reviews

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Primary Mother Care and Population

Eds Glen Mola, Jim Thornton,
Michael Breen, Colin Bullough,
John Guillebaud, Frank Addo

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Rating: ★★★★★ for
importance and novelty;
★★★ for content, layout,
and usability

A remarkable thing about Maurice King is his ingenuity in getting his controversial ideas into print. Motivated by public health and humanitarian concerns, he has long pursued a well researched, passionate, somewhat eccentric, and tireless campaign to avert demographic and environmental disaster in an increasingly overpeopled, overconsuming world. Now entering the fourth quarter of his first century, after several decades of engagement and leadership in primary health care in developing countries, King has reinvented himself as “knowledge engineer,” a sort of literary puppeteer. The editors of this book, all colleagues from his years of work and travel, have contributed ideas and critiques. King, however, has done much of the writing and design.

The layout is idiosyncratic. As knowledge engineer, King presents basic biomedical and technical information in a reader friendly, idiom-free style with few long words. The book is intended as a “library,” a resource, for traditional birth assistants, midwives, and doctors in under-resourced developing country settings.

The book has 29 chapters: encyclopaedic in content, kaleidoscopic in visual style. It is full of diagrams, cartoons and, in the key first and final chapters, wry and robust comment. Those end chapters are hard hitting—and are the reason why Oxford University Press, publisher of King’s earlier books (including the influential *Medical Care in Developing Countries*, 1982), declined this one. King has identified a pantheon of demons that, severally and separately, act to suppress urgently needed public discussion of overpopulation in “demographically entrapped” countries such as Malawi and various neighbouring African states. Such countries, living beyond their resource base means, are destined, argues King, for tragedy: starvation, fratricide, or abandonment (by emigration).

The final two words of the book’s title are important. The book’s greater aim is to inform people everywhere about the possibilities for controlling fertility, for having planned and healthy children (or, preferably, one planned and healthy child), thereby helping the world avert a succession of local and regional crises.

It is also evident from the final chapter, notwithstanding the humour, that King is mightily frustrated by all 25 population demons. These are the diverse demons of conventional thought; human frailty and foible; disciplinary conservatism (especially African demography); state self interest (read “USA and its CIA,” with which King reports having had mysterious, sinister contact while under presumed surveillance at the 1994 United Nations Population Conference in Cairo); and political correctness on the part of international agencies such as the United Nations Development Programme and Unicef.

King adduces various lines of evidence for his demonology. It is certainly plausible that the United States has long acted to preempt international discussion on the need to slow population growth in much of the world. Various key foreign policy pronouncements from earlier decades underscore this position, hinting at the need to avoid reciprocal discussion of overconsumption by affluent America. US demographers have set the boundaries of the modern discipline, and, currently, few demographers will engage with the topics of “environmental carrying capacity” or “demographic entrapment” (despite recent papers implicating population overload in the contemporary crises of Rwanda and other parts of sub-Saharan Africa).

The solution that King now advances is a more frontal attack, an exposé. This, predictably, is what gets him offside with journal editors and book publishers, unnerved by open criticism of the citadels of intellectual and political power. In his final chapter King advocates, in politely Latinised language, that a genu robustum (a strong knee, to the groin) be directed at Demon 21, the United States government and its population tabooing agencies. To highlight the point, there is a drawing of the knowledge engineer (in gardening trousers and coat—irreverent, in case Uncle Sam takes himself too seriously) delivering a genu robustum.

King hints that this book is his final opus. He urges others to rally to the cause, in an overcrowded, overexploited world. It is a pity that mainstream publishers have not been courageous enough to publish this volume. There is a balance in King’s argument here that was missing in his earlier preoccupation with population growth. He articulates clearly the dual problem of, firstly, overpopulation, dramatically captured in “Figure X” (showing the African population tripling over the past four decades and set to triple again over the coming century) and, secondly, overconsumption—and their disparate distribution between the world’s rich and poor.

The book deserves a wider audience than it may get. Knowledge engineering is one thing; but engineering the distribution and sales is another. The budget price production will help—and it is difficult not to notice the vivid pink cover. King’s indefatigable efforts in the pursuit of a better world for future generations are to be applauded.

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2150—starvation and violence permitting, Africa is set to exceed its carrying capacity seven and a half times.

2050—starvation and violence permitting, Africa is set to exceed its carrying capacity five and a half times.

1970—population 364 million: food balance becomes negative, carrying capacity is reached.

Talk About Sex: The Battles over Sex Education in the United States

Janice M Irvine

University of California Press,
£16.95/\$24.95, pp 282
ISBN 0 520 23503 7
www.ucpress.edu

Rating: ★★

Sex education is a vital issue for any country, but within nations there are divisions over how it should be delivered. As a psychologist specialising in research on sex and relationship education in the United Kingdom, I was interested to see how a similar Western country (the United States) managed.

Janice Irvine details the struggle between the Christian religious right and liberal sex educators (primarily SIECUS—the Sexuality Information and Education Council of the United States) since the 1960s. Her book describes how the liberal

groups who want to broaden sex education believe that sexual problems—particularly teenage pregnancies and sexually transmitted infections—arise from a lack of comprehensive education (a view that I support). On the other hand, she points out that the religious right, which support abstinence until marriage, believe that sexual problems result from the availability of sex education. Irvine describes continued and hopeless divisions around issues of sex information, access to abortion, understanding of HIV and AIDS, and sexuality. The book constructs liberals as caring and understanding, while the religious right are homophobic, misogynistic, and generally bigoted.

In view of the book's subtitle, this is perhaps predictable. Yet a more balanced overview might have been to broaden the debate out from the splits between SIECUS and the old and new religious right. Perspectives on sex education have evolved since the 1960s—particularly as a result of lesbian and gay studies, feminism, and the growing men's movement—adding much to the debate. Yet these perspectives are largely absent. The book also underplays the view of other religions towards sex education, particularly Judaism and Islam.

However, the book does offer a fascinating insight into how two fundamentally

different groups have tried to persuade the rest of the United States to believe them. Both have used the media, politicians, and schools to promote a comprehensive sex education curriculum. Irvine humorously describes how, in the 1980s, certain Christians (jokingly referred to as “fundies in their undies”) promoted sex within marriage through popular selling books. Irvine is quick to point out that this approach firmly placed the woman in an obedient and subservient position—providing sex to her husband as part of her marital role. But the book also muddles “liberal” with “sex positive,” forgetting that many of the underlying messages within liberal sexology are still underpinned with ideologies that may polarise the sexes and rely on stereotypes.

Anyone interested in the history of sexology will find this book invaluable—it is certainly easy to read and seems unlikely to date. However, I was left feeling that this was not the book for sex educators or healthcare providers wanting to know about delivering sex education.

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Sweet Medicine

ITV 1, Thursdays at 9 pm,
from 4 September

Rating: ★

Remember *Peak Practice*? In one memorable episode, an attractive female athlete is provisionally diagnosed as having arthritis and told to rest pending the test results. That same evening, we see her limbering up to train on the local track. Fortunately, the (young and dishy) general practitioner is driving by, and screeches to a halt in time to pursue her, shouting, “Don’t do it, Donna.” He catches her before the first bend, thus averting permanent damage. Cut to a soft focus shot of the silly girl in the doctor’s arms and a look of a professional job well done in his come-to-bed eyes.

The latest medical television soap, *Sweet Medicine*, is more of the same. With a cast headed by the actress Patricia Hodge, the 10 part series follows the personal and professional lives of the Sweet family, who run a surgery in a fictional Derbyshire village. The GPs are young, gorgeous, and idealistic, and the plot repeatedly turns on the contrived moral dilemmas they face in relation to the unlikely illnesses and risk behaviours of patients of the opposite sex. As moral custo-

dians of their village, they are forever popping up in homes, schools, and cafés to deliver advice or check if it is being followed.

