"In medicine, trust is key—and this is not the product of our training or qualifications"
Des Spence, p 51

PERSONAL VIEW **Richard Brueton**

Expatriate surgeons have advanced orthopaedics in Africa

The light suddenly went out, but the window in the wall of the theatre let us see that the ununited femoral shaft fracture was now firmly held by an old fashioned unlocked intramedullary nail, kindly provided by donors. I was spending three weeks at the Africa Inland Church Hospital in Kijabe, Kenya, 50 km northwest of Nairobi. It was 2001, and I was visiting Africa for the first time, before spending two years in Malawi. I had come from the United Kingdom, where I was still working in the NHS as an orthopaedic surgeon.

There was no permanent orthopaedic surgeon in Kijabe—Kenyan or otherwise. Trauma was managed predominantly by visiting US orthopaedic surgeons, who stayed for weeks, months, or occasionally a few years. In their absence, the general surgeons got by. I had found myself at the sharp end—in a world of compound fractures from road traffic crashes together with untreated and often un-united or malunited fractures. A radius and ulna malunited at three months provided a challenge.

Before I left Kijabe I was told that it was customary to leave any useful items that you could do without—clothing, for instance. So I decided to leave a pint of blood and an orthopaedic textbook. The value and scarcity of blood had been brought home to me in rather a dramatic way. I had been in theatre when a general surgeon who was operating on a bleeding patient called a visiting medical student to ask if he would like to give "another pint" of his precious O negative. He kindly agreed.

The book that I left was *The Rationale of Operative Fracture Care* by Joseph Schatzker and Marvin Tile, first published in 2005. This was a valued asset that I had brought from the UK. Certainly I had found it useful in Kijabe, so it now remained in theatre for anyone who might be passing through.

The hospital in Kijabe had started as a base established by missionaries from the Africa Inland Mission in 1903. The first hospital at Kijabe—Theodora Hospital—opened in 1915, and the first building of the present complex opened in 1961. Situated high above the rift valley to escape the mosquitoes, the grave of a missionary doctor provides a poignant reminder of how it used to be: "K W Allen 1886-1955 Satisfied Ps 17.15."

Ten years later, in 2011, I returned to Kijabe and the hospital above the rift valley. Expecting to be at the sharp end once more, I was amazed to find four orthopaedic consultants and eight orthopaedic trainees, all of whom were Kenyan. The hospital had united with the paediatric orthopaedic hospital on the same site run by the international child healthcare organisation, Cure International. The hospital now had nine operating theatres and 340 beds, compared with the four theatres of 10 years ago.

I had found myself at the sharp end—in a world of compound fractures from road traffic crashes together with untreated and often un-united or malunited fractures

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Gone were the days of open reduction and retrograde unlocked nailing of femoral fractures. This was a brave new world of closed intramedullary locking nails and total hip and knee replacements. The surgical implant network generation (SIGN) nail was now in widespread use. This intramedullary locking nail enabled the nailing of tibial fractures without image intensification. Ingeniously it was also being used for femoral fractures, although it was not designed for this purpose. Kijabe was on the SIGN programme that had begun in 2003 and is supported by local donations. I was even able to help in the open reduction of an acetabular fracture, complete with three dimensional reconstructions from Nairobi. A training scheme run by the College of Surgeons of East Central and Southern Africa (COSECSA) was well under way, and the first Kenyan trainees at Kijabe were about to emerge from the programme. Ten years older, I was pleased that I could adopt more of a teaching and assisting role.

One day in theatre, I could not help but notice a young Kenyan orthopaedic resident engrossed in a textbook as he prepared for the next operation. I saw that it was a copy of *The Rationale of Operative Fracture Care*. In disbelief I opened it and found inscribed on the inside cover, "For the use of Orthopaedic Surgeons visiting Kijabe Hospital, 21/4/01." Ten years later I left the same book in Kijabe for a second time. As for leaving another pint, I decided that this time it was probably prudent to return home with a full blood volume.

