Why don't practices encourage patients to enrol on the organ donor register online, asks Des Spence, p 1090

The highs and lows of policy based evidence

PERSONAL VIEW **David Colquhoun**

Remember George W Bush? For him it was simple. If a scientist told him an inconvenient truth, the messenger was fired, and someone more compliant got the job. In every area from global warming to the existence of weapons of mass destruction he chose to base policy on fantasy and wishful thinking. It seems that the UK home secretary, Alan Johnson, has something in common with Bush. When the Advisory Council on the Misuse of Drugs (ACMD) said something he didn't like, its chairman, David Nutt, got fired (*BMJ* 2009;339:b4563).

In a democracy there is no doubt that decisions must be made by politicians. Sceptical though one may be about politicians, I'm not sure that I'd want to live in a country ruled by scientists. Politicians have wider responsibilities than scientists, and they can be voted out if we don't like the decisions. Why, then, the explosion of indignation when Professor Nutt got the sack?

In the House of Commons Mr Johnson said, "I asked Professor Nutt to resign as my principal drugs adviser, not because of the work of the council but because of his failure to recognise that, as chair of ACMD, his role is to advise rather than to criticise government policy on drugs." But Mr Johnson had it wrong. Nutt, unlike, for example, the chief scientific adviser, is not a civil servant. He is an academic. It is his job to be independent. He is paid nothing for all his hard work on the ACMD. He has a day job to do as well. It is his job to criticise whatever he thinks it right to criticise.

Mr Johnson had it wrong. Nutt, unlike, for example, the chief scientific adviser, is not a civil servant. He is an academic. It is his job to be independent

The ACMD was set up by the Misuse of Drugs Act 1971[2]. Section 1 of the Act makes it clear that the duties of the council are to offer advice to ministers, "where either the Council consider it expedient to do so or they are consulted by the Minister." They do not have to wait to be asked.

Nutt didn't wait, and he got fired. Twitter was ablaze, quickly followed by the mainstream media.

This furore arose simply because Nutt said that cannabis was less dangerous than tobacco and alcohol (true) and that more people were killed and brain damaged from riding accidents than from ecstasy (also true). His Eve Saville lecture, for the Centre for Crime and Justice Studies at King's College London, seems to have been the immediate problem. There is nothing in the paper that directly criticises the prime minister or the home secretary, and there is nothing in the rules that says his academic publications have to be cleared with the Home Office.

Don't worry though, we have a democratic system, with an opposition. But the shadow home secretary, Chris Grayling, didn't oppose. On the contrary he said, "Let me start by reiterating my view that the home secretary's decision on Friday regarding Professor Nutt's future was the right one."

Luckily there was a doctor in the House. The Liberal Democrat MP Evan Harris said, "With every personal attack on David Nutt, and every piece of cod science [Alan Johnson has] produced, the home secretary deepens the crisis of mistrust between scientists and the government. The scientific community will not take this lying down—and sources of government advice are likely to dry up."

Harris hit the nail on the head: who on earth will want to spend years of unpaid work to produce the best evidence they can and then get abused and fired for their efforts? Politicians are apt to invoke the precautionary principle when discussing illegal drug use, but it isn't quite as simple as that. The precautionary principle can result in harm to people. Perhaps the reason for including ecstasy with heroin in class A was to make people think that ecstasy was as dangerous as heroin (not true, but precautionary). But it is just as likely that people will conclude that heroin is as safe as ecstasy. That's the danger of lying, however good the motives.

Leaf storm: cannabis is at the centre of the row over scientific advice to ministers

In a sense, we owe Nutt a great debt. His problems have brought to a head the crisis in the relations between science and government. This is only the latest case in a long history of politicians basing their decisions on ideas that are simply untrue. That cannot be good for anyone. The Department of Health has for years ignored the evidence about alternative medicine. It is nothing short of surreal that the House of Commons Science and Technology Committee is now, in 2009, holding hearings to assess the evidence about whether pills that contain nothing whatsoever can cure diseases. The widely expected change in government is not likely to help, judging by the support given to Mr Johnson by the shadow home secretary. The Tories may not go quite as far as their MP David Tredinnick, who asked a parliamentary question about the need for research into homoeopathic borax as a cure for foot and mouth disease.

