reviews

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

My First MRCP Book

Hugh Montgomery, Neil Goldsack,
Richard Marshall

Remedica Publishing, £25,
pp 320
ISBN 1 9013465 01

Rating: ★★★★★

The examination for membership of the Royal College of Physicians (the MRCP) is not easy. In fact it can be demoralising, gruelling, and expensive. The authors of this clever revision guide say that there is no better doctor than the general

medical registrar who has just passed the MRCP. This is because the exam assesses a vast range of detailed medical practice at a high level. The link of experience with knowledge is tested as never before. The attainment of those four extra letters after their surname is a dream held by many eager young senior house officers.

Fortunately this book is not just another revision guide. I have never read a textbook with such intelligent potential. It is a complete and structured course, designed to provide you not only with a wide variety of information but also with the relevant strategies for its application. The format is deceptively simple. As with a workbook, you start from first principles and are given comprehensive lists for each subject, and then your knowledge is tested again and again with sample exam questions. This may not sound earth shattering, but the beauty of this book is that it expounds on its

basic premise by using some sensible educational theory.

The intention is that you learn in many different ways and appreciate the information rather than just memorise it. The book uses several tools: historical vignettes, mnemonics, pictures, poems, puzzles, tables, and equations. They all reinforce the facts and—dare I say it—make all this arduous learning enjoyable. And that it is humorous and well written makes it all the more useful.

Although its structure and execution are sound, this book may still leave you wanting more; even the authors admit that you will need more textbooks than this slim volume for a complete and rounded MRCP education. However, as someone who is still studying, I have no hesitation in recommending this book.

Paul Grant senior house officer, William Harvey Hospital, Ashford, Kent
drpaulgrant@orange.net

Tony Copperfield's Primary Care Scream

Butterworth-Heinemann,
£17.99, pp 248 plus CD Rom
ISBN 0 7506 8793 2
www.elsevierhealth.com

Rating: ★★★★★

I mostly gave up reading the general practitioner trade magazines some years ago. Reading them was like having an endlessly pessimistic friend following you around, whispering in your ear all the time. I would alternate between impotent rage and mute depression. Now that they go into the bin, I no longer feel the entire world is against me, and I've stopped having the injections. The exception, which I always read, is Tony Copperfield's splenic rant in *Doctor* magazine against all that is wrong with being a doctor in general, and a GP in particular.

For a while I did wonder if Tony might be my doppelgänger. He seemed to have attended the same farcical management meetings as me, in which banal "mission statements," entirely devoid of use or content, were endlessly ("inclusively") debated. He was obviously there on that out of hours home visit to one of the "lumpen proletariat at the shallow end of the gene pool." He was at my shoulder when I "knelt in the pool of vomit, by the fag burnt sofa, illuminated only by the light from the satellite decoder and a rerun of *Peak Practice*."

Not only did he seem to follow me around, but he also seemed to read my thoughts. Otherwise how did he know what I was thinking when I got that nice private consultant's letter about the "delightful" patient telling me that, surprisingly, her whole body, multisystem pan-investogram was normal.

Tony's targets are not just the "clinical governance gestapo" (with their "patronising bullshit"), academics pontificating on one clinic a month ("until you've felt your feet stick to a hallway carpet you can't call yourself a frontline medic"), nurses ("they must learn to suppress their desire to cover their own arses"), and patients. GPs also earn his ire. As he stingingly points out: "Nobody with their eyes open could deny that there are plenty of pretty iffy GPs out there."

Tony inhabits a world that lies in that hinterland between the real and the surreal. That it is so startlingly familiar to us is testament to

the ludicrous nature of our work. We see his characters every day. Ms Stargazer, the vegetarian urban road warrior who brings her unvaccinated children Moon Calf and Poppy Seed for homeopathic treatment, may be a fictional character—but only just.

Tony Copperfield is quite simply fantastic. He is unbelievably funny and, strangely, he is also extraordinarily and improbably wise. He cuts, searingly, through the sanctimonious dishonesty that so often pollutes healthcare politics ("I once sank so low that I used the word 'autonomy' without irony"). Most importantly, everything he writes is truer than fact.

