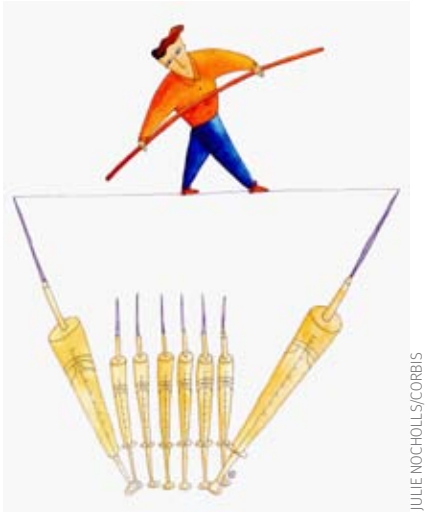
"Sometimes we need to be doctor centred"
Des Spence, p 154

Knowing the score: a doctor addict tells his story

PERSONAL VIEW **Anonymous**

The vein stands up, proud and inviting. The syringe sits on the bedside table, the new orange needle gleaming expectantly. One of the small benefits of being a doctor and an addict is that clean needles are easily available, and the risk of HIV and hepatitis B or C infection is low. I had used a green needle to draw up the drug, a needle that can reach right to the bottom of the ampoule, so that not one drop will be missed. Beside the syringe lies the empty packet of Cyclimorph; the red and blue packaging is so distinctive to me that if it was lying on the road a mile away I would spot it.

Everything is quiet, the doors are closed, the curtains pulled, it is all dark except for the bedside lamp. I am alone in the house; there is no glamour here, no drama, no heroin chic—it's just a selfish, venal, deceitful, squalid, solitary vice.



JULIE NOCHOLLS/CORBIS

I tap the vein lightly with my forefinger, testing the bounce. The vein is engorged and will be easy to access, little chance of missing the vein and the drug leaking into the subcutaneous tissues, which would leave a painful and visible bruise and, even worse, would mean losing some of the drug.

I lift the syringe, flicking it and holding it up to the light to ensure there are no air bubbles. The needle slips in painlessly; it feels like a kiss, just a moment's resistance till the wall of the vein is penetrated. I draw back on the syringe to confirm I am in the vein, and oh, the relief of seeing the dark blood froth into the syringe, a red flag signalling go. Now there is nothing between me and the drug.

Everything is ready, the pleasure of the anticipation is almost spent. I slip off the tourniquet and slowly press the plunger fully in.

I need to act quickly now to prepare for the rush, to experience it fully. I don't want any outside stimuli that might interfere with the consummation. I whip out the needle and press firmly on the site with a dark red paper tissue. A white tissue would show up the blood too obviously and might turn up somewhere inconvenient. The firm pressure will restrict localised bruising and make the injection site less easy to spot and also will help keep the vein patent for future use. I take off my glasses, switch off the light, lie back, close my eyes, and wait.

I received support from my wife and family and friends and from my colleagues and staff. And most of all from my patients, as my addiction is now common knowledge; their compassion and forgiveness have been humbling

Within seconds I feel the rush coming on, a wonderful, warm tidal wave stroking my whole body. And just as quickly it is gone; that's it, done, all over. Was it worth it?

I am slightly sedated but not overly so. I could walk down the street and exchange greetings and partake in conversation, and only those who knew me well would think something was wrong: my voice might be deeper, my pupils dilated, but nothing very obvious.

I should still feel relaxed but at once I am aware that that was my last dose. I have no more supplies of the drug, so withdrawal effects are inevitable. I've been through withdrawal before and it was terrible. I know that, theoretically, withdrawal effects should not begin until eight hours after the last dose, but such is my fear of withdrawal that I begin to feel uncomfortable after only a few hours.

I can't settle, I know what is to come, it hangs over me like a weight. I start to feel cold and sweaty, my skin prickly and uncomfortable. Or maybe I just think I am starting to feel that way, just my fear playing tricks.

