reviews

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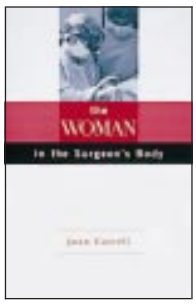
The Woman in the Surgeon's Body

Joan Cassell



Harvard University Press, £21.95, pp 267
ISBN 0 674 95467 X

Rating: ★★★

"Anybody but the girl! Give me a trained monkey—I'd rather have anybody but the girl!" So raged a male senior surgeon in theatres when scheduled to have a female trainee assisting him. This is just one episode illustrating this riveting study on women surgeons in the United States. "What's an anthropologist doing studying surgeons?" the author was asked while conducting a study on male surgeons; she replied (perhaps jokingly), "Well, there were no other primitives left." She now turns her attention to women surgeons, and clearly the term primitives was not a misrepresentation of many of their male colleagues.

The author studied 33 women surgeons of differing ages practising in eastern and mid-western United States. There was a wide representation of career stages and surgical subspecialties. She spent five days spread over a two week period shadowing each surgeon and also conducted structured, tape recorded interviews. She observed relationships with colleagues, patients, nurses, and trainees as well as aspects of family life. The aim of her study was to examine differences between male and female surgeons and the internal and external forces affecting these differences.

Each chapter examines a key area and is vividly illustrated with extracts from the taped interviews as well as descriptions and analysis provided by the author. The frantic, fast paced, almost hysterical way of life in an American department of surgery provides an enthralling background. The author sensibly lets the interviewees speak for themselves when she wishes to make a point. As the author herself says, whether or not you agree with her interpretations, the women surgeons are engrossing.

Some difficulties experienced will be familiar to any woman working full time in a busy job either in or out of medicine. While working lengthy hours, the woman also has the major responsibility for the running of the home, social life, and ensuring reliable child care. As one of the surgeons interviewed remarks, "We need a wife." Other factors described could also apply to many careers—for example, the lack of senior women as role models or mentors and isolation in male dominated departments.

Other episodes illustrated were truly appalling and surely must be unique to general surgery. It is hard to believe that these incidents could happen in the 1990s. Sexism was both covert and overt. Examples include a weekly departmental meeting where the only female member of the team was forced to listen to explicit descriptions of the type of sex the male residents had had the night before. More sinister still was the lack of recognition for good work and subsequent lack of promotion or sidelining by senior male colleagues into unpopular subspecialties. Grosser injustices such as lower pay for women surgeons doing the same job as their male counterparts and little or no maternity leave could, I hope, not happen in Britain.

The women themselves, however, were inspirational. They combined surgical excellence with compassion in a unique way. They overcame prejudice to provide outstanding patient care and excellent teaching for juniors. After reading this, it was humbling to wonder how one's own practice would appear if held up to such close scrutiny. This must be a therapeutic aspect of the book for readers.

This study could only have been conducted by a female anthropologist. It is hard to imagine a man gaining the confidence of the surgeons interviewed to obtain images of such clarity. I hope that this excellent book is widely read—but in particular read and taken heed of by male surgeons.

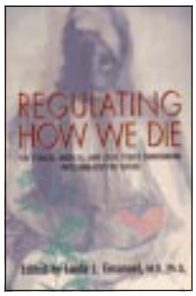
Sarah Creighton, *consultant, Department of Obstetrics and Gynaecology, University College London Hospitals*

BUCKINGHAMSHIRE COUNTY MUSEUM

In Theatre by British artist Susan Macfarlane. Her series of 26 oil paintings depicting images of breast cancer treatment is one of three exhibitions linking art and medicine being displayed at the Buckinghamshire County Museum, Church Street, Aylesbury HP20 2QP (tel: 01296 331441) until 6 December. Also showing are photographs by Ben Edwards on the daily life of a cardiac surgeon, and artwork by children from the Chelsea Children's Hospital School

Regulating How We Die: The Ethical, Medical and Legal Issues Surrounding Physician-Assisted Suicide

