

BMJ **Aequanimitas**

Daniel Sokol

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VIEWS & REVIEWS

Medical researchers need to stop hamming it up

PERSONAL VIEW **Mark Lawson**

We probably agree, don't we, that the media are bad at medicine. For example, on a recent edition of the Victoria Derbyshire phone-in show on BBC Radio 5 Live, which likes to bill itself as "the nation's conversation," the country was discussing the proposal to inoculate children against chickenpox.

A woman who called in was against the idea, warning that, having been encouraged to catch the virus from her sister in what used to be parental practice, she had gone on to develop meningitis and septicaemia and been given the last rites. But despite this she had later developed chickenpox for a second time in adulthood. When Derbyshire, with the fast radar for barminess that becomes natural to phone-in hosts, expressed surprise at this medical history, the caller explained that the first occasion had involved an "inner" symptomless virus but that she had later suffered an "outer" bout.

Derbyshire ended the conversation as quickly as if there were botulinum bacteria on the receiver and then, in the way of her programme, read out two contrasting emails, along the lines of "Jack in Cardiff says jabs are bad: we must allow the body to build up its natural defences; but Wendy in Leicester disagrees: be safe, inoculate."

I am not a doctor. My only qualifications for writing in this publication are lifelong hypochondria and having watched almost every episode of *Holby City* and *House*. But there's something I need to expectorate here. The radio exchanges quoted above are a perfect example of the media's "irresponsibility" on medical issues about which doctors so often complain. The listener could only be baffled (is their child's illness "inner" or "outer"?), while the BBC's rules of "balance" left the impression that

Keen for publicity and funding, research groups now treat individual drinks and foods as if they were nutritional Osama bin Ladens

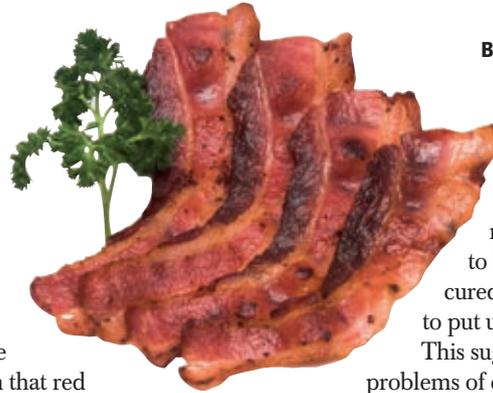
the half-rhymed slogans of non-qualified medical practitioners ("jabs are bad" versus "be safe: inoculate") are equally valid contributions to the debate.

Such hysterical relativism is standard in the mainstream media's coverage of medicine. One day the front pages scream that red wine will kill you, the next that cabernet sauvignon is a life saver. In the same week in November, headlines yelled that being overweight gave you cancer but also that additional fat raised the survival rate from infections and operations.

In the past I've argued that these confusions are the fault of journalism. Failing to acknowledge that medical science is a system of advocacy, in which prosecution and defence teams test a theory to destruction, newspapers have tended to present theory and argument as if they were fact, turning footnotes into headlines. They have also failed to understand, or explain, the mathematics of risk.

Given a report that researchers in Ottawa have discovered that consumption of (let's say) toffee apples has been shown to raise the risk of bowel cancer by two thirds (and here I add a warning to phone-in show researchers: this is a fictional example), the reader believes that their occasional fairground treat has a 66% chance of killing them, whereas the truth is that the general population's already relatively small risk of such tumours may be just very slightly higher.

Recently, though, something has changed, and I've come to a second opinion: some quacks are now as bad as hacks in this regard. Take the recent row over whether bacon gives you cancer. This was the conclusion most media outlets drew from the World Cancer Research Fund's report into the causes of cancer (*BMJ* 2007;335:897). But, having looked at the report, I think the problem is not irresponsible journalists but



Bacon: going critical

irresponsible medical researchers. The report really seems to have said that cured meats are likely to put us beyond a cure. This suggests that the

problems of exaggeration and simplification now lie with the doctors. Keen for publicity and funding, research groups now treat individual drinks and foods as if they were nutritional Osama bin Ladens. Coming to believe that hysteria is the only language the media understand, medicine has become fluent in such gibberish itself.

