reviews

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Forensic Sciences in Clinical Medicine: A Case Study Approach

William R Anderson

Lippincott, Williams and Wilkins, £123.95, pp 272
ISBN 0 397 58777 5

Rating: ★★

Forensic pathologists have undoubted expertise in documenting and interpreting injuries. However, at least in the United Kingdom, their main audience is the legal profession in coroner's, civil, and criminal courts. Dr Anderson, an American forensic pathologist with over 20 years' experience, argues that their experience could be usefully applied to the audit of the clinical outcomes and the education of clinicians involved in the management of trauma victims. He has attempted to implement this philosophy in this text, directing it at trauma clinicians as well as forensic and general pathologists. Consequently, in contrast to other forensic pathology textbooks, this monograph is much more clinically oriented.

Individual chapters are based predominantly on types of injury or post-traumatic complications. They are centred on a series of case histories from the author's personal case files. The text consists almost entirely of a series of extended picture legends to over 700 colour and black and white photographs, mainly of the gross injuries but also of trauma scenes, histopathological sections, electrocardiograms, and radiographs.

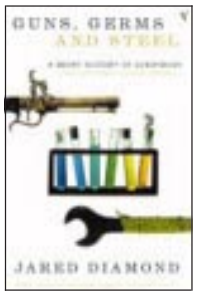
The idiosyncratic organisation provides both the major strengths and weaknesses of the book. The quantity of illustrations far exceeds the standard forensic pathology texts, with abundant photographs of the appearances of a wide variety of injuries, but some are clearly superfluous and, although the clinical and macroscopic autopsy pictures are largely of good quality, many of the photomicrographs are poor. The accompanying text contains much useful information, and some of the case histories provide compelling reading and several salutary lessons. However, the exercise occasionally becomes irritating because text and accompanying illustration are often separated, necessitating frequent page turning, there is unnecessary repetition, and the text sometimes alternates confusingly between different case histories.

Nevertheless, this publication presents an interesting and novel approach that, if one can persevere with the deficiencies of organisation, could be usefully read by trainee forensic pathologists, general pathologists involved in coroner's work, forensic physicians, and any clinicians involved in the management of trauma and its medicolegal implications. Indeed, any clinicians who may encounter victims of general physical or sexual assaults would be well advised to at least read the sections on evidence management and guidelines on chain of custody.

Kevin Hollowood, *consultant histopathologist, John Radcliffe Hospital, Oxford*, **Deborah Rogers**, *honorary senior lecturer, St George's Hospital, London*

Guns, Germs and Steel: A Short History of Everybody for the Last 13,000 Years

Jared Diamond



Vintage, £8.99, pp 480
ISBN 0 09 930278 0

Rating: ★★★

"Why is it that you white people developed so much cargo and brought it to New Guinea, but we black people had little cargo of our own?"

Jared Diamond, a professor of physiology who also writes about ecology and evolutionary biology, has written this book in response to the above question. The 400 pages wade through 13 000 years of history to explain why the Spanish conquistador Francisco Pizarro destroyed the Atahuallpa's Aztec empire so quickly, as well as why the development of so much "cargo" occurred in Europe rather than in New Guinea.

The author summarises the main explanation as: "History followed different courses for different people because of differences between people's environments, not because of biological differences among the peoples themselves." Examples from places as diverse as the Fertile Crescent, Mesoamerica, and Western Australia are then used to support this.

The climate and east-west axis of the Eurasian land mass allowed a unique collection of flora and fauna to develop. Of the world's 56 heaviest wild grass seeds, 33 are found on the main Eurasian land mass. Eurasia was also advantaged by possessing 72 mammalian candidates for domestication. The abandoning of the hunter-gatherer lifestyle allowed permanent settlements to develop, leading to the evolution of disease and freeing sections of the population from producing their own food. By the 15th and 16th centuries, Europe had overtaken China in terms of colonising technology. Competition between European neighbours prevented a single edict halting any innovation deemed undesirable, unlike in China, which had turned its back on some advancing technologies.

