Book of the month

Palliative Care for Non-Cancer Patients

‘With what shift and pains we come into the World we remember not; but ’tis commonly found no easy matter to get out of it’—Sir Thomas Browne (1605–1682)

‘I am not afraid to die. I just don’t want to be there when it happens’—Woody Allen (1935–)

From times of common religious faith to the more secular societies of today, terminal illness and intimations of death have always presented the medical profession with one of its greatest challenges. Yet only recently has a serious attempt been made to focus on how to manage the final months of a distressing disease and, in particular, how to educate doctors in this vitally important aspect of their work. It is frightening to recall how ill prepared my own generation of young doctors were to cope with the problems of patients with terminal illnesses. If they were seen at any length by our chiefs or their junior staff, we were invariably excluded; I can still recall sleepless nights worrying about what I was going to say the next morning to patients who had incurable diseases. Quite early on as a student I began to suspect that most of the pastoral care was being provided by the ward sister, an impression subsequently confirmed on many occasions. Some years later, when I ran a small unit that treated patients with leukaemia in the days when only very primitive chemotherapy was available, I discovered the value of group meetings with the medical and nursing staff and patients’ relatives so that between us we could evolve systems for support. Incidentally, at the same time, it became apparent that some of these patients could have many months of good-quality life if, when they became refractory to chemotherapy, they could be relieved of pain and anxiety—an experience which is still a main reason for my concern about the euthanasia movement.

Surveys conducted during the post-war period, and following the development of the Marie Curie movement, suggested that patient management in terminal-care homes was, though well meaning, often totally inadequate because of lack of skill and training. It was about this time that Cicely (now Dame Cicely) Saunders, whose experience as a nurse and almoner had motivated her to improve the care of terminally ill patients with cancer, decided to train as a doctor with the specific objective of addressing this problem. Within ten years of qualifying she had opened St Christopher’s Hospice, dedicated to patient care, research and education. The hospice movement spread rapidly and was undoubtedly one of the major achievements in the past half-century of British medicine. Although still poorly funded by government and heavily reliant on charitable gifts, the movement has brought Dame Cicely’s message to the attention of doctors world-wide.

Although it was natural that the hospice movement should focus at first on patients with cancer, Dame Cicely declares in the foreword to Palliative Care for Non-Cancer Patients that it was never her intention to restrict this approach to one particular disease. Rather, she hoped that the experience with cancer, gained in the early days of the movement, would be equally applicable to other forms of terminal illness. The editors, Julia Addington-Hall and Irene Higginson, invited experts in different fields of medicine, not all of them directly involved with the hospice movement, to define approaches to the palliation of illnesses within their particular specialties. Certain themes appear regularly enough to suggest that, while the expertise of those trained formally in palliative care may be valuable in many cases (particularly chronic neurological or cardiorespiratory disease and AIDS), specialist knowledge within the individual fields may also be important in improving the wellbeing of patients in the terminal stages of illness. Nowhere is this more evident than in the chapter which deals with sickle cell anaemia, where the concept of palliative care is stretched to the extreme. While it is true that the painful crises in this disease require expertise in pain relief, and that a chronic inherited disease which may produce symptoms from early childhood requires knowledgeable psychological support and lifelong advice from a well-informed team, there is much more to it than this. Painful crises need to be dealt with by doctors who have genuine expertise in the management of this condition; such crises may herald much more serious complications in which sickle cells are sequestered into the lungs, spleen or other organs and it is vital that the patients are treated in a multidisciplinary unit with extensive knowledge and experience in their care.

Indeed, many of the discussions in this book deal with the symptomatic management of patients with longstanding incurable illness, highlighting the fact that there is a grey area in the minds of many doctors and nurses between management of such chronic disease and the kind of care provided by the hospice movement. Clearly, many of the attitudes and skills of the latter are germaine to the care of any chronic illness, just as the skills of individual specialties have much to offer patients in the terminal stages of their diseases. But the hospice movement as developed by Cicely Saunders has taught us so much more about the management of terminal illness than good pastoral care and adequate pain relief, and its lessons and attitudes clearly ought to permeate every aspect of clinical practice.