The problem is, though, that such inflated rhetoric is likely to have the effect of leading patients to believe that medical advice is cyclical and cynical: that, if we wait a few years, another report will come along arguing that any parent who fails to stuff junior with a bacon butty every morning is guilty of neglect. As I understand it, advice to general practitioners is to make targets for patients reasonable and achievable: start by losing a kilogram rather than four. And as the British cancer specialist Karl Sikora has said—arguing that the World Cancer Research Fund's views on bacon are "too severe"—such scaremongering reports make themselves too easy to ignore.

On another recent radio phone-in, a doctor ranting about the "obesity time bomb" and the "alcohol time bomb"—and very possibly the bacon sandwich nuclear bomb—was reduced to silence when the presenter asked why, despite all these explosive devices on our dinner tables, life expectancy in the West keeps rising. The truth is that health is a complex pattern of genetics, environment, lifestyle, and plain bad luck. And, if they want to save their bacon, medical researchers need to stop hamming it up.

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**Research
governance:
a lesson from
George Melly and
the BBC, p 1048**



CHAPMAN/REX

REVIEW OF THE WEEK

A deficit of attention to impartiality?

Media coverage of drug treatments that fails to allow the manufacturers a voice does no favours to drug sceptics, says **Iain McClure**

What Next for Craig?

Panorama, BBC 1, 12 November at 8 30 pm

Rating: ★★☆☆

Attention deficit hyperactivity disorder (ADHD)—the subject of this week's *Panorama*, the BBC's flagship investigative journalism programme—has become a totem of many modern concerns. A condition that encompasses impulsivity, overactivity, and difficulty in maintaining attention—and with an alleged prevalence of between 5% and 10% (www.sign.ac.uk/guidelines/fulltext/52/index.html)—it has repeatedly hit the headlines as being not just a product of developing psychiatric knowledge but also a symptom of increasing malaise in capitalist societies. Its unique position among child and adolescent psychiatric disorders as a condition that is widely believed to necessitate at least a trial of a stimulant drug (in most cases) has led to concern about psychiatry's simplistic reduction of the brain and that ADHD in particular is “a pharmacological response . . . crudely searching for a disorder” (*BMJ* 2005;330:1276).

Whatever the truth regarding such issues, the facts are that the number of diagnoses of ADHD is on the increase and that prescriptions of psychostimulants have risen accordingly. In a recent guideline the UK National Institute for Health and Clinical Excellence said that in 1998 there were 220 000 prescriptions for methylphenidate and dexamfetamine in

England, at a net cost of £5m (€7m; \$10.3m); by 2004 the number had almost doubled to 418 300, at a cost of £13m (www.nice.org.uk/guidance/index.jsp?action=byID&o=11572).

In recent years the UK has produced high quality, evidence based guidelines that, essentially, advise clinicians that when ADHD symptoms do not respond to behavioural treatment then a psychostimulant should be prescribed. However, what if the evidence on which such guidelines are based is flawed?

A key evidential mainstay of the pro-drug lobby is the ongoing multimodal treatment study of children with ADHD (the “MTA study”) by the US National Institute of Mental Health. The most comprehensive study of behavioural and drug treatment interventions in ADHD, it has published convincing evidence that carefully monitored management of drug treatment with monthly follow-up was more effective than intensive behavioural treatment of ADHD symptoms. Inevitably, use of psychostimulants has increased since this opinion. It was with great interest, therefore, that I watched *Panorama's* exploration of new evidence that the MTA study's crucial conclusion was now being questioned by experts associated with its original findings.

