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Medicine and Books

Uneven work of reference

Mosby's Medical and Nursing Dictionary. Ed Laurence Urdang and Helen Harding Swallow. (Pp 1484; £9·95.) C V Mosby. Distributed by YB Medical Publishers. 1983.

Despite the word "medical" in the title, this is not a medical dictionary for doctors: it is intended for nurses and medical ancillary workers. It marks a departure from the traditional lightweight pocketable nurses' dictionary. Its nigh on 1500 pages and 3¾ pounds (1700 g) weight place it firmly on the shelf when not in use. The editors planned a dictionary-encyclopaedia and indeed it is a mixture of brief definitions and some quite lengthy monographs. The A to Z section is followed by a 32 page colour atlas of anatomy and 288 pages of useful and extremely detailed tables. Many of the definitions and monographs are excellent, in particular those on immunology, microbiology, parasitology, and anatomy. Regrettably there are grounds for adverse criticism elsewhere.

There is much information that is inappropriate for a nurses' dictionary which adds to the bulk of the book and presumably to its price. Examples follow. Irrelevancies: Nuremberg tribunal, Helsinki declaration, entropy, rare elements and their atomic weights having no medical application, and the law of universal gravitation; this last a ready excuse for breaking a thermometer? Heaves, by the bye, is a chronic disease of horses. I am all for versatility, but surely there are limits. Extreme rarities: melioidosis and the syndromes of Crigler-Najjar and Cronkhite-Canada. Abstruseness: an account of the four types of metaphyseal dysostosis, the anatomy of the ala vomeris bone, the iliac circumflex lymph node, and the superior ulnar collateral artery. As for the procerus muscle, which "draws down the eyebrows and wrinkles the nose," its contraction may well be the response to learning of its action. Words of common parlance: blush, body, burp, imprisonment, and sender. Phrases whose meaning is self evident: blood test, laboratory error, career ladder.

Much information is of no use to the non-American reader, which might not matter if the British equivalents were also given. More than 2000 proprietary drugs are named, hardly any of which correspond to British proprietaries—even the generic names do not always correspond to ours. You will look in vain for isoprenaline, noradrenaline, lignocaine, paracetamol, pethidine, or cromoglycate. They are all there, but unrecognisable under their American generic names. This will not do for a book offered for sale in the United Kingdom. As to abbreviations, you will not find SRN, SEN, RCN, GNC, or (heaven forbid) NHS among a host of those that are meaningless to us, or even misleading—for example, CNS, clinical nurse specialist; SBE, self breast examination; and LBW, low birth weight, which may at least raise a smile. Differences between American and British spelling may give rise to difficulty in finding a word where the difference lies at or near the beginning of a word—for example, aetiology, caecum, and oedema. A few prefatory words of guidance, as given in *Stedman's Medical Dictionary*[1] (though here I must declare an interest as a former contributor) would have been helpful.

There is further evidence of imbalance in the overrepresentation of certain disciplines. Here are some entries in applied psychology of nursing: humanistic existential therapy, implosion, a page on varieties of "coping," and dynamic nurse patient relationship. Much space is given to eponymous methods of obstetric delivery, but I failed to find anything on the physiological process of parturition. Female catheterisation is accorded three quarters of a page in a special entry, but male catheterisation receives merely oblique mention in a brief general account. Illustrations of the flea and louse show insects 4 cm in maximum dimension with no indication that the images are magnified.

There are important errors of omission. For example, the computed tomography scanner refers only to examination of the head. Antiemesis is not included in the actions of metoclopramide. On the contraindications to oral contraceptives no mention is made of increased risk with obesity, cigarette smoking, or age. On the management (or "intervention") of pain of moderate severity the writer advises, in addition to drugs (unspecified), "cognitive dissonance" (think of something nice) and for severe pain, opiates, pethidine, and "waking imagined analgesia" (think of something very nice). The two and a half pages on pain include no mention of aspirin or other non-steroidal anti-inflammatory drugs or even acetaminophen (paracetamol). In my search for a pointer to these drugs I looked up analgesic, but got only a four word definition.