Ed Linda L Emanuel



Harvard University Press, £11.95, pp 315
ISBN 0 674 66654 2

Rating: ★★★★

All physicians are confronted with dying, which is difficult emotionally when dealing with patients and their relatives, and professionally when the question of "helping" a patient to die is raised. Associations that come to mind are compassion, alleviation of pain, autonomy, dying with dignity, and withdrawing treatment—but, above all else, "Do no harm." These terms conjure up intense emotions, opinions, expectations, and, for some, memories. As the book notes, "Physician-assisted suicide and euthanasia may appear to be a hot new topic. But the questions have been debated since before Hippocrates. Some arguments change, but mostly they do not. And yet questions are urgent, and answers must be rendered anew for society's current context."

Regulating How We Die is divided into three parts: considerations for, considerations against, and empirical, historical, and legal perspectives. The book "aims to clarify and balance the arguments concerning physician-assisted suicide and euthanasia and to direct attention to the root issues that motivate calls for their use in our own time." The list of the 10 contributors is a *Who's Who* for bioethics and health law, and they cover the breadth of ethical, moral, and legal issues that surround physician assisted suicide and euthanasia. Of special interest are chapters on "Facing assisted suicide and euthanasia in children and adolescents" and "Religious viewpoints." Although the legislative focus is on the Netherlands and United States, other countries, like Britain, are fully considered.

Medical and nursing staff, patients, and families are at some time confronted with death. Physicians guide us throughout our lives in living with the best possible health. When death is near, the role of the physician as helper is still expected by some, even if it means the ending of pain, suffering, humiliation, fear, and life. "What bothers the physicians is the claim that patients have a right—a right 'against' the physician—for performance of an obligation to help patients kill themselves. Actual clinical situations in the real world are often not simple, and the relevance of ideas such as self determination and mercy are far from clear. Even among physicians who recognise a moral obligation to assist dying patients with suicide, putting that policy into practice in actual situations is often problematic."

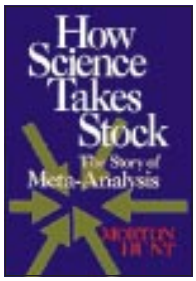
This is a big step from legalising euthanasia. Widely accepted is the view that "legalising euthanasia would degrade physicians to the position of executioners."

Regulating How We Die is a valuable source of balanced information for those who are faced with these questions. Written with grace and clarity, the book comprehensively explores the arguments for and against—cross cultural, religious, moral, and ethical aspects are considered. It will "help to guide those who must make very difficult decisions, whether at a level of public policy, in the personal practice, or among their own family members." As a reference and resource, it will be valuable and relevant for a long time to come.

Ariel Rosita King, *doctoral student, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine*

How Science Takes Stock: the Story of Meta-analysis

Morton Hunt



Russell Sage Foundation, £24, pp 256
ISBN 0 87154 389 3

Rating: ★★★

Morton Hunt has mastered the seemingly impossible task of conveying to a broad range of readers, in a language that can be understood by all, the genesis and development of meta-analysis. Although only recently "discovered" in medicine, meta-analysis has a longer tradition in the social sciences, particularly psychology, and this is where Hunt begins his story.

Many of the personalities who helped develop meta-analysis are interviewed, including Gene Glass, Joseph Lau, Graham Colditz, and both Iain and Tom Chalmers. Several important developments are reviewed, including the recent development of the Cochrane Collaboration. What is missing, probably because of publishing deadlines, is the recent development by the US Agency for Health Care Research and Policy to fund several centres for evidence based practice. Its association with the Cochrane Collaboration and other groups will be important to foster.

What Hunt uncovers, and which I believe is little known within medicine, is the contribution that meta-analysis has made in helping develop social policy, particularly in the United States. Much of this work has been conducted by the Program Evaluation and Methodology Division of the General Accounting Office—examples of its work include comparing the surgical treatments of lumpectomy and mastectomy for breast cancer, and determining the appropriate driving age for particular states. Unfortunately, Hunt informs us, the division has been disbanded, another casualty of "downsizing."

