John Updike, diagnostician of the human condition, p 242

"You can't have swine flu"

PERSONAL VIEW **Susan Mayor**

"Never assume" is a good maxim for life in general, but it seems particularly apt as we try to get to grips with the first major new disease to hit us for some time.

I immediately dismissed the possibility that I may have had swine flu when I suddenly developed a high temperature, headache, sore throat, and cough on the last day of attending a major oncology congress in Orlando, Florida.

At the time (the end of May) only a small number of British people had developed the infection after holidaying in Mexico. I hadn't been to Mexico, so I couldn't have it. And as a freelance medical journalist and editor I can't be ill—otherwise news stories don't meet their deadlines, pages go empty, and I don't get paid.

After downing two ibuprofen pills I wrapped up some reports, finished my packing, and made my way to the airport. I coughed throughout the flight to the United Kingdom but put that down to the air conditioning. My overwhelming need to lie down when I got home and my sore eyes I put down to jet lag. The need to stay in bed for the next couple of days I attributed to a virus I had picked up at the congress.

Having promised to act as news editor on the *BMJ* that Friday, I dragged myself out of bed, dosed myself up with ibuprofen, headed to the office at BMA House, and edited news stories all day. I couldn't still be ill, as I had used up my assumed time limit of 48 hours to get rid of a virus. But only too aware that I still felt unwell, I avoided going too close to anyone, and no one got a hug or kiss that day. I made sure I sneezed into a tissue and washed my hands regularly.

My observational study (n=1) suggests that the assumption that swine flu causes only mild illness may have been simplistic

I agreed with the duty editor when he said that he was fed up with stories on swine flu and that he didn't think it was really going to come to anything anyway, so I suggested that we put stories online but not in the print issue of the *BMJ*.

I coughed so badly during that night that I had to stand up to get my breath back, and my husband thought I needed some medical advice. After phoning our general practitioner, whose office was closed for the weekend, he took up their telephone answering machine's suggestion to phone NHS Direct. The person on the phone asked to speak directly to me, and I croaked my way through their questions, rather surprised to be moved up to the next level—the combination of symptoms (sore throat, dry cough, headache, high temperature, sore eyes, feeling very sick, and muscle aches) seemed to be the trigger.

We came to the million dollar question: "Have you been abroad recently?" Yes, but not to Mexico, only to the United States. The US was now considered at high risk as well, so I should be tested for the virus, the NHS Direct nurse said, adding that she would contact the nearest GP to get them to come and test me.

"You can't have swine flu," argued the rather grumpy GP phoning from the nearest deputising service. Another assumption. She had asked what my temperature was, and I had admitted that I didn't know, because I'm not the sort of person who ever checks their temperature (I don't even own a thermometer). The defining characteristic of swine flu is a particularly high temperature, so you can't have it, she said, with a slightly perverse logic.

And from whom had I caught it? Again, I had to admit that I didn't know—but I added that it may have been one of the 30 000 oncologists at the meeting I had just attended. After taking advice, she called me back and said I had better be tested—but they couldn't come out to me, so I would have to drive to the surgery and be tested in the car park. In the end, I was led into the surgery by a side door, passing other patients waiting outside.

The GP who swabbed my nose and throat also clearly assumed that I wasn't infected. He put on an apron and mask only after having a nice chat with me about how much he liked playing golf in Orlando. He gave me a pack of Tamiflu, with the reassuring comment "not to worry, you won't have swine flu."

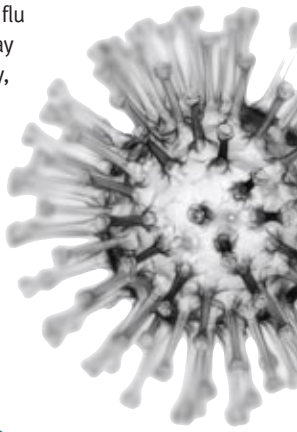
The Health Protection Agency phoned two days later to tell me that I was infected with A/H1N1 influenza. Very surprised, I then assumed that I would quickly recover from the "mild flu-like illness" that was being portrayed in the media. But no. I felt so unwell that I ended up staying in bed for nearly three weeks.