Here are examples of the errors of commission. The pulse rate in the "average adult varies from 50 to 100." I would not be happy with a patient whose resting rate was 100, but surely a change in rate in a patient with gastrointestinal haemorrhage from 80 to 100 might be grounds for concern. The illustration of the thyroid gland (p 1177) is wrongly labelled. Cupping and drinking two to three litres of fluids daily are mentioned among treatments for emphysema, but nothing said about stopping smoking. For stress incontinence there is no mention of surgery. More alarming is the advice to give heavy sedation for status asthmaticus. If the writer implies that this should be given with "controlled positive pressure respiration" this is not clearly stated. No mention is made of corticosteroids. After all this, it would be churlish to cite spelling errors.

I cannot recommend this book. It makes no concessions to British usage. The quality is uneven and the number of errors is unacceptably high. This is a pity because it is very good in parts.

BERNARD J FREEDMAN

Reference

1 *Stedman's medical dictionary.* Baltimore: Williams and Wilkins, 1982:xiv.

Tales of medicine before Freud and antibiotics

Diary of a Medical Nobody. Kenneth Lane. (Pp 252; £1·75.) Corgi Books. 1982.

Money and medicine are the dominant themes in Kenneth Lane's *Diary of a Medical Nobody* just as they were the dominant themes in the lives of young doctors between the wars and continue to be in the lives of many doctors today. In 1929 if you didn't have capital to see you through the lean years as you learnt your trade as a specialist or to buy your way into a practice, then you were condemned to be an assistant.

As an assistant you had little money and little chance to do things in your own way. Dr Kenneth Lane only just avoided this miserable fate. Not only did he not have any capital, but he owed £320 to the Kent Education Committee for his education and £8 to his brother for a suit. Most practices wouldn't consider such an insolvent candidate, and he had to search high and low for a practice where "money was not the central factor."

His search took him to the coalmining area of Somerset and an application to become the fourth partner in a practice. He liked the partners and they liked him, but they wanted £2000. They were willing to accept £500 immediately and £1500 over the next three years. This seemed impossible to Dr Lane, and he had written a note regretting that he would not be able to take up the offer when he heard that money might be available through the Medical Sickness Society. This part of the financial saga ends happily, and Dr Lane establishes himself in the practice where he is to spend his life.

With money problems put to the back of his mind for a moment, Dr Lane can start his doctoring. In the middle of the night, as if in some Rembrandt painting, he performs his first forceps delivery, and because he is terrified of being overseen by an older doctor who is "nursing a resentment" against him he does the delivery and gives the anaesthetic himself. All doctors will recognise this tendency to do a little more than you are competent to do for fear of being humiliated by calling out a sneering senior. Later Dr Lane treats a patient at death's door with pneumonia in a caravan because the local surgical hospital refuses to admit a medical case. Further drama is provided by the farmer, who wants to evict the caravan from his land. The story ends happily, as do many in this slightly fairytale book, but not all do. Dr Lane has to do his first tracheostomy on a gypsy boy with diphtheria while his gypsy companions dance outside the window. He cuts in what he hopes is the right place to encounter only blood. As his nerve begins to fail the matron tells him to cut right through the cricoid, and he is rewarded with bubbles of air. The gypsy shaman, whose ineffective treatment has kept the boy away from the doctor until this late stage, is contemptuous of both Dr Lane's diagnosis and his treatment, and she is not at all surprised when the boy dies the next morning.

Most doctors practising today have known only the antibiotic era and will be fascinated by Dr Lane's descriptions of his struggles with pneumonia, diphtheria, and meningitis. The climax of the book is Dr Lane's first use of sulphonamides to treat meningococcal meningitis in the autumn of 1938. But just as interesting are his descriptions of how the doctors felt about neurotic illness. Freud published his *Interpretation of Dreams* in 1910 and his *General Introduction to Psychoanalysis* in 1910, but his ideas don't seem to have reached anybody in Somerset in the 1930s. Nobody was very keen on neurotic illness, just as many doctors are not today; the great compensation then was that neurotic patients brought in a sizeable part (Dr Lane calculates half) of the practice income. Interestingly too, while lower class patients were "neurotic" upper class ones were "sensitive."

The financial theme in the book is wrapped up very closely with medical etiquette. Early in his career Dr Lane has an experience that will be as strange to a young doctor now as managing pneumonia without antibiotics: he arrives at a

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Lateral thinking was never one of my strong points, so I hope I will be forgiven for not immediately spotting the connection between this cartoon of Queen Victoria by Max Beerbohm and the small collection of letters, portraits, and books on show in the library of the Royal College of Physicians. It's simple really. Quite fortuitously, and I quote, "her reign fits nicely into six display cases." No doubt the good lady would be thrilled and delighted to know this, although I suspect that she would be less thrilled by five of the six portraits of her that are on display in the exhibition. I can only describe them as peculiarly unattractive.

