A good example of Manners' approach involves the treatment of psychiatry, which seems to be good fodder for his arguments. Four of the 9 chapters concentrate on psychiatry, but the themes of discontent and anxiety spill over to other areas of the book. Often psychiatry is a target for exploring the behaviour of the pharmaceutical industry. Although Manners uses the quote "Medicalization of discontent is a growth industry,"[1] he ends the chapter reminding us that, for the health consumer, "There is no end to our discontent."

We also see in the book some of the reality of science. Many of us hold the dream of "truth" in science, that its methods are deliberate and altruistic. But here we see science as almost random chance and its products frequently developed more for potential financial gain rather than benevolence. This may be uncomfortable for those of us who have put our faith in evidence-based practice or who subscribe to the common belief that our prescribing is based wholly on evidence or science.

Inarguably, we have all benefited from medicines, directly or indirectly. Unfortunately, their adverse effects have been a major cause of morbidity and mortality, and many of our prescriptions are given (or requested) for non–life-threatening illnesses. Many researchers have struggled to examine the influences on our prescribing behaviours, often with the hope of improving these behaviours. Unfortunately, the influences are numerous, complex and at times subtle or even subversive.

Super pills examines why some of our favourite pills have become so popular, the influences that made them so and the repercussions. If you write prescriptions, take medicines or are concerned about the use of pharmaceuticals, I recommend that you read *Super pills*.

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REFERENCE

1. Loe M. *The rise of viagra: How the little blue pill changed sex in America*. New York: New York University Press; 2004.

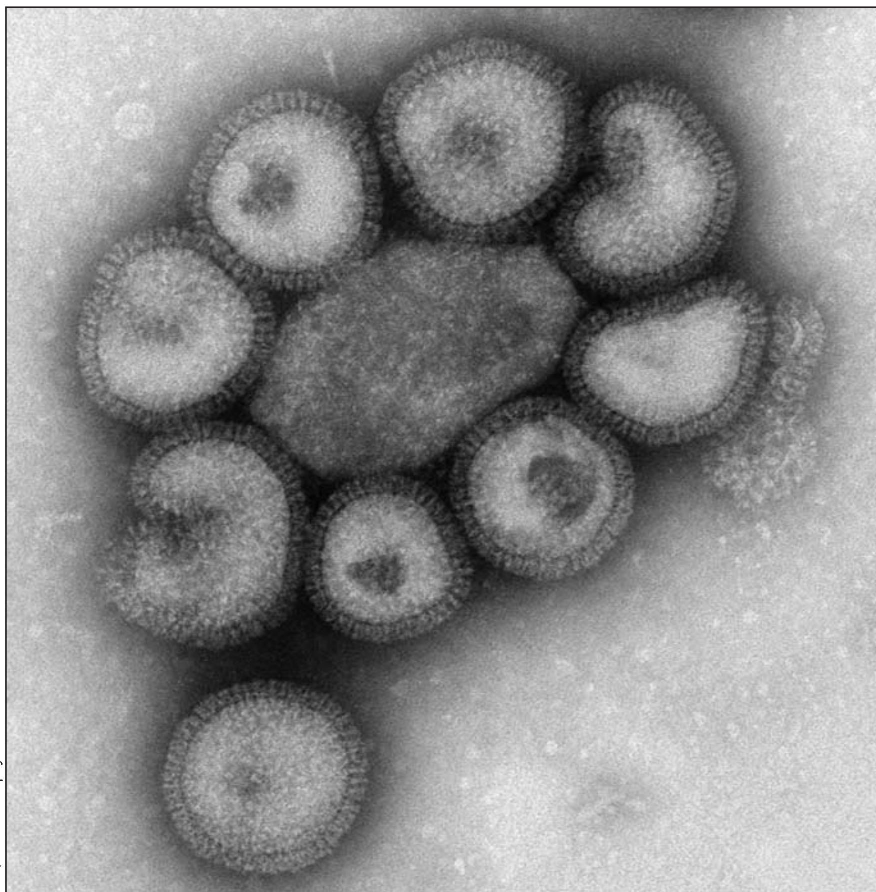
Room for a view

Influenced

Why do we, as physicians, feel let down when we get sick? Do we expect that we are somehow immune from something as universal as illness? Striving constantly for perfection, do we feel abandoned by our bodies when we become ill? I'm not sure what bothers us more — the feeling of vulnerability or dispensability.

During my combined infectious disease and critical care fellowship, I recently became ill with influenza and had to face my own vulnerability and dysfunctional need to feel indispensable as a physician. As a result of my illness, I have a renewed respect for influenza and am more convinced than ever that health care workers should receive influenza vaccination — not only to protect their patients but to spare them an experience similar to mine.

