

A month as a GP in the earthquake area of Pakistan

Wednesday is set aside for the antenatal clinic here at Bach Christian Hospital, a small facility with about 50 beds and situated a few miles to the north of Abbotabad, Pakistan. As a male doctor I have little role and am currently enjoying a morning off from outpatients — much to the chagrin of my wife, also a GP, who has no such luxury. The scenery is beautiful in the foothills of the Himalayas, but the view belies the tragedy that occurred during the earthquake of a month ago [October 2005]. The combination of compassion fatigue and the topography of the area affected seem to be leading to the inevitability of a secondary wave of thousands of further deaths as winter approaches. This catastrophe would be too big for any country, rich or poor, to cope with alone. Pakistan is not rich.

Our month's stay here was planned some time ago and long before the earthquake. Our son was born in this hospital, and much of our own growing up was completed during the 6-year period in the 1980s when we worked for the Church of Pakistan; our subsequent careers have not let us forget these formative years. We work in an inner-city practice in Bradford and this has meant that our language and experience of the environment here in Pakistan (from which many of our patients in the UK have come) have been immensely useful, and our special interests in diabetes and women's medicine are particularly relevant. Our ties to the UK are weakening and this time away was planned as an exploratory trip to see how our particular skills could be useful on a potentially more long-term basis. The earthquake appeared to change all that. What possible use could two primary care doctors be? What were more obviously needed were orthopaedic surgeons and logisticians, as well as lots and lots of material aid.

Subsequent events, however, have supported the reassuring emails we received but I am indeed glad that we were

not here a month ago. I know that all the staff were exhausted, but anybody can hold a retractor and there was no shortage of volunteers. Our abilities would have been irrelevant as normal life in outpatients was suspended. This is no longer the situation. The immediate victims are mostly either dealt with or dead, although there will, no doubt, be a second wave of orthopaedic complications. What the future holds for a whole generation of subsistence farmers who have lost family, limbs, houses and most (or all) of their material possessions in a country with little concept of insurance and when the world's attention has moved on is, frankly, beyond our imagining. At present, the mixture of orthopaedic review and general surgical and medical outpatients is, by and large, within our capabilities although we remain on an extremely steep learning curve. It is sobering in the extreme to know that behind virtually every routine fracture, amputation, and skin graft there are husbands, wives, brothers, sisters, and others who never made it here. The Brits are notoriously loath to show emotion and I feel the usual need to avoid clichés — but the dignity and compassion witnessed in those who accompany each of the injured to outpatients could easily move us to tears.

With such a resilient response so soon, I have no doubt that in 6 months the effects of the earthquake will be less apparent, and those agencies who specialise in long-term development will take their rightful place. Signs are already here in the return of the huge interest in primary care subjects that arise in the daily informal planning meetings after morning worship; perhaps a little unusual in a hospital that has been traditionally surgically based. This may in some degree be prompted by our presence but must also be because family medicine is a comparatively new but very active area of interest in this country. In the family medicine department here

there are two American doctors and one from Pakistan who is on the rotation in this specialty. The Aga Khan Hospital in Karachi is a prime mover in this field, with a post here at Bach Hospital.

The morning debates are wide ranging, and I find them hugely interesting. I do not find this in the UK and the reasons are not too hard to find. In the UK, the answers seem to have been worked out for us a long time ago and the proceeding over which I have no control — and QOF is the logical culmination of this. I have difficulty in avoiding a niggling question in my mind. Am I the doctor I thought I would become when I entered medical school, or a highly skilled and very well paid management technician trying to complete a paint-by-numbers picture that has been created by the government? And, if I am, worthy as it is, do I actually like the completed picture? I am reasonably familiar with some of evidence base upon which the QOF research is based and am grateful for this — because in Pakistan, or at least in this area of Pakistan, or any less than developed country, I know that different rules must apply.

This brings me to the second main point of this essay, the first being to remind potential donors of the continuing tragedy of this earthquake. In the UK, drug costs are of particular importance to the government, and, as servants of the state and with a loyalty to it as well as the patients, they are of relevance to us as clinicians. In-depth statistical tools are rightly used to work out cost-benefit analyses with various figures as to drug costs, surgical interventions, QALYs, all derived from research grounded in developed countries, and we are advised accordingly. I have no particular argument with this. With relevance to diabetes, my own area of interest, statins are available here — at a price. Even glitazones are on the horizon. As is well recognised, the population of South Asia is on the wrong part of the exponential rise of type 2 diabetes, and the combination is

Flora medica

Richard Lehman

From the journals, January–February 2006

New Eng J Med Vol 354

119 This paper is worth finding and keeping handy — it tells you which exotic disease your patient is likely to bring back from which exotic destination.

229 Some pretty exotic substances are used to treat cystic fibrosis these days (see the excellent editorial on page 291), but the latest is the most abundant on the Earth's surface — hypertonic saline. Inhaled regularly, it helps to clear secretions and reduce infective episodes — possibly because it makes patients cough a lot.