Anyone who shares my obsession with secondhand books with their familiar comforting smell and faded inscriptions will warm to this exhibition. The elegant brown ink prose of the letters on display bridges the years and allows you to identify with the physicians of the day. Bryan Batty's medical notebook is open to show alarming instructions on how to "throw up" a solution of some unpronounceable root into the rectum twice a day. Clearly a purge designed to wash away more than the sins of the unfortunate patient.

The portrait of Napoleon III seems incongruous among the noble profiles of former members of the college, but the explanation for his presence lies in a comprehensive description of his state of health. Dr Robert Ferguson's minute observations are well worth reading and led to the diagnosis of "general nervous exhaustion"—plus ça change. . . .

Though some of the articles are of less interest than others, I was amused by an advertisement for a sanatorium in Highgate, in "the most healthful part of England," lying "within easy distance of London." On a more sober subject, the notes of John Mitchell Bruce FRCP on the last illness and death of Benjamin Disraeli make compulsive reading. 19 April 1881: "1.15 breathing altered, 1.30 low mutterings, 1.45 chicken one piece, one piece bread and butter, brandy, 2.00 asleep, 2.45 cold perspiration, 3.30 RC 26 × 2 ? (my question mark), 4.30 died." I wonder how his demise would be recorded now? No doubt he would have been shoved on an intensive care unit, submitted to invasive "supportive therapy," and denied the brandy.

The appeal of this exhibition is idiosyncratic but I enjoyed it, and for the benefit of those who might do likewise, it runs until early September.

TESSA RICHARDS

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patient's door at the same time as one of the other GPs in the town, and they both stand over the patient competing for the diagnosis and the patient's allegiance. Dr Lane gets himself into trouble at another stage for distributing food parcels to the poor in the area. The problem is that some of those to whom he gives parcels are patients of another practice, and the gifts are interpreted as bribery.

Dr Lane has written his book using his wife's diaries, and although it has the slightly embarrassing title of *Diary of a Medical Nobody* it is not set out like a diary. But like a diary it becomes a little tedious to read because it fails to develop and it contains too many homilies that don't matter when hidden in a diary but which make us squirm when published. Twice Dr Lane ends chapters by concluding that characters were not bad chaps, and some fiercer editing and a little more mustard in the writing would have made for a better book. Those who seek literature should look elsewhere, but those who want tales from a vanished medical world will find great pleasure here.

RICHARD SMITH

Promoting principles of biochemistry

Biochemical Aspects of Human Disease. Ed R S Elkeles and A S Tavill. (Pp 729; £49·50.) Blackwell Scientific Publications. 1983.

The recent discussion in the *BMJ* of the role of the referee of submitted papers and the guidelines he should be given is of no help to the book reviewer. Not for us the opportunity to advise a redraft, publication elsewhere, or frank rejection. Our major guidelines come from the authors themselves. What are their stated aims in writing their book, are these praiseworthy, and how successful have they been in achieving them?

The intentions of Dr Elkeles and Professor Tavill are beyond reproach. They want to maintain (their word) "awareness in clinicians of the relevance of basic biochemical principles to an adequate understanding of disease mechanisms" and to share with them "their excitement at the rapid advances being made by research in both clinical and basic science departments." Any excitement I might have felt at these stirring words took a knock to see that two chapters dealt with "Drug reactions and interactions" and "Auto-antibodies and disease." Although these essays are well written, their topics are more than adequately covered elsewhere and seem inappropriate in an ostensibly biochemical setting. Very few references are later than 1980, and one of these is even in press, which suggests that the book has had a lengthy gestation.

But stillborn it is not. The healthy mix of distinguished English speaking authors from both sides of the Atlantic and from Australia provides many good things. Some chapters achieve an excellent synthesis of the biochemical and clinical aspects of disease processes. Appropriately enough these include those by the editors themselves—Elkeles on diabetes mellitus and, perhaps the pick of the bunch, Tavill and Cooksley on liver disease. Other successful contributions are those of G R Thompson on plasma lipids and hyperlipoproteinaemias, J S Woodhead on calcium metabolism, G H Elder on disorders of haem synthesis, E C Gordon Smith on biochemical aspects of haematology, and R O McKeran on central nervous system diseases. T M Andrews writes well on metabolic disorders of muscle but takes a more optimistic view of thymectomy in myasthaenia gravis with thymoma than do most authorities. These topics lend themselves naturally to a biochemical understanding of disease mechanisms. It is no reflection on the authors that the biochemical basis of the psychoses will inevitably provide thinner copy.

