Afghanistan--humanitarian aid and military intervention don't mix.

The Back Pages

viewpoint

A New World Order

FOR Nelson Mandela, unlike Gandhi, ends justify means. In particular, violence is an appropriate reaction to oppression if other means of redress fail:

'We had contended that, for the ANC, non-violence was an inviolate principle, not a tactic to be changed as conditions warranted. I myself believed precisely the opposite; that non-violence was a tactic that should be abandoned when it no longer worked...'

'We were embarking on a new and more dangerous path, a path of organised violence…'

'But if sabotage did not produce the results we wanted, we were prepared to move on to the next stage: guerilla warfare and terrorism...'

Mandela was determined that if necessary the ANC would kill South African whites because the actions of the minority imposed on his people powerlessness and poverty. The decision to prepare for war was taken, not by any democratic process, but by a small group of determined men.

Mandela is regarded as a saint.

The loss of life in Manhattan and Washington in September was a tragedy. The suffering of the victims and the grief of the bereaved are matters for unqualified sadness. And our sadness may be tinged with guilt. We, too, are beneficiaries of the global markets that the people and buildings of New York vibrantly symbolise. None of us can feel detached.

The news media are full of the traditional responses of a threatened community: 'evil, cowardice, barbarism,' on one hand, and 'civilisation, democracy, moral outrage, justice and retribution' on the other. But if we pause to remember that, for a century, a tiny proportion of the world's population have had a monopoly of power and wealth and have consistently ignored the aspirations of the majority, then Bin Laden's actions (if it was him) seem to have strong parallels with Mandela's. So we face irreconcilable inconsistency: Mandella is a saint, whereas Bin Ladin, for the same actions, is the devil.

It is true that the ANC was democratic for as long as that was practical, but we do not know to what ends Mandela might have gone had he not been confined on Robben Island. We cannot easily take refuge in the awfulness of the act in New York. Hiroshima and Dresden are at least comparable. The existence or not of a declaration of war seems trivial when we talk of global injustice on a massive scale for a century. We may quibble over the detail, but on the face of it, there are broad parallels.

I think we have to conclude, in our sadness and grief, that moral outrage and its attendant talk of defending civilisation against evil is hopelessly mired in irrationality. These words and ideas seem incapable of offering a view of our situation that makes sense. Is there an alternative?

Groups of chimps who live together make war from time to time on neighbouring troupes. They do so because they harbour genes that make them that way, and those genes are there because, in preceding generations of social primates, genes for warlike group behaviour have proved good at getting into the next generation. Rape and pillage is much older than the Vikings. Our formative evolutionary years were probably spent in much the same kind of social conditions as chimps, so we should expect to be tribal and xenophobic. A Martian would see football supporters as an intensely homogeneous group, but football supporters see the opposition as creatures from the underworld. We share with chimpanzees a wholly irrational capacity to invent distinctions between them and us, between goodies and baddies. It colours our every perception. It enables those small numbers of us who live in order and prosperity to ignore the majority of us, who do not.

Let us be sad with America, because their loss is ours. We feel it intensely. But let us be sad too, and proportionately sad, for Africa, ravaged by AIDS and famine. Let us be sad with the mothers of American bankers, and with the mothers of dispossessed Palestinian boys. Equity, not evil, should be our preoccupation. We need to know ourselves better and to recognise the very peculiar behaviours which our primate ancestry confers. For a start, we might leave tribalism at the turnstiles.

"*The Observer* is a broadsheet, not a tabloid ... It has a number of columnists for whom I have great respect ... Yet they share their newspaper with a man who writes nonsense ..."

Neville Goodman hunts down the Barefoot Doctor, page 952

"We find ourselves drawn in to the deepening mystery of how we feel what we feel."

Ken Macleod on Consciousness, Digest, page 956

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Afghanistan humanitarian aid and military intervention don t mix

FOR years the people of Afghanistan have been caught in one of the worst humanitarian crises in the world. In all provinces where Médecins Sans Frontières (MSF) work, a clear degradation in nutritional status has been seen. In the first part of this year, an outbreak of scurvy was detected and cases of cholera were on the rise.

The current drought, now in its third year, has been catastrophic. Harvests have failed and livestock have been decimated. Seeds have been eaten and rivers have dried up, leaving too little water for drinking or irrigation. The serious food crisis risks evolving into a famine.

The war, drought and food crisis has forced thousands of Afghans to flee their homes: 66 000 people were displaced to refugee camps in Mazar-i-Sharif out of a total of 150 000 in the northern provinces, 228 000 were displaced in two camps in Herat province in the West, and 100 000 more in Kandahar in the South. In August 2001, an estimated 100–200 people were arriving every day in the camps in Herat province. Already, 1 million refugees had fled to Pakistan, 400 000 to Iran, and 100 000 to Turkmenistan, Uzbekistan, and Tajikistan. The United Nations refugee agency, UNHCR is planning camps along the Afghanistan–Pakistan border for a further 1.5 million refugees.

Two decades of conflict have taken their toll on Afghanistan. The country's health system is among the worst in the world and all indicators — infant mortality, malnutrition, lack of access to water — paint a desperate picture.[1] MSF has been working in Afghanistan since 1979. But recently its work has been greatly reduced. Aid agencies, on whose work thousands of lives depend, have found it increasingly difficult to deliver assistance in recent years, as many regions are inaccessible because of the conflict.

The threats of war following the terrorist attacks in the United States on September 11 had greatly increased the security risk for expatriate workers and forced the majority of aid agencies to withdraw to neighbouring countries. The airstrikes at the beginning of October, the chronic lack of aid, and the onset of winter will only magnify the humanitarian catastrophe.

MSF's expatriate staff have withdrawn from all but two provinces (Faizabad and Eshkashim in the north), although experienced local staff continue to work in many provinces. In the month since September 11, MSF has delivered 40 tonnes of medical and food supplies to its programmes in northern and western Afghanistan, but getting aid into the country is difficult at best, and in some locations impossible. The US airstrikes were accompanied by food dropped into Afghanistan. However, the amount of food dropped was vastly insufficient to meet the needs, and airdrops are in any case the least effective way of delivering aid. 'It's a bit like throwing a bundle of £5 notes up in the air in Oxford Street,' said Geoff Prescott, the head of MSF in Pakistan. 'The people who grab the notes first will not be the needy and vulnerable.'

Of far greater concern is the mixing of humanitarian aid with military objectives. If the military are involved in delivering humanitarian assistance, it can be regarded by their opponents as an act of war: aid and aid workers can be legitimately targeted, and so denied to people in need. This was seen during the Kosovo crisis when NATO troops were present in the refugee camps and the camps were shelled by Yugoslav forces. In Pakistan, in early October, some United Nations offices were attacked. When the bombing stops, how will the Afghans tell humanitarian aid agencies apart from humanitarian bombers?

The military can provide help to people in danger in certain circumstances. Logistical resources are frequently deployed to respond to natural disasters, and peacekeepers have an important role to play in protecting civilians caught in conflict. But every time a military power that is belligerently involved in a conflict describe their actions as humanitarian, this vital concept is eroded. Aid agencies are perceived as less neutral and less independent, and staff will find it increasingly difficult to work and will be increasingly targeted. Civilian victims are less likely to be treated according to the rules of war, which insist on protection from aggression and the right to independent assistance.

Today the people of Afghanistan are in desperate need and have almost no assistance. Millions are faced with starvation. The UN has massively reduced all actions and aid workers now wait across the border in preparation for either a massive refugee crisis, a return to Afghanistan, or both. On one side, tons of aid and hundreds of staff; on the other side millions of people suffering.

