A patient's diary:
episode 11 — A fright at the opera

26 OCTOBER

My appendix scar seems to have healed up nicely and I have been back at work for a week. All my other abdominal organs seem to have settled down as well since I had the operation which is most gratifying. Mr Cutler, the surgeon, did explain to me that while he was 'inside' he had taken the opportunity of checking my liver and it looked to be in 'very good shape'. I'm not quite sure how he can tell just from feeling the shape of the largest organ of the body that its intricate internal machinery is not malfunctioning and he may have just been trying to reassure me. However, having done a little more research on the internet during my convalescence I have actually come to the conclusion that I may have been mistaken about my liver right from the beginning. Oh I know I was quite convinced that it was swelling up and that the bile ducts were leaking and so forth, but new research that I have found on some of the websites throws an entirely new light on my symptoms. In fact I said to Dr Teacher only yesterday that I thought in retrospect that my liver may have been functioning normally all along. He was quite amazed, naturally, as he has heard me complain about it for many months.' No,' I said to him, 'it is my belief that all the trouble is really coming from my pancreas.' The pancreas is a very little known organ. It is behind the stomach you see, you see, deeply placed and obscure but we neglect it, Dr Teacher, I told him, at our peril.

In point of fact I hadn't come to discuss my pancreas. I reassured him hastily about this because I could see he was looking a bit despondent. 'No,' I said, it's this nasty, fruity cough I have come about. I've had it for a week now and I'm a bit worried in case there could be anything on my lungs.' He listened to my chest, which they don't always do for an ordinary cough so it's worth making a special point of asking. I know a little about auscultation of the chest because I have this rather useful book at home called Diseases of the Thorax Part 1. It's a proper hardback medical book with 300 illustrations in black and white and 16 colour plates. My uncle Stanley, who suffered a lot from his chest, got it in the Charing Cross Road in London and he left it to me in his will when he passed on. Dr Teacher's auscultation was fairly brief but I suppose they get used to doing it quickly with so many patients to see. I don't like to appear to be telling him how to do his job of course but I did just casually ask if he had heard any amphoric breathing anywhere. No, he said it was all quite clear. No whispering pectoriloquy? I enquired daringly. Any suggestion of post-tussive suction?

'What are you talking about, Norman,' said Dr Teacher mildly. 'Have you been reading that chest book again?' I laughed light-heartedly and said he must forgive me for being a little concerned. It was just that I thought there might be one or two cavities here and there in my lungs that I didn't want to feel I was neglecting.

'They are not like cavities in your teeth, Norman, 'said Dr Teacher. 'You only get them in your lungs with tuberculosis. That's very rare these days except in people with malnutrition or HIV infection and I doubt if either of those applies in your case, eh?' I said no I didn't think so (although I have missed out on my vitamins some days when I've been in a rush to get to work). 'Couldn't I have an X-ray, 'I asked, 'just to be on the safe side?' So he gave me a form for an X-ray and a prescription for that useless simple linctus which I threw away. Simple linctus for simple souls, is what I think of that stuff. No antibiotic of course. You have to beg on your bended knees for one of those nowadays. It's because of the severe downward pressure on costs that the government is exerting, in my opinion. Or, could it be, horrid thought, that Dr Teacher actually suspected that I did have TB and was waiting for the X-ray to confirm his diagnosis. As I walked down the street I began to feel quite queasy. There is an awful colour picture in Diseases of the Thorax Part 1 of a tuberculous cavity with a bare little artery snaking across, just waiting to crumble and gush with blood …

Then, in the evening, Hilda had the television switched to BBC 2 for an opera from Covent Garden. It was sung in Italian with English subtitles. I'm not really one for opera myself; I prefer a well-made play. But Hilda likes to watch it now and then so I don't object. I couldn't help noticing that the heroine had a nasty little cough, rather reminiscent of my own. It must be difficult to sing with a cough and I wondered why she had not been replaced by someone else for this performance. I pointed this out to Hilda who turned a tearful face to me and said. 'Oh, Norman it's part of the story. She has consumption. TB, you know. Ever so sad. Her young man's father makes him leave her because of the life she has been leading. He comes back to her in the end but it is too late. She's going to cough up blood and die in his arms.' I began to sweat freely and felt distinctly unwell. Looking in the mirror in the hall I could see that my cheeks were flushed and my eyes unnaturally bright. I decided to take a few of the antibiotic tablets that I keep for an emergency and a stiff dose of whisky. Then I crept off to bed with my hot water bottle.

