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Letter from . . . Chicago

Paranormal events

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Walking through the ragged mountains of Virginia, his excitable imagination inflamed by the morphine without which he could not exist, the melancholy Augustus Bedloe was suddenly startled by the loud beating of a drum. A minute later a shrieking half-naked dusky man rushed past him, closely pursued by a huge growling hyena. Overcome by terror he sat down beneath a tropical palm tree. Readers of Edgar Allan Poe will remember how minutes later Mr Bedloe found himself in the holy city of Benares, fighting the onslaught of the mutinous crowd, now advancing against the rabble, now retreating, now rallying again, until suddenly he was fatally struck in the temple by a poisonous arrow. That night his soul surveyed the silent city, took a disinterested look at his greatly swollen corpse, and gently flitted back to the mountains of Virginia. His physician, the learned Dr Templeton, an expert in magnetism and mesmerism, heard the story without surprise, having personally known a Mr Oldeb who had died 47 years earlier during an insurrection in Benares; and, struck by the remarkable physical similarity between his deceased friend and his patient Bedloe, he had already tentatively concluded that the soul was "on the verge of some stupendous psychal discovery." Unfortunately he clumsily put an end to his studies by inadvertently treating his patient's fever and head congestion by applying a poisonous leech to his temple.

To the best of our knowledge neither the gloomy Mr Bedloe nor his namesake spelt backwards have given further signs of participation in the affairs of this world. But Dr Templeton might have been interested in the case of Ms Loretta Lynn, the singer who recently admitted under hypnosis that she had been King George II's girlfriend. For years she had lived in terror, aware that the king's best friend was trying to seduce her and fearful that the king was going to be murdered. But in 1760 the king suddenly died from a dissecting aneurysm, and the mistress survived only long enough to be strangled by the perfidious friend.

Somewhat on the same lines, in Equality, Illinois, an elderly arthritic woman recently disappeared from her home and was nowhere to be found. The police strongly suspected murder, the woman being so crippled that she would have been unable to walk any distance. On turning in desperation to some local psychics they were informed that the body could not be found until the remains of a man were first discovered. Ten days later someone brought in the skull and bones of an unknown man. With the help of an appropriate stipend one of the psychics now went into a trance and transformed himself into the missing lady, walking and talking like her even though he had never met her, and at last leading the investigators to the site where the body was hidden.

From the University of Virginia, meanwhile, two psychiatrists

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have reported the case of the 37-year-old Marathi woman who has never left Nagpur but who during trance-like states becomes transformed into a Bengali woman of the early 1800s, thus moving not only 725 miles to the east but also 180 years back in time. Able to speak Bengali only during her trances her language is of the period, pure and unadulterated with modern English words; and she displays an amazingly detailed knowledge of the people, places, and prevailing conditions of her time. The investigators are reported to regard her xenoglossy (ability to speak a foreign language without having learnt it) as a truly paranormal experience; but the editors of the *American Journal of Psychiatry*, while agreeing to publish the case, do not necessarily believe that we are on the verge of a "stupendous psychal discovery." Yet reincarnation may be no more illogical than the assumption that each life is encompassed by a finite period of time, believes one of the authors, a psychiatrist specialising in parapsychology, who travels 55 000 miles each year examining people who have lived a previous life. During the past 12 years he has accumulated a file of 1700 cases from all parts of the world—including the "highly evidential case of a village boy in Lebanon"—a large series that clearly puts to shame the single uncontrolled case of Dr Templeton.

Fun, fire, and fraud

Yet all this may not necessarily impress Mr Norman Cousins, whose laughing cure would also fail to pass the test of rigorous statistics, and whose highly successful *Anatomy of an illness* is not so much the story of a paranormal experience as further proof of the public's insatiable appetite for books about medicine and about hospitals—especially the kind that lack sanitation and are overrun by promiscuous *x*-rays and tranquillisers, by ravenous staphylococci and overcooked vegetables, by harmful food dyes, bleached bread, and insensitive nurses. Mr Cousins's illness occurred in 1964, when he developed an undefined connective tissue disorder, perhaps viral or rheumatic, perhaps precipitated by toxic Soviet hydrocarbon fumes. Admitted to hospital he finds himself simultaneously venesected by four technicians, each from a different department, and he suffers with inequanimity the inherent inefficiencies of a system that even Benito Mussolini would not have been able to set right. But the sedimentation rate is still 80, the joints hurt like hell, and Mr Cousins is barely able to move. He now also discovers that anti-inflammatory agents may damage his adrenals, his platelets, and his collagen, so he decides to do without. Instead, being possessed by an indomitable will to live, he will treat himself with mammoth doses of ascorbic acid and laugh himself to health with funny movies. Then the miracle happens: the pains begin to go away, either because Mr Laurel stimulates endorphins, or because Mr Hardy takes his mind off his joints, or because Mr Cousins has a paranormal desire to live, or because, as may be reported some time in the future, Soviet-induced arthralgias run a self-limited course (at least outside the Greater Kabul area) and will therefore respond to laughing as well as to crying, to ascorbic acid as well as to laetrile, or perhaps even to a good venesection, carried out simultaneously by four non-poisonous leeches from Dr Templeton's collection.