To bridge this vast gap, a large-scale independent humanitarian relief effort is required, aimed directly at reaching the most vulnerable. This response could be led by the UN with a clearly understood humanitarian mandate, in collaboration with independent aid agencies. All parties to the conflict must allow for the delivery of large-scale aid convoys by humanitarian actors. The Taleban and its allies have the same responsibility towards civilians in war. Aid must get into Afghanistan and must be delivered by people who are not involved in the fighting.

Nathan Ford

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Perestroika in primary care

NOBODY'S twigged yet. I don't think anyone has realised. My partners haven't really thought about it: I suppose they just accept that it is the way it is because it is. But this is the new openness. More open than Russia, more accessible than .gov.uk yet nobody else is doing it in primary care. At least, not on this scale.

What we are doing is publishing everything we do on the World Wide Web. Not just a website with the usual patient leaflet information, but everything. All our practice activity, performance monitoring, and audit. Good and bad — sorry, I mean good and 'areas which we might consider developing'. And there is a lot of it. Audit cycles that freewheel from John O'Groats to Land's End. Management and computer protocols for every action and data pathway. Clinical guidelines to cover nearly every eventuality.

Why? Because it's there. No, there's more to it than that. In the 1980s, with my flashy new desktop computer running Windows 3.1 (remember that?) I started to collect useful desktop information which helped me with my day-to-day consulting. I looked for a quick and easy way of presenting the data and discovered Windows helpfiles. Quick, though not always easy to produce. Nevertheless, I liked the idea of links from one information area to another. The internet had started to develop, and the web browser with its pure and easy HTML had appeared — this seemed to fit all my requirements and, to enable sharing of information around the practice, could even easily be added to the networked system which we would be getting soon. But 'soon' became 'sooner or later' as it often does in the IT struggle, and I was left with this really useful information resource. The web seemed an ideal place to share it. And it grew. When the practice finally got its intranet, it grew faster, others wanted to add information to it, and all this appeared on the website too, including the audits and protocols. The protocols were put there as they might be useful to others; the audits were there simply because the intranet was a useful place to put them, so they didn't get lost.

So all this data, all this performance monitoring, all this audit is now available to patients. They can look at it if they wish, see how their hypertension should be managed, and see how well hypertension is managed in the practice. And some do. No patient has yet said to me, 'Shouldn't I be on aspirin? Your protocol says I should,' or 'I've been started on an ACE inhibitor and my U&Es haven't been checked yet,' but I'm sure the time will come. Nobody in the practice has felt threatened by it, but perhaps they just haven't thought hard enough about it.

Maintaining a website of this size is clearly a lot of work. But it is a hobby, and in itself a learning tool for me. There is also an innate responsibility to provide up-to-date and accurate information. The site is used by many individual doctors and practices as a resource, a well of stimulation and a tool for development. So the practice must continue to develop. This is therefore good for the practice.

There is a debate to be had here. This is probably a Big Thing, but is it a Good Thing? Should this degree and type of information about a practice be available to patients? What should they be comparing it with? Does it aid patient choice, and how much do they really understand? Should all practices provide it? Or is it another of those great ideas that no other practice can match? The challenge is yours, should you wish to accept it.

The Well Close Square website is at **www.wellclosesquare.co.uk**

Bradley Cheek

trefor roscoe

The internet domain system — Part 2

THE organisation that controls domain name issue internationally is the Internet Corporation for Assigned Names and Numbers (ICANN), a technical coordination body for the Internet. Created in October 1998 by a broad coalition of the Internet's business, technical, academic, and user communities, ICANN assumed responsibility for a set of technical functions previously performed under a US government contract by The Internet Assigned Numbers Authority (IANA, http://www.iana.org/) and other groups. Specifically, ICANN coordinates the assignment of the following identifiers which must be globally unique for the Internet to function:

- Internet domain names,
- IP address numbers, and
- protocol parameter and port numbers.

In addition, ICANN coordinates the stable operation of the Internet's root server system.

The original top-level domain suffixes are not now enough for international companies and the US market. There have been several proposals for new domains and after much debate they are now becoming available.

As mentioned in the first part of this column (September Back Pages), **.int** denotes an international organisation, such as the World Health Organisation or the United Natations, and will apply to very few entities. Domains that can be registered by anybody include **.biz** for businesses, **.info** for general use and **.name** for individuals. These go with **.museum** for museums; **.coop** for business cooperatives, and **.aero** for the aviation industry.

Among the top-level domains ICANN passed on were proposals that would segregate web content for children and adults, with top-level domains, including **.kids** and **.xxx**. Other rejected contenders were **.web** and **.tel**.

Clearly, there is little logic to the overall system, it is rather dominated by the USA (no-one uses **.co.us** as far as I know) and it may be many years before everyone understands it and those entitled to domains buy them back off people who have bought them hoping to make a quick killing.

In the meantime, would anyone like to buy www.dna-test.com or www.health-promotion.info?

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TRIPs revisited

In the September issue of the Back Pages, Jeremy Strachan, Secretary of the British Medical Association (former lawyer, and ex-Executive Director of Glaxo Wellcome) asked why countries have signed up to TRIPS if it is so iniquitous.[1] The answer is simple: if you want to be a member of the World Trade Organisation (WTO), then you have no choice.

Many developing countries signed up to the World Trade Agreements in the hope of increasing markets in areas of interest such as textiles and agriculture, with little idea of how TRIPS would impact on health. As of 1992, (before TRIPS), 48 countries (including Finland, Spain, and Portugal) chose to exclude pharmaceutical products from patentability.

A producer who has a market monopoly is free from market competition and, unless pricing policies are in place, can charge whatever price the market will bear. While patents do not give the owner the right to charge whatever price he chooses, they do give the opportunity to do so by providing a market monopoly. In Brazil, the price of AIDS drugs fell by 82% over five years as a result of generic competition, while the price of drugs that had no generic competitor remained stable, falling only 9% over the same period.[2]

TRIPS contains flexibility designed to balance public and private interests. However, this is under-appreciated by Western governments and the pharmaceutical industry, who push for a much stricter interpretation, forcing countries to exclude those elements that allow for public health to be protected. South Africa has been taken to court by the pharmaceutical industry for attempting to pass a law which was perfectly compliant with TRIPS, that prevented implementation of health legislation for more than three years. Thailand has been pushed by US market for the past 10 years to adopt patent laws much stricter than is required by the World Trade Organisation.[3] Similar struggles are currently underway in many less developed countries.

At the next WTO ministerial conference in November, in Doha, Quatar, developing countries have proposed a ministerial declaration stating that 'nothing in the TRIPS agreement shall prevent countries from taking measures to promote and protect public health'. The minimum that industrialised countries can do is support this call.

Patents are an incentive for innovation, but the public has little influence over what is being invented. Drug research and development, almost exclusively confined to the private sector, is driven by profit prospects rather than public health needs. Patent protection has increased over the past 20 years, but an analysis of the new chemical entities brought onto the market in this period shows that the mean innovation rate has fallen, with an increase in the number of 'me-too drugs' of little or no therapeutic gain. Millions continue to die from tuberculosis and malaria every year, but virtually no new drugs have been developed in over 30 years.[4] The pipeline for drugs for tropical infectious diseases, which kill around 14 million people every year, is virtually empty. Exacerbating this neglect, drug resistance is wiping out drugs that were once effective.

High pricing can be overcome under the current system if countries are allowed to prioritise health wherever patent monopolies are a barrier to drug access. The lack of drug research and development into 'non-profitable' infectious diseases that take millions of lives every year will require a new strategy. A compulsory research obligation could be framed that would require industry to reinvest a percentage of pharmaceutical sales into R&D for neglected diseases, either directly or through public programmes. Such a mandate, framed in a global treaty, would correct the current imbalance between private sector rights and obligations under present international agreements and provide legal options to make drugs for neglected diseases global public goods. Public sector non-profit making R&D capacity should also be promoted.

