101 Questions to Ask Your Doctor

Dr Tom Smith has been writing since 1977, after spending six years in general practice and seven years in medical research. He writes the 'Doctor, Doctor' column in *The Guardian* on Saturdays, and has written three humorous books, *Doctor, Have You Got a Minute?*, *A Seaside Practice* and *Going Loco*, all published by Short Books. His other books for Sheldon Press include *Heart Attacks: Prevent and Survive*, *Living with Alzheimer's Disease*, *Overcoming Back Pain*, *Coping with Bowel Cancer*, *Coping with Heartburn and Reflux*, *Coping with Age-related Memory Loss*, *Skin Cancer: Prevent and Survive*, *How to Get the Best from Your Doctor*, *Coping with Kidney Disease*, *Osteoporosis: Prevent and Treat* and *Coping Successfully with Prostate Cancer*.

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For Mary

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Introduction

One of the abiding memories of my boyhood was a picture on my grandfather's wall. Called 'The Doctor', it showed a distinguished man with a grey beard sitting by the bed of a sick girl. He is full of deep thought, looking into the distance. The child is ashen-faced, lying semi-conscious, dying.

Luke Fildes' painting was a favourite of the Victorians, reminding them of the reverence in which they held their doctors and of the fragility of life. The doctor–patient relationship was a one-way process: knowledge and wisdom flowed from doctor to patient, and the family was properly in awe of him. In those times the doctor was, of course, always male.

Something of that reverence remained into the last half of the twentieth century. As a young doctor in hospital and in my early years in practice I was acutely aware of the expectations my patients had of me, and that it was almost impossible to live up to them. If the patients put us on a pedestal, we were well warned by our teachers not to climb on to it ourselves.

Even as a small boy, I knew that my grandfather took a very different view of the painting from me. He was attracted by the patrician figure of the doctor, and I was saddened by the figure on the bed. For me the doctor was irrelevant. Why was he not doing something to cure the child, instead of simply waiting for her to die? My Victorian grandparents loved that doctor – I saw him as a hopeless irrelevance. He had a wonderful bedside manner, but it was of absolutely no help to the child. What he needed was something to cure her illness – and in Victorian times he didn't have it.

Whenever I hear that a doctor has 'a great bedside manner' I think of that painting. Maybe I have it, maybe I don't. But what we do have, these days, is the ability to cure so many people of their illnesses, and that takes precedence.

Medicine has changed generally. The old emotional 'feel' between doctor and patient has diminished, and in doing so it has altered fundamentally the old relationship between us. We have become scientists with a specific job to do for each person we see, and you have had to become content with much less of our time. Communications between us have had to become concise and effective for your illnesses to be understood, diagnosed and treated, and the bedside manner is much less relevant.

The positive side of this sad (I as a doctor feel the sadness as much as you do as a patient) change is that we are far more able, in every sphere of medicine, to offer you treatments that really work and will not only make you feel better, but also keep you from serious harm. It starts with the way we are all trained in medical school. We are taught how to talk to patients, how to take a history, to perform the appropriate examinations and tests, to come to a diagnosis, then initiate treatment or refer to a specialist. It explains how the consultation isn't random, but highly structured, so as to be efficient and also fast and accurate. It also explains how patients, seeing their doctors for the first time, can help or hinder them in the process. As each consultation is scheduled to take around ten minutes, that's vital.

You may find you have quite different perceptions from your doctor's about what the initial consultation is about and how it should proceed. You may also be surprised about the need for follow-up, and how you and your doctor will develop a long-term relationship around your illness. We spend much more time than we used to on following up illnesses or preventing potential illnesses, and there are plenty of examples, taken from my own experience as a doctor, for you to compare with your own experiences.

This book covers some of the topics that tend to get left out of this process. Today's tailored consultations don't always leave room for the random, the quirky and the plain trivial. That's

where these questions come in. As you'll see, they're quite a mixture, from general medical knowledge, to questions that are so specialized that only one person may ever have asked them.