In their summary, the editors get to the heart of the difficulties of providing palliative care across the whole
range of clinical practice. With the increasing age of the population this will become an even greater challenge in the near future. The hospice movement must expand and provide more centres of excellence for the specific purpose of setting standards of clinical care, research and education. It must also be integrated increasingly into medical education, at both undergraduate and postgraduate level. And there may be a case for expanding its institutional scope, as has occurred in the case of AIDS, towards other chronic debilitating illnesses. Considering the diversity of skills required and the increasing workload, the care of the terminally ill, and certainly the chronically ill, will for the most part have to remain within individual hospital specialties, the community and the family.

The hospice movement should never have been required but, as so wonderfully demonstrated by Cicely Saunders, it most certainly was. Addington-Hall and Higginson have given us much to think about in their wide-ranging discussion of its broader possibilities. The educational role of hospices is now obvious but there is also a desperate need for research in every aspect of the field. With established religions now playing little part in comforting the dying, with our multiracial society expressing many different attitudes to death, with medicine’s increasing ability to prolong life, this long-neglected activity of our profession will grow in importance. If the educational endeavour is successful it should be possible, in the longer term, to develop interactive networks between hospital specialists, primary care clinicians, patients’ families and the expertise of the hospice movement of a sort that will offer adequate standards of management, care and support for those with incurable disease or the consequences of ageing.

D J Weatherall
Weatherall Institute of Molecular Medicine, John Radcliffe Hospital, Oxford OX3 9DS, UK

REFERENCE

The Madness of Adam and Eve: How Schizophrenia Shaped Humanity
David Horrobin

That there is an association between insanity and exceptional achievement has often been suggested. Nietzsche observed that ‘it seems impossible to be an artist without being diseased’, whilst J R Nisbet’s The Insanity of Genius actually argued ‘The greater the genius the greater the unsoundness’. Nisbet was enthusiastically cited by William James in his monumental study of religious conversion and innovation, whilst the psychiatrist Henry Maudsley, no romantic aesthete he, wondered ‘what right have we to believe Nature under any obligation to do her work by means of complete minds only? She may find an incomplete mind a more suitable instrument for a particular purpose’.

Maudsley turned against the fashionable Victorian eugenics precisely for this reason—that associated with radical creativity there was often a touch, or more, of frank insanity, and by preventing the latter we might lose the former. Take a list of authors of such a book series as the ‘Modern Masters’: it will be evident that more than the expected total (around 2% of the general population) of these have had a serious psychotic illness; or a first-degree relative who has. And, since Karlsson, we know that the relatives of psychotic Europeans have more than an expected figure for achievement in creative pursuits, loosely defined.

David Horrobin postulates an evolutionary inheritance of schizophrenia to back his theory of the nutritional causation of this illness. His argument? That a mutation in proto-hominids around five million years ago allowed fat to be taken up more efficiently by the brain and subcutaneous tissue. The essential fatty acids necessary for optimal brain functioning were to be found in riverine areas (as fish, molluscs, insects, reptile eggs, larvae and crustaceans) and became more accessible to us with our useful bipedal gait: we became fat and hairless, and later, bone-marrow eating as we gained a further mutation predisposing us to dyslexia and schizotypy (a schizoid personality—pervasive, idiosyncratic and individualistic). Further mutations around 100 000 years ago, related to the phospholipase A2 cycle, gave us the potential for bipolar disorder, frank schizophrenia and psychopathy (which are associated in families). And creativity? Frank psychosis was initially avoided by a water-based diet rich in the fatty acids required by the brain, and what were then only attenuated psychoses proved apt to fuel human religion, symbolism and art, as well as giving us rather single-minded leaders and the potential for pastoralism and agriculture and thus a more sedentary lifestyle: which ultimately led to the Industrial Revolution and its diet, now with large quantities of saturated fats but a reduction in the range and amounts of essential fatty acids and other micronutrients. And thence
the explosion of psychosis in the modern world, the genetic mutation no longer kept within bounds by adequate nutrition.