As each hour passes the symptoms get worse. They are real now and accompanied by muscle pains, abdominal cramps, and diarrhoea. I know that there is no significant medical risk, and individually the physical symptoms aren't that bad. Put me in a warm room with plenty of fluids and they'd be tolerable.

But the anxiety, the anxiety, is overwhelming; I am like a vibrating string. I cannot sit for even a moment without having to get up. Once up I have to sit down again, and I know this will continue for the next 36 hours—someone take this cup away from me. I've been ill before, I've had injuries before, I've had bad times before, but nothing has ever unmanned me like withdrawal, nothing has ever left me so scared, so lacking in courage and resistance. There is no way out, no way to escape.

Except to take another dose, which would relieve all the symptoms instantly—it would be like a miracle. But I don't have another dose, and if I did I'd only be postponing the ordeal. I've had the pleasure, and now I have to pay the price. The preparation was elaborate and the consequences prolonged and grim, yet the gratification was only fleeting. It is a transaction that makes no sense, a kind of madness. But, I promise to myself, this is the last time. I won't put myself through this ordeal again; this time I'll stay clean.

But I didn't, and I continued using until at last I went for help. And help, and hope, is out there: Narcotics Anonymous, the doctors' and dentists' groups, addiction specialists. Withdrawal can be managed and staying clean encouraged; the vast majority of addicted doctors achieve recovery. The General Medical Council will need to be informed, but my experience has been that they considered addiction a health issue and were sympathetic rather than punitive. I received support from my wife and family and friends and from my colleagues and staff. And most of all from my patients, as my addiction is now common knowledge; their compassion and forgiveness have been humbling. It has made me a better doctor, more understanding of human frailty because my own frailty is so stark.

I have been clean for some years now, though like every addict I can only take one day at a time; I was clean today, and I will try to stay clean tomorrow.

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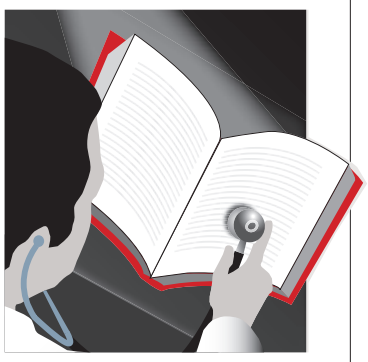
See **EDITORIAL**, p 107, **FEATURE**, p 124, **ANALYSIS**, pp 127, 129, **RESEARCH**, p 135

High anxiety

BETWEEN THE LINES
Theodore Dalrymple



Could it have been that one or more of the murderers was under the influence of cannabis?

English writers came late to cannabis by comparison with the French and Americans. Théophile Gautier published his *Le Club des Hachichins* in 1846 and Fitz Hugh Ludlow *The Hasheesh Eater* in 1857. By contrast the first English book on the subject was *The Confessions of an English Hachich-Eater*, published anonymously in 1884, and now thought to be the work of Sir William Laird Clowes (1856-1905), *Times* correspondent and author of a seven volume history of the British navy.

Sir William writes: "I dare say that English doctors are for the most part ready to confess that they know very little about this drug." One of the reasons for this, he says, "is a difficulty in obtaining potent hachich in England." But, as he rightly adds, "that difficulty is not now insuperable."

Sir William was a great fan of the drug. "I have found it to be a nepenthes, a sweet bringer of delicious oblivion, and a generous parent of delightful dreams . . . I hope to enjoy its effects many times again." And he believed it to be harmless: "I can conscientiously say that, as far as I know, I am not one whit the worse for my experiences with this delightful drug."

As the reviewer of the book for the *Edinburgh Courant* put it, "We would not be surprised if some foolish individuals endeavoured to procure some of the drug, with a view to experiencing the sensations described by the author."