Ninety per cent of all biomedical research and 60% of all profits from pharmaceutical drugs are in the USA, while Africa represents around 1% of drug sales worldwide. Of the 1393 new drugs approved in the past 20 years, only 1% are for tropical diseases, which account for almost 10% of the global disease burden. The medical profession must pay serious attention to the way medicines are researched, developed and sold, and to the global laws that surround this increasingly inequitable process.

Nathan Ford

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Médecins Sans Frontières
124-132 Clerkenwell Road, London EC1R 5DJ.

Deprivation soap

As I wrote my recent review on inequality and general practice 'Unequal to the task' (published in the June issue of the *BJGP*), I was mindful of an old adage. A good clinician, it is said, can recognise chicken pox. A good teacher can describe chicken pox. But a gifted clinical mentor can describe, at the bedside, how to recognise chicken pox. I therefore topped and tailed the formal part of my article with some 'real' clinical material that attempted to illustrate socioeconomic deprivation 'at work' in everyday practice in a format that would be recognised by any GP. It was labelled a 'vignette' and spiked by the editor. Your deputy editor has negotiated himself a more human brief. You've had the lecture: here comes the ward round.

One busy day in 2001...
David heard them coming. He saw so much of them that he wondered if he knew them better than he did his own children. They were spagging over the assault on his door handle. He instinctively pushed things to the back of the desk, particularly the sharps box, the new home of the used needle and syringe that he'd found in the concrete stairwell to the Drummonds' damp flat the last time he was there. At least she'd come to the surgery today.

The Drummond twins were in. Nothing was safe. Their mother sat down heavily, making a tactical error: she allowed her bag to slide to the floor in retrieving the baby's dummy. Another consultation was under way, the third in a month. As David watched the twins fall on the bag he tried to focus his medicine — what should he do, what could he do, to best control the fits of this young mother when she often forgot to take her 'eplims'. The children were probably in danger, as the health visitor rightly pointed out.

There was no order of play — the baby had a fever, the last boyfriend had left her with massive rent arrears, one twin had a bruise, yes — she was taking the tablets, she had fallen out with the playgroup supervisor. But there was a pitch invasion: Pamela began to cry as the twins climbed over her onto David's desk. Sirens turned to air-raid. Then it was all over; they were gone. The silence was palpable and so was the odour of overripe nappy contents. Three dissected cigarettes garnished the carpet. The notes acquired a Post-it: 'speak to health visitor'. David rang the bell and opened a window.

Brigadier Flood seemed to linger on the door handle. He placed a crisp copy of the *Daily Telegraph* on the corner of the desk, wiped his sticky hand with a pristine handkerchief and looked suspiciously at the chair before sitting down.

'Sorry to burden you, old man — a REME job. Shall I drop the old bags?' It took thirty seconds at attention to diagnose a hernia and file the owner's request for a letter to his choice of local surgeon at 'The Highway'. 'If it's alright with you I'll fix the appointment — Jane's got the number from when she had her private privates job — as we call it in the family. Anyway I may see old Sawbones at the club and fix it there; I suppose he can read and write, eh?' A waft of aftershave and a new fold in his daily and he was gone. David took another very deep breath but for a very different reason.

Five busy weeks later ...
David inched out of the long drive from 'The Lodge' and returned to his surgery through the neighbouring housing estate. He wondered why it always so amused the coroner's officer to turn every reported sudden death into a spelling bee; surely he was familiar enough with the word 'embolus' by now. The surprise call from the Brigadier's wife had been one of those that he had known, instantly, to be bad news. All he'd been able to do was confirm the death, note the swollen leg, cover the corpse and fumble his way through some consoling remarks. It was painfully obvious that he had no relationship with the widow. Although the couple had been on his list for several years all he'd been required to do was to acquiesce to their demands. Their medical needs had mostly been met by the 'independent' sector but the activities of the Reaper in the post-operative harvest are classless.

The next patient was unexpected and so were the circumstances. Angela Drummond held open the door for her twins — each hand in hand with a tall young man. The baby was clean and pink. The boys clung onto their charge, one climbing onto a knee: peace had broken out. Their mother had had no fits for over six weeks.

Tod, she had said with a blush, made sure she took her tablets. Could she take the Pill with them? The familiar menisci of a love bite on her neck winked at him as he took the blood pressure. As the family left, their new member turned and thanked David for all his past help and care. Angela had told him all about 'her smashing doctor', and 'would the health visitor be able to weigh the baby at clinic this week when the kids were being jabbed?' David was transfixed: general practice is nothing if it is not uncertain.

futurology

Postcards from the 21st Century

Time heals! Using time as a currency

This is the ninth article in our continuing series, Postcards from the 21st Century, commissioned and edited by Alec Logan, Deputy Editor, BJGP, *London, and Paul Hodgkin, Primary Care Futures.*

THE Rushey Green Group Practice in Catford, South East London, has an unusual approach for those who are depressed, lonely, feel disempowered, or just want to meet others and have some fun. How does it do this? By prescribing time through the 'time bank' that it has started.

In 1998, I attended a seminar on time banking by Dr Edgar Cahn, a law professor who developed time banks as a way of providing non-medical services for older people — helping them to stay in the own homes, keep hospital appointments, and stay healthy.

The idea has been developed in the United States during the past 15 years and is now an international movement, with time banks in Latin America, China, Japan, and Central and Eastern Europe as well as the USA and UK.

Time banking is a way of linking people's needs and others' assets through a mutual exchange system that uses time as a currency. Community time banks, of which there are currently 20 in the UK, can be based in the neighbourhood community centre, health centre, school, library, café or any other venue where people met. People earn time credits when they give their time, and spend their credits when they need a hand.

Time banks are one way of putting neighbours in touch with each other and are a practical way to build social capital. They are co-ordinated by a paid time-broker, who recruits members, links up people who can help each other, and records transactions in the free TimeKeeper software. One hour shared equals one 'time credit'. Using the skills and imagination of local people in this way has widened the services available to our patients and transformed how we as a practice perceive them.

In the United States the time-banking concept has been used to improve health in a number of ways. Sentara, a major integrated health system, ran a three-year time dollar experiment, which had 400 people earning an average of 670 hours a month. Among other things, they developed a telephone support system for asthmatics which resulted in participants having fewer visits to A&E and were admitted less often and for shorter periods. Overall, the programme saved around $200 000 in two years through reduced hospital costs. A similar telephone support system to prevent glaucoma in diabetics is run by Care Xchange, a time dollar programme developed by Blue Shield Insurance in California.

So, having already toyed with the idea of the practice joining the local LETS scheme I could see the potential of time banking for both patients and the practice. Edgar Cahn visited the Rushey Green Health Centre in 1999 to talk to GPs, health workers, and patients about how the time bank could make a difference. The practice worked with the New Economics Foundation to develop the idea and funding was given to pilot the project by the King's Fund. The Rushey Green time bank was launched in March 2000.

We are only just beginning to find out how time banks might be used in the context of UK primary care, but it is already clear that time banking is valued both by health professionals and participants. The fact that the scheme is supported by the practice, and that the time-broker facilitates and oversees initial contacts, encourages people who would not normally feel up to traditional volunteering. Often people never cash in their 'time credits' but the system of time accounting is still important because it makes the gift of volunteering visible in a socially acceptable way.

But perhaps the most appealing aspect of time banks is that it is those who give time who benefit most. Through helping, meeting with others, and making new links within their community, participants feel better about themselves and in turn may become healthier. These health benefits are particularly important for older people. They stay active for longer and can therefore gain physical as well as emotional benefits. This fits with a range of evidence[1,2] about the importance of social links to maintaining health.