As Horrobin himself admits, this does sound like yet another ‘just so story’ of evolutionary psychiatry. But let’s test it out. It has certain advances on the usual ‘palaeolithic genes in the modern world’ tales of lost innocence—for instance, in the emphasis on partial stages of psychosis, the likely polygenetic associations of schizophrenia, the correlation with abnormal phospholipid chemistry in the psychoses, and the apparent increase of schizophrenia in the modern world. And not least for the association between the single-mindedness and abhorrent creativity of the schizophrenic experience and our customary expectations in others of distanced cruelty, abstract rationality, the tendency to ethnic differentiation and consequent hatred, our readiness to accept messianic and psychopathic leaders, and our constant need for novelty and curiosity. In fact our whole fractured humanity.

Roland Littlewood
Anthropology and Psychiatry Departments, University College London, London WC1E 6BT, UK

Comprehensive Urology
Editors: Robert M Weiss, Nicholas JR George, Patrick H O’Reilly

With their Comprehensive Urology Professor Weiss and his coeditors are aiming at the gap between introductory books and the multi-volume definitive texts. Urology trainees will testify to the limited choice of good books of this kind. The book consists of 47 chapters split into eight broad sections. The first section concerns basic science and the second investigative urology. They then proceed through paediatrics, benign conditions of the upper and lower tracts, oncology, andrology and finally the bits and bobs, such as trauma and lasers. Each of the chapters follows a structured format—introduction, background science and physiology and then on to diagnosis and management. The information is conveyed in a very readable fashion and is backed up by references as necessary. Key points for each chapter are presented at the beginning in a highlighted box. Indeed, one of the book’s strongest elements is the general layout of the text, tables and pictures. The text is uncluttered and easy to read. The tables and diagrams complement the text well and again are easy to follow. Colour pictures of histology, anatomy and operative fields are well produced and of high quality. Reproduction of radiology films is also excellent.

In urology as in all other surgical specialties, minimally invasive surgery is increasing. Endoscopy has long been the backbone of urology, but the scopes are getting smaller and more flexible, allowing a greater range of treatments to be offered without resort to the knife. Perhaps the biggest change, and the hardest to accept, is the increasing tendency to use minimally invasive surgery in oncology. There is a chapter each on endoscopy and laparoscopy, and both these techniques are mentioned elsewhere, for example in chapters on stones and renal tumours. The laparoscopic prostatectomy, however, is not discussed.

The book itself is a decent size, not too heavy and being hardbacked will probably survive in a trainee’s case. Equally, it makes an ideal reference book for the home or library. I often leave the hospital with a nagging question thrown up by the day’s work. There is an acid test for a book of this nature. Can one face reading it after driving home, bathing the kids, a bite to eat and maybe a glass of wine or a beer? With this one my answer is yes, and it will probably tell you what you want to know.

C Richard W Lockyer
Solent Urology, St Mary’s Hospital, Portsmouth PO3 6AD, UK

Disorders of Hemoglobin: Genetics, Pathophysiology, and Clinical Management
M H Steinberg, B G Forget, D R Higgs, R L Nagel
Cambridge: Cambridge University Press, 2001

The disciplines of molecular biology and haematology have been closely intertwined. Many of the initial insights into the general principles of protein structure and function were obtained during the course of work on the haemoglobin molecule performed by Perutz, Pauling and others. The subsequent realization that just a single amino-acid substitution in the β-chain of haemoglobin is responsible for sickle-cell disease, with its wide range of clinical manifestations, laid a basis for the revolution in understanding of human disease at the molecular level. Since then, research work on the organization and regulation of expression of the globin genes has continued to lead the way in providing understanding of wider principles of eukaryotic gene expression and its control.

