For the Patient's Good. The Restoration of Beneficence in Health Care. *Edmund D. Pellegrino, David C. Thomasma. Oxford University Press, New York, 1988, 240 pp., $29.95. ISBN 0-19-504319-7.*

Edmund Pellegrino is well known within family medicine as a friendly critic of the discipline. Those turning to this his latest book, written with David Thomasma, expecting to find more of the same will find instead Pellegrino the philosopher: a formidable exponent of rigorous philosophical argument. In this book, a companion to their 1981 volume *A Philosophical Basis of Medical Practice,* Pellegrino and Thomasma present a new theoretical basis for medical ethics, replacing autonomy and paternalism with a model of beneficence-in-trust.

Readers unfamiliar with philosophical exposition will find the first four chapters slow going. The authors begin with careful definitions of terms; present and critique the current models of autonomy and paternalism; and propose their new model of beneficence. Briefly, beneficence is described with six major features (fundamental philosophical characteristics) and four axioms. The four axioms will be most readily understood by physicians: (1) both physician and patient must be free to make informed decisions and to act fully as moral agents; (2) physicians have the greater responsibility in the relationship because of the inherent inequality of information and power between themselves and those who are ill; (3) physicians must be persons of personal moral integrity; and (4) physicians must respect and comprehend moral ambiguity yet not abandon the search for what is right and good in each decision. A short chapter entitled "Why Good Rather Than Rights" moves from a historical view of the metaphysical substratum to theories of relational good and a reexamination of autonomy. The fourth chapter presents beneficence-in-trust as a further development of the fiduciary model, and concludes with a brief example of the model as used by the New Jersey State Supreme Court in a recent case. These first four chapters presuppose familiarity with a specific method of exposition and analysis and a working knowledge of philosophical history that many physician readers may not possess.

The next five chapters of the book comprise a section exploring the implications of beneficence for physicians and patients. Physician readers will find the two chapters entitled "The Good Patient" and "The Good Physician" insightful and provocative. The latter chapter is particularly wide ranging in scope, tracing themes of virtue, rights, and duties from Plato and Aristotle through such contemporary philosophers in medical ethics as MacIntyre and Jonsen. Practical knowledge of historical schools of philosophy and of the protagonists participating in current ethical debates will help here, but these chapters have much to offer the uninitiated as well.

Practicing physicians will find the third and final section of the book most interesting, dealing directly as it does with familiar clinical dilemmas: making decisions under uncertainty, making decisions for incompetent patients, and the physician as gatekeeper. The chapter on gatekeeping is especially fitting in today's medical environment, and its clarity and insightfulness are exceptional. The penultimate chapter brings the beneficence-in-trust model to bear on current paradigmatic cases in medical ethics (eg, Quinlan, Saikewicz) with powerful effect. The final chapter brilliantly summarizes the authors' arguments by proposing a "medical oath for the post-Hippocratic era," in effect rewriting the Hippocratic oath of commitment as if beneficence rather than older models were used.

For the Patient's Good will challenge readers at all levels of knowledge in medical ethics. It is not likely to be easy reading for anyone, but it amply repays careful study for those seriously interested in current fundamental debates in medical ethics. It is a book that one can return to time and again for fresh and revealing insights as one's own experience in ethical dilemmas matures.

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Neonatology: Basic Management, On-Call Problems, Diseases, Drugs 88/89. *Tricia L. Gomella (ed), M. Douglas Cunningham (assoc ed), Fabian G. Eyal, Welton O'Neal (consulting eds). Appleton & Lange, Norwalk, Connecticut, 1988, 428 pp., $19.95 (spiral). ISBN 0-8385-1280-1.*

A nurse calls to say that a newborn has just vomited bright red blood. A resident asks how to evaluate a 24-hour-old infant who has not yet urinated. The laboratory calls to inform you of an infant with a serum sodium of 127 mmol/L (mEq). If you are hesitant about how to react to these problems, this pocket-sized, spiral-bound manual provides answers to 25 such situations, presented in just this clinical format, and arranged alphabetically according to the "on-call problem." Concise discussions list the essential additional information that should be sought, the likely differential diagnosis, and a plan for initial management.

