Letter from . . . Chicago

War games

GEORGE DUNEA

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With the landing at Gallipoli the war moved into a new phase. The allies marched swiftly through the Balkans, occupied Budapest, then suddenly turned east to relieve the embattled troops of Czar Nicholas. On the same night the Shah restored the ancient glory of the Persian empire, his victorious troops penetrating as far as the Danube; the armies of Frederick the Great broke ranks at Leutzen; Scipio perished ignominiously at Zama; and the third world war ended in an impasse. In the kitchen Epaminondas hopelessly mismanaged the battle of Leuctra; and Hannibal's elephants ran amok, trampling down friend and foe alike. Later, at the diplomatic table, perfidious Albion betrayed the French, concluded a secret alliance with the Central Powers, but then turned around to stab the Germans in the back, so that in the end nobody won but the Turks.

That night no one slept, but the hostilities ceased in the morning when the boys went out to eat pizza for breakfast, leaving the house in hopeless disarray. But more confrontations are in the offing, for war games are the rage, and a New York company offers a bewildering array of 190 games—each with a set of rules and its own cardboard battleground and opposing armies. The latest game, "A Mighty Fortress," is about the Reformation and Counter-reformation, with rules conferring powers of excommunication and a theological debate results table allowing players to win, be exiled, or burn at the stake. Furthermore, "Siege of Constantinople," "Descent on Crete," and "Drive on Stalingrad" are on the drawing boards, also "Airwar"—and indeed the conflagration has even spread to the stars. The supporters of the Old Republic have revolted against the Galactic Empire, imperial stormtroopers have captured Princess Leia's spaceship, and long lines of adolescents and adults are waiting outside the cinema to witness the vapourisation of the planet Alderaan and the final duel between Obi-Wan Kenobi and the evil Darth Vader.

Warlike sounds

And so war, the most malignant scourge of mankind, continues to fascinate—and even we, the most modern of medicine men, make warlike sounds.[1] So that we fight obesity, diabetes, or multiple sclerosis; constantly plan new strategies against cancer; increase our therapeutic armamentarium; exhibit fight or flight reactions; have our lymphocytes turn against us; and witness a constant battle between the ego, id, and superego. We fight off colds, enslave our mitochondria, may reach a stalemate with the invaders, and suffer when our defences are weakened.[1]

Now concerning the medical care of war's heroes, the *Chicago Tribune*[2] has peevishly complained that "Citizens foot bill for military élite's convenient clinic"—and has reported how the US Air Force, while at peace, spends a quarter of a million dollars annually to provide "exceptionally convenient" medical services to an élite corps of 664 generals, colonels, and top civilians. The services, located in a well-equipped clinic on the Pentagon's top floor near the executive offices, are provided by a staff of two full-time doctors (paid about $42 000 each annually), a dentist, nurses, 10 medical technicians, and two clerks. The clinic enables officers to obtain convenient and personal flight eligibility examinations with almost no waiting. Attendance at the clinic is light, with some shifts seeing no more than a handful of patients—including an officer who cut his finger on an oyster shell at lunch.

By contrast, the article continued, junior Air Force officers must travel 20 miles to a Maryland Air Force base for their check-ups—and lesser ranking officers in the armed Forces have to attend an overcrowded clinic in the Pentagon shopping area or "concourse," where seven doctors provide treatment to thousands of less privileged individuals. Elsewhere the army also faces a critical doctor shortage, with "demoralising mismanagement and red tape leading many young medics to quit after one duty tour." In addition, there has been mounting criticism of the services provided to the veterans of America's wars, and a task force of the same *Chicago Tribune*[3] reported that the Veterans Administration had swelled into a huge inefficient organisation riddled with red tape and with its hospitals ailing as much as their doctors. Treatment is impersonal and episodic, the outpatient facilities inadequate, and the overall operation wasteful—with patients in hospital unnecessarily or staying too long. Many of the hospitals are understaffed, mainly because of uncompetitive working conditions, there are not enough nurses, and a shortage of technicians causes serious delays in obtaining laboratory test and *x*-ray results, even in emergencies. An outdated dispensing system results in large amounts of drugs being lost or stolen; psychiatric services are mostly inadequate; the physical plants, often of pre-second world war vintage, are antiquated, crumbling, or in out of the way inconvenient areas; and excessive medical school influence in some of the university-affiliated hospitals interferes with the daily operations.

Inadequate care

Similar findings emerged from the recent study conducted by the National Academy of Sciences at the direction of Congress. These findings included deficient outpatient care, too many acute beds, insufficient chronic care facilities—also inefficient use, inadequate staffing, and services of inconsistent quality. Medical care was satisfactory in some hospitals, especially in those affiliated with medical schools, but substandard in others, particularly in some of the psychiatric hospitals. The report concluded that the Veterans Administration programme was obsolete and unduly costly, and should be restructured and integrated into the general health system. "I do not think that

Cook County Hospital, Chicago, Illinois 60612
GEORGE DUNEA, MB, FRCPED, attending physician

veterans' hospitals should be closed" said the study group's chairman, "but in the long run they should be public hospitals."

