reviews

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Traffic Safety

Leonard Evans

Science Serving Society,
\$99.50, pp 445
ISBN 0 9754871 0 8
www.ScienceServingSociety.com

Rating: ★★

On 7 April 2004 hundreds of organisations around the globe hosted events to raise awareness of road traffic injuries and their grave consequences and enormous costs to society. For the first time in the history of the World Health Organization, this day—world health day—was devoted to road safety. Dr Lee Jong-wook, WHO's director general, officially launched the *World Report on Road Traffic Injury Prevention* in Paris and handed a copy to President Chirac. Around the same time Leonard Evans published his second book, *Traffic Safety*. In the preface Evans says he has tried to place more emphasis on policy and to go "to the heart of the problem, with unconstrained analysis of the inadequacies of government in one of its chief responsibilities—to protect life and enhance public safety." The book, though centred on the United States, succeeds in doing this.

According to WHO estimates, each day as many as 140 000 people are injured on the world's roads, more than 3000 die, and some 15 000 are disabled for life. If present trends continue, by 2020 the number of people killed and disabled every day on the world's roads will have grown by more than 60%, making road traffic crashes the third leading contributor to the global burden of disease and injury. Already, young adults have a higher probability of dying after a road traffic crash than from an infectious or non-communicable disease.

The number of deaths resulting from road traffic crashes shows no sign of decline except in a handful of high income countries. This is partly because traffic safety has still not developed as a scientific course of study in most countries and because the number of job openings for people who want to pursue a career as a full time road safety professional is small. Scientific information is hard to find, mostly scattered piecemeal in technical periodicals, as the field of traffic safety is a complex, multidisciplinary

gathering together of expertise in specialised areas of study. Therefore *Traffic Safety* is a timely addition to a small number of books that present the evidence on road safety logically and scientifically.

The book explains the complexities involved in recommending road safety measures. It includes numerous examples that illustrate the common mistakes researchers make when they use simple methods to try to understand complex and confounding variables.

Evans is at his best explaining counterintuitive results. Antilock braking systems were expected to reduce crashes significantly, but the data show an increase in rollover crashes, because better braking performance encourages greater speed. The rate of crashes in the winter months (with snow on the roads) is substantially lower than in summer. Evans suggests that unfavourable driving conditions in winter reduce speed and the amount of travel. Expensive, high tech driving simulators do not contribute to our understanding of road safety, because simulators measure what "the driver can do," whereas "safety is determined primarily by driver behaviour, what the driver in fact chooses to do."

Young adults have a higher probability of dying after a road traffic crash than from an infectious or non-communicable disease

The introduction of measures in the United States to reduce exhaust emissions was accompanied by increases in the use of sport utility vehicles (SUVs), in the number of miles travelled per vehicle each year, and in the number of injuries and deaths resulting from traffic collisions. These unintended effects arose because people changed their preferences as ordinary cars became more fuel efficient and lighter and because SUVs seemed to offer greater protection and more powerful engines at relatively low prices.

The book is a valuable collection of facts about traffic safety, including facts related to vehicles themselves, the environment, roads, drivers' performance and sex and age factors, alcohol consumption, air bags, and enforcement and policy issues.

It is an excellent primer that teaches you how to examine and analyse data on traffic

IMAGE SOURCE: EX FEATURES

The rate of crashes in winter is substantially lower than in summer

and crashes. Its strength is in its cold statistical approach. Evans is right in saying that the future of road safety lies in the prevention of crashes, and few people are likely to contest his recommendations of automatic alcohol detection devices, speed control, and cameras that record drivers who run red lights. His chapter on air bags will be controversial, as he believes that "it is indefensible public policy to compel consumers to purchase items (air bags) that cost more than the benefits they provide." Similarly, many would not agree with his views on past US policies and future directions.

Evans is upset that the road safety record in the United States has not kept pace with the "best" in Europe. He tries to look at failures in US safety policy ("led by lawyers") but does not examine the influence of lifestyles that depend on cars. The book has little discussion of traffic patterns other than those seen in the United States.

The treatment of broader policy issues is not the strength of this book; this should not, however, detract from the value of this highly readable, entertaining, and educational volume on the scientific evidence regarding road safety interventions. There is far too much ignorance about road safety measures among transportation professionals and policy makers, most of whom rely on folklore. Evans's book dismisses much of the folklore very effectively, and this is its most important contribution.