A companion section takes a system-oriented approach, and in outline form, aided by charts, tables, and algorhythms, gives an overview of such entities as cardiac abnormalities, drug withdrawal, infectious diseases, surgical problems, and others. Content includes pathophysiology, risk factors, clinical findings, expected laboratory findings, and management with some comments on prognosis.

Other clinically useful sections cover the techniques involved in a variety of special procedures, ranging from heelstick to extracorporeal membrane oxygenation, and the commonly used medications with neonatal dosages and comments on application and side effects. There is also a list of the potential effects of

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various drugs with lactation. An appendix provides some useful reference charts, tables, and normograms.

The basics of newborn care are covered in the first section, titled "Basic Procedures," which includes delivery room management, nutrition, fluids, respiratory care, and physical examination. Taken in its entirety, this small, concise manual is quite comprehensive in its coverage of the essential information required to provide care to the sick neonate. It is the product of multiple authors, edited to maintain a uniformity of format, and presented in a manner to facilitate easy retrieval of information. It can be recommended to any clinician actively engaged in newborn care, and is particularly suited to serve as an immediate guide to the solution of unanticipated or unfamiliar problems.

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Essentials of Clinical Nutrition. *Elaine B. Feldman, F. A. Davis Company, Philadelphia, 1988, 605 pp., $35 (paper). ISBN 8036-3431-5.*

In this trade paperback, the latest volume of the *Essentials of Medical Education* series edited by David T. Lowenthal, the author intends to cover "a certain minimum body of nutritional knowledge, or competence" that is necessary for the physician. The author provides at least these essentials and a good bit more. The organization of the volume is standard for a nutritional text and includes basic principles of nutrition, nutrition throughout the life cycle, modalities of nutritional support, malnutrition, and nutritional aspects of disease. The table of contents of this book would serve nicely as an outline for a curriculum in clinical nutrition for medical students, family practice residents, or practicing family physicians.

The book is well organized and clearly written. Most of the chapters are quite interesting, and most of the graphs, tables, and illustrations are clear and concise. The section on basic principles of nutrition probably contains more biochemistry and detail than is essential for physician education as well as several figures that are difficult to interpret. Although specific references are not provided for the data presented in this book, the information is for the most part up to date and reflects mainstream ideas in clinical nutrition. There is relatively little discussion of some of the more controversial aspects of clinical nutrition, but that may be appropriate for a volume intended to deal with essentials. This book would probably be most useful to physicians at any stage of training or practice who would like a relatively brief overview of clinical nutrition.

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Families and Health (Volume 10, Family Studies Text Series). *William J. Doherty, Thomas L. Campbell. Sage Publications, Newbury Park, California, 1988, 160 pp., $19.95, $9.95 (paper). ISBN 0-8039-2993-5.*

The meaning and significance of the word *family* in family practice remains unclear in 1988, nearly 20 years after the specialty's formation. This book, a gem in both value and clarity, makes an important contribution to relating health and illness to family structure and function. The authors, experienced practitioners and educators in family system medicine, have written an intensely referenced, authoritative basic science textbook that describes why caring for the family for the benefit of the patient is not only desirable but essential for excellent health care. The authors wisely avoid the question of whether family-centered medical care is the foundation of an entire specialty, but the book's richness of detail and comprehensive scope provide a strong foundation for both research and clinical practice in family practice.

The book is organized according to a family health and illness cycle proposed by the authors. This cycle represents the spectrum of family-centered medical care from prevention to rehabilitation or death. The cycle generates a structure of five chapters reviewing the relationship of family structure and function to health promotion, vulnerability and disease onset, illness assessment, acute response to illness, and chronic illness. The book provides little in the way of specific clinical techniques for assessing and intervening in the family; a text addressing clinical strategies and skills is sorely needed for family physicans. This book provides the basic science foundation for a comprehensive clinical approach.

In summary, this is a well-written, readable, and authoritative approach to relationships between families, health, and illness. I would recommend it as a primer for researchers, and a reference for family physicians at all levels of training and experience.

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Allergic Diseases from Infancy to Adulthood (2nd Edition). *C. Warren Bierman, David S. Perlman. W. B. Saunders Company, Philadelphia, 1988, 824 pp., $95.00. ISBN 0-7216-1513-9.*

This textbook on allergic diseases was "first conceived and developed for physicians who provide primary patient care." This area of medicine is certainly relevant to the family physician, and the authors present the wide range of allergic diseases in an extremely readable format.

