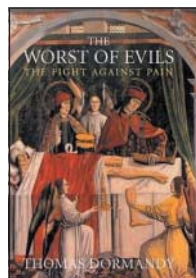


# reviews

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## The Worst of Evils: The Fight Against Pain

Thomas Dormandy



Yale University Press,  
£19.99/\$35, pp 560  
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Rating: ★★★★★

Milton thought pain was a perfect misery and the worst of all evils. But Thomas Dormandy has shown us that humans have taken bold and positive steps to remove this evil and misery. In his historical account of the pursuit and conquest of pain the author has explored ancient mythology, literature, philosophy, music, painting, opera, war, famine, disease, and heroism, moving between science, literature, and history of the ancient and new worlds with consummate ease. As someone with limited linguistic and literary skills I found the book somewhat overwhelming but fascinating nevertheless.

In mythical and ancient times pain was considered a gift of gods; so were the remedies of the time: wine and the poppy. Faith was the basis of everything, including the “painless” deaths of countless martyrs. A multiplicity of saints flourished to help deal with ailments; an example was St Fiacre, whose merciful intervention was sought to relieve irritation around the anus. The Crusades popularised the use of opium in the West. This was a time when mandrake, cannabis, belladonna, garden lettuce, and hemlock ruled the world (and the bedrooms).

The Renaissance saw attempts to understand the body and its afflictions. Anatomy had the edge over other disciplines, as it could be permanently—but often inaccurately—depicted in paintings. Tobacco became a drug; syphilis found its way into many households; needless wars were fought; and amputations were done without anaesthesia. This period witnessed the foundations of modern medicine by such people as Harvey, Descartes, and Paracelsus. Mesmerism was used to relieve the pain of

surgery. I wonder what would have happened if anaesthetic gases had not become popular soon afterwards?

The book has some chilling descriptions of operations done without any anaesthetic, such as the mastectomy on Madame d'Arblay. It is somewhat sad, but encouraging, to know that the surgeons of those days were really nervous wrecks before, during, and after surgery, despite their outwardly pompous attitudes and manners (perhaps true even today). I found the chapter “Terror of the Knife” particularly harrowing. Massive surgical bleeding and almost inevitable infections must have disheartened many.

The search for ways to nullify pain during surgery began in earnest in the 19th century. Pain was seen by some as desirable, but the social changes of the day did not offer much support to this view. Thanks to work by European inventors and American entrepreneurs such as Crawford Williamson Long, Horace Wells, and William Morton, anaesthesia became something very useful. The book gives dramatic and detailed descriptions of the first anaesthetic administrations and some fierce rivalry between some of the pioneer gas men of North America. Public demonstrations of surgery were common, visitors being charged a fee to watch.

Chloroform soon attracted royal patronage, with John Snow's use of it on Queen Victoria. Of all the celebrities, Snow was really the one who popularised anaesthesia as a science. Dormandy details the early years of anaesthesia, the first anaesthetic related cardiac arrest (the lucky person survived), and the first death from an anaesthetic. There were important moves to vilify anaesthesia. Women, elderly people, and the young (and, of course, other races and the lower classes) were deemed not to need much of it. But mortality after operations was less with anaesthesia than without, thus saving this young specialty.

Developments in physiology, pathology, and pharmacology followed. Germs were discovered, and antisepsis was introduced. Cocaine stepped in as a useful local anaesthetic; so widespread was its use that it was inevitable it would become a drug of



William Morton's first public demonstration of ether anaesthesia, Boston, 1846

misuse as well. However, pain and suffering remained the worst of evils for most people. The book's description of Mrs Humphry Ward and her ailments would shame most regular users of the NHS.

