

VIEWS & REVIEWS



“The wanton promotion of osteoporosis and treatment of the young is bad medicine”
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Haiti: I want to go back

PERSONAL VIEW **Richard Villar**

After three earthquakes and as many wars, I should be in control. Yet fresh back from Haiti I am not. As I grow older emotionally I become more involved, not less. As I become more experienced I find it harder to detach myself from my surroundings. The callous, hard young man who first went to war in his 20s has become something of a softie three decades on. My job, as part of the United Kingdom’s emergency response, is to enter disaster zones while the locals leave. Haiti is a classic example: as five of us stride from our chartered aircraft towards the airport buildings in Port-au-Prince, 5000 inhabitants are hastening in the opposite direction.

My job is outwardly simple. Reach the disaster zone by the most rapid means and set up a field surgical facility for the team that is hot on my heels. The situation is pitiful: bodies line the streets, limbs protrude from shattered buildings, and those who survive stagger aimlessly with fixed gaze. There is no water, no food, and little fuel, and aftershocks are frequent and unpredictable. Orphaned children scream for their parents, while parents shout for their offspring. Where can they go? Where can anyone go? The smell of death is everywhere. Smoke and dust rise from the city while white United Nations vehicles in their hundreds hurtle almost haphazardly, soldiers with weapons drawn.

Making sense of such a situation is difficult, but I realise that however experienced I may be it is impossible to deal with everything. Close your eyes and think of the most horrendous disaster your imagination will allow. Now double it, triple it, quadruple it, maximise it beyond proportion, and then you have Haiti. The population is destroyed, their ramshackle buildings broken. No one has

So much of disaster relief is based on personal relationships

been spared. It is difficult to handle the stories you hear. A young girl heard her friends suffocate one by one under masses of rubble; it is not always a rapid death in an earthquake. A husband removed his wife’s foot with a machete so that she could escape. Another held up a crumbling wall to allow his family time to run outside, only to perish himself. My driver bursts into tears when remembering his brother who died. I almost do the same when I see the smouldering, broken femur of a child lying outside the ruins of a school that collapsed, killing all inside. Through this we, the Merlin emergency response team, must complete our task.

I locate the ideal spot for our field hospital—five abandoned tennis courts—and start work on some of the patients. I spend much of my time counselling the young, invigorating and enthusing, persuading them that they represent the future of their now destroyed Haiti. They look at me in disbelief. What do I know, I can see them thinking. I am a doctor and a foreigner. I’m used to my luxuries and no doubt sleep in a comfortable bed. I tell them otherwise. I too am sleeping outdoors, at the end of the runway in Port-au-Prince. I too am down to one meal a day, of a quantity insufficient for someone half my size. I too am frightened as I listen to the dogs whine just before another aftershock. I find myself snapping unjustifiably at a colleague when I would normally step back. The disaster affects everything you do, everything you think, breathe, and feel.

Somehow we finish our task with barely minutes to spare before the full surgical party arrives. I see old hands in the team, some good friends, with whom I worked in Kashmir, Java, and elsewhere. I sense them brace for the emotional assault that they know will follow, just as I had done days before. Meanwhile the younger members, some without disaster experience, are still bright eyed. I wonder how they will feel when they see their first dead body lying in the street, bloated and irregular. How will they react when a gang member enters the clinic brandishing his gun?

Suddenly it is over. With the team in place, the hospital created, and surgery under way, it is time for me, the surgical fixer, to go. One by one I tell

my Haitian colleagues, the nurse, the carpenter, the local gangland boss who has offered us protection. Each looks at me in disbelief, as if I have betrayed them. So much of disaster relief is based on personal relationships. Yes, these shattered people need food, water, and all those items that aid agencies can provide. Yet what they treasure most is friendship; a smile; a handshake; a shoulder on which to lean; someone who will sit with them and on occasion hold their hand and share a mutual sorrow; someone who will encourage them to abolish despair and help, emotionally at least, to start life again.

My driver is particularly hard hit. He does not believe I am going. “You must return,” he insists. I promise to do my best, muttering something about two or three months, while knowing that my return to Haiti is unlikely. “I have no present to give you,” my driver adds. He looks around him. “All I have is this.” He hands me the tiniest packet of chewing gum as a leaving present. It is genuinely all he has.