The book presents basic immunologic pathophysiology and then deals with specific allergic diseases, their evaluation and treatment. There are over 120 extremely well-done il-

lustrations which add to the readability of this in-depth textbook.

This book is not a short reference to allergic diseases. Although it is appropriate for use by the primary care physician, its in-depth discussion and 824 pages make it a textbook best utilized in libraries or by the physician with a large allergy practice. I would certainly recommend it to the primary care physician who wants an in-depth yet practical resource book in his library.

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Interpreting the Medical Literature: Practical Epidemiology for Clinicians (2nd Edition). *Stephen H. Gehlbach. Macmillan Publishing Company, New York, 1988, 218 pp., $21.95 (paper). ISBN 0-02-341270-4.*

Keeping up with new developments in the health care literature relating to the etiology, diagnosis, treatment, and prognosis of medical conditions is a daunting task for most clinicians. The increasingly sophisticated and at times arcane methodologic language found in journal articles often makes it difficult for readers to understand clinical and epidemiological research findings. *Interpreting the Medical Literature: Practical Epidemiology for Clinicians,* by Dr. Stephen H. Gehlbach, is an important and welcome text that greatly helps to demystify the epistemology and praxis of biomedical research.

This concise, well-written, and highly entertaining paperback builds upon the success of the first edition (1982). Lucid descriptions are provided of key methodologic concepts (eg, reliability, validity, sampling, bias, statistical significance, confidence intervals, sensitivity, specificity, predictive value, risk, and causality), and published findings from a variety of relevant recent and classic medical studies help to emphasize the major points. Liberal use is made of illustrative figures and tables. In the second edition, two new chapters have been added that effectively cover (1) commonly used statistical tests for categorical data, continuous data, correlation, and regression analysis; and (2) case-series studies, editorials or letters, and reviews (including metaanalysis).

In terms of recommendations for a future third edition of this marvelous text, this reviewer would like to see more discussion of such topics as the likelihood ratio, exploratory data analysis techniques, and ethnographic or qualitative research. Readers may also be interested in a review of other books and articles on the subject of "interpreting the medical literature" (eg, see the excellent McMaster Clinical Epidemiology Rounds series in the *Canadian Medical Association Journal*). Finally, a chapter on critiquing articles relating to the cost effectiveness and quality of medical care would be most useful given the growing number of published studies on these subjects.

Interpreting the Medical Literature can be profitably studied by medical students in undergraduate courses or clerkships, by residents and fellows in journal clubs and research practicums, and by experienced clinicians who wish to review the fundamental concepts of clinical epidemiology and keep up with the rapidly changing world of medical practice.

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Putting Prevention into Practice: Problem Solving in Clinical Prevention. *Richard K. Riegelman, Gail J. Povar (eds). Little, Brown & Company, Boston, 1988, 407 pp., $18 (paper). ISBN 0-316-745219-7.*

Official recommendations abound in the field of preventive medicine. The Canadian Task Force, US Task Force, and American Cancer Society are just a few examples of organizations with experts and opinions that rarely agree. The family physician is left with the difficult task of deciding whom to believe.

Physicians hoping to find the "right answer" to this problem will not find it in this book. The authors' goal is to help the reader think through the problems of clinical preventive medicine. The reader will indeed develop a good understanding of the complex issues involved in this field. The physician will also begin to appreciate why no "right answer" exists for many public health problems.

The book is well organized and very readable. The first five chapters provide basic background information needed to understand and analyze the problems presented in the remainder of the book. Fourteen topics in primary, secondary, and tertiary prevention are then presented as sample problems. Subjects include current controversies such as cholesterol screening and osteoporosis prevention. Also intriguing are chapters on problems receiving less publicity such as varicella prevention and child restraints.

Each of these 14 chapters begins with a clinical case followed by a review of the data available on the particular problem. A series of study questions, with answers in the back, guide the reader from data analysis to the development of recommendations. Despite multiple authors, this format is remarkably uniform.

A teacher's guide in pamphlet form is included with the book. The pamphlet contains suggestions for using the book for teaching students and physicians, sample test questions, and an annotated bibliography for suggested additional reading. The book can also be used as the text for a self-study course for 54 hours of AMA approved category 1 CME credit.