Yet the public hospitals, recently scrutinised by a commission on public-general hospitals, also have their share of trouble. These hospitals, some 1900 of them, account for one-third of all US hospitals, are run by the State, county, or city, and some are university affiliated. Some are very large, catering mainly for the urban poor, and are staffed by full-time doctors, interns, and residents; others, in smaller towns, suburbs, and rural areas, act as community hospitals and serve private patients. They provide various services such as burns units, emergency care, training of doctors and allied health professionals, much primary care, and programmes for alcoholism, tuberculosis, drug abuse, and prisoner and psychiatric care. For many patients who cannot afford private care they offer equal treatment, regardless of race or social position.

Not all public hospitals are in trouble, but many are underfinanced because of insufficient local, State, and federal support —this at a time of increased demand for services because of cutbacks in welfare programmes. Their buildings tend to be outdated and outmoded; and their administration inept and inefficient, because of the constraints of local government regulations and the pressures of volatile local politics. Yet, the report concludes, public hospitals offer services that the private sector may be hard put to replace, as well as opportunities for experimenting with new programmes, new forms of reimbursement, and new approaches to service delivery. Their urgent need, however, is for better financing mechanisms, for new forms of governance, and for improved local planning, with closer delineation of responsibilities and integration of roles between public and private hospitals.

Alexander the Great

Finally, last June marked the 2300th anniversary of possibly the greatest warrior of all times, the man who within 12 years overthrew an empire that had lasted 200 years, conquered the greater part of the eastern world, became worshipped as a god, and forever changed the course of history. Alexander of Macedon died, aged 32, in 323 BC in Nebuchadnezzar's palace at Babylon. None of the 20 contemporary accounts of his life have survived in the original; but 1500 monographs have been written about him in the last 150 years, and interest in his life continues unabated.

Fair and light skinned and with a most agreeable odour exhaling from his skin—perhaps because of a fondness for ointments and sweet spices—Alexander was famous for the liquid intensity of his gaze; and his eyes may have been of different colour—suggesting either magical powers of bewitchment or perhaps that he was born out of wedlock and that King Philip was not his father.[4] He carried his head turned towards his left shoulder and with an upward gaze—a posture that his successors affected to imitate but which may have been due to torticollis (with shortening of the right sternomastoid, flattening of the right side of the face, and asymmetry of the eyes)—a birth injury attributed to the goddess Diana being unable to supervise his delivery on account of fire destroying her temple at Ephesus on the day of his birth.[5,6]

Alexander drank heavily, killed several people, was frigid at first, and later homosexual. He loved his mother but hated his father—as shown by his ruthless pursuit of Darius but his kindly treatment of the Persian's wife and daughter.[7] In battle he was wounded four times by arrows and twice by spears, once with a sword, and once with a stone. Three wounds were serious: a compound fracture of the tibia, a cerebral contusion followed by transient amaurosis, and a right-sided penetrating chest wound ("with breath together with air shooting forth") needing the removal of a large arrow by Perdiccas with his sword or by his surgeon Critobulus or Cristodemus.[6] In Asia Minor he developed a fever, probably malaria, from bathing in the river Cydnus, but recovered after drinking a strong medicine despite warnings that it may have contained poison.[8] His body after death remained fresh and fragrant, though neglected in a hot, sultry place for several days. His golden sarcophagus was taken by Ptolemy into Egypt but vanished during the third century riots in Alexandria.

Alexander probably died from an infectious disease[9]—malaria, amoebiasis, or dysentery; perhaps yellow fever, pneumonia, or typhoid—and the royal diaries report that he had a high fever, was already speechless as the army filed past him, and died after an illness of some 12 days. But in an alternative version Alexander filled the huge beaker of Hercules with unmixed wine, downed it at a gulp, instantly shrieked aloud as if smitten by a violent blow, and died in great pain, suggesting an abdominal catastrophe or poisoning. Legend has it that enemies from Greece sent him a poison deadly cold as ice, distilled from a rock at Nonacris and so penetrating that no vessel but an ass's hoof could hold it. Both Plutarch and Arrian deny this version; but "those accustomed to the deaths of powerful men will not be surprised that Alexander's death is a mystery which is hard to solve beyond all dispute."[10]

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Known alcoholics are often admitted to hospital as medical or surgical emergencies with restriction of oral intake, including alcohol. Is it reasonable to give them ethanol intravenously at the first sign of delirium tremens?

In a strict pharmacological sense it is reasonable to give alcohol in decreasing doses to help withdrawal. This is somewhat analogous to using methadone in heroin withdrawal. In a clinical sense, however, non-alcohol measures are preferable. The aim is to wean alcoholic patients from alcohol addiction and, particularly if they are cooperating, it is important that they should have been without alcohol for some time when they leave hospital. This alone will not, of course, induce long-term abstinence and they will need further measures, but starting on a period of sobriety after some alcohol-free days in a setting where alcohol is not freely available is important. Chlormethiazole (Heminevrin) is a useful drug and just as effective as decreasing doses of alcohol. It can be given intravenously or by mouth. It should probably not be given for more than seven days, however, because of the risk of dependence. Chlordiazepoxide (Librium) may also be used.

Is arachnoiditis a common complication after laminectomy and how should it be treated?

Arachnoiditis is not a common complication after laminectomy. Retraction and handling by instruments without protecting the cord coverings by cottonoid swabs is a prime cause. There are, however, some cases where arachnoiditis occurs without apparent cause. Treatment varies from masterly inactivity in mild cases to a course of steroids, such as dexamethasone, in severe cases. Fortunately it is a very uncommon complication.