Another therapeutic approach is hyperthermia, the heating of the body to 42°C, offered at a 93-bed Chicago hospital as an alternative to total marrow transplantation for advanced cancer. Promoted with brochures, the treatment is administered in comfortable surroundings, the patients being picked up in limousines from the airport to spare them any possible inconvenience. The heat is claimed to kill tumour cells without causing harm to normal tissues, especially if supplemented by special metabolic diets, laetrile, vitamins, and enzyme injections. Coffee enemas constitute an essential part of the regimen, producing immediate subjective improvement by stimulating the liver to eliminate toxins. Side effects are said to be uncommon, although some patients have tolerated the heat poorly and have developed extensive burns or brain damage. A deposit of $5600 is required before hyperthermia is begun, but the total cost is merely $20 000; and so successful has this programme been that the hospital revenues for 1978 exceeded $5 million.

Unfortunately this ingenious cure has recently been exposed by a task force of the *Chicago Tribune* and is now no longer available to the public. But be that as it may, the hyperthermia coffee enema programme pales into unimportance compared with the discoveries of another undercover team of reporters, which recently documented large-scale fraudulent practices that on a national level may cost automobile drivers some $3 billion.

In a series of articles published in the *Chicago Sun-Times* the reporters described how an elaborate network of swindlers extract large sums of money from insurance companies by inducing victims of minor car accidents to fake serious injuries. Several law firms are at the heart of the system, and the lawyers, many of whom have already had convictions or suspensions of their licences, promise their prospective clients that they can make some money for them. A patient with nothing more than a few bruises, therefore, will be advised to complain (and keep complaining) of pains in the neck, shoulders, or head, of double vision, headaches, dizziness, or perhaps of an inability to move. Some prospective clients are even paid by the lawyers to simulate injuries, and, thus motivated and counselled, they may well leave the lawyer's office wearing a collar, with a referral to a co-operative chiropractor or doctor. A wide variety of physical signs are now elicited without the need for a physical examination; then comes a week in hospital for traction and physical therapy; two weeks of phoney treatments at an accident clinic; two more weeks off work; and a sizable settlement by the insurance company—but the bill must not be too big or the insurance company may be tempted not to settle but fight the case in court.

The newspaper also included detailed descriptions and even photographs of doctors and chiropractors taking part in this scheme. It was disclosed that several small private hospitals depended heavily on these arrangements in order to achieve a high bed occupancy. One particular hospital had become known as the "whiplash centre"; another maintained a large "orthopaedic service" yet had neither orthopaedic doctors nor physical therapists on its staff; and several hospitals had considerable discipline problems because the patients, bored with having nothing to do, gave rowdy parties, got drunk, and took drugs to pass the time. Indeed, in one hospital almost all the patients were so-called accident victims, and anyone genuinely ill was immediately transferred out.

The series also described how the lawyers depend for their clients on a large referral network of accident chasers. This includes thousands of amateurs such as hospital employees, ambulance attendants, tow-truck drivers, or car-repair men who will make a referral to a lawyer for anywhere between $10 and $100. Even policemen in uniform have been known to help accident victims to a lawyer of their choice. Then there are the professional chasers, who wear flashy clothes and drive expensive cars equipped with police radios, and who in some instances have become millionaires. In some cases chasers have been known deliberately to cause accidents in which innocent people have been injured; at times the chasers will include themselves among the victims, so that in one accident with 10 people on a bus it took 25 ambulances to transport all the victims to the hospital. Frequently the chasers carry guns, so that "if someone tries to take your business you blow his head off." During the last year's DC-10 airplane crash in Chicago at least 15 chasers posed as rescue workers, looking for identification items in the debris of the plane, one case being worth $10 000 if a proper referral was made. So far the attempts to stamp out this swindle have failed, for a police crackdown would eliminate only the amateurs to the great benefit of the professional chasers; the insurance companies apparently have an excuse to extract higher premiums from automobile drivers; and lawyers have successfully blocked legislative efforts to introduce a no-fault insurance law. As for the doctors, the actions of a few unfortunately further tarnish

the image of a profession that hardly needs more adverse publicity.