Although the authors state the book is "written by and for clinicians," the family physician with a busy clinical practice will probably not find it helpful. Family physician educators, however, or clinicians with a particular interest in preventive

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BuSpar® (buspirone HCl)

References: 1. Newton RE, *et al:* A review of the side effect profile of buspirone. *Am J Med* 1986;80(3B):17-21. **2.** Lucki I, *et al:* Differential effects of the anxiolytic drugs, diazepam and buspirone, on memory function. *Br J Clin Pharmacol* 1987;23:207-211. **3.** Lader M: Assessing the potential for buspirone dependence or abuse and effects of its withdrawal. *Am J Med* 1987;82(5A):20-26.

Contraindications: Hypersensitivity to buspirone hydrochloride.

Warnings: The administration of BuSpar to a patient taking a monoamine oxidase inhibitor (MAOI) may pose a hazard. Since blood pressure has become elevated when BuSpar was administered concomitantly with an MAOI, such concomitant use is not recommended. BuSpar should not be employed in lieu of appropriate antipsychotic treatment.

Precautions: *General*—*Interference with cognitive and motor performance:*** Although buspirone is less sedating than other anxiolytics and does not produce significant functional impairment, its CNS effects in a given patient may not be predictable; therefore, patients should be cautioned about operating an automobile or using complex machinery until they are reasonably certain that buspirone does not affect them adversely. Although buspirone has not been shown to increase alcohol-induced impairment in motor and mental performance, it is prudent to avoid concomitant use with alcohol.

Potential for withdrawal reactions in sedative/hypnotic/anxiolytic drug dependent patients: Because buspirone will not block the withdrawal syndrome often seen with cessation of therapy with benzodiazepines and other common sedative/hypnotic drugs, before starting buspirone withdraw patients gradually from their prior treatment, especially those who used a CNS depressant chronically. Rebound or withdrawal symptoms may occur over varying time periods, depending in part on the type of drug and its elimination half-life. The withdrawal syndrome can appear as any combination of irritability, anxiety, agitation, insomnia, tremor, abdominal cramps, muscle cramps, vomiting, sweating, flu-like symptoms without fever, and occasionally, even as seizures.

Possible concerns related to buspirone's binding to dopamine receptors: Because buspirone can bind to central dopamine receptors, a question has been raised about its potential to cause acute and chronic changes in dopamine mediated neurological function (eg, dystonia, pseudoparkinsonism, akathisia, and tardive dyskinesia). Clinical experience in controlled trials has failed to identify any significant neuroleptic-like activity; however, a syndrome of restlessness, appearing shortly after initiation of treatment, has been reported; the syndrome may be due to increased central noradrenergic activity or may be attributable to dopaminergic effects (ie, represent akathisia).

***Information for Patients*—**Patients should be instructed to inform their physician about any medications, prescription or nonprescription, alcohol or drugs they are now taking or plan to take during treatment with buspirone; to inform their physician if they are pregnant, are planning to become pregnant, or become pregnant while taking buspirone; to inform their physician if they are breast feeding; and not to drive a car or operate potentially dangerous machinery until they experience how this medication affects them.

***Drug Interactions*—**Concomitant use with other CNS active drugs should be approached with caution (see **Warnings**). Concomitant use with trazodone may have caused 3- to 6-fold elevations on SGPT (ALT) in a few patients. Concomitant administration of BuSpar and haloperidol resulted in increased serum haloperidol concentrations in normal volunteers. The clinical significance is not clear. Buspirone does not displace tightly bound drugs like phenytoin, propranolol, and warfarin from serum proteins, but may displace less firmly bound drugs like digoxin. However, there was one report of prolonged prothrombin time when buspirone was given to a patient also treated with warfarin, phenytoin, phenobarbital, digoxin, and Synthroid.

***Carcinogenesis, Mutagenesis, Impairment of Fertility*—**No evidence of carcinogenic potential was observed in rats or mice; buspirone did not induce point mutations, nor was DNA damage observed; chromosomal aberrations or abnormalities did not occur.