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

Saturday

Ian McEwan

Jonathan Cape,
£17.99, pp 279
ISBN 0 224 07299 4

Rating: ★★★★★

Hey, Saturday—get up late and it's okay, but not for Henry Perowne, consultant neurosurgeon. Although he is usually "thoughtlessly content" at the weekend, today just happens to coincide with the anti-war demonstration on 15 February 2003. His day starts and ends with a bang.

Perowne is a rationalist, with a boyish enthusiasm for modern science and at odds with the cynicism of these "baffled and fearful" days. Reflecting on trans-sphenoidal hypophysectomy, he considers the procedure "humane and daring—the spirit of benevolence enlivened by the boldness of a high-wire circus act." A true descendant of US neurosurgeon Harvey Cushing and

something of an Everyman, he is Joyce's Leopold Bloom as FRCS. His stream of consciousness can eddy within seconds from contemplating the fate of his urinary waste to the ongoing debate on Iraq. Like Bloom he is uplifted by music and cooking, has a difficult daughter, and clashes with the damaged and angry, as in his road rage incident with one Baxter, who has Huntington's disease. Perowne thinks, even as Baxter threatens him, "this is how the brilliant machinery of being is undone by the tiniest of faulty cogs, the insidious whisper of ruin, a single bad idea lodged in every cell, on every chromosome four."

Our man is working too hard—"on his rounds he hits the corridors with an impatient stride his retinue struggles to match." Doing excessive sessions trying to tidy up the turbid ebb and flow of human misery is proving tough. He "knows himself to be incapable of pity. Clinical experience wrung that from him long ago." Envious of the simple joys of others he thinks "there has to be more to life than merely saving lives." He needs a sabbatical; instead he gets Baxter.

The writer researched this novel by observing operations over a two year period. The result is a masterly marshalling of detail combined with a probing narrative drive that chisels expertly to a neat conclusion. McEwan's heavy appropriation of medical

jargon reflects his tipsy delight in adapting these words for a literary purpose. Here he is on the tentorium cerebelli: "a pale delicate structure of beauty, like the little whirl of a veiled dancer." With stereotactic precision McEwan wields his pen like a gamma knife to dissect out the essential practice of a surgeon. Readers may find themselves titubating wearily in woeful recognition of the trials that daily face Perowne—"forty-eight years old, profoundly asleep at nine thirty on a Friday night—this is modern professional life."

Ambiguity and doubt on how to deal with the threats of a post September 11 world contrast with the "safe and simple profession" of neurosurgery. How Perowne copes with Baxter—"cruel, weak, meaningless, demanding to be confronted"—chimes with the dilemma posed by Saddam. Actions have consequences, the age old question is posed—what is the morally correct way forward? McEwan seems to diagnose that in both politics and surgery "the difference between good and bad care is near-infinite."

One minor gripe: it's difficult to believe that a neurosurgeon doesn't have an on-call rota these days, making every glass of wine on a Saturday an unnecessary gamble.

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Are the media running elderly drivers off the road?

Drivers over the age of 65 are the safest drivers of any age group. Even the commonly cited statistic of a higher risk of crash per kilometre among this group has been shown to be an artefact: low mileage is intrinsically risky, and studies show that when this is controlled for the older drivers perform as well as, if not better than, younger drivers (*Transportation Research Part F: Traffic Psychology and Behaviour* 2002; 5:271-4). Despite this evidence many European governments have enacted restrictive legislation directed at them.

The negative perception extends to the American Medical Association's 2003 guideline *Assessing Fitness to Drive in Older People*. Although the guideline is clinically useful, its preface still emphasises the "risk" posed by older drivers.

Much of the literature on older people's medical fitness to drive concentrates on risk rather than mobility. Might a negative image of elderly drivers in the media be an important factor in shaping public and medical opinion on the issue?

To help answer this question we searched the electronic archives of 15 UK and Irish national and regional newspapers from January 1999 to May 2004 for references to older drivers. We assessed whether the articles were negative or positive to older drivers or balanced. We identified 51 relevant articles, of which we independently judged 17 to be negative, four positive, and 30 even handed. When we excluded brief reports on fatal crashes, we found the results for opinion or editorial articles to be 15 negative, four positive, and seven balanced. Headlines included "Keep the over-50s off our M-ways," "Old dear trashes 7 cars," "MP calls for old to get special licences," "Silly old buggy," and "Fanatic speed cop targets old folk."

