including some essential intravenous antibiotics. The switchboard remains out of action, but the CD4 count machine has been fixed.

There are also contradictions. The laboratories cannot test creatinine, yet a renal dialysis service has started up. I met the longest surviving dialysis patient, most patients with renal failure having died. Each dialysis session costs $80, with erythropoietin costing between $80 and $120 a month.

Zimbabwe has just 900 working doctors, including only 19 paediatricians, for a population of about 10 million; the United Kingdom has 180 000 doctors for a population of 60 million. Some healthcare professionals are beginning to return, though people remain anxious about the country's stability and their own prospects, given the ongoing political situation and human rights abuses.

After three years the 800 bed hospital now has a haematologist, who provides a daily bone marrow biopsy service. There is a child with a haemoglobin count of 3 g/dl, thought to be the result of a haematological malignancy, and his bone marrow biopsy is done that day.

I attended one of the busy community clinics and was struck by the experience, diligence, and patience of a former Médecins Sans Frontières doctor. He sees patient after patient, some whose treatment for tuberculosis is failing and many who are coinfected with HIV and are very sick. One woman is a walking skeleton, and I'm amazed that she is able to walk unaided. The doctor is trying to build up her weight and strength before she is started on antiretrovirals (ARVs). The family reports an improvement. We see other patients who are being followed up and are now well on ARVs and treatment for tuberculosis. ARVs are available for those who need them, through the Global Fund, although there is a waiting list; the clinic is starting 20-40 new patients a week on treatment. Children of 13 and 14 years old are beginning to present, thought to have contracted HIV via vertical transmission, and are termed slow progressors.

I visited Murambinda hospital in Buhare district, a 200 bed mission hospital, and was impressed with the quality of services and care provided. The hospital is part of a tuberculosis programme striving to spread the reach and improve the quality of care to patients with the disease and those coinfected with HIV. Now that the laboratory service is more reliable, the programme is beginning to look at the serious problem of treatment failures and multidrug resistant tuberculosis.

At last there is some optimism in Zimbabwe—but there is a long way to go, as the political system remains fragile.

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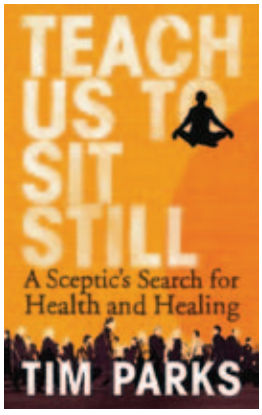
REVIEW

Prostate pain: a long, long story

One man's story of his illness underlines the gap that often exists between doctors' and patients' understanding, finds **Christopher Martyn**



Teach Us to Sit Still: A Sceptic's Search for Health and Healing
Tim Parks
Harvill Secker, £12.99, pp 352
ISBN 978-1846553998
Rating: ★☆☆☆

Back in the 1970s, before student railcards had been invented, it was OK, if you were a bloke, to stand at the roadside and thumb a lift. Being poor at the time, I did it quite a lot. The discomfort and unreliability were offset by the idea that this was a countercultural, romantic way to travel. Even when cold and wet you could kid yourself that you were following in Jack Kerouac's footsteps. The most exciting rides were in big articulated lorries for their lofty view of the landscape and the casual aplomb with which the drivers controlled their huge loads. The dullest were from lonely old codgers who picked you up because they wanted someone to talk to. Until I learnt to say "biology" when asked what I was studying, admitting that I was a medical student usually provoked the telling of a long story featuring baffled doctors, an operation in the nick of time, and the largest gallstone (or hernia or aneurysm) that the surgeon had ever seen.

The first 200 pages of *Teach Us to Sit Still* reminded me of such stories, although its author is far less restrained than the kindly people who gave me lifts. He describes in unembarrassed detail not only his chronic intermittent lower abdominal pain, nocturia, and other difficulties with micturition but the circumstances in which they occur. We learn, for instance, that he needed to defecate four times just before embarking on a kayaking trip and what a serious problem this poses if you're wearing a wet suit. On another occasion, in a restaurant lavatory, his urinary stream is so feeble that the light, on an automatic timer, goes out, leaving him in the dark with a half emptied bladder and unable to locate either the pan, the switch, or the way out.

Fortuitously he has a friend who is a urologist. It's not clear whether a history is taken or an examination performed, but prostate specific antigen measurement, bladder ultrasonography, radiography, and cystoscopy are arranged. Everything turns out to be normal—or at least insufficiently abnormal to explain the symptoms. He declines an offer of transurethral resection. A trial of α blockers leads to unacceptable adverse effects.

At a conference in India he takes the opportunity to consult an ayurvedic practitioner who detects a block in the flow of "vata" (not a joke: vata is one of the three ayurvedic bodily humours, along with kapha and pitta) and recommends enemas of sesame oil and herbs and the construction of an astrological birth chart, both of which he rejects. Then comes a trip to Harley Street, where his symptoms are given a label of bladder neck dyssynergia, and a second trial of α blockers is recommended. For reasons he doesn't fully explain he's sure that drugs aren't the answer and vows not to see any more doctors.

Instead he resorts to the internet. Googling "prostate pain" produces endorsements for royal jelly, zinc supplements, fresh parsley juice, and much else. In the end he realises that the multiplicity of cures on offer can mean only that none of them works. He does, however, order a book with the ridiculous title *A Headache in the Pelvis*. When it arrives he reads that he really needs to travel to California for a special type of anal massage, but he makes do with exercises to promote something called respiratory sinus arrhythmia breathing, which is a preparation for something else called paradoxical relaxation. He finds that this helps a bit. Next he tries shiatsu massage.

By now you must be as bored as I was. And we still haven't reached the dénouement. I don't think that I shall be spoiling anything for anyone if I say that eventually he found that learning to meditate brought an end to the pains, although he doesn't say whether he can pee any better.

Obviously this book wasn't written for doctors, and I'm doubtful whether they will enjoy it much. They will have heard versions of this story many times before from their own patients whom they tried hard, but failed, to help. Indeed at one level this particular narrative is little more than a long and self absorbed account of the inner journey of a man desperately seeking meaning in and relief from chronic (but not incapacitating) symptoms, who eventually manages to find both through visipanna meditation. Yet before dismissing it entirely it's worth remembering that the author is a successful writer and academic—one of his novels was shortlisted for the Booker prize—and probably a lot cleverer than we are.

Recently John Launer suggested that the abbreviation MUS, usually taken as shorthand for medically unexplained symptoms, should really stand for medically unexplored stories (http://pmj.bmj.com/content/85/1007/503.full). He argued that the narrow focus of the typical clinical encounter fails to give patients an opportunity to construct a meaningful narrative about their symptoms. Although the way in which doctors interpret signs and symptoms often leads to beneficial results, patients frequently find the explanations they offer inadequate and unsatisfying.

These explanations, Launer thinks, must often seem like the substitution of an authoritarian medical account for the specific description brought by the patient. Perhaps he's right. If so, the moral of the story told by Parks is that intelligent, educated, and apparently rational people may think about their health and illnesses in ways that hardly begin to overlap with ours.

Intelligent, educated, and apparently rational people may think about their health and illnesses in ways that hardly begin to overlap with ours

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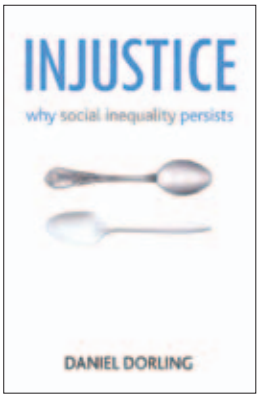
bmj.com/video
Professor Michael Marmot, chair of the World Health Organization's commission on social determinants of health, discusses the effect of the world's financial crisis on global health in a *BMJ* video at www.bmj.com/video

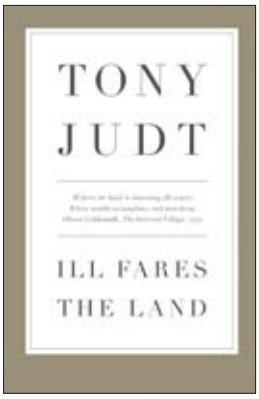
REVIEW

How can we rediscover the magic of more equal societies?

