reviews

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House

Hallmark Channel, Sundays at 9 pm and Mondays at 1 am
www.hallmarkchannel.co.uk
Currently showing in the US on Fox
www.fox.com/house/

Rating: ★★★☆

At only 45, Hugh Laurie is well on the way to becoming a national treasure. His credentials are impeccable. Old Etonian, member of a losing Oxford and Cambridge Boat Race crew, hilarious portrayer of upper class twits in *Blackadder*. And in the 1990s, playing Bertie Wooster to Stephen Fry's Jeeves, he was lovable Englishness personified.

So when the *BMJ* sent preview tapes of his new show on a satellite channel, I was looking forward to a cheerful evening. OK, it was a US series, and OK, he was playing a doctor, but the theme would surely be Gussie Fink-Nottle meets Malibu Beach, and I was going to enjoy it.

Never very adept with the video player, I watched the first few minutes with no sound. First surprise. This was Laurie unshaven, in *101 Dalmatians* mode. Remember how scary he was as Cruella de Ville's henchman, intent on drowning those puppies? Then I mastered the remote. Second surprise. He had an American accent.

I sat mesmerised by the transformation. It was as if your best mate had changed sex. He seemed to be doing it awfully well but what would the Americans make of it? The third surprise came as I actually listened to the words. Boy, was he being rude.

But not in a Graham Norton-style sexual innuendo way. His lines were cynical, clever, and hurtful. He was like Humphry Bogart playing Philip Marlowe but without the niceness. By way of explanation, his character, Dr House, is in constant pain and walks with a stick (very convincingly)—the result of damn fool colleagues' failure to diagnose a thrombosis.

Gregory House is a brilliant diagnostician who regularly solves cases that leave ordinary doctors baffled. He heads a team of three good looking young MDs of mixed gender and ethnicity, including a floppy haired Englishman who says at one point,

"Actually, I'm Australian." House snaps back: "You put the Queen on your money. You're British."

The plots are complex, drawn from the smallest print in the largest medical textbooks. Differential diagnoses of mind-boggling obscurity are hurled back and forth without a hint of irony among the frowning team until House stops them with another flash of grim insight.

Occasionally the jargon is clarified for the viewer, who doesn't really want explanations. Watching *Miss Marple* or *Midsomer Murders* we soon lose track of the details, preferring to rely on the detective to sort it all out. The difference here is that even at the very end, House never smiles. "Humanity," he says, "is overrated."

He belongs to a long tradition of cantankerous heroes, going back to Ironside, Dirty Harry, and, before them, Sherlock Holmes (who was of course modelled on a medical teacher). UK viewers will hear echoes of Sir Lancelot Spratt, though House is more shocking: "Treating illness is why we became doctors. Treating patients is actually what makes most doctors miserable."

Not a good role model, then, for today's new doctors, educated to be touchy-feely people persons. Or are we getting it slightly wrong? Medical schools are starting to wonder if the anti-Spratt pendulum has swung too far. They are beginning to suspect that a profession may need a few brilliant but difficult people.

Believing as I do that politeness costs nothing, why didn't I hate the show? Mainly because it makes no claim to unmask reality. Created by a team of non-medical writers (with diligent researchers, clearly), it sets its crusty hero amid a caring team and gives him all the best lines. To emphasise that this is unreal, the camera occasionally zooms inside the patient's body, letting us see neurones at work.

But, like so many top-class US series, this is fantasy with a knowing edge. It is a rebellion against blandness—ratings were tepid until *House* was scheduled immediately after *American Idol*, a talent show in which Britain's Simon Cowell lacerates

Laurie: "saying something like 'coronary artery' gives me a nosebleed"

wannabe pop stars. Verbal brutality sells these days.

Doctors may well enjoy watching a stubbly, tieless consultant who fights with hospital management (and wins), challenges patients to sue him if they dare, and unleashes vitriolic sarcasm on a trendy mum who refuses to have her child vaccinated. Laurie's father, a Scot, was a general practitioner in Oxford (and nothing like House, of course) but Hugh thinks Dad would have liked the show.

It is a hit in the US—as good as *Desperate Housewives*, says the *Washington Post*. Ump-teen episodes have been ordered and Laurie, having pulled out of the next Superman film, is working endless 16-hour days. The accent is flawless but hard work. "Saying something like 'coronary artery' gives me a nosebleed. I have to lie down in a dark room for 20 minutes."

Perhaps, like Conan Doyle, he will tire of his creation before the public does. Or a reputed £240 000 an episode may keep him going. Either way, it's good to see him doing well. Being a national treasure in two countries is pretty cool, even for an Old Etonian.

James Owen Drife professor of obstetrics and gynaecology, Leeds

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

Priceless: On Knowing the Price of Everything and the Value of Nothing

Frank Ackerman, Lisa Heinzerling

The New Press,
£17.95/\$25.95/£39.95,
pp 277
ISBN 1 56584 850 0
[http://www.thenewpress.com/
books/priceless.htm](http://www.thenewpress.com/books/priceless.htm)

Rating: ★★

Priceless poses an important question—how should we value the things that we cherish, such as the environment and human life, and assess risks to them? The authors reject the proposition that cost-benefit analysis can be used to assign monetary value to the environment and health because the outcomes are often antithetical to human decency. Such analysis, for example, leads to the conclusion that toxic waste should preferably be dumped on to the developing world. After all, life is already short in the developing world, and the presence of low wages and poor productivity means that the dumping will be inexpensive in both action and consequence.

Another example of cost-benefit analysis gone awry is the use of Quality Adjusted Life Years (QALYs) to rank health care. QALYs provide a numerical measure of health over time and, as more good health is desirable, the effort to provide the most QALYs at the least cost appears sensible. When the state of Oregon, however, tried to rationalise its healthcare system using QALYs they ranked treatment for thumb sucking and dental problems ahead of that for ectopic pregnancy, cystic fibrosis, and AIDS. Using QALYs also devalued the lives of elderly people (who have fewer QALYs to live) and disabled people (who have reduced QALYs). Furthermore, there is the problem of assigning comparative numerical values to different diseases. Rank values have been assigned to diseases by asking people bizarre questions such as how much they would be willing to pay to avoid a year of bladder cancer versus a year of bronchitis. It is easy to agree with the authors that these are not the sorts of questions likely to provide for good health care.

Although *Priceless* poses an important question, there are serious problems with the proposed solution. Certainly it is ridiculous to ask people what they might pay to avoid a cancer bearing toxin, for example, and then assume that a company can “pay” an amount to disperse that toxin. At the same time, however, it is equally ridiculous to believe that society can function with only positive consequences. People want to be able to travel, communicate, use consumer goods, and have the comfort of running water, electricity, and gas appliances, to

name just a few elements of modern existence. A grown up society accepts that these things will inevitably go wrong sometimes and that injuries, even severely destructive and fatal ones, are bound to happen. Equally it is understood that all risks, including life threatening ones, cannot be avoided. This is not to accept passivity in the face of danger but to demand realism as to what steps can and should be taken.

It is here that *Priceless* badly fails the reader. In *Priceless* the “company” is always the bad guy. I liked this theme in the *Alien* movies but in an academic work it is problematic. The belief, favoured by *Priceless*, that the company will always take the cheap and dirty option is just as biased as the belief, favoured by right wing economic groups, that the company can do no wrong. Sometimes a company will ignore a risk it really ought to tackle but sometimes the risk is really much too small and indeterminate to be worth the cost of pursuing. When it comes to carcinogens and toxins, for example, *Priceless* assumes that there is no safe threshold. This is, of course, untrue as many things that can be toxic in large doses (salt, sugar, and even water) are harmless or beneficial in low doses.

Priceless urges “precaution in the face of scientific uncertainty,” but the authors needed to attack this idea with the same zeal as they attacked cost-benefit analysis. If they had done so they would have noticed that everything new carries uncertainty and that abiding by the precautionary principle can have negative consequences. For example, *Priceless* argues that the decision to ban the pesticide DDT because of the uncertain effects of DDT accumulation in fat tissue was a good one, but the book fails to acknowledge even that DDT had helped to successfully control malaria in large parts of the world. The uncertain threat of DDT trumped the certain threat of malaria with fatal consequences for vast numbers of people.

The banning of DDT is considered a good idea by the authors, not just because of the uncertain health effects of DDT, but also because the perception of risk itself is bad for people's health. The authors state, “Certain kinds of risk not only frighten people, they also make people severely anxious, depressed, distrustful, and angry.” The authors fail, however, to consider people getting so angry and depressed about risks because their fears are inflated by books like *Priceless* that have a jaded view of modern society. Instead of being reassuring, approaches based on precaution, which assume everything to be dangerous unless proven otherwise, encourage needless anxiety and introspection and promote unnecessary, unfounded and unshakable bitterness and cynicism. Rather than taking society forward, such bitterness and cynicism throws society into reverse gear, where, ironically, we are likely to miss real dangers and forgo real opportunities to tackle them.

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NETLINES

● The assassination of John F Kennedy was one of the major news making moments of the second half of the last century and is still shrouded in controversy. On <http://mcadams.posc.mu.edu/medical.htm> is a review of some of the medical evidence about the killing. The site has a huge volume of material, and is fascinating.

● The Australian and New Zealand Joint Faculty of Intensive Care Medicine has produced a useful publications page (www.jficm.anzca.edu.au/aacm/journal/publications.htm). In fact, two separate publications are available here: the quarterly *Critical Care and Resuscitation Journal* and the annual handbooks of the *Australian Short Course on Intensive Care Medicine*. Access to the content, in an impressive archive for both publications, is unrestricted. Much of the content is stored as PDF files, so you will need Adobe Reader to read the files, but this is available for free (from www.adobe.com).

● Trying to get funding for health related research and don't know where to look? You could visit the “RD Info” site (www.rdinfo.org.uk). Though operated jointly by the University of Leeds and the Leeds Teaching Hospitals NHS Trust and funded by the Department of Health, it has information on European and international sources of funding as well as British sources. It comprises a sophisticated database with a large volume of funding sources aimed primarily at British researchers, and it is easy to use.

● Nothing beats a joke to break up a busy, hectic day, so check out the Medical Mirth Archive (www.globalfamilydoctor.com/extras/medical_merth/mirth_archive.htm). This is simply a long page, filled with a lot of jokes that are either medical or have a medical association. Simply scroll down the page and read the jokes, most of which are short and to the point, and many are suitable for PowerPoint presentations. A lot of the jokes are corny, but some may cause a grin.

● Web logs or “blogs” are personal journals that are a burgeoning internet phenomenon, and many medical ones are springing up all the time. The “Kevin, MD Medical Weblog” (www.kevinmd.com/blog/) is an enjoyable and frequently updated collection of reflections from a US based primary care physician. It has great links to various source materials.

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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.

Unlicensed to heal

How did an advertisement for a so called psoriasis "remedy" get accepted by several national newspapers?

Cashmere Beauty is a "new unisex organic cream," which, according to advertisements that have appeared recently in three UK national broadsheets, offers "an effective alternative to toxic prescriptive products treating Psoriasis, Eczema or any irritated complexion." The advertisement, headlined "Psoriasis & eczema remedy discovered," also claimed that Cashmere Beauty "heals effected [sic] skin, including: scar tissue, bumps, mild acne and stretch marks." It further claimed the product was "dermatologically tested and FDA approved."

To find out more, readers were urged to visit Cashmere Beauty's website (www.cashmerebeauty.com), where they could learn that the cream is made from fresh ("not powdered") cashmere goats' milk and ponder the prices of The Miracle Bar (£10) and a 30 ml pot of the Rapid Recovery Cream (£34.50).

Now the UK Advertising Standards Authority (ASA) is investigating whether or not the advertisement, which appeared in the *Times*, the *Independent*, and the *Guardian*, falls foul of its code.

A quick Google search shows that before the ad's appearance last month, Shahriar Nazemi, founder and owner of the company Cashmere Beauty, had already achieved considerable success gaining editorial coverage for his product. It received mentions in publications as diverse as British *Vogue* ("Read the name and you'll already feel better") and the Warner Bros online entertainment magazine ("Hollywood's answer to the fountain of youth"). But, for better or worse, journalists do have some latitude in what they write. Readers might justifiably be expected to exercise some cynicism with regard to their superlatives.