***Pregnancy: Teratogenic Effects*—**Pregnancy Category B: Should be used during pregnancy only if clearly needed.

***Nursing Mothers*—**Administration to nursing women should be avoided if clinically possible.

***Pediatric Use*—**The safety and effectiveness have not been determined in individuals below 18 years of age.

***Use in the Elderly*—**No unusual, adverse, age-related phenomena have been identified in elderly patients receiving a total, modal daily dose of 15 mg.

***Use in Patients with Impaired Hepatic or Renal Function*—**Since buspirone is metabolized by the liver and excreted by the kidneys, it is not recommended in severe hepatic or renal impairment.

Adverse Reactions (See also Precautions): *Commonly Observed*—The more commonly observed untoward events, not seen at an equivalent incidence in placebo-treated patients, include dizziness, nausea, headache, nervousness, lightheadedness, and excitement.

***Associated with Discontinuation of Treatment*—**The more common events causing discontinuation included: central nervous system disturbances (3.4%), primarily dizziness, insomnia, nervousness, drowsiness, lightheaded feeling; gastrointestinal disturbances (1.2%), primarily nausea; miscellaneous disturbances (1.1%), primarily headache and fatigue. In addition, 3.4% of patients had multiple complaints, none of which could be characterized as primary.

***Incidence in Controlled Clinical Trials*—**Adverse events reported by 1% or more of 477 patients who received buspirone in four-week, controlled trials: *Cardiovascular:* Tachycardia/palpitations 1%. *CNS:* Dizziness 12%, drowsiness 10%, nervousness 5%, insomnia 3%, lightheadedness 3%, decreased concentration 2%, excitement 2%, anger/hostility 2%, confusion 2%, depression 2%. *EENT:* Blurred vision 2%. *Gastrointestinal:* Nausea 8%, dry mouth 3%, abdominal/gastric distress 2%, diarrhea 2%, constipation 1%, vomiting 1%. *Musculoskeletal:* Musculoskeletal aches/pains 1%. *Neurological:* Numbness 2%, paresthesia 1%, incoordination 1%, tremor 1%. *Skin:* Skin rash 1%. *Miscellaneous:* Headache 6%, fatigue 4%, weakness 2%, sweating/clamminess 1%.

***Other Events Observed During the Entire Premarketing Evaluation*—**The relative frequency of all other undesirable events reasonably associated with the use of buspirone in approximately 3000 subjects who took multiple doses of the drug under well-controlled, open, and uncontrolled conditions is defined as follows: Frequent are those occurring in at least 1/100 patients; infrequent are those occurring in 1/100 to 1/1000 patients; and rare are those occurring in less than 1/1000 patients. *Cardiovascular*—frequent: nonspecific chest pain; infrequent: syncope, hypotension, hypertension; rare: cerebrovascular accident, congestive heart failure, myocardial infarction, cardiomyopathy, bradycardia. *Central Nervous System*—frequent: dream disturbances; infrequent: depersonalization, dysphoria, noise intolerance, euphoria, akathisia, fearfulness, loss of interest, dissociative reaction, hallucinations, suicidal ideation, seizures; rare: feelings of claustrophobia, cold intolerance, stupor, slurred speech, psychosis. *EENT*—frequent: tinnitus, sore throat, nasal congestion; infrequent: redness and itching of the eyes, altered taste, altered smell, conjunctivitis; rare: inner ear abnormality, eye pain, photophobia, pressure on eyes. *Endocrine*—rare: galactorrhea, thyroid abnormality. *Gastrointestinal*—infrequent: flatulence, anorexia, increased appetite, salivation, irritable colon, rectal bleeding; rare: burning of the tongue. *Genitourinary*—infrequent: urinary frequency, urinary hesitancy, menstrual irregularity and spotting, dysuria; rare: amenorrhea, pelvic inflammatory disease, enuresis, nocturia. *Musculoskeletal*—infrequent: muscle cramps, muscle spasms, rigid/stiff muscles, arthralgias. *Neurological*—infrequent: involuntary movements, slowed reaction time; rare: muscle weakness. *Respiratory*—infrequent: hyperventilation, shortness of breath, chest congestion; rare: epistaxis. *Sexual Function*—infrequent: decreased or increased libido; rare: delayed ejaculation, impotence. *Skin*—infrequent: edema, pruritus, flushing, easy bruising, hair loss, dry skin, facial edema, blisters; rare: acne, thinning of nails. *Clinical Laboratory*—infrequent: increases in hepatic aminotransferases (SGOT, SGPT); rare: eosinophilia, leukopenia, thrombocytopenia. *Miscellaneous*—infrequent: weight gain, fever, roaring sensation in the head, weight loss, malaise; rare: alcohol abuse, bleeding disturbance, loss of voice, hiccoughs.