It would be tragic if this sorry affair were to discourage honest scientists from trying to offer honest advice. I have the impression that we need a few more doctors in the House.

David Colquhoun is professor of pharmacology, University College London **d.colquhoun@ucl.ac.uk**

Cite this as: *BMJ* 2009;339:b4564

See NEWS, p 1047

REVIEW OF THE WEEK

On the concept of trauma

A new book tells the story of how the traumatic victim became culturally respectable, finds **Simon Wessely**

The Empire of Trauma: An Inquiry into the Condition of Victimhood
Didier Fassin and Richard Rechtman (trans Rachel Gomme)
Princeton University Press, 2009, pp 304
ISBN 978-0691137537
£16.95
Rating: ★★★☆

I recently gave a talk at our local school. My subject: shell shock in the first world war. I asked the pupils to name the most famous soldier of that war. Some named Wilfred Owen or Siegfried Sassoon (none named or even knew about the "old boys" of their school whose Victoria crosses were honoured on a board in the hall in which I was speaking). But for them the most influential soldier of that conflict was neither their own forgotten heroes nor the war poets but a person who never existed: Captain Edmund Blackadder. Their views of the first world war had been shaped not by historians but Richard Curtis and Ben Elton. And so when we reached the topic of my talk, the prevailing view was that victims of shell shock usually ended up being shot for cowardice. I tried to argue that it was not so simple, but *Oh! What a Lovely War* and Captain Blackadder were more than a match for my attempt to reclaim the Great War for history.

Of course, much has changed since 1918, even if we have little to be complacent about when it comes to the contemporary treatment of mental breakdown in soldiers or indeed any one else. But my audience was wrong in seeing this as a simple journey from ignorance to enlightenment, because, as Didier Fassin and Richard Rechtman elegantly describe in their new book, the story is more complex—and more interesting. The authors, trained in both medicine and anthropology, argue that what has happened is nothing less than a fundamental change in what it means to be "traumatised." Look in the index of any standard psychiatric textbook up to the 1970s and trauma means head injury. But nowadays to call a person "traumatised" refers to their mental and not physical state. Fassin and Rechtman point to the "huge difference in society's attitudes to 'trauma neurosis' in the late nineteenth century and 'post traumatic stress disorder' in the late twentieth century," but, unlike my school pupils, they don't believe that this is simply due to advances in psychiatric diagnostic skills or to a more enlightened or compassionate society.

Fassin and Rechtman are French, so inevitably sentences are long, concepts are complex, and Derrida, Foucault, and that old charlatan Lacan make their appearances, but they are no intellectual impostors. However, like many French intellectuals they tend to overestimate the influence of psychoanalysis, in this case on the development of the concepts of shell shock and trauma in the aftermath of the first world war. True, W H R Rivers looked after Siegfried Sassoon (albeit briefly), and Freud gave evidence for the defence in the trial of the Viennese neurologist and Nobel laureate Julius Wagner-Jauregg, accused but acquitted of brutal treatment of war neurotics. But neither was as influential as historians of psychoanalysis or Booker prize winners would have us believe. The first world war, far from revolutionising attitudes to war neurosis, did almost the opposite and reinforced existing doctrines and prejudices.

A more typical example of the medical response to the conflict comes from the career of John Collee. Before the outbreak of war Sir John was a well known scourge of the new workers' compensation acts. From the titles of his books—*Fraud and its Detection in Accident Insurance cases* (1913) and *Malingering and Feigning Sickness* (1913)—it is not difficult to guess his position. During the war he was appointed president of the special medical board set up to examine soldiers suffering from so called functional nervous disorders, and after the war he became the minister of pensions' medical director. The war had reinforced, rather than changed, his views, as reflected in the conclusions of the 1922 Shell Shock Commission: war neurosis was a problem of character, to be solved by better selection, leadership, training, morale, and discipline.

