

# VIEWS & REVIEWS

## Zimbabwe: an eyewitness account

PERSONAL VIEW **Kate Adams**

**N**o soap in a hospital? Can you believe it? But this is Zimbabwe, a country whose public health system was once the envy of neighbouring countries and that now has the lowest life expectancy in the world: 34 for women and 37 for men. This statistic continues to shock and disturb me; Zimbabwe is, after all, not a country at war.

Of course, HIV has had a great impact. But it is mainly the policies pursued by Robert Mugabe's Zanu PF party that has moved Zimbabwe, once the bread basket of this part of Africa, to a basket case.

In late October 2007 I spent 10 days in Zimbabwe. I am a trustee of a charity, Zimbabwe Health Training Support, whose aim is to support the training of health professionals and medical students in Zimbabwe. During my stay I ran workshops on medical ethics for junior doctors and consultants. I gave a talk to GPs in Bulawayo on how quality is assessed in general practice in the United Kingdom. While in Bulawayo I stayed with a physician and spent part of my week shadowing him. I also shadowed a GP.

HIV seemed to pervade all healthcare encounters. As many as 70% of inpatients in the public hospital in Bulawayo had an HIV related disease. Many people present with advanced disease—a death sentence. The HIV clinic in Bulawayo is supported by the Clinton Foundation, but a shortage of drugs and resources has meant that it has been closed to new entrants since August, except for children, pregnant women, and healthcare workers. I spoke to a pharmacist concerned about the future supply and reliable delivery of antiretrovirals. Some Zimbabweans who work in South Africa get their antiretrovirals there. One young man had fraudulently been given painkillers as part of his triple regimen therapy. He presented with an immune reconstitution syndrome. He needed

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**Inflation continues to soar**

chemotherapy, but this wasn't easily available and anyway he didn't have the money to pay for it.

The HIV clinic has 2500 children on its register. A morning spent with the paediatric nurses revealed the human tragedy. I met numerous orphaned children with HIV being cared for by aunts and grandparents. Because of the food shortages in Zimbabwe a charity was donating food to people with HIV to help feed their families.

I wondered why there seemed to be so many small children and babies with HIV, given the availability of treatment for pregnant women. A paediatrician said one reason is that there is no easily accessible milk in Zimbabwe, so mothers continue to breast feed beyond six months, putting their babies at further risk of acquiring HIV.

Shortages of medical equipment and drugs are severe. Thermometers were being shared between wards, no glucose sticks were available for monitoring diabetes, and certain antibiotics could not be obtained. A lack of catheter bags and pads meant that incontinent and immobile patients had to lie in urine. One patient had metastatic pancreatic cancer. There was no morphine to control his pain or dexamethasone to reduce his brain swelling. Patients in outpatient clinics told us they had difficulty getting basic drugs for ordinary medical conditions

such as heart disease, diabetes, and asthma. One patient couldn't afford to buy a steroid inhaler. A girl was walking around for a week with a fractured arm not in a cast as neither of the public hospitals had plaster of Paris. The tragedy is that it never used to be like this.

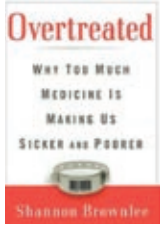
Healthcare professionals are leaving their work daily. A paediatrician and a physician had left the week before I arrived. No one begrudges them for leaving, but work schedules inevitably become more intense for those remaining. Non-governmental organisations try not to poach health service staff, but they pay in hard currency. Inflation continues to soar—during my short stay prices increased by a third. Nurses I met couldn't afford to eat on their pay. A typical nurse's monthly salary of 17 million Zimbabwean dollars (£290; €385; \$570) doesn't go far when transport to and from work costs \$Z400 000 each day. One nurse I met relied on financial support from a relative (a nurse) working in Britain.

Simply surviving in Zimbabwe is exhausting. People spend a lot of time searching and queuing for food. Basic foodstuffs such as bread, sugar, and flour are hard to find. Many people survive on one meal a day. There is a desperate shortage of fuel, and people have to go to Botswana to get it. Every day there are cuts in power and water supplies—one part of Harare had not had any running water for six weeks.