I didn't want to pass the virus on to my family. My two sons were taking A level and GCSE exams at the time, and I kept away from them even before I knew I had A/H1N1, because I didn't want them to be ill during their exams. So I was stuck in my bedroom, lying down because I felt so sick, unable to read because my eyes were so sore, coughing away, and with only BBC Radio 4 for company and flowers from close colleagues to cheer me up. A Health Protection Agency risk officer assessed the *BMJ* staff, and the person who had sat nearest to me was given Tamiflu, but, fortunately, none of them developed swine flu.

"You haven't got swine flu," said my GP, phoning back after my husband had contacted the practice because I didn't seem to be getting better. He assumed that the fax sent by the Health Protection Agency saying that I had influenza type A meant that it wasn't A/H1N1. When I phoned the agency to check I wasn't going mad, they explained that GPs had been sent a letter explaining that this was the wording that they would be using for patients testing positive for swine flu, "to protect patient confidentiality." They assumed that GPs would read their letters.

But the mix-up didn't really matter, as my GP wouldn't come to see me anyway, because he would have to put on an apron and mask in the street, which would be worrying for everyone.

I did feel better in the end. But my observational study (n=1) suggests that the assumption that swine flu causes only mild illness may have been simplistic. Sadly, the recent deaths of people who apparently had no underlying illness also indicates that assumptions that swine flu poses no real risk may have been premature.



PASIEKA/SPL

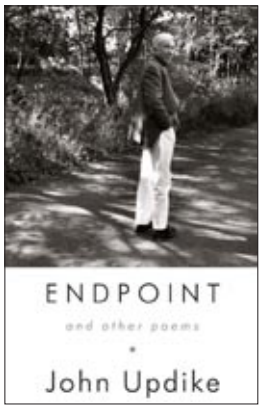
Susan Mayor is a freelance journalist, London
susanmayor@mac.com

Cite this as: *BMJ* 2009;339:b2969

REVIEW OF THE WEEK

Diagnostician of the human condition

The late, great John Updike's last work is a sequence of poems about his final illness. **John Quin** asks whether there can be a more doughty chronicler of physical decline



Endpoint and Other Poems
John Updike
Hamish Hamilton, £12.99, pp 97
ISBN 978-024114472 5
Rating: ★★★★

John Updike, who died in January, was by some distance the most prodigiously gifted and prolific of contemporary American literary masters. His metaphorical gifts were exceptional, and his observational skills led to conclusions as persistently correct as the bottom line of all those *New England Journal of Medicine* case reports. You could say after a reading of his work that with great accuracy a diagnostic procedure had been performed.

Here, in his last collection of poetry, we find him settling into "that decade in which, I'm told, most people die." Age he must, but "die I would rather not." And yet he knows of course that he will. Plaintively he requests, "Be with me, words, a little longer." Being the doughty chronicler he was ("Our time's greatest man of letters," Philip Roth said) he must set it all down, even the worst that will happen to him, as long as he can hold a pen, type a key.

Updike noticed everything. He was literature's Monet; to paraphrase Robert Hughes, he was only an eye, but what an eye. He points out a clotted traffic jam in Phnom Penh, a feeble sun in Portrush, Northern Ireland, lean girls in tall and pricey boots in St Petersburg. Even here in this slim collection written in the weeks before his death he informs us about his own arthritic left hand, the fated golfer Payne Stewart's silky swing, the rapper Queen Latifah's sweet smile, Doris Day's jutting butt, the stoic delicacy of Virginia creepers, the new watch that will tick in his own coffin.


HULTON ARCHIVE/GETTY IMAGES

Updike was not one to be afraid of the accusation of being up his own fundament

Updike was not one to be afraid of the accusation of being up his own fundament. Witness his poem "Colonoscopy," musing on his own bowel, "its segments marked by tidy annular construction seams as in a prefab tunnel slapped up by the mayor's son-in-law."

His gastroenterologist "has a tan just back from a deserved vacation from his accustomed nether regions"—sun and skin again, an old theme of his, and has anyone written on psoriasis as well as Updike did, most memorably in his memoir *Self-Consciousness*?

Endpoint is a sequence of poems about his final illness, the last written as recently as last December. On 6 November he notes a possible wake-up call: "It seems that death has found the portals it will enter by: my lungs, pathetic oblong ghosts, one paler than the other on the doctor's viewing screen." By 23 November he's in Massachusetts General, Boston, undergoing a scan and being visited by some of his grandchildren, then "politely quizzing them on their events and prospects, all the while suppressing, like an acid reflux, the lack of prospect black and bilious for me."

