reviews

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

Snake Oil and Other Preoccupations

John Diamond

Vintage UK, £7.99, pp 285
ISBN 0 099 42833 4

Rating: ★★★★★

Every doctor in the country should mourn the passing of columnist John Diamond, who died of oral cancer in March. Not only was he the scourge of the charlatans in the alternative medicine industry, but he was also the champion of today's embattled medical practitioners, who cannot open a newspaper without reading of yet another heinous crime or error perpetrated by one of their colleagues.

"We used to like doctors," he says in this book published posthumously last month. "But that was in the days when there was some communal respect for people who knew things we didn't. Now all such esoteric

knowledge is regarded as suspect, as somehow unjust. If knowledge is power and power should, in a democracy, be in the hands of us all, then it follows that knowledge should be in our hands too. Except that—wouldn't you know it?—knowledge and skills are so terribly hard to acquire. It takes years stuck away in libraries..."

Of course, Diamond cannot help bringing into this defence of the medical profession a reference to his hobby horse—his contempt for the promoters of untested alternative remedies. He points out that the only ones who benefit from all the media scaremongering about doctors are the alternative quacks: "the medical democrats whose knowledge is so basic you can find it all in a Teach Yourself book at the local Waterstone's."

For those who despise alternative medicine, this book is a gold mine. It starts with six chapters of a book on complementary medicine that Diamond was writing when he died, which comprehensively takes the system apart. It also contains numerous revealing anecdotes about the "cynical charlatans (or honestly foolish dreamers) who prey on gullible unfortunates," as Richard Dawkins says in his foreword. No anecdote is more telling than that of the kinesiologist, who agreed to subject his treatment to a double blind

controlled trial, and who, when the trial showed it didn't work, exclaimed: "You see, that is why we never do double blind testing any more. It never works." Since he "knew" that applied kinesiology worked, and the best scientific method showed that it did not, there was obviously something wrong with the scientific method.

But the book will also appeal to more general readers because it also contains a collection of some of Diamond's funniest and most poignant newspaper columns, from the *Times* magazine, the *Sunday Telegraph*, the *Jewish Chronicle*, and *She* magazine, which cover such subjects as sex addiction, middle age, nannies, and selling roses on the Cromwell Road.

The combination is an odd, but stimulating mixture of polemic and frippery. In a touching introduction to the book, Diamond's brother-in-law, Dominic Lawson, editor of the *Sunday Telegraph*, reveals that when he went into Diamond's study the day after his death, he found that his computer was still switched on and the last words of the sixth chapter of his book were on the screen. "Let me explain," the words said. Tragically, he was never given the chance to do so, but this book ensures that his guns are not silenced. See *Personal view* on p 291.

Annabel Ferriman *BMJ*
aferriman@bmj.com

Diamond is forever

A Lump in my Throat, BBC 2,
Sunday 15 July at 9 pm

The John Diamond cancer industry rolls on, with a little of what Diamond himself called "a squalid and self-referential cynicism." First the newspaper column; then the book *C. Because Cowards Get Cancer Too*, the television documentary, and the stage play; and last month, posthumously, another book (about alternative medicine) and a television dramatisation.

When Diamond, already an award winning journalist and broadcaster, first discovered a lump in his throat in March 1997, he wrote about it in the *Times*, in the entertaining but often trivial regular column that at that time went under the banner "Something for the weekend." After the lump turned out to be

a cancer he wrote column after column about it—and his—progress.

In 1999 the writer and radio and television producer Robert Katz got the idea of reading some of the original columns on stage. Victoria Coren adapted the material, and in February 2000 Katz performed it in the 50 seat Grace Theatre above the Latchmere pub in Battersea Park Road, south London.

Now Coren has devised a new version for television, using some material from the original play and some from the 1999 television documentary, fragments of which were interspersed in the dramatisation. But whereas Katz simply stood in the theatre reading rather than performing, on television Neil Pearson, as Diamond, enacted the material with a mixture of straight to camera and voice over, aided by sundry other actors and extras. And whereas Katz's stark rendition let nothing stand between Diamond and the audience, the television dramatisation intrusively interposed itself, turning verisimilitude into verismo. For instance, when Diamond recounts an argument with a nurse, during which she said

that she appreciated his anger and heard his shouting, we understand that she said nothing of the sort, but that Diamond is using artistic licence to paint a picture of her placatory attitude; when, in the dramatisation, we hear an actor actually say the words, we begin to wonder how much is true and how much fictional. In another telling detail, the actor playing Diamond's doctor looks forbidding and wears spectacles to match; in the documentary his original does not. Of course, as I have suggested elsewhere (*BMJ* 2000;321:1599-1602), there is probably as much fiction in autopathography as there is autobiography in fiction, but Diamond's style is so vivid and immediate that on the page you think you can distinguish the two, whereas on the screen it was doubtful.