A little less than a year and a half down the line, and the preliminary results from the time bank are promising.

The Rushey Green time bank has 60 members (55 individuals and five organisations) and has generated around 3000 hours of service, in activities such as befriending, running errands, giving lifts, arranging social events, woodwork, poetry writing, baby-sitting, gardening, swimming, fishing, teaching the piano, catering, and giving local knowledge. Time bank members have also been active in recruiting new members to the scheme.

The time bank is made up of 29% men, and 71% women. Forty-four per cent of the participants are from minority ethnic groups, 33% are over 65 and 52% have some kind of disability. This focus on the elderly and disabled has meant that it has been very hard

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For more information on the Rushey Green Time Bank visit ***www.londontimebank.org.uk*** *or e-mail:*

work, particularly for Liz, our co-ordinator who has had to set everything up and deal with all the publicity! New members often need nurturing and a great deal of personal attention to give them the confidence to meet others and make the transition from receiver to giver. The group is still relatively small with a limited range of needs and skills, so it is not always possible to give members a role as immediately as we would like. Such problems take time to overcome, but we have succeeded in making the bank a valuable asset for the practice.

GPs and health workers at the practice make 60% of the referrals; others come from members recruiting in the waiting rooms and among neighbours, and from outside agencies.

A survey of time bank members carried out by Dr Isabel Garcia, a partner at the practice, found that the time bank had:

- improved participants social networks outside of their home and family;
- given a sense of self-worth to people who had previously been passive recipients of care, and had reduced the burden on traditional carers in the form of both family and social services; and
- provided an alternative for health workers who understand the social causes of ill health to traditional medical treatments, such as antidepressants.

Meanwhile, the time bank has expanded to include a part time DIY worker, who will train time bank participants in simple home repairs such as fixing handrails and loose carpets or fitting smoke alarms. This scheme aims to prevent falls and accidents, as well as develop DIY skills.

An in-depth, independent evaluation of the time bank is now underway. Led by researchers at King's College and supported by the King's Fund, the evaluation will describe the working of the time bank and measure its impact on health and well being over the next two years.

As a GP, however, the time bank has already proved its worth to me, by giving me a tool with which to begin to tackle some of the social causes of distress and ill health in the practice; it has transformed my view of many people whom I had previously seen as dependent; and I've seen the depressed and isolated coming back smiling and empowered through their involvement.

Richard Byng
Karen Smith

The *Observer*'s Barefoot Doctor

Explanations for the credulous

'What I want to know is why you're publishing this stuff.' 'He's very popular,' she replied. 'I don't doubt that,' I said, 'but it's nonsense.'

There was a short pause.

'Isn't it just another way of looking at things?', she asked. 'Yes, sure,' I agreed, 'in the same way that thinking the Earth is flat it is indeed another way of looking at things.'

The conversation was

NOTHING in this article is new. By this, I do not mean that it is plagiarised. But if the world were a logical place, where force of argument and evidence held sway, there would be no need for it. What I have written here has been written before; sometimes by me, but also by many others, of whom I single out (with apologies to his co-author) Petr Skrabenek[1] and, more recently and famously, John Diamond.[2] Our common theme is the irrationality of alternative medicine.

Whatever its many faults, orthodox medicine moves on. Old treatments are discarded; new treatments take their place. Long established treatments which make sense to doctors and are popular with patients, are examined and found wanting.

Alternative medicine (I am not going to try to distinguish the terms alternative and complementary) is a mirror image of this. The treatments emerged at some time in the past, sometimes centuries ago, and are revered because of that. There is no development, just endless repetition of belief systems; to quote from Skrabanek: 'alternative medicine does not derive from any coherent or established body of evidence'; and from Diamond, 'they are based on erroneous and disproven theories about the workings of the body, which predate modern medical science by some hundreds of years'.

Alternative medicine is popular because orthodox medicine does not have all the answers and orthodox practitioners are short of time. Because of lack of time, but sometimes because of lack of training or empathy, some orthodox practitioners treat the disease but ignore the patient. When patients are told by orthodox practitioners that there is little that can be done — whether for terminal illness or for benign but chronic illness — it is understandable that patients look elsewhere. Another, more recent factor in the popularity of alternative medicine is distrust of science. This distrust has complex roots in the interactions between science and politics but is to some extent deserved; for example, because of the way the BSE disaster was handled, and partly because of the irresponsibility of the media in their reporting of health 'scares'.

The Observer has health coverage, two pages long, in its colour supplement magazine *Life*. (This in itself is worthy of comment. In other countries, for example in France, health and science are covered properly, as if they are real news, worthy of serious comment. *The Observer* relegates medicine to nestle among the recipes and fashions of its colour magazine; *Le Figaro* devotes considerable space on its science page more than once a week.)

Just over a year ago, *The Observer* began dedicating half a page to 'an alternative look at health issues'. Its author is Stephen Russell, who calls himself the 'Barefoot Doctor'. *The Observer* is a broadsheet, not a tabloid. I like to think that what I read in *The Observer* about Afghanistan, the economy, or the politics of the NHS is at least based on facts. It has a number of columnists for whom I have great respect — Nick Cohen and Will Hutton are two. Yet they share their newspaper with a man who writes nonsense. On one side of the page in *Life* are serious medical discussions; on the other are fairy stories.

Those who read my regular column in the Back Pages of this journal may recall some of Stephen Russell's ideas of how the body works (January 2001, page 85); the ears are the flowers of the kidney, so tinnitus is a result of depleted kidney energy; memory is not so good pre-menstrually because blood is diverted from the spleen, which is the organ governing short-term memory. These are not Stephen Russell's ideas alone; they can be found in books about Chinese medicine. Every week, *The Observer* is publishing this rubbish.

After the column appeared, I sent it, with a letter of complaint, to the editor of *Life*. I wrote a short letter to *The Observer*, which appeared in their correspondence columns, pointing out that our understanding of how the body works has moved on in the last 5000 years. I enclosed a photocopy of the letter when I reminded the editor of *Life* that he had not replied. Eventually, I received a phone call from one of the editorial staff. She said they were passing my letter on to Mr Russell, and asked if that was what I wanted.

'No', I said. 'What I want to know is why you're publishing this stuff.'

'He's very popular,' she replied.

'I don't doubt that,' I said, 'but it's nonsense.' There was a short pause.

'Isn't it just another way of looking at things?', she asked.

'Yes, sure,' I agreed, 'in the same way that thinking the Earth is flat it is indeed another way of looking at things.'

The conversation was going nowhere so I accepted her offer to pass on my letter and awaited Mr Russell's reply. It was prompt, and I will quote from it.

'…a readership with even a passing knowledge of a form of medicine that has consistently proven its efficacy over the last five millennia would be evolved enough to

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essay

know that the liver is not actually a plant with the eyes as its flower. Likewise, the kidney and ears. You are of course right that if taken literally this is nonsense. [I hope] my readers are not immune to the wonders of poetry. I use these terms metaphorically.'

There is no evidence in the orthodox sense that Chinese medicine as a whole has proven its efficacy (although some of its herbs are efficacious enough that they have side-effects). The Chinese are not notably more healthy than we are. They suffer different diseases; they do not yet suffer to the same extent the diseases of Western overconsumption and of longer life expectancy. The 'evidence' that Chinese medicine works is anecdotal and self-fulfilling (if it's survived 5000 years it must be right).

I don't mind Mr Russell using metaphor. Analogy, for which metaphor is often used, is useful for explaining ideas, especially to people with no basic knowledge of a subject. When a patient is told that the liver is the power station of the body, or that the kidneys are part of a water purification system, that is metaphor. But no principle is being illustrated by referring to the eyes as the flowers of the liver. Poetry it may be; but it is nonsense poetry, which could seriously mislead given the limited understanding that many people have of anatomy and physiology.

Mr Russell goes on in his letter to say that we in the West must not become arrogant about the advances of orthodox medicine — which is true. He avers that he never denigrates Western medicine — which is also true. He does not criticise Western medicine, he writes, because he does not know enough about it to do so; he asks me to show the same respect, and ends his letter by wishing for an end to 'pointless polarising'.

I wrote back to Mr Russell. I have tried four times, politely but fruitlessly, to enter into further dialogue. He receives, according to a *Life* profile of him (8 July 2001), 30 to 40 e-mails every hour from all around the world asking for help. I don't know how many he manages to reply to, but he doesn't reply to mine.

The book shops are crammed with books on 'health fiction'. It is easy to find examples of erroneous ideas about diseases, their causes and cures. It is finding them in a serious newspaper that is especially upsetting. Perhaps it is a little unfair to pick out Stephen Russell, who writes well, sympathetically, and with good humour when engaged on touchy-feely matters of how to live life less stressfully. But 'pointless polarising' is not pointless and respect is not an option when possibly ignorant people are told that hair is controlled by kidney energy (8 October 2000); the heart controls the sleep function (29 October 2000); the kidney yin is responsible for the integrity of the knee joint (12 November 2000); plantar fasciitis is caused by blocked kidney energy constricting the bladder meridian (19 November 2000); palpitations are caused by deficient kidney chi energy not holding the heart in check (11 February 2001); the skin is influenced by the energy of the lungs and the colon (25 February 2001); skin tags on the neck are owing to the spleen not properly separating pure from impure fluids (25 March 2001); the spleen holds things up against gravity and if unbalanced causes piles (1 April 2001); vertigo arises from deficient liver energy causing weakness in the gall bladder meridian (15 April 2001); blood pressure is lowered by pressing a finger in the groove behind the ear (27 May 2001); and the energy in the body passes through a different organ or bowel every two hours (1 July 2001). Mr Russell often precedes his explanations with 'according to oriental medicine', but I could just as easily write that according to ancient Britons the nose is the cauliflower of the spleen. It would be wrong, and so is oriental medicine.

When Mr Russell explained that bed-wetting occurs because of deficient kidney energy and that acupuncture was useful (22 July 2001), a urological colleague who specialises in enuresis wrote to the Press Complaints Council. Their answer was that Mr Russell's column was clearly entitled 'An alternative look at health issues', and therefore no action was necessary. Perhaps a column titled 'A revisionist look at history issues' is next; I dread to think what may appear in it.

In the same issue of 22 July 2001, a GP, Michael Dixon, also wrote in *Observer Life* arguing the case for an integrated health service. He hopes that increased patient power, NHS resources, and vociferous advocates of integrated medicine will close the rift between the orthodox and the alternative. I do not deny that alternative therapists do a lot of good; but they do not do it because of their alternative therapies. They do it because they care, and they take time. As long as alternative medicine seeks explanations in terms of mysterious energy channels and organs governing functions over which they have not the remotest control, then melding orthodox with alternative medicine is — to use a metaphor that is entirely appropriate — like devising university courses combining astronomy with astrology. There is no place for this in the NHS, and there is no place for it in a serious newspaper.

Neville Goodman

Human frontiers, environments and disease: past patterns, uncertain futures
Tony McMichael
Cambridge University Press, 2001
PB, 413pp, £14.95, 0 52180311 X

TONY McMichael believes, as stated in the preface of *Human Frontiers. environments and disease*, that 'the health of populations is primarily a product of ecological circumstance'. In this amazing book he seeks to explain why.

What are 'ecological circumstances'? These include not only chemical and microbiological quality of air, water, and soil, but also food supplies, the capacity of environmental 'sinks' to absorb society's wastes, and climatic patterns. For example, water can be seen simply as drinking water, or as environmental sink for waste, widening the scope for what should be considered a potential determinant of adverse health effects.

McMichael supplies a broad account spanning several million years of human evolution and large numbers of human societies and their diseases. It is a unique source of information about human ecology, and successfully and powerfully makes the case that 'within the larger scheme of things, human health and survival depends on our maintaining a functional ecosphere that can continue to support human biological and social needs'.

The book is composed of 12 chapters divided approximately into three sections, dealing respectively with the evolutionary backdrop to human biology (chapters 1–3), how past changes in human ecology have affected patterns of health and disease (chapters 4–9), and how current global environmental change might affect future health and disease (chapters 10–12). Thirty-five pages of notes provide a substantial number of references for readers interested in more. The graphs and figures are clear.

The style is relaxed but succinct: I have seldom encountered a text where the essential points about disease causation were given so pleasantly and effectively given within a short paragraph. The remarkable thing is that the author does that as well as providing a new, ecological, perspective on each of the many diseases covered.

The book is valuable to three groups of people. For a general interest reader with no background in medicine, the book provides a wide-ranging but accessible review on health and its determinants, with a succession of mini-episodes on separate topics within each chapter that makes the story enjoyable. Care is taken to explain several medical terms to allow access to this type of reader.

For medical doctors, McMichael provides perspectives that may be unfamiliar. The interested general medical reader can learn about the historic and evolutionary background to what they encounter in their daily practice.

Thirdly, epidemiologists, who have traditionally thought of disease causation in linear terms, using the 'A causes B, provided C is not a confounder' type of paradigm. To them, the author throws a formidable challenge. That traditional way of thinking about disease is deeply ingrained in medical and non-medical science; it is however likely to be completely inadequate to describe the 'real' determinants of disease, such as the ecological pressures that are of such great concern to the author. It is even less able provide an evidence basis for interventions. However, to epidemiologists, the book represents an invitation to explore new methods for studying disease causation, and more than that, to develop a new way of thinking about it.

What did I like about the book? First, the range of topics covered. Several long-term perspectives on the ecological determinants of human health are provided in separate chapters on infectious diseases, food and its availability, industrialisation, demography and the population explosion, affluence and poverty, and urban living. The fact that the breadth of subjects covered does not detract from the depth of insight and the amount of detail provided is truly impressive. This could only be possible for a great mind standing from a very special vantage position: that of an epidemiologist who had been appointed to the lead chair in that

discipline in one of the institutions with the largest number of population health scientists with an international reputation in their field. The product is a compendium of the most credible among the new ideas on disease causation, combined with the outlook of the author. Another aspect I liked is the balanced judgement of the author in summarising opinions in controversial areas.

The difficulties of the book are few. One could argue that McMichael's firm belief that ecology is of primary importance in explaining human health, disguises for him the importance of other factors, such as cultural and power relationships between and within human groups. However, this is implicitly acknowledged in chapter 11, where the 'political ecology' of health is discussed in relation to current links between globalisation and environmental degradation. At times a touch of condescension filters through the polite style of the author. This is perhaps inevitable, given the great number of topics touched, and the need to synthesise so much information for the sake of the flow of the argument.

Tony McMichael has had many original thoughts about industrialisation, population dynamics, and global pressures on the environment as causes of adverse health effects. These thoughts appear to have evolved following discussions with other public health scientists at the London School of Hygiene and Tropical Medicine and elsewhere in the last eight to ten years. A crudely simplified version of his message is that 'population expansion, coupled with mindless management of consumption of natural resources, might kill the planet and the human species'. Contrary to other similar statements by others, this book says it with great wisdom and authority, and aims mainly to stimulate and educate rather than incite to action. Perhaps paradoxically, this may then lead to the most effective action by all interested in the health and welfare of human populations.