Sir William has nothing but contempt for the "Dr Omnibus" who warns him that the drug will weaken his brain. "Dr Omnibus, with all my respects, is a fool. It is he who says, 'Don't drink beer—it is adulterated. Don't drink spirits—they destroy the coats of the stomach. Don't drink tea or coffee—it ruins the digestion and deadens the nerves.' In similar strains, he makes onslaughts on tobacco, on corsets, on lobster salads . . . Do you heed him? Of course not. But we all know that the old gentleman must have something to prattle about."

Sir William describes cannabis dreams. He had one of them on the way home from visiting a surgeon friend in Hammersmith. He had the sensation of flying through the London streets. One of his fellow pedestrians appeared to him to have, instead of a mere nose, "a large, red, curiously forked, carrot-like proboscis, which he moved at will, just as the octopus moves its tentacles." Then "the proboscis was growing at a wonderful rate, shooting out new tentacles with great speed . . . They were of a bright orange colour, and, in shape, much like attenuated spoons . . . At last one of the wandering tentacles touched me, and I was tenderly enclosed in a sort of living and pulsating network."

There is no accounting for taste, of course, but this did not sound to me all that delicious an oblivion or delightful a dream (to quote Sir William). And I could not help thinking of a friend who moved from Hammersmith—and England—when the third person was murdered on the street in which he lived. Could it have been that one or more of the murderers was under the influence of cannabis? My friend did not bother to inquire.

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

The Greatest Benefit to Mankind: A Medical History of Humanity

By Roy Porter

First published 1998

A true medical classic should read as if the author wrote the book with your exact needs in mind, and when my interest in medical history burgeoned at medical school I found such a book in *The Greatest Benefit to Mankind*. Roy Porter, then professor of social history at the Wellcome Institute, said in his introduction that he wrote the book because when "[I am asked] to recommend an up-to-date and readable single-volume history of medicine, I have felt at a loss to know what to suggest. Writing it has made it clear why so few have attempted this foolhardy task."

Certainly the scope of his work is ambitious, ranging from the roots of healing in prehistory to the impact of HIV on health care in the late 20th century. Along the mostly chronological journey he detours to several backwaters of history ignored elsewhere, providing us with some of the book's most colourful characters. In the four pages he devotes to ancient Egypt Porter not only explores their understanding of health and disease based on the ebbs and flows of the Nile but introduces us to Iri, the keeper of the royal rectum, assumed to be the pharoah's enema provider, who memorably illustrates the Egyptians' preoccupations with bodily motions.

WELLCOME IMAGES

Porter: passion for the patient's perspective

The book continues with more familiar topics: the Middle Ages and the influence of Islamic medicine, the Renaissance, the Enlightenment, and Victorian science. Key topics, such as the development of modern surgery, psychiatry, and public health, merit their own chapters. The themes and characters in these chapters will be familiar, such as William Harvey's theory of the circulation, but Porter's incisive analysis deepens our understanding of their subtleties. He does not simplify Harvey as a modern physiologist but explains his deeply Aristotelian understanding of the body: "It was not a machine, but was moved by vital forces." He then explains how the anatomical discoveries of others served as a platform for Harvey's discoveries.

Such a wide scope and detailed analysis risk turning an accessible history into a turgid reference work, and at 833 pages Porter's book is certainly larger than many textbooks. Despite this his flowing style, his eye for personal historical detail, and his clear passion for the patient's perspective in medicine make this an eminently readable popular history. Yet the book does still work as a reference, with a comprehensive index and a gargantuan bibliography—47 pages in all.

Sadly, Porter died soon after he retired in 2002, and it is now 13 years since this work's first publication. Yet the book remains fresh and is simply without peer as an accessible but thorough history of medicine. This classic has its place on the shelf (or more likely the bedside table) of any doctor with even the most passing interest in the history of medicine.

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Doctor centredness

FROM THE FRONTLINE
Des Spence

I have at least tried to read many of the scriptures on "the consultation"—a topic rightly treated with reverence in general practice. There are many "models of the consultation," and each generation of general practitioners has its own fads, silly phrases, and hand signs. Such self reflection is now spreading across the medical profession, and even surgeons are expected to ask, "Do you want a hug?" and to actually listen to patients. (Obviously they still ignore their answers.) We have replaced the functional and gruff paternalism of the past with the soft language of choice, patient power, and a non-judgmental stance. This is all wrapped in the woolly jumper that is "patient centredness." But has all this change in the doctor-patient relationship been for the better?