296 You don't have to kill bacteria to get rid of them — you can just disarm their invasive mechanisms. This may be the best way to eliminate *Vibrio cholerae*.

333 Smoking more than 30 cigarettes a day carries a high risk of lung cancer whatever your ethnic origin. Below that, the risk may be higher in African–Caribbean patients in the UK, as it is in African–Americans in this US study.

462 This study managed to find hundreds of US babies with infant botulism and treated them with anti-botulinum globulin. The botulism isn't the work of *Al Qa'ida* but due to *Clostridium* in the infant bowel.

Lancet Vol 367

122 Cervical cytology has used the same crude sampling technique for decades — wouldn't it be better to change to liquid-based cytology? Not according to this systematic review.

303 When the influenza pandemic arrives, forget about being able to cure everybody with antivirals. This systematic review rubbishes amantadine and rimantadine, and finds that the neuraminidase inhibitors are useless for prevention and not much better for treatment.

314 A wonderful decline in sudden infant death syndrome followed the simple observation that it happened more to babies sleeping face down. The strong remaining message is that nobody should ever sleep with a baby on a sofa.

320 If you don't want to become a vegetable, eat more of them. This meta-analysis shows that fruit and veg prevent stroke in a dose-related manner.

397 A paper that should change your practice and save lives. If a child has a high fever, leg pains, and cold peripheries, bear in mind that these can herald meningococcal disease, and act accordingly.

JAMA Vol 295

172 David Sackett first showed us how to use diagnostic tests in a Bayesian way, and this is well illustrated by the use of D-dimer

for pulmonary embolism and deep vein thrombosis (see page 199). It's not that D-dimer itself is definitive: it's the way you use it — a triumph of Sackett over serum.

285 Rationing of hernia referrals has already arrived, but is it evidence-based? Sort of: inguinal hernias rarely incarcerate, but often get bigger and uncomfortable, at which point get them mended.

306 A systematic review showing that low-dose aspirin does work for primary prevention of stroke in women and heart attacks in men; odd that it failed in the British Doctors' study of the 1980s.

499 Pregnancy does not protect against depression: women who give up their antidepressants when they get pregnant usually relapse.

536 How to diagnose peripheral arterial disease rationally: get a hand-held Doppler.

Arch Intern Med Vol 166

38 The study that finally confirms that PSA stands for Perfectly Stupid Attributes in screening for prostate cancer: even digital rectal examination is of unproven value.

101 Consider asking your patients, 'Are you at peace?' when they are dying, and be prepared to find them spiritual support if they need it.

201 Erectile dysfunction is common in men referred for coronary disease investigations, and increases the risk of a positive result; in primary care (page 213), it may precede vascular disease, but we lack, er, hard evidence.

Ann Intern Med Vol 144

73 In late middle age, stop thinking about exercise and do some: it may prevent dementia.

172 Kidney buffs tell us we should calculate the Glomerular Filtration Rate rather than glance at the creatinine, and they get support from this study, which shows that it correlates with outcomes in high-risk hypertensives.

Guest Journal: Queueing Systems

As your PCT seeks ever-more creative ways of managing demand without lengthening waiting times, perusal of this journal becomes increasingly essential. Of particular interest is Argon and Androttir's 'Partial Pooling in Tandem Lines with Cooperation and Blocking' (52: 5–30).

Plant of the Month: *Skimmia* 'Kew Green'

Thriving on any kind of soil (and neglect), this small evergreen shrub forms a handsome mound with wonderfully fragrant yellow-green flower-heads.

understandably irresistible to the pharmaceutical companies. Who can argue with the phrase 'statins are usually indicated as part of the treatment of diabetes'?

I can. It is unfortunate in the extreme that the results of the research based on analyses done in developed countries are extrapolated to areas such as here, the North West Frontier Province of Pakistan. For the best possible motives doctors are prescribing such drugs and the patients are buying them at the expense of basic living requirements, usually for very short periods of time. This cannot be right. The recently published International Diabetes Federation guideline for diabetes makes a valiant attempt at remedying this, including, for the first time, a 'minimal care' guidance option for such situations, but still misses the point in that it is too narrowly focused on the illness itself.

What is required is evidence on which to base what I intuitively know to be true — that a recommendation to buy a statin (or indeed a dose of many other preventative drugs) is, ultimately, harmful to the majority of those living in these areas. A spreadsheet that would include variables such as: patient income; cost of a loaf of bread (or equivalent in the local staple diet); ethnic origin (if it affects complications of the disease); cost of a month's supply of drug; and likely beneficial effect over a period of, say, a year, would be immensely useful, being flexible enough to deal with those few who can indeed afford such drugs. A primary care institution could design protocols around the results — and I would be happy to start with diabetes here. But I am not a computer programmer and I know that my return to the UK in a week will bring the normal tyranny of the urgent over the important. Can anybody help?

Jim Newmark, Qalandarabad