I enjoyed and learnt a good deal from the chapters on gastrointestinal biochemistry by L A Turnburg and on protien metabolism by W P T James. Both contributions are, however, largely devoted to the biochemistry of normal physiology and are not related sufficiently to everyday clinical pathophysiology. Three chapters deal well with the biochemistry of inflammation, hormone action, and the prostaglandins.

The remaining chapter, on biochemical aspects of hypertension by J L Reid and H J Dargie, highlights the problems that I believe many of the authors faced in being asked to deal with large topics in relatively few pages. Reid and Dargie cover catecholamines, the renin-angiotensin system, aldosterone, prostaglandins, the management of specific disorders, and the action of hypertensive agents. It is impossible to do this in 35 pages, even as succinctly as they manage it, and also achieve the tingle of excitement the editors are seeking. Throughout the book the constraints of space lead to a somewhat superficial treatment of several important topics. Speaking selfishly, I was sorry that the editors, clearly with difficult decisions about which topics to include, left it almost completely anephric.

Judged by the editors' stated aims, *Biochemical Aspects of Human Diseases* cannot be counted a complete success. It is, however, well written throughout and few clinicians will not find something of interest and relevance. In any subsequent edition I would suggest more cross reference between chapters, which would give the book more unity, and at the very least provide some up to date references.

B I HOFFBRAND

Learning more about drugs

Recent Advances in Clinical Pharmacology 3. Ed Paul Turner and David G Shand. (Pp 288; £26.) Churchill Livingstone. 1983.

One of the fascinating things about working with old established drugs is realising how little we often know about them. Heparin has been in use for over 40 years, but, as Dr Bjornsson points out in his contribution to *Recent Advances in Clinical Pharmacology 3*, until relatively recently little has been understood about its clinical pharmacology. His chapter clearly delineates areas of knowledge and of ignorance about heparin and offers practical advice on its clinical use that will be of value to anybody who contemplates using the drug.

Similarly, when we consider the wide range of cytotoxic drugs available it is perhaps not surprising, particularly to those of us already converted to the idea, that pharmacological principles need to be applied if the efficacy of treatment is to be improved. Dr McEwen and Dr Slevin review ways in which a clinical pharmacological approach can contribute to cancer chemotherapy—in the design and evaluation of clinical trials, in the investigation of pharmacodynamics, and in the overall care of patients with cancer. Other high spots in the book were the chapters on the dynamics of drug action in the elderly, on central effects of beta adrenoreceptor blocking agents, and on angiotensin-converting enzyme inhibitors. The chapter on angiotensin-converting enzyme inhibitors deals predominantly with the pharmacology of captopril and demonstrates eloquently how knowledge about this drug developed and how we still do not fully understand its clinical pharmacology.

The problem with multiauthor books of this sort is, of course, that they are often written at least a year before they are in print. Several contributors comment on the fact that their articles reviewed published works up to February 1982. This presents a particular problem for authors writing on a subject in which relevant research is likely to be published after their chapter has been written, an example in this book being the secondary prevention of myocardial infarction. The authors of

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this chapter were optimistic, however, in thinking they could cover the entire range of this problem in six sides of typescript with six tables.

I was disappointed by the chapters that began and ended the book. The first was on analytical techniques in clinical pharmacology and started with a simple description of gas liquid chromotography; it then dealt in more detail with gas chromotography, mass spectrometry, and high pressure liquid chromotography. There was, however, no mention of other widely used techniques such as radioimmunoassay, homogenous enzyme immunoassay (EMIT), radioenzymatic assays, or physiocochemical techniques such as receptor binding assays. A mention of these, with some indication of their uses and limitations, should really be considered in a future volume. The last chapter, on the actions of opiates, was thorough but unfortunately dealt virtually exclusively with animal studies and did not relate these to human pharmacology.

In the preface to this third volume of the series the editors comment on the infectious excitement of clinical pharmacology and hope that the volume will transmit it to the readers. Do they succeed? Certainly some of the authors manage to convey their enthusiasm through the written page. The topics covered illustrate the fact that clinical pharmacology makes an important contribution to the care of patients be they neonate, adult, or elderly. There is sufficient good material to overcome the weak spots and I am sure it will find a well thumbed place in most hospital libraries. Whether at £26 it can be said to be a necessity for the general physician is another matter entirely.

