

(BPS) model of medicine as propounded by George Engel (1913-2000) in a 1977 paper in *Science*.¹ The contributors are divided about whether this was a reaction to the narrow and restrictive 'biomedical reductionism' that had become dominant in medicine, or whether it grew out of an internecine turf war in American psychiatry. Engel had a foot in both medicine and psychiatry. He was brought up by his uncle Emmanuel Libman (of Libman-Sacks endocarditis fame) and became an internist. In his younger days he described psychoanalysis as 'hogwash', but in 1941 was virtually forced by his boss, Soma Weiss, to do ward work and research with the psychiatrist John Romano, who was fully integrated into the medical service. In 1946 Romano persuaded Engel to move with him to Rochester where they integrated psychiatry and medicine in the curriculum and in the same year Engel began to undergo psychoanalysis himself.

Whether Engel was a prophet of a new age is open to question and his seminal paper contains no data and no explicit plan of action. As Edward Shorter points out in the admirable historical survey that forms the first chapter of this book, Engel was part of a long tradition of people who preached holistic medicine. In the 1880s Hermann Nothnagel in Vienna described medicine as 'treating sick people not diseases' and in 1927, Francis Peabody wrote an eloquent treatise called 'The care of the patient'. The state of medicine and psychiatry has been a frequent topic of discussion in our household. My psychiatrist wife thinks psychiatry has gone to the dogs, with its practitioners making a diagnosis from the *DSM* (the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders*), and then prescribing pills. I lament that scopes and catheters in medicine have squeezed out history-taking and treating the patient as a person.

Arguably Engel's most important paper was 'A life setting conducive to illness: the giving-up-given-up complex', published in 1968.² By the time of the 1977 *Science* paper he was swimming against a tide of effective drugs in both medicine and psychiatry. Several contributors to *Biopsychosocial medicine* mention the discovery of *Helicobacter pylori* which dealt the *coup de grâce* to psychosomatic research on peptic ulcers. George Davey Smith, in typically iconoclastic fashion, points out that spiral bacteria were described in the stomach in 1899 and antibiotics advocated for peptic ulcers in 1948. For him, this means that the discovery of *H. pylori* was delayed for years by the BPS model and the mindset it created. Yet lots of people have *H. pylori* without ulcers and even more have dyspepsia without *H. pylori*. A dip into the psychological or social background will often give valuable clues to the aetiology of the latter, a point made in this volume by Drossman in connection with irritable bowel syndrome (IBS). Yet, in an era when clinics have to run to time, who dares open Pandora's box in outpatients?

One problem with the BPS model is that it is seen as the antithesis of the 'medical model', and indeed its adherents often use the latter as a term of opprobrium. Both seem to me to have their place. George Davey Smith says that, if he were to have a heart attack, he wants a doctor who is up to date with the best somatic treatments. This is fine and I doubt that even the most diehard psychoanalyst would disagree. Nevertheless one would hope that this cardiologist steeped in evidence would realise that the patient is a person with a life outside the coronary care unit. On the other hand the cardio-

logist may be less good at dealing with chronic disease or the large group of patients who in Peabody's time were talked about as having 'nothing the matter with them'.³ They are particularly badly served by 'organic' doctors; repeated tests may lead to the assumption that an (organic) diagnosis has not been made because the crucial test has not been done. Those with non-specific chest pain, IBS, fibromyalgia and chronic fatigue syndrome are surely the people for whom the BPS model is ideal, as recognised by Simon Wessely in his witty and wise foreword to the book.

The 12 speakers at this meeting are rather a mixed bag and the result is a rather patchy book. I like to see the discussions printed as they are here, but often they seem to go round in circles. Had I not been asked to review it, I don't think I would have read the whole book. Nevertheless, there is much food for thought. The chapter by Jos Kleijnen is highly recommended to all who believe in the biblical certainty of randomised controlled trials.

The sad truth about the schism between medicine and psychiatry in the twenty-first century is emphasised by Simon Wessely, who points out that when he sees patients in the general hospital they first detail the problems with their soma. In the Maudsley over the road, they invariably kick off with their sadness and anxiety. Yet, further probing invariably shows that those with fatigue and pain have sadness and those who are sad have fatigue and pain. An internist who ignores the psyche is not doing a good job – which is all I think Engel was trying to say.

References

- 1 Engel GL. The need for a new medical model: a challenge to biomedicine. *Science* 1977;196:129–36.
- 2 Engel GL. A life setting conducive to illness: the giving-up—given-up complex. *Bull Menninger Clin* 1968;32(6):355–65.
- 3 Peabody FW. The care of the patient. *JAMA* 1927;88:877–82.

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Recovery after stroke

Edited by Michael P Barnes, Bruce H Dobkin, and Julien Bogousslavsky. Cambridge University Press, Cambridge 2005. 668pp. £95.

Even ten years ago the idea that a book on stroke recovery extending to over 600 pages could be written would have been met with disbelief. Only since the publication of the review of meta-analysis of the stroke unit trials has there really been a belief that stroke is a treatable condition. Even now the funds allocated to stroke research are pitiful, compared to comparable conditions, in terms of their public health implications. For every £1 spent on stroke, £20 is spent on heart disease and £50 on cancer, with only a small proportion of the stroke research monies going on the longer-term consequences of stroke compared to acute pharmacological interventions. This is the case not just in the UK but also in the USA and the rest of Europe.

This book is a welcome addition to the stroke literature, which has few equivalent texts. It is beautifully presented and is well referenced up until 2003. In 25 chapters authored by contributors from

around the world, the topics covered range from regenerative ability in the central nervous system and cerebral reorganisation after stroke to the evidence base for therapy, the use of imaging and the use of technology in rehabilitation. Complications of stroke such as incontinence, visual impairments, balance disorders, aphasia, depression, pain, sleep disorders and cognitive problems are all dealt with separately; however, the paucity of stroke-specific studies means that it is often necessary to rely on research done in other neurological conditions. What is missing is a comprehensive review of the burden of disability following stroke. The introductory chapter on epidemiology, aetiology and avoiding recurrence perversely avoids presenting the data on the prevalence of impairments and disability in cerebrovascular disease which would put the rest of the book into context, and instead discusses issues more appropriate to a text on stroke prevention. Chapters lack a consistent framework and some, such as the one on movement disorders, are disappointing in that they fail to address the management of the eloquently described problems.

Two chapters in particular are worth highlighting because they deal with issues that are common but rarely discussed in the research literature. The chapter on sexual dysfunction brings together information that is of huge importance to patients but seldom discussed with them. From the studies quoted over half of stroke sufferers experience a deterioration in sexual performance or

satisfaction leading to discontentment, and yet where are the research studies exploring possible treatments? I was disappointed that the wisdom or otherwise of using drugs, such as sildenafil, after stroke is not even mentioned, as it is one of the questions that I am most often asked by patients when discussing post-stroke impotence. The chapter on 'Depression and fatigue after stroke' likewise covers a frequently neglected symptom, presenting fascinating data on the assessment, epidemiology and association with lesion location. There has however not been a single interventional study in this area despite it affecting up to half of all stroke victims. The final chapter by Donal O'Kelly, giving the patient's perspective, should in my opinion be read first because it contains a vivid description of what it feels like to have a stroke and puts the rest of the book into context.

Despite my few minor quibbles this book that has a great deal to recommend it. Having read it, I have come away feeling that there is an enormous amount about stroke that I didn't know, that there are a huge number of unanswered questions that need more research, and that the services my patients receive after stroke leave much to be desired.

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Letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by email to: Clinicalmedicine@rcplondon.ac.uk.

International Medical Graduate Training

Editor – I read with interest the articles on improving international graduate medical education in the UK (*Clin Med* March/April 2005 pp 126–32; *Clin Med* March/April 2005 pp133–6).

Whilst I applaud the aims of the proposals and sponsorship schemes. I think it is important not to lose sight of the effect of medical migration on a country's ability to provide healthcare in both the short and long term.

The hospital I work at in Rural KwaZulu/Natal has 10 doctors to serve a population of 250,000 people. Next year five of the doctors are planning to go to the UK after finishing their compulsory year of community service. Admittedly, we will probably be sent some replacement junior doctors who will again leave and emigrate after one year of service. I doubt rural hospitals such as ours will benefit from the return of highly trained physicians who will usually situate themselves in tertiary institutions or private practice, away from the population that needs them most.

I hope the proposed schemes will be tailored to the needs of the country sending graduates for training and that there will be follow-up to ensure that trainees return home and work where they will benefit their community most.

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Rheumatoid arthritis and *Proteus*

Editor – The article by Dubey and Gaffney (*Clin Med* May/June 2005, pp 211–14) may have given the wrong impression to CME readers, as the authors describe rheumatoid arthritis (RA) as 'a disorder of unknown aetiology'.

We have used the concept of 'molecular mimicry', which in the past worked for rheumatic fever, and adapted it for the study of RA. Patients suffering from RA in England were shown to have elevated levels of antibodies to the urinary microbe, *Proteus mirabilis*.¹

Molecular mimicry has been demonstrated between the 'susceptibility sequence'