With the early part of the 20th century came advances in neurophysiology (although George Bernard Shaw called some of the Nobel prize winning practitioners animal torturers). Barbiturates were synthesised, perhaps helping millions. Attempts were made to control trigeminal neuralgia, and women were given large doses of morphine and scopolamine for painless labour (often without their agreement). One of the brilliant chapters describes Auguste Renoir's constant fight against rheumatoid arthritis. Aspirin made its commercial appearance, almost unchallenged, and reduced the agony of millions suffering in the 1918 flu pandemic. Other drugs of note were phenacetin, which led the way for many other analgesics, and curare, as an aid to surgery. Research into the physiological and pharmacological basis of pain mushroomed.

Pain clinics and hospice movements were established in the later part of the 20th century. I have met John Bonica on a few occasions and have followed the brilliant career of Cicely Saunders (obituary *BMJ* 2005;331:238); their personal stories, as given in this book, somehow make me feel a part of history.

I am unsure of the target audience for this book. It is, however, a near perfect historical record of the struggle against pain, although the hard won victory is as yet incomplete.

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Items reviewed are rated on a 4 star scale  
(4=excellent)



## Letting Him Down: making the euthanasia decision easier

*Laten Stikken* (*Letting Him Down*) will be shown, subtitled in English, at the World Congress of Right to Die Societies in Canada this month and then later at events throughout the Netherlands.

The man, Thijs, lies dead. His widow, Ankie, and his general practitioner, Freek, sit nearby, shocked. "That was terrible... the suffering... you would not wish that on anybody," says Ankie. Freek replies: "Naturally... terrible." Then the grieving widow blurts out: "Couldn't you have prevented that? You knew he never wanted that. He gave you the form years ago."

*Laten Stikken*, which means "to let suffocate" but has been given the looser translation of *Letting Him Down*, is a film made by the Dutch Society for a Voluntary Ending of Life. It is aimed at helping GPs and patients break the silence surrounding euthanasia—a silence that the society believes is denying due consideration of patients' legitimate requests. Even though the Netherlands has agreed a legal framework for permitting voluntary euthanasia, thus achieving "quality" in practice, this most difficult decision for doctors remains a complex and lonely one.

Last year the society published *Euthanasia: A Different View of Practice*, which was based on a sample of 14 accounts from surviving relatives and was aimed at raising concerns from the patients' viewpoint. In the ensuing debate the society's director and a former GP, Rob Jonquière, argued that each

year hundreds of doctors delayed euthanasia until it was too late, used morphine instead to induce a coma, or simply ignored the request altogether. The Dutch Medical Association denied that "hundreds" of such cases existed and called for a balance between doctors' responsibilities and patients' rights.

In 2001, of 9700 requests for euthanasia 3800 were accepted. Of the remainder, some of the people died before euthanasia was needed, while other cases failed to meet all the legal requirements, such as that the person be suffering unbearably and hopelessly. However, possibly thousands of unmet requests remain. The society's book, Dr Jonquière believes, showed how both patients and doctors continually "beat around the bush" out of a misplaced consideration for one another, with unpleasant consequences.

Now *Letting Him Down* aims to make things easier for GPs and patients. Actors illustrate the many painful moments when chances to talk are missed. Dialogue between the grieving widow and her dead husband's GP is intercut with flashbacks to crucial turning points in the patient's history, such as the delivery of the first euthanasia request 10 years earlier and the time when Freek first told his patient he was terminally ill.

Some of the dialogue is painfully Pinteresque. Told he is dying, Thijs says: "You know I have this... declaration? And I can count on you. If I can't go any further... if I don't want any more?" Freek promises "to help" and "to do everything."

Later Ankie accuses Freek: "You knew he wanted 'it' done." But Freek replies: "If he had asked me, 'What's your position on euthanasia?' I could have told him that there are conditions and that I don't find it a tea party. But he never asked. And I was not prepared for it."

Ankie, becoming increasingly upset, shouts: "How long do you need to be prepared? You ignored his declaration. You fobbed Thijs off." To which Freek replies. "What then would you have done?"