So now let us fast forward to modern day France. In 2004 Chirac appointed Nicole Guedj as the new minister for the rights of victims. One of her first actions was to propose a new law establishing a "presumption of good faith," which would make illegal any expression of doubt about the authenticity of a victim's testimony in the absence of strong contradictory evidence, a direct analogy of the presumption of innocence in criminal trials. Sir John would have failed to understand, let alone endorse, her views, but they are symbolic of the profound change that has occurred in what it means to be traumatised or to be a victim.

Having and showing compassion towards those who have suffered is one of the attractive aspects of human nature, but as Robert Hughes argued in *Culture of Complaint*, elevating the status of the victim in our society, let alone in our legal system, is not without a cost. It is desirable for victims of disaster to comment on their experience and for us to consider how we might improve services for them and their families. But victims now often become involved in questions about how such disasters either can or should be prevented. Surviving a rail or air crash does not make one an expert on rail or air safety. Furthermore, elevating and occasionally venerating victim status doesn't just lead to questionable changes in public policy: it may not always have desirable consequences for the victims themselves. The risk in assuming the role of the victim for a prolonged period is that the person is in danger of being defined, and defining themselves, not by what they are and have achieved but solely by what was done to them.

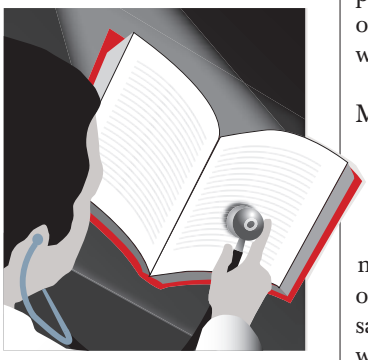
So now psychiatrists, psychologists, and counsellors have, paradoxically, found themselves victims of the new politics of trauma. Just when they had established themselves with the trappings of professional legitimacy (conferences, journals, accreditation, guidelines, standards, learned societies and the rest) they face competition and challenges to their expertise from the public. Of course, mental health professionals never seem far away from either challenge or crisis, which is why the work is so demanding but also stimulating and never dull. Much the same is true of *Empire of Trauma*. Like psychiatry itself, it is not for the faint hearted but is worth it in the end.

Simon Wessely is director, King's Centre for Military Health Research, Institute of Psychiatry, King's College London Simon.Wessely@iop.kcl.ac.uk

Cite this as: *BMJ* 2009;339:b4577

Sound sleep advice

BETWEEN THE LINES
Theodore Dalrymple



Sound sleeping doctors should take to heart what Bennett says: "Sound sleepers are as odious as perfectly healthy persons. Their sympathetic imagination has been weakened by nocturnal prosperity"

The author Arnold Bennett was a much loved man, even though Virginia Woolf disparaged what she thought was his work's reactionary realism. When he lay dying from typhoid in Baker Street in 1931 (it is startling to recall that, within living memory, people could still die from typhoid in Baker Street) straw was strewn on the road to lessen the noise of traffic and thereby ensure his tranquillity during his last days.

Coming from a modest background in Staffordshire, he appreciated the good things of life that were not to be taken for granted in his birthplace. His appreciation was not vulgar or ostentatious but deeply and sincerely felt: Bennett was a thoroughly civilised, tolerant, and decent man, a character that is by no means universal in literary circles.

His short essays, of which he wrote a prodigious number, are engaging. They are hack work, of course, written purely for money, of which Bennett was above averagely fond; but an author's talent is often seen to advantage in such work, and what he knocked off in an hour can still be read with pleasure and profit 80 or 90 years later. Bennett's qualities as an essayist, apart from ease and elegance of style, were genial common sense and a complete lack of snobbery, intellectual or social, without ever losing a sense of ethical and aesthetic values (a difficult trick to pull off).

Here, for example, in "Buying and Reading Books," is how he divides the practice of reading: "I would divide reading into three classes—reading for information, reading for wisdom, reading for emotion." He recommends that we do not confine ourselves to any one category, because "if the reader sticks exclusively to the first he may tumble into pedantry; if to the second, into didacticism and schoolmasterishness; if to the third, into weak gush." Not immensely profound, perhaps, but true, often forgotten, and well expressed.