Giovanni Leonardi

How many people can the Earth support?
Joel Cohen
Norton, 1995
PB, 532pp, $15.95

In 1967, the economist Colin Clark estimated that the Earth could feed a maximum of 157 billion, at a subsistence level. In 1679, the microbiologist, Antoni van Leeuwenhoek thought our planet might support 13 billion people. Each used a similar method: extrapolating the population living in a part of Holland to the entire arable area of the globe.

This book assembles several dozen similar estimates — most put the ceiling of human population at well over ten billion (current population approaches 6.2 billion). Unlike many guesses (such as the height of Mount Everest), Cohen points out that estimates of the maximum population which the Earth can support have become more variable with time. Cohen suggests that this reflects greater uncertainty. It may also reflect subtle differences in the question.

Most estimates studied by Cohen are restricted to a literal interpretation of his book's title. They calculate the maximum human population that the Earth's arable land, water and forests can feed and clothe, but tacitly assume that humans are perfectly disciplined, perfectly co-operative and that the Earth's natural and ecosystem services will function irrespective of the degree to which nature is transformed.

Cohen's book contains much material not normally taught to demographers. For this reason alone, every demographer should read it. Estimable as it is, however, I have two concerns. Cohen is dismissive of the concept of demographic entrapment. This postulates that excessive population has negative feedback effects to the economy and society. Entrapment theory suggests that rapid population growth, in conjunction with limited opportunities for migration and exports, helps to explain the 1994 genocide in Rwanda — Africa's most densely populated nation. Supporters do not deny the importance of ethnic hatred, but suggest the civil war would have been less deadly had young Rwandese land to farm, rather than drifting, prospectless, to the city. Cohen does not mention Rwanda.

The other major omission is of complexity theory and carrying capacity. That is to say, to what extent do factors such as foresight, conflict, and the appropriation of carrying capacity by privileged and powerful populations (and hence their denial to less empowered populations) mean that actual human carrying capacity is less than that which might otherwise be possible? This is not surprising for a book published in 1995.

I look forward to the next edition.

Colin Butler

in brief

It's difficult to concentrate on a Sunday morning when *The Observer* reports on its front page that Prince Charles is to become 'a Government "design tsar"... stamp(ing) his vision of classic architecture on Britain's new hospitals.' (**http://www.observer.co.uk/uk_news/story/0,6903,573654,00.html**). For the modernists among us, such a move can only provoke anxiety. Are we to see health centres re-designed with mock-Georgian porticos? Getting the architects to deal with carbuncles, rather than simply sending them to the nurses to be dressed?

Which, if nothing else, introduces another of HRH's enthusiasms, complementary medicine, and a splendid new reference work, **The Desktop Guide to Complementary and Alternative Medicine**, edited by Edzard Ernst (Mosby, 2001, ISBN: 0-7234-3207-4). Whether we are Believers or not in complementary medicine, our patients often are, and to bury our heads in the sand and refuse to offer some intelligent opinion is probably a cop-out. Patients on cyclosporin, for example, might need to know that taking cuddly, eco-friendly St John's Wort just might lead to the rejection of their transplanted kidney, information unlikely to be forthcoming from lentil-popping herbalists. Ernst and his co-editors supply succinct and comprehensive summaries of clinical trial data, and their book (with now obligatory CD-ROM) is easily navigable. Strongly recommended. As is **Managing Osteoarthritis in Primary Care** by Gillian Hosie and John Dickson (Blackwell, 2000, ISBN: 0-632-05353-4). At last OA for GPs, by GPs — knowledgeable, concise, well illustrated, and competitively priced.

Meanwhile, before we all rush off to join Médecins Sans Frontières (page 946), read **The Dressing Station**, by Jonathan Kaplan (Picador, 2001, ISBN: 0-330-48480-4). Kaplan is a surgeon, which explains the accurate, though ludicrously portentous opening sentence — 'I am a surgeon, some of the time'. Somehow I cannot see a public health physician pronouncing thus ... but thereafter a stirring, moving, at times angry, sometimes witty tale unfolds. Adrift in the South China Sea on a rusting cruise liner beset by typhoid; watching NGOs in Kurdistan fight for the highest public profile ... impassioned prose.

Finally, the Sublime — eleven days remain to see **Masaccio: 'The Pisa Altarpiece'** (until 11 November 2001) at the National Gallery in London (admission free), celebrating the 600th anniversary of the birth of Masaccio by reuniting the National Gallery's 'Virgin and Child', the main panel of his 'Pisa Altarpiece', with surviving fragments from collections in Berlin, Los Angeles, Naples, and Pisa.

And the Ridiculous. Readers in search of a bargain, should consult Justerini and Brooks' autumn bin-ends (tel 0207 484 6400), and half price **Chateau d'Yquem, 1er Grand Cru Classe, 1985**. Twelve bottles reduced from £1500 to £750. Only one slight problem — all 12 bottles are contained within one bottle, an Imperial. Yes, one six litre bottle! At exactly what sort of party do six litres of exquisite dessert wine require to be sunk, all at once? Answers to the AUDGP ...

Alec Logan

The feeling of what happens:
body, emotion and the making of consciousness
Antonio Damasio
Vintage, 2000, PB 385pp, £8.99, 0 09 928876 1

The private life of the brain
Susan Greenfield
Penguin Books, 2000, PB, 258pp, £5.99, 0 14 026491 4

CONSCIOUSNESS and, correspondingly, a sense of self, has always been a somewhat elusive concept to scientists. Historically it has been left to philosophers to attempt to identify how it is that we actually feel things and what that may be like. But in the 21st century, with huge advances in neuroscience, in particular with imaging techniques that show us in fine detail some of what happens within the brain, we find ourselves drawn in to the deepening mystery of how we feel what we feel.

The development of emotion is one of the characteristics that is believed to set human beings apart from other animals. Awareness and comprehension of emotion is one skill that general practitioners often use in their everyday practice of the art of medicine. In order to experience emotion, human beings have developed their consciousness to a higher level than other animals.

But how has this development taken place? Antonio Damasio, a leading professor of neurology, outlines his thinking on the way in which our consciousness has evolved to enable us to experience the feeling of what we feel. In a magnificent and complex book, *The Feeling of What Happens*, Damasio outlines his current state of understanding about the concept of consciousness by drawing on work from developmental biology, psychology, neurology and neurophysiology and continues by exploring the evidence on the biology and neurology of knowing and consciousness. He develops his thinking in a methodical and meticulous way, at times repeating complex arguments in differing ways to ensure understanding by the reader. His language is rich and clear, which makes reading about the complexities of the workings of the human brain more pleasurable than I ever remember at medical school! The use of case studies illuminates many of the more fascinating theories.

Understanding the differences between varying levels of consciousness allows us to learn how it is that we not only feel emotions but how we feel the feelings that accompany them.

This is not a book for night-time reading but it will draw you in time and again to enlighten understanding in this most complex of human activities.

Susan Greenfield, in *The Private Life of the Brain*, adopts different but complementary strategies to illustrate this peculiarly human experience. She skillfully weaves into her text concepts as apparently disparate as the thoughts of children, drug misusers, schizophrenics and all of us as we dream. She questions the similarities between differing triggers to emotion — 'the softest whisper telling you that you have cancer', 'a small smile from a lover across a room' or the sudden unexpected death of someone you love. All of these and many more precipitate a symphony of chemical and electrical activity across the brain in the blink of an eye that gives us the feeling of emotion. But how?