I must have slept fitfully for a while and then I woke with a great spasm of coughing. I thought I was going to choke. And then, to my horror, I felt something warm trickling down my chin. With

Verdi's masterpiece provokes a psychosomatic haemorrhage, but Dr Brenda comes to the rescue.

trembling fingers I switched on the bedside light and forced myself to look down at the snow-white sheet on which a bright crimson stain was already spreading rapidly. It was true then. The final haemorrhage had come. I looked for Hilda but she was already telephoning the surgery. 'They won't come in the middle of the night,' I quavered, 'you'll have to get an ambulance'. Then I saw that it was daylight and the alarm clock said 7.45 am. Although weak from loss of blood, I remembered that the practice still have to do their own emergency calls in the morning and the OOHDOC Emergency Service hands over at 7.30.

It was Tuesday so I knew it would be Dr Brenda on duty, which gave me some comfort. I didn't think there would be much she could do but I imagined her cradling my head in her lap, oblivious of the splashes of blood which bedizened her white night dress and saying 'Alas, I am too late to save him,' while I gazed up into her eyes and said (or perhaps sang) 'Farewell, farewell …'. Then I think I must have fainted because the next thing I remember is Dr Brenda sitting on my bed (in her anorak), and clamping a piece of gauze round the soft part of my nose. 'Hello, Mr Gland', she said. 'You've had rather a nasty nose bleed but I think it has stopped now. My, what a mess! Some cold water would be the best thing for those sheets, Mrs Gland and it should come out of the duvet cover as well. Now, Mr Gland, Just hold that on to your nose for me for another 5 minutes by the clock'.

I don't think I'll bother with the chest X-ray and I don't think I'll be watching any more operas on television — not the ones about health problems, anyway.

We are grateful to John Salinsky for these extracts from Norman Gland's diary.

Mike Fitzpatrick

A grim future foretold

In his introduction to his interim report on the future of the NHS, surgeon Ara Darzi claims that he is a 'doctor not a politician'.[1] Although Lord Darzi has only recently joined the government, his report confirms how rapidly he has learned Labour's cynical doublespeak. The report's bullet point sentences provide the familiar rhetorical cover for the centralised command and control policies through which the government has sought to impose what it regards as 'populist' reforms in the NHS. Proclaiming its commitment to be 'ambitious' in raising the 'quality of care', the report insists that the NHS must 'respond to the aspirations of patients and the public for a more personalised service by challenging and empowering NHS staff and others locally'. As Neville Goodman memorably observed in his critique of an early New Labour policy statement on 'clinical governance', it would be possible to rearrange the clauses in this sentence in several ways to produce an equally meaningful (or meaningless) result.[2]

Who is going to 'challenge and empower' NHS staff? (And, in passing, who are the 'others' who are similarly objects of these ominous verbs?) As any government initiative to 'challenge and empower' can only come from above, the adverb 'locally' is here used in the New Labour sense of 'centrally'. How are NHS staff to be challenged? Presumably GPs will be challenged by competition from Darzi-style polyclinics run by Tesco and Boots. The result, as Iona Heath has argued, is likely to be the fragmentation of primary care services that may challenge budgets without 'empowering' anybody, least of all those in the greatest need of high quality health care.[3]

Darzi-style 'empowerment' is not just for NHS staff. Patients too, are to be 'empowered to make their decisions count within the NHS'. In a radical rhetorical flourish, the Darzi report insists that we must 'change the way we lead change'. How? Well, by the expedient of 'the response to patient needs and choices being led by clinicians'. Although this sounds like the same old process of change being led by hospital consultants — like Ara Darzi — in reality, it is just another combination of weasel words to disguise bureaucratic diktat. Who is to decide what any particular patient needs? What is the meaning of choice for a sick person, afflicted with an inherent deficit in medical expertise and confronted with a range of equally unsatisfactory care options? While the Darzi report may satisfy the new prime minister's need for a high-profile initiative on the NHS, its proposals are based on a profound misunderstanding of its current predicament. Take one example. An underlying theme of both his current report on the future of the NHS and his earlier 'Framework for Action' on health services in London is that the dramatic increase in the numbers of patients turning up at hospital A&E departments is the result of restrictions on access to GP surgeries. It is perhaps not surprising that, as a tertiary care hospital specialist, he has not noticed that the rise in A&E attendances over the past 20 years has taken place in parallel with an expansion in the availability (and quality) of primary care services. Both these trends have a common origin in the medicalisation of society: medical entrepreneurs and political opportunists, bureaucrats and journalists have combined to promote awareness of every medical condition from AIDS to yaws, while anxious citizens have embraced health as both a transcendent goal and focus of existential angst. Just as NHS Direct has provoked more attendances at A&E and surgeries, more surgeries staying open for longer will attract and create more patients, and even more patients of GP polyclinics will end up in A&E and other forms of hospital care. Lord Darzi may win more votes for Gordon Brown, but at the cost of increasing the burden of health care on the exchequer — and of making more people ill.

REFERENCES

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