After a lifelong fear of flying he is now safe on the ground but notes this of his terrors: "the flight through the dazzling air, with the blinding smash, the final black—will be achieved from thirty inches, on a bed." On 22 December he writes, in a poem about undergoing a computed tomography guided biopsy: "All praise be Valium in Jesus' name." He recalls how he lay there "secure and warm and thought creative thoughts." And then:

> All would be well, I felt, all manner of thing.
> The needle, carefully worked, was in me, beyond pain,
> aimed at an adrenal gland. I had not hoped
> to find, in this bright place, so solvent a peace.
> Days later, the results came casually through:
> the gland, biopsied, showed metastasis.

In an ungracious moment it is easy to think of Updike as a brainier, more worldly version of John Boy Walton, with that Pennsylvanian upbringing in his beloved home town of Shillington set down for eternity, his schoolmates "providing a sufficiency of human types . . . all a writer needs, all there in Shillington." You might even argue that the town was his Springfield (the US everytown of the Simpsons). And, going cautiously further with the Simpsons comparisons, you could see Updike as Ned Flanders, an upright Christian moralist, irritatingly right, unfathomably reasonable, irrepressibly optimistic. See Big John, surrounded by so many Bart and Homer Simpson uncouth types, a-typing with a fraction of his infectious curiosity. "How do manufacturers of tools make a profit?" Updike asks us in one poem here. If you could come up with a decent explanation for him, well, you bet he'd thank you and think your answer was okely dokely.

In the last poem in the sequence, "Fine Point," his thoughts return, as they have so centrally in his work, to his faith, quoting Psalm 23.6:

> The tongue reposes in papyrus pleas,
> saying, *Surely*—magnificent, that "surely"—
> *goodness and mercy shall follow me all*
> *the days of my life*, my life, forever.

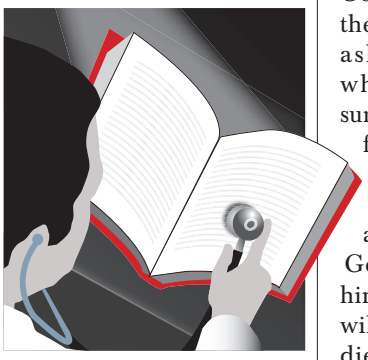
In "Stolen," ostensibly about missing paintings, he asks: "When wise and kindly men die, who will restore disappeared excellence to its throne?" Who, indeed?

John Quin is consultant physician, Royal Sussex County Hospital, Brighton john.quin@bsuh.nhs.uk

Cite this as: *BMJ* 2009;339:b2948

A telling tale

BETWEEN THE LINES
Theodore Dalrymple



Medical practice is to medical ethics what literature is to philosophy

For half a century the Indian author R K Narayan chronicled the everyday life of his fictional town of Malgudi, in reality his home town of Mysore. He had that ability to see (and convey in words) a universe in a grain of sand that is, perhaps, the mark of a great writer.

The protagonist of his short story "The Doctor's Word," published in 1947 in the collection *The Astrologer's Day*, is Dr Raman. He is a specialist of sorts: people go or are brought to him only as a last resort. This causes Dr Raman to demand why they did not come to him earlier, exactly the question I used peevishly to ask in a tropical country where I once worked when people were brought to me with paraplegia caused by Pott's disease of the spine. The answer was that it was only then that they lost faith in the power of magic to effect a cure.

Dr Raman is respected, however, because of his plain speaking: "He was not a mere doctor expressing an opinion but a judge pronouncing a verdict." He tells patients when they are dying because "he never believed that agreeable words ever saved lives."

His principle of plain speaking is sorely tested, however, when he is called to the bedside of one of his closest friends, Gopal, who is dangerously ill. On asking why he was not called earlier, he receives the reply, "We thought you would be busy and did not wish to trouble you unnecessarily"—precisely the answer I received 30 years later as a locum general practitioner when called to the bedside of an 80 year old man who had become severely anaemic from chronic rectal bleeding.