My only fear is that, if the wind changes while I'm reading this book, I may end up looking like Kingsley Amis and sounding like Auberon Waugh. But hey, as Tony says, sometimes shit happens.

Kevin Barraclough general practitioner,
Painswick, Gloucestershire

Conflict of interest: KB has always wanted to be Tony Copperfield.

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: 020 7383 6244, Fax: 020 7383 6455
email: orders@bmjbookshop.com
Online: bmjbookshop.com
(Prices and availability subject to change by publishers.)

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

New US drama outrages plastic surgeons

Imagine that you are a hotshot Miami plastic surgeon and you've just had an unfortunate—well, fatal—incident performing liposuction on a South American drug dealer who paid you cash upfront. Why the disaster? You were dumb enough to let the guy's brother into the operating room (for even more cash), where he went berserk. Would you dump the corpse into a Florida swamp? Furthermore, would you know enough to tie hams to the victim, because alligators love pork?

Consider that you refuse to do free work on a kid who needs skin grafts for burns. Or that your partner picks up a gorgeous woman in a bar, has throbbing sex with her, and then persuades her in the clear light of morning that she needs work on her forehead, her eyelids, her cheekbones, her breasts, and her tummy.

No wonder America's plastic surgeons are annoyed. These scenarios come straight from *Nip/Tuck*, a new US television programme featuring two plastic surgeon partners that was first broadcast on the FX cable channel last week. The programme was developed by Ryan Murphy, who interviewed a plastic surgeon as a newspaper reporter and was surprised to find that the doctor suggested plastic improvements for him.

One of the show's characters is a sleazy charmer and a terrific salesman; the other is slightly less sleazy and a more talented surgeon (he knows when his partner put the buttock implant in upside down). They work in Miami, a centre of plastic surgery for an elderly population and stylish young people and also a city connected to Latin American

crime. One reviewer headlined the programme "Miami Slice."

US broadcasters try out episodes of new TV series during the summer to gauge viewer response and decide whether the series will run in the autumn. *Nip/Tuck* attracted 3.7 million viewers and is the top-rated new series premiere.

Its debut on 22 July came at a bad time for the image of US medicine. Less than a week later (27 July) the widely watched investigative programme *60 Minutes* described a problem at Tenet Healthcare systems in Redding, California, where a cardiologist is said to have recommended unneeded coronary bypass surgery, bringing income to the hospital and misery to patients.

The American Society of Plastic Surgeons (www.plasticsurgery.org) and the American Society for Aesthetic Plastic Surgery (www.surgery.org), which represent most board-certified plastic surgeons in the US, both posted press releases on their websites condemning *Nip/Tuck*. However, the groups didn't want too much publicity, on the grounds that it would only attract more viewers to a show that they feel does not represent the way plastic surgeons work.

Dr James Wells, president of the American Society of Plastic Surgeons, told me that the programme "reached to the bottom of the barrel. It was salacious, done grotesquely. It gave little consideration to tissue care. It was speeded up, slapdash ... slambang, the worst example of stereotyping."

He said that about 11% of the group's members did only cosmetic surgery and about 8% did only reconstructive surgery. The rest did a mixture. His own practice in Long Beach, California, was about 60% cosmetic surgery, 40% reconstructive surgery, he said, and he and many plastic surgeons did work for free in the community and in overseas missions.

Dr Robert Bernard, president of the American Society for Aesthetic Plastic Surgery (ASAPS), who does cosmetic surgery and reconstruction after mastectomy, said, "Doctors educate patients. They disabuse patients of unrealistic expectations. The programme sends a subliminal message that plastic surgery is harmful ... Most patients are happy with their outcomes." He added that doing work for free was part of the norm.

Plastic surgery is a growth industry in the United States, as ageing baby boomers try to remain youthful, or at least youthful looking. Figures from ASAPS show that cosmetic procedures have increased 228% since 1997. There were nearly 6.9 million cosmetic surgical and non-surgical procedures in the US last year. Botox injection was the most popular, with more than 1.6 million procedures last year, up an astonishing 2400% since 1997. The leading surgical procedure is liposuction.

Nip/Tuck is not the only US programme to play upon Americans' drive for self improvement and ageing baby boomers' attempts to stave off physical decline. There

is also a show called *Extreme Makeover*, which turns mousy nobodies into sexy beauties. It usually involves bigger boobs and a nose job.

