reviews

BOOKS • CD ROMS • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS • MINERVA

ART

The Time of Our Lives

Exhibition at the New Museum of Contemporary Art, New York, until 17 October

Situated at the lower end of Broadway, where it runs through NoHo and SoHo (north and south of Houston Street, respectively), the New Museum of Contemporary Art is currently hosting two exhibitions, one of which is purportedly concerned with ageing. Specifically, it is meant to remind us that we will all grow old (if we are fortunate) and that older people are disenfranchised by modern society; more specifically, by modern Western society. The catalogue essays are replete with intimations of ageing that the curators have detected in themselves (such as “elder moments,” when one loses track of what it was one wanted to say), and more alarmingly, of ageism, reified in the attitudes portrayed in soap operas towards comic elders, who send themselves up whenever they are centre stage.

From this premise, we are treated to projects in which high school classes read to camera about the pathophysiology of osteoporosis and calcium metabolism;

The Giant, 1992 by Jeff Wall

The Personals: Improvisations on Romance in the Golden Years, 1998 by Keiko Ibi

rather voyeuristic interviews with infant school children asked about their grandparents' deaths; and numerous black and white, life size (and larger) photographs of elderly people with their kit off. What does it all mean? The stated aim of seeing a nude “elder” is that it forces the viewer “to confront images of ‘elderly’ nude bodies as perfectly natural, graceful, and elegant rather than as something hidden, deemed unworthy of consideration, and therefore banished as the subject matter of art.”

There we have it; Lucien Freud and Rembrandt missed something after all. The problem with this show is that, although the aim is admirable, most of the work is unremarkable. Once a nude photograph has been used to make a point in and of itself there seems little else to do but to walk on. However, the curation has been so idiosyncratic that there are works that have crept in which seem more concerned with the passage of time, rather than “age,” and these pieces hold the attention.

Bruce Cannon has created a cast iron clock, antiquated in design but inlaid with a LED, which can be programmed to count off the time to its owner's death (on the basis of its being programmed with actuarial statistics). Cho Duck Hyun, a Korean artist, has produced a series of works entitled “Genealogy,” comprising large framed canvases in which the canvas continues flowing onto the floor, like a bridal gown. Within these frames are portraits in graphite, drawn in such detail that they look like photographs, with a sepia

hue. They seem to be of families at weddings and other special times in their lives, but, in fact, the protagonists were alive at different times and are of different ethnicities: Koreans, Chinese, and Japanese. The artist pays homage to the family structure and, in creating fictitious genealogies, exerts some reparation over the divisions in his culture. This is exquisite work, beautifully executed and compelling, and is reminiscent of Christian Boltanski's anonymised photographs of the “Dead Swiss.”

On the theme of death, the outlier in the exhibition must be a small work by Ida Applebroog, “Marginalia.” This oil on canvas seems to be the pages of a notebook, with names and dates of birth, obviously skewed, and continuing beyond the picture surface. The curators argue, disingenuously, that this work is relevant as it is about those “not given the opportunity to grow old.” In fact, the text is taken from a notebook kept at the Mauthausen concentration camp. It is a moot point whether the holocaust can be addressed through art, but this small canvas throws into stark relief much of the trivia that surrounds it. Most of all, it brings to mind other depictions of frail, naked bodies, unencumbered by the vicissitudes of “elder moments.” As one of the wall panels reminds us, “Do not resist growing old—many are denied the privilege.”

Sean A Spence *De Witt-Wallace research fellow, Functional Neuroimaging Laboratory, New York Hospital-Cornell Medical Center, New York*

Surgical Emergencies

Eds John Monson, Kevin O'Malley

Blackwell Science, £75,
pp 448
ISBN 0632 050 470

Rating: ★★★★★

The past two decades have seen rapid advances in the diagnosis and treatment of surgical emergencies. These can be accounted for by both technological progress and conceptual developments. Examples of technological advances include the inroads of laparoscopy, previously the monopoly of gynaecologists, into general surgery and the expanding field of radiological imaging. Conceptual progress may initially seem less dramatic but is perhaps even more important. It has taken several forms, such as the better definition of old entities—for example, the systemic inflammatory response syndrome (SIRS) or the new terminology describing the local complications of acute pancreatitis—and the challenging of traditional dogma—such as non-operative management of severe liver injuries or gunshot wounds of the abdomen.

Of course, technological and conceptual progress are closely interrelated and impact on each other. The distinction between infected or non-infected pancreatic necrosis would have remained clinically meaningless without the technique of image guided fine needle aspiration of the necrotic tissue and bacteriological analysis. Overall, progress in

the management of acutely ill (or injured) surgical patients is to be measured, at least partially, not in how much less aggressive we have become but how much less invasive, sparing our patients dangerous diagnostic procedures or unnecessary operations.