By describing 'the story so far' and illustrating it with references to seminal works of the past, Greenfield leads us into an understanding of the development of a child's world and that child's developing consciousness and emotion. By using examples where the mind is significantly altered by drug taking (alcohol, cannabis, LSD, ecstasy, and morphine) we can begin to understand something of the intricate complexities of brain functioning. Susan Greenfield advances her theory by exploring the state of dreaming and the experience of depression before concluding with a fascinating chapter on 'the human condition'. Her conclusions are not really conclusions as such, rather an indication of what may be more fruitful ways to progress in our search for an understanding of emotion. She ends the book with a chapter on the reality of a neural correlate of consciousness that is more difficult and less readable than the book as a whole.

Some of us who work in situations where dealing with strong emotion is part of what we do are often challenged by those emotions. The key concepts of this book however are that mind, self, and consciousness are all closely intertwined — 'emotion is the most basic form of consciousness and … minds develop as brains do — both as a species and as an individual starts to escape genetic programming in favour of personal experience-based learning'. As the mind evolves and we understand the things that we experience more fully, so we then gain increasing control over what happens to us. 'All the time, experiences leave their mark and in turn determine how we interpret new experiences.'

Individually, these books investigate differing aspects of similar phenomena and taken together they build a fascinating awareness of present understanding of the purpose and experience of emotion — perhaps a key component of what makes us who we are.

Rod Macleod

Overheard in Barcelona...

at the Third International Congress on Biomedical Peer Review, September, 2001...

"All sentences that begin with 'We' are lies."

Simone Weill
quoted by Richard Smith, *BMJ*

"I am an editor. If you want to complain about that sort of thing [editorial decisions], then see a psychiatrist."

Drummond Rennie, *JAMA*

"To consult a statistician after an experiment is finished is just to ask him what the experiment died of. He is being asked to conduct a post mortem."

RA Fisher, quoted by Doug Altman

"If you had a drug called 'Peer Review' and you took it to the FDA, they'd laugh at you."

Drummond Rennie, *JAMA*

The epidemiology of tantrums

It is sad, but, once you begin to think like an epidemiologist, you cannot stop. The whole world is perceived in terms of case definitions, exposures, outcomes, and the validity of their measures. Your constant effort to eliminate bias and adjust for confounding leaves you exhausted at the end of a standard day, broken down by age (damn, there I go again).

I was recently on holiday with friends whose family included two-year-old twin girls. Their 'terrible twos' were typically tainted by tantrums, causing me to muse on the incidence of these events in comparison with singleton two-year-olds, and the impact on parents. I noted that, when one twin had a tantrum, the other joined in, thereby doubling the severity of each tantrum. I hypothesised that each twin would initiate, on average, a standard frequency of tantrums, and therefore that the total impact of tantrums — the tantrum factor — would be squared rather than doubled for parents of twins (and cubed for triplets). Combined with the general parental observation that the seriousness of the tantrum is inversely proportional to the seriousness of the event that precipitated it, this can be expressed as:

$$T = \frac{kn^2}{s}$$

where T is the tantrum factor, n is the number of two-year-old siblings, s is the seriousness of the precipitating event (range = 0–10), k is a tantrum factor loading, dependent upon the attitude of the parents, range = 0–1, such that 0 = absolute relaxation, and 1 = absolute tension.

On proposing this formula to my twin-rich friends, they suggested grimly that further refinements were required to allow for parental sleep lost during the preceding night, time since the child(ren)'s last feed and whether both parents were available to manage the tantrum experience. In turn, my suggestion that the tantrum loading factor (k) was related to both the number of previous tantrums expressed by the child(ren) and the average impact of these, was approved. After several workings, my current proposal is therefore:

$$T = \frac{[2n_1^2\,(k + p - 1)] + h}{n_2 s}$$

where n_1 is the number of two-year-old siblings, n_2 is the number of parents available, p is the total number of hours of parental sleep lost the preceding night, and h is the number of hours since the child(ren)'s last meal

and:

$$k = \frac{\Sigma\,(T_i - \bar{T})^2 + 1}{n_i}$$

where T_i is any previous value of T, $\bar{T}$ is the average of all previous T values, Σ is the sum of these calculations, n_i is the number of previous tantrum events, and 1 ensures that the value is always greater than 0 ... with the rule that, where $n_i = 0$, $k = 1$.

Research suggests that standard conditions might be: one two-year-old; first tantrum event; four hours' parental sleep lost the previous night (two hours per parent); two hours since the child's last meal; both parents available; average seriousness of precipitating event (s = 5). Under these conditions, with the above formulae, T = 1.0. This strikes my epidemiological perception as a reasonable standard. If twins are present instead of the standard singleton, T = 3.4, an appropriate modification of my original squared hypothesis, and a basis from which to observe the natural tantrum history during my holiday. As conditions deteriorate, T will tend to increase arithmetically for singleton two-year-olds, but geometrically for twins. Furthermore, while experience of previous tantrums has a modifying effect with singletons, the opposite is found to be true with twins. On the second tantrum, with twins, two hours later (with no intervening food), the same precipitant but only one parent present, T rises to 7.0. Prolonged starvation and further tantrums take their toll, with T rising to 23.2 two hours later (Table 1). If both parents had been available, T would be halved in each case.

Comparison with singleton two-year-olds is shown in Table 1. Although the original observation was that twins' tantrums' impact approximately squared the singleton equivalent, allowance for other variables may increase this effect exponentially.

Table 1. Comparison of tantrum factors (T) for singleton and twin two-year-olds under varying conditions.

	Singleton	Twins
(1) Standard conditions (see text)	1.0	3.4
(2) 2nd tantrum, 2 hours after standard, one parent*	2.2	7.0
(3) 3rd tantrum, 3 hours after standard, one parent*	2.1	11.4
(4) 4th tantrum, 4 hours after standard, one parent*	2.3	23.2
(5) As (3), but with both parents	1.1	5.7
(6) As (4), but with both parents	1.1	11.6

*other conditions as standard

These observations will permit the standardised measurement and comparison of parental trauma secondary to children's temper tantrums across a range of conditions. Unfortunately I ran out of graph paper during our holiday. Furthermore, the beach subsequently represented a more valuable use of this epidemiologist's time.

Management of Drug Misuse in Primary Care Programme

THE RCGP is launching its Certificate in the Management of Drug Misuse training course with three pre-masterclass conferences. The conferences are being held for GPs who wish to be trained at intermediate level in drug misuse and who have already signed up for the course.

The one-day pre-master class conferences will be held in London, Leeds, and Bristol on 16, 18, and 31 October 2001. The Certificate course, funded by the Department of Health, will cover five full days of study spread over a period of approximately six months. The pre-master class conferences will cover the basics of drug misuse for the 400 GPs and 60 prison doctors who have registered.

Each pre-masterclass will follow the same format and will cover many different areas of drug misuse. The morning session will look at the epidemiology and natural history of drug misuse, drug prevention and harm reduction and the afternoon session will focus on drug misusers in different situations, such as pregnancy and being in prison. Leading speakers include Professor John Strang of the National Addiction Centre, Dr Duncan Raistrick of Leeds Addiction Unit, and Dr Mary Piper of the Prison Health Policy Unit.

Funding is being made available, from the Department of Health, to allow for protected time for the candidates and trainers to undertake the training, and to ensure time to undertake the course assignments. A bursary will be received by all GPs undertaking the course.

The course will continue, through master classes and assignments, to cover areas considered to be core skills and knowledge at an intermediate level. It is being delivered using local networks of over 40 GP trainers who have already demonstrated that they operate at intermediate or specialist level. Each of these GP trainers will train up to 10 candidates, and each has received training to ensure consistent standards are maintained and that the content follows the designed curriculum.

The course has been set up to develop a core of GPs in the field of management of drug misuse to enhance the provision of services to patients. The key aims of the programme are to enable GPs to fulfil the aims of treatment as outlined in the DoH document *Drug misuse and dependence: guidelines on clinical management*; develop the role of GPs in local strategic planning and commissioning; and improve standards in primary and secondary care.

