Letter from . . . Chicago

Conflicting evidence

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Hardly a week goes by without the newspapers reporting a dramatic breakthrough, a new study—often promising but still preliminary, difficult to evaluate, sometimes based on flimsy data, sometimes the evidence conflicting with previous findings. Here is a laxative—it turns out to be psyllium (Metamucil)—that promises to lower cholesterol levels. There is a new tablet—bismuth subsalicylate—that may prevent travellers' diarrhoea. Low protein diets may enhance the effects of drugs in Parkinson's disease; a new salve made from blood speeds the healing of skin ulcers; a test for detecting cancer of the colon measures the absence of sialic acid and is "incredibly simple." Soon scientists will quantify total body water and fat with low frequency sound waves, and surgeons will implant animal hearts into human chests.

Here a psychologist has concluded that infants sent to day care centres at too early an age may develop psychological problems, those spending more than 20 hours in day care becoming anxious, aggressive, and insecure. There an epidemiologist has found that loners, socially isolated people, are two to three times more likely to die than controls who maintain a social network—a spouse, friends, an organisation—and that psychological factors or happiness make no difference, a bad marriage being better than no marriage at all. Another scientist warns against excessive optimism, a function of the left side of the brain, an "illusion of invulnerability" getting people to take inordinate risks because they feel immune or at least less likely to develop cancer or die from accidents than their fellow men. People practising controlled behaviour and suppressing their anger at their spouses are twice as likely to die prematurely than those who give vent to their feelings. And if your job makes you sick—announces a large billboard in California—from overwork or even the stress of being fired call the hotline and it will help you file for compensation claims or sue for damages.

Economics is another area for conflicting conclusions. Will the economy grow by 2% or 4% next year? Should the federal reserve tighten its hold on the money supply or loosen it? Will interest rates go up or down? Do we need more incentives or more controls? Privatisation has become the buzzword, fuelled by the perception that government programmes breed sloth, waste, inefficiency, mismanagement, or corruption. Among recent candidates for privatisation are the prisons, grossly overcrowded and often ready to erupt into ugly riots. Several states, unable to build enough jails to accommodate the rising prison population, are now turning to the private sector to build and manage new penal institutions. Already private companies are running detention centres for illegal aliens and juvenile offenders, as well as providing services such as drug treatment, medical care, and vocational training. It remains to be seen if they can do a better job than the government.

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Free care for 250 000 millionaires

In health care things might also be done more efficiently with less government interference. Among the programme needing restructuring is Medicare, now costing \$90 billion a year to take care of the Americans over the age of 65 years, including 250 000 millionaires and another million with incomes over \$50 000 a year. Some proposals envisage a means test to identify people in need of assistance and a tax deductible savings account arrangement for the others.[1] This would grow considerably during an average of 30 years of employment, could be self managed, and should eventually more than cover the medical costs of most people. This is especially so since many older people are affluent, their children having grown up, and their living expenses being small. It is argued that such an arrangement would bring back a feeling of responsibility into a system that is now often abused because it is free.

Even more contradictory are the results of studies on diet. Yet people are constantly being told to change their eating habits, often on rather flimsy evidence. Some time ago two prestigious research institutes advised women to reduce their fat intake to less than 30% instead of the more usual 40% of total calories because of a reported association between fats and breast cancer. Now another study has failed to show any relation between the two, so that the whole issue has to be looked at again. Other factors such as total calories or various unidentified ingredients may eventually turn out to be important in accounting for the different incidence of breast cancer in different countries. Nor does anybody know if perhaps the fat intake might need to be reduced to 10% of total calories; meanwhile any dietary advice on this matter is premature.[2]

Then there is the strange finding that heart attacks and also strokes are more likely to occur at 9 am, reported by a Harvard investigator who is his worst sceptic but knows of no other way to interpret his data.[3] Moreover, he has found 14 earlier studies coming up with the same conclusion, all published in "obscure" journals. He has been unable to attribute his findings to changes in the pulse rate or blood pressure but is looking at plasma catecholamines and platelet stickiness. Obvious therapeutic implications include the administration of slow release long acting drugs at night or taking other agents, such as vasodilators, immediately on waking. Another approach might be to avoid the fatal hour altogether by staying in bed until mid-morning—a common practice among people supported by public welfare funds, who indeed have no reason to live dangerously by rising earlier.

"Give a man a fish and he'll eat for one day"

Yet increasingly a consensus is developing that something needs to be done to reform the present wasteful welfare system—there are more than 70 separate programmes. Set up in the era of the great society of the 1960s to help the poor, it was not without regard to the non-poor producer lobbies that were to benefit from it. Growing in the past two decades into an enormous bureaucratic hodgepodge, it

discourages work, causes families to break up, and even rewards teenage pregnancy. It isolates the poor in unattractive vertical slums that become eyesores and hotbeds of crime, and encourages a tradition of living on handouts and no work that is passed from generation to generation. A growing awareness of the need for change has led several states to institute reforms—for example, consolidating programmes, awarding cash supplements for working recipients, providing counsellors and job training, and perhaps subsidising jobs where none are to be found. Above all, there is an attempt to get away from the practice of penalising those enterprising poor who currently would lose all benefits were they to take a job. Already some states have moved in that direction, in order to solve a difficult and expensive problem, by setting up programmes combining job training with education, child care, and some health insurance. "Give a man a fish and he'll eat for one day," recently said one state governor, "teach him to fish and he'll never go hungry."