***Postintroduction Clinical Experience*—**Rare occurrences of allergic reactions, cogwheel rigidity, dystonic reactions, ecchymosis, emotional lability, tunnel vision, and urinary retention have been reported. Because of the uncontrolled nature of these spontaneous reports, a causal relationship to BuSpar has not been determined.

Drug Abuse and Dependence: *Controlled Substance Class*—Not a controlled substance.

***Physical and Psychological Dependence*—**Buspirone has shown no potential for abuse or diversion and there is no evidence that it causes tolerance, or either physical or psychological dependence. However, since it is difficult to predict from experiments the extent to which a CNS-active drug will be misused, diverted, and/or abused once marketed, physicians should carefully evaluate patients for a history of drug abuse and follow such patients closely, observing them for signs of buspirone misuse or abuse (eg, development of tolerance, incrementation of dose, drug-seeking behavior).

Overdosage: *Signs and Symptoms*—At doses approaching 375 mg/day the following symptoms were observed: nausea, vomiting, dizziness, drowsiness, miosis, and gastric distress. No deaths have been reported in humans either with deliberate or accidental overdosage.

***Recommended Overdose Treatment*—**General symptomatic and supportive measures should be used along with immediate gastric lavage. No specific antidote is known and dialyzability of buspirone has not been determined.

For complete details, see Prescribing Information or consult your Mead Johnson Pharmaceuticals Representative.

U.S. Patent Nos. 3,717,634 and 4,182,763

MJL 8-4225R2

Mead Johnson
PHARMACEUTICALS
A Bristol-Myers Company
Evansville, Indiana 47721

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medicine should enjoy this book and find it quite thought provoking.

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The Only EKG Book You Will Ever Need. (2nd Edition). *Malcolm Thaler. J.B. Lippincott Co, Philadelphia, 1988; 270 pp., $19.95 (paper). ISBN 0-397-50773-9.*

As the author points out, there are a number of electrocardiogram (ECG) texts currently available. Most family physicians have at least one or possibly more ECG texts in their library for reference purposes. Some texts are extremely brief, giving only the basic information regarding the interpretation of electrocardiograms, and others go into great detail regarding every facet of electrocardiography including extensive information on vector propagation. The author of this text has attempted to present a course in electrocardiography that keeps information simple and uncomplicated. The graphics he has chosen that complement the text are extremely well done. The book begins with the basics of electrocardiography, progresses toward recognition of cardiac hypertrophy and arrhythmias, and moves on to conduction blocks and myocardial infarction, ending with a very helpful summary chapter that reviews an 11-step method of reading electrocardiograms. Included in the text are clinical histories of the electrocardiograms presented.

A special section entitled "Finishing Touches" reviews electrocardiographic changes present in a number of special clinical situations including electrolyte disturbances, pulmonary and central nervous system disorders, and the athletic heart. I found this text to be easily read, understood, and it would be an excellent reference for medical students, family practice residents, and the practicing family physician.

Fran Larsen, MD
Ventura, California

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ONCE DAILY
ISOPTIN® SR
(verapamil HCl)
240 mg scored, sustained-release tablets

CONTRAINDICATIONS: 1) Severe left ventricular dysfunction (see WARNINGS), 2) Hypotension (less than 90 mmHg systolic pressure) or cardiogenic shock, 3) Sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 4) 2nd or 3rd degree AV block (except in patients with a functioning artificial ventricular pacemaker), 5) Patients with atrial flutter or atrial fibrillation and an accessory bypass tract (e.g., Wolff-Parkinson-White, Lown-Ganong-Levine syndromes), 6) Patients with known hypersensitivity to verapamil hydrochloride.

