these crimes remains undetected for many years.

Anecdotally, explicit reporting of court cases can have both temporary and long term effects on particular communities. I work in a town where two 10 year old boys were convicted of the murder of Jamie Bulger. For a couple of months, patients already suffering from depression and anxiety, especially those with young children of their own, appeared more distressed when the media reported detailed accounts of Jamie's injuries. The effects were fortunately temporary. In east Manchester, anger and distress caused by the Moors Murders still surfaces intermittently 30 years later, even among people who knew neither the victims nor the perpetrators. Much of this community's distress seems to be related to graphic descriptions of the torture the child victims experienced before their murders.

Explicit reporting of violent cases that remain undetected for some time may have detrimental effects on public attitudes to victims. Rosemary West's surviving children

have all asked for forgiveness for their mother or protest her innocence. The public is not likely to understand how torture by a close family member can lead to partial or complete suppression of memories of the abuse or powerful mixed feelings of affection and revulsion towards the abuser. Instead victims may be blamed for not getting help sooner, thereby preventing the torture and murder of later victims. Voyeuristic responses from the media may sometimes be as damaging psychologically as the original abuse.

On the other hand, censorship of explicit details of cases such as the West trial can have negative effects on the attitudes of the public. There is a danger that censored reports of the West trial sound too much like fiction, anaesthetising the public to these barbaric crimes, with several possible adverse consequences. The public may not report their suspicions or evidence of similar crimes, authorities may become indifferent to the public's suspicions, immature or irresponsible people may become violent without

realising the horror of what they are subjecting their victims to, and the public may start to believe the perpetrator's claims of innocence and make punitive or dismissive judgments about the victims' culpability for the crime.

A balance needs to be struck. There is virtually no research to guide us on the specific effects on the public of reporting court cases of exceptional physical or sexual violence, despite mountains of reports of the effects of fictional violence on television on young people.

I am glad that the media did suppress some of the explicit details of abuse at the time of the West trial, but they should have told the public that censorship was happening each time it occurred. I also think that the public should now gain access to the suppressed court case material in a way that is not sensationalised or forced down everybody's throats, perhaps in a book whose royalties support the victims of the crime.—RICHARD MORRIS, senior lecturer in psychiatry, University of Manchester

PERSONAL VIEW

Hospital culture shock

Ewoud G Bos

Anybody who goes to work in a different part of the world should expect a culture shock. Faced with unfamiliar attitudes and customs you are constantly uncertain about how to behave and, therefore, ill at ease. Before we left for the Middle East we read a lot about Arab culture and customs and tried to fit in some language study as well. We now feel most stress not in the shops or with the language but where we did not expect it, in our medical work in the culture of the hospital.

We work in the Arabian Gulf alongside mostly Indian doctors. Our hospital began life a century ago as a charitable institution. When the increasing standard of living made it possible to charge a fee our hospital started doing so. We now function as a small, private, open access hospital with a total workforce of about 220 people. The general health of the people is excellent and most speak English well enough for an easy consultation. The hospital remains firmly committed to providing good health care on a non-profit basis. We do this in competition with the government system of free local health centres backed up by two prestigious modern hospitals and a large number of fee charging private local practitioners in small clinics. Our hospital's good name, easy access, usually short waiting times, personal attention, and moderate pricing make us a popular choice for many. The hospital operates a charity budget to help those with financial difficulties.

We fully agree with the background and non-profit aims of the hospital and expected to fit in well. We greatly appreciate the warm welcome and assistance the hospital gave us when we arrived. But coming from Britain we are now experiencing culture shock as we realise how the need to keep the hospital running influences the management of the patient. We feel a little as if we are failing the hospital if we do not generate enough revenue to pay for our wages, especially as in our first months here we have not yet built up a following of patients of our own.

"We realise how the need to keep the hospital running influences the management of the patient."

In our medical training we are continually told not to ask for investigations unless the result is likely to alter our management. But a hospital like ours needs a well equipped laboratory—and for a laboratory to be viable a sufficient number of investigations needs to be performed. Moreover, in this part of the world patients may not consider themselves taken seriously if investigations are not done. So there is gentle encouragement to offer investigations even for minor illnesses or repeat them more often than is strictly necessary.

In our work as junior doctors in Britain we are criticised heavily if we book unnecessary review appointments. Here there is gentle encouragement to ask patients to reattend. It shows personal interest and so helps binding of clients. The hospital can also charge a small fee for the short "Is all well now?" visit.

At home we hear a lot about the dangers of

overprescribing. In the Middle East and beyond patients often expect to be prescribed several medicines when visiting a doctor. Why should we spend a long time explaining that they do not really need them? They may well remain dissatisfied—paying for a consultation but not receiving any medicines—and decide to go to another doctor or buy them over the counter. Our clinic staff show their surprise if no prescription is given: "Doctor Ewoud doesn't write medicines." So there is gentle encouragement to prescribe as it is quicker, makes the patient happy, and also keeps the pharmacy stock from going out of date. We are under the impression that the consumption of antibiotics in this country is many times higher than in Britain, which is likely to result in a much higher resistance against first line antibiotics.

My wife—who is a part time general practitioner—often discusses patients with her colleagues. She feels her confidence being undermined when they say that they would have ordered several investigations and prescribed various medicines for a patient whom she has just treated satisfactorily with explanation and reassurance.

If hospital and patient collude in this way should we go along with it? Perhaps we are in that phase of cultural adaptation where you feel that everything is better back home. We are here for a short time; perhaps if we stay long enough we will move on to appreciate the strong points of this system. Or are we not the right people to work in this way?

It seems to us that these pressures—of selling patients more than they really need—are unavoidable in a system dependent on market forces. And even a hospital committed to the best non-profit motives cannot escape their influence. It should make those who think that market forces can help to contain health care costs in Britain think again.—

EWOUT G BOS is a paediatrician in the Arabian Gulf