reviews

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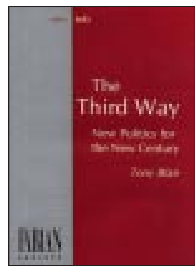
The Third Way: New Politics for the New Century

Tony Blair



Fabian society, £3.50, pp 20
ISBN 0 71630588 7

Rating: curiosity ★★★★, coherence ★

The plot is simple. Once upon a time, there was a world of secure jobs, large firms, low unemployment, relatively closed national economies, and strong communities underpinned by stable families. In that world social democratic governments could pursue their goals by simply using the instruments of state power. But that world has gone. Globalisation and other changes now mean that social democratic measures no longer work. Yet we should not give up on important centre left values—equal worth, opportunity, responsibility, and community. Governments will have to learn new skills, however. They must work in partnership with the private and voluntary sectors. They must devolve power. And they must avoid bloated central bureaucracies.

Taken literally, this diagnosis spells bad news for the NHS, which, along with the Civil Aviation Authority and the Church of England, is one of the few nationalised industries left in Britain. It would naturally imply something like the social insurance sickness funds for health care found in Germany, where the ideas of Christian democracy have sought to reconcile a commitment to social solidarity with a concern to limit the power of the state.

Yet, at this point, the argument bottles out. For Tony Blair, the NHS is a formidable achievement. That is why more money was found for it in the comprehensive spending review. The reduction of waiting lists is a priority, and there will be more rigorous monitoring of costs and quality. In other words the "third way" in health is a continuation of postwar policies by another name.

Such a paradox is not hard to understand. In the field of health services the story line of the third way is inconsistent with the high level of public support that the NHS enjoys. But the problem arguably goes deeper. In health care Tony Blair is a prime minister with a Christian democratic project working with a popular social democratic legacy.

Does this matter? After all, the world of politics rarely fits the neat categories of political ideology. And, of course, politicians can be forgiven many inconsistencies when they win landslide elections. Yet if we want an acid test of the third way it is mentioned in passing on page 14—long term care for elderly people. Only when we see how the Blair government handles this issue will we know whether the principles of the third way transcend the economic individualism to which it purports to be the successor.

Albert Weale, *professor of government, University of Essex, Colchester*

Cannabis and Cognitive Functioning

Nadia Solowij

Cambridge University Press, £50, pp 290
ISBN 0 521 59114 7

Rating: ★★★

People who have enjoyed using cannabis describe feelings of mild euphoria, pleasant alterations of perception, relaxation, and increased sociability. Others may experience anxiety, panic, or even psychotic reactions. Cannabis intoxication can produce measurable impairments in concentration and short term memory, difficulties in goal directed activity, slowed reaction times, and altered perceptions of the passage of time.

Despite public interest, and consequent generous research funding, evidence for persistent cognitive dysfunction has so far proved elusive. It is difficult to assess the level of intake of cannabinoids over a long period in humans, and other drug use may be a major confounder. Cannabinoids such as δ-9-tetrahydrocannabinol (THC) may lie in body fat stores for months, so the identification of irreversible cognitive effects requires the testing of subjects who have been drug free for a long period.

In the first part of her monograph Solowij presents a historical perspective on the neuroscience of cannabis. Early research on brain morphology in animals exposed to cannabis produced no obvious evidence for long term changes. The identification of a brain receptor with high affinity for THC in 1988 gave some direction to further work. Receptors are richly distributed in brain areas involved in memory and attention such as the hippocampus, and hippocampal lesions mimic many of the acute effects of cannabis. In animal models THC receptor function has been shown to change with chronic exposure, and the changes may explain tolerance to some of the acute cognitive effects of cannabis. A natural ligand, anandamide (from the Sanskrit word for bliss), was identified in 1992. Intriguingly, compounds extracted from chocolate have recently been shown to interact with cannabinoid receptors.

Since memory and attention are affected strongly by cannabis intoxication, and since long term users often complain of being easily distracted, the author developed an elegant experimental model for studying selective attention. Subjects were presented with auditory stimuli of varied tone and position, and asked to respond only to one type of stimulus by pushing a button. The more difficult the discrimination task, the poorer the performance of intoxicated subjects compared with controls.