Newspaper reporting of issues relating to older drivers in the United Kingdom and Ireland is largely negative in content and is at variance with the evidence. The potential consequences of such representation are to distort the political and societal context within which doctors practise medicine and promote healthy ageing. The media reflect and shape public opinion. In particular, the media can influence the public's perception of health related issues. One example is the inordinately high level of success with cardiopulmonary resuscitation in television series such as *ER* (*New England Journal of Medicine* 1996;334:1578-82).

This leaves professionals with two tasks. Firstly they need to be mindful of such prejudices when dealing with individual patients. When they are discussing resuscitation with their patients they should consider

the unrealistic survival rate of cardiopulmonary resuscitation portrayed on television. So too, when discussing driving ability with older patients—and in particular with their relatives—doctors need to take into account the negative perception of older drivers among the general public and to strive to ensure that the mobility of older people is not prematurely and unnecessarily curtailed.

The second task is for our professional bodies—doctors, geriatricians, transport planners—to work with journalists and opinion formers to educate them and make them aware that the major concern with transport and health for older people is usually access to transport rather than the imagined threat that older drivers represent to other road users. The Organization for Economic Cooperation and Development has recommended just such an approach (*Ageing and Transport: Mobility Needs and Safety Issues*, 2001), emphasising the need for information campaigns that prioritise mobility over risk. New medical curriculums are already well oriented to social and behavioural sciences; a brief taste of media studies may help doctors understand and combat negative perceptions among the public that shape their work environment.

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The Lemon Princess

Written by Rachael McGill
From an original idea by Ruth Carney
West Yorkshire Playhouse, Leeds, until
5 March 2005

Rating: ★★★★★

If you can get to Leeds, you must see this play. Powerful, moving, and thought provoking in equal measure, this is great theatre. At its heart, *The Lemon Princess* tells the story of a father's love for his teenage daughter, as she is transformed from a spirited young woman into a dependent and terminally ill patient, brain injured by the neurodegenerative condition variant Creutzfeldt-Jakob disease (vCJD).

Although billed as a fictional account of a vCJD sufferer, the play draws heavily on director Ruth Carney's conversations with Stephen Forber, whose daughter died from the disease in 2001. With access to Stephen's diaries, and through her own research, Ruth developed the project into a wide ranging piece that also examines the politics surrounding vCJD and its link to mad cow disease—bovine spongiform encephalopathy (BSE). The play exposes the UK government's desire to avoid serious damage to the British beef industry, even in the face of growing evidence of a potential risk from eating infected meat.

The action begins in 1995 and follows Mike, a comedian at a Leeds club, and his daughter Becky, through her early symptoms, diagnosis, and experimental treatment in New York for vCJD. Becky's initial clinical improvement raises everyone's hopes, and Mike gives her the nickname Lemon Princess as she gradually takes on the yellow pigment of her medication. But the treatment proves to be too toxic and has to be

Elaine Glover as Becky Clayton and Ian Reddington as her father, Mike

stopped. Mike becomes desperate as he watches his daughter deteriorate further.

Interwoven with this personal story are several other narrative strands, including the attempt by two UK researchers to convince the government of the potential link between BSE and vCJD. The play also cuts to the BSE inquiry, where ministers squirm under cross-examination. And one of the characters, the *Daily Post* journalist who has befriended Mike and funded the trip to the United States, interjects throughout the play to provide a sensationalist commentary on plot developments.

The playwright, Rachael McGill, describes the play as political theatre, and it certainly raises questions about what governments choose to tell the public. But there are also lessons about the self serving interests of the media, and how professional rivalries within academia can work against the interests of patients. Yet despite tackling these weighty issues, this is still a hugely entertaining, funny, and accessible play. At times highly televisual—cutting between scenes at breakneck speed—and with a strong narrative, it seems likely that the television executives will be beating a path to the writer's door.

An ambitious project, the play could be criticised for tackling too many issues

surrounding vCJD. Yet the uncompromisingly honest central story of Mike's struggle to save his child anchors the disparate parts firmly together.