For more information contact the Course and Conferences Unit tel: 020 7581 3232

Down their Drink An online package for excessive drinkers

IN the UK, it is estimated that 27% of men and 13% of women currently exceed sensible drinking levels and are at risk of becoming 'problem drinkers'. When problem drinking is identified, usually at a health check or a health screening, the traditional treatment options offered to patients until now have been limited to counselling from either their doctor or an alcohol counsellor. For many problem drinkers, the prospect of discussing their private drink problem with anyone is often deeply unappealing and not taken up. For them, an effective self-help alternative may be more attractive and present a better chance of success.

In October **www.downyourdrink.org** — a new online self-help programme, for anyone concerned by their drinking — was launched at the Alcohol Education and Research Council Annual Seminar. The 'Down Your Drink' website provides an interactive programme which aims to help problem drinkers develop safer drinking habits. The website is confidential, free of charge, and accessible 24 hours a day from any PC connected to the Internet. The course is based on the latest, proven practical methods to reduce drinking as recommended by leaders in the field and takes less than an hour a week, for only six weeks. Programme members set their own drinking targets, decide when and where to complete the programme, and receive individual feedback. Importantly, information is provided in a non-judgemental format, and to ensure confidentiality, members choose their own alias user name just for the programme; they are not required to surrender their private personal details.

Limited user surveys of Down Your Drink are encouraging: patients particularly liked the self-assessment questionnaires, the 'drinking genie' which calculates alcohol consumption and expenditure on drink automatically, as well as the light-hearted 'Cyber Saloon', where members can take a well-deserved break from the programme.

The programme has been developed by clinical psychologist Stuart Linke and Paul Wallace, a professor of primary care — a leading specialist in the use of telecommunications for delivering new modes of health care. The website is fully funded by the Alcohol Education and Research Council. With the increasing popularity of websites like NHS Direct, it is hoped that doctors will add www.downyourdrink.org to their list of websites they wish to recommend to patients.

For more information or to obtain leaflets about the programme you can visit the web-site, or telephone: 0207 530 2378 or email: info@downyourdrink.org

The 7th London Workshop on Evidence-Based Health Care

This popular one-week workshop, which will use small group teaching methods, and will be held at a conference centre in Central London from 8–12 April 2002. It will offer three separate tracks (Yellow track: Learn the basics; Green track: Develop and share teaching resources; and Red track: Managing change for effective clinical practice).

For further details see the website **http://www.ucl.ac.uk/open learning/training/**

For fliers or an application form please email the course administrator, Marcia Rigby on **ebp@ucl.ac.uk**

Places will be strictly limited to ensure high quality small group teaching so please apply early to be sure of a place.

Trish Greenhalgh

neville goodman

PFI

MR Blair has taken no notice of my letter (Back Pages, July 2001). When Professor Allyson Pollock published a series of articles in the *BMJ* in 1999 describing the ill effects of the Public Finance Initiative (PFI) on the NHS, Tony Blair dismissed them. Only the first of the articles had appeared, but no matter. Tony was not going to let 'ideology' (his way of describing Pollock's carefully reasoned evidence) stand in the way of modernisation of the NHS.

Mr Blair gave a speech at a London hospital in July, and his position has not altered. Immediately after extracts from his speech were broadcast on Radio 4's *PM* programme, the BBC interviewed Professor Pollock. Her criticism was scathing. Blair's statements lacked any substance; they were generalisations without any hard facts about how his ideas were to be achieved. Wherever PFI was introduced, private profits were made at the expense of the provision of service. Glib talk of using the private sector is a nonsense when there are only 10 000 beds in the private sector, but New Labour's stewardship of the NHS has seen the closure of 12 000 beds in the public sector. PFI always means contraction of service, and worse terms and conditions of service for staff. To realise the reality of PFI, said Professor Pollock, all one had to do was repeat 'Railtrack' to oneself a few times.

Mr Blair is forever spouting the mantra that ideology is no longer important; all that matters is whether it works. He's wrong. First, it's not just whether it works but how it works. Slavery worked quite well for the slave owners, but the correct ideology won in the end and slavery was abolished. Second, whether PFI works is uncertain; how else could there be so much discussion and disagreement? So Mr Blair's unswerving pursuit of PFI is ideological.

Perhaps Mr Blair's next move will be to silence Professor Pollock. Bob Kiley, the New Yorker brought in by Ken Livingstone to sort out the London Underground, (an American, note) is firmly opposed to private involvement. Kiley has been sacked and an injunction taken out to prevent him speaking about two recent reports critical of private–public partnership on the Underground. Perhaps Professor Pollock had better submit her future writings to US journals.

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Paternalism

paternalism *n*, a system or tendency in which provident fostering care is apt to pass into unwelcome interference.

Chambers 20th Century Dictionary

MODERN vocationally trained GPs rush to denounce the spectre of paternalism, with its overtones of 'Daddy (doctor) knows best'. But we are loathe, and rightly so, to hand over complete responsibility to patients, thus delegating our professional judgement and taking no part in the selection of treatment options.

Informed shared decision making is the mantra of choice: the middle way (more Buddhist than New Labour, though). Perhaps being a woman I find it harder to adopt a paternalistic stance, although I am sure my male colleagues will object that they are all able to get in touch with their feminine side when necessary. I hate being put on the spot: 'Well what would you do, doctor?' This question usually arises when HRT is being discussed (I am too young to have a personal preference), immunisation (sorry, no children) but thankfully not vasectomy (you'd have to ask my husband and he won't come within two miles of the surgery if he can help it). Sorry, the game plan is that I list the options, the pros and cons of each, your risk of developing *x, y* or *z*, if you do A, B or C or don't take M, N or O. This takes about eight minutes. You have one minute to choose and that leaves me one minute to write a prescription or 30 seconds to ask about your holiday and 30 seconds for you to ask about mine.

Funnily enough, I like this game.

However, there are times when a surge of testosterone rushes through my organs and I find myself telling patients what is going to happen. Reflecting on this, as all good GPs in possession of a Personal Development Plan do, I have realised that my dictatorship almost always arises from a situation where hospital admission is desirable from my point of view and unbearable from the patient's. The situations are such that a period of discussion, mulling over and follow-up is not feasible. If I acted on the patient's wishes, I would also be adhering to the government's agenda of fewer hospital admissions. But there I go again, ordering an ambulance, advising on a take-in kit and mumbling the platitudes of 'You'll be home again soon, it's only for a few tests and you'll be a new person when you come out'.

The last two patients whom I decided unilaterally to admit, both died. Now you could deduce from this that I was therefore right to send them in in the first place; they were obviously very sick people. Or you could be unkind and suggest that yes, they were ill, but hospitals being the unhealthy places they are, the patients had no chance of survival once they had been removed from their own terrain.

Taken to the extreme, paternalism leads to enforced admission for mental health problems. Patients who are sectioned are deemed in some way to be at risk to themselves or to others while being incapable of making informed decisions themselves. In these interactions the hand of the paternalistic doctor is held and guided by a social worker. Still, it is a process that rightly makes many GPs feel uncomfortable. As someone said to me recently regarding compulsory treatment: It's not the *compulsory* that is objectionable, but the *treatment.* (Any objections to compulsory aromatherapy?).

As GPs we are pulled in many directions. Some parents make an informed decision not to have their children immunised. Doctors cannot control the information on which a decision such as this is based. Selective information giving is a sneaky way of retaining authority. But trust your patients to find the missing link, and remember — if the patient disobeys you, can't ground them for the rest of the week.

the Back Pages in 2002

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