Once outside Haiti I sit in the restaurant of my luxury hotel in the Dominican Republic. I feel guilty. I am exhausted, of course, having not slept or washed for a week. When I think no one is looking I use my napkin to remove a small tear from the corner of one eye. Why should I feel like this? I analyse my thoughts. I telephone my wife but reach no conclusion. Perhaps it is because I am deserting my surgical friends. Perhaps it is because I sense the right place for me is where hardship is greatest, and that is not always my own country. Perhaps it is because I am alive when so many others, with lives more worthy than mine, are dead. I cannot explain what I feel but know, if there was an aircraft outside, I would climb its steps and go back to Haiti.

Richard Villar is consultant orthopaedic surgeon, Wellington Hospital, London NW8 9LE
rmv@myself.com

Cite this as: *BMJ* 2010;340:c695

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- ▶ Review of *Contact Wounds: A War Surgeon’s Education* (2006;332:428).
- ▶ In Pakistan’s earthquake zone global relief has so far failed its test (2005;331:1151).
- ▶ Review of *MASH: An Army Surgeon in Korea* (1998; 317: 1599).



When saying goodbye feels like betrayal

Ye olde antismoking lobby

We tend to forget what it is to be young and to wish to appear older than we are. Every time, therefore, that I pass the bus stop nearest my house and see a pale youth loitering there, lighting the cigarette by means of which he hopes to persuade the world that he is both tough and fully adult, I want to snatch the wretched thing from his grasp and upbraid him for his foolishness. I never do, of course.

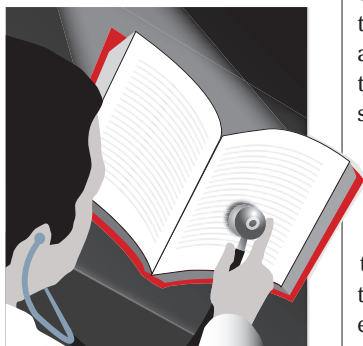
Perhaps I should simply put into his hand Dr Tobias Venner's tract, first published in 1623 and then again in 1650 and 1660, entitled *A Brief and Accurate Treatise Concerning the Fume of Tobacco, Which very many, in these dayes, doe too too licentiously use.*

Venner (1577-1660) was the first doctor to extol at book length the medicinal value of the waters of Bath, where he practised for many years and in whose abbey he is buried. He was an early advocate of brushing the teeth to avoid decay and bad breath, warned against drinking waters that had passed through lead pipes ("troublesome to the stomach, and ponderous to all the bowels," though "these hurts are well removed in their boyling"); he believed strongly in bran for the prevention and treatment of constipation.

So preoccupied was he, indeed, with diet as the means to health that an unfriendly memoirist said of him that his brains were in his bowels.

Dr Venner is not quite so vehement in his denunciation as James I of England, who ended his *Counterblaste to Tobacco* with the ringing words "a custom loathsome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs, and in the black stinking fume thereof nearest resembling the horrible stygian smoke of the pit that is bottomless."

BETWEEN THE LINES
Theodore Dalrymple



How I long to go up to a pale smoking youth and say to him: "Foolish boy! Cease this minute from exsiccatting your windpipe! Do not eliquate your pinguie substance! Refrain from absuming your geniture!"

Nevertheless Dr Venner is eloquent enough: "It drieth the braine, dimmeth the sight, vitiatheth the smell, dulleth and dejecteth both the appetite and the stomach, destroyeth the concoction, disturbeth the humours and spirits, corrupteth the breath, induceth a trembling of the limbs, exsiccateth the windpipe, lungs and liver, annoyeth the milt, scorcheth the heart, and causeth the bloud to be adusted."

This is not all—though what else it does will not be easily understood by modern readers: "Moreover, it eliquateth the pinguie substance of the kidnies and absumeth the geniture." To exsiccate is to dry out; to adust is to scorch; to

eliquate is to melt the more fusible substances of an alloy leaving solid the less fusible ones. The pinguie substance is fat. To absume is to waste away, and the geniture is the human seed (Venner is quoted in the *Oxford English Dictionary* in its definition of both exsiccate and geniture).