Orthopaedic care has progressed in Africa partly as a result of expatriate surgeons spending some of their careers working in less developed countries, treating the local population, training local surgeons, and working beside African surgeons trained abroad. Importantly, COSECSA has also provided a structure for the teaching and training of surgeons within Africa. In the future I hope that African surgeons will be trained within Africa and no longer need to travel to the West, from where they may never return. African surgeons trained in Africa are more likely to stay to treat their own local populations.

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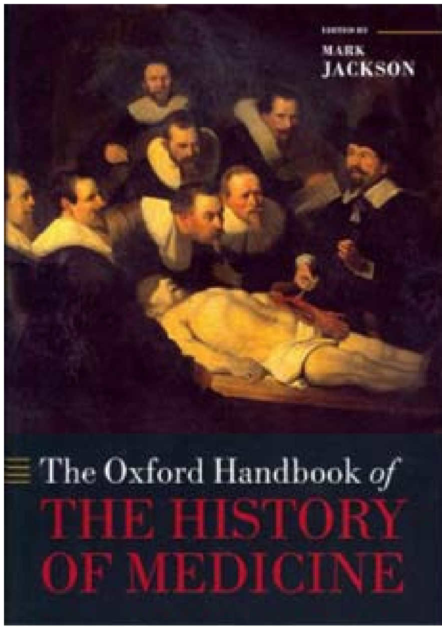
REVIEW OF THE WEEK

Our medical heritage has lessons for the future

It's no longer focused on great men and great movements. **Helen Bynum** explains why the history of medicine matters and how this book sites our medical past firmly in the context of the present—and the future



The Oxford Handbook of the History of Medicine

Edited by Mark Jackson

Oxford University Press; 696 pages; £95

ISBN 978 0199546497

Rating: ★★★☆

The Oxford Handbook of the History of Medicine is a coming of age compendium. The call for a new approach to medicine's past was made in the early 1970s. It aimed to release medical history from the grip of its "great men and great movements." The new social history of medicine, rather than creating an ever more fine grained chronology of progress, sought instead to uncover the social determinants of health in their historical context. So successful has this been that Mark Jackson's well edited volume has dispensed with the word "social" in its title and cut to the chase. What emerges clearly from this book is the breadth of today's history of medicine and its integration with the methods and insights of the social sciences.

On top of everything else they have to do, today's doctors are often exhorted to develop their human side. Learning about the history of medicine has been a way of doing this, and despite the recent rise of other medical humanities the subject remains popular. The suggestions for the future that close each chapter of the book point to its continued development. If you are a budding historian looking for potential angles to pursue, this is a good place to begin.

Learning about how doctors behaved in the past, as well as what they knew, has now been matched by details of how their patients sought out, appreciated, or disliked the kinds of medicine they were offered. For instance, Philip Van der Eijk considers how mental illness and mental health in the ancient Graeco-Roman world can be understood by exploring the heritage of Greek philosophy, literature, and religion as well the usual medical texts. He points out too how the recognised Hippocratic medicine was but one of many options available to patients seeking relief.

This emphasis on pluralism is discernible everywhere. The second part of the book (there are three: "Periods," "Places and Traditions," and "Themes and Methods") is concerned with geography as well as time. In today's global village, medical pluralism is increasingly obvious. Understanding the dynamic history of the key healing traditions of the world (Chinese, Islamic, African, and South Asian practices are reviewed) provides a window onto these very different medical pasts. Politics and ethnicity collided during the colonial histories of many countries. Exciting new histories are being written from Australasia, the developing nations of South America, and the former communist bloc, where medical care was arranged on overtly politicised lines.