Of course, if it helps support people with cancer and enlighten the rest of us, that is all to the good. But in the end this amusing dramatisation did not give me the lump in my throat that I got from hearing Robert Katz read the same material on that cramped little stage in Battersea.

Jeff Aronson *clinical pharmacologist,*
Radcliffe Infirmary, Oxford

Preventing Violence

James Gilligan

Thames and Hudson, £6.99,
pp 144
ISBN 0 500 28278 1

Rating: ★★★

Jim Gilligan knows something about violence. For 25 years, he has been directing provision of psychiatric care to inmates of Massachusetts prisons. He advises presidents and prime ministers; he influences policy and educates others. So when Jim Gilligan says he knows how to prevent (or at least reduce) violence, you want to listen.

Dr Gilligan has a number of radical ideas. He argues that traditional approaches to violence prevention, which emphasise punishment, actually make violence worse; and the more severe the punishment, the worse the violence grows. Violence is more likely where there is a culture of shame. Key risk factors for shame include rigid gender role stereotyping, with resulting distorted views of what is to be "masculine" or

"feminine," and entrenched social hierarchies, based on inequalities of opportunity, income, and hope.

One of the real strengths of Gilligan's analysis is the emphasis on both the individual and social contributions to violence. The complexity of violence often means that researchers and commentators focus on either the micro or the macro level view.

Gilligan concludes that we can reduce violence by reducing social inequality and other stigmata of shame. We should also stop putting people in prison except in those cases where people need a type of therapeutic restraint for the protection of others. If we do this, we should provide therapy and education for violent offenders, rather than deprivation, isolation, and more shame. Topically, he argues that the decriminalisation of cannabis would also help to reduce violence.

But here's the problem—that just by calling something a medical issue doesn't make it any less political. Although I think Gilligan would like to make violence a health problem, his proposals are not just the prescription of an excellent doctor. They are intensely political in terms of how power and goods are dealt out in human societies. He knows this, of course, and ends the book with an interesting discussion of who profits from the failure to prevent violence, who has an interest in keeping it going. This is a particularly painful example: Gilligan and his team started an education programme in

their prison for the inmates. There was some evidence that six months after release those who had completed the programme were at reduced risk of offending. When the new (Republican) governor of Massachusetts heard about this, he stopped the programme "in case it encouraged people to commit crimes to get an education."

It would be good to have some debate with Dr Gilligan on how to apply his ideas in the UK and on some other issues as well. For instance, Gilligan is critical of punishment as a "moral" response to violence, but I wonder if he really wants to dispense with the "moral" altogether. Violent men (and women—not much discussed in the book) do seem to have difficulties engaging in moral reasoning that includes others. However, this is not to say that they do not possess a strong moral sense of themselves and their offences. I wonder whether some of the violence we mete out to offenders is part of a sense of collective unconscious guilt; I also wonder whether theology has any part to play in developing therapeutic interventions for the violent.

All citizens have an interest in reducing violence, and this book is written in such a way as to be accessible to a range of readers. And here's another thought which may encourage you to buy it: I bet Dubya would hate it.

Gwen Adshead consultant psychiatrist and psychotherapist, Traumatic Stress Clinic, UCL/Middlesex and Broadmoor Hospital

Mosquito: The Story of Mankind's Deadliest Foe

Andrew Spielman, Michael D'Antonio

Faber and Faber, £10.99,
pp 248
ISBN 0 571 20980 7

Rating: ★★★

With climate change and increased international travel, mosquito borne illnesses are flaring up all over the globe. This book tells the story of some of the mosquito species that contribute to human diseases such as malaria, yellow fever, dengue fever, filariasis, and viral encephalitis.

One such species is *Culex pipiens*, which lives in towns and cities rather than swamps and which caused the epidemic of West Nile viral encephalitis in New York city in 1999. How did a mosquito borne virus from Africa

get to America? The authors are dismissive of terrorism or an African tourist as the explanation, but blame either the illegal trade in birds or aircraft stowaway mosquitoes. It is one more example of the deadly consequences of diseases with no borders, when encounters occur between endemic mosquito borne infections of one region and non-immunes from another.