Disorders of Hemoglobin provides a comprehensive review of both the scientific and the clinical aspects of human erythropoiesis and its disorders. It offers a collection of well written chapters by leading international investigators, many of whom are able to refer to the contribution their own research work has made to the field. The chapters are grouped in eight sections covering the basic science of haemoglobin and red-cell physiology and the related clinical disorders—the thalassaemias, sickle-cell disease and other haemoglobinopathies. The chapters are detailed and succeed in providing state-of-the-art summaries of their topic area. All are extensively referenced and enable the reader to
appreciate which original scientific papers have led to current models of thought. Furthermore, especially in the first basic science section, many of the chapters include detail of the history of the understanding of their topic areas, illustrating well the development of thinking over time on particular aspects of the field. A particular highlight is the chapter by Max Perutz on the molecular structure and function of haemoglobin.

The sections focusing on the thalassaemias, sickle-cell disease, other sickle haemoglobinopathies and the rarer disorders of haemoglobin function and stability are again comprehensive, detailed and well written. These diseases are discussed very much from a scientific angle and the chapters emphasize molecular pathophysiology, together with physical chemistry and rheology where appropriate. The chapters on clinical management are strong and there is generally clear reference to the evidence base provided by experimental and clinical trial data. Of particular interest are the chapters summarizing the extensive role of malaria in defining the epidemiology of human red-cell disorders and the chapters updating the current thinking on treatment strategies, including iron chelation, hydroxyurea therapy, bone marrow transplantation and gene therapy.

In summary, this is a fine and accessible text that can be recommended for students, scientists and clinicians who seek detailed reviews of red-cell disorders and their clinical management. For MRCPaht haematology candidates who are daunted by the length of the whole book I would recommend selective reading of the chapters on clinical management (sections 2–4) and laboratory diagnosis (section 6). These chapters are as good as I have found anywhere. This text is not well suited to those preparing for MB or MRCP examinations, who can gain the information they require from much shorter works.

Tim Somervaille
Department of Haematology, University College London, London, UK

---

The Cambridge Medical Ethics Workbook: Case Studies, Commentaries and Activities
Michael Parker, Donna Dickenson
Cambridge: Cambridge University Press, 2001

Our clinical practice is steered by ethical principles. They guide the decisions we make in our clinics and ward rounds; what we tell our patients, and what we omit to tell them; the research we do. Medical ethics and law are now part of the core curriculum for medicine. The Cambridge Medical Ethics Workbook sets out to be both a textbook and a work of reference. In reviewing it, my plan was to dip in and out, reading subjects that took my interest. For me a book that did not provide a rewarding self-contained read over a cup of tea was likely to remain on the shelf.

The pattern of all the chapters is similar. A brief introduction is followed by a case presentation. This may be based on an individual patient or the resumé of a controversial problem in clinical practice. From the cases it is clear that the authors understand the issues that arise in clinical practice. The discussion is developed by use of short papers, often by authors writing from contrasting perspectives. These form a backdrop of expert opinion against which ‘activity boxes’ encourage readers to develop their own views and draw on their own experiences. The result is a satisfying sense of having thought through the issues oneself. Each section is well referenced.

Some sections are particularly thought-provoking. A short piece introduces the subject of HIV trials in developing countries. Antiretrovirals, given as part of triple therapy, had proved successful in reducing vertical transmission of HIV. In the developing world, however, such treatment remained unaffordable. UNAIDS generated great controversy in deciding to test less complex antiretroviral regimens against placebo in countries that could not afford triple therapy. Many people were outraged: in a developed country, a placebo controlled trial would not be considered ethical if a proven therapy existed. Seemingly, ethical standards were being relaxed because the patients were from poor countries. Two papers putting contrasting views are presented. One by a South African ethicist argues that standards of care in research should be the same wherever the trial is conducted, rich or poor. But a joint statement from the US National Institutes of Health and the Centers for Disease Control and Prevention defends the research, which they partly funded. They claim that, since developing nations have no access to triple therapy, a trial using such a treatment would be unrealistic and therefore unethical. The ensuing discussion is engaging but in my opinion misses the essential point. What is unethical is that so many children are born with HIV when effective preventive treatment exists. If we do nothing to change this, our ethical standards and declarations become suspect. Why are we concerned that individuals in a trial should receive the best standard of care, yet say nothing when those around them are left untreated.