This book has certainly succeeded in each of its chapters in accounting for the modern developments in surgical emergencies and trauma. Of course, one could disagree with the occasional (usually small) point. This is a reflection on the persistence of controversies in surgery despite the steady advance of evidence based medicine. I was particularly impressed by the book's appropriate blending of sound and trusted clinical principles with advice on how best to investigate and treat a given clinical situation, at a time when options have been multiplied and complicated by refinements in technology. The chapters on trauma have refreshingly transcended the basic approach taught in the advanced trauma life support (ATLS) programme and provide useful algorithms even for the practised surgeon. The illustrations (photographs and drawings) are of an extremely high standard.

Roger Saadia *professor of surgery, University of the Witwatersrand, Johannesburg, South Africa*

The BMJ Bookshop will endeavour to obtain any books reviewed here. To order contact the BMJ Bookshop, BMA House, Tavistock Square, London WC1H 9JR.
Tel: 0171 383 6244, Fax: 0171 383 6455
email: orders@bmjbookshop.com
Online: www.bmjbookshop.com
(Prices and availability subject to change by publishers.)

WEBSITE
OF THE
WEEK

Douglas
Carnall
BMJ
dcarnall@bmj.com

Randomised controlled trials This week, a series of four articles considers the place of the randomised controlled trial as we approach the second century of experience with the concept. Its basic principle is genuine uncertainty as to which treatment arm of the trial it would be in a patient's best interests to enter. This is not necessarily an easy concept to transmit, but obtaining patients' fully informed consent for a trial necessitates doing so. The world wide web can help with resources to inform patients' decision at this time. At 207.121.187.155/NCI_CANCER_TRIALS/zones/Booklet/index.html is a web leaflet for patients that explains what a clinical trial is and discusses some of the issues that must be considered before informed consent can be given (or obtained).

One of the uncertainties that used to dog investigators is now hopefully of only historical interest: the question of possibly relevant trials done and then lost, with the results buried in the grey literature or in obscure journals. The various initiatives over the past decade to register trials at an early stage and thus avoid publication biases are now starting to bear fruit. Once you get past the Current Controlled Trials' registration page at www.controlled-trials.com/ (free, but irritatingly slow last Friday afternoon), you enter a database of databases that register the start of controlled trials. By keeping the required minimum dataset small, the site's owners have succeeded in obtaining information from several sources, including the UK National Research Register and the MRC's own register of research in progress, and the site claims to be highly automated in the way it draws its data from the underlying sources. With this, and access to the meta-analytic activity of the Cochrane Collaboration (www.update-software.com/ccweb/cochrane/revabstr/ccabout.htm), it should become easier to be confident that proposed new research does not duplicate the old.

BOOKCASE

● Opinions about attention deficit hyperactivity disorder are polarised. In the Christmas edition of the *BMJ* Steven Rose argued that it was little more than diagnostic neologism—an example of the medicalisation of everyday life. G D Kewley, author of **Attention Deficit Hyperactivity Disorder. Recognition, Reality and Resolution** (LAC Press, £12.50, ISBN 0 9534748 01), on the other hand, has no doubts that it is a medical condition with a biological rather than a social explanation and that people with it benefit from treatment. Whether you agree with him or not, he has certainly succeeded in explaining his views clearly.

● Most clinicians will know from their own experience how new techniques for characterising DNA have improved diagnostic precision in many human genetic diseases. But the social, ethical, and psychological consequences of developments in molecular genetics are only slowly being appreciated. **The Troubled Helix: Social and Psychological Implications of the New Human Genetics** (T Marteau and M Richards, Cambridge University Press, £18.95, ISBN 0 512 58612 7) explores these issues in some depth. First published a couple of years ago, it is now available in paperback.

● Forty per cent of men over the age of 70 have prostate cancer, but there is still no consensus about how they should best be treated. **The Treatment of Prostate Cancer—Questions and Answers** (Available free from Covent Garden Cancer Research Trust, ISBN 0 902166 72 7) has been written for patients and frankly explains the uncertainties and risks associated with different treatments. It is clearly written, and many sufferers should find it helpful both in reaching an informed decision about which treatment to opt for and in knowing what to expect.

● The excretion of small amounts of albumin in urine is associated with increased risk of both renal and cardiovascular disease, especially in patients with diabetes. **Microalbuminuria: Biochemistry, Epidemiology and Clinical Practice** (P H Winocour and S M Marshall, Cambridge University Press, £37.50, ISBN 0 521 45703 3) attempts to summarise the formidably large literature on the subject in a traditional narrative way. Diabetologists will be most interested in the chapter on management, although I can't help feeling that a systematic review and meta-analysis of the many small randomised controlled trials might have led to more definite conclusions than those offered by the authors.

Christopher Martyn *BMJ*
cmartyn@bmj.com

PERSONAL VIEW

Self regulation at work: a case study

Professional self regulation is besieged. Reports of fraudulent, or incompetent, doctors appear almost daily. Even the General Medical Council's mantra, "Protecting patients, guiding doctors," suggests that patients need defending against doctors intent on harming them. Headline abuses of medical privilege do occur, yet there is danger in denouncing self regulation without recognising its strengths.

WH is deaf. He is a 40 year old job sharing principal and a general practitioner trainer. He probably became deaf as a teenager, but his deafness has become a practical problem only within the past few years. His deafness is moderately severe with a loss of some 100 decibels. Even with powerful bilateral hearing aids, much of his hearing is visual.