Throughout the book several statistical procedures for combining seemingly disparate data from individual studies are explained. The discussions of these "effect sizes" are nicely threaded together, with additional examples and explanations, in an appendix by Harris Cooper, a prominent scientist in the development of meta-analytical techniques. Social scientists have been more liberal than their medical counterparts in how to handle issues of subgroup analysis and sensitivity analysis. It is possible that the medical community will embrace the use of meta-regression to help tease out the various contributions that independent factors have on estimates of a treatment's effectiveness. For the sceptics, there is even space devoted to some of the problems and pitfalls facing the continued development of this science.

More attention could have been given to some issues highlighted through meta-analysis. We now have a more complete understanding of issues surrounding publication bias, less tolerance for underreporting of research, and have uncovered the occasionally less than desirable behaviour of some authors and the pharmaceutical industry. Most of these experiences can be transferred to other areas of research and are the result of rigorous efforts to improve the conduct of meta-analysis. The issue of standards for the reporting of meta-analyses is not discussed either, perhaps awaiting the second edition.

Overall, I think the book is great reading, even on holiday, which is when I read it. It will be particularly important for those interested in the thorny issue of how to use the results of meta-analysis to help develop useful policies for improving the health of the nation.

David Moher, *director, Thomas C Chalmers Centre for Systematic Reviews, Children's Hospital of Eastern Ontario Research Institute, Ottawa, Canada*

SEPTEMBER BESTSELLERS

1 **Oxford Handbook of Clinical Medicine, 4th ed**
RA Hope, JM Longmore, SK McManus, CA Wood-Allum
OUP, £14.95, ISBN 0 19 262783 X

2 **Oxford Handbook of Clinical Specialties, 4th ed**
JAB Collier, JM Longmore, TJ Hodgetts
OUP, £14.95, ISBN 0 19 262537 3

3 **Hot Topics in General Practice, 2nd ed**
E Stacey
Bios Scientific, £24.95, ISBN 1 85996 251 3

4 **Stedman's Pocket Medical Dictionary**
Williams and Wilkins, £5.95,
ISBN 0 683 14528 2

5 **Essential Statistics for Medical Examinations**
B Faragher, C Marguerie
Pastest, £13.50, ISBN 0906896827

6 **Notes for the MRCGP, 3rd ed (updated for the new modular MRCGP exam)**
KT Palmer
Blackwell Science, £19.95, ISBN 0 86542 777 1

7 **Evidence Based Medicine: How to Practice and Teach EBM**
DL Sackett, W Scott Richardson, W Rosenberg, RB Haynes
Churchill Livingstone, £15.50,
ISBN 0 443 05686 2

8 **The Insiders' Guide to Medical Schools**
S Calvert, I Urmston
BMJ Books, £9.99, ISBN 0 7279 1269 0

9 **Oxford Handbook of Acute Medicine**
P Ramrakha, K Moore
OUP, £16.95, ISBN 0 19 262682 5

10 **How to Read a Paper: The Basics of Evidence Based Medicine**
T Greenhalgh
BMJ Books, £14.95, ISBN 0 7279 1139 2

BMJ Bookshop

SOUNDBITES

"There is nothing morally repugnant about supplying your own health care: you are freeing up the NHS to look after somebody else."

"She [matron] was a dragon and she was a champion and we want her back."

Ann Widdecombe, shadow health secretary, at the Conservative party conference

"I did that service, I did it well and I deserve to be paid. If you call out a plumber in an emergency you would expect to receive a bill."

Dr John Stevens, consultant psychiatrist, in his quest for £540 from American Airlines for responding to an in-flight medical emergency

CD roms

The National Research Register

NHS Executive

Update Software, available free from the NHS Executive

Rating: ★★★ (★★★★ for promise, ★★ for product)

The public pays for the NHS, and for the NHS research and development programme. This is more than adequate justification for making information on research projects taking place within the NHS publicly available. The *National Research Register* is a CD ROM containing five research databases: (*a*) a database of projects funded by the NHS Executive, (*b*) a database of trials funded by the Medical Research Council, (*c*) a register of research registers, (*d*) a register of reviews in progress, and (*e*) a database of health related research at the two centres at the University of York.