The international perspective is maintained throughout the book. A child’s competence to consent to treatment is discussed in some detail. In the UK, case law determines that a ‘differential tariff’ exists. In other words a competent child may consent to treatment, but may not refuse it if an adult with parental responsibility consents on his or her behalf. Under such circumstances consent is meaningless. In Italy the competent child’s right to consent and to refuse is enshrined in legislation. In Finland strong legislation
demands that the child’s voice is heard but this has proved difficult to translate into practice.

The layout of the chapters is odd. I would have liked an introductory chapter that sketched the broader issues. Instead I found this information scattered throughout the text. The book begins with a discussion of the ethical issues raised by developments in modern medicine. Part two examines the care of particularly vulnerable groups such as the elderly and the young. Lastly, in part three the wider ethical themes in healthcare are discussed. One feels it would be almost better to start at the end and work backwards. The section on autonomy, competence and confidentiality is a good introduction to ethics but is hidden away in chapter five. I would have appreciated a short discussion of the history of medical ethics.

This is a book with a great deal to commend it. The discussions are enlivened by an excellent panel of contributors, and the format is engaging. It makes you think—an enjoyable experience over a cup of tea.

Tony Lopez
Institute of Child Health, Tyndalls Road, St Michael’s Hill,
Bristol BS2 8BJ, UK

The Notorious Astrological Physician of London: Works and Days of Simon Forman
Barbara Howard Traister
Chicago: University of Chicago Press, 2001

Simon Forman became notorious after his death in 1611. He was tainted with involvement in the scandalous death of Sir Thomas Overbury in the Tower on 14 September 1613. Overbury had been imprisoned for refusing an ambassadorship to Russia. Had he accepted the post, it would have got him out of the way of James I’s favourite Robert Carr (Viscount Rochester, soon to be Earl of Somerset) and Frances Howard, wife of the Earl of Essex. Carr and Howard were carrying on an affair at court and hoping to marry after getting Howard’s marriage annulled, which they eventually managed. Overbury had advised Carr, and was strongly opposed to the relationship—so it was planned to remove him abroad. Unfortunately, Overbury refused to get out of the way, was imprisoned for saying no to the King, and died. In 1615, after Carr quarrelled with James’ new favourite George Villiers, rumours circulated that Overbury had been poisoned for knowing too much, and Chief Justice Coke undertook an investigation. Howard eventually pleaded guilty to the poisoning and obtained a pardon, while Carr was found guilty in a prosecution and spent six years in the Tower himself until pardoned in 1622. During the investigation, Anne Turner, widow of a physician and friend of Howard’s, was accused of having helped Howard to procure Carr’s love by consulting Forman, who had used black arts to help them before himself dying suddenly. Turner and three others attached to the Countess were executed for their part in the affair, although Mrs Forman escaped. Ever after, Forman’s name was associated with deep plots and demonic magic. In 1974, A L Rowse wrote a book (Simon Forman: Sex and Society in Shakespeare’s Age) that continued to depict him as a representative of the lusty and superstitious Elizabethan age: to Rowse, Forman was a foolish magician, a sexual glutton, and a physician to the highest ranks of English society.