Europe could conquer the New World because of the Old World technology of the guns and steel of the book's title. However, the lethal nature of the Europeans' germs, especially smallpox, made them possibly the most important of the three factors. The author argues that the advantages conferred by these factors were caused by an accident of geography, rather than biological superiority.

Throughout the book Jared Diamond keeps returning to New Guinea, a country that he has studied and explored in great detail. His insistence on applying explanations to New Guinea casts doubt on his own, and other people's, theories and eventually bored me. However, while not necessarily agreeing with all that it says, I found *Guns, Germs and Steel* an interesting and informative account of the rise of human civilisation and of the reasons for the arrival of "white cargo" in New Guinea.

Alex Brooks, *second year medical student, Guy's and St Thomas's Medical Schools, London*

Reviews are rated on a 4 star scale (4=excellent)

War and Public Health

Barry S Levy, Victor W Sidel

Oxford University Press,
£42.50, pp 432
ISBN 0 19 510814 0

Rating: ★★★

This book provides an excellent collection of material on the impact of war on public health, and it provides a valuable starting point for much needed debate.

War and violent political conflict are detrimental to health and health systems. In some cases, of course, violent political conflict may lead to the longer term establishment of a more equitable health and social system, but even in these situations populations and systems suffer in the short to medium term. *War and Public Health* highlights the debates that took place in the middle 1980s and early 1990s regarding nuclear and other weapons of mass destruction, the impact of war on public health, and the role of health workers in peace advocacy.

In 1998 we witnessed the testing of nuclear devices in India and Pakistan; anxieties about the systems controlling the nuclear arsenal of the former Soviet Union; intense military action against Iraq and the latter's development of weapons of mass destruction; and terrifying testimony to the South African Truth and Reconciliation Commission of the development and use of chemical and biological agents during apartheid. Currently, we are horrified by ethnic repression and annihilation. All these powerfully bring home the current importance of *War and Public Health*.

As we approach the next millennium, we need to learn from experiences emerging since the end of the cold war: how should we have responded to Somalia, Rwanda, or former Yugoslavia? To what extent could early signs of pending conflict be identified and the slaughter avoided?

However well intentioned, humanitarian relief may, at times, offer limited benefit and, at worst, may contribute to the prolongation or exacerbation of conflicts. Maximising the benefits and minimising the harm from relief assistance during and after complex political emergencies is a considerable challenge, and one that requires careful evaluation and partnership between donors, providers, academics, and affected populations.

A key challenge is establishing links between humanitarian relief activity and future development of health services and systems, ensuring that relief inputs do not simply replace but rather support pre-existing systems and bolster their resilience. Replacing existing systems with parallel ones almost guarantees that, when funds for humanitarian relief dry up or are diverted to the next emergency, little system support survives. We are currently witnessing the privatisation and professionalisation of humanitarian responses: what are the implications for future practice?

Every conflict has perpetrators, predators, and perpetuators. Promoting violent conflict can provide opportunities to seize assets and to reinforce political and economic advantage. Health assistance and food aid in emergencies may themselves become contested resources over which struggles for control and enrichment continue. We need to understand the political economy of conflict, and the way in which our globalising world may predispose to increasing tensions and conflicts and may affect the effectiveness and equity of our responses.

Many fundamental and searching questions remain. Is conflict a root cause of the decline of health and health systems in unstable countries, or are both conflict and malfunctioning health systems manifestations of maldeveloped societies? How does the provision of services reinforce (or reduce) divisions within society? What are the limits of national sovereignty, and when and how should an international response be articulated? How should military and humanitarian action interface? What are the key challenges for health policy and planning in countries emerging from conflict, and how can international aid most effectively support indigenous capacities during this time of transition? To what extent does addressing health needs and developing services and systems provide opportunities for re-establishing a sense of community, rekindling livelihoods, and reducing the festering after effects of war? How can we ensure that, in the aftermath of war, the foundations are laid for a more equitable and humane society in the future?