National Research Register is no *Playstation*. In fact, it's duller than ditch water, and a browse before bedtime is as good as a hot bath for bringing on sleep. Then again, *Das Kapital* was dull yet it spawned a revolution. Indeed, the challenge with this CD is to consider the promise not the product. Imagine future research participants dipping into the projects database to discover the status of the projects in which they took part, including when and where they can find the results. Or future patients, mindful of their social responsibility to contribute to resolving uncertainties about treatment effectiveness, scanning the database of ongoing trials to see if they can take part in any. And perhaps the taxpaying public of the future will audit research funding, and write indignant letters to regional directors of research and development when they stumble on trivial research funded with public money.

Together, these developments might challenge the outdated notion that health research is owned by funders and investigators rather than those from whose health experience new knowledge is constructed. But the *National Research Register* has a long way to go. The projects database is incomplete, with only non-commercial research listed; the database of MRC clinical trials contains only 168 trials (don't expect to find Sir Austin Bradford Hill and streptomycin here); and the register of registers does not include the Cochrane Controlled Trials Register, a startling omission considering that this is the largest register of randomised trials in existence. However, this project has recently been revamped, with a new improved version of the *National Research Register* planned for early next year. Rome was not built in a day, and this CD ROM will take some building too.

Ian Roberts, *director, Child Health Monitoring Unit, Institute of Child Health, London*

@ www

WEBSITE OF THE WEEK

http://www.chiro.org/home.shtml Chiropractic is in the news this week with a paper in the *New England Journal of Medicine* challenging its efficacy in the management of childhood asthma (unsurprisingly) but also in the management of back pain (see p 1036). If spinal manipulation is going to work for anything it must be the latter, but no differences were found in time lost from work between the treated patients and the controls.

If your route to this information is from the chiro.org website you would be fairly informed of the results of this study through links to newspaper articles on the web (though not directly, interestingly, to the abstract published on the *NEJM*'s own website), and to a rebuttal (http://biz.yahoo.com/prnews/981007/va_aca_nej_1.html). This is fair play, and a useful counter to the tendency for major journal articles to cause media hysteria for a week and amnesia thereafter.

Although the page design is not entirely consistent, it gives the site a pleasingly non-corporate flavour and never descends into navigational awkwardness. While chiro.org scores top marks for timeliness and for its gamut of technology led features, it falls down on some fundamentals. There is an ftp directory (a list of down loadable files) of chiropractic history but little on the principles that underlie contemporary practice. If it is to fulfil its aim of building "an Internet site where ALL Chiropractors … put aside their differences and work toward providing the best information and communication possible," it will have to work much harder on providing good quality content.

Douglas Carnall
BMJ

PERSONAL VIEW

Virtual politics in the new NHS

Neither the white paper for England, *The New NHS: modern, dependable,* nor its subsequent guidance has done anything to address the real political problem of the health service: the apparently irreconcilable collision between the ever growing demand for health care and the finite resources available. What it has done, and herein lies its considerable political skill, is to transport us into another dimension of virtual politics. It was indeed "a triumph of style over content," as Rudolf Klein and Alan Maynard have observed, but that, after all, was its ambition and not merely the unfortunate consequence of incompetent drafting.

The purpose of virtual politics is to create a parallel world where belief in the difficult reality of change in a particular policy arena is suspended and all becomes possible. In virtual politics, it is the immediate symbolism of the policy illusions which is of paramount importance, rather than the practicality of the content. If successful, a pressing political problem is obscured, or public attention is diverted, or both.

It is not a new idea, but an interesting development of an old one where politics is regarded as literally a creative art. Given the intense political heat generated by the demand and supply mismatch in health care (as manifest, for example, in rising waiting lists, increasing emergency admissions, and overspent health authorities) something significant has to be seen to be done in order to hold the line. Thus does the process of policy formation become an end in itself, rather than the means to an end.

There are several criteria to be met if the exercise in virtual politics is to be successful and the illusion believable. Firstly, it must at least placate, and if possible engage, the dominant power groups.