Dr Raman operates on Gopal but without expectation of success. Gopal wakes after the operation and asks Dr Raman whether he will survive. Dr Raman finds himself unable to return a straight answer and prevaricates. Gopal then asks him to witness his will, because if he dies intestate the circling human vultures will rob his widow of his rightful estate; and he knows that if Dr Raman agrees to witness the will it means that he believes that he, Gopal, will die.

Gopal is weak and sleepy after the operation.

"Dr Raman called, 'Gopal, listen.' This was the first time he was going to do a piece of acting before a patient, simulate a feeling, and conceal his judgment.

"He stooped over the patient and said with deliberate emphasis, 'Don't worry about the will now. You are going to live.' The patient asked in a tone of relief, 'Do you say so? If it comes from your lips, it must be true . . .'"

Shortly afterwards Dr Raman gives his assistant instructions to ease Gopal's passing with an injection if the expected death struggle becomes too painful. But in fact Gopal does not die, and the next day Dr Raman says to his assistant, "How he has survived will be a puzzle to me all my life."

Only six and a half pages long, it seems to me that "The Doctor's Word" might serve as a useful starting point for the teaching of medical ethics, for medical practice is to medical ethics what literature is to philosophy.

Theodore Dalrymple is a writer and retired doctor

Cite this as: *BMJ* 2009;339:b2953

MEDICAL CLASSICS

A Grotesque Old Woman

By Quienen Massys **Painted in 1513**

Hanging in the National Gallery, London, is *A Grotesque Old Woman*, by Quienen Massys, contrasting starkly with the images of youth and beauty that otherwise dominated the Renaissance. The painting always attracts attention and is one of the most popular in the gallery. A favourite of art historians and casual observers alike, this iconic image may even have inspired Leonardo da Vinci, although it is now widely accepted that Massys copied da Vinci. The old woman has spawned several impersonations, such as the illustrator John Tenniel's duchess in the pages of Lewis Carroll's *Alice in Wonderland*.

Until recently it was presumed that Massys had intended the painting, rather than being an actual portrait, as a piece of social satire on mature women who battle to maintain a youthful appearance. However, it is now accepted by the National Gallery that *A Grotesque Old Woman* is an accurate portrait of a woman with Paget's disease of the skull. Comparison with clinical photographs of patients with Paget's disease shows similar deformities of the skull, with bossing of the forehead and prominent enlargement of the orbital ridge. The maxilla is extensively enlarged, and the prominent maxillary arches contribute to the disproportionately large distance between the base of the nose and upper lip. The nostrils are similarly distorted. Dequeker noted (*BMJ* 1989;299:1579-81) that this bony remodelling gives the face "something of the wild animal about it—the lion. This typical face has been called by clinicians 'facies leontina,' as seen infrequently in patients with Paget's disease."

Furthermore, the woman has markedly deformed clavicles, which are abnormally enlarged and bent. The collarbones are often a specific focus for the bone changes in Paget's disease. The old woman's right hand is in a somewhat abnormal position. The bony swelling of the carpometacarpal and distal interphalangeal joints of the thumb (a "squared thumb" appearance), coupled with the swelling of the other metacarpal-phalangeal and both proximal and distal interphalangeal joints, indicate osteoarthritis, another condition associated with Paget's disease. The inclusion of so many subtle but clinically accurate signs of Paget's disease is probably not coincidental. Massys may or may not have been intending to satirise, but we can be reasonably sure that the subject of the painting was not the product of random deformities that the painter fashioned together.

NATIONAL GALLERY, LONDON/THE BRIDGEMAN ART LIBRARY

As a medical student I worked with Professor Michael Baum on this painting, my first real exercise in the art of clinical observation and, in essence, my first ever "diagnosis." The skills I learnt from investigating the portrait have stayed with me since.

Christopher Cook, foundation year 1, North Central Thames Foundation School, London Deanery
christopher.cook@doctors.org.uk

Cite this as: *BMJ* 2009;339:b2940

When it's worth repeating

FROM THE FRONTLINE
Des Spence

FROM THE ARCHIVE: See also Iona Heath on breast screening, "It is not wrong to say no," *BMJ* 2009;338:b2529

I have a get rich quick idea. Sack all the editorial staff of a typical men's or women's magazine. Then just add a new glossy cover each month, keep up the advertisements, and recycle old fashion photos from the past 20 years to pass off as "new" retro fashion. Genius! A profitable magazine with no overheads. Even the *BMJ* recycles ideas and stories—but some ideas are worth repeating, one such being the harms of screening.