In summary, then, the fume "overthroweth the spirits, perverteth the understanding, and confoundeth the sense with a sudden astonishment and stupidity of the whole body."

How I long to go up to a pale smoking youth and say to him: "Foolish boy! Cease this minute from exsiccatting your windpipe! Do not eliquate your pinguie substance! Refrain from absuming your geniture!"

It wouldn't work, of course. The only way to make youngsters stop smoking is to make it compulsory. Then it would be as odious to them as Latin declensions.

Theodore Dalrymple is a writer and retired doctor

Cite this as: *BMJ* 2010;340:c585

MEDICAL CLASSICS

Madame Bovary By Gustave Flaubert

Published 1857

The eponymous heroine of *Madame Bovary* is the second wife of Charles Bovary, a country public health doctor who "understood absolutely nothing" of his lectures when studying medicine and failed his public health service examination on his first attempt.

Charles falls in love with Emma Bovary while tending to her father's broken leg. Once she marries him Emma has trouble assuming the role of a country doctor's wife. Beautiful and desirous of the freedoms enjoyed by men, she finds her new life tedious and stifling. She daydreams about living in Paris and enjoying the attentions of a handsome, witty, and distinguished man or at least a husband who doesn't fall asleep over *La Ruche Médicale*.

After two years of marriage Emma clearly becomes depressed, and the couple relocate to the market town of Yonville-l'Abbaye. They become friends with the town's apothecary, Homais, who is keen to ingratiate himself with the new doctor as he has recently been reprimanded for infringing "article I of the Law of Ventose of the year XI, which forbids anyone to practise medicine unless he holds a doctor's diploma." Meanwhile Emma embarks on a passionate affair with a local landowner, Rodolphe.

In a period of contrition midway through the adulterous episode *Madame Bovary* seeks a way to kindle a feeling of admiration for her husband. Homais has "recently read high praise of a new method for the treatment of club-foot" and being keen to put their small town on the map persuades Emma to join him in encouraging Charles



to try the procedure on a local "cripple," Hippolyte. Emma hopes that success will enhance Charles's reputation and give her reason to be proud of him. Hippolyte is reluctant to receive the proffered philanthropy but eventually agrees to the operation. Charles cuts Hippolyte's tight and brittle Achilles tendon, encases the foot in a specially constructed box, and goes home to congratulate

himself and enjoy the pride of his wife. Homais departs to write the case up for a Rouen newspaper. Hippolyte is left to endure his treatment and within days begins to suffer from pain and fever. The affair ends badly. Hippolyte's gangrenous leg must be amputated above the knee by a fully qualified medical practitioner, who does not spare Charles a public shaming. Thenceforth the amputee taps around Yonville on a wooden leg as a constant reinforcement to Emma's scorn of Charles. She embarks on another affair and becomes mired in regret and debt. "In an ecstasy of heroism" she makes a decision to end her life and tricks the apothecary's assistant into giving her access to arsenic, which she takes not at all expecting the agonising death that ensues.

In a letter of October 1852 Flaubert wrote of the novel, "I want my readers to weep." Perhaps one does not weep so much as resign oneself to recognising as truth this display of humanity's vanity and self deception.

Kirsten Patrick, assistant editor, *BMJ* kpatrick@bmj.com
Cite this as: *BMJ* 2010;340:c616

For more on clubfoot, see *CLINICAL REVIEW*, p 308, *OBITUARY*, p 317

Bad medicine: osteoporosis

FROM THE
FRONTLINE
Des Spence



“One in two women and one in five men over the age of 50 in the UK will fracture a bone, mainly as a result of osteoporosis,” says the National Osteoporosis Society. But osteoporosis is an abstract numerical concept. As judged against a young white person at maximum bone density, it is defined as the 1% of people with the lowest bone mineral density shown on dual energy x ray absorptiometry (DXA) scanning, while the lowest 16% are defined as having osteopenia (erroneously called preosteoporosis). By this definition one in eight young women currently has osteoporosis or osteopenia, and the proportion rises to more than half after the age of 50. This has prompted calls for more DXA scanning and doomsday predictions of a “silent epidemic.” These numbers have spawned a thousand emotive magazine articles and enormous public anxiety.