How can a deaf general practitioner practise? Differently, is the answer. Despite high technology, telephone conversations are impossible, so all calls go to his secretary, and those requiring a personal reply are made using her as a third party. Lip reading is a major part of his communication, ensuring maximum eye contact throughout the consultation; no notekeeping can be done until afterwards. Even the patient's "dreaded list" is welcome. Home visits present no additional problem; he can organise hospital admissions by returning to the surgery to make a joint phone call. Night time work, so telephone-intensive, is no longer possible. WH makes no attempt to hide his deafness, and patients are remarkably positive about it.

But is he safe to practise? Denial is so easy, but a throwaway comment from a respected source to WH's wife—"I'm surprised WH can work with his level of hearing"—meant that denial was no longer possible.

"Most doctors who become ill can deal with the problem themselves, with the support of colleagues where necessary," advises the GMC. So far as WH could judge, his performance was safe; and he had adjusted his working arrangements to accommodate his deafness and protect his patients. But he retained a nagging worry, not that he was unable to hear heart or Korotkoff sounds—for he can—but that he might miss a vital sentence during a consultation, the clue to an important diagnosis. The only valid test of this would be direct observation by another experienced general practitioner, preferably a trainer experienced in assessment.

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email editor@bmj.com

Communication was always adequate and mostly excellent

"Doctors are responsible for maintaining ... their standard of performance.... They should be prepared to take some joint as well as personal responsibility for their own and their colleagues' work," is the GMC's advice. Some colleagues could be discounted as having too close an interest in the result, such as partners in the practice, WH's own general practitioner, or close medical friends.

NB is a 45 year old full time principal and a trainer in the same city. He has received training as an assessor for the new GMC performance procedures. To WH he was on that borderline between acquaintance and friend, allowing WH not to be observed by a stranger, but also allowing NB to be impartial.

A chance meeting, a blurted out request, and a few tears set the process in train, followed by a proper meeting to establish ground rules. NB contacted the GMC health section and a specialist in occupational medicine, and this resulted in some practical suggestions. These included documenting the problem areas for WH, and how they could be compensated for; considering engaging a stenographer at practice meetings for real time transcription; and informing the health authority of the measures taken so far.

For NB to observe WH we selected a routine surgery. Patients were asked permission at the time of booking their appointment. NB made notes specifically on the impact of WH's deafness on each consultation. We then identified patients he might find particularly difficult: very elderly people, depressed people, those with a speech impediment, and those with a mental handicap. One patient from each category was invited to a second surgery. In each session NB's judgment, based on objective criteria developed for the GMC performance procedures, was that WH consulted safely. NB also telephoned WH's partners to identify concerns they may have been unable to express to WH. This has been fully documented.

Self regulation can work. Cynics may say of us that one doctor conspired to hide another's incapacity for work. Rather, we regard it as a necessary exercise in assessing a potential risk and a rewarding chance to offer help to a colleague with a problem. Furthermore, local self regulation can be more searching than external procedures. A general practitioner whose performance has been questioned would not be directly assessed in a joint surgery, yet our circumstances allowed us to apply such a discriminating, albeit threatening, test. Self regulation has strengths. We discard it at our—and the public's—peril.

William Hamilton, Nicholas Bradley
general practitioners, Exeter

SOUNDINGS

Luvvies' guide

Damon Seerewij is a renaissance doctor. His exhibition of abstract medical art opened recently at the Galerie La Vage in Paris, but his day job is professor of molecular umbiloscapy at the University of Palm Beach. Author of more than 200 papers and a syndicated column, he recently converted to Buddhism.

Who was your most influential teacher? Hippocrates. Everybody knows his name, but only a few of us have read him in the original Greek. I love his sly sense of irony.

Which event has had most effect on your work? The birth of my daughter. Suddenly, life clicked. I think of that moment every time I email a paper to a journal. And I take the video whenever I travel.

What would be your advice to a newly qualified doctor? Forget everything they taught you. Look, live, paint, weep, think.

How do you relax? I swim with a friend who happens to be a dolphin.

What is your favourite film? "A night at the opera." I see myself as a fusion of Groucho and Harpo, while Margaret Dumont personifies the medical establishment.

What is your greatest fear? Losing my humility.

What are you currently reading? Nietzsche's *Die Geburt der Tragödie*, *Unzeitgemässe Betrachtungen* and *Menschliches, Allzumenschliches*.

What is your greatest regret? Not learning German.

What alternative therapies have you tried? Did they work? I regularly practise yoga but I see it as mainstream. For me, aspirin is alternative. I tried it and it didn't work.

What is the greatest love of your life? After my daughter, the Angkor Wat in Cambodia—its serenity started me on the road to Zen. My wife will kill me for that answer but I'll be reincarnated as her husband.

What is your worst habit? Quoting too much from Jackson Pollock when I lecture on molecular medicine. Audiences just don't get it.

How would you like to die? There's no need to threaten me. If you don't like pretentiousness just turn the page.

James Owen Drife professor of obstetrics and gynaecology, Leeds