Traister will have none of it, although she almost manages to avoid saying so. From examination of Forman’s extant manuscripts (which survive in large parts but only for years before 1603, the rest presumably having been destroyed or confiscated at the time of the Overbury trials), Traister finds him to have been serious and diligent, engaged in medical practices typical of the period in both methods and clientele (poor and ordinary people figuring far more than the few high-placed ones); he was a virgin until the age of 30 and afterwards hardly a rake. Hers is, in fact, a fundamentally revisionist account. What a pity, therefore, that it is not more robustly presented. Forman’s reputation is dealt with only at the end, although she remarks throughout on Rowse’s opinions. Forman’s life and character are available, but only if the reader makes an effort. For instance, she notes that, apart from the Rev. Napier to whom Forman taught astrological medicine, Forman seems to have been almost friendless, and thus vulnerable to attacks by the College of Physicians and others. (Napier’s practice on patients with troubled minds was detailed thoroughly by Michael MacDonald in 1981.) How individuals managed in a corporatist society does not figure in her analysis, however; instead, she lightly touches on whether ‘self-fashioning’ is a fair word for his life, carefully waffling on the point. She quotes at length from his writings, and then summarizes what he wrote, which doubles the descriptions and risks irritating either those familiar with Elizabethan prose and spelling (for whom the summary is not necessary) or those for whom the quotations will be almost unintelligible. Above all, one comes away disappointed that Traister has not gone more deeply into Forman’s system of thought, which is treated descriptively but not probed analytically.

In short, Traister’s study is by implication a fundamental revision of the accepted view of Forman. For the student of Elizabethan medicine and society, there is much of interest. But she has not been bold enough, or made her mind up clearly enough, about many issues to make it enjoyable for the uninitiated. The notorious Forman himself may have been equally ambiguous about himself in his journals, but
hardly so in public. He deserves a more judgmental treatment.

Harold J Cook
Wellcome Trust Centre for the History of Medicine at UCL, 24 Eversholt Street, London NW1 1AD, UK

Clinical Knowledge and Practice in the Information Age: a Handbook For Health Professionals
Jeremy C Wyatt
93 pp  Price £12.95  ISBN 1-85315-483-0 (p/b)

First come I; my name is Jowett;
There’s no knowledge but I know it.
I am master of this College;
What I don’t know isn’t knowledge.—Balliol Rhymes

Jowett was regius professor of Greek at Oxford and master of Balliol in the 1870s. He had a brilliant memory and intellect which he applied only to the things that interested him—though his interests were broad. His students and colleagues wrote the rhyme with just a little irony, and much admiration.

Each branch of medicine has its modern-day Jowetts, whose advice is sought in the most difficult cases. But we are all in the ‘knowledge industry’. Can the rest of us (and the organizations in which we work) do anything to keep ahead of what Wyatt calls the tidal wave of new data? Or are we doomed to become increasingly out of date as we get older? Wyatt mentions a randomized study in which Canadian doctors were sent (in fourteen weekly instalments) an education pack about the management of hypertension. The best predictor of the target doctors’ subsequent decisions about antihypertensive treatment was their year of qualification, not whether or not they had received the pack. Perhaps most doctors do not read unsolicited information, do not believe things they read from an unfamiliar source, or are unconvinced about the need to change.

Wyatt is director of the Knowledge Management Centre at the School of Public Policy in London. He is a physician with a longstanding interest in medical informatics, and his ten articles on ‘knowledge for the clinician’ appeared monthly in JRSM from April last year. These are the basis for Clinical Knowledge and Practice in the Information Age: the chapters appear in a slightly different order from the original articles, a preface and index have been added, and Sir Michael Peckham has written a foreword (mentioning that the Government recommends the creation of a National Health Informatics Forum—something which I expect Wyatt to be headhunted for).

Wyatt is a convincing advocate for the problem-based approach, ‘which means finding solutions to clinical problems at the time they arise, or soon after, with minimum effort. It means looking up the answer whenever we are unsure about what happened or what to do. It means transferring CME [continuing medical education] from an intensive two hours a week (or a few days a year) to a minute here, three minutes there . . . it emphasizes problem solving . . . such as how to find relevant answers fast—not the learning of facts’. If the answer cannot be found immediately, he recommends various actions (including eventually, if still unsuccessful, quietly moving on to something else). He also recommends that we occasionally look things up even when we think we do know them, since we may well find that we were very wrong.

Wyatt analyses the pros and cons of various information sources including published guidelines, textbooks, journals, electronic databases, multimedia packages, the Internet, local intranets and colleagues. Each is discussed in an illuminating way, with many highly quotable nuggets of information. Did you realize that, as a matter of public policy and to encourage the dissemination of knowledge, book authors and publishers are ‘never’ found liable for negligence due to errors, but that guideline writers (and people who blindly follow inappropriate guidelines) may be? Or that, even after finding the relevant ‘page’, it takes 40% longer to read something on-screen than to read it from paper? Or that abstracts disagree with the actual journal article in almost 30% of cases? As if by example, I was disappointed to see that one of my favourite nuggets—the assertion that general practitioners receive 15 kg of guidelines alone each year—is not substantiated in the original paper.

In other sections of the book, Wyatt discusses decision support systems, barriers to change, ways to improve the quality of patient information, and (briefly) patient-held electronic medical records. The latter should be a great timesaver, since we spend so much time asking patients the questions they have already been asked by other doctors.

The book is well-referenced throughout, often referring to journals available online. This, and the discussions of many intriguing online information sources, means that you will probably want to be near a computer when you first read it. At the moment, of course, you can access Wyatt’s articles on JRSM’s website. I’m sure he would approve, but the printed handbook is much more convenient for frequent use. Order extra copies of this thought-provoking book for your information and technology department, your librarian, and (if they have been slow in funding the necessary infrastructure) your business managers.

Theo Fenton
Mayday University Hospital, London Road, Croydon CR7 7YE, UK
So you Want to be a Brain Surgeon? A Medical Careers Guide (2nd edition)
Editors: Chris Ward, Simon Eccles

The feisty title should not mislead—this is by no means niche marketing but a panorama of medical career opportunities which could do much to avert professional disillusionment in future. Humour leaves an accessible and intensely informative review of every possible medical career option available in the UK. The training pathways, necessary qualifications and nature of work are outlined comprehensively; relevant statistics are quoted for each specialty, including numbers of posts and proportion of women currently employed. In the tradition of the best consumer guidebooks, symbols are awarded—he here to summarize fundamental issues which will concern all likely recruits. Frowning faces represent stress levels on a scale of one to five, and a disconcertingly large number of specialties, including general practice and obstetrics and gynaecology, score highly. A five-dagger score represents seriously competitive careers such as cardiothoracic surgery: few specialties, notably care of the elderly, earn only one. No doubt some practitioners could challenge these rather subjective assessments but they illustrate vividly some highly relevant considerations.

The text is replete with useful information (including salary prospects and contact addresses), and much of the commentary resembles the personal advice of wise and thoughtful mentors. No myth remains unchallenged—paediatricians are not ‘big kids’ swinging stethoscopes and wearing Disney ties’. Aspiring paediatricians may be cheered by reading that the best aspects of their chosen specialty are its variety, the ‘high cure rate in most areas’ and the availability of flexible training. But they are warned of emotional stress (four frowning faces).

The format is consistent for each specialty, making comparison easy. Perhaps you are looking for an interesting low-stress career which is not overtly competitive? Consider nuclear medicine, but note that there are only 40 posts in the UK. Radiology, where 24% of posts are held by women, is also claimed to be a low-stress specialty, but readers may not entirely believe the author when he claims that the worst thing to happen could be ‘getting barium—or worse—on your suede shoes and dealing with colleagues who know everything’. What about family planning (now known as community gynaecology)? With only 66 posts, 60 of them held by women, this is a rapidly expanding and much needed specialty; surprisingly, both competitiveness and stress score highly. However, many people might find this work more appealing than obstetrics and gynaecology, where the worst aspects of the specialty are said to be nightwork, heavy routine workload and fierce competition for posts. A highly competitive doctor looking for a really fascinating job might actually want to be a brain surgeon. Most people will know that the difference between God and a neurosurgeon is that God does not think he is a neurosurgeon—although the author suggests that many neurosurgeons would see that as one of God’s failings.

The editors are right in commenting that ‘there would be less regret and disillusion in medicine if doctors had chosen the right career in the first place’. The range of medical career opportunities is probably greater than many graduates appreciate. Medical students and recently qualified doctors are entitled to top-quality career advice, and this book is just that. A canny consumer’s guide to the profession, it should be widely read and consulted by all who are still uncommitted in their medical careers and by those who advise them.

Jane C Symonds
Department of Microbiology, Russells Hall Hospital, Dudley DY1 2HQ, UK

Contraception in Practice
Editor: Stephen Killick
London: Martin Dunitz, 2000

The approach of Contraception in Practice is refreshingly different from that of existing texts. Instead of covering the methods one-by-one, it selects medical conditions and patient groups and looks at their contraceptive needs and the interaction between disease and method. The book highlights the many benefits of contraceptives, often badly neglected in textbooks. The topics seem to have been chosen somewhat at random, but they are all situations encountered quite often and are therefore relevant to many clinicians. Medical conditions range from cancers to subfertility. Patient groups include those at risk of sexually transmitted infections and couples whom nothing seems to suit. The editor has chosen five chapters of gynaecological orientation, reflecting his own interest. Equally he could have examined physical disability, autoimmune disorders, diabetes, inflammatory bowel disease, haematological disorders, psychiatric disorders or epilepsy—all of which present complex management issues. Anyway, the contributors have been picked because they are leading authorities and the approach is very practical—what you do with the patient in front of you.

Throughout, the diagrams are exceptionally clear and the references are comprehensive. Each chapter ends with two case histories which are well presented and give a sense
of how the guidance can be used in the sometimes confusing world of clinical practice where there seem to be limitless numbers of situations to be faced. Detracting from this is inconsistent editing, with IIUCD being used as an abbreviation in some chapters instead of the internationally approved IUD for intrauterine device, and sexually transmitted diseases in some chapters instead of the more up-to-date sexually transmitted infections.

The chapter on arterial disease (chapter 4) seems to me the least satisfactory, and its deficiencies are aggravated by the use of crossheads which I suspect were not proof-read by the editor. Some of these, I think, summarize the publisher’s interpretation of what the authors mean, but in fact have a rather different sense.

The authors of chapter 4 do not quote the MICA study which shows no difference in risk of myocardial infarction for combined oral contraceptive (COC) users taking gestodene or desogestrel pills compared with levonorgestrel formulations. This is not because the book was written before this paper was published since it is cited in the previous chapter. The crosshead announces that ‘COCs containing third generation progestogens may have a lower rate of myocardial infarction’. On stroke, the crosshead states ‘modern low dose COCs do not increase the risk of any kind of stroke in healthy non-smokers’. The consensus summarized by a World Health Organization (WHO) Scientific Group is that the risk of ischaemic stroke is increased 1.5-fold in those without risk factors and more in those with risk factors.

Next, the authors of chapter 4 quote from the WHO publication on medical eligibility criteria for contraceptive methods, reassuring readers that it is safe to prescribe the combined oral contraceptive pill to well-controlled hypertensives. In my view this should be qualified a bit more to read something like ‘young women with uncomplicated mild essential hypertension whose blood pressure is well-controlled by therapy may on occasions be given low-dose combined oral contraception under close specialist supervision’.

Later these authors, who are based in the USA, claim that obesity is not a contraindication to oral contraception. This conflicts with advice in the UK which generally regards a body mass index of 40 and above as an absolute contraindication to the combined pill because obesity is a risk factor for both arterial disease and venous thromboembolism. Finally, it is said that the antidiabetic troglitazone (not available in the UK) increases the metabolism of contraceptive steroids, implying that this agent might cause breakthrough pregnancies. In fact, thiazolidinediones and other antidiabetics have their hypoglycaemic effect antagonized by oral contraceptives but there is no clinically important effect on steroid levels.

Elsewhere the book is well written and informative. Overall I enjoyed it and would recommend in particular the elegant chapter on migraine and the sensitively written chapters on teenagers and those with learning disability.

**Sam Rowlands**

Reproductive and Sexual Health Services, E&N Herts NHS Trust, UK