

book reviews

Transplant: from myth to reality

By Nicholas L. Tilney. Yale University Press, New Haven CT 2003. 336pp. \$30.

The treatment of life-threatening organ failure by whole organ transplantation was as bold as cutting the Gordian knot, or so it must have seemed to the surgical pioneers of the approach. Technically it was straightforward – any dextrous, nimble-fingered individual could do the joins. It was the immunology that proved the most refractory. This book describes the history and development of a therapeutic modality that has matured from headline-making ‘firsts’, to a procedure so routine that it is now considered almost tedious by some surgeons. The anatomic challenge must have been delicious, but once solved the surgeons stumbled (and their patients perished) in the barbed wire of rejection. From a situation of having no survivors we now have standards which expect, for example, 90% of kidney transplants to function at 12 months. Understanding, preventing and treating rejection has been the real achievement. The story of the slowly won campaign is intriguing, but the imbalance of serendipity and science should remind us not to be credulous of the glib and overconfident scientific merchants of today. So how did we get from 0% to 90% in 53 years? It took, first of all, bold surgeons (unfettered by risk-averse agencies of control) and desperate patients to prove the principle. Considering the state of anaesthesia and imaging, and the paucity of antibiotics and artificial organ support, never mind the crude immunosuppressants, it was a miracle that the transplant worked at all, let alone for a few days or weeks.

It took a second wave of surgeons, immunologists and physicians to do the difficult bit. Nicholas Tilney is well placed to recount the story, having been involved in the early clinical programme in Boston. He writes from the perspective of a US surgeon/immunologist. One senses that he felt a need to describe the remarkable evolution of transplantation and his current concerns. His personal insights are fascinating, but his determination to cover all the mythology and superstition of the distant past comes across as a clumsy attempt at completeness. It does not enhance the book. His pride in the achievements of the transplant community is balanced by the examination of motives, personalities and mistakes. One suspects that he was more diplomatic in print than he would be in private, but can nevertheless glean the darker sides of the story. He has tackled contentious issues head on – for example the influence of pharmaceutical companies, paid organ donation and the current unattractiveness of academic careers in transplant surgery.

It is a useful book with some valuable parts – but it could have been so much better. Despite the editorial help of four assistants it still needs surgery; both resection and reconstruction. The style is in parts pure *Reader's digest*. Clichés, generalisations and attempts to cover too much ground in single paragraphs jarred this reader. The literary references and descriptions of historical beliefs came across

as an attempt to make the book a scholarly work as well as a narrative one. In one paragraph he manages to mention Dante, Milton, Blake, Mary Shelley, Oscar Wilde and Kafka!

It is a useful book, but incomplete and imperfect, perhaps because the author was trying to reach too broad a readership.

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Accessing health care: responding to diversity

Edited by Judith Healy and Martin McKee. Oxford University Press, Oxford 2004. 398pp. £49.50.

British Airways Flight 2740 banks steeply over the snow-dusted Jura mountains as the lights of Geneva Airport fade in the evening haze. Framed by the cabin window, Mont Blanc attracts the last rays of a clear spring sun as I settle down to the concluding chapter of *Accessing health care: responding to diversity*.

I am returning home after three days at the World Health Organisation, as part of a hastily convened conference in which the world's reaction to a potential influenza pandemic was debated. The three pillars of the response – public health, anti-viral drugs and vaccines – were pondered over at great length in a series of working groups. Each detail emphasised not so much the diversity of the world population's ability to access health care as the dichotomy of the health experience between people who live in ‘developed’ and ‘developing’ countries.

The challenge presented by a pandemic is easy to comprehend; its magnitude is not. The avian flu virus is resourceful, the epitome of Darwinian evolutionary principles. Once a new variant ‘learns’ to infect man, and initiates person-to-person spread, the prerequisites for a pandemic are present. Combine a particularly virulent strain with a few coughing passengers on an intercontinental flight and within a few months a significant proportion of the world's population could be affected. Pandemics tend to occur every 20 to 30 years: the next one is overdue.

The world's response is less predictable. How utilitarianism, contractarian theory and pluralist theories of justice – so eloquently and succinctly presented by editors Judith Healy and Martin McKee in the first chapter of this book – are played out on an international (as well as national) stage will determine the outcome.

Here is the conundrum. Until a vaccine can be produced against the pandemic virus (probably months after the initial identification), public health measures and expensive anti-virals of questionable effectiveness are the mainstay of a response. But few (if any) countries have the resources to stockpile adequate amounts.

Furthermore, at the very beginning (if one can pinpoint it) of a potential pandemic there is a theoretical possibility of preventing a pandemic by using world stocks of anti-virals to saturate the focus of new infection and nip it in the bud. There is therefore an argu-

ment for the 'developed' countries to divert at least some of their capacity to create an international stockpile (to benefit all as well as themselves) in addition to their national stockpiles (which benefit only them). However, if this should fail to contain the spread of infection how will public-spirited governments then inform their citizens that they have already donated much of their very limited stock to another country in a futile (when assessed retrospectively) gesture? The inequalities will not stop there, though. The few countries with the capacity to produce a vaccine will come under enormous pressure to protect their own citizens. But which citizens will it protect first? Those most severely at risk (the old and chronically ill)? Those providing essential services? The economically active? Where will minority groups figure in this allocation? So one scenario highlighted for me many of the challenges of providing an equitable health care system in an inequitable world, the subject of this book.

The introductory chapter illuminates the complex ethical and philosophical concepts mentioned above in a deceptively straightforward fashion. So carefully are you led through each argument that you only find at the end that the conclusions reached could be considered paradoxical and begin to be daunted by the practical steps required to achieve such services. Each chapter then looks at examples of 'minority' groups having their access to health care jeopardised in some way; because of gender, age or ethnicity, or by virtue of being the first in a county or the last to join a country. Most concentrate on the sociological and political context of what is happening, some – but not many – describe attempts at resolution. Even fewer present the results of successful interventions.

Bringing the disparate threads together in the last chapter, the editors highlight the arguments for and against the 'separation' or 'integration' of services in order to provide best care. They are at their most convincing when they argue that this issue cannot be ignored. However, like their contributors, they do not go deeply into the practical barriers to achieving this aim.

Having spent the last five years trying to reduce inequality in access to health care in the UK, I can understand their reticence. The second edition, or perhaps even the twenty-first, should concentrate on this. The basic issue is that equity of access is not the same as equity of use or, more importantly, equity of outcome. Indeed, because of differential knowledge and ability to benefit, outcomes can be unpredictable despite the best intentions.

My final thought as the lights of Gatwick Airport approach is, Where does diversity start and finish? At NICE we are usually invited to issue guidance on the 'major killers' such as heart disease and cancer. But what about the patient with an 'orphan' disease? They can also feel that they have a right to the same investment in the management of their disease as any other 'minority' group.

I look forward to the second edition.

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