Write an obituary for the *BMJ*

Stephen Lock

"In every individual," wrote Dostoevsky in *From the House of the Dead*, "there is a spark of the Divine." It should be the aim of every obituary to convey this spark to a reader who has never known the subject. Yet how rarely is this achieved; instead the writer falls back on prolixity, cliché, and a curriculum vitae. There is little idea of this subject's uniqueness, of how things would have been different had he or she never lived.

This is not to sneer at obituary writers or at what they produce. They have an exceptionally difficult task, and the reasons for their failure are self evident. Almost inevitably inexperienced writers confronted with an emotional task and a short deadline, they find that they knew the subject far less well than they thought. And almost inevitably they then turn to and follow published obituaries which, instead of conveying uniqueness, have relied on sentiments more appropriate to a 19th century tombstone than to a 20th century journal.

Whether conventional or justified, however, condolences for relatives are best put into a personal letter.¹ Like other features in the journal, the *BMJ*'s obituaries are primarily for readers who want their attention held in the same way as elsewhere and, as recent correspondence has confirmed,² read them avidly. Nevertheless, for some time the editor has been faced with a paradox: whereas non-obituaries undergo rigorous peer review and have a high rejection rate, until recently obituaries did not, and most of them were published with only shortening. Given the continuing large increase in the number of doctors, the inevitable happened, with a heavy backlog of accumulated obituaries, some of them relating to doctors who had died several months previously.

Editorial selection committee

What is the solution to the "problem" of the obituaries? To apply the drastic "gatekeeper" approach used for the rest of the journal would be cruel and unpopular, yet a modification of this might solve some of the difficulties. In particular, peer review might help in distinguishing obituaries that are justifiably long from the ones that are not. Thus this summer the *BMJ* convened a small editorial selection committee to review every obituary and to decide whether it should be in the form of a shorter (60-120 words) or longer (200-400 words) notice (there is also a third category, a death notice recording brief facts about a doctor, when nobody has responded to an invitation to provide a short appreciation as well). All these accounts are prepared in the editorial office, which takes responsibility for shortening the original (though the name of the author who supplied the information is given in parentheses).

Clearly the new system has not been operating long enough for any disadvantages to become apparent. Nevertheless, even now three aspects of the new system need to be emphasised to help the tyro suddenly faced with having to write an obituary. Firstly, with the aim of being the reader's surrogate, the five person committee has been chosen to be as diverse as possible in terms of age, discipline, and geography. Secondly, any decision in favour of a longer over a shorter notice

is based on the interest of the account rather than on the rank of the subject. Lesser known doctors may generate much more interesting obituaries than "first rank" ones because they had more interesting lives—careers before or outside medicine, sporting or war-time activities, for example. (That said, however, many—though not all—of the medical great and the good are just that because they have achieved more than the rest of us.) Conversely, many of the short obituaries remain in the memory for a single fact well brought out by the writer: I have never forgotten, for instance, an account many years ago of an enthusiast who, though crippled by arthritis, rigged up a series of ropes and pulleys in his hillside garden so that he could continue with his major interest in life. The third factor to emphasise is that inexperienced obituary writers can be helped by a checklist suggesting what each type of notice should contain. The remainder of this article is devoted to some recommendations by the *BMJ*'s obituary editorial committee, together with an appendix of phrases to avoid.

Shorter notices

Shorter notices (60-120 words) need the following:

- Full names of subject, including any nicknames
- Principal appointment in career, with place and dates
- Date and place of birth
- Date and place of qualification
- Up to two subsequent diplomas or degrees; any honours
- Date and cause of death
- Two or three distinguishing sentences (on, for example, undergraduate career, wartime service, hobbies, achievements within and outside medicine), eschewing phrases to avoid (see below)
- Name of spouse and number of children, grandchildren, and great grandchildren. Family medical connections
- Date and place of any forthcoming memorial service.

Longer notices

Longer notices (200-400 words) need all of the above (though some facts may be inserted into the narrative). They also need a fuller treatment of what made the person's life so special for the outsider that justice cannot be done in a shorter account. For example, such an account concerned the life of Cecil Hackett, who, encountering supposedly bony lesions in yaws in the Sudan in the 1930s, went on to become the expert on the condition as well as making deductions about the way syphilis was introduced into Europe (p 682). Too many writers, however, pad out an account of their subject's life with a banal list of his or her successive appointments, a feature particularly prone to occur for academics or service officers and infinitely tedious for

readers if it supports no thread of an evolving life (what in fiction the Germans would call a *Bildungsroman*).