Digital records may mean that the experiences of people who had been reduced to numbers can be resurrected, creating what one demographer neatly terms "evidence-based medical history"

Can the same be said of the history of medicine in the West, as cities and states became more interested in the health of their populations and the control of diseases? Excellent chapters on what is meant historically by public health and a comparison of the political economy of health and welfare provision in several countries, including the United States and the United Kingdom, show the power of vested interests, lack of transparency, and why medicine is not value neutral. These themes seem particularly apposite as the shake up of the English NHS and welfare services are debated in the UK, leading to some inevitable questions. What can we learn from the past? Does the history of medicine provide neatly digested information for doctors, policy makers, and politicians should they care to look?

We have moved on from the naive if optimistic idea that knowledge of the past can provide a simplistic template for the present and future. The history of medicine is not the handmaiden of modern medicine. It's too feisty for that, but it encourages critical thinking and acknowledges complexity. The rapid growth of interest in the body means that seeing things in a corporeal light has moved beyond the older focus on clinical gaze and dissected bodies in the morgue. Yet the tensions between medical and patients' needs surfaced again in the Alder Hey and Bristol Royal Infirmary scandals, as the chapter on medical ethics and the law discusses. On the brink of individualised genomic medicine, it has become apparent that we are indeed not all the same. So it's good that knowledge of the different bodies of women, children, adolescents, older people, and chronically sick people provoke new questions and insights and give a voice to their past experiences.

We are increasingly aware that we don't live in a microcosm. Separate chapters in this book cover the history of where the human body sits in relation to the bodies of animals, and the wider environment. Historical demography and epidemiology have shown patterns and trends in the course of disease. Now digital records may mean that the experiences of people who had been reduced to numbers can be resurrected, creating what one demographer neatly terms "evidence-based medical history."

Without preaching to anyone, this book reminds us that there is value in the independent inquiry into our long past, our sickness and health, and the role and meaning of medicine for its own sake, as well as for what it might be able to tell us. It's not neat and clean, but it's important.

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BETWEEN THE LINES **Theodore Dalrymple**

Leave the quacks alone

Joseph Sampson Gamgee (1828-1886) was one of three brothers all of whom made it into the Valhalla of British posthumous eminence, the *Dictionary of National Biography*. A surgeon, he is remembered today mainly for the absorbent dressing that he invented and whose use he advocated; he also had a quarrel with Joseph Lister over antisepsis. He was a contemporary of Lister's at medical school and went on to examine Lister's methods, which he praised though not without reservation. Lister took this badly, as if he who was not wholly for him was wholly against him. This is not a completely uncommon human trait, as anyone who has ever sat on a hospital committee will know.

Gamgee had been a surgeon in Malta during the Crimean war and was not altogether a sweet tempered man himself, at least if the tone of his pamphlet *Medical Reform: a Social Question Comprehensively Studied with the Light of Philosophy, History, and Common Sense*, published in 1857, is anything to go by. In the form of two open letters to the prime minister, Lord Palmerston, Gamgee attacked the Medical Reform Bill, which, once it became an act, established the General Medical Council and the medical register.

The pamphlet appears to have been written in white heat, as a last ditch attempt to avert the passing of the bill: "I hope in the few hours which elapse before the time appointed for the third reading of Mr Headlam's bill, a resolution will be come to, if not to reject it for ever, to send it before a Select Committee . . ."

Gamgee's objection was that the bill and act entrenched the power of what he called "the money-gorged palsied corporations," that is to say the royal colleges of physicians and surgeons. On the latter he was particularly hard: "The ancients of the College of Surgeons have, in their dotage, been deaf to the voice of science, have struggled against popular opinion, have oppressed the Medical Profession; and at its expense, at the sacrifice of learning, and of the people's welfare, have divided in a virtually self-elected *coterie* the proceeds of gain ill-gotten, by power undeserved, in a borough as rotten as old Sarum, but infinitely more disgraceful . . ."