Culex pipiens was also implicated in an outbreak of Rift Valley virus in Egypt in the late 1970s. This outbreak was caused by simultaneous infection of mosquitoes by virus and microfilariae, which wounded the mosquito's gut and allowed virus to penetrate its saliva, leading to human Rift Valley viral infections. This important observation meant that other Mediterranean countries with this mosquito but without filariasis were not at risk of Rift Valley virus outbreaks.

Readers from "down under" may be disappointed to find no mention of Kunjin and Murray Valley encephalitis, although Ross River virus does rate a mention. But one of the strengths of this book is its selectivity. Spielman has been a key worker in research into mosquito borne disease, and so brings a unique perspective to the story, which is told well for a non-medical audience.

The brief history of yellow fever research in Latin America in the 1880s underlines just how much research ethics and methodology have changed. Perhaps researchers battling fastidious research ethics and grant

committees will be interested to know that back then, mosquitoes which had bitten yellow fever victims were allowed to feed on healthy subjects in unblinded uncontrolled experiments. It is also the story of individual researchers and their idiosyncrasies and egos. Plus ça change...

What practical advice can be offered to travellers to avoid these mosquito borne diseases? The best protection is wearing appropriate clothing and a repellent based on DEET (N,N-diethyl-meta-toluamide) when going outdoors. According to the authors, electronic zappers and ultrasonic repellents are ineffective, but permethrin impregnated bednets are effective.

In view of the increasing resistance to insecticides and chemotherapy, perhaps the greatest promise to ending mosquitoes' deadly assault on man is to render them impotent by genetic manipulation. As for genetically modified food, however, there are still unanswered questions about the advisability of this approach. More to the point, what chance is there that antiglobalisation and ecology activists will accept a genetically modified mosquito? Perhaps the major challenge for health research this century will not be so much any actual advances in molecular biology as convincing an increasingly sceptical public of their benefits.

David Brewster clinical dean, Northern Territory Clinical School, Darwin, Australia
david.brewster@nt.gov.au

Items reviewed are rated on a 4 star scale
(4=excellent)

PERSONAL VIEWS

End of term report for Alan Milburn

(following his government's response to the House of Commons Select Committee on Health's second report on public health; see p 249)

Dear parent/guardian,

I have become rather worried about Alan's performance in the last few months. In particular much of his written work has left a great deal to be desired. I am also sorry to say that Alan and some of the bigger boys have been picking on the public health team, who, as you know, are a small group and not as tough as many of the other children.

Most disappointing of all was his recent essay on improving the public health, for which he was given a borderline fail grade. Although he had a brave attempt at addressing the problem, his ideas were poorly developed and he showed little evidence of reading around the subject.

Firstly, he implied in the essay that public health improvements were all to do with transport, education, housing, and so on. While these factors have a major part to play, to have not seen a role for the NHS in improving the health of the public was a serious oversight. He should take a look at a book written by one of our old boys, Donaldson (whom I thought Alan had met), who clearly spells out the contribution the NHS can make

in primary, secondary, and tertiary prevention. I never much liked this taxonomy but what it says in simple terms is as follows:

- Primary prevention seeks to prevent the onset of a disease. The goal is to alter some factor in the environment, to bring about a change in the status of the host, or to change behaviour so that disease is prevented from developing.
- Secondary prevention aims to halt the progression of a disease once it is established. This is achieved by early detection or early diagnosis followed by prompt, effective treatment. An example of secondary prevention is screening.
- Tertiary prevention is concerned with rehabilitation of people with an established disease to minimise residual disabilities and complications.

Clearly much of this preventive activity takes place within the health service. Indeed, these programmes are patient centred, and use age, sex, and other registers that are held in the NHS.

Secondly, some years ago the public health teams at the health regions all became civil servants. Alan took this curious idea further by suggesting that the way to improve the public health was to reduce the size and numbers of health authorities and call them "strategic"—a dramatic reduction from 90 to 30 strategic health authorities.

He didn't seem to realise that the public health team would be reduced to a peacekeeping force whose main task would be to monitor the performance of the service as a kind of "governance police" responsible for detecting deviant death rates. No time to be strategic, and no time or other resources to develop and run health promotion programmes.

Thirdly, Alan should have thought more clearly about the public health function at the primary care trust level. Although staff from health authorities will transfer to primary care trusts, many health authorities have modest public health and epidemiology skills and these will be divided between six to eight primary care trusts—barely one public health doctor for each primary care trust. He was correct to say the public health team is more than just medical input, but few health authorities have reached the staffing level recommended by Acheson in 1988, of 15 for every million people. At a time when, throughout medicine, clinical teams need to become larger and more specialised, no such proposal is made for public health—instead the opposite is proposed.

Fourthly, perhaps the most disappointing part of Alan's essay was the lack of vision for the future. I wondered whether foot and mouth disease had rather left Alan in a state of confusion, so all he could think about was culling. Where was the vision for the future? Public health departments could become centres for health promotion and disease prevention. Why shouldn't we see a future of public-private partnerships where supermarket nutritionists work with NHS dietitians and patients to help improve eating habits and culinary skills? Why can we not envisage a future where health clubs work in partnership with colleagues in physiotherapy and sports medicine to offer pleasant, effective exercise programmes for all the population, not just superannuated professionals who are already fit? In a recent essay reviewing progress on prevention, McPherson, an able boy, said much still needed to be done on the prevention front (*Lancet* 2001;357:1790).

Alan should remember what Nick Day, the master in charge of cancer studies, said: "For every five pounds we spend, three should be on prevention, one on screening and one on treatment." Busy hospital trusts and primary care trusts can do a lot, but they cannot do everything.

Do encourage Alan to try harder, because if he does, I am sure he could have a rewarding life in public health.

All the best,
Michael Clarke
(Deputy Head in Optimistic Studies)

Michael Clarke *professor of epidemiology, University of Leicester*
mc69@leicester.ac.uk

Did foot and mouth disease leave Alan confused, so all he could think about was culling?

WEBSITE OF THE WEEK

Preventing violence A book review in this week's *BMJ* (p 289) reflects on ways of preventing violence. There are many types of violence and countless groups working to stamp out the problem both here and in the United States, which, according to many commentators, is experiencing a violence "epidemic." One excellent site is www.domesticviolencedata.org—an information coordinating system for domestic violence projects in the United Kingdom. The Home Office also has a dull page of links to other government antiviolence programmes (www.homeoffice.gov.uk/domesticviolence). Further afield, both the Family Violence Prevention fund (fvpf.org) and the Center for Study and Prevention of Violence (www.colorado.edu/cspv) are working to combat violence in the US.

Violence in schools is an increasing problem, particularly in America following the recent fatal school shootings. In the light of this, the Virginia Youth Violence Project (<http://curry.edschool.virginia.edu/curry/centers/youthvio/>) is working to identify effective methods for violence prevention in schools. An interesting, thorough article on this topic can be found at (http://eric-web.tc.columbia.edu/monographs/uds107/preventing_contents.html).

Increasing numbers of attacks on staff in the workplace, particularly within the NHS, have received a great deal of media coverage. The NHS has launched a zero tolerance campaign, which has an excellent site at www.nhs.uk/zerotolerance/. The British Association for Accident and Emergency Medicine has produced its own guidelines for staff in A&E departments (www.baem.org.uk/violence.htm). On a wider scale the Health and Safety Executive also provides guidelines for workers (www.hse.gov.uk), while www.workplaceviolence.co.uk provides a forum for sharing ideas on the subject.

Helen Barratt
BMJ
Clegg scholar
hbarratt@bmj.com

Living on the edge

It is terrifying to find a lump in your neck. You also feel slightly embarrassed. How long has it been there? Could that be why you have drenching night sweats, a chronic cough, and severe chest pain, and can't walk up the stairs? I was reassured for a while by the diagnosis of tuberculosis, but six weeks later when I had turned into a walking MRCP short case by occluding my left subclavian vein—the first time I have ever felt a properly deviated trachea—I realised that it was something serious. Lying in the casualty department finding out that I had a huge tumour in my chest was strangely calming. I wasn't frightened of dying; I just suddenly realised how much I loved being alive. When I contemplated the enormous CT guided biopsy needle sticking out of my chest, I began to realise the full extent of the terrifying experiences that we doctors inflict on patients every day.

Two days later we heard that it was lymphoma—B-cell non-Hodgkin's, to be precise—and cracked open a bottle of champagne as I now had a fighting chance. I think that you have to have a strong belief that you will get through, and keeping that belief strong is often hard. I became used to seeing my chances reflected back in people's eyes and found it isolating being a cancer patient. It's not that the doctors didn't care, but how much can you care in 10 minutes? I didn't strike up any friendships during chemotherapy as it seemed inappropriate to ask people on the day ward "So what sort of cancer do you have?" It's not that nobody listens, it's just that you don't feel you can talk.

To try to improve the terrible spinal headaches that I had from the intrathecal methotrexate, I went to see an aromatherapy masseuse who had been recommended to me. After I had explained why I was bald she told me she was a spiritual healer and asked if I wanted some healing. Well I was taking anything that was going and, despite being a sceptic and a scientist, I thought why not. And there it began: understanding, warmth, and healing. I can just hear you thinking "poor daft girl, all that intrathecal methotrexate has made her soft in the head," so I'll try to explain. You know how you feel after a double overbooked clinic when everybody and everything is demanding more attention and time than you have: totally drained as if your energy has been

sucked out. Now compare that with a day outside doing something you love with people that you love and how you feel energised and happy. Well that's what healing is like, rebalancing and revitalising your energy. Don't get me wrong, I wasn't about to chuck in the chemotherapy—it's just that conventional medicine treats only the part of you it can see is sick and I was stuck being viewed as a 30 year old with stage 4b non-Hodgkin's lymphoma. Complementary medicine takes a more holistic approach and tries to treat all of you. I think it's vital to find the right therapy for you and the right practitioner. I'm sure much of the success is down to the relationship between you both, and different complementary therapies will suit different people. I am no idealist and I can see that as most complementary medicine is private the practitioners have

the time and money to make their therapies enjoyable (well anything is, compared with chemotherapy), but surely anything that makes you feel good will keep you more positive. The mind is a powerful thing. We know that stress is immunosuppressing, we live in an age where our lifestyles are considered to be

more stressful than ever before, and we know that most cancers are on the increase. Why shouldn't alternative therapies that make you feel better boost your immune system? The way I looked at my situation was that the chemotherapy and radiotherapy would blast the tumour away, but unless my body took over its job of immunosurveillance, I wouldn't go into remission. I also took echinacea, a herbal remedy which works by boosting immunity.

So I went into complete remission (uncertain)—typical oncologist-sitting-on-the-fence-speak—and went back to work. All was going well until five months later I began getting a few night sweats, felt tired, and began coughing again. I opened my CT scans in the kitchen (another long story) and read those dreaded words "recurrent lymphoma." This was the consensus view of two teaching hospitals and I didn't feel I had the energy to do it all again. Straight after one of my hospital appointments I went to see my healer and she told me that it wasn't recurrent lymphoma and I believed her conviction. As it turned out, it wasn't.

Complementary medicine does exactly what it says: complements conventional medicine which we know has so many limitations. It can give you that edge and sometimes that's what you need to survive.

Susannah Baron specialist registrar in dermatology, Leeds General Infirmary
zannerzu@aol.com

Why shouldn't alternative therapies that make you feel better boost your immune system?

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

SOUNDINGS

Betrayal in blue pinstripe?

Not long after Labour's first landslide victory, I attended a lecture by someone from the Department of Health. It was a rather odd experience. The DoH apparatchik had the appearance one would expect from superimposing all the features of an identikit box: a sort of homogenised Warren Beatty. His prose had the same sort of rather amorphous allure. Both speaker and speech would not have looked out of place in the colour supplements, between an in depth profile of Liz Hurley and a full page advertisement for Häagen-Dazs ice cream. And yet after I had listened to the speech I felt oddly better, in the same way one does after listening to Alastair Cooke on the radio: a wiser person, a confidante. It took some years for the sense of betrayal to be complete.

Last week I sat opposite another apparatchik as he explained that, because our list size was 90 patients short of the required number, we could not have a full replacement for a retiring partner. I tried to explain that we are a small, rural, non-dispensing, low earning practice. I said that we offered an extremely high level of personal care, and that we performed many procedures that would normally be carried out in hospitals. But this was of no interest to him. We were 90 patients short, and that was that.

I returned home, shaking and sweaty. On the kitchen table were piled recent missives from the DoH. They spoke of the need for more doctors, of more support for primary care, of the need for excellence and personal care. The gulf between the vacuous words before me and the unblinking indifference of the bureaucrat was breathtaking.

It was my first brush with the field of medical politics, and I felt stunned and impotent. There was about the experience a surreal passivity I normally associate with dreams: when events implode on you randomly and your fate, like that of Ulysses, is contingent on the petty jealousies of flawed gods.

Richard Smith asked a few weeks ago why doctors were so unhappy. Maybe it is because so much of what we do because we genuinely believe in the NHS is unacknowledged. Maybe it is because we seem to be powerless in the face of autocrats who do not like doctors.

But are we downhearted? Well, yes we are a little, actually.

Kevin Barraclough general practitioner, Painswick, Gloucestershire