It may be well to point out, however, that not all cases of cervical traction are the result of fraudulent schemes. Some are merely a consequence of the well-intentioned rule, prevalent in many hospitals, that all patients must have a routine chest *x*-ray examination on admission. So it happened last year at St Elsewhere's Hospital that a particularly unkempt man was making a terrific row because little green men kept on walking across the foot of his bed. Needless to say, no such unusual neurologic syndrome had ever been observed at St Elsewhere's. The nurses, after vainly trying to restrain the patient by applying flimsy gauze bandages to his arms and legs, were conferring what to do next when the patient suddenly broke loose from his restraints and kicked a particularly fat nurse in a part where the discomfort must have been minimal. The nurse was rushed to the casualty department, where the houseman decided to play safe and admit her for observation. The *x*-ray films of her lower back were normal, but, alas, the routine chest *x*-ray examination showed a linear fracture of a lower cervical vertebra. So the nurse spent the weekend in traction, and the drunk was transferred to the county hospital, where they applied leather restraints and treated the little green men with chlordiazepoxide. The story ended happily on Monday morning, when the radiology consultant unequivocally attributed the supposed fracture line to a fold of soft tissue from an unusually obese neck, thus releasing the nurse from traction and exonerating the drunk from possible charges of assault and battery.

The final event concerns a woman brought to casualty DOA (dead on arrival) but successfully resuscitated by the resident, who found that the body was still warm. The blood gases, as treatment was begun, were pH 7·31, P_{CO_2} 130 mm Hg, P_{O_2} 40 mm Hg, HCO_3 58 mmol/l, improving after one hour to pH 7·46, P_{CO_2} 38 mm Hg, and P_{O_2} 130 mm Hg. While students of acid-base chemistry may wish to pause and ponder about these unusual values, the others may proceed. There was a phone call some two hours later that someone had been seen falling out of a police squadrol (the local Black Marias), and eventually the story was discreetly pieced together. It appears that the woman, a known case of dementia, had been sitting in the middle of downtown with a bag over her head, muttering imprecations in a strange language (a case not of xenoglossy but of Polish extraction). Two policemen picked her up and put her in the back of a squadrol, but, as they were driving to the hospital at high speed, they must have suddenly looked back and realised to their horror that she had vanished. What happened subsequently is mere conjecture, which is why paranormal events are so difficult to understand.

Today's Treatment

Use of anaesthesia

The anaesthetist and the pain clinic

J W LLOYD

About 12 years ago there was an explosion in the topic of chronic pain management. Until that time, with the exception of opium which was first used in the third century BC, the field had been singularly barren. It is difficult to explain this long sterile period on the basis of pain being good for the soul, but indeed both Aristotle and Plato believed that pain was a passion of the soul and could be conquered by reason. The fact that this view was held for 2000 years did much to delay progress in the management of pain.

Pain remains today one of the most complex, irrational, and yet fascinating subjects in medicine. Technological advances and a greater understanding of the physiology and anatomy of pain have done much to further progress, but much is still empirical without scientific basis.

These gaps in our knowledge are being gradually filled in by experience gained largely in pain clinics that are now a feature of most large hospitals. Anaesthetists have taken the primary role in organising and managing these clinics, perhaps by virtue of their training, and in Britain run 98% of pain clinics.

Pain clinics are essentially outpatient clinics. If more than simple nerve blocks or the prescription of drugs is required lack of inpatient facilities becomes a limiting factor. Such facilities though desirable are by no means universally available. Clinics are broadly of three types: (1) pain clinic; (2) pain clinic with access to beds; and (3) a pain unit with autonomous control of beds.

Attendance at pain clinics is reserved for those suffering from intractable pain, and this may be defined as pain that has been present for over a month and is unremitting despite treatment. It is often associated with cancer, but this is misleading as many non-malignant conditions are equally capable of producing pain. In the Oxford Regional Pain Unit 28% of the patients admitted have pain of malignant origin. This contrasts with a figure of 70% ten years ago. Unfortunately it does not mean that cancer is on the decline, but that the range of admissions has widened with a threefold increase in the total number of admissions (figure). This is perhaps indicative of the wider range of intractable pain now being tackled by pain clinics throughout the country. Referrals may be open or closed—that is, after specialist screening within the parent hospital. In the Oxford Regional Pain Unit the source of referrals is general practitioner (40%), radiotherapist (25%), orthopaedic (15%), neurosurgical (12%), and miscellaneous (8%).

Management

Thorough assessment is of the utmost importance. It may be lengthy and require admission to hospital. This is often difficult in a general hospital and is best carried out in a pain relief unit

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