The Nordic societies and Japan have kept the faith with the goal of social equality. Why can't the rest of the world, asks **Robin Stott**



Injustice: Why Social Inequality Persists
Daniel Dorling
Policy Press, £19.99, pp 400
ISBN 978-1847424266
Rating: ★★★☆



Ill Fares the Land: A Treatise on our Present Discontents
Tony Judt
Allen Lane, £20, pp 256
ISBN 978-1846143595
Rating: ★★★☆

Inequality is a significant marker for and cause of poor health. Why is it so persistent, and why isn't there a much greater clamour about it? Both these books explore these issues.

Both attribute the emergence of fairer societies after the great depression to enlightened public policies, such as genuinely redistributive taxation, regulation of the banking systems, and introduction of the welfare state. These were made possible by shared values of peoples drawn into the collective struggle to survive the depression and subsequent wars. Public service—personal action for the collective good—was widely considered to be an honourable and fulfilling way of life.

So by the end of the 1950s want, ignorance, disease, squalor, and idleness—the ills that William Beveridge defined in his report that formed the basis of the UK postwar welfare state as those most necessary to combat—had been much reduced. The United Kingdom and the United States were fairer societies than they had ever been; but with the felling of the Beveridge giants an unforseen new social dynamic emerged. No longer did our rich Anglo-Saxon societies believe that individual aspiration could be met through public action. Action for purely personal gain became the norm. Not so much, "What needs to be done for the public good?" but "What can I get for myself, preferably with tacit public approval?"

Dorling is crystal clear in believing that this came about because the powerful were anxious about losing their privileges in a more equal society. Implicitly and explicitly, the powerful recognised that the elevation of the market to be the arbiter of good policy was likely to consolidate their hold on power. So instead of actions being for the public good, they had only to be for the market's good. Over the next 50 years the huntsmen of the apocalypse regrouped, added a fifth steed, and came galloping into our society in the guise of elitism, exclusion, prejudice, greed, and despair.

Dorling warns that all of us in the more privileged sections of society buy into one or other of these perceptions. Are the poor really less able, the bankers more deserving, the gated communities more important, the children of the rich more worthy recipients of the best university education, the poor innately more likely to commit suicide, become depressed, and fall into despair? Shouldn't the children of the rich be enabled to inherit their parents' property without paying much inheritance tax? Both authors (Dorling in a more forensic and hard hitting way) believe that many people in society's privileged sectors hold such views. Thus the everyday life of communities entrench the inequalities, making it ever more difficult to reverse them.

The Nordic countries and Japan have kept the faith, with equality as a societal goal. Their excellent health statistics testify to the benefits this brings and exemplify the truth of the fairness proposition. How can the rest of the rich world, particularly the UK and US, rediscover the magic of more equal societies? Neither author offers a blueprint; but both suggest that local community organisation—opening the political space for dissent and constructive dialogue—and brave leadership would help the vital change in thinking that they say is essential.

Because they don't examine policy options in any great detail, neither book explores how narrowing the wealth gap in rich countries will reverse the even greater injustice of our times: the spiralling gap between the have and have not nations. So while I can understand their reluctance to explore the ways forward, not doing so is a serious flaw in these otherwise thought provoking books, for surely any solutions proposed for rich nations must also address this gap. There are now fresh ideas, such as a global commitment to a fair shares deal for climate change (www.climateandhealth.org) and direct transfers of money to poor people, which would move us to a fairer society locally and globally and which afford health professionals specific platforms for advocacy.