In "Clothes and Men" he praises smartness and elegance of dress as a spiritual achievement, as a service not to the self but to others. Of the fop he says: "The fop is not without his use in society. He keeps tailors alert. He may often be an ass, but he is also an idealist, a searcher after perfection; and we have none too many searchers after perfection, and an ass engaged in that quest is entitled to some of our esteem." This is worth reminding ourselves of, now that we devote so much attention and shopping time to buying what will make us look shabby and undignified.

His essay on insomnia repays the short time a doctor might spend on it: "This subject should not be handled lightly, nor without a kindly regard for the sensibility of the great fellowship of non-sleepers, who as a class appointed to suffer receive far less sympathy than they deserve." Never has the effect of a sleepless night been better or more succinctly described: "The victim of insomnia, having seen the slowness of dawn, arises with every nerve tattered and the capacity for happiness ruined. His morning is a desolation."

Sound sleeping doctors should (but mostly won't) take to heart what Bennett says: "Sound sleepers are as odious as perfectly healthy persons. Their sympathetic imagination has been weakened by nocturnal prosperity. They do not understand, and in their arrogance and self-complacency they do not want to understand."

Let us not be like that.

Theodore Dalrymple is a writer and retired doctor

Cite this as: *BMJ* 2009;339:b4523

MEDICAL CLASSICS

De Rerum Natura (The Nature of Things)

Lucretius Published circa 50 BC

De Rerum Natura is science, including medical science, in verse. The Roman aristocrat Lucretius (99-55 BC) was a follower of the Greek philosopher Epicurus of Samos (341-27 BC). His narrative poem in six books was an attempt to publicise the Epicurean view of the universe in Rome. The underlying concept is that everything in the world, including human beings, consists of clusters of an infinite number of atoms that move around in an infinite void and in an unpredictable manner. Determinism is not a concept in this philosophy, and neither is immortality. These atoms vary in size, density, shape, speed, and concentration. Ambitious in scope, the comprehensive world view that Lucretius provided seems in some ways modern, in others rather quaint. The aim of the poem was to teach its readers not to fear death, which in Epicurean philosophy was the main obstacle to tranquillity of mind, the vital prerequisite for a contented life.

Lucretius's and Epicurus's concept of human beings entails a mind-body division; the senses arise from different atoms moving through our bodies at varying speeds and in varying concentrations. While mind and body are independently sensate and can become sick and can suffer pain independently of each other, they are born, grow, age, and die together. The mind, made up of small, round particles, is located deep within the chest and forms a "compound nature" with the spirit, which is dispersed through the movement of the limbs.

The senses and basic human instincts all follow the pattern of the circulating atoms. Smell is caused by streams of particles entering the nostrils. Their different shapes affect creatures differently. Vision arises from images or films that emanate from the surface of things. In people with jaundice, seeds of greenish yellow colour streaming out from their bodies and mingling with their environment cause the patient to see everything around them in greenish yellow.

Another, directly medical theme of the poem is the description of the effects of an epileptic seizure: the victim is "as if struck by lightning" and falls to the ground, foaming at the mouth, groaning and limbs shuddering, raving, growing rigid, twisting and turning, breathing irregularly, and tiring out the limbs by thrashing about.

In book 6 Lucretius describes the 5th century BC great plague of Athens in great (and gory) detail, especially the horrific physical symptoms, which seemed to start in the eyes and throat, moving to the chest, and then the mind; patients' breath was fetid. Mind and body weakened, and death approached usually over eight days, accompanied by permanent retching and cramps in the extremities, pain, unquenchable thirst, and disturbed senses. No one escaped, whether careless or careful, whether in town or in the country. Habitual burial rites remained unobserved, and each family tried to cremate their own while the epidemic raged. The book suddenly ends here, but the description is so vivid as to make this sixth book a medical classic all by itself.