The emotional and public death of Jade Goody saw a widespread demand for yet more and earlier cervical screening, despite the fact that 1000 women must be screened for 35 years to prevent one death and that the lifetime risk of overdiagnosis after a positive smear test result is 40%. Recent research questions the benefit of mammography screening for breast cancer (*BMJ* 2009;339:b2587). But have such findings made the debate any more reasoned? Regrettably, no. In the public psyche there is an unshakeable belief that screening is a good thing. But many doctors, myself included, are sceptical of the absolute benefit of screening; the simplicity of the claim that "early diagnosis" saves lives is too seductive and open to confounding to be wholly true.

We need to examine the facts. The *BMJ* study indicates that a third of women have been told they have breast cancer when they don't have a progressive disease. Women are enduring unnecessary chemotherapy, radiotherapy, lumpectomy, or mastectomy. These are not some vague psychological scars of screening. Also, many members of the public and indeed of the profession equate "screening" with surviving "early" cancer but understand that screened patients die too. In the United Kingdom there has been a headline grabbing 40% fall in the number of deaths from breast cancer since screening was introduced in 1988, but in all the debates the proponents of screening have been selective with the facts. For there has also been a near identical reduction in the number of deaths in the younger, unscreened population.

Tear stained reasoning should not blind us to the fact that screening for skin, breast, cervical, and prostate cancer (not to mention screening for high cholesterol, hypertension, or osteoporosis) generates overdiagnosis, overtreatment, and health anxiety. Doctors are complicit in the theft of society's most precious possession of all: a sense of wellbeing. So, let's repeat: screening, whatever its benefits, also causes widespread, real, and lasting harm.

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

Cite this as: *BMJ* 2009;339:b2973

See RESEARCH, p 206

Are some doctors more equal than others?

STARTING OUT
Kinesh Patel

What is a doctor worth? Forget the emotional claptrap, I'm talking about what really matters: money, moolah, cash, whatever you want to call it. "More than we're paid," is the usual, rather sullen, response.

This question is easy to answer. We all think we're valuable and underappreciated. Some even think of themselves as indispensible.

Here's a more difficult question, though, and many will disagree with my responses. Are some doctors worth more money than others? Well, no, if you look at national pay scales. But of course the reality is that some doctors are more equal than others. Merit awards, clinical excellence awards, and all manner of administrative stipends result in major differences in pay.

But should doctors' basic pay be the same? Does a pathologist in Bangor really merit the same amount of pay as a neurosurgeon in Edinburgh? And before I get inundated with emails from angry Welsh pathologists (a pretty ferocious brood), let's be clear: financial remuneration should not be confused with importance, the case of academics in all disciplines being a prime example.

What would derogation from national pay scales mean? Pay in some popular specialties and areas, such as cardiology in London, would probably fall, whereas specialties in rural areas with shortages, such as pathology, would be permitted to offer higher pay to attract applicants to areas with recruitment problems. Think of it as a kind of Modernising Medical Careers for consultants.

For, like it or not, the NHS is a business—a state funded business, granted, but a business all the same. Hospitals get paid for activity, which is why the apparent masterly inactivity of physicians often contrasts poorly with the plethora of procedures that surgeons perform.

So, given that it is a business, paid for by activity, why should we not get paid by individual activity too? We all know that the NHS can be a wonderful haven for the inefficient. Whether radiologists read 40 x ray pictures in an afternoon or 80, their pay is the same. Why see 15 patients in a clinic when you can have a nice chat and a cup of tea and a biscuit, and see 10? There's always someone else to finish off the work, even when the pressure is on.

Where is the carrot, the incentive? And within the NHS, unlike in the private sector, there is certainly no stick to chasten inefficient doctors.

Some quality control would, of course, have to be in place, but such controls should already be implemented, whether payment is made by activity or not. Many other professions seem to manage this sort of payment regimen perfectly well. Why should medicine be any different?

Kinesh Patel is a junior doctor, London
kinesh_patel@yahoo.co.uk

Cite this as: *BMJ* 2009;339:b2917