Electroencephalograms entrained to the auditory signals (event related potentials) provide evidence that irrelevant stimuli are processed more fully in the brains of non-intoxicated long term users than in non-users. Long term cannabis users therefore seem to fail to ignore irrelevant stimuli. The longer the duration of cannabis use, the greater the effect.

Solowij argues that there are subtle effects of long term cannabis use which may, in some individuals, be irreversible. Whether the cognitive deficits she describes represent real handicap remains to be seen.

Philip Wilson, *general practitioner and senior research fellow, Glasgow*

RCOG Dialog CD ROM: Vol 1: Issue 1: January 1998

Royal College of Obstetricians and Gynaecologists

Noor Informatics Consultants, £295 for college members (personal annual subscription)
ISSN 1460 258 X

Rating: ★★★

This is the first of a twice yearly series from the Royal College of Obstetricians and Gynaecologists from which registered individuals can gain credits for continuing medical education. The programme gives a printout of how much of the CD has been worked through and so how many points have been earned.

The first important thing is that it works—both in Windows 3.1 and Windows 95—and you don't feel as though you are waiting for things to happen. This makes the programme easy to use and work through. I am a "put it in and play" person when it comes to software, and so being able to use it without recourse to the manual was ideal. It is also easy to browse through the contents without initially getting into too much detail and then pick out cases you are interested in: this strength is also a weakness.

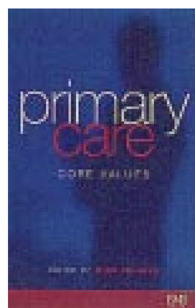
There are 50 cases with details of initial history and examination, usually with investigations, followed by a management section. Multiple choice questions are included at all points with good hypertext links. Once you get into a question, though, you cannot get out without answering it. There are good images of scans, clinical findings, and histology. You can try to spot the problem yourself or get the programme to show you. Each case then has a justification section with the reasons for the multiple choice answers with other background material. It is hard to disagree with most of the answers given as they tend to be fairly straightforward. It may be that in later series more contentious areas can be put in.

The level is just about adequate for membership of the Royal College of Obstetricians and Gynaecologists. If the aim is to ensure everyone stays at membership level for all areas of practice this CD will achieve that. There is a good balance of cases, but the fact that you can jump from one case to another leaves one of the problems of continuing medical education, which is that people study subjects that they already know and ignore those that do not interest them. A CD for a department is reasonably priced, but to register the whole department to use it for continuing medical education is not. I think it will be most used as preparation for the objective structured clinical examination in membership rather than by consultants for keeping up to date.

D J Tuffnell, *consultant obstetrician and gynaecologist, Bradford Royal Infirmary*

Core Values in Primary Care

Ed Mike Pringle



BMJ Books, £25, pp 128
ISBN 0 7279 1268 2

Rating: ★★

Twenty years ago the US Institute of Medicine enunciated, perhaps a little ironically, the four fundamental principles of primary care: accessibility, comprehensiveness, coordination, and continuity. These principles represent an enduring framework for considering and evaluating the contribution that a primary care sector makes to a healthcare system. In this edited collection of essays from the *BMJ* an international cast of contributors explores these and other aspects of primary care in an attempt to identify and redefine core values likely to survive in a climate of seemingly endless change and reorganisation.

This is not an easy task. Primary care is not a value system, but a system for providing first contact with medical care for individuals and their families. In a slim volume it is difficult to avoid being parochial, notwithstanding distinguished contributions from Canada and the Antipodes. Primary care in the Third World hardly gets a look in. There is, however, plenty in these pages to stimulate and inspire.

From Mike Pringle's prefatory rallying cry, through Ian McWhinney's beautiful account of the perennial characteristics of good primary care, to Iona Heath's marvellous essay on primary care, health, and the good society, a compelling picture of the crucial role of primary care emerges. Les Toop, from Christchurch, New Zealand, provides a valuable account of the "sustained partnership" between doctor and patient. Other contributors deal with the changes occurring in primary care in the NHS. Julia Neuberger focuses on the need to resolve conflicts between patients' priorities and those of the medical care system. Chris van Weel and Jacky Hayden deal with the important topics of evidence based care and education and training. John Roberts has the difficult job of analysing five market systems for providing primary care, and he concludes by offering the criteria elaborated by President Clinton's taskforce on health care as goals for reform in the medical marketplace.