It is now difficult to be honest with patients. Obesity and addiction are "illness," not the product of personal choice. Childhood personality and behaviour problems, for which in the past general practitioners would have given basic parenting advice, is now label gunned and stacked into pigeonholes. We say nothing when patients assert their inability to work, even when our inner voice is telling us differently. We accept the misuse of the benefit system, which has generated a culture of worklessness, wasting millions of lives and excluding large parts of the population from society. We know that patients abuse insurance claims by exaggerating symptoms, which we don't challenge. We acquiesce to demands for drugs, referrals, and investigations when patients refuse to accept our opinion.

Many social and personal problems have been brought inappropriately under the medical umbrella instead of being taken up by broader civil action and debate. It is now impossible to be an effective gatekeeper, and some general practitioners have given up the fight. Confrontation leads to complaints, which are difficult, time consuming, and undermining, so we avoid them, however unreasonable the patient. And doctors have become legitimate media punchbags, with a whole profession tarnished by the actions of a few. "Patient centredness" often gives patients what they want but not what they need, and this undermines society.

You can have too much of a good thing. Sometimes we need to be doctor centred, when it is wrong to do just as the patient asks. We need a return to honesty, to professional discretion, and to a profession that stands together over hard choices. This is not about professional power but for the sake of society and above all to help patients. We need to rebalance the doctor-patient relationship. The time has come for a little less wool and a bit more steel.

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Mathematics is everywhere

STARTING OUT
Kinesh Patel

"He's the man with the funny ties who does Channel 4 news isn't he?" My house officer looked somewhat anxious after uttering these words, seeing the crestfallen look on the professor's face indicating that this wasn't the answer he was expecting when asking about John Snow, the father of epidemiology and discoverer of the cause of cholera.

We all have our favourite questions when teaching; and, against much modern educational theory, these often tend to be the ones people get wrong. How much radiation is a patient exposed to for each chest x ray picture taken? The answer is 0.03 mSv. And an abdominal x ray picture? That's 0.7 mSv. And while 0.7 mSv may not sound like very much, if we consider that our background annual radiation dose is 2.4 mSv, an abdominal x ray equates to a surprising four months of background radiation, whereas a chest x ray equates to a meagre four days.

Unfortunately working out a radiation dose in a manner that is accessible and easy to understand requires factual knowledge and some mathematical mental agility, which is not indoctrinated—forgive the tautology—into us as part of our education. Many of us do vaguely recall being taught about normal distributions and P values at medical school, not to mention the dreaded mouthful of the two tailed t test. But applying maths in everyday clinical practice and communicating the results to real patients is a world away from the esoterics of undergraduate statistics.

Maths is everywhere in medicine. From calculating drug doses and infusion rates to determining how effective a diagnostic test is at picking up a condition, it is impossible to get away from it, no matter how hard we try. And because we don't generally have a very good working knowledge of mathematics we can leave ourselves open to serious error.

When was the last time you sincerely questioned a negative imaging result? When was the last time you found a serious abnormality on a test and told the patient it was likely to be nothing? Many tests on which we rely heavily are far from perfect: a nuclear medicine scan will only pick up about eight in 10 patients with coronary artery disease, duplex ultrasonography in skilled hands will miss one in 20 deep vein thromboses.

With our increasing reliance on testing and scanning, these questions become ever more pertinent. Partly this is a result of the target driven desire to rule in or rule out a diagnosis to get the patient out of hospital or their general practice as quickly as possible; part stems from our innate difficulty in questioning the typed word. But perhaps the most difficult part to overcome is that which was indoctrinated in us at medical school: the fear of questioning the radiologist.

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