Dos and don'ts

Obituaries are news, and hence they need not only to be accurate but to be as topical as possible. The following suggestions should help to achieve this:

- Tell the *BMJ* that the subject has died and that Dr AB will be responsible for an obituary, preferably within a fortnight
- Remember that the notice is exclusive to the *BMJ* and should not be sent to another newspaper or journal as well (although it is quite acceptable for a different notice to be sent elsewhere)
- Decide on the type of notice (shorter or longer)
- Check the facts (dates of birth, qualification, and death)
- Provide all the facts listed above under shorter notices
- Provide at least three sentences to highlight the subject's unique contribution (more if a longer notice is being submitted). Friends or relatives, or both, may help with this, but if you find this impossible you are probably not the right person to be writing the account
- Check the account with the family or friends, or both
- Provide a photograph of the subject (preferably with the date it was taken). A passport photograph will not do since it is always disfigured with an official stamp
- Keep to the deadline.

Self written obituaries

Self written obituaries were introduced several years ago with the aim of getting the facts right as the basis for an appreciation by somebody else. Even so, I am not sure that they have been a great success (and I can say this because the original idea was mine). Too often, the attempt turns out to be a self justification or an apologia, and, though there are exceptions (such as the much quoted self obituary by Archie Cochrane³), I think that appreciations by disinterested colleagues are to be preferred—as they are to be preferred to the panegyrics written by spouses or children.

Phrases to avoid

Certain phrases occur over and over again in obituaries and, I believe, should be avoided (box). To be

No hobby but his/her work

The most popular general practitioner in Loamshire

The best clinical teacher in Britain

Had all the time in the world for his/her patients

With his/her death truly comes the end of an era

Widely respected for his/her conscientiousness/clinical prowess

Shrewd clinical acumen

Adored/beloved by all his/her staff/patients/colleagues

A person of total integrity

Took on a load that would have daunted/crushed/killed anybody less resolute/tough

We shall not see his/her like again

Did not suffer fools gladly

sure, in the individual case they may be justified: applied universally, however, they are unlikely to be true, if only on statistical grounds, while such repetition has a stultifying effect on readers. In a little remembered prewar book a Dutch academic, Professor Georges Renier, devoted a whole chapter to our national conviction that everybody and everything in England was the best in the world: he produced quotations to show that, according to its inhabitants, among many overweening attributes it had the best landscape, the best zoo, the safest airline, the best statue (Eros), the finest judicial system, and the most capable civil service, as well as the best bakers in the world.⁴ Much the same could be said about obituaries written about doctors. Nobody wants old scores paid off in spiteful, dismissive passages, but, equally, a recital of glib stock phrases is just as inadequate. Hence writers should adopt the third possibility: giving the truth about a rounded human being with his or her foibles as well as achievements. All of us would prefer to be remembered in this way not only because it is as we really were but because it is also much more interesting and readable than the conventional honeyed platitudes.

1 Lock S, Smith R. Obituaries: the future. *BMJ* 1995;311:143-4.

2 Letters. Obituaries. *BMJ* 1995;310:660-2.

3 Cochrane AL. A L Cochrane [obituary]. *BMJ* 1988;297:63.

4 Renier GJ. *The English: are they human?* London: Williams and Norgate, 1931.

A MEMORABLE PATIENT

A lesson once learnt . . .

One year ago in the *BMJ* Meg Patterson described her flash of recollection during a life threatening operation in a remote part of Darjeeling, when severe abdominal bleeding occurred with no blood available for transfusion.¹ She had witnessed Norman Tanner, a surgical giant of his time, pack the bleeding area with gauze and close the wound.

Some years ago I was called to operate (in central London, with excellent facilities) on a man on whose unprotected head had fallen a brick from a great height. His occiput was depressed and his wound bled a little, but his general condition was good. It was 11 pm. I was not helped by the presence of the professor of surgery and his entourage who had finished their no doubt simple task in the neighbouring theatre and stayed to see how neurosurgery was conducted. I found the torcula completely

destroyed, so that on removing the depressed bone profuse bleeding came from sagittal and lateral sinuses. After 11 units of blood had been used the laboratory was becoming anxious, as indeed was I. My thoughts flashed to a neurosurgical meeting many years previously where Professor George Grey Turner, famous for his heroic hind quarter amputations, described his satisfaction with the use of gauze packing for uncontrollable haemorrhage after removing a meningioma. I took a large gauze swab intended for a head dressing, and closed the scalp over it, to the sound of muttering from the professorial team. A week later I removed the gauze and replaced the bone fragments. The patient did well, but was never to know how much he owed to an old time general surgeon.—KENNETH TILL is a retired neurosurgeon in Somerset

1 Patterson M. A memorable patient. *BMJ* 1994;309:157.