It seems that plastic surgeons are an easy target. A medical journalist colleague told me that plastic surgeons were the only doctors who "walk the edge." How many doctors have their own press agents and send out their own press releases, she asked—only some plastic surgeons, plus a few dermatologists and a few cosmetic dentists. I and other medical journalists often get press releases from doctors who do cosmetic improvement, while news about other doctors comes from their academic institutions or their papers in a medical journal.

Nip/Tuck was promoted in a full page, four colour advertisement in newspapers showing a woman's eye peeking through surgical wraps, with stitches—not eyeshadow or eyeliner—above and below the eye. The headline said, "Truth is only skin deep."

Maybe we should look further.

Janice Hopkins Tanne *medical journalist, New York*

A scene from *Nip/Tuck*

Hit parade bmj.com

These articles scored the most hits on the *BMJ*'s website in the week of publication

JUNE

- Editorial: A cure for cardiovascular disease?**
2003;326:1407-8
16 344 hits
- Editorial: Persistent atrial fibrillation: rate control or rhythm control**
2003;326:1411-2
4745 hits
- Editor's choice: The most important *BMJ* for 50 years?**
2003;326 (28 June)
4439 hits
- Clinical review: Percutaneous coronary intervention: cardiogenic shock**
2003;326:1450-2
4276 hits
- Clinical review: Positron emission tomography**
2003;326:1449
4050 hits
- Editorial: Managing pulmonary embolism**
2003;326:1341-2
3602 hits
- Paper: A strategy to reduce cardiovascular disease by more than 80%**
2003;326:1419-23
3348 hits
- Clinical review: Acute coronary syndrome: ST segment elevation myocardial infarction**
2003;326:1379-81
3232 hits
- Primary care: Newly diagnosed type 2 diabetes mellitus**
2003;326:1371
3135 hits
- From the editor: Preparing for partnership**
2003;326 (14 June)
2795 hits

Gay tobacco ads come out of the closet

Smoking causes more deaths in America than AIDS, drug overdoses, suicide, homicide, and car crashes combined. Gay men are at particularly high risk of being killed by tobacco, as almost half of gay men smoke (*American Journal of Public Health* 1999;89:1875-8). How did the tobacco industry gain such a stranglehold over the gay community?

One theory points the finger at the industry's subtle campaign to court gay men. Since the early 1990s tobacco companies have quietly advertised cigarettes in gay media, contributed to gay organisations, and sponsored gay community events.

These activities have given the tobacco industry legitimacy among gay men. Yet the industry has been reluctant to publicly acknowledge its gay love affair.

Two recent studies of internal industry documents show that Philip Morris, America's biggest tobacco seller, devised a strategy to target gay men while denying that such a strategy existed.

In 1991 the company made large donations to AIDS related causes in response to the gay community's boycott of Marlboro cigarettes and Miller beer, two Philip Morris products. The boycott was a protest against Philip Morris's support of Senator Jesse Helms, an opponent of gay rights and AIDS funding. As product sales

began to fall, Philip Morris pledged money to AIDS organisations and the boycott was quickly dropped (*Tobacco Control* 2003;12:203-7).

Shortly after, the company donated \$10 000 (£6166; €8696) to the Gay and Lesbian Alliance Against Defamation. Philip Morris was starting to gain acceptance within the gay community through its corporate philanthropy, and it turned this acceptance to its advantage.

Its advertising agency advised the tobacco giant that the gay community was an "area of opportunity" and that the company could "own the market." (*American Journal of Public Health* 2003;93:988-93). Philip Morris therefore placed the first ever cigarette advert aimed at gay men in the October/November 1992 issue of *Genre*, a gay men's periodical.

Genre had alerted the national media about the upcoming advert. The *New York Post* (14 August 1992) smirked: "Don't look now Marlboro Man—but you've got a brand-new gay partner." Faced with this public attention, Philip Morris denied that it was targeting gay men and pointed out that it had also placed cigarette adverts in heterosexual magazines such as *Playboy*.