The overarching storyline closely mirrors what we would all recognise as the standard medical day (consultations, sex, paperwork, sex, emergencies, sex, meetings, sex, etc). When an old flame pitches up in a skimpy top with an unconvincing sore throat, we see everything in Dr Nick Sweet’s body language except his actual hard on. We know he will be unfaithful to his lovely young wife before long.

The main character—the much loved but clinically inept senior partner of a country practice—is cold in his grave by the end of the first episode. His legacy will pervade subsequent instalments as examples of his decisions come to light and vex the next generation of partners: his nephew, son, and daughter in law. How much should they cover up for the old duffer—and how can they save the patients he mismanaged before it’s too late? The first iatrogenic emergency is the village slob, who has been picking up repeat prescriptions for weight losing diuretics. A blood test sent by the young heroes shows that the tablets were “killing him,” so he is pulled in pronto and cured by the rapid consumption of two jugloads of tap water.

The medicine itself is the worst I’ve seen on television—and, worryingly, panders to a host of contemporary misconceptions. A six month old infant, alert and bonny to even the untrained eye, is apparently failing to thrive on the grounds that he whinges a lot. The blood tests come back normal, and the GP concurs with his anxious but sensible

The Sweet family: gorgeous and idealistic

parents (a cuddly gay couple—nice touch) that there’s something going on. “I’d like to send Henry to hospital for some tests to see if he has any allergies,” he says. “How long will it take?” they ask. “A day—two at most.” The tests confirm cow’s milk intolerance, and the GP immediately does a home visit to deliver a jumbo can of soya milk.

If *Sweet Medicine* goes to a second series, the producers would do well to hire an on-set medic to make sure that the x rays are the right way up and edit out the blatantly dangerous pearls of medical advice (“there’s no bruising or rash, which rules out meningitis”). Until then, you can either (a) not watch it or (b) suspend your professional judgment entirely and enjoy the rumpy-pumpy.

Trisha Greenhalgh *professor of primary health care, University College London*

The Third Degree. MMR: Can You Decide?

BBC Three, 11 September, 9 pm

Rating: ★

I have a confession to make. I am entirely in favour of the MMR (measles, mumps, and rubella) vaccination, and actively support its use. I am for all vaccination programmes, because I believe in protecting our communities, and I have seen at first hand what happens in countries that do not enjoy the privileges that we have in the United Kingdom.

That said, I find it quite tough being a general practitioner—getting caught in the middle between caring for individual patients while still defending the “masses.” And I find parents who happily support the general notion that our children should be vaccinated, yet withhold their own cherubs from doing their bit towards herd immunity, utterly selfish.

So I was looking forward to watching this programme about how parents decide whether or not to have their children vaccinated. I was hoping that it might reveal some original insights into what it is to hold conflicting views and how these conflicts are converted into decisions. Four “undecided” parents—two mothers and two fathers—with

children of vaccinateable age came together to listen to experts giving “evidence” about the MMR vaccine.

But early in the programme—which was broadcast on a BBC digital channel aimed at the 16–35 age group—it became clear that the two mothers had clearly made up their minds before the proceedings had begun. They were simply assimilating the strands of the arguments that best fitted their preconceived ideas. They were not going to choose the MMR vaccine, whatever “evidence” was placed before them. The two fathers admitted that they were more inclined than their wives towards having their children vaccinated, but ultimately both men deferred to their wives to make the final decision. This was a television programme not about decision making, but about stereotyping.

The experts included three doctors. There was a GP who was positive about MMR, and believed that there was no connection between his son’s autism and the vaccine. The parents wrote him off as interesting but biased because obviously he stood to make money from achieving vaccination targets. There was a doctor who privately administered separate vaccines. His services were also viewed with a degree of scepticism.

The only doctor who articulated an argument in favour of the MMR vaccine and who could not be easily discounted on the grounds of financial reward was a paediatrician. He explained that science, and even a limited understanding of immunology, could not account for the speed with which some children had

Decision time over MMR

apparently acquired the regressive symptoms of autism after being vaccinated. The human immune system did not function in this way. Developing severe neurological symptoms just two hours after being vaccinated was scientific proof that it could not be the vaccine that was causing the problem.