Does this book represent rhetoric for true believers or is it likely to change minds? Have Pringle's contributors avoided complacency and self congratulation? Perhaps a little of all of these, and perhaps appropriately. They have all experienced much of the best of primary care and may have been protected from the worst. In the future, as healthcare systems become more integrated and the divisions between primary and secondary care increasingly blurred, we will probably need to try to rediscover the core values of patient care.

Roger Jones, *Wolfson professor of general practice, Guy's, King's, and St Thomas's School of Medicine, London*

OCTOBER 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. **British National Formulary No 36 (September 1998)**
BMA/Royal Pharmaceutical Society, £14.95, ISBN 0 85369 415 X
3. **Oxford Handbook of Clinical Specialties, 4th ed**
JAB Collier, JM Longmore, TJ Hodgetts
OUP, £14.95, ISBN 0 19 262537 3
4. **Stedman's Pocket Medical Dictionary**
Williams and Wilkins, £5.95, ISBN 0 683 14528 2
5. **Clinical Medicine, 4th ed**
P Kumar, M Clark
WB Saunders, £28.95, ISBN 0 7020 2019 2
6. **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
7. **Essential Statistics for Medical Examinations**
B Faragher, C Marguerie
Pastest, £13.50, ISBN 0 9068 9682 7
8. **How to Read a Paper: The Basics of Evidence Based Medicine**
T Greenhalgh
BMJ Books, £14.95, ISBN 0 7279 1139 2
9. **Notes for the MRCGP, 3rd ed (updated for the new modular MRCGP exam)**
KT Palmer
Blackwell Science, £19.95, ISBN 0 86542 777 1
10. **Health and Environmental Impact Assessment**
BMA
Earthscan, £14.95, ISBN 1 8538 3541 2

BMJ Bookshop

Shell shock patients: from cowards to victims

In 1980 I was a rural government medical officer in southeastern Zimbabwe when the civil war ended and Robert Mugabe's guerrillas could show themselves and seek treatment. One of these lay unmoving but alert in his soiled bedclothes day after day on my ward, without wounds or obvious pathology. As my concern about an atypical encephalopathy subsided, I came to see him as a case of some sort of combat stress and eventually talked him back into life.

An admirable three part television series on shell shock started this week with the first world war (*Shell Shock*, Channel 4, Sundays 8 00 pm). In fact, a better place might have been the American civil war, where military doctors were perplexed that men could die not just of wounds or disease but also of what they called "nostalgia"—a contagious condition associated with morbid homesickness. "Nostalgia" became an epidemic as the war dragged on, accounting for more cases than dysentery.

During the first world war, there were 13 000 cases of shell shock in the British army by 1915, and 200 000 over the entire war. An early article in the *BMJ* described a sergeant with a paralysis of his trigger finger preventing him from firing a rifle. The television series included telling footage of the man deaf to all sounds save the word "bomb," whereupon he would scramble under his hospital bed. There was an outbreak of hysterical blindness, weird gaits, and intractable shaking, almost all in ordinary soldiers. It was interesting that officers tended to present (and to be handled) differently.

Worried by the loss of manpower, the army set up special hospitals. One of these, Craiglockhart in Edinburgh, was described by the poet Siegfried Sassoon, an inpatient, as "a mausoleum filled with the morbid slumbers of men haunted by self-lacerating failures to achieve the impossible." Some psychiatrists drew on Freudian ideas of repressed trauma, ushering in the talking cure. Their French peers tried electric shocks to the affected part, soon to be adopted in Britain too (quicker than talking), and in Germany doctors used hypnosis. What they all shared was an ethical dilemma in that their efforts were directed to returning men to the trenches.

Although the War Office recognised shell shock as a genuine war injury in June 1916, the imperative for the army remained that men should kill and be killed as commanded. We will never know how many of the 307 British soldiers executed for "cowardice" had indeed suffered acute medical incapacity beyond their control, and how many had made a rational decision in a murderously irrational situation. Fifteen thousand men were still in hospital with shell shock in 1921.

The second part of the series moves on to the second world war. The lessons of the first war were forgotten and the prevailing line was that men would not break down if they had good training and leadership. However, the army was staggered by the extent of hysterical symptoms in those evacuated from Dunkirk, and 200 psychiatrists were recruited. Gung ho pioneers such as William Sergeant, who saw psychoanalysis as useless talk, promoted physical treatments including amytal or insulin coma to open up the unconscious mind and release its demons. Electroconvulsive therapy without anaesthetic began to be deployed in an increasingly indiscriminate fashion.