WARNINGS: Heart Failure: ISOPTIN should be avoided in patients with severe left ventricular dysfunction. Patients with milder ventricular dysfunction should, if possible, be controlled before verapamil treatment. ISOPTIN should be avoided in patient with any degree of left ventricular dysfunction if they are receiving a beta adrenergic blocker (see DRUG INTERACTIONS).**Hypotension:** ISOPTIN (verapamil HCl) may produce occasional symptomatic hypotension: **Elevated Liver Enzymes:** Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Periodic monitoring of liver function in patients receiving verapamil is therefore prudent. **Accessory Bypass Tract (Wolff-Parkinson-White):** Patients with paroxysmal and/or chronic atrial flutter or atrial fibrillation and a coexisting accessory AV pathway may develop increased antegrade conduction across the accessory pathway producing a very rapid ventricular response or ventricular fibrillation after receiving intravenous verapamil. While this has not been reported with oral verapamil, it should be considered a potential risk (see Contraindications). Treatment is usually D.C.-cardioversion. **Atrioventricular Block:** The effect of verapamil on AV conduction and the SA node may cause asymptomatic 1st degree AV block and transient bradycardia. Higher degrees of AV block, while infrequent (0.8%), may require a reduction in dosage or, in rare instances, discontinuation of verapamil HCl. **Patients with Hypertrophic Cardiomyopathy (IHSS):** Although verapamil has been used in the therapy of patients with IHSS, severe cardiovascular decompensation and death have been noted in this patient population.

PRECAUTIONS: Impaired Hepatic or Renal Function: Verapamil is highly metabolized by the liver with about 70% of an administered dose excreted as metabolites in the urine. In patients with impaired hepatic function the dose should be cut to 30% of the usual dose and the patient closely monitored. In patients with impaired renal function verapamil should be administered cautiously and the patients monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacological effects (see Overdose). **Use in Patients with Attenuated (Decreased) Neuromuscular Transmission:** Verapamil decreases neuromuscular transmission and may prolong recovery from neuromuscular blocking agents. In patients with attenuated neuromuscular transmission lower doses of verapamil may be warranted.

Drug Interactions: Beta Blockers: Concomitant use of ISOPTIN and oral beta-adrenergic blocking agents may result in additive negative effects on heart rate, atrioventricular conduction, and/or cardiac contractility. Excessive bradycardia and AV block, has been reported. The combination should be used only with caution and close monitoring. **Digitalis:** Clinical use of verapamil in digitalized patients has shown the combination to be well tolerated. However, chronic verapamil treatment increases serum digoxin levels by 50% to 75% during the first week of therapy and this can result in digitalis toxicity. Upon discontinuation of ISOPTIN (verapamil HCl), the patient should be reassessed to avoid underdigitalization. **Antihypertensive Agents:** Verapamil administered concomitantly with oral antihypertensive agents (e.g., vasodilators, angiotensin-converting enzyme inhibitors, diuretics, alpha and beta adrenergic blockers) will usually have an additive effect on lowering blood pressure. Patients receiving these combinations should be appropriately monitored. **Antiarrhythmic Agents: Disopyramide:** Disopyramide should not be administered within 48 hours before or 24 hours after verapamil administration. **Flecainide:** Concomitant administration of flecainide and verapamil may have additive negative effects on myocardial contractility, AV conduction, and repolarization. **Quinidine:** In patients with hypertrophic cardiomyopathy (IHSS), concomitant use of verapamil and quinidine may result in significant hypotension. **Other: Nitrates:** The pharmacologic profile of verapamil and nitrates as well as clinical experience suggest beneficial interactions. **Cimetidine:** Variable results on clearance have been obtained in acute studies of healthy volunteers; clearance of verapamil was either reduced or unchanged. **Lithium:** Pharmacokinetic (lowering of serum lithium levels) and pharmacodynamic (increased sensitivity to the effects of lithium) interactions between oral verapamil and lithium have been reported. **Carbamazepine:** Verapamil therapy may increase carbamazepine concentrations and produce related side effects during combined therapy. **Rifampin:** Therapy with rifampin may markedly reduce oral verapamil bioavailability. **Phenobarbital:** Phenobarbital therapy may increase verapamil clearance. **Cyclosporin:** Verapamil therapy may increase serum levels of cyclosporin. **Anesthetic Agents:** Verapamil may potentiate the activity of neuromuscular blocking agents and inhalation anesthetics. **Carcinogenesis, Mutagenesis, Impairment of Fertility:** There was no evidence of a carcinogenic potential of verapamil administered to rats for two years. Verapamil was not mutagenic in the Ames test. Studies in female rats did not show impaired fertility. Effects on male fertility have not been determined. **Pregnancy (Category C):** There are no adequate and well-controlled studies in pregnant women. ISOPTIN crosses the placental barrier and can be detected in umbilical vein blood at delivery. This drug should be used during pregnancy, labor, and delivery, only if clearly needed. **Nursing Mothers:** ISOPTIN is excreted in human milk, therefore, nursing should be discontinued while verapamil is administered. **Pediatric Use:** Safety and efficacy of ISOPTIN in children below the age of 18 years have not been established.

ADVERSE REACTIONS: Constipation 7.3%, dizziness 3.3%, nausea 2.7%, hypotension 2.5%, headache 2.2%, edema 1.9%, CHF/pulmonary edema 1.8%, fatigue 1.7%, dyspnea 1.4%, bradycardia 1.4%, 2° and 3° AV block 0.8%, rash 1.2%, flushing 0.6% and elevated liver enzymes (see WARNING). The following reactions, reported in less than 1.0% of patients, occurred under conditions (open trials, marketing experience) where a causal relationship is uncertain; they are mentioned to alert the physician to a possible relationship: angina pectoris, atrioventricular dissociation, arthralgia and rash, blurred vision, cerebrovascular accident, chest pain, claudication, confusion, diarrhea, dry mouth, ecchymosis or bruising, equilibrium disorders, erythema multiforme, exanthema, gastrointestinal distress, gingival hyperplasia, gynecomastia, hair loss, hyperkeratosis, impotence, increased urination, insomnia, macules, muscle cramps, myocardial infarction, palpitations, paresthesia, psychotic symptoms, purpura (vasculitis), shakiness, somnolence, spotty menstruation, Steven-Johnson syndrome, sweating, syncope, urticaria.

Treatment of Acute Cardiovascular Adverse Reactions: Whenever severe hypotension or complete AV block occur following oral administration of verapamil, the appropriate emergency measures should be applied immediately, e.g., intravenously administered isoproterenol HCl, levarterenol bitartrate, atropine (all in the usual doses), or calcium gluconate (10% solution). If further support is necessary, inotropic agents (dopamine or dobutamine) may be administered. Actual treatment and dosage should depend on the severity and the clinical situation and the judgment and experience of the treating physician.

OVERDOSAGE: Treatment of overdosage should be supportive. Beta-adrenergic stimulation or parenteral administration of calcium solutions may increase calcium ion flux across the slow channel, and have been used effectively in treatment of deliberate overdosage with verapamil. Clinically significant hypotensive reactions or fixed high degree AV block should be treated with vasopressor agents or cardiac pacing, respectively. Asystole should be handled by the usual measures including cardiopulmonary resuscitation.

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Stories of Sickness. *Howard Brody. Yale University Press, New Haven, Connecticut, 1987, 310 pp., $25.50. ISBN 0-300-03977-8.*

This provocative book is difficult to review in the space available. It touches on many different aspects of medicine including sociology, philosophy, literature, and ethics, and while it often produces flashes of recognition, it also frequently provokes rebuttal and irritation. The theme of the book is that we can best care for our patients by listening to the unique stories of their lives and illnesses. Brody develops a framework that includes the sick role and the effect of illness on life plans and self-respect as a means for understanding these stories. He then illustrates his arguments with several classic stories from literature. Finally, he offers his model as a general approach to medical ethics, suggesting that attention to the narrative aspects of an ethical dilemma will foster a fuller appreciation of the events.

I had a number of problems with the book. Too much ground is covered too superficially, with an abundance of distracting footnotes. If indeed patients' stories are unique, then fitting them into such a prescriptive framework seems at least paradoxical. It would have been helpful to illustrate the argument with stories of real patients rather than synopses of works of literature. Finally, his narrative theory of medical ethics is unconvincing as a useful tool in resolving ethical dilemmas.

I encourage those interested in being challenged by the ideas discussed in this book to read it for themselves. For those seeking a more practical, comprehensive, and less prescriptive view of the role of stories in medical practice, I recommend *The Illness Narratives* by Arthur Kleinman.

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