MORI poll halfway through showing that most of those polled thought that the NHS would no longer exist in 10 years' time. The difficulty with this style of television debate is that the emotional response of one side—the workers in the system—overwhelms them, leading to an unseemly attempt to hold the floor by shouting. The management point of view was given more calmly and thus appealed to the moderator, who tended to give these speakers more time. However, most of their contribution consisted of jargon—for example, using a mixed economy of service to obtain quality outcomes, and value for money. No explanation was given of how either of these could be usefully

measured or compared between organisations.

Those who emerged with honour from this rather ragged debate included Phillip Hunt from the National Association of Health Authorities and NHS Trusts, on the side of reform. He suggested that in a controlled market system the pressures for efficiency in the public sector could be provided by the private sector competing at the margins, and that no further move to privatisation should be made. Another valuable contribution was from Professor David Hunter of the Nuffield Institute for Health, on the side of those who were attempting to make the reforms work. He pointed out that no objective evaluation

of the reforms had yet been made and that no other country in the world had made a competitive system work, so it was unlikely to work in Britain.

On the whole the first half of the programme worked better than the second—the debate was one sided, the contribution from those working in the system was less articulate, and they were given less opportunity for expression than the reformers. At the end of the programme Professor Hunter pointed out that the NHS was introduced to replace the previous splintered, disorganised system of care; let us not return to that.—LESLEY BROMLEY, *clinical senior lecturer in anaesthesia, The Middlesex Hospital, London*

PERSONAL VIEW

The tip of the iceberg

Alison McCartney

I palpated a lump in my epigastrium nine months to the day after delivering my third child when I was 43. I was not alarmed since I had had an easy pregnancy and returned to work two months later as a consultant pathologist. I felt well. True, I was tired, but who is not with a full time job and three children, especially a small baby who still woke me five or six times a night. I was fatter than I liked but I had not visited the gym very often to tighten the rectus muscles which had separated. Mild epigastric pain could be easily accounted for by snatched lunches.

I persuaded my husband's senior partner of my health and my diagnosis, of which I was rather proud, of a desmoid tumour in the upper rectus. Since we have a specialised soft tissue unit at St Thomas's Hospital I asked him to refer me. The soft tissue surgeon felt it and told me that the lump was not in the abdominal wall but in the liver. I went upstairs to my office clutching my plain abdominal x ray film and thought of all the benign causes of enlarged liver after pregnancy.

The scanning staff were rather evasive, murmuring about a diffuse process. As I waited for the liver biopsy thoughts of occupationally induced hepatitis B or C or even cirrhosis, induced by a shared bottle of wine each night, flitted through my mind. The idea of malignancy did not occur until I asked the senior registrar to turn the two liver cores in the pot towards me. They were white.

Later the senior surgeon showed me the scan. Approximately half of the huge liver was filled with metastatic tumour. I had been feeling the tip of the iceberg. He then found ascites and a 3 cm lump lurking at the back of my right breast, without nodes. Carcinoma or lymphoma? I wanted desperately to go home, despite the liver biopsy. I telephoned my husband during his evening surgery. He was with a patient. He said afterwards that he

felt as though he had been hit with a 12 ton truck. He came to collect me and we tried to behave normally for the children and nanny's sakes.

Aspiration cytology of the breast lump next morning confirmed a carcinoma and the liver biopsy specimen showed an oestrogen receptor rich tumour. I started on tamoxifen and had a radiation oophorectomy the next week. We went on holiday to Italy as we had planned, but breast tumours continued to grow and the ascites increased, despite the pocketfuls of lira dumped in the Trevi Fountain in Rome. We managed to climb the

"I do not think that the tumour could have been diagnosed much earlier."

last part of Vesuvius, but by the time we returned I started to feel much worse, with violent headaches, lassitude and profound nausea, vomiting, and abdominal pain, presumably due to stretching of the liver capsule.

Starting on steroids transformed me. My husband said that it was as if I had been fitted with an outboard motor. This reminded me that fired up by hydrocortisone I had written a Personal View six months before while attached to an intravenous line full of antibiotics. It was a lighthearted view of the effects of acute adult epiglottitis on a confirmed foodie. My abrupt transition from apparent health to stridor and complete inability to talk or swallow even saliva precipitated the urge to communicate. The *BMJ* kept it for a while and then published a less solipsistic Lesson of the Week. One letter which followed suggested that in this rare disease occult malignancy should be sought. With my long lifelines and grandmother's genes this had not seemed relevant to me; it does now.

I am now in my fourth cycle of epirubicin. My transaminases preclude full dosage but my tumours seem to be shrinking. Part of my hair has fallen out, but I and the oncologist

are now firmly of the opinion that I am not going to die just yet and seem to be going into remission.

To present with a full house of stage IV carcinomatosis, with hepatic and osseous metastases at 44, when I did not even know that I was playing the game, creates problems. I work as much as I can. My concentration is poor at times and I am relieved that my MPhil student passed her viva five days after I was diagnosed and that the PhD student and other positions were not currently full. My sandwich students are working well and my collaborators are taking up the slack, as are my diagnostic colleagues. The charity which largely supports my post is being encouraging and thoughtful.

At home we have told only the older children that I have something the matter with my liver which requires treatment. At 10 and 8 they accept this and as the threat of imminent death seems to have receded for a while we think this wiser. I want to do it well when the time comes and am seeking advice.

Unlike many other patients I am not angry. I do not think that the tumour could have been diagnosed much earlier and if any doctor was at fault it was me for not taking symptoms seriously. Although breast cancer is an increasingly common tumour, it is still unusual to present with such a short history. Possible aetiological factors may have included eight pregnancies since the age of 33 and intermittent use of the pill over a 23 year span, although always low dose because my father died of pulmonary embolus after an accident at the age of 50. Thinking of him the day after my last round of chemotherapy produced floods of tears because my son always refers to him as "my grandfather who died young." Although I know I have to die, as liver metastases seem to be incurable, I want to do the best I can with whatever time is left. If remission occurs it may be that a treatment to rival the use of cisplatin in testicular tumours or the treatment of Hodgkin's disease may preserve me to emulate my grandmother and her sisters, who all lived into their late 90s or reached the century. I want to be a doughty old lady too.—ALISON MCCARTNEY is a senior lecturer in ophthalmic pathology