CHANNEL FOUR

However, there was resistance in high places to these trends. Churchill believed that psychiatrists could do harm "by asking odd questions" of ordinary men in interviews; some generals refused to have psychiatrists on their staff; and in north Africa, where there were high levels of what was now to be called "battle exhaustion," there were calls for reinstatement of the right to shoot deserters. The air force remained determined to stigmatise those who could not cope, their diagnosis being LMF (lacking in moral fibre). None the less, advance planning for D-Day included provision for battle exhaustion, and an entire psychiatric hospital was established within a month of the first landings. It is telling that a quarter of all initial D-Day casualties were psychiatric.

Part three in the series deals with the Falklands and Gulf wars. It is interesting how much more "psychological" the modern soldier sounds than his predecessors. A victim identity, particularly if medically certificated, has taken a special place in contemporary society, inevitably shaping what a soldier thinks has happened to him. It is a pity that these sociological issues were not discussed in the programme.

The major conundrum now facing the British army is Gulf war syndrome, not mentioned in the series, and the extent to which it is psychosocially shaped. The politics and psychomorality of post-traumatic stress disorder, the diagnostic tag that has usurped its predecessors, is a story in itself. This term was first applied to US veterans of the Vietnam war by psychiatrists who were part of the anti-war movement. Together with the old bugbears—suspicion about malingering and a fear of contagion if the military climate was too permissive—this issue is as pertinent today as it was in 1918.

Derek Summerfield, *psychiatrist, Medical Foundation for Caring for Victims of Torture, London*

WEBSITE OF THE WEEK

http://www.ukcia.org/ The UK Cannabis Internet Activists met on line back in 1995, taught themselves HTML (the markup language used by all web browsers), and got to work on building a site that is clearly organised and nice to look at. A site edited by partisans must be interpreted with caution, but the approach seems responsible and incorporates links or references to information from many reputable sources.

These include the BMA, whose report recommending a change in the law to allow research on the use of cannabinoids in chronic illness, published almost a year ago to the day, has plainly been influential. This week the House of Lords' Science and Technology Committee concurs (p 1337), and there seems little doubt that change in the law will follow. Events in the United States are moving in the same direction, following pressure from groups such as the Campaign for the Restoration and Regulation of Hemp (http://www.crrh.org/). A total of seven states—covering a fifth of the nation's population—have directly contradicted federal drug laws in recent referendums. Far more sites argue for reform than for the status quo: despite an assiduous morning's browsing on a high speed network, anti-drug sites proved elusive. On the internet at least, those fighting the war on the "war on drugs" are definitely winning.

While advocacy abounds, hard scientific evidence about cannabis is hard to find. There are, for example, no trials reported at **http://www.controlled-trials.com/**, although its presence refutes earlier reports (http://www.bmj.com/cgi/content/full/317/7167/1258/c) that the website does not exist. Hint for press officers: if you want to publicise your website take care to supply the correct URL.

Douglas Carnall
BMJ

PERSONAL VIEW

Britain needs a national cancer institute

Within the past few months five potential new cures for cancer have been announced. These announcements have increased the sales of newspapers, boosted the share prices of certain biotechnology companies by 600%, and raised hopes in the hearts of the 278 000 people a year who develop cancer in England and Wales. Such pronouncements have been a constant media feature since 1980 when the Imperial Cancer Research Fund announced that it was going to spend £1m on interferon, the wonder drug of the time, for treating cancer.

You could cynically comment that such announcements represent the devious attempts of snappily dressed public relations consultants to bolster share prices and promote fund raising for cancer charities. But are they? Although there is no doubt that financial public relations consultants do attempt to manipulate the media, the cancer charities have an ever present and laudable need to draw in financial support to promote cancer research.

In Britain cancer research is funded by the government and through several charitable organisations. The most important of the charities are the Imperial Cancer Research Fund and the Cancer Research Campaign, whose annual budgets are £60m and £55m respectively. The government funds cancer research through the Medical Research Council at a level of £14.8m a year. Other sources of government money include the Department of Health, which spends £9m a year, the NHS research and development division, which funds £0.4m of research a year, and the Scottish Office, which spends £8m on cancer research a year. Cancer kills 22% of the British population and yet cancer research is funded at only £2 per head a ear.