It's clear that the health professions, which for at least 30 years have had excellent evidence about the importance of inequality to health outcomes, have not offered the leadership to combat the problem

In making it clear that they aren't offering solutions Dorling and Judt are staying true to the intuitively attractive Australian Aboriginal saying, "Traveller, there is no path, paths are made by walking." But surely we now know enough to put an occasional signpost in the sand?

Our collective inability to act on the good information that we have made reading these books unsettling. The health professions, which for at least 30 years have had excellent evidence about the importance of inequality to health outcomes, have not offered the leadership to combat the problem. Furthermore, in our own lifestyles and choices we often perpetuate or even aggravate inequality. Are we collectively buying into the view that Sophocles offers Electra's sister as a justification for her inaction: "Sometimes justice is too high a price to pay"?

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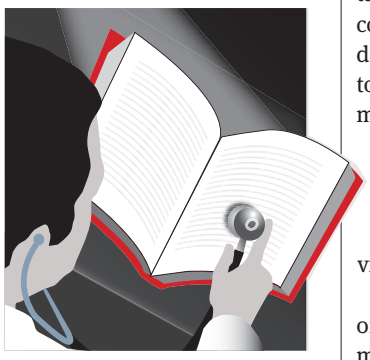
See RESEARCH, p 291

A slippery slope

BETWEEN THE LINES
Theodore Dalrymple



Most of the doctors who take part in Dr Hashimoto's experiment are motivated by ambition and are discomfited not by their conscience but only by the prospect of exposure and disgrace

Many writers have been doctors; some have been medical students who never qualified; yet others contemplated medicine as a career but chose otherwise. In the third group is Shusako Endo, a Japanese novelist. He chose to study French literature instead of medicine.

One of his most powerful novels is *The Sea and Poison*, about a young doctor in wartime Japan who, through being too weak to refuse, takes part in a murderous experiment on an American prisoner to find out how much of the lung can be cut away before death ensues.

The book was published in 1958, well before the scale of Japanese forced experimentation on prisoners and others, mostly in Manchuria, was generally known. It was a brave book, for it tackled a subject that was about as uncomfortable as a subject can be. It won one of the most important literary prizes in Japan and was translated into English, but the subject was soon relegated to the back of the world's mind for another few decades.

The protagonist of the story is Dr Suguro, who works as a junior in a university unit devoted to the treatment of pulmonary tuberculosis by surgical means. The author delineates the slippery slope down which not only Suguro but all the other doctors, including the chief, Dr Hashimoto, known as "The Old Man," slide.

Dr Hashimoto is determined to become dean of the medical school after the death of the former dean. He thinks he will strengthen his chances of election if he performs a successful and spectacular operation on a young female relative of the former dean who happens to have tuberculosis.

The operation is a catastrophe; the patient dies on the table. There is then a cover up: the patient, dead, is taken back to her room and her mother told that the operation went well, though the next days are so dangerous that no visits are allowed.

Endo's description of the operation is a masterpiece of compression; the tension is such that one's heart beats faster as one reads, like the heart of the sinking patient.

After the operation Dr Hashimoto's chances of being elected dean are slim. He tries to regain favour by agreeing to the request of military doctors that he should experiment on US prisoners who are due to be executed anyway. One is rather reminded of the notorious Dr Kevorkian, who advocated medical experimentation on condemned prisoners in his book *Prescription: Medicide, the Goodness of Planned Death*.

Most of the doctors who take part in Dr Hashimoto's experiment are motivated by ambition and are discomfited not by their conscience but only by the prospect of exposure and disgrace, which they hope to avoid by a conspiracy of silence. They know shame but not guilt.

The book is all the more powerful for being quite short. Pascal once apologised for the length of his letter, saying that he had no time to write a shorter one. It is as wrong to suppose that the importance of a book is proportional to its length as to suppose that the moral deformations of which Endo writes are confined to one nation.

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

Tableau de l'Operation de la Taille (Picture of a Lithotomy), from the 5th Book for Bass Viol

By Marin Marais **First published 1725**

The bass viol (also known as the viola da gamba) is a supremely expressive but delicate musical instrument. It has been described as the closest an instrument can come to the human voice but was eclipsed by the more robust cello for several centuries

However, a renaissance over the past four decades has allowed us to enjoy again this subtle and emotionally direct instrument. Marin Marais (1656-1728) was one of the greatest of composers and performers of the viola da gamba, and his music gained a wider audience with the 1991 film *Tous les Matins du Monde*. Although little is known of Marais's personal life, through his work we glimpse a wonderfully flexible and humorous musical personality. For example, *La Gamme* (*The Scale*) is a wonderful fantasy based on the notes of the scale but incorporating all the latest fads from Italian opera.

Some of his works have medical themes, of which the most famous is the description of an operation to remove a bladder stone. The piece is short, as was the operation in those days—a skilled operator could perform the task in just under a minute. The course of the operation is easy to follow. Onomatopoeically there is a tremolo when the patient confronts the medical equipment; a rising diatonic scale when mounting the operating chair; descending parallel thirds when the catheter is introduced; fast and (for a viola da gamba) high pitched tremolo during the operation itself; punctuated rhythm in alternating fourths and rests finally dying away, representing the weakening flow of blood; and descending melodic movements when the patient is taken to bed.

The tonal structure mirrors the tension: the preparation of the operation in E minor, the preparation of the actual incision in a quasi-undulating harmony, the painful part of the operation in the subdominant A minor, and the care of the patient after the surgical treatment in a modulation back to E minor. The suite's next movement, les Rélevailles, pictures the recovery and joy on surviving the operation, not surprising considering that nearly half of those who underwent the procedure died. We do not know if Marais underwent lithotomy himself, but commentators suggest that the intensity of the musical experience is consistent with an intimate experience of this brief but brutal experience.

Did Marais undergo lithotomy?

For a doctor the fruits of listening to this piece are many. Apart from its innate musical pleasures it is in many senses a visceral time capsule of the origins of surgery, the ingenuity and hubris of our predecessors, and the importance of speed in medicine and surgery. Marais also caught some of the excitement of new developments in urology, which were propagated in France during his lifetime. The lateral perineal approach was pioneered by the surgeon Pierre Franco in the 16th century and popularised by an untrained pseudo-monk, Jacques de Beaulieu (1651-1714), possibly the Frère Jacques of nursery rhyme fame.

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bmj.com/podcasts

An extract of a recording of this music is included in this week's *BMJ* podcast (http://podcasts.bmj.com/bmj/), with the kind permission of the Orpheon Foundation. For more information and/or to order a CD of the recording, visit http://web.mac.com/vazquezjose/iWeb/EU-Project/Operation-Marais.html.

Hair haters

FROM THE FRONTLINE
Margaret McCartney

Des Spence is away

Summer time, and the hair removal business is in full strip-off swing. Salons offer waxing from toes to eyebrows, and no longer is it only women and Tour de France cyclists who are proffering their sprouting legs in exchange for smoothness and pain but the modern male too.

Vaniqua is a relatively new intervention with an internet presence. It is a cream, 11.5% eflornithine; and its manufacturer tells health professionals that facial hair is "a common problem worth taking seriously." The official website offers a five question test for women to assess whether they have a problem ("unwanted facial hair remains a social taboo that can cause women anxiety, embarrassment and even contribute to psychological distress . . . Approximately 40% of women report having some degree of unwanted facial hair . . . Does unwanted hair growth make you feel sad? Are you keen to reduce your unwanted hair growth?" and so on).