"As to the question of QUACKS . . . I am unable to define them as to ensure their recognition by the officers of the law"

Gamgee argued that there should be no medical monopoly and no medical orthodoxy, because it was from the free play of ideas and practices that truth and improvement emerged. He then, somewhat inconsistently, argued that the bill held doctors to a standard that did not apply to quacks but would not prevent them from practising: "The quack is a business-man, and always takes his fee before he gives his advice. And if he cannot be legally appointed surgeon to a hospital or a ship, may I ask, Has the ignorant, mischievous quack ever applied for those offices? You will say he will incur penalties if he does anything to imply that he is registered under the Act: then he will glory in his superior freedom, and have a large brass plate in his door, deeply lettered, 'John Snooks, Herbal Doctor and water-caster, *not registered*.'"

Not that he thought quacks should be driven out of business: "As to the question of QUACKS, I have nothing to propose for their regulation; because I am unable to define them as to ensure their recognition by the officers of the law. Such a definition would be a real addition to the English Language and to lexicography generally."

He then utters a cry anathema to all modern British politicians: "More reality, less tinsel, is what we want." On the contrary, reply the politicians: more tinsel, less reality.

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

The National Health: a Radical Perspective

A book by David Widgery; first published 1988

The NHS faces misguided reorganisation, creeping privatisation, cuts, increased waiting lists, and stagnant wages. Although they are eerily familiar, these are not just today's problems, but also those of 1988, when the general practitioner from east end London and left wing activist David Widgery wrote his book *The National Health*.

The book was published on the 40th anniversary of the inception of the health service and was a polemical intervention against the penny pinching cuts of Margaret Thatcher's premiership. It makes a powerful case for universal healthcare. Widgery writes movingly of being an "Attlee child," nursed through childhood polio by the NHS, and he is keen to defend that provision.

Widgery gives a historical overview of the development of the modern medical profession and health service, and how it arose from private teaching hospitals and the workhouses. He describes how the profession jealously guarded its authority against competitors such as midwives, and fought too against the foundation of the NHS as a threat to its autonomy.

Widgery honestly assesses the limitations of the NHS, an activity often today seen as tantamount to advocating privatisation. He makes the case that not everything the state does is synonymous with socialism. He recognises that the NHS is a top down institution under bureaucratic rather than staff control, and that it reflects the inequalities of society more broadly, through health inequalities and the inverse care law.

Much here was ahead of its time. Widgery's recognition of the social basis of so much of ill health was radical at the time but has become more widely recognised. Likewise, his sharp criticism of the drug industry and its practices has become mainstream. He is critical of the cottage industry nature of much of primary care provision at that time and calls for a modernising and broadening of general practice, and its centralisation into multidisciplinary and multipractitioner health centres. Whether Widgery would have been impressed with the implementation of these ideas in the polyclinics of recent years is a moot point.

Some parts of the book show its age. Widgery's overview of the industrial militancy of the 70s and 80s puts today's limited union action in perspective. I was not previously aware of the junior doctors' strike of 1975 and the violent break up by management of the occupation of Hounslow Hospital in 1977. Other things have moved on. Widgery argues that the profession and its conservative assumptions are "refuelled by the male offspring of doctors"; today their female offspring are present too.

Overall, the book induces sadness. By and large Widgery's socialist tradition has gone. Widgery's untimely death came only a few years after he wrote the book. His defence of universal healthcare from government attack and interference seems back at square one. Although we may not agree with every tenet of his politics, *The National Health* provides a great example of a doctor who was committed to fighting for his patients, politically as well as medically.

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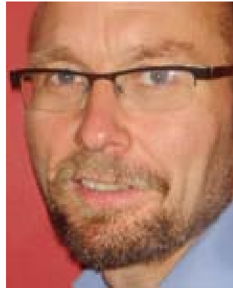
FROM THE FRONTLINE **Des Spence**

Continuity is never out of fashion

Fashion changes. Looking at photos, we cringe at what we once wore, but marvel at how much hair we had. Medicine is faddishly fickle, with trendy diagnoses, buzz words, tomahawk tendon hammers, and bow ties. In general practice we once talked of "burnout"—the sense that you become an emotional husk (like being a parent but at work), so overworked that you ceased to function or care. In the 1990s work stress was so intense that it took physical form. We are all left burnt at the edges, distressed looking old medical professionals. But no one seems to mention burnout any more.