Michael Wilke, founder of The Commercial Closet (www.commercialcloset.org), an organisation that monitors advertising aimed at the gay community, said that the tobacco industry "wanted it both ways—to reach the gay audience but not garner too much attention outside of this arena."

Why was the industry so coy about acknowledging its ties with gay men? Elizabeth Smith, of the Malone Research Group at the University of California at San Francisco, which published the two studies of internal industry documents, said that the reluctance was because of "homophobia on the company's part—it didn't want to be associated with the gay community."

While the company clearly wanted the gay market, she said, it didn't want to

The Altria advertisement in *Pride03*

weaken the macho image of its chief product, Marlboro. It didn't want the wider community to think that the super-masculine Marlboro Man might be gay.

Philip Morris's tactic of "closeted" gay marketing continues to this day. This year's San Francisco gay pride celebrations in June were commemorated with a magazine called *Pride03*. It carried a full page advert for Altria, Philip Morris's new name (the Malone Research Group says that the company changed its name "to hide the taint of tobacco"—see www.altriameanstobacco.com). The advert surely aims to promote acceptance of Altria among a gay audience, yet the company says it is not trying to reach any specific group. Brendan McCormick, manager of media relations for Philip Morris-USA, said: "Our audience is adult smokers and that audience is diverse."

Given the alarming rates of tobacco deaths among gay men, isn't it rather cynical for Altria to be placing any adverts at all in the gay media? "Adult smokers," said McCormick, "can make choices about the products they wish to purchase. We think that adult smokers should have access to information about our products."

Publishers of gay magazines that carry tobacco adverts use a similar argument to justify their position. "Many publishers," said Michael Wilke, "would say that readers can make decisions on their own." Some publishers have even hailed the adverts as a sign that gay men are no longer being excluded from society.

But what kind of social inclusion is this? Being considered another potential target for a lethal product is hardly a great leap forward for gay rights. As one gay tobacco control activist commented, "This is a community already ravaged by addiction. We don't need the Marlboro Man to help pull the trigger" (*American Journal of Public Health* 2003;93:988-93).

Gavin Yamey deputy physician editor, BestTreatments (www.besttreatments.org),

GY's competing interests are at http://bmj.com/aboutsite/comp_editorial.shtml

Nothing to celebrate: is the gay community "an area of opportunity" for tobacco giant Philip Morris?

PERSONAL VIEW

Poppies in Kosovo, gerbera daisies in Basra

This time the gerbera daisies will evoke memories for me. Last time it was poppies—deep blood red poppies (*BMJ* 1999;318:1707). Back then, in May 1999, the poppies lit the Macedonian fields outside the refugee camps—camps full of Kosovar Albanians fleeing ethnic cleansing. A splash of colour, incongruous amidst the misery of people who had lost everything. The daisies—pastel shades, covered in dust, struggling to survive without water—symbolise for me that there is hope amidst neglect.

I found them in a corner of the palace garden. The palace is magnificent: huge, high ceilinged rooms, miles of corridor, marble floors, and surrounded by a high wall and protected by acres of landscape that deny the outside. Opulence and gross extravagance on a scale you could not imagine, reflecting great wealth and self importance. Strange that the man for whom the palace was built liked the same flowers as I do.

I am in Iraq, seconded to the Foreign and Commonwealth Office. Three of us from the Department of Health are here in Basra. We work in the southern office of the Coalition Protection Authority, which covers an area the size of Scotland. We are the regional government working within a multinational effort alongside Iraqi technocrats to regenerate a country. The politics of the conflict are not my concern. I see only a country systematically starved of resources, whose people were punished through purposeful withdrawal of the basic necessities for life, a people subjugated by fear and corruption. This is how they were repressed.

Basra itself suffered since the uprising of 1991. The policy of neglect was deliberate. The infrastructure has crumbled. The recent conflict cannot be blamed for the complete lack of essential services. Looting and deliberate sabotage in the aftermath of the conflict have contributed to the immediate and acute problems. Power is intermittent, the water supply is unreliable, rubbish lies in the streets, and salaries have not been paid for months. Gun battles regularly punctuate the dark hours. Society has almost broken down, and people look after themselves to survive or make money from the chaos.