The advertising of products making specific medical claims is supposed to be different. Under the British Code of Advertising, Sales Promotion and Direct Marketing (www.asa.org.uk/asa/codes/cap_code/), strict guidelines govern the use of terms such as "remedy" and "heal"; primarily, as such descriptions imply a physiological effect, products using them must be licensed by the Medicines and Healthcare products Regulatory Agency. Furthermore, psoriasis is specifically mentioned on a "serious" list of ailments for which claims about treatment should not be made unless a product is so licensed. Cashmere Beauty has no such licence.

As for its claimed FDA (US Food and Drug Administration) approval, that is open to interpretation. While individual ingredients might have been passed as safe, the agency takes a dim view of any cosmetic product claiming it has been given its approval.

"I'm quite amazed that the ad was allowed to get through," said Christopher Griffiths, professor of dermatology at the University of Manchester. "The only treatments that give good results in psoriasis and atopic dermatitis are prescription drugs." Adding that it wasn't uncommon for patients seeing him to come wielding computer printouts or newspaper cuttings showing products making similar claims, Professor Griffiths said: "This sort of thing just raises false hopes."

Gladys Edwards, chief executive of the Psoriasis Association, also voiced concern about the vulnerability of patients and said she was disappointed so many newspapers took the Cashmere Beauty ad in the form it appeared. "We are especially concerned that the advertisement makes reference to the FDA, which we fear could mislead the public about the nature of the product and its status, particularly in the light of the use of the word 'remedy'."

Donna Mitchell, ASA spokeswoman, said the strength of the self regulatory system of newspaper advertising in the UK lay in the fact that if an advertiser would not voluntarily stop running an offending ad,

then publishers would not take it. There was in any case, she added, a legal backstop through the Office of Fair Trading.

However, it remains incumbent upon publishers to ensure ads conform to both the ASA's guidelines and the law in the first place. In the case of Cashmere Beauty, that proved to be an unreliable system. Out of the UK national broadsheets, only the *Daily Telegraph* queried the ad with the authorities and the paper refrained from publishing it.

So what kind of checking procedures take place in the advertising departments of UK national newspapers? Simon Kilby, head of agency sales at the *Guardian*—where the ad was 20 cm high and across two columns—said there were several stages at which warning bells might sound. Firstly, there was the sales department, which booked ads; secondly, there was advertising services, which handled copy; and thirdly, the pre-press stage. After that, editorial might pick up infringements when proofing pages.

"However, all these departments are manned by humans, so there's always the element of human error," said Mr Kilby. "We book thousands of ads every week."

Simon Cooke, ad director at the *Independent*, said that while those booking ads at his and other newspapers were "in no way qualified to make a decision about claims made in ads," his department was always up to date with ASA alerts. "But there's always one or two that get under the radar."

Cashmere Beauty's Mr Nazemi seemed reluctant to detail to the *BMJ* either the clinical evidence behind the claims made for his product or the nature of its alleged FDA approval. In an email, he explained that it was "very busy here."

However, in an earlier call he admitted: "We're a young company and there is a learning curve for us." Whether national newspaper advertising departments have such an excuse is a moot point.

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Getting their goat: some experts are worried that such ads could raise false hopes

PERSONAL VIEW

Choose and book—whose choice is it anyway?

Last summer I took part in many of the workshops held across London for the NHS's national programme for information technology. Organised with little notice and undergoing continual cancellation, rescheduling, and relocation, many of the sessions somehow resulted in vibrant discussions with clear conclusions. The people who went were keen, if not passionate, to do what they could to make sure the outcome would be the best possible. We were unanimous in wanting to make sure that the NHS offered programs that used the best possible features of existing software and clinical practice and that offered clinicians and patients a signed pathway to the best possible care. We were clearly told by the session leaders from British Telecom and IDX, the companies involved, that their contract was to design and supply clinical software to be used universally across the NHS.

What did we get when we were presented with the draft version? We were shown screens of a third rate computer program lifted from the existing system of US hospital administrators. Its screens of nursing notes were cumbersome and displayed none of the features we had asked for. Promised that this early version was only for demonstration purposes, we departed disappointed.

Invited to a regional interim meeting at the BT tower, we were enthused by the somewhat glitzy opportunity to ascend to the conference facilities at the top, but our enthusiasm was defused by the lame presentations by various strategic health authority IT leaders. Afterwards a senior team member privately disclosed considerable embarrassment at the software demonstration, which had moved backwards from the versions shown months earlier.