But questions remain about the blurring of fact and fiction in the play. When we see scenes from the BSE inquiry, it is not clear what is verbatim text and what is dramatic licence. Rachael McGill explains: "The BSE inquiry in the play contains much verbatim material . . . If anything, I have toned down the politics because on stage the truth would have looked like caricature." But this still leaves a sense of unease at having to trust the playwright's interpretation of some of the testimony.

Although we saw a preview performance, the production seemed remarkably tight and polished. And despite some variability in the characterisations—there are 13 parts played by just five actors—this is a strong cast, with two outstanding performances.

Ian Reddington, who plays Becky's father, Mike, conveys such a degree of raw emotion, of a parent battling against both internal demons and establishment forces, that by the end you are overwhelmed by the sheer numbing grief of his loss. "I saw her first five steps and her last five," he tells us in his final speech. And Samantha Robinson, who effortlessly moves between playing research scientist Dr Caroline Harding and Becky's 9 year old sister, Charlie, brings a physicality and veracity to the child's role that is both instantly believable and hugely impressive.

The Lemon Princess is a powerhouse of a production that should generate discussion and debate among the public, the medical and scientific communities, and perhaps even reach the ears of our political masters. Miss it at your peril.

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The play exposes the UK government's desire to avoid serious damage to the beef industry over BSE/vCJD

NETLINES

● Sometimes drugs that have been around for a while have new indications or restrictions. For help with drug reappraisal check out www.nyrdtc.nhs.uk/publications/Drug_updates/drug_updates.html from the Newcastle Regional Drug and Therapeutics Centre. The topic areas cover common prescribing issues, and the related reviews are short and easy to read. Sensibly, recognising that older parts of the archive will ultimately go out of date, the site highlights articles more than 18 months old and suggests that the reader rechecks the literature.

● With all the focus recently on trying to reduce the epidemic of obesity, have you thought of suggesting to patients that they buy a pet? Well, the Pet Health Council has and has produced an article, "Are there any human health benefits in owning a pet?" (www.pethealthcouncil.co.uk/people.shtml). If you are interested after reading the article then look at the Frequently Asked Questions and peruse the leaflets section. One leaflet explaining the benefits to health of owning a pet (in Word format) can be downloaded.

● Guidelines on chronic obstructive pulmonary disease are always handy, and an excellent contribution is the Australian and New Zealand COPD Reference Site (www.copdx.org.au/guidelines/index.asp). Thanks to a simple interface, the material is easy to access either from the index at the side or by clicking through the pages at the bottom of the screen, and a summary page is available if you don't want to study the site in detail.

● Cancer Care Ontario has produced an excellent collection of cancer fact sheets (www.cancercare.on.ca/reports_cancerFacts.htm). These are monthly updates looking at a particular aspect of cancer medicine. With a wide variety of subjects, including high smoking rates and prostate cancer mortality, they make for well written and interesting information leaflets for patients. The site has an impressive and easily accessible archive that goes back more than four years.

● Confused about the principles of evidence based medicine? Point your browser at this excellent online tutorial on evidence based medicine (www.hsl.unc.edu/services/tutorials/ebm/index.htm), a basic guide to the philosophy behind the subject. Scroll down while reading each page and then when you come to the end just click to get the next. It's mainly text, with a sprinkling of tables and some hyperlinks. However, it's well designed, very readable, and educational.

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We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email address

PERSONAL VIEWS

Station interviews: all change?

In the late 1980s it took me 10 interviews to obtain a senior registrar post in neurology. In each interview I was called before a committee and asked in a fairly unstructured way about my previous jobs, research, audit and management skills, and interests outside medicine. The panel then chose the candidate who had interviewed the best—or, more likely, the candidate who despite the interview had remained the first choice from various pre-interview discussions, recommendations, and references. A sweaty hour with fellow interviewees would end with a door being opened, the lucky name being called, and the remainder of the group hearing how close it had been and how any of us might on another day have been appointed.

Whether such a process led to the appointment of the person who could actually do the job was never questioned. The limited data available indicate that it may not have done, since clinical performance actually correlates rather poorly with the quality of applications and performance in panel interviews. Perhaps for that reason, candidates were encouraged to "look around" for the important pre-interview interviews, and consultants were expected to discuss candidates among themselves. References were available beforehand, and there was less need to read between the lines, given that there was no need to share them with candidates.