Birte Twisselmann, web editor, bmj.com
btwisselmann@bmj.com

Cite this as: *BMJ* 2009;339:b4562

It's better to give

FROM THE FRONTLINE
Des Spence

For a child, a day meanders; for a teenager, the weeks roll; in your 20s the months tumble; and after you have children the years whizz by—I recall not a day of my 30s. We greedily squander time, taking it for granted. Until the "it'll never happen to me" inevitably does. Then time is the only valued possession: anything for a few moments more with our loved ones. I once carried an organ donor card, but it perished in the part of my wallet full of video shop cards and business cards from pushy colleagues I had taken only out of politeness.

The UK has a chronic lack of transplant organs, and attempts are being made to increase donation. But currently only 60% of relatives agree to requests to donate if the patient is not on the organ donation register. Proposals for presumed consent schemes have faltered, amid resistance and a fear of undermining the doctor-patient relationship. So, recently the General Medical Council floated a new idea: general practitioners would be required to ask all dying patients about organ donation.

But as the idea drifts by, the guns are coming out. Most patients dying at home have metastatic cancer or are very elderly; neither group are straightforward organ donation candidates. Also, many patients specifically choose to die at home to avoid excessive medical intervention—and this runs counter to transplantation. Anyway, how will organs be salvaged in the community setting? Finally, general practitioners struggle even to discuss where people want to die, so asking, "Oh, and can we have your liver?" seems a non-starter.

But there seems an obvious solution. Why don't practices encourage patients to enrol on the organ donor register online? Registering takes only about a minute, and we could place a computer in the waiting room. At any time of year there will be someone there, but more so in these darkest of months. Furthermore, why not incentivise this activity through the quality and outcomes framework (QOF), creating one useful outcome in a thousand stupid ones? Then, if one day our life support machine has to be turned off, many more of us can offer a stranger that rarest of gifts: time.

Des Spence is a general practitioner, Glasgow
destwo@yahoo.co.uk

Cite this as: *BMJ* 2009;339:b4546

An interest in teeth

THE BIGGER PICTURE
Mary E Black

Teeth were a major topic here this week. Our vet let my 12 year old son, after persistent maternal cajoling, sit in on dental surgery for our dog. He also showed him puppies on ultrasound and several sick dogs from the shelter. I like my children to see various career options, so they do not blindly follow the family ant tracks into the fourth generation of medics. If they end up choosing medicine they will have relatives and connections in most specialties, lining up to test their resolve, comment on their application essays, and give them the benefit of their experience.

Maja also had an early interest in teeth, and after completing high school she went on to qualify as a dentist. Maja comes from a Serbian family with no graduates, no money, and no connections. They are Roma, the most discriminated against minority in Europe. Many Roma children get stuck in special education classes or get almost no education, but Maja aimed a lot higher and succeeded. This June she became the first ever Roma to get a Harvard degree.

I have mentored Maja for some years, filling in the gaps that come from her having no close role models and limited connections with professional networks. I introduce her to people, share opportunities, give feedback on her scholarship applications, talk things through. She soaks up all suggestions and has cut through the barriers she faced, born outside the club of the educated, the informed, and the connected. Tomorrow she will start her second master's degree in health management. What she offers me is engagement, a good dose of reality and common sense, and a deep understanding of how minority participation and leadership can develop. These days we discuss public health as peers, through the different lenses of our ages and backgrounds. The years of mentoring were well worth it for both of us. We respect each other.

Lots of kids have an interest in teeth, but not all will get the chance to see where that might lead. For my son nothing is ruled out; he can follow his interests, he goes to a good school, his family backs him, he can defer earning a wage. He has a fair shot at success, whatever he chooses. But for every child like my son there are many, many more children who will not have or who will not see much of a choice. They have no professional ant tracks to follow or to diverge from. Society is the poorer for their exclusion.

Anyone reading this article has skills, contacts, and experience that could help a marginalised young person succeed. Hippocrates set the ball rolling; I am just enlarging the target.

Mary E Black is a public health physician, Belgrade, Serbia drmaryblack@gmail.com

Cite this as: *BMJ* 2009;339:b4526