This is also true of "continuity of care." This red hot topic once vexed hospital and general practice alike. The argument ran that best care could only be delivered if responsibility was with one individual who was also often available. Involving multiple medical professionals leads to the "collusion of anonymity" (another defunct concept), where the patient is lost, falling between the gaps between different professional responsibilities. Many people are involved, but no one is actually responsible, in this all too familiar multidisciplinary mayhem. And anecdote suggests things are getting worse rather than better.



In medicine, trust is key—and this takes time, and is not the product of our training or qualifications

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But life-work balance has usurped continuity, and many counter that the concept of continuity is outdated. Now we have "handover," with effective transfer of care between shifts, electronic systems giving better to access results, and records and communications that mean that doctors can be contacted wherever they are. But the strongest argument against the need for continuity is the rise of "clinical competence."

If we invest in training clinically competent doctors, through exams and evaluations, then it matters not who looks after the patient, runs the logic (a notion that suggests previous generations weren't trained to be clinically competent).

This is, of course, reductionist drivel, because it suggests that medicine is mechanical, deliverable with robots armed with an appropriate flow chart. But clinical care is not that simple. Health seeking behaviours, health beliefs, and culture are all fundamental. But in medicine, trust is key—and this takes time, and is not the product of our training or qualifications. And despite training all doctors practise in different ways. So once the debate about the health bill burns out, either by its withdrawal or through a simple non-participation boycott of all its institutions, the royal colleges that are tasked with quality of care might want to review the issues of continuity, for clinical competence is not enough. Some things should never be out of fashion; continuity is one of them.

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PAST CARING **Wendy Moore**

Extreme measures in breast cancer surgery

The rage for breast surgery attained manic proportions in the late 19th century in the United States and Europe. But the trend was driven by surgeons, not women, and the results were far from aesthetic. Surgeons in ancient Egypt described breast cancer, but wisely refrained from wielding the knife. Caution reigned until the first known attempts at mastectomy were made in Germany in the 17th century. Prints show women stoically undergoing breast amputations by surgeons using forceps, knives, and cauterising irons, long before the arrival of anaesthesia or antisepsis.

In 1748 the German surgeon Lorenz Heister described using a fork, or ropes attached to lances, to lift the breast before amputation, but warned against operating if the axillary lymph nodes were affected, because "the Virus of the Cancer, which lies concealed in the other Parts, will make the same Disorder break out in a short Time." The London based John Hunter cautioned that "leaving the least part of the cancer is equal to leaving the whole." Eagerness to advance understanding of breast cancer led to the taking of extreme measures. The French surgeon Jean Astruc discounted black bile as the cause after baking and eating a tumour with a slice of beef as his experimental control in 1740.

Surgeons grew bolder in the 19th century. The novelist Fanny Burney wrote a rare, detailed, and harrowing description of her mastectomy at the hands of Napoleon's surgeon Dominique Larrey in 1811. With only a "wine cordial" against the pain she felt "the dreadful steel" as it "was plunged into the breast" and "began a scream that lasted unintermittingly during the whole time of the incision." She lived 29 years more.

Emboldened further by the advent of anaesthesia and antisepsis, surgeons advocated more and more aggressive methods. It was William Stewart Halsted in Boston who made radical mastectomy routine for every case of suspected breast cancer. His disciples went even further, removing ribs, collarbone, and even shoulder joints for the smallest of tumours. They saved many lives, but they also performed surgery on unknown numbers of benign lumps, mutilated countless women, and killed thousands.

Jean Astruc discounted black bile as the cause after baking and eating a tumour with a slice of beef as his experimental control

bmj.com
Sources are on bmj.com

Conservative voices were shouted down throughout the 20th century even when figures began to show that simple mastectomy coupled with radiotherapy was as effective as more extreme methods. It was the mid-1980s before science prevailed in breast surgery—for cancer at least.

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