At least then I could console myself that my interview performance had not necessarily influenced the outcome. The Calman reforms have changed this. Interviewers' previous knowledge of a potential registrar's abilities must now be suspended, conversations with supervising consultants can no longer occur, and references now serve only as a safety net. This levelling of the playing field has upgraded the importance of the 30 minute interview, as it is now the sole opportunity that future employers have to assess a candidate. It is therefore essential that the interview should truly assess the qualities required.

Imagine an orchestra recruiting by panel interview and asking a potential violinist, "How well do you play?" Or a driving test comprising only a theory test by committee. Yet the standard interview for a specialist registrar commonly does involve such questions as, "How good are you in clinic?"—as if the answer could really inform the appointment process. The apocryphal story of the appointment of a blind radiologist is a reminder that sometimes even basic eligibility criteria (can the candidate do the work?) might easily be overlooked.

Imagine an orchestra asking a potential violinist, "How well do you play?"

To improve the selection of specialist registrars we must first analyse their role, identify the core competencies required, and then decide on appropriate assessment criteria, preferably agreed nationally. Key target areas for selection might be clinical expertise, communication skills, empathy, problem solving, team working, professional integrity, organisational skills, and coping with pressure. Application forms should emphasise competency statements and personal statements, each with specific examples.

The Welsh Deanery is piloting "station" interviews at which various aspects of knowledge, skills, and attitudes are assessed, usually against predefined criteria, at separate stations by groups of interviewers working in parallel. For example, in specialist registrar interviews in neurology we discuss the curriculum vitae in one room, assess research, audit, and teaching in a second room (including a presentation by the candidate prepared in the 30 minutes beforehand), and observe a consultation with a simulated patient in a third. Other possibilities are a practical skills station, an "in tray" exercise, and a group problem solving exercise. Interviewers' scores are submitted before any discussion, and the final decision is reached in a meeting of all interviewers.

Station interviews have advantages beyond being a more relevant assessment of prospective employees. The system is fairer in giving candidates more time to demonstrate their abilities (each has three interviews of 30 minutes and another 30 minutes to prepare their presentation), exposure to more interviewers (perhaps nine interviewers at three stations), and the opportunity of a fresh start at each station no matter how they performed on the last. But it is more expensive, ideally the assessors require specific training, and assessment tools for scoring communication and presentational skills are still evolving.

Nevertheless, it seems inevitable that more assessment of practical skills will be used in medical recruitment. The methodology continues to develop; but already the process allows a confidence that successful candidates will have demonstrated the core skills required for entry to the training programme. In 10 years' time it will probably seem a little odd that it is presently possible to appoint specialist registrars to five year posts with only their word that they can do the job.

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A new dawn for antiretrovirals

Last year may be remembered as the year when antiretroviral drugs began to be available to people living in Africa. I worked in South Africa's KwaZulu-Natal region last year and was involved in setting up one of the first antiretroviral clinics.

KwaZulu-Natal, which stretches along the east coast of South Africa, is renowned for some of the most beautiful scenery in the country, but it also holds a much bleaker claim to fame. It has the highest prevalence of HIV-1 infection in South Africa, with 38% of people testing HIV positive at the end of 2003, according to health department statistics. On the medical wards in Ngwelezane Hospital the prevalence of AIDS was about 80%.

Every evening a stream of skeletal young people would arrive at the hospital doors. Doctors and nurses who have seen the HIV epidemic grow over the years often turned these patients away, as so little could be done. The casualty department was reserved for trauma, of which there was plenty in the form of gunshot wounds, stabbings, and injuries from traffic collisions. The medics, in defence of their undertreated patients, encouraged the use of rehydration, antibiotics, and analgesia. Unfortunately this merely encouraged more people to present to hospital, and the wards filled up with moribund patients.

It didn't take long to understand why general medicine is so understaffed in South Africa. Most doctors go into areas where changes can still be made to patients' lives, such as surgery or obstetrics and gynaecology. Others choose the private sector and avoid the medical wards, as so little can be done. Many choose to work overseas, further compromising staffing levels. Something had to change, and the hospital applied to the Department of Health to be accredited for providing antiretroviral treatment.

The process of obtaining antiretrovirals for the community was slow and prone to red tape. People doubted whether the government would provide the drugs at all, but as the general election loomed things began to change. Medical staff interested in prescribing antiretrovirals were sent on training courses in Durban. The atmosphere there was a stark change to our township hospital, and we entered the hall of an expensive hotel, armed with glossy folders. The talks were inspiring, the instructions thoughtful and careful. South Africa is aware that it is in the spotlight with respect to using antiretrovirals in poorly resourced areas. If the programme doesn't work, and the situation is worsened by resistance resulting from poor compliance, the sceptics who doubted the success of freely available antiretrovirals will be proved right.

Compliance was our biggest hurdle. We knew from the diabetes and hypertension clinics that patients weren't always able to get to hospital when their drugs ran out. Also, the stigma of HIV infection is still a big problem, although matters have much improved. Among our best allies were members of the Treatment Action Campaign, who visited townships around the hospital and provided information about HIV and antiretrovirals.

We set up the clinic at the back of the hospital. In three days a large waiting room was built. Nurses from rural clinics were recruited and trained. Patients who fitted the eligibility criteria for treatment with antiretrovirals were screened, counselled, and asked to attend an HIV workshop with a partner or friend. Attendance at these meetings, which were held in Zulu, expanded as we moved from the clinic room to a disused ward. Once patients were evaluated and

found to fit the criteria for treatment they were given a one month course of co-trimoxazole. When they returned, the pills were counted to see whether they

had complied with the treatment. If compliance was a problem, we addressed the factors making it difficult for patients to take the tablets daily.

On 5 May 2004 the first patient in Ngwelezane was given antiretroviral treatment. The effect on the hospital was dramatic. As I gave a progress report to the rest of the hospital, members of other specialties who had previously looked rather sorry for the medical department pricked up their ears. They asked questions about how they could refer their patients to the clinic, what needed to be done, and what side effects to look out for. The doctors and nurses, under the leadership of Dr Lawal and Dr Haselau, continue to work tirelessly, and the clinic has expanded exponentially. More than 300 adults are now taking antiretrovirals, and the paediatric department has also begun its roll out. We have had adverse effects, and 20 deaths, but most of the people attending the clinic are making good clinical progress. All the people attending the clinic have so far complied with treatment, and none has been lost to follow up.

Being able to offer antiretrovirals in South Africa has many positive effects. At best they will reduce opportunistic infections, keep families together for longer, and reduce transmission of the virus. But at the least they will breathe hope into the general medical wards of South Africa, as doctors and nurses are finally allowed to offer some treatment to most of their patients.

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SOUNDINGS

Tort

For most of my adult life I thought that a tort was a sort of sophisticated lemon curd pudding. Rather recently I discovered that it is a medieval French term for a wrong, and is the basis for the medical negligence system that we all dread.

The principle itself is simple and attractive. If you injure someone else by acting badly you must compensate them. A child in the playground would applaud its inherent justice. But the child may go on to wonder why the injured person is given help only if the other person is at fault. Two children with cerebral palsy may have similar needs in life, but the one whose lawyer proves that the midwife didn't notice the dips on the cardiograph will have millions of pounds in help while the other will have none. Fault must be proved and the amount paid bears no relation to the degree of fault or the means or needs of the injured person.

That's odd. And if you make a mistake are you necessarily morally culpable? We all make mistakes. This system is described as "distributive justice." It is certainly distributive since nearly half the total costs go in fees.

If we were designing the thing from scratch, sitting in one of those dreadful health service planning meetings (God forbid), then a reasonable question would be: What is the purpose of the system? Is it to punish and deter wrongdoers? Or is its purpose to redistribute wealth to those who need it because of accidental harm? I think we would decide (probably after interminable posturing about "ownership" and "inclusivity," and other such obscure terms) that punishment and redistribution of wealth do not make easy bedfellows.

The odd thing, to someone looking at it for the first time, is why such an expensive and clearly flawed system still exists. I do recall as a child having similar blinding revelations, such as the insight that if no one bothered with money then we could all have as many sweets as we wanted. I have realised subsequently that this analysis was possibly simplistic and am wary about repeating the mistake. But the conclusion that the medical negligence system is almost unbelievably bad does seem inescapable. It is hugely expensive, interminably protracted, desperately painful for all those involved, and fundamentally unfair. So all those in favour ... ?

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