The Infectious Disease Service was busy as usual at the large inner city teaching hospital where I was working. There were many consults and no junior house staff, making for hectic days. I was on call over the weekend when I was informed about a possible influenza outbreak on a ward. A patient had tested positive for influenza and had likely exposed 3 roommates, one of whom was already symptomatic. I saw all 3 patients, suggested isolation and appropriate treatment, and left a message for Infection Control to follow up on Monday. I continued seeing consults until late in the day, finishing up in the evening. That was Sunday.



CDC/ Dr. F.A. Murphy

They may be small but ... Influenza virus particles (virions) in a negative-stained transmission electron micrograph.

Monday was a long day but uneventful. By Tuesday night I was feeling unusually tired but thought it was because I had worked through the weekend. I convinced myself that a run would make me feel better and headed out on my favourite route. My usual run, however, was anything but usual — I was exhausted, my legs felt weak, and my body was sore. I barely made it home. I had to walk up the last long hill, out of breath, my spirit broken. I was so dizzy that I had to stop to sit on the side of the road to recoup.

I ignored the soreness in my throat and continued to deny the obvious connection to the patients I had seen over the weekend.

That night my muscles ached. I had a hard time holding onto the belief that my run was the sole culprit. I went to bed hoping that I would feel better in the morning, that the aching would pass and be quickly forgotten. I awoke, however, to intensifying muscle pains. I ignored the soreness in my throat and continued to deny the obvious connection to the patients I had seen over the weekend. I went to work as usual — denial must be ingrained in us. By mid-morning I could no longer discount the chills, the screaming pain in my throat, and the severe headache impairing my concentration.

My staff-person sent me home. I tossed and turned in bed that afternoon, evening and night, but I couldn't sleep. The fever started that night, raising my discomfort to anguish. My hair, pyjamas and bed sheets were soaked with sweat. The rigors were unsettling. After a sleepless night, I called in sick the next morning — something I'd never done in residency. I stayed in bed with my cough drops and syrup. My ribs were sore from the constant coughing.

Only at the insistence of colleagues, and in spite of the strength of my denial, did I agree to start taking oseltamivir after about 36 hours of illness. I made the trip into the hospital to collect a nasopharyngeal swab for testing and to pick up my medication. My symptoms slowly eased, and by the fourth day, I felt well enough to go back to work. The results of my swab were not back yet, but I was convinced that I wasn't a risk to my patients because I was taking medication. You would think a physician would know better.

Work was draining. In the afternoon the laboratory called to let me know that my swab was positive for influenza A. Finally I realized some common sense, and although it took some scrambling to find a colleague to cover for me, I decided to go home. Even though I was taking oseltamivir, I was probably still shedding virus, and to be looking after patients was not in anyone's best interest. I felt guilty for passing my work onto colleagues.

My weekend off-call was spent sleeping, drinking fluids and consuming more cough drops. My cough still turned heads in the grocery store, but my ribs were healing. I settled back into my routine.

As I started to feel better, I began to feel cheated, realizing that I had contracted influenza despite being vaccinated the previous fall. The laboratory confirmed that my strain was included in the vaccine. With the vaccine having over 80% effectiveness, I was miffed at being a vaccine failure. Me, a doctor, a vaccine failure — how was that possible? You would think physicians would understand that nothing in medicine is 100%, but this doesn't seem good enough, even for us. I suppose I might have been much sicker without the vaccine — something I should remind myself, a small consolation nonetheless.

Weeks have now passed, and this experience has provided a valuable opportunity for introspection. Not without irony, becoming ill helped me to understand better the concept of illness. Being a patient is a scary experience; the "other side" is not one I'd like to stay on. And although as physicians we have the ability to treat and cure disease, we are still vulnerable to illness ourselves. We are not indispensable, and illness is not a sign of weakness. I have also acquired a renewed respect for the influenza virus. And despite being a vaccine failure, I'll be lining up for my vaccination next fall — 80% protection is a lot better than none. A repeat of this illness is not welcome.

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Models of composure

Things cannot always go your way. Learn to accept in silence the minor aggravations ... — William Osler, 1903

Should equanimity be so widely praised for all physicians? — Howard Spiro, 1992

Our virtues are most frequently but vices in disguise. — François, Duc de la Rochfoucauld

Do we move too placidly amid the noise and haste, or not placidly enough? Do we know how to put anger to good use? Tell us about the times you've made a fuss, and — just maybe — improved things a little. We welcome submissions of unpublished poetry, memoir and fiction for The Left Atrium. The writing should be candid, but patient confidentiality must be respected. A sense of humour never hurts. In general, prose manuscripts should be limited to 1000 words and poems to 75 lines. Vent your spleen at pubs@cma.ca