reviews

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Menorrhagia

Eds Shirish S Sheth, Christopher Sutton

Isis Medical Media, £84.95,
pp 362
ISBN 1 899066 93 4

Rating: ★★★

Menorrhagia is a topic of considerable importance to both women and their gynaecologists. It is a common complaint which causes women to attend their general practitioner and, after they have reached a gynaecologist, is often treated by major surgery. It is thus a topic which is worthy of an in-depth text.

Menorrhagia is indeed comprehensive, covering all aspects of the subject in considerable depth and including some rather peripheral issues. The contributions are made by experts in the field, but, as this is constantly changing, some information is inevitably out of date already. The book is put together as separate chapters, and experts in the same subject are not necessarily included in the same section as would normally be the case. This makes the book difficult to work through as there seems to be no particular reason for its layout. The different chapters contrast considerably in style and content, reflecting the different approaches of those with particular medical or surgical expertise and of those from different sides of the Atlantic. On reading this book, I think I learnt as much about how gynaecology is practised in the United States as anything else. The book's aim is not terribly clear, and the introduction does not specify for whom the book was written.

In Britain the current emphasis is on evidence based medicine. One or two of the chapters do take this approach with thorough and thoughtful contributions, but others are full of personal opinion not supported by data. Personally, I would welcome the results of studies showing that vaginal hysterectomy is indeed superior to total abdominal hysterectomy, since this is a view expressed by some gynaecologists with religious fervour. There has never been a randomised study, and we all know that the indi-

cations for the two are often different. Ray Garry gives a reasoned approach with a summary of the literature before finishing the chapter with his own view. The chapter by Professor Sheth assumes that readers will all agree with him and that if they do not do most hysterectomies by the vaginal approach it is because they are poor surgeons. Since at least 75% of hysterectomies are performed by the abdominal route in both Europe and the United States, there are obviously a lot of surgeons who lack the necessary skills or the desire to acquire them. It has always interested me that the scars inflicted on the abdomen by a caesarean section are not deemed important and do not impair recovery after childbirth, whereas such scars are apparently of great importance when inflicted during a hysterectomy. Since 95% of women who have an abdominal hysterectomy are highly satisfied, I am not sure why it is perceived so negatively by some gynaecologists.

I would welcome the results of studies showing that vaginal hysterectomy is indeed superior to total abdominal hysterectomy

There is considerable difference in practice between the United States and Britain. In Britain there is a tendency to underdiagnose rather than overdiagnose, unlike in the United States. For many of our women, hysteroscopy would be considered overinvestigation, whereas it seems to be the norm in the United States. In Britain non-invasive investigations are used before invasive investigations, and there are guidelines such as those set up by the Royal College of Gynaecologists as to the best practice in investigation and management of menorrhagia, which provide some consistency. Under these guidelines, dilatation and curettage is rarely carried out.

I think part of the difficulty I had with this book is that the US definition of dysfunctional bleeding differs from that used in the UK. This category covers a substantial proportion of women who are treated by hysterectomy as well as medical treatments. In Britain it is considered to be bleeding problems in the absence of pathology, and a woman with a uterus equivalent to a 12-14 week pregnancy would not be diagnosed as having dysfunctional bleeding because she obviously has pathology. The working definition in the United States is bleeding without "significant clinically detectable pathology." Per-

haps the greater obesity of some US women affects diagnosis, but if readers are not aware of the different definitions they may find the discussion confusing.

I cannot believe that a surgeon who performs an operation with which he or she is not happy is fulfilling the Hippocratic oath

The book has some excellent contributions but also considerable overlap. The chapter on "Pathophysiology" is thoughtful and thorough, but it inevitably overlaps with that on "Aetiology and investigation." I particularly enjoyed the information given on haematological aspects, although these are relatively rare in gynaecological practice. A lot of information in this chapter would be very useful for reference at the appropriate time. This is true of other contributions. Myolysis is discussed in considerable detail, as is laparoscopic assisted myomectomy. These procedures are applicable to very few gynaecologists, but it is useful to be aware of the possibilities.

My feelings about this book were crystallised on reading the chapter by David Oram, in which he apologises for being indecisive. He actually considers the alternatives very carefully and gives a view that is not necessarily his own but is based on best evidence. I thought his was one of the best contributions, and the apology was entirely unnecessary. I was left to make up my own mind having followed his reasoning.