Also addressing the problem of hunger, but in a more global manner, are two students of the problems of famine, its causes, prevention, and relief.[4] They point out that famines have occurred throughout history, there having been over 1800 in China and more than 180 in Britain since the beginning of the christian era, while during the bubonic plague of the Middle Ages some 43 million Europeans are believed to have died of hunger. Epidemics, wars, and bad weather are the usual causes for the repeated crop failures that culminate in famines; but the final common culprits are often governments, which precipitate crises through improper policies and mismanagement. Yet in most cases famines can be prevented by proper planning arrangements to provide relief and, in the long run, by sound economic policies. At present Africa constitutes the greatest problem. Successive famines have occurred in recent years, especially in the subSaharan area, where much could be done by instituting long term policies.

But in the developed countries, despite occasional reports of hunger, the problem is often one of excessive alimentation. One such difficulty arises in intensive care units where acutely ill medical or surgical patients often receive large amounts of calories, by mouth or intravenously, supposedly in order to help wound healing, increase general resistance, and allow weaning from the respirator. Such hyperalimentation has become common practice and is widely accepted in spite of being expensive and potentially hazardous. It complicates management because large volumes of fluid are given and must then be removed. In the presence of renal failure this often leads to the insertion of continuous filtering devices into the circulation so that the excess fluid put in at one end now has to be taken out at the other. Complications often arise in the form of electrolyte imbalance, excessive nitrogen retention, infection, bleeding from the continuous heparinisation, and trauma from the femoral or subclavian catheters. Yet it seems that studies confirming the value of hyperalimentation in acutely ill patients are few (if any) and unconvincing. The practice then seems to be based mainly on clinical impressions, often promoted by enthusiastic surgeons, chest physicians, or intensive care specialists, whose fervour reminds one of the earlier zeal for bleeding and leeching. Different aminoacid combinations are now being targeted at different organs. Only the other day a surgical resident was explaining with no little pride how his patient with multiple organ failure was receiving Pulmocare for his lungs, Hepaticaid for his liver, and Nephramine for his renal failure.

Ethical problem of withholding nourishment

Yet even less susceptible to scientific analysis is the problem of withholding food and fluids from hopelessly ill patients. In recent years a consensus has developed that competent patients may refuse food along with other treatment, and that force feeding them represents an invasion of their privacy and an infringement of their constitutional rights. In several cases the courts have now upheld this position whenever hospitals have refused to comply with patients' wishes out of fear of being held liable for malpractice. A patient with paraplegia actually filed a $10m suit against the physician and the hospital that had fed her against her wishes. Also reaffirming this position was a recent decision in the case of a totally paralysed man who could communicate only by nodding in response to messages written on a board. He also asked to "not suffer any more," but it took six months of litigation for a nervous hospital to stop feeding him though a tube.

Even more controversial is the issue of withholding food and fluids from patients who are clearly dying or irreversibly comatose.[5,6] This problem arose as our ability to keep comatose patients alive for long periods of time coincided with increased consumer activism, a tendency to sue doctors, and growing participation by the courts. Even doctors rarely agree, some arguing that fluids should be given to the very last because of respect of the sanctity of human life, others fearing that stopping intravenous fluids would break the bond between the doctor and his patient. It should be remembered in this context that Karen Quinlan, though clearly comatose beyond all hope of recovery, received nasogastric fluids and nourishment for almost a decade.

Most doctors, however, have felt trapped in the middle. Uncertain of all the legal ramifications, they were taken aback when two doctors were charged with murder after stopping (with the concurrence of the family) the supply of intravenous fluids to a dying patient. Last year, however, the American Medical Association's ethics committee agreed that fluids could justifiably be discontinued in terminal or irreversibly unconscious patients, provided that the family concurred. Citing this opinion several judges recently ruled to that effect, notably in the case of a comatose Boston fireman who was thus allowed to die last October. Yet undoubtedly more developments are to be expected in this delicate and controversial ethical issue.

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Is infectious mononucleosis a contraindication to continuing oral contraception? If so for how long?

Although infectious mononucleosis affects young adults and is fairly common in colleges and universities,[1] there is surprisingly little specific information on whether it contraindicates oral contraception. More than 90% of patients show increased serum liver enzyme activity, representing mild hepatic inflammation, and about 10% develop hepatomegaly or jaundice, which can occasionally be serious.[2] Traditionally patients are advised to avoid alcohol for three to six months, though the need for this has been questioned.[1] With other liver disorders such as infectious hepatitis combined oral contraceptives are contraindicated only while liver function test results remain abnormal,[3,4] though some authorities suggest that women should wait for at least six months before restarting combined oral contraceptives[5] and that liver function test results should be rechecked a month or two after restarting.[4,5] With infectious mononucleosis I suggest stopping combined oral contraceptives while liver function test results remain abnormal and restarting once they are normal. Patients should be carefully counselled about alternative contraceptive methods: low dose progestogen pills may be used by women with abnormal liver function test results[4] and for maximal efficacy could be combined with a barrier method.—JAMES OWEN DRIFE, senior lecturer in obstetrics and gynaecology, Leicester.

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