Are we really in the midst of an epidemic of such mirror inflicted misery? UFH—the newly awarded acronym ensures that we pay attention—is something that women are being encouraged to take to their doctors. "Unwanted facial hair is a social taboo . . . Many people, and even some doctors, may be unaware of how disruptive unwanted facial hair can be in a woman's life . . . Work with your doctor, if necessary, to help him or her understand . . . It is a serious medical condition because it detracts from your quality of life."

And does it? Hair isn't dirty—something so common might even be normal. Is a cream (at just under £30 (€36; $47)) that can cause acne and burning sensations worth it? Sure, there are likely to be women with hormonal problems such as polycystic ovaries at one end of the scale, but should all female facial hair go unwanted? Should we all be ashamed and persuade our doctors to write prescriptions?

If still unwanted, then perhaps it can be a little more accepted. The salon I go to is owned and run by women of Indian and Pakistani origin. Threading, requiring nothing more than a reel of cotton and an occasional pair of scissors, are the only tools of their trade. The thread is twisted and wrapped around the offending hairs: a few minutes and a few pounds, and you're done.

The typical British beauty salon consists of private rooms to which you are led and where your imperfections shall be dealt with in strict confidence. In my salon your facial hair is removed without fuss and in full view of the waiting room. There is no shame. This is normal, and it's what you do. Have a glass of water, and tell us how your holiday was. The first time, centre stage, I was a little embarrassed; the second time, a little braver. I asked if they did other bits of the body as well. Did they? The look was one of horror. "No, no," said my expert threader. "No! everything else is—just fine."

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Ye olde Tudor health market

PAST CARING
Wendy Moore

COLIN CRISFORD

For choice and control in health care it would be hard to beat the Tudors. The creed of "no decisions about me without me" was fundamental to the buoyant Tudor healthcare market. And the average Elizabethan with a lingering venereal sore or a troublesome bout of scaldhead (ringworm of the scalp) could rejoice in a bounty of health providers offering a colourful array of therapies.

Sixteenth century medicine was a cut throat business, with intense rivalry between practitioners competing for work. With an estimated ratio of one practitioner for every 200 patients the Tudors were spoilt for choice. And although the College of Physicians did its best to lord it over London's surgeons and apothecaries, the vast majority of healthcare providers in the capital and elsewhere were unlicensed, unregulated, and largely uneducated. So a city such as Norwich between 1550 and 1640 could boast an impressive 174 medical workers, including 22 doctors of medicine, 46 barber surgeons, 36 apothecaries, and one "astrologer, glover, and empiric," along with assorted midwives, bonesetters, stonecutters, and herbalists, all eager to offer a sure cure for bubonic plague or a guaranteed remedy for smallpox.

It is little wonder that William Clowes, surgeon to Elizabeth I, cautioned his readers "not to commit themselves into the hands of every blind buzzard that will take upon them to let blood" and to avoid the "runagates and vagabonds" who did "daily abuse Physic and Surgery having no more perseverance, reason or knowledge in this art than has a goose."

He need not have worried. The Tudor afflicted knew how to drive a hard bargain. With admirably high expectations Tudor patients negotiated sophisticated contracts that promised impressive outcomes for fixed prices. Inevitably there were rich pickings for the lawyers. A complaint in 1575 found one hapless surgeon guilty of failing to cure a woman of the "morbo gallico (syphilis)." Offered a choice between paying a fine and fulfilling his contract, he wisely agreed to a fine.

The wily burghers of Norwich often struck contracts with local practitioners to treat the city's poor that paid half the money in advance and half after recovery. So Miles Mayhew received 30 shillings up front and 30 shillings later for successfully removing bladder stones from one patient. But did this cornucopia of medical choice succeed in "liberating" the Elizabethans from disability and disease? Hardly. Poorly regulated, and faced with mounting social problems and intractable public health challenges, ye olde Tudor health market had no chance.

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