D N BATEMAN

Comparisons of care for the elderly

Contributions to the Study of Aging. No 1. "Geriatric Medicine in the United States and Great Britain." David K Carboni. (Pp 159; £23·95.) Greenwood Press. 1982.

In Britain geriatric medicine has been a recognised specialty for 35 years. In the United States it is not yet recognised, and this is unlikely to change in the near future. Yet both countries have similar population profiles; both face similar problems in the provision of health care for the aged; and both are concerned to do their best for the elderly patient. Why should their attitudes to geriatric medicine be so different? This is the question addressed by Dr Carboni, a medical sociologist who directs the Center for the Study of Ageing in the University of Bridgport (Connecticut). Because he is not a doctor he is perhaps able to stand back from medicopolitics and take a more detached view.

One reason, he says, for the failure of geriatric medicine to gain recognition as a specialty in the United States is a power struggle within the medical profession. At one time a specialty arose when a generalist limited his practice to a particular area of medicine. But today each new specialty claims territory that was formerly the preserve of another, and until there is consensus it is hard to change the status quo. Geriatric medicine, it is claimed, has no techniques or body of knowledge unique to itself. All doctors should know about aging and should apply that knowledge to their own specialty. In the United States 80% of physicians are certified specialists, qualified by an approved course of training and the passing of an examination. But almost all take primary referrals and are not, as in Britain, appointed by competition to a consultant post. Moreover, family practice has been resurrected recently in the United States and family practitioners see a specialty of geriatic medicine at primary care level as a threat. The distinction between general practitioner and consultant, so familiar to us here, does not exist. So the whole structure of medicine is inimical to the development of a comprehensive geriatric service led by consultants. Academic departments of great distinction are doing excellent research, particularly in the social and psychological aspects of aging, but few teaching hospitals yet have departments of geriatric medicine. There are no geriatric services which medical students can use as a model, and the question "Who is to teach geriatric medicine?" has never received a satisfactory answer.

In Britain, on the other hand, we have an increasing number of professors of geriatric medicine. We have proper separation of general and consultant practice, with responsibility for the elderly clearly defined, and the primary care team with its health visitors and community nurses is one of the glories of the National Health Service. Because there is some lay influence in the NHS we are able to plan services to meet the identified needs of the population; allocation of manpower and resources are not entirely dependent on the pressures of the market place. All this has made possible, with initial support from the Department of Health and Social Security, a specialty of geriatric medicine. It is hard to think of this as anything other than an advantage—and many foreigners evidently think so too, to judge by the numbers who attend courses on geriatric medicine and visit our departments. The achievements and potential job satisfaction are there for all to see provided that the service receives proper priority and a reasonable share of resources.

I found this a fascinating and heartening book, though at almost £23 I do not suppose that many people will buy it. The author has researched his subject well and his description of geriatric medicine in Britain rings true, despite the fact that his research was done in 1977. Things have moved on since then. Most districts have a good geriatric service and, with an increasing number of geriatric medical beds in district general hospitals, long waiting lists are mostly a thing of the past. We now have 500 consultants in geriatric medicine, making it the third largest medical specialty after general medicine and paediatrics. Recruitment is looking up and standards are rising. Even relations with general medicine, for a long time rather uneasy, are getting better and joint appointments are becoming more common.

Dr Carboni is too discreet to say what he thinks should be done in America, but he quotes with approval a fine piece of sociological jargon, that the clinical management of the disabled elderly requires a fundamental rethinking of the "medical care practice paradigm." British readers will, I think, continue to be thankful for the National Health Service, which, for all its faults, ensures that the elderly receive good medical treatment and support when they most need it. We should not be ashamed to count our blessings.

R E IRVINE

Contributors

BERNARD J FREEDMAN is consulting physician at King's College Hospital, London.

RICHARD SMITH is assistant editor of the *BMJ*.

TESSA RICHARDS is assistant editor of the *BMJ*.

B I HOFFBRAND is a consultant physician at Whittington Hospital, London.

D N BATEMAN is a senior lecturer at the Wolfson Unit of Clinical Pharmacology, University of Newcastle upon Tyne.

R E IRVINE is physician to the department of medicine for the elderly at St Helen's Hospital, Hastings.

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