So what should we do about cancer research? Shall we continue to leave it to charity and market forces or should we follow the example of the United States? In 1975 Richard Nixon announced a new initiative for cancer research to the world. Cancer was going to be cured in his lifetime and $1500m of federal money was identified for this initiative. Cancer research was promoted through the National Cancer Institute, a federally supported conglomerate of skyscraper buildings situated in Washington within the National Institutes of Health. Grants were issued to research workers and cancer research pump primed. The US government has continued funding cancer research. The House Appropriations Subcommittee has just apportioned $2.788bn to the National Cancer Institute for the fiscal year 1999, which is in contrast to the level of support for cancer research in Britain and was more than was requested.

So was the Nixon initiative sensible or was it a waste of money? Although cancer has manifestly not been cured, the initiative was worthwhile and has led to the promotion and stimulation of academic research into the origins of cancer. The US leads the field of cancer research. Projects have been funded which have led to a tremendous change in the way that we view the detailed scientific events that lead to cancers. It is clear that it is only by promoting basic research that we will gradually come to know the science of cancer and target and develop new treatments for the condition.

> Cancer kills 22% of the British population and yet cancer research is funded at only £2 per head a year

In Britain the idea of the triumph of intellect over a lack of resources is dominant, but it is impossible to conceive that cancer research in Britain is achieving a great deal when it is so underfunded. Cancer research is a complex enterprise and requires the cooperative efforts of many people. It requires coordination and skilful fast track financing of potentially beneficial projects. Although there is much to be said against centralisation, it cannot be said that pooling intellectual resources and scientific plant is inherently bad for cancer research.

Nearly every civilised country has a national cancer institute and the aims and ambitions of such centres include the instigation, prioritisation, and coordination of cancer research and treatment. Britain remains virtually the only country in the developed world that does not have such an organisation. The time is right to have a national project suitable for the millennium and perhaps the £900m spent on the Millennium Dome would have been better spent on a national cancer institute. Let us have an institute which houses high achieving, judiciously financed, and coordinated and fast tracked cancer research. Let us make this a suitable target for a millennium appeal.

Jonathan Waxman, *consultant physician and chairman of the Prostate Cancer Charity, London, and* Ian Gibson, *MP, chairman, All Party Cancer Group, London*

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**

SOUNDINGS

Getting about

The average speed of commuter traffic in central London today is two miles an hour—the same as it was in 1910. This median value obscures the increasingly frequent experience of total gridlock for minutes, and occasionally hours, at a time. My university office is situated in one of several blocks on a shrinking NHS hospital site whose car park has been taken over by industrial plant "until further notice." The surrounding streets sport red (not yellow) lines and menacing traffic wardens.

For all these reasons, I have given up driving to work. Since my morning responsibilities include the school run, I leave the car parked in tidy suburbia, outside the house of an old lady who used to watch darkly from behind her net curtains while I unloaded my folding bicycle from the boot. Now, having apparently excluded sinister motives, she gives me a cheerful wave every morning and has even, on occasion, come to the door to get a better look at the Brompton.

"Clever, that," she remarks, as I deftly pull full sized seat, handlebars, pedals, wheels, lights, carrier, and suspension from the impossibly small black object I have just placed on the pavement. "I expect it's Japanese."

It's British, actually, and the slick unfolding manoeuvre comes with practice. On my first attempt I managed to get both saddle and handlebars facing the wrong way and a misplaced brake cable hung disjointedly from the crossbar until a passing motorist stopped to help. The three mile trip into work now follows tree lined cycle paths on Hampstead Heath and takes 15 minutes, including repackaging the bike and filing it on the bottom shelf of my cupboard.

It is an encouraging sign of our times that folding cycles are currently enjoying the status of fashion accessory to the extent that at smart city centre venues, they meet with fewer disapproving glances than mobile phones and can be handed in at the cloakroom in exchange for a raffle ticket. At a recent committee meeting at BMA House, it was heartening to see no fewer than five similar machines lined up next to the briefcases.

Why is that so significant? Because if a critical mass of our negotiators has indeed discovered the folding cycle, it will shortly become a tax deductible item for us all.

Trisha Greenhalgh, *general practitioner, London*