The truth is that osteoporosis is not a disease but merely a risk factor for fracture, particularly of the hip. Age over 80 is by far the single greatest risk. Also, there is an assumption that effective “treatment” exists. However, there is limited evidence of the effectiveness of the widely prescribed bisphosphonates in the primary prevention of hip fracture in people with no history of fracture, even in highly selective study populations of elderly people. For secondary prevention the small reduction in hip fracture is again in highly selected elderly populations.

On closer inspection this research carries the scars of big pharma, with relative risk reductions, non-clinical outcomes, and composite end points. I can find no mortality data and not even convincing evidence of reduced back pain. The treatment paradox of managing medical risk—that the individual patient is unlikely to benefit personally from treatment—is not even acknowledged. But the key issue is that these data should not and cannot be extrapolated to a younger population. But this is what is happening: an overdiagnosis disease creep. In our practice a fifth of prescriptions of bisphosphonates are for people under 60, with the youngest in their 20s.

A recent Canadian study noted an age adjusted decline in the number of hip fractures since 1985 of 30%, a decline that treatment doesn't account for. Does this reflect a fundamental change in epidemiology, with the passing of the deprived generations of the early 20th century? The term osteoporosis is an age dependent concept; primary prevention is questionable in all but the most frail; and “osteopenia” should be struck from the medical lexicon. The wanton promotion of osteoporosis and treatment of the young is bad medicine, and that is even before we consider the drugs' side effects.

Des Spence is a general practitioner, Glasgow destwo@yahoo.co.uk
Cite this as: *BMJ* 2010;340:c643

Elementary, my dear

PAST CARING
Wendy Moore



COLIN CRISFORD

Ever since Sherlock Holmes first sprung on the Victorian literary world more than a century ago, readers have been enthralled by the detective with the legendary powers of observation. But while Holmes enjoys enduring global fame, few general readers suspect that the inspiration for Arthur Conan Doyle's ruthless, cocaine addicted sleuth was a Scottish surgeon.

Holmes made his first appearance in 1887 when Doyle published his novel length mystery *A Study in Scarlet* in *Beeton's Christmas Annual*. Readers were immediately entranced, but once they knew the identity of the double murderer in the story they were just as keen to unmask the model for Doyle's charismatic detective.

The master of suspense kept them waiting five years before he revealed that the man behind the brilliant mind was none other than his former medical teacher, Joseph Bell. Publishing his first collection of stories, *The Adventures of Sherlock Holmes*, in 1892, Doyle included a dedication to “my old teacher, Joseph Bell, M. D.,

etc.” And in a letter to Bell that year the writer admitted, “It is most certainly to you that I owe Sherlock Holmes.”

Born in 1837 into a Scottish medical dynasty, Bell qualified in Edinburgh. But although he was acclaimed for his remarkable powers of deduction, the genial doctor was passed over for university posts and only secured a full surgeon's post at Edinburgh Royal Infirmary in 1871. Meanwhile, students flocked to his lectures on clinical surgery at the Extra-Mural School of Medicine, outside the university; and his *Manual of the Operations of Surgery*, published in 1866, became a standard textbook. But Bell's main claim to literary fame stemmed from his meeting with a 19 year old medical student in 1878.

Having begun his medical studies at Edinburgh two years earlier, Doyle enrolled in Bell's lectures and was inspired by the popular teacher with his astonishing diagnostic methods. After briefly scrutinising his patients with his piercing eyes, Bell would astound students by announcing

that one man worked as a cobbler or another had been recently discharged from a Highland regiment after returning from Barbados, purely from aspects of clothing, manner, and medical condition. Doyle closely observed his mentor, and although he soon abandoned his career in medicine to write full time, he never forgot his teacher.

Describing the first meeting between Holmes and Watson, Doyle reproduced Bell's observational skills almost exactly when the detective pronounced: “You have been in Afghanistan I perceive.” In the tradition of life mimicking art, Bell would later pose for photographs wearing the characteristic deerstalker and cape. And Watson? Elementary, my dear: Doyle probably based the bumbling doctor with his balding pate and handlebar moustache on another Edinburgh surgeon, Patrick Heron Watson.

Wendy Moore is a freelance writer and author, London wendymoore@ntlworld.com
Cite this as: *BMJ* 2010;340:c586