I have great admiration for the healthcare staff I met. They had to be so resourceful and were constantly having to solve problems. I was impressed by the clinicians' skills. As is the case in many developing countries, doctors' clinical and interpretive skills are often very sharp as so few tests and investigations are available.

I was left with a lasting impression of people who, in spite of incredibly difficult circumstances, had not lost their humanity, sharing food and water and helping each other out in whatever way they could. Kate Adams is a general practitioner in Hackney, London, and a trustee of Zimbabwe Health Training Support [kateadams@doctors.org.uk](mailto:kateadams@doctors.org.uk)

Oliver Sacks's  
master class in  
case reporting,  
p 101



**Overtreated: Why Too Much Medicine Is Making Us Sicker and Poorer**  
Shannon Brownlee  
Bloomsbury,  
£12.65/\$25.95, pp 352  
ISBN 978 1 58234 580 2  
Rating: ★★☆☆

REVIEW OF THE WEEK

# What is wrong with US health care

A new book brilliantly sets out the problems with US health care. But overtreatment isn't the whole story, and the solution is another matter, says **Douglas Kamerow**

Yet another book about the healthcare “system” everyone loves to hate? Yes, indeed, but this is a good one. Journalist Shannon Brownlee systematically documents the problems, deftly mixing statistics with telling anecdotes and quotations. She also profiles healthcare heroes and villains at greater length.

If you ask doctors why US health care costs so much, we'll say that the for-profit medical system and litigious lawyers are the problem. Drugs cost too much because of the rapacious drug companies. Administrative costs are too high and are multiplied by the vast number of health plans and insurance companies. And because we're worried about lawsuits, we practise defensive medicine and order too many tests so we don't miss anything.

Brownlee enumerates and rejects most of these explanations. She uses overtreatment as her organising principle and the ultimate cause of all the problems with US health care. She explains what drives unnecessary care in the US, starting with John Wennberg's variation studies. His brilliant insight about and documentation of the shocking variability of care and costs within small areas and across the country immediately raised the question of whether some areas were getting too much medicine or whether others were getting too little. Almost always, it seems, it's the first.

This leads to a discussion of the assessment of appropriate care and the dirty little secret that “stunningly little of what physicians do has ever been examined scientifically.” Brownlee ticks off a list of surgical procedures, screening tests, and medical treatments that have been widely accepted only then to be proved useless or harmful once studied: radical hysterectomy, frontal lobotomy, x ray screening for lung cancer, proton pump inhibitors for ulcers, hormone replacement therapy for menopause, and more. She goes into great detail to tell the sad, expensive story of high dose chemotherapy with bone marrow transplantation for advanced breast cancer. Many treatments are still based

more on sound reasoning than sound evidence and on hope rather than knowledge.

Although the rise of evidence based medicine has helped reduce overtreatment a little, the US legal system still punishes doctors for not doing “enough” (meaning everything possible), despite evidence based guidance to the contrary. As one of the few countries in the world that permits advertising of drugs directly to consumers, the US has to contend with the resulting obsession among patients with new and ever more expensive drugs, often with questionable benefits. Furthermore, the lack of electronic medical records and coordinated care leads to medical errors, misprescribing, and more overtreatment.

In a system dominated by subspecialists, each with a range of expensive tests and procedures to order or perform, it is no wonder that an estimated 20% to 30% of the resulting tests are needless. The law of supply and demand doesn't, of course, apply to medicine; in fact, supply drives demand. The presence of more hammers only makes more things look like nails. Waste, inefficiency, millions spent on marketing and administration—it's all here and well documented. America has a perfect storm of circumstances, all of which lead us to ever more utilisation without a commensurate improvement in outcomes.

Overtreatment isn't the whole story, though. There are also plenty of incentives for insurance companies to deny care that may be needed so as to maximise profit. Michael Moore's recent film *Sicko* (*BMJ* 2007;335:47) features a number of people with insurance who are denied appropriate care and a man whose job it was to deny them that care. Certainly the millions of uninsured people in America aren't being overtreated; their problem is getting routine treatment of any

sort. So I would quibble with Brownlee's title but not with the substance of her book.

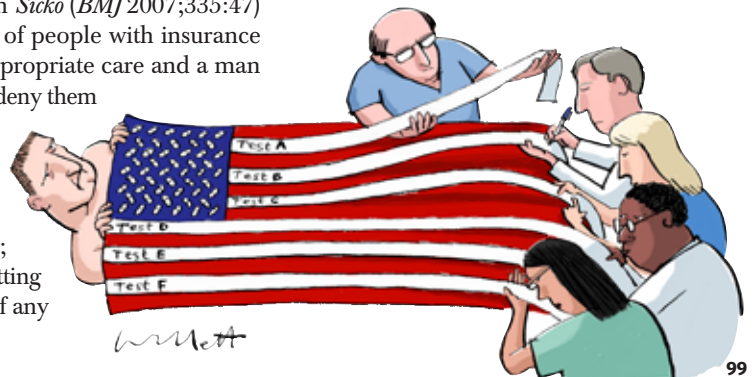
The big question, of course, is what to do about all this—a much more difficult problem than documenting it. Brownlee makes sensible recommendations. Praising the recently reformed Veterans Health Administration, she proposes that it take over the hospitals that can't or won't fix themselves. She advocates better coordination and accountability, universal electronic medical records, and more widespread use of evidence based medical care.

More evidence is needed about what works and what doesn't, and that requires the type of research that the National Institutes of Health doesn't usually fund. Brownlee tells the story of how a small US government agency was almost put out of business in the 1990s because its evidence based guidelines upset powerful enemies. She suggests that the Agency for Healthcare Research and Quality be given more funding and a mandate to develop and disseminate comparative information about drugs, procedures, and treatments.

These are all good ideas. The beginnings of a blueprint for change are undoubtedly in this book, but it is difficult indeed to imagine where the political will and funding will come from to effect the massive reforms that are needed.

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**Competing interests:** DK worked at the Agency for Healthcare Research and Quality from 1994 to 2001.



# The treatment paradox

FROM THE  
FRONTLINE  
Des Spence



He sat in a crisp, double breasted, pin striped suit, nursing a leather FiloFax and flipping through the glossy charts showing pension growth. I nodded confidently to cover my bewilderment at his sales pitch. Twenty minutes later he crushed my hand and left, with my signature on a monthly investment. Five years later I scratched my now shaven head in bewilderment at the evaluation quote of £67. I complained about mis-selling to the financial ombudsman and vowed never to be fooled or confused by an “expert” or numbers again.

Whether it’s worth treating high cholesterol is a common enough question. No one who sees the charts and listens to the sales pitch would doubt it—but numbers are open to being spun. Let’s consider the trial known as WOSCOPS—the west of Scotland coronary prevention study (*New England Journal of Medicine* 1995;333:1301-8). It wasn’t by chance that the west of Scotland was chosen. The participants were men aged between 45 and 64 in the most socially deprived area in western Europe. More than three quarters (78%) were current or former smokers, and their average cholesterol concentration was 7 mmol/l. If lowering of cholesterol concentration was going to work anywhere it was going to work here. The study ran for five years, and the researchers reported a 32% reduction in cardiovascular mortality in the group of men who took statins. (Similar reductions

were seen in all vascular events, but death is the irrefutable end point whose delay is most of interest to patients.) Other studies have replicated similar results, and so the pandemic of “cholesterol” swept the world.

But the numbers can be presented in another way. Converting the 32% relative risk reduction into an absolute reduction gives a derisory 0.7% reduction in cardiovascular mortality and a number needed to treat of 143 over the study period. Although it may be cheating, this figure can be annualised to give 715 to prevent one vascular death. So, putting it crudely, some 714 patients a year gain no benefit from treatment, even in the highest risk population in the world. With persistent disease creeping into younger and lower risk groups, along with a background decline in the prevalence of ischaemic heart disease, these numbers are likely to be higher.

This is the “treatment paradox”: that an individual patient, despite many years of investment in taking statins, gets virtually nil health benefit. Any relative benefit is seen only at the population level, even for composite cardiovascular end points. The treatment paradox is true of all treatable risk factors such as hypertension and osteoporosis. Patients might rightly scratch their heads and complain about mis-selling if the numbers were presented in this way. But trust me, I am no expert.