The roles are then swapped, in the film's key educational device, and the society's idea of an "ideal" consultation is enacted. In this scene the dialogue begins with the delivery

by the still healthy patient of the written euthanasia declaration. "You have my declaration?" asks the patient. "You mean your euthanasia declaration?" the GP replies. They discuss the circumstances in which euthanasia should be given. The GP explains things from his point of view: "It is difficult for me. I became a doctor to cure people, not to..." "Murder them?" replies the patient. "No, no," insists the GP, "absolutely not. We prefer to talk about ending life at a patient's request." He then adds: "It is important that we grow towards this together. You must realise that euthanasia is not just any old job." Finally the GP makes it clear that they must talk further as soon as the patient's prognosis becomes hopeless.

Dr Jonquière explains that the film is aimed at closing the gap between the reality portrayed in the first part and the ideal in the second. "We want to show that euthanasia should be a process begun before there is any suggestion of a malignant disease—a path that both patient and doctor must take while continuing to communicate."

In the small number of cases where things go wrong, he fears, they go badly wrong, resulting in much anger and sadness and with patients literally left to die. The common thread when problems occur, he says, is poor communication.

He says, "Doctors are trained in procedures, laws, criteria, drugs, and technical matters, but the heart of the problem is the fear—it [euthanasia] is something he'd rather not do. We accept that patients have no right to euthanasia and that doctors can't offer any guarantees; but if you don't talk you will never come to a well considered decision, that you do it or you don't."

Doctors specially trained in the Dutch Medical Association's support and consultation in euthanasia programme are likely to take part in debates coupled with the film's showing this autumn.

The association agrees that good and timely communication is essential and welcomes anything that aims at improving communication and the quality of medical decisions. But it also stresses "shared responsibility." The association's Eric van Wijlic said, "There are always circumstances, such as the onset of dementia, where it is difficult or impossible to accept a euthanasia request. That is why doctors and patients must, early on, come to a common understanding about whether they can find common ground in this area and establish the limits."

He says that Dutch doctors are acutely aware of their social responsibility. Decisions on euthanasia are among the most difficult that Dutch doctors will ever have to make. "It affects doctors professionally and personally and makes unbelievable demands. Doctors must choose between their professional desire to protect life and another choice to end it."

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CHARLOTTE BOGAERT

Painful dialogue: Ankie, the patient's widow, and Freek, his general practitioner



## PERSONAL VIEW

## Sleep walking to another Stanley Royd?

In August 1984 an outbreak of salmonella food poisoning at Stanley Royd Hospital, a large psychogeriatric hospital in Wakefield, Yorkshire, claimed the lives of 19 patients. Just over six months later, in April 1985, an outbreak of legionnaires' disease at Stafford District General Hospital caused the deaths of 28 people.

Public inquiries into these outbreaks were established by the then Department of Health and Social Security, and their findings were published in 1986. The inquiries, in highlighting concerns about the decline in available medical expertise in environmental health and in the investigation and control of infectious diseases, called for a review of the responsibilities and authority of medical officers of environmental health—the local public health doctors who at the time were responsible for investigating outbreaks of communicable diseases in the community.

The then secretary of state, Norman Fowler, asked the chief medical officer, Donald Acheson, to undertake a “fundamental examination of the role of public health doctors, including how such a role could best be fulfilled.” The result was *Public Health in England*, published in January 1988, which emphasised the need for properly staffed local public health departments, led by a director of public health and including a consultant in communicable disease control working alongside other public health consultants.

When adequately staffed, these new departments worked well, and their teams of public health doctors assumed 24 hour responsibility for control of communicable diseases, under the clinical leadership of the consultant in communicable disease control. Indeed, they stood the test of time until their fragmentation in April 2002, with the demise of health authorities and the creation of smaller primary care trusts.

In January 2002, when concerns about terrorist attacks with infectious disease agents were high after September 11, the current chief medical officer, Liam Donaldson, produced *Getting Ahead of the Curve*, a new strategy for combating infectious diseases in England. This resulted in the creation of the Health Protection Authority (HPA) as a standalone government organisation outside the NHS. The authority was largely funded by the primary care trusts, and by April 2003 the fragmentation of the “old” public health departments was completed, as consultants in communicable disease control and their staff transferred from NHS employment into the HPA.