This *The New NHS* has done by giving the medical and (less predictably and less significantly) the nursing professions the lead role in the primary care groups and confirming the pariah status of managers. Secondly, the illusion must gain the support of the army of analysts, advocates, and apologists who research, report, and construct opinion on the NHS. Without their energetic maintenance of the policy dream machine its ability to sustain the illusion that its world has meaning is drastically reduced. Thirdly, it must capture the public's sympathy through imaginative innovations with media appeal. Hence *The New NHS* gave us NHS Direct and specialist appointments within two weeks for everyone with suspected cancer classified as urgent by their GP: excellent copy.

Given that these criteria were met, the virtual NHS was off to a flying start. But how long could the illusion be sustained in the face of the reality of the constraints on change in the health service: the inflexibility of the existing demand for services, the marginal room for manoeuvre in most health authority budgets for any redistribution of activity, and the weak or non-existent lines of accountability between health authorities and the independent—that is, private—general practitioners?

Initially, the answer seemed to depend on the pace at which the reforms were to be introduced. The slower the rate of change and the more they were introduced on an experimental or cosmetic basis, the greater the chance that the traditional reliance on the medical profession (in one form or another) to deal with the manifold demands of the British patient could continue undisturbed until a real solution to the demand and supply mismatch in health care could be found.

> There must be no challenge to the medical profession

But there is now a major difficulty with this scenario. If the virtual world of the proposed reforms is to be maintained there must be no challenge to the medical profession on whose cooperation the existence of the virtual edifice depends. Yet partly in response to public pressure surrounding the case of the Bristol consultants and partly as a result of its emerging drive for quality the government has now embarked on a clinical governance policy which does precisely that. State intervention is proposed in territory which has historically been part of the sacrosanct sphere of medicine's system of self regulation.

If the medical profession interprets these proposals as a surreal product of the policy dream machine then all will be well. But if it views them as a challenge to medical autonomy then the heat and light generated by the reality of power and conflict in the NHS will rapidly subdue the virtual images of harmony and goodwill which the government has so far sought to project.

Grim reality will re-emerge where a make believe £21bn increase in the NHS budget is really £9bn, the promised 7000 new doctors cannot be cloned into existence, and the new bureaucratic tier of primary care groups will mean more managers.

If you would like to submit a personal view please send no more than 900 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or e-mail **editor@bmj.com**

Brian Salter, *professor of health services research, University of East Anglia*

SOUNDINGS

We won't forget you, Bill

A month ago my car became unwell and I had to bring it to the mechanic. My opinion of the mechanic rested solely on his ability to fix my car; his personal life, and specifically whether or not he had committed adultery in the recent past, was of no concern to me. Neither was it any of my business. We are not made of rock, we are not gods; we are flesh and blood, we are all human, and we all share the vulnerability of our humanity.

The president of the United States is a uniquely powerful and influential figure. Since the Troubles began in Ulster in 1968 no president has taken any great interest in us. This is quite understandable. The US has its own problems, and on a global scale we are too small and unlovely to worry about.

And then Bill Clinton became president and leant his ear and the authority of his office to the solving of our problems; the pressures and influences he was able to bring to bear have been a vital part of the peace process, lending it an unstoppable momentum. I accept that his behaviour with Monica Lewinsky was cheap and tawdry, and his attempts to cover up also hard to defend. "O what a tangled web we weave … ." The reputation of his presidency will forever be tarnished by his mistakes; the office demands a degree of dignity the squalid publicity surrounding the affair has denied him.

But we shouldn't lose sight of the great good he has done for Ireland; set against his achievements his mistakes become very trivial indeed. In his two visits here he displayed charisma and knowledge and enthusiasm enough to battle and charm even the most hardened cynics. Well, perhaps not all of them; "Lock up your women" was Ian Paisley's response to the president's last visit.

Just this month we have seen traditional antagonists, previously defined almost purely by their mutual enmity, sitting down together in a democratically elected body, something unthinkable and beyond all hope a short time ago. Our children now have a future where the big issues will be the real ones, the environment and the economy, rather than which flag flies over us or which football team we support.

So thanks Bill; you will always have our gratitude and always be welcome in Ireland.

Liam Farrell, *general practitioner, Crossmaglen, County Armagh*