The programme introduced us to two teenagers, Craig and Yasha, both of whom were given a diagnosis of ADHD at age 4 years. Both have spent many years on various forms of psychostimulant treatment. At the start we were shown successive scenes of how, after years of drug treatment, Craig's behaviour was clearly no better. Likewise Yasha had become increasingly prone to acts of self harm while taking psychostimulants and had recently been weaned off them, after she was admitted as a psychiatric inpatient. The programme's pitch was clear: in the long term the drugs don't work.

Enter William Pelham, of Buffalo University, New York, who has a research record showing the effectiveness of long term behavioural interventions for ADHD patients, their parents, and their teachers. He is also, on a dramatic note, a member of the MTA steering committee. Acknowledging that “in the short run” psychostimulant treatment helps children to “behave better,” Professor Pelham's message was simple: that the MTA study had “exaggerated the beneficial effect of medication” and that there is no indication that medication is “better than nothing” in the long run.

So, we've all been conned. *Panorama's* pill had slipped down a treat. The drugs don't work. But . . . hold on a minute, where was the argument? Covering such a complex subject in just 30 minutes is, I acknowledge, a tall order, but has good journalistic process been followed here? Firstly, Professor Pelham should have been grilled more. We didn't hear any detailed explanation of why the new results now emerging from the ongoing MTA study question the earlier findings. Most importantly, the elephant in the room—the drug industry—and its undoubted role in this continuing saga were not even mentioned. Some attempt should have been made to interface Professor Pelham's remarks with a response by the drug manufacturers or one of their apologists within the medical profession. Without this, the programme was unbalanced, as we were left with no idea of the manufacturers' responses to this important allegation that the long term, mass consumption of their products is pointless.

When a flagship programme like *Panorama* covers an important issue it should cover both sides of the argument. What we need on this subject is balanced coverage that treats us as intelligent participants in the debate, not as attention deficient dupes.

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The drugs may not have worked for Craig, but what does that tell us?

Itchy fingers

FROM THE
FRONTLINE
Des Spence



The period between school and university was spent cutting grass at £1.80 an hour, and many a university night and any brief holiday were spent working in a bar or restaurant kitchen. But now I was on a medical career break, wandering the world. I gazed over the volcanic lake in Java. It was wonderful just to do nothing. I straddled the equator, a white emulsion line painted on broken jungle tarmac, dodged orang-utan urine, and looked nervously on to Krakatoa. I learnt what it was to be a visible minority—my hairy arms were stroked by groups of laughing Indonesians, and my wife smiled as she was told that blonde was considered a sign of intelligence.

But doing nothing is not easy. Current medical protocols have a non-negotiation policy with patients' symptoms. We blast off the doors with investigations, releasing clouds of clinically irrelevant biological variations, and then indiscriminately empty a magazine of interventions, which are all in the name of "best practice" and the "patient." But little attempt is made to understand the patient's culture, setting, or previous health seeking behavior. This is a policy of absolute total medicine; there is no art and no reflection. Outside our medical compound the alternative therapy militia are increasing in influence and controlling many of the streets.

Illness can be divided into self limiting conditions or an unstoppable biological cascade of degeneration or proliferation. In reality, our power to intervene in either of these scenarios is limited, and any delay in diagnosis has little impact on any eventual outcome. So it would make sense to adopt a policy of "wait and see." But this would involve doctors putting the safety catches on the weapons of mass investigations and would involve a significant change in our aggressive medical culture. Rather than focusing on all the investigations we can do, undergraduate and postgraduate training should highlight all the investigations we shouldn't do—the forgotten craft of non-intervention. Perhaps then accepting clinical uncertainty—the core skill of a doctor—might come more easily to us and help us to free patients from unnecessary anxiety.

Meandering through Asia should be a compulsory part of NHS training for all those stressed-out and battle-weary consultants and general practitioners. Let them return home with sun bleached hair, friendship bands, and yin-yang tattoos. We need to restore the ancient balance between the art and science of medicine and recognise the power of doing nothing.