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# Development lesson

OUTSIDE THE BOX  
Trisha Greenhalgh



I was waiting on a dusty street corner in one of Africa’s poorest countries, with six teenagers. To pass the time, I invited them to give me 10 differences between “third world” and “first world” countries.

“Easy,” said one. “We’re doing this in Geography. GDP.”

“Okay, so people don’t earn much. What’s the impact of that?”

They surveyed the rows of stinking slums. “People can’t afford nice houses. No kitchens or bathrooms. And the roofs sometimes fall off.”

“Why do you think they don’t earn enough money to buy nice houses?”

“I think they might not be able to read. And there probably aren’t enough jobs to go round.”

“Why not?”

Silence while they contemplated where jobs come from.

“Well, they can’t work on a farm

because there’re no farms. Nothing grows here.”

This was true. The country was built on rock.

“And no factories either. All the goods are imported.”

“You could build a business, like those call centres in India. But I guess they don’t know how.”

We were observing a man arc welding pipes in the middle of the pavement, surrounded by hordes of barefoot children. Car horns drowned the imam’s chant from the nearby mosque.

“They don’t seem to care about safety. Everyone drives really crazy.” We recalled the limble beggars and the little boy with the missing eye.

“What about health?” I asked.

“I think they would get diseases living so close together and having to poo in the drain.”

“If you didn’t have a job you’d

get depressed.”

“They have way more children. I guess because some of them die. The mothers must get really tired.”

“People think it’s cool to smoke”—pointing to an enormous billboard advertising Camel cigarettes.

A man limped by on a disfigured club foot. I explained that this was probably congenital.

“So if you’re born with some problem they can’t fix it like they could in England.”

Our lift was finally pulling up. One final question: “Right, you clever kids, how would you solve all these problems?”

Eventually one of them ventured a solution. “I think,” she said tentatively, “I would start by building a school.”

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# Notes and queries

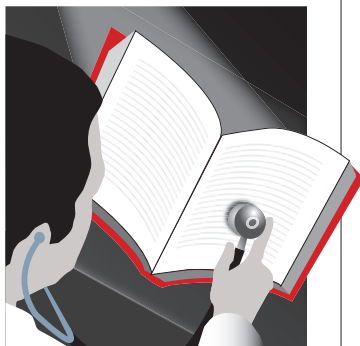
When, many years ago, I began to frequent second-hand bookshops, I would reject as damaged or soiled those books with marginal notes written by previous owners. Nowadays, however, I often find the annotations more interesting than the books themselves; and recently in a second-hand bookshop I found irresistible a slim volume entitled *Marginal Notes by Lord Macaulay*, “selected and arranged” by his nephew, Sir George Otto Trevelyan, and published in 1907. I couldn’t resist it.

“Macaulay’s library,” writes Trevelyan, “contained many books, of no great intrinsic value in themselves, which are readable, from the first page to the last, for the sake of his manuscript notes inscribed in immense profusion down their margins.” As an instance, he cites an annotation in one of the six volumes of Miss Anna Seward’s letters, in which she draws a parallel between Erasmus and Erasmus Darwin. Wrote Macaulay in the margin: “One might as well make a parallel between Caesar and Sir Caesar Hawkins.”

In the same bookshop I found a copy of the late Sir Raymond Hoffenberg’s *Rock Carling Lectures* of 1986 on clinical freedom. It had once belonged to a professor of medicine of great eminence who inscribed his name in it. How did it come to be in the bookshop? Honestly or dishonestly? As a hoarder of books, I assume that everyone is like me and never parts from a book except by amputation without anaesthesia.

The book contained but one marginal note. Quite often marginal notes are made only in the first few pages of a book, as if readers lose interest once they have made their feelings known; but Hoffenberg’s book is so short that one may assume that the single note is indicative of

## BETWEEN THE LINES Theodore Dalrymple



**It is surely rather odd that Mrs Thatcher’s view of the professions as conspiracies against the laity should have coincided so exactly with George Bernard Shaw’s**

the reader’s passion, even though it occurs near the beginning.

It is written on page 5, opposite the words, “The formation of the Royal College of Physicians in London in 1518 provided the first instance of licensing of doctors by a purely professional body. This introduced the idea of self-regulation by the profession, and heralded a shift of emphasis from the intellectual or academic skills inherent in the attainment of a university degree to the demonstration of practical skills.” On the inner margin, the

annotator has written in a cultivated hand in pencil: “Patient or doctor? Thatcher would say Trade Union!”

There are two puzzles about this note: was it written by the eminent professor who inscribed his name on the front of the book, or by a third party, and was it written in agreement or disagreement with Mrs Thatcher’s view? I am not sufficiently skilled a graphologist to answer the first question with any certainty; as to the second, it is inherently unanswerable, short of tracing the professor in question (if it was he who wrote it) and asking him. Speaking for myself, however, I derive a considerable pleasure from uselessly pondering the imponderable. How terrible it would be if all questions could be answered.

It is surely rather odd that Mrs Thatcher’s view of the professions as conspiracies against the laity should have coincided so exactly with George Bernard Shaw’s. Of course, their solutions to the problem were rather different: powerful management on the one hand and nationalisation on the other. Somehow, we’ve managed to end up with the worst (or is it, as some would have us believe, the best?) of both worlds.

Theodore Dalrymple is a writer and retired doctor

## MEDICAL CLASSICS

### The Man Who Mistook his Wife for a Hat and Other Clinical Tales

By Oliver Sacks Published in 1985

Oliver Sacks describes himself as a “physician and naturalist,” and as he has written on matters as disparate as ferns, the periodic table, and encephalitis lethargica I am inclined to agree. It is this collection of case reports, however, that I consider to be his finest work.

The book is in four parts: “Losses,” “Excesses,” “Transports,” and “The world of the simple.” I discovered it in the sixth form, and it inspired me to study medicine and to practise—like Sacks—in the manner of James Purdon Martin, in which “patient and physician were co-equals . . . learning from and helping the other . . . between them arriving at new insights and treatment.”

Neurology is a fascinating and forbidding subject in equal measure, and the author guides the reader on a path to surreal and “unimaginable lands,” thanks to a combination of mellifluous prose and vivid imagery. Despite the book being more than 22 years old and with some terms that would now be considered pejorative, the stories and their messages remain important.

Sacks ponders on the “privative” language of neurology, how “deficit is its favourite word” and how it struggles when conceptualising an excess, rather than a loss, of function. A parallel can be drawn with the comments of a patient, Rebecca, who believes that doctors focus on the diagnosis and treatment of what is lost, to the detriment of what is retained—a lesson we are yet to learn.

An interesting case is that of Dr P, who has a visual agnosia. We learn how he “pats water hydrants” as if they are children and “addresses carved furniture knobs” yet is surprised at their silence. On leaving the consulting room “he reached out his hand and took hold of his wife’s head, tried to lift it off, to put it on.” This sentence is so alien and fantastic it seems plucked from a work of science fiction.

A home visit unearths a beautiful metaphor: we see the progression of Dr P’s pathology charted by his art, as it becomes less “realistic and naturalistic” and more “geometrical and cubist.” Through such visits Dr Sacks delineates both the “I and the It” of his patients.

Another patient, Jimmie G, has Korsakoff’s syndrome. Although 49 years old, he is unable to form or recall memories after his 19th birthday. He views the world with a childlike “innocent wonder,” and we are left wondering whether a “man without a past or future, stuck in a constantly changing, meaningless moment” could be said to have a soul.

This book shows that normal and abnormal are not mutually exclusive categories but arbitrary points on a continuum, influenced by their context. It makes us think about our practice and is surely a master class in case reporting. As an aside, it cites James Parkinson as the first practitioner of street medicine (a pastime that surely all doctors indulge in) in the 1800s, long before the BBC popularised it in *Street Doctor* (*BMJ* 2007;334:157). David Warriner, F2 paediatric trainee, Scarborough  
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From the archive: for a review of Oliver Sacks’s *Awakenings*, see *BMJ* 2007;334:1169.