War and Public Health offers a comprehensive and valuable review of the adverse effects of violent political conflict on health and health systems. The agenda must now shift to refining our critiques of humanitarianism; improving the evidence base for interventions; enhancing our understanding and sensitivity to the differing needs of, and link between, relief and development; examining the ethics of intervention in the face of war crimes and genocide; and continuing to support campaigns for a more just, equitable, and peaceful next millennium. Our immediate job must be to learn as much as possible from the tragedy that is Kosovo: how can it be that "Never again" has happened once more?

Anthony Zwi, *head, Health Policy Unit, London School of Hygiene and Tropical Medicine*

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NETLINES

● The virtual notice board for the Cochrane Acute Respiratory Infections Group is at **nceph.anu.edu.au/user/rnd868/arigroup.html**. The website is primarily text based but, even so, makes an interesting read. Its description of the work of the Cochrane Collaboration and the Acute Respiratory Infections Group brings home to users just how much work goes into preparing and maintaining this important resource.

● In a clever adaptation of internet technology **www.egroups.com** allows communication between individuals with a common interest by standard internet facilities such as the web or email with no additional software required. Even better, the service is free but, not surprisingly, supported by advertising. Among the many groups, those with health and medical interests are well represented. For example, a forum for UK based consultants in communicable diseases is at **www.egroups.com/list/ccdc-uk/info.html**.

● Textbooks are now well established on the web, and a good example is at **icarus.med.utoronto.ca/carr/manual/outline.html**. This is a primary care guide of ear, nose, and throat problems and before using it, read the introduction, which can be found from the contents page. It adopts a practical and common sense approach to ENT problems and though it is neither comprehensive nor complete, it can be very useful. There is also a smattering of hypertext links to other associated topics (hopefully there will be more) either within the manual or on to the internet itself. Though still evolving, this resource shows how medical educational material can adapt to the web.

● The New Zealand Guidelines Group has published a collection of their completed work, as well as work in progress, at **www.nzgg.org.nz/library.htm**. This is by no means a comprehensive listing, but there are some interesting and potentially useful guidelines available, and at least there is a reference for the paper version of those guidelines that are not published on the web. It is also worth looking at other sections of the site: in particular, there is an excellent collection of resources, including links to other collections of guidelines, which can be accessed from **www.nzgg.org.nz/help.htm**. However, it would be better if all guidelines were housed in one site without the need to follow links. Perhaps one day we will see the rise of such a supersite.

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We welcome suggestions for websites to be included in future Netlines. Readers should contact Harry Brown at the above email.

ads ads ads

"Don't smoke," buy Marlboro

The annals of literature are full of instances of misanthropes, knaves, and other antisocial characters who come to see the error of their ways and spend their declining years doing good works and helping their fellows. We were therefore intrigued by an announcement late last year by tobacco giant Philip Morris that it was prepared to spend $100m a year in a US campaign to reduce young people's smoking. Was this, at last, an honest attempt by Philip Morris to end its seductive marketing practices that have led to the tobacco addiction of millions of children and teenagers around the world?

Philip Morris has produced a series of television advertisements entitled "Think. Don't Smoke" and has made them the centrepiece of its antismoking campaign for teenagers. The advertisements tell children that they have a choice whether to smoke. Do they work?

The answer is probably not, according to a study released earlier this month (*Wall Street Journal* 7 April). Focus groups of 12-16 year olds were shown the Philip Morris antismoking adverts along with those from California, Massachusetts, Florida, and Arizona. The children found the Philip Morris adverts to be the least effective of all in making them "stop and think" about not smoking. Some of the respondents said that the Philip Morris adverts sounded more like a parental lecture, and overall there was a feeling that they lacked substance and good reasons not to smoke.

It is reasonable to wonder why Philip Morris would undertake a multimillion dollar antismoking campaign that would seemingly undercut its efforts to attract new customers (90% of new smokers in the United States are under age). After all, Philip Morris is still spending far more on cigarette marketing that affects children adversely than on keeping tobacco out of their hands.

In fact, the Marlboro Man, the rugged all-American cowboy tobacco icon, is one of the best reasons to be sceptical of Philip Morris's intentions. Marlboro's 40 year global advertising campaign is arguably one of the most successful in the history of advertising. