Against a backdrop of disease generated by disruption of civilisation, the book provides some insight into the structure of casualty handling employed by the opposing forces and the factors that limited the planned implementation. Vast numbers of wounded arriving over short intervals test the efficiency of any medical facility and those so employed in the Spanish Civil War were spared little of this. Aerial bombardment of marked hospitals and of civilian populations were the new challenges imported from Nazi Germany and Fascist Italy that diminished available facilities on the one hand while increasing the demand on the other. The mechanised warfare of the first world war had furnished considerable experience of the surgical techniques necessary to improve the chance of survival following serious injury where wounds were heavily contaminated. The successful endeavours of the Spanish surgeon, Trueta (later to work to acclaim in the orthopaedic department at Oxford) to improve on these outcomes in the dawning antibiotic era are recorded in full. Appropriate emphasis on the administration of equine tetanus antitoxin and especially development of blood banks to meet the increasing perception of the widespread need for transfusion were developments that contributed to knowledge of their beneficial effects as well as their complications. In relation to blood transfusion, the practical contributions of Bethune, Saxton and Eloseguie are mentioned. The influence of British nursing on the military effort is accorded some detail. The authoritarian and formidable Mercedes Mila, an orthodox practitioner and product of British training, at one end of the spectrum is contrasted to the rich, dilettante, amateur but headstrong and brave expatriate Priscilla Scott-Ellis at the other. Their endeavours to galvanise members of female religious orders and the general republic into an effective military nursing service make interesting reading.

There are the inevitable harrowing accounts of atrocities and substandard medical facilities overwhelmed by death and disease. The detailed dangerous encounters Broggi made as a consequence of attempted defection are the equal of any contemporary military thriller.

One is left with an overall impression of a collection of largely referenced and valuable but selective anecdotes. Personally, I would have preferred a more comprehensive account where the military analysis of situation, mission, command and control, communications and security were examined from the medical perspective with comment on the successes and failures. Denied this, an otherwise interesting if muddled book lacks the comprehensive perspective it might have embodied.

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Succeeding as a hospital doctor, 3rd edn

By Roger Kirby and Tony Mundy. Health Press, 2007. 240 pp. £6.00.

How do we define success? At one of my first medical senior house officer interviews I was asked to cast my mind forward, to the occasion of my retirement party in the distant future: 'What do you think your colleagues would say about you on such an occasion? Would patients be present? How would you like to be toasted?'. This was a very good question and it had me stumped. How do we like to be seen by our peers and patients? What kind of praise and fulfilment are we after? What makes one successful?

Success is certainly a multifaceted issue and it is clear that there is no easy definition. Different people are motivated by different forces and in the sphere of hospital medicine there are multiple measures that we can use to rate our development and success. Being doctors we are already self-selecting, ambitious, high achieving and usually rather competitive. Comparing one's 'success' with one's contemporaries, however, is not clear-cut at all. Do we go by fame, wealth, position or a satisfied family life? Is the pre-eminent professor of cardiology with a handsome Harley Street practice more successful than a lowly hospital practitioner who works part time and spends more time with his family or has significant outside interests such as running an art gallery or sailing?

If we take it for granted that a hospital doctor aiming for a successful career climbs the traditional ladder to consultant level; clinical skills, technical competency and expertise in one's specialty have already been thoroughly tested, but what happens next? The point is that there are a huge number of diverse means to express our thirsts for intellectual stimulation and personal development. The third edition of *Succeeding as a hospital doctor* explores this in depth and touches on many of the relevant issues. From the basics of managing your medical career through to research, administration and management, the opportunities of making your mark in the NHS and private practice are covered.

Where this book succeeds is that there a huge amount of basic, common sense advice available, something often absent from similar texts:

> *... the single largest problem when finding your focus, setting goals and yet maintaining a healthy and rewarding life outside medicine is time – generally the most successful people are those who manage their time, and themselves, most effectively.*
>
> *Successful consultants know what they are going to do and how they are going to do it; they set themselves objectives towards a final goal (and then maybe a further goal when that one has been achieved).*

The book covers just about every area relevant to the active, engaged hospital doctor; training for success, learning about changes in disease management and keeping up to date – not being left behind is important, especially in this insatiable age of evidence-based medicine. Next is the importance of surviving in the modern NHS and how if affects our working practices. What about extended roles and involvement in hospital management; being asked to join a committee is always flattering, but is it necessary? There is also a section on effective communication – increasingly important – which is essentially an overview rather than an in-depth analysis, and includes advice on dealing with difficult colleagues, managers, the media, chairing meetings and making presentations.

Of course there are going to be times when things are not so rosy, the section on 'crisis management' looks at complaints, the causes of medical mistakes and reducing errors, 'We should develop a cross-checking mentality and be meticulous in everything we do'. The chapter on making your name in private practice is especially apt, 'choose one's consultant colleagues more carefully than a spouse' avoids the potential pitfalls associated with business rela-

tionships. Remember most doctors have no business experience and have no consideration of the importance of a 'limited liability partnership'. No book on senior doctoring would be complete without a section on clinical governance and self-regulation and all the usual aspects are covered including again 'finding out what you can do to reduce the risk of adverse events' – 'you are not working in splendid isolation but as part of as a team' we are informed, as well as the perverse dangers of intellectual arrogance.

So, is this text likely to help one succeed as a hospital doctor? Well it is certainly not a 'how to' guide, but for those who are determined to succeed and have palpably considered taking action in such a direction, it will act as a useful guide along the way.

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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 sent by email to: Clinicalmedicine@rcplondon.ac.uk

Thrombolysis for ischaemic stroke

In their article dealing with thrombolysis treatment for acute ischaemic stroke, Jenkins *et al* (*Clin Med* June 2008 pp 253–8) omitted mentioning two other important flaws in the National Institute of Neurological Disorders and Stroke (NINDS) trial.[1]

Firstly, the relevant part of the trial (part 2), that provided the main impetus for this form of treatment, relied on a global test statistic as the primary measure of outcome, and not on incontrovertible hard end-points. The global statistic was itself a composite function of four inter-related neurological scores (the Barthel Index, the Modified Rankin Scale, the National Institutes of Health Stroke Scale, and the Glasgow Outcome Scale). Clinically and statistically significant differences depending on any such composite of inter-related scores must be inherently suspect.

Secondly, part 2 of the trial also required that patients in the control and active treatment groups not receive aspirin in the first 24 hours. Thus, patients treated with recombinant tissue plasminogen activator (tPA) were compared to controls in receipt of suboptimal standard therapy. To overcome the risk of serious intracranial bleeding due to combined therapy with tPA and aspirin, the investigators should have administered dummy aspirin to the active treatment group and genuine aspirin to the controls.

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Reference

1 Tissue plasminogen activator for acute ischemic stroke. The National Institute of Neurological Disorders and Stroke rt-PA Stroke Study Group. *N Engl J Med* 1995; 333:1581–7.

In response

We thank Kumana and Cheung for their comments and accept that there are often inherent weaknesses and limitations in neurological scoring systems, although the degree of potential statistical error in this case is debatable in our view. We believe the core aim of the NINDS study was to demonstrate improvement in disability following thrombolysis and, in this respect, we consider that the end-points chosen by the investigators were reasonable. We agree with Kumana and Cheung that the omission of aspirin was not ideal.

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Post-infective irritable bowel syndrome and dyspepsia

Spiller, in his interesting review (*Clin Med* August 2008 pp 417–9), tabulated nine outbreaks of gastroenteritis followed by irritable bowel syndrome (IBS). However, just as IBS is merely one component of the functional irritable gut syndrome, so some after enteritis had dyspepsia as well as IBS, a phenomenon not detectable using Rome I questionnaires.

The early two Sheffield and three Nottingham studies were uncontrolled. A general practitioner database found that 12 of 318 patients with documented bacterial enteritis developed new IBS, 11 times uninfected controls.[1] In Beijing, 329 of 450 with Shigella gastroenteritis were followed for one to two years as were 243 unaffected siblings or spouses.[2] Functional bowel disorders developed in 10% who had dysentery <1 week, 31% for 1–2 weeks, and 35% >2 weeks, significantly higher than in controls. A year after a Shigella outbreak in Seoul, incidence of IBS was 17%, but 6% in age- and sex-matched healthy volunteers.[3] Two years after a Canadian *Escherichia coli*/*Campylobacter jejuni* outbreak, IBS incidence was 24% but 10% in controls.[4]

Dyspepsia was investigated in two studies. Three months after the Nottingham *C. jejuni* infections 30 with IBS scored 9 for indigestion and 8 for diarrhoea – significantly higher than 28 'controls' (6 and 3) or 40 healthy volunteers (3 and 3).[5] A one-year follow-up study of a salmonella outbreak in 1,243 Catalan villagers gave a cumulative risk of IBS of 11.6% *v* 1.5% in controls; the risk of dyspepsia (pain, discomfort, fullness, nausea) was 17.2% *v* 3.3% in controls.[6] At 12 months there were 18 villagers who had developed only dyspepsia, 9 with only IBS and 15 with both.