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Hippocrates

A question of trust

I have never met G. Timothy Johnson, but I think I could like him. A former practising physician who went into American broadcasting fifteen years ago, he contrives to write about the relationship between American physicians and American patients in a way which is gentle, penetrating and makes good sense. At the beginning of this year he admitted in the *New England Journal of Medicine* that he was increasingly thankful that he no longer needed to practise medicine to earn a living [1]. In two delicious open letters – one to Medical Consumers and one to Doctors – he puts his finger on some of the causes and consequences of what he calls "the mistrust and even bitterness that so often characterize relationships between doctors and patients nowadays". Neither letter can be summarized; each of them needs to be savoured, and then saved for re-reading. In his view the souring of the doctor–patient relationship lies very much at the door of those doctors who have taken advantage of their relative freedom and autonomy to seek excessive gain. That may not be so true in all societies; elsewhere medical arrogance rather than medical avarice has sometimes seemed to lie at the root of the problem. Running throughout his letters there is, however, also a universal thread wherever he touches on the consequences of the lack of trust between the two parties in the health care encounter. The test of mutual trust in the United States, I have always understood, is the question "Would you buy a used car from this man?" The medical equivalent must have something to do with the placebo response. Where faith in the physician's desire to help and heal has evaporated, leaving only a conviction that he is selling cures at the highest possible premium, all that one has left to believe in is the technological quality of his devices and his drugs; medical care has become a mechanistic process; the analogy of the used car dealer may be even closer than one is inclined to think.

1 Johnson GT. Restoring trust between patient and doctor. N Engl J Med 1990;322:195–197.

The perils of policy making

The more deeply the public health administration is called upon to involve itself in the way society faces risk, the greater the possibility that it will somewhere make monumental mistakes. If that has not happened to a great extent in the past it is perhaps because the process of policy making in the health field (to say nothing of the process of bringing such policies into effect) takes so much time that fundamental errors in the approach may become evident before anything very dreadful happens. The point arose with the artificial sweeteners particularly at the time when it seemed that a ban on cyclamate might be driving the public to have recourse to saccharin without any certainty that this was indeed safer; that particular story is currently being played out once again, indeed, with accusations that aspartam, despite its ability to disintegrate into two amino acids, is a new potential risk in the teacup.

Earlier this year Gregory provided a worthy analysis of the problem of uncertainty in health risk assessments [1]; it was complemented by an attempt by Barnard to determine how scientific and legal principles interact when one is dealing with the risk issue in regulation [2].

Matters like this come to mind when one reads Elisabet Helsing's critical new account of the way in which National Nutrition Policies came into being (or failed to do so) at the two poles of Europe, i.e. Greece and Norway [3]. Essentially, both these countries had experienced changes in mortality patterns before, during and after the Second World War, which puzzled epidemiologists and cardiologists. As in other countries which had suffered an enemy occupation, the period of deprivation and near-starvation had surprisingly been a relatively favourable one in terms of cardiovascular disease. In Norway, post-war economic recovery and the dramatic upswing in the economy which followed it, was accompanied by an epidemic of heart disease striking particularly at middle-aged men. The reaction at the public level was concrete and effective; armed with the conclusions published by the American Heart Association in the early 1960's and with data of its own, Norway set about developing a national nutritional policy which was designed to influence both what was produced and what was consumed. Greece, for a series of reasons, did very little; in part that may have reflected a Mediterranean laisser-faire attitude to policy making; in part it must have a been a consequence of the health-giving reputation of the traditional Greek diet, which gave no cause for great concern.

In retrospect it is good that in the North (and Norway gradually found a following) society was guided into healthy food production and healthy eating; the progressive fall in the consumption of saturated animal fats has only partly been achieved as a result of public demand and commercial acumen; a great deal of pushing and pulling in the public health sector has been needed to catalyze the process. What one wonders, however, as a non-expert reader, is how specific public health intervention should be as knowledge becomes more secure or at least more detailed. Will one do well to follow the latest view on precisely which type of saturated fatty acid is good for us? Or to reduce our intake of sugar in the light of theories which seem solid enough but which are still the subject of a hammer-and-tongs attack by the sugar industry?

What seems unquestioned, with this comparative study to hand, is that the time of laisser-faire policies in the South should by now be past; if a government does not busy itself with guiding (or at least preserving) the Greek diet, the population could well be manipulated by commercial processes into less healthy channels. Greeks, one may think, will remain happy with their olives for a long time to come, but will the commercial voice of the parabolic aerial not progressively succeed in luring them from Olympus to the Butter Mountain? Such things are entirely conceivable in the nineties; if they materialize, there may be need for a firmer hand in nutritional policy after all.

1 Gregory AR. Uncertainty in health risk assessment. Reg Toxicol Pharmacol 1990;11:191–200.
2 Barnard RC. Some regulatory definitions of risk: interaction of scientific and legal principles. Reg Toxicol Pharmacol 1990;11:201–211.
3 Helsing E. The initiation of national nutrition policies: a comparative study of Norway and Greece. Thesis, University of Athens. Groningen: Styx Publications, 1990.

Appendicectomy – infected or otherwise

Appendicectomy is one of those few operations which is performed on such a massive scale that even a district hospital has masses of material available for study when setting out to find ways of rendering it safer. Taking as a challenge Krukowski's review figures of 1988 to the effect that wound infection follows between 2% and 34% of operations on an acutely inflamed appendix (with up to 100% of wound infections if the appendix is gangrenous or has perforated), Vennits and his colleagues in Denmark set out to determine the risk factors [1]. Pooling the resources of fifteen workers at eleven district hospitals throughout Denmark over a two-year period, they carried out a randomised study which ultimately covered 2097 evaluable patients. Patients were randomly allocated to a group receiving 2 g of cefotoxin (40 mg per kilo body weight in the young) or to a control group. Where there was perforation antibiotic treatment was also given preoperatively, but with antibiotic follow-up randomised to three or five days.

Their regression analysis, quite apart from confirming the known greater risks in cases of gangrene and perforation, brought out some of the subtleties. Age was one of the risk factors in most subgroups, with a sharply increased risk in adults as compared with children, the rate of infection going up most steeply between the ages of 15 and 44. The period elapsing from the time of the first symptoms to operation was, as might have been anticipated, significant; where gangrenous cases were obliged to wait more than 48 hours the risk of post-operative wound infection was 2–4 times higher than in those reaching the surgeon earlier. Putting these factors together, Vennits and his colleagues arrive at the well-documented recommendation that all patients over 25 coming for appendectomy should be given preoperative antibiotic prophylaxis which can handle both aerobic and anaerobic micro-organisms; cefotoxin seems to fit the bill. It is also clear that if there is gangrene or perforation, intraoperative antibiotic treatment pays off, with follow-up for three days proving as effective as that for five.

1 Vennits BP, Bauer T, Hahn-Pedersen J et al. Faktorer bestemmende for udviklingen af sårinfektion efter appendektomi. Ugeskr Læger 1990;152:157–160.