Overall, the information in this book can be found elsewhere, but I think it will be a useful reference text in the future. In Britain our aim is to decrease the number of hysterectomies carried out. There are good, less invasive, alternatives. The statement made by Hippocrates to "do no harm" is quoted. I cannot believe that a surgeon who performs an operation with which he or she is not happy is fulfilling the Hippocratic oath.

M A Lumsden senior lecturer, department of obstetrics and gynaecology, Queen Mother's Hospital, Glasgow

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(4=excellent)*

Sex, Gender and Health

Eds Tessa M Pollard, Susan Brin Hyatt

Cambridge University Press,
£12.95, pp 184
ISBN 0 521 59707 2

Rating: ★★

There has been considerable interest in gender and other inequalities in health over the past two decades. An orthodoxy became established that, despite lower mortality among women, now seen virtually throughout the globe, women experience more morbidity than men (a generalisation that has been challenged in recent years). A frustration with some existing literature is that, despite social and legislative changes and challenges to the roles and opportunities for women and men in the latter part of the 20th century, "evidence" or "facts" about gender and health are often quoted with little reference to the time and context in which data were gathered, thus reinforcing the orthodoxy.

This tendency is sometimes apparent in this book. Its origins in a 1997 Biosocial Society workshop are perhaps reflected in the rather disparate collection of chapters. I most enjoyed the chapters by Emily Rousham and Susan Brin Hyatt. Rousham's analysis of gender bias in South Asia shows that, rather than a universal neglect of girls, gender discrimination—as evidenced in child growth and nutritional status—is a response to economic adversity and is alleviated when conditions improve.

Initially, I had expected Hyatt's chapter, "Poverty and the medicalisation of motherhood," to reiterate criticisms of the medicalisation of reproduction. Instead, it interweaves three different strands: the story of a woman whose psychosurgery for violent behaviour was covered on national television, an historical analysis of how mothers in deprived circumstances became the object of medicalised intervention, and contemporary accounts of how mothers on a council estate cope with poverty. Hyatt argues that "the combination of maternal status and poverty alone, without corroborating evidence of any other serious behavioural or physiological dysfunction, has been enough to warrant intensive surveillance and direct intervention."

Both these chapters are especially interesting as they begin to explore more

complex interactions between gender and socioeconomic circumstances. This is part of a growing trend, in Britain at least, and, although Patricia Kaufert is right to assert in her contribution that women have remained relatively "invisible" in many population health models, there has been active research over the past few years on whether the determinants of ill health, and the causes and extent of inequalities in health, are the same in men and women.

The book is intended for students of human sciences and anthropology and aims both to show how anthropologists have sought to explain gender differences in health and "to bring social and biological anthropologists together." While it realises these aims, it perhaps works less well in providing an interdisciplinary, rather than an anthropological, perspective for the more general reader. None the less, it provides insight into the current debate within anthropology and is a useful source for material from other societies, which have tended to be woefully neglected in the general debate on gender and health.

Kate Hunt senior research scientist, MRC Social and Public Health Sciences Unit, Glasgow University

Competing interests: KH is coeditor of *Gender Inequalities in Health*, Open University Press.

Second Opinions—Stories of Intuition and Choice in the Changing World of Medicine

Jerome Groopman

Viking, \$24.95, pp 243
ISBN 0 670 88801 X

Rating: ★★

Coming on the heels of a recent Institute of Medicine report stating that medical error is the eighth leading cause of death in the United States—with a higher mortality than for breast cancer, AIDS, and automobile accidents, and accounting for as many as 98 000 fatalities a year—Dr Groopman's book couldn't be more timely.

The author, a distinguished Harvard oncologist and haematologist, describes eight separate incidents of misdiagnosis, medical hubris, and egregious error—two of which affected him personally. To alleviate severe pain from a nerve pinched by a bulging lumbar disc, he enlisted the help of an

overenthusiastic surgeon instead of opting for bed rest, anti-inflammatory drugs, and tincture of time; he has never fully recovered from the surgery. Later, his firstborn son developed an internal obstruction at 10 months of age and almost died because of physician delay and misjudgment.

Groopman goes on to describe the case of a woman with leukaemia wrongly diagnosed as having asthma, a patient with melanoma who became the object of professional infighting about the availability and advisability of different forms of interferon treatment, and a young physicist told that he had less than six months to live unless he had a bone marrow transplant and the ensuing tussle between specialists about the usefulness of that approach. In fact, there are several examples here of physicians jockeying for who's right and who's most qualified—turf battles—and Groopman, inevitably involved in most of the skirmishes, is not above a bit of preening when, as is almost always the case, his view is the correct one.