Since 2003 the separation of primary care trusts' public health doctors and colleagues in the HPA has moved ahead at a pace. Joint bases for trust and HPA doctors, often in old health authority buildings, have become an increasingly rare phenomenon, as the HPA has restructured to become a more regionally focused service—leading to increasingly less day to day dialogue between the NHS and the HPA at the local level. Also, shared on-call rotas, which involved trust and HPA doctors taking joint responsibility for an area, are now threatened, as the HPA seeks to strengthen its own regional out of hours rota.

The effect of all this is increasingly to leave groups of isolated public health doctors in primary care trusts, with atrophying skills in communicable disease control, responsible for carrying out the statutory duties of their trusts with regards to communicable disease.

Outside normal working hours, in particular, potentially vital decisions about communicable disease control now rest with these doctors: shades indeed of the run up to Stanley Royd.

The HPA, meanwhile, continues to concentrate resources on preparing for major emergencies such as pandemic flu. This is entirely

understandable, given the political and media spotlight that falls on the issue whenever a chicken sneezes, but one that risks less focus on common communicable disease issues.

What can be done about this? Apart, that is, from taking the opportunities created by the latest reorganisation of the NHS in England to reintegrate the HPA's communicable disease consultants with the public health staff in the new larger primary care trusts? Regrettably, this does not seem to be an option, so directors of public health and chief executives in these new organisations will need to be clear about just what is expected of them with regard to communicable disease control and then ensure that they have either the necessary staff or the money to contract someone else to do it for them.

They will need to leave on one side the fact that the entire financial resource that used to fund their local team of consultants in communicable disease control now sits with the HPA and dig deep to find the money again. They may even have to recreate the post of local consultants in communicable disease control employed by the NHS as part and parcel of their deliberations, as failure to take action soon may well leave them sleep walking to the next Stanley Royd.

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**Primary care trusts may even have to recreate the post of local consultants in communicable disease control**

## SOUNDINGS

*The history of box ticking*

No one knows when or where the first human being ticked the first box. The word “tick” does not appear in the Bible. Archaeologists have found no traces of boxes—ticked, crossed, or otherwise—in Egyptian papyruses, French caves, or Asian temples. Someone has even proposed the highly implausible theory that in the past great civilisations flourished without questionnaires.

Aerial photography in Peru, however, has revealed regular rows of box like shapes covering an area of several square miles and headed by pre-Inca glyphs for the sun (“Yes”), the moon (“No”), and a cloud (“Don't know”). Yet none of these boxes appears to have been ticked, leading some to suggest that this is the first recorded example of a non-responder.

The modern questionnaire was developed in the 19th century by psychologists studying small children who could not read or write. By the end of the 20th century questionnaires were widely used in Britain to monitor the medical profession. Logical as this progression seems to us now, it was not without controversy.

Early in the 21st century there was a wave of early retirement among British medical teachers. They complained that no matter how inspiring their teaching, students always reacted by asking them to tick a box in a logbook. Older teachers grumbled that assessment of the infinitely subtle art of medicine had been reduced to computerised sudoku.

In 2012 the Third International Congress on Medical Box-Ticking achieved the remarkable feat of agreeing a single generic form for all medical questionnaires—psychosocial research, undergraduate and postgraduate training, peer review, and performance feedback from colleagues, patients, patients' relatives, and managers.

This proved to be box ticking's high-water mark. A backlash developed among lay people, who initially expressed discontent by ticking all the middle boxes, regardless of the questions. Resistance then crystallised into a global movement called “Stick Your Boxes” (“SYB”)—or, in some countries, “SYBB”), demanding more free space for comments. Questionnaires slowly evolved into blank sheets and became extinct because nobody could be bothered to read them.

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