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George's last stand

OUTSIDE THE BOX
Trisha Greenhalgh



Diana Melly spoke gently to her elderly, frail, cancer ridden husband. "George, you know you're not well. When do you think it would be a good time for you to stop performing on stage?"

The old man raised his head suddenly. His answer was defiant and pitched at the camera. "When I'm dead!"

The BBC documentary team, who had set out to capture Melly's colourful domestic life and final jazz tour, realised early in their filming that his metastatic lung cancer and progressive dementia raised ethical issues. They sought his consent to continue.

"Go ahead," he drooled. "You can film what you like so long as it's not too disgusting for a family audience."

"Even your lung cancer and your dementia?"

"They're important," he replied, indicating, presumably, an awareness that the documentary

would not be authentic without them. So the cameras followed our patient into the consulting room as he stripped to the waist and said "99" and later when he took to his bed, exhausted and confused, in his final hours.

Interspersed with archive clips of the young Melly strutting his stuff in smoky clubs, this portrait of the fading away of one of UK showbusiness's most familiar figures was both gripping and uncomfortable. The programme (broadcast last week) rose above the typical "reality TV" approach in which a week of fly on the wall footage is ruthlessly edited for material that will titillate or shock. Death was happening to Melly; and death—with all its indignity—was filmed alongside his last few public performances and his reflections on life as an entertainer, adulterer, and father.

I had half an eye on the television and half on my laptop, on which I

was attempting to answer questions from a multicentre research ethics committee about a planned study of people with mild dementia.

How will potential participants' capacity to give consent themselves be assessed? Will the research involve any foreseeable risk or burden for these participants or interfere in any way with their freedom of action or privacy? How will a fluctuating level of capacity to consent be handled? And so on through three pages of supplementary forms.

Research governance questions are a pain in the neck but also a good way of protecting some of the vulnerable participants some of the time. But in terms of how to engage with the needs and wishes of an individual who fits the criteria for the Mental Capacity Act 2005 I learnt more from the BBC.

Trisha Greenhalgh is professor of primary health care, University College London p.greenhalgh@pcps.ucl.ac.uk

In memoriam

Am I morbid when I say that there comes a time in life when you wonder what people will say about you when you're gone? The answer, of course, is that they won't think at all about you, at least for much or most of the time. Life itself dictates that it must go on even without our help: we are as pebbles dropped into a pond, causing a few ripples at most.

When Dr Levet, whom Boswell described as "an obscure practitioner of physic" and who came from the humblest background, died in 1782 aged 77, the landlord with whom he had lodged for many years wrote

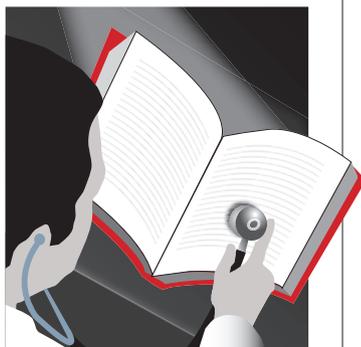
a commemorative poem that immortalised him. It happened that his landlord was Doctor Johnson, himself 72 at the time.

Their relationship was a strange one. Levet was not talkative or amusing when he did talk, but it seems that Doctor Johnson took comfort in his taciturn presence and may have been lonely without it. Levet left Johnson's house every day to do his rounds in the worst slums of London. Johnson used the occasion of Levet's death to reflect on how our journey through life is blind and ends in woe: "Condemn'd to hope's delusive mine,/As we toil from day to day,/By sudden blasts, or slow decline/Our social comforts pass away." It is clear that Dr Levet was a very considerable prop to Johnson, who lamented his death deeply.

What did Johnson see in Levet that elicited such admiration in the poem? Levet, who had worked as a waiter in a coffeehouse in Paris, was encouraged by some French surgeons to attend lectures on anatomy and physic and then returned to England to practise among

BETWEEN THE LINES

Theodore Dalrymple



Sometimes Levet would receive payment in drams of alcohol, and Doctor Johnson said that he was perhaps the only man who ever became intoxicated through motives of prudence

the poorest of the poor. "In misery's darkest caverns known,/His useful care was ever nigh,/Where hopeless anguish pour'd his groan,/And lonely want retir'd to die."

It is unlikely that he was ever able to do much for his patients but offer them placebos and bring them comfort, but that was much in the circumstances. Levet was not a scholar or a gentleman, but Johnson saw his virtues and appreciated them: "Yet still he fills affection's eye,/Obscurely wise, and coarsely kind;/Nor, letter's arrogance, deny/Thy praise to merit unrefined."

It was Levet's modesty that touched Doctor Johnson, who all his life struggled, with varying degrees of success, against the sin of pride. Levet never refused an appeal for help, nor did he charge his patients very much: "No summons mock'd by chill delay,/No petty gain disdain'd by pride,/The modest wants of ev'ry day/The toil of every day supplied."

Sometimes Levet would receive payment in drams of alcohol, the only fee available; and Doctor Johnson said of him that he was perhaps the only man who ever became intoxicated through motives of prudence.

Often in my life I wished that I could have been as Robert Levet, but ambition and (let us be frank) a desire for gain have prevented me from being so, as I suspect they have prevented many another. Of how many of us could it be said that, as Johnson wrote of Levet, "His virtues walk'd their narrow round,/Nor made a pause, nor left a void?"

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

Aequanimitas By William Osler

I have long held the dangerous belief that Osler's essays, judiciously used, could render teachers of medical ethics redundant. Virtually all the medical student needs for ethical behaviour is contained within them.

One of Osler's most famous essays, *Aequanimitas*, was first delivered to newly minted doctors in 1889 as a valedictory address at the Pennsylvania School of Medicine. Osler urges his young audience to "consider but two of the score of elements which may make or mar your lives." The first is imperturbability, which refers to "calmness amid storm, clearness of judgment in moments of grave peril." This poker faced composure, he claims, is essential to instil confidence in impressionable or frightened patients. Imperturbability is in part acquired through experience and a thorough knowledge of medicine. With these in hand, "no eventuality can disturb the mental equilibrium of the physician."

The second, related element—equanimity—has been the subject of some debate among Osler scholars. While some have interpreted it as apathy—the absence of emotions—others have read it as "metriopatheia," measured or moderated emotions. To acquire the virtue of equanimity, Osler recommends a tolerant, somewhat non-judgmental attitude towards our fellow humans. "The more closely we study their little foibles of one sort and another in the inner life which we see," he remarks, "the more surely is the conviction borne in upon us of the likeness of their weaknesses to our own." He continues: "The similarity would be intolerable, if a happy egotist did not often render us forgetful of it." Osler also advises us not to seek certainty when it cannot be found but



Osler: benevolent presence

and, should defeat come, cultivating a cheerful equanimity will make the pain easier to bear. When matters of principle or justice are in play, then "cling to your ideal," Osler urges, even in the face of evident failure.

Osler's essay is a classic for several reasons. Firstly, he tackles head-on a timeless question: what makes a good doctor? The ideals he proposes do not fade with passing years. His writing is meticulously crafted—each phrase, word, sound, and intonation deftly chosen, at times blurring the line between prose and poetry. Rich in cultural and literary allusions, the essay can be enjoyed by the teenage reader and erudite professor alike. What is rare is that Osler's scholarship is not tainted by pretentiousness: "You remember in the Egyptian story, how Typhon with his conspirators dealt with good Osiris"—well, no, I remember no such thing, but this ignorance engenders curiosity rather than shame. Even when discussing sombre matters Osler comes across as a benevolent presence, a calming hand on our shoulder: "It is sad to think, that for some of you, there is in store disappointment, perhaps failure."

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