None the less, much of what might be learnt here has to do with abandoning pretensions to omniscience. As Groopman puts it: "knowledge in medicine is imperfect. No diagnostic test is flawless. No drug is without side effects, expected or idiosyncratic. No prognosis is fully predictable." Moreover, he believes that most litigation grows, not out of honest errors or even frank malpractice, but from unresolved anger and poor communication. "Physicians are not

used to admitting when they are wrong," he says, "and plainly stating to the patient and family that an error was made, a lab test overlooked, a finding missed on a physical exam, or an incorrect drug prescribed."

In all of this, the author's message is salutary: evaluating medical advice is the greatest challenge for every patient. Armed with knowledge, steadied by family and friends, and calling on intuition, we can gain clarity and insight in order to make the best possible decisions.

But in giving his message, Groopman is also dilatory and serves up a good deal of euphuistic fluff with his thesis. He indulges in narrative excesses such as "the setting sun igniting a blaze of crimson," "the embracing sun held the city in a pleasant grasp," and "winter's icy tongue." The protagonists' stomachs tighten and pulses quicken, cold pains grip their hearts, brows fall, and eyes become heavy. The concocted dialogue is stilted, and one British doctor, for example, is made to include "bloody" or "old boy" in every utterance. And the several gratuitous swipes at managed care, which has arguably brought a greater degree of rigour into medical practice, seem self serving and out of place.

In fact, although Groopman's message is an important one, it probably could have been confined to a full length magazine article in, say, the *New Yorker*, for which he is a staff writer in medicine and biology.

David Woods president, Healthcare Media International, Philadelphia, USA

A Philosophical Disease: Bioethics, Culture and Identity

Carl Elliott

Routledge, £12.99, pp 256
ISBN 0 415 91940 1

Rating: ★★★

Bioethics needs philosophers with medical experience, and even more it needs philosophers who can write well and interestingly about bioethics without oversimplifying the issues. Elliott scores on both counts: he deploys considerable philosophical erudition and an ability to combine literary and philosophical sources to help us understand the dilemmas of modern medicine. In doing so, he certainly celebrates complexity. He fails, however, to be persuasive on either of his other main theses—that we have much to learn from Wittgenstein about bioethics and that general suspicion of

theoretical approaches to bioethics is warranted.

In a fascinating chapter entitled “What’s wrong with living heart transplantation?” Elliott tries to solve the riddle of how it is possible generally to admire those who are willing to lay down their lives for others but to deny them this admiration and the right to earn it when they require medical assistance. His unpacking of the dilemma and its complexities is admirable, though I found his style and methodology indistinguishable from those that he implicitly and explicitly criticises. He notes that a “doctor is supposed to value the interests of his patients *equally* . . . By performing the transplant, he is endorsing the donor’s sacrifice, and thereby valuing the interests of the recipient more than those of the donor.” Elliott appeals to the theory of equality but misunderstands its demands. He fails to notice that if the doctor refuses to carry out the transplant he will be valuing the interests of the donor more than those of the recipient. Since, by hypothesis, both donor and recipient can’t live, equality understood as “equal valuation of interests” cannot help with this dilemma—either way one person’s crucial interests are sacrificed. However, giving weight to the autonomy dimension of the requirements of equality might indicate a resolution, since one course of action equally respects the autonomous decisions of both parties.

While developing his “General Antitheory of Bioethics,” Elliott criticises those philosophers who deploy theories of personhood but misses his target. He thinks that the structure of arguments from personhood is: “X is a person; therefore killing X is wrong.” He ridicules such arguments by suggesting that “trying to define what a person is in order to get moral guidance about the acceptability of ending a being’s life is like a man trying to define what ‘sister’ is in order to get moral guidance about whether it would be morally acceptable to have sexual relations with her.” But the structure of arguments from personhood is quite different. Theorists who give personhood a prominent place try to identify the various features of an individual that make that individual morally important in particular ways, including ways that make its life morally valuable. Thus, it is not because an individual is a person that its life is morally valuable, rather it is because it has those features that make life morally valuable that it is a person. In theories of personhood, the fact that an individual is a person is the conclusion of a moral argument, not, as Elliott suggests, one of its premises.

John Harris *Sir David Alliance professor of bioethics, University of Manchester*

The Virgin Suicides

Directed by Sofia Coppola,
American Zoetrope

On general release worldwide

Rating: ★★★

Adolescent angst, crazy psychiatrists, blood in the bath, religious repression, flares, and silly haircuts. This beautifully filmed novel about the suicides of five teenage sisters in 1970s Michigan, made by the Coppola family, fails to miss a cliché while also providing a poignant insight into suicide in young people.

Told as a verbal jigsaw puzzle by clueless adolescent lads trying to understand the horror that happened next door, the film skillfully contrasts the incomprehensibility of the girls’ suicides to outsiders with an insightful portrayal of the personal powerlessness of young women in religious America.

Voyeurism is a prominent theme. The voyeurism of the lads next door echoes that of the curtain twitching, small town community, watching over coffee as the family drifts into madness and death. Nobody lifts anything more than a martini glass to save

the girls, illustrating the power of the educated middle class over their children—the same scenario in a working class family would have undoubtedly resulted in attempts to save the girls.

There is a clear failure of the helping systems to come to the aid of the sisters—Cecilia, Lux, Bonnie, Theresa, and Mary. “You’re not even old enough to know how bad life gets,” Cecilia is told by the hospital doctor after her first suicide attempt. Her apt response—“You’ve never been a 13 year old girl”—clearly challenges us to try to understand her act as a logical result of the choices open to her. Perhaps not surprisingly, the most unsympathetic character is Cecilia’s psychiatrist, overplayed in stereotypically crazy style by Danny de Vito. It seems impossible for films to avoid showing psychiatrists as either crazy, punitive, or superhumanly insightful.

The girls are very clearly not depressed, apart from the youngest, Cecilia. The others just drift away from a life they had never been allowed to fully share because of their parents’ religious and personal anxieties. Their suicides are acts of anger, loudly shouted as the only apparent option open to them within their view of the world.

The characters in the film are well drawn, particularly the adolescents, saturated with sexual awakening, insecurity, and idealism. Kathleen Turner and James Wood provide superbly ordinary

Five sisters failed by the system

parents who just get it wrong in balancing affection and control, before dissociating into madness towards the end. The cliché of religious repression is unavoidable, but neatly tacit, with the film set in the American north, not the south, and the family being Catholic rather than hell raising Protestant.

Like the recent Oscar winning film *American Beauty*, *The Virgin Suicides* challenges us to examine the consequences of traditional versions of love and family life. “They never lacked for love” was their mother’s only response, highlighting the danger of narrowly defined versions of affection, responsibility, and acceptable behaviour.

Russell Viner *consultant in adolescent medicine and endocrinology, University College and Great Ormond Street Hospitals, London*

Class war

"An absolute scandal" was the phrase Gordon Brown used to embroil the government in a class war with Oxford University (*Times* 26 May). With the emphatic backing of the *Sun* (26 May), which enjoyed "his blistering assault on stuck up Oxbridge 110%," Mr Brown had ignited a much larger media debate on education, elitism, and class.

Laura Spence, a sixth former at Monkseaton Community High School in North Tyneside, was "unhesitatingly spat out" by the Oxbridge admissions system, according to Peter Wilby, editor of the *New Statesman*, in his letter to the *Guardian* (28 May). The 17 year old's application to study medicine was rejected after an interview at Magdalen College, Oxford. She went on to secure a place at Harvard University in the United States.

The debate intensified when the BBC gained exclusive access to the comments of Dr Ajit Lalvani, a member of the interview panel. His notes said that Laura lacked confidence "as with other comprehensive school pupils," despite being "outstandingly intelligent" and destined to make an "excellent" doctor. Dr Lalvani defended his

comments by saying that he was trying to ensure that the interview panel compensated for any disadvantage given to her by her state school background. Gordon Brown, however, saw it as "an old establishment interview system" failing state school children.

The *Times* (27 May) was quick to put the facts into perspective. Despite Mr Brown's claims that Laura had the "best A level qualifications you can have," she has yet to complete them. The 22 other applicants contesting the five places available had equally excellent GCSE grades. And of the five who were successful, three are women, three are from ethnic minorities, and two are from comprehensive schools.

Dr Kelley, the head teacher at Monkseaton, said in the *Times*: "These [students] are people we cannot afford to lose." But did Britain need to lose Laura? She had offers to study medicine at Newcastle, Nottingham, and Edinburgh but rejected these for a biochemistry degree at Harvard. To believe that Oxford is the only centre of excellence in Britain for medicine is simply misguided. Why was she so driven to attend an "ivy league" university? Julie Burchill, the contentious *Guardian* columnist, reminded us that "going to Oxford really doesn't matter any more, except to a certain sort of grasping, insecure middle-class mediocrity" (3 June). And by applying to universities that she had no intention of attending, Laura may have actually deprived others from getting medical school places.