And what of the health service? There are no drugs. Hospitals have run out of oxygen and have been looted of beds and equipment. There are no laboratory reagents. Elective and diagnostic procedures are impossible, with intermittent power and no essential clinical supplies. There is a public health crisis. The cold chain has broken down, and immunisation programmes have been suspended for more than six months. We have cholera, typhoid, and whooping cough.

Water is contaminated with sewage. On street corners children take water from pipes that have been deliberately broken because pumps are not working and water is not reaching their homes. There is not enough fuel. Food, previously supplied on ration, is scarce and expensive.

Three of us. Where does one start? The British military here have done a wonderful job. Our medical colleagues—young regimental medical officers and senior medical command staff—have made huge strides in understanding the key structures and personalities and the immediate problems facing this region. Together we have a plan that covers immediate and longer term issues. Much of the plan rests on leadership emerging from the local profession—a tall order, given the political unrest and undercurrent of corruption. Self determination

is the key; an imposed health economy will not work, nor is it for us to decide. We can only try to support, guide, and advise. But in the transition our leadership is essential.

In this chaos we must stay focused on the long term objective: an Iraq that gives its people choice and provides health, employment, shelter, adequate nutrition, and security—basic needs for all. That there is no service now must not distract us from the task. But this is difficult when we are faced with the inevitable personal tragedies. People come to our office hoping for help, for a gift that might transform their lives. One morning, a five year old boy and his loving, gentle father came to the gate. The boy has thalassaemia, common here, and needs a blood transfusion. Nothing is free; even blood comes at a price. The price is unaffordable for a man with no job. The blood transfusion service has been destroyed. The boy, yellow under his dark skin, will die without treatment. One day, sooner than later, I hope, we will have identified the way to replace this essential service, along with all the other life saving services that are lost. Other children may then live. This boy cannot wait that long. He needs a solution now. I cannot offer hope. His papers tell me his blood group is B+, the same as mine. But how many more children might need my blood? That is no way to solve the problem, even though it might make me feel better today. Later, in my office, I cry uncontrollably with impotent rage.

I will stay focused. Things will be better. There must be hope amidst neglect. Like the gerbera daisies, the will to survive is strong, and from the dust something good may grow. I may have helped. I hope so.

Celia Duff deputy regional director of public health, East of England Regional Public Health Group
celia.duff@dia.pipex.com

SOUNDINGS

Honorary woman

More than half the UK medical graduates starting their first jobs this week are women. They'll say: so what? More than half the babies born are girls. It's no big deal.

Historically, though, it is. After being excluded from medicine for 500 years, women will soon form the majority. The change is fastest in my specialty, where 74% of UK career senior house officers are women. An American journal recently asked, under a picture of a woolly mammoth and a man in a white coat: "Are male ob/gyns headed for extinction?"

Silly question. Of course we are. Hardly any male students now consider a career in obstetrics and gynaecology. Last week on our medical campus I noticed a summer school full of male postgraduates—aspiring surgeons, of course. To an obstetrician this was an unfamiliar sight.

How do you face extinction with dignity? We fiftysomething obstetricians started our careers in an era of small quotas of female students, when sexism and schoolboy jokes were common (though by no means universal) among our teachers. We understand the anger of contemporaries who had to fight old fashioned prejudice, or who gave up the battle.

But we've been caught in the crossfire for 20 years now. The backlash against male obstetricians has taken the form, not of frontal assault, but of surreptitious jokes. Newsletters of maternity consumer groups peddle the image of uncaring male consultants. Radical midwives brief politicians against us. And the new generation of women obstetricians cannot resist the odd jibe.

All we can do is join in with humorous self deprecation. Twenty years of apologising, however, is enough. We're leaving. In 2001 the average retirement age of obstetricians was 57. They gave all sorts of excuses, including the ageism endemic in the NHS, but I think they would have stayed if they felt appreciated.

It's time for the victors in medicine's battle of the sexes to show some magnanimity. For me, the process started last month when a group of distinguished female colleagues made me an Honorary Woman. No surgery or hormones, you understand, and no paperwork—only a feeling of liberation. Enough to write this article, at least. I shall wait a few more years before setting up the Medical Men's Federation, dedicated to promoting the interests of the new minority.

James Owen Drife professor of obstetrics and gynaecology, Leeds