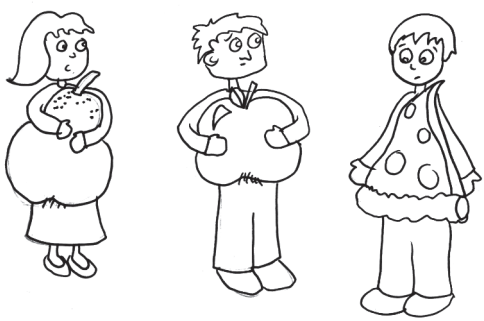
One point I would like to make: they are all genuine. That is, every question has really been asked by a real person at some point. Some of them have come to me via the pages of *The Guardian*, where I've been doing my best to answer such queries for a number of years. Others may have been put to me at parties in more or less unguarded moments. Still others may be the 'hand on the doorknob' or the 'while I'm here' variety, that get popped out just as the patient is leaving the surgery after a consultation ostensibly about something else. For this reason, they may echo very real fears the person may have, too. But I hope that, for whatever reason you're reading this book, you'll find the answers reassuring and informative. And if you need to know more, or are seriously worried about something, do visit your own GP and ask your own questions.

1

Obesity

Q: I've read that there are two different types of obesity – apples, who put weight on around the middle, and pears, who put it on round the hips. The article stated that the 'apples' are at higher risk than 'pears' of heart attacks. Is there any statistical basis for this? Do you have figures for how high the risk is for a given waist measurement? I'm an apple, by the way.

A: Waist circumference is a good guide to the risk of early death. In a study of nearly 400,000 healthy Europeans, each added 5 cm of waist measurement increased men's risk of early death by 17 per cent and the women's risk by 13 per cent. Interestingly the link was higher if the person had a relatively low body mass index – so that if you have a paunch, but are not very muscular, you are at the highest risk. That's confirmed by another study concluding that a thicker calf muscle in old age may protect you against heart attacks. A high waist-to-hip ratio (more fat around the waist than hips) also indicates a higher than normal risk. So apples should really try to shed the abdominal fat. Sorry.



Q: My 12-year-old son and I are both overweight and want to choose an exercise to help us lose the excess. We have tried swimming up and down a pool and find it boring, so we are thinking of jogging or cycling. What are their advantages and disadvantages?
A: The big advantage of cycling for you is that the saddle takes 70 per cent of your body weight, sparing your hip joints while your muscles improve and you shed your excess fat. In jogging your hip and knee joints have to cope with forces between two and three times your body weight. That's a huge strain until you get nearer to a normal body shape. So cycling has the advantage, initially, over running. However, much depends on how much you enjoy either activity, and whether or not you can both cycle in safety. You need less kit when running, except that when running on roads and pavements you must have shoes that absorb the shock of pounding on them. Can you cycle to work and school? That would be a good start, and would help your son's self-confidence, too.

Q: I have put on five stones since I married ten years ago. Diets don't work. What else can I do?
A: Losing weight is never just about eating less. You must also exercise more. If you keep eating a variety of food while cutting down on the amount and never rushing a meal, and add a brisk hour's walk every day, you are bound to lose weight. You will feel fitter, be ready for more exercise, and your appetite will lessen, too. You will then be in a virtuous circle of losing weight, rather than a vicious circle of gaining. When eating, reduce the amount you usually put on your fork or spoon, chew it more slowly, and put down the cutlery between bites. Take at least 20 minutes over your main course, so that your 'anti-hunger' chemistry kicks in before you have finished your meal. Then you will find you have eaten less at each meal, without making you ravenous. Drinking plenty of water with each meal helps too.

Q: Is it true that for some people becoming fat is a matter of a different metabolism from normal, and not because they eat too much or exercise too little?
A: No, it's not. The human metabolic rate, that is the rate at which we burn foods to provide us with energy, is very strictly controlled, and varies very little from one person to another. Think about your body temperature. Everyone knows that it is 37 degrees Celsius, and the slightest increase or decrease in it denotes some form of illness – like a fever or hypothermia. The body's metabolism in normal health is geared to work within very strict limits and at this very controlled temperature. The metabolic rate only alters in illness or under conditions of real stress.

One example comes from problems with the thyroid gland. It helps regulate our metabolic rate. If it is overactive, we do everything faster, at a higher heart rate. We are physically overactive and have a ravenous appetite, but lose weight. If it is underactive, everything slows down, including our heart rate and our mental processes, and we put on weight. Both these conditions are illnesses, and if your thyroid gland is normal your obesity can't be laid at its door.

For stress to change your metabolism, you need to be under attack by a sabre-tooth cat (the old hunter-gatherer example) or by your average high street mugger. Or perhaps you are watching, on TV, world politicians making a mess of things again. The urge to fight, or to flee from, an enemy will release a surge of adrenalin that will increase your metabolism for a while. However, that is just temporary, and your metabolism soon returns to normal when the threat has passed. Unless you are in a state of constant anger or fear for every waking hour, which is in effect an illness, your metabolism will remain inside the strict limits set for every human being, in the same way as your temperature does.

Q: My friend has brought back from America some ma huang. She says it helps her lose weight. What is your opinion on it?
A: You should not use it. Its other name is ephedra, and it contains a lot of chemicals that stimulate the heart, one of which is the prescription drug ephedrine. It is on the banned list for athletes. Ma huang side effects are reported to be much worse than those from ginkgo biloba and kava, two other popular alternative herbal remedies. Among them are a very fast heart rate and a rise in blood pressure. Don't be fooled into thinking that because it's 'natural' it can't be dangerous. Deadly nightshade, foxglove and monkshood are natural, but you wouldn't dream of taking them.

Q: What is it that makes me so hungry all the time? I'm sure that it's what has made me fat.
A: Whether we are hungry or not depends on the levels of a substance called leptin in our blood. Leptin is released by fat cells into the circulation after we have started to eat a substantial meal. When it reaches the brain, it attaches to nerve cells in the 'hunger centre' deep in the brain. That switches off our feeling of hunger, and we stop eating.

So why don't we use leptin to lose weight? Shouldn't we take a dose of it, switch off our hunger mechanisms, and slice off the pounds? Sadly, it doesn't work as simply as that. Overweight people actually produce a lot of leptin naturally, but they also produce a protein called CRP in fairly large quantities. CRP destroys the circulating leptin before it has a chance to bind to the hunger cells, so they don't switch off their hunger. The more leptin we give to an obese person, the more CRP they produce, so that giving leptin will never be the answer for them. It seems that what we need to do is to find a way of shutting down CRP production. The scientists are working on it, but don't hold your breath – it may just introduce other complications into the hunger–satiety balance.

2
Diabetes

Q: I have diabetes and have had minor heart problems: I have had chest pains on doing fairly strenuous exercise. My doctor advised me to take aspirin every day to prevent a heart attack or stroke, but a recent press report suggested that it doesn't work. Do I really have to take it?

A: The report (on 2,500 Japanese adults) was on the taking of aspirin to prevent complications in people with diabetes who are otherwise healthy. They had so few trial 'events' (illnesses) that it was impossible to show whether or not aspirin helped or worsened their prospects of heart and circulation complications. (Diabetes raises the risk of both.) As you already have a heart problem, that trial was irrelevant to you: your doctor is following standard guidelines in prescribing aspirin. Whether it will help to prevent heart attacks and strokes in diabetes without any sign, yet, of vascular complications, was the subject of two large trials. They both suggested that aspirin would help prevent circulation problems in diabetics of either type (insulin and non-insulin dependent), so GPs like myself routinely prescribe it for them, unless there is a direct contra-indication (such as a previous reaction to aspirin, stomach ulcers or inflammation, or bleeding problems).

Q: I have diabetes, and my doctor has asked me to take a statin drug daily to lower my cholesterol, along with an aspirin and drugs to lower my blood pressure, over and above my usual diabetes tablets. Why do I have to take so many medicines, especially as my blood pressure and my cholesterol levels aren't all that high?