By this stage, the Labour party spin machine had created a populist campaign to

Laura Spence, "spat out" by Oxford

appeal to working class voters. Mr Prescott told an audience at the University of Greenwich, that the government would introduce cash incentives for universities that increased their intake of state educated students. Ironically, I had suggested this idea in the *student BMJ* the previous week (22 May), just before the Laura Spence story broke.

The *Times* reported that Robin Cook wanted more top jobs in the civil and diplomatic services to go to women, black people, Asians, and people from diverse social backgrounds. Then a report by the Sutton Trust, a philanthropic educational body, was leaked to the *Observer* (28 May). The report stated that students from the private sector filled 39% of places in all subjects at Britain's top 13 universities. If selection had been purely according to grades, the figure should have been 28%. Consequently, the *Observer* revealed government plans to offer easier entry for state school students into medical schools and to introduce Harvard-style "talent spotters" to tour state schools to identify and encourage promising students.

John Stein, professor of physiology at Magdalen College, Oxford, hit back at ministers. In a letter to the *Telegraph* (1 June), he wrote that the real scandal was their failure to support efforts, including his own, to help educationally disadvantaged pupils get into Oxbridge. He accused David Blunkett and former school standards minister Stephen Byers of showing "a polite interest" in his summer school programme for state school pupils, but not giving it any financial backing.

The current Labour government abolished student grants and introduced tuition fees. Now it is considering substantial cuts to university funding, according to the *Times Higher Educational Supplement* (2 June). How ironic, therefore, that it is using the tale of Laura Spence to promote the need to widen access to education. The *Daily Mail* reported that a pupil from an independent school is 10 times more likely than a state school pupil to obtain three A grades in A level exams. This is what prevents more state school students getting into the best British universities. This scandal is the fault of the government, and not of the "elitist" universities.

Jason O'Neale Roach *BMJ*

WEBSITE OF THE WEEK

Back pain This week two articles in the *BMJ* suggest that the amount of back pain experienced in Britain has increased, largely as a result of increased reporting of mild to moderate symptoms (pp 1552, 1577). Medicine is unlikely to have the answer: rather, patients will overcome their pain by modifying their behaviour.

Most people who overcome chronic back pain do so by becoming more physically active—whether by walking more or taking up an exercise like yoga. OnHealth's consumer portal offers "Yoga at your desk," a series of fast loading animations and instructions that lead the user through a series of exercises (look in the toolbox at the foot of the home page at www.onhealth.com/).

As usual with common problems, there are as many websites that discuss back pain as there are seconds in the day, so I abandon the general search engines for my favourite medical portal, Hardin's Meta-Directory (www.lib.uiowa.edu/hardin/md/index.html), which is a directory of directories organised under broad specialty headings. This presents the usual classificatory difficulties of "deep" sites—that is, those that require the user to make more than one click to reach the final informational destination. Does back pain belong under "anaesthesiology and pain," "rheumatology and arthritis," "orthopedics," "family medicine," or even possibly "neurology and neurosciences"? And how happy am I going to be clicking on each in turn, waiting for the page to download, and then using the "back" button once I discover it is irrelevant? That's why you need text word searching over the whole site, which happily is provided, and soon I have discovered a new informational tool, the US Department of Health's colossal amalgamation of guidelines at www.guideline.gov/. The first hit here pulls up an authoritative guide to assessment and management of back pain, as does a search on OMNI (www.omni.ac.uk/). Take your pick, and don't slouch at your screen.

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PERSONAL VIEW

Politically correct references

In my day we were not stupid enough to suppose that references were the key to getting a hospital consultant job. They were just one more worry. Given a fair wind at interview we knew perfectly well that telephone calls would long ago have been made, discussions at the 19th hole would have taken place, and the chosen candidate's on-call roster would be into the third draft. We knew, too, that references for the also rans would have been taken up, made available to the advisory appointments committee, and read out, or better still read—all of them—after the interviews but before crunch time.

References (and the choice of referees) were important. Without them the appointments committee could rely only on candidates' opinions of themselves from self-serving curricula vitae or from self confident interviews. Some doctors who excel at their job do not always excel at interview; a referee can say that. References gave honest views from independent arbiters with nothing to lose and nothing to gain: honest because, in law, the arbiters were responsible for them. Although you could, and did, read between the lines, it probably told you as much about the arbiter as about the candidate. With a cruel or stupid or covertly racist reference you might hint to an unsuccessful candidate a change in referees.

Even in these politically correct days consultants still have to write references. If a senior house officer is looking for a specialist registrar job I spend about an hour or so at the word processor; two to three hours if a specialist registrar is looking for a consultant job. Having given trainees a promise to do my best, they trust me to do my best. But why bother? I ask the question since references do not seem to mean what they used to mean, what I think they mean, what trainees think they mean, or what they ought to mean. And they are not read. There has been a subversive sea change driven by the positive discrimination lobby of the equal opportunities industry.

I did not realise the full implications in all their horror until I rang medical staffing about a new consultant appointment. "When do we see the references?" I asked.

"See them?" she replied.

"Watch my lips," I said. "Do we see the references, all of them, before the appointments committee meets, as it meets, or after

it meets—that is, when the interviews are done but before we have made up our minds?"

"No," she said. "You may see the references for the putative favoured candidate, Doctor, after, and only after, you have made up your minds."

"Not before?"

"Before? Are you mad? References are a joke. How many times have you yourself seen the rubric 'Dr X claims that he used to work for me'? We in medical staffing have no remit to confuse the minds of fuddy duddies on an interview panel. If we got an honest reference like that what on earth would happen to our equal opportunity policy?"

"Equal opportunity, you mean, as between the good and the bad?" I suggested helpfully, and I meant it to sting.

"Quite," she said.

You have but to scan the columns of the *BMJ*'s advertisement supplement: "Working towards equal opportunities"—Aintree Hospitals NHS Trust; "Committed to equal opportunities"—Royal Hull Hospitals; "We are committed to employing a workforce which reflects the diversity of the local community"—The Whittington Hospital (they employ deadbeats and dropouts, do they?); and my own institution "The Trust operates an Equal Opportunities Policy and encourages applications from disabled people and those with an ethnic minority background." Euphemisms for colour and race are weasel words, racist in themselves. We want the best man or woman we can get.

On references a trust may technically have no written policy. Technically, perhaps; but in the current climate its personnel department, from the need to protect the trust from dark suspicion, would think itself foolish to have no policy at all on what you might call "good practice." So it has become customary to share the contents of references with the interview panel following a discussion about the favoured candidate only. The panel is unlikely to see references from unfavoured candidates. "The government is looking closely at race relations and sex discrimination. Any failure of NHS trusts to adopt good practice may result in attendance at an employment tribunal."

When a trust feels under pressure to set its own standards of political correctness from fear of an employment tribunal (self censorship) it is a bad lookout for medicine. It is unfair to the individual. What is more, it has a questionable legality. To put it bluntly, it's cobblers. If you must read my references read them. No one can stop you.

Peter V Scott consultant anaesthetist, Redditch

SOUNDINGS

Meetings

If you wanted to become a better doctor, what would you do?

We—me and three friends in the hospital—are trying to find the answer to this question through a course we started earlier this year on the doctor and patient relationship at the most respected psychotherapeutic institute in Brazil.

Every Monday evening, we four and three more doctors sit down with four psychologists in an effort to understand what is happening inside the doctor and the patient and in the metaphorical space between them—all of it with a minimum of psychological jargon.

It's symptomatic of our age that this course nearly didn't happen at all. We had difficulty getting enough doctors in the hospital either interested enough or with free time to attend it.

After a broad analysis of the doctor's status from the time of Hippocrates to the present, and an introduction to the psychoanalytical view of development since birth and childhood, we are now facing the hard question of the so called difficult patients. We are trying to work out why they are difficult, why we feel this way about them, and how we should deal with them, all based on examples from our own practices.

And the group itself is an example of what we are looking for. There we are, doctors and psychologists, consciously putting aside our professional language and deeply ingrained habits of thought to find a shared vocabulary, in the true meaning of the word communication (let's reassemble it to spell common-(i)-action and we can discover something new about it).

But what is the hardest to face: the difficult patient that we dislike or the "good" one whom we can't help or who can be helped only through a long and painful treatment?

How frequently do we come to feel for the latter what we feel for the former, hating them for putting us in the difficult position of relieving suffering by enhancing it? That is the question that my friend Dr Franco wants to raise at the next meeting. At the time of writing I still don't know what will come out of it, but we will see ... and by the way, unanswered questions aren't so annoying as they are thought provoking, are they?

Ricardo S Silva psychiatrist, São Paulo, Brazil

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