The four parents threw science out of the window in favour of gut responses and emotional decisions. For a split second the two fathers wavered. The science was presented simplistically, and compellingly. But sadly, it was not sufficient to persuade any of them. Both men agreed that they were beginning to be swayed, but neither was prepared to cross their wives.

Ultimately, it seems to me that the real issue is about science, and the fact that many people in Britain do not trust scientific explanations. But it is also an issue about understanding risk. Many millions of children around the world have been safely vaccinated with MMR and only a tiny number of those have subsequently been diagnosed as having autism. Most people appreciate that the risk of being diagnosed as having autism is small, and the vast majority do not make a connection between autism and MMR. But some people do, and it is this significant minority in the UK that is threatening the safety of all our children by refusing MMR. For some inexplicable reason, the original *Lancet* study that triggered these people’s fears—poorly conducted as it was and involving just 12 children—is more compelling to them than the mountains of subsequent data that have consistently failed to replicate the original findings (*Lancet* 1998; 351: 637–41).

This programme failed to inspire me. The questions were dull and the arguments had all been heard before. The programme makers made no effort to discuss the concept of risk. I’m suffering from MMR fatigue. People will believe what they want to believe, and sadly, in the United Kingdom at least, we seem to have become a nation of people that trusts science only when it’s convenient to do so.

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

WEBSITE OF THE WEEK

Population One of the strengths of the internet is that it can provide up to the minute data about events and developments, both locally and globally. As the world and information about it changes, so can the internet. It is not surprising, therefore, that the internet is full of sites about the changing size and shape of the world’s population, a theme of a book review in this week’s *BMJ* (p 626).

www.ibiblio.org/lunarbun/worldpop shows a counter totalling the increasing world population second by second. It is a classic case of six more babies born in the time it took you to read this. It is also possible to set the date and time to see the world’s population at any given time since 1970. The difference between then and now is startling.

The site of the United Nations Population Fund (www.unfpa.org) provides information about its aims and role in helping to control populations worldwide. As well as news items and details about population issues, there are good links to publications and an opportunity to view the fund’s 2002 report *State of World Population 2002: People, Poverty and Possibilities*.

The Population Reference Bureau (www.prb.org/) has an up to date collection of articles concerning current population trends across the world. The site also has a useful search tool that allows visitors to access data about different variables such as the percentage of children who are breast fed and the percentage of married women aged 15 to 19 who use the oral contraceptive pill. For the more visually minded, www.population.com provides pyramid charts to show the distribution of population by age and sex, country by country.

Most of the available websites were informative. How refreshing that once in a while the web surfer does not have to wade through too much useless clutter, despite entering only one word on google.com

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PERSONAL VIEW

Has the President's Council on Bioethics missed the boat?

When George W Bush established the President's Council on Bioethics in 2001, sceptics insisted that it was laden with "conservative" scholars who were unlikely to engage in wide ranging, non-partisan ethical debate. I want to sidestep the question of whether the forensic table at the council tilts to the Republican right rather than the Democratic left. Instead I want to criticise the council's purpose and substantive contribution.

According to presidential executive order 13237, "the Council shall advise the President on bioethical issues that may emerge as a consequence of advances in biomedical science and technology." Specific biomedical technologies noted in the council's mission statement include "embryo and stem cell research, assisted reproduction, cloning, uses of knowledge and techniques derived from human genetics or the neurosciences, and end of life issues." Many people would argue that no topic in bioethics is more important than these. In contrast, I suggest that the council's narrow scope removes from discussion many of the most important issues.

Were the body called the President's Council on Novel Biomedical Technologies, the focus on embryo and stem cell research, cloning, and "enhancement technologies" would be perfectly understandable. However, the very name of the council suggests that it is supposed to have an expansive agenda encompassing issues in bioethics. There are several longstanding ethical, legal, and social issues that ought to be the proper focus of the council.

More than 40 million people in the United States lack health insurance. A council on bioethics that is serious about ethical issues related to health care ought to address core social questions concerning access to basic healthcare services. The terrorist attacks in the United States and current efforts to improve security highlight the importance of having an effective healthcare infrastructure. Although Democrats and Republicans may have different perspectives on how to address access to health care, basic questions concerning social justice and access ought to be near the top of the agenda in any discussion of bioethics.

Sections of many US cities are violent urban wastelands. Widespread violence related to firearm use destroys families, wastes lives, and has major economic consequences. Lack of job opportunities makes it impossible for families to move to safer, more expensive neighbourhoods. Underfunded educational institutions fail to provide students with the

tools they need to land meaningful jobs. Service providers are unwilling to establish shops and other businesses in violent, impoverished areas. Poor people have difficulty getting basic goods and services. The widening disparity in income is closely connected to disparities in health status and morbidity. The yawning gap between the wealthiest and the poorest citizens of the United States is an important health issue and a matter for careful ethical analysis.

Equally troublesome are questions concerning the role the United States should play in the area of international health. President Bush and various US philanthropic organisations have made significant international investments in AIDS research and treatment. The National Institutes of Health have funded important work addressing ethical and legal issues connected to the conduct of multinational clinical trials. A more cosmopolitan outlook might enable the President's Council on Bioethics to address important questions concerning global health, transnational medical research, and the relation between international aid and international health.

Criticism of the council needs to be tempered with acknowledgment of the need to set reasonable limits on what the council can and should accomplish. Still, the focus on ethical issues most closely connected with advances in biomedical science and technology means that the council is looking at several rather speculative concerns instead of addressing urgent matters. For example, council members are presently addressing ethical issues related to the possibility of developments in life extension technologies and the achievement of "immortality." While this issue might be of pressing concern to fruit flies and nematodes, there is no reason to think that humans are on the verge of becoming "posthuman immortals." Last year the council scheduled meetings on genetic enhancement of muscle and genetic enhancement in sports. A body of this stature ought to focus on issues of national and international importance.

By limiting itself almost exclusively to advances in biomedical sciences and technology, and ignoring broader social issues, the council risks promoting a "bread and circuses" approach that entertains with the spectacle of enhanced bodies and immortal lives but offers little meaningful and substantive ethical analysis.

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SOUNDINGS

Weapons of mass destruction kill dinosaurs

In a second I realised that my eyes had deceived me, that I had misread the two headings and falsely combined them, and that "Saddam's weapons of mass destruction" was a separate article from "Killer dinosaurs." Nor did I pay attention to such items as "Aliens among us," "Psychic advice from Serena," "Conspiracies," and "The chamber of the bizarre." But my interest was drawn to an article supposedly written by a former funeral director claiming that 35 people are buried, embalmed, or cremated alive each day in the United States.

"It is a closely guarded industry secret," writes the author, "that nearly one in 50 people who are pronounced dead aren't dead after all—they're comatose" and "everybody has heard of people waking up at their own funeral." Hence the need to take precautions to avoid being painlessly bled to death and embalmed prematurely, or waking up "six feet under in a stuffy coffin" or in a "flame-drenched crematorium oven."

Some modern technology is no better than applying a mirror to the mouth and nose of the potential traveller to the underworld. For what are we to make of an item last year in a major Swedish newspaper reporting that "soon before the organ donation the patient started to move. The doctors had believed that the man was dead, but a check revealed that he was alive, and the organ donation was rapidly cancelled."

Also to feed a morbid imagination is a newspaper item describing how doctors thought that they felt a pulse in a woman who had been placed in a body bag in a refrigerator for three hours. Mercifully they were wrong. Yet in *The Premature Burial* Edgar Allan Poe wrote that "to be buried alive is, beyond question, the most terrific [agony] which has ever fallen to the lot of mere mortals. That it has frequently, very frequently, so fallen will scarcely be denied by those who think. The boundaries that divide Life from Death are at best shadowy and vague. Who shall say where one ends, and the other begins?"

But we must not believe everything we read. And we may definitely rest reassured that the dinosaurs are in no danger of being exterminated by smallpox, nerve gas, or atomic radiation.

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