Then there is "choose and book"—an IT module we will all be expected to use. This has a national implementation date, requiring universal application, of the end of December 2005. The idea is that all patients will, at the point of their referral, be given options of time, place, and date and that either the referral can be booked there and then or the patient is given a reference number and telephone numbers to confirm an appointment later. The module's blurb says that it will take GPs 20-30 seconds to progress through the screens. Who says? And on what evidence?

We sat through about half an hour of frustration while three trainers struggled with their computers to demonstrate the module. The application screens are slow, and the computers often fail to pick up the programs. There is no integration with

existing clinical systems or with Microsoft Outlook. No alert box shows to let you know that tasks await completion or that a specialist has bounced the referral back to the referrer to suggest an interim clinical intervention or even to reject the referral. Tasks need separate screens that take several minutes to refresh and change. Promises abounded that the final application would be speedy and that our comments would be taken back to the people developing the software, but we were all too long in the tooth to do anything other than grin bleakly.

On PowerPoint presentations we were shown smiling GPs and specialists, happy with the trial software they had been using, but our requests for names and addresses so we could speak to them were met with silence. We were flashed anecdotes about clinicians who are pleased with the facility, but when we asked for figures on improved patient pathways or clinical outcomes we were answered with rueful smiles. When we

got really frustrated we were told that this was a period of change that would have to be managed across the health service. We politely pointed out that the phrase "change management" applied to pro-

gressive developments, not a reversal to Neanderthal processes. The conversation was moved on.

Finally we were shown the really frightening module. "Choose and book" is intended to be the preferred pathway for GPs to seek advice, without referral, from colleagues in secondary care. Here there is a big problem. The advice cannot be filed, by either the consultant or the GP. Once the replies have been sent, the advice is deleted from the choose and book screens, and no mechanism exists to integrate it with clinical results. There is no file note for the GP or the consultant. This is a major clinical governance issue.

The ambition of the NHS agenda for IT change should be applauded. It is unfortunate that the system appears to be no advance on existing services. It is frightening that the political drive to implement the system is failing to take account of professionals' anxieties. It is alarming that despite the vast sums being invested the system appears to be primitive.

Before allowing its delivery, clinicians from all backgrounds must demand a service that is rigorous in terms of clinical governance, friendly in its user interface, fast, and relevant to the needs of clinicians and patients.

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SOUNDINGS

An oblique passion

Throughout my life I have had a persistent, rather dilettante interest in mathematics. I dabble a little, drift away with pressures of work and family, but always seem to return.

It is, I think, the calm that draws me back. It is detached from the grit and noise of the medical world—a place of clean lines and perfect spheres, of abstract objects that glisten in the imagination in a sharp, multidimensional light. Sometimes I see them as solid shapes etched with dew. I suspect that this is very pathological.

I have mostly kept quiet about my interest as revealing it tends to provoke either incredulity or derision. I think part of the image problem lies with mathematicians themselves. They mostly have beards with dried soup stains, and an odd, childlike humour characterised by an abundance of puns, and they are prematurely good at crosswords. In fact they have all the attributes of a strange, priestly cult. They are unworldly, isolated, and unintelligible unless you are an initiate. They speak and write an arcane, runic script, which, somewhat bizarrely, seems to be the language of God.

It is this script that is, I think, one of the attractions for me. If I look at the mathematical notebooks I have kept over the years the symbols are rather beautiful. My handwriting has always been ugly. But the mathematical notation—the neat black narrative on the white page—seems a thing of beauty to me.

One of the things I find strange is that, despite covering quite a lot of mathematical ground over many years, I have rarely actually made it out of the 19th century. O level gets you past the Greeks. A level takes you as far as the 17th century. But it's almost impossible to get into the 20th century. There is presumably a vast century of work accessible to almost no one. And yet it will end up explaining the world because it always does.

Someone once said that in mathematics the answer often appears before the question. It seems to underlie the structure of everything, which is, I suppose, unsurprising since it is essentially the study of patterns abstracted from reality.

The other great thing about it is that there is no role play; and no one ever asks me, their voice pregnant with concern, how I feel about it.

Kevin Barraclough *general practitioner, Painswick, Gloucestershire*