John Snow and anaesthesia

As an admirer of all that Dr Snow did, Smith has done for the John Snow Society, I comment reluctantly on her review (December 2003 J R S M) of the recently published biography. Why does she describe Snow as curmudgeonly? Sir Charles Locock, in his 1859 presidential address to the Royal Medical and Chirurgical Society, eulogised Snow as follows: 'Dr. Snow was recognised everywhere as a remarkably modest and unassuming man, strictly honourable, of a thoroughly amiable disposition, and few have been more regretted by all who had the pleasure of knowing him.' Hardly the description of a curmudgeon.

How did his decision to speculate in 'the new and controversial technique of anaesthesia' militate against the recognition of his contribution to medicine? The controversy, if it had any existence at all, was against obstetric anaesthesia, and it did not last long. Snow could list the Queen and members of the nobility among his patients. His contribution to the science of anaesthesia was well recognised in his lifetime, and has been ever since. He is one of the supporters of the Royal College of Anaesthetists' coat of arms, and the Association presents a John Snow Silver Medal.

There would be no point in the Michigan-based authors belonging to the John Snow Society, because it does not publish proceedings. However, I, who was the authors' gofer on this side of the Atlantic for some four years, and whose name appears on the title page, have been a member for more than ten, and I can testify that three of the authors, during visits to London, bought memorabilia from the John Snow Society and visited the eponymous pub.

I was present at the late Dick Ellis' memorable Blessed Chloroform Lecture. That there has been only one does not indicate a lack of interest in Snow; the Proceedings of the
History of Anaesthesia Society and the anaesthetics journals provide evidence to the contrary. Has anyone been invited to deliver a second blessed Chaldean Lecture? Anaesthetists being a self-effacing lot goes with the specialty, not willing to publicize themselves.

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REFERENCES

John Snow and St George's

In her review of Chaldean, Chaldean and the Science of Medicine: A Life of John Snow (December 2003 J RSM) Ronald Stanwell-Smith is right to point out that John Snow’s achievements have met with little recognition in Britain, while his true worth has been properly celebrated in the USA, because of “the traditional British manner of delayed acknowledgement of non-military heroes (particularly in science)”. In 1847, John Snow was invited to give other anaesthetics to dental outpatients at St George’s Hospital and in A Short History of St George’s Hospital (Athlone 1997) Terry Gould, anaesthetist himself, wrote “St George’s may proudly boast of its connection with this great medical pioneer”. However, in 1997, when De Alex Thrulow and some of his anaesthetic colleagues at St George’s Hospital made a formal proposal to call his department ‘The John Snow Department of Anaesthesia’, it was rejected by the majority of anaesthetists there. They obviously thought that a ward and a pub named after John Snow were sufficient honour.

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Evidence-based and complementary medicine

The two articles on evidence-based medicine versus complementary medicine, published in the January 2004 J RSM,1,2 would perhaps be more convincing if they did not ignore the numerous drugs which we are happy to peddle and the benefits of which, while “evidence-based”, are all too obviously either doubtful or negative. As I survive into retirement I have to listen more and more to the experiences of friends and relations who are on various tablets. Many are on six or more different compounds, often given to counteract the side-effects of the others. Some are more or less disabled by their pills. As a purely social acquaintance one cannot be too inquisitive about the exact identities of the substances involved, but ordinary conversation often raises doubts about what has been prescribed and what for.

An example might be provided by a close relation, aged 74, who was found at a routine examination to have a marginally raised blood pressure. He was given medication for this, and as a consequence suffered from dizziiness, which prevented him from driving a car. He went back to the surgery, where he saw another doctor, who put him on another medicine for the dizziness. This gave him a dry mouth and indigestion, so he went back to the surgery again, where yet another doctor diagnosed depression and put him on an SSRI. Following this he became confused and inarticulate and even more depressed. His wife and daughters began to think about funeral arrangements. Fortunately he went back to the surgery again, where he saw the practice principal, a woman on the verge of retirement and still applying a measure of commonsense, who decided that there never had been any hypotension and took him off all medication. He is now symptom-free and alert and drives his car all over the county where he lives.

This is an anecdote. Does that mean we must ignore it? How many such anecdotes constitute evidence? How can there be a controlled trial of old folk who see too many pills? Which drug company will subsidize such a trial?

My first experience as a house physician in 1955 with Donald Hunter, then senior physician to the London Hospital. He used to say that we were leaving the period of dangerous surgery and entering that of dangerous medicine. He seems to have been right.

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REFERENCES

Diagnosis of abdominal tuberculosis

From their retrospective survey (December 2003 J RSM) Mr Rai and Mr Thomas conclude that, in suspected abdominal tuberculosis, diagnostic laparoscopy is the investigation of choice. They do not refer to a similar report by myself and colleagues on 14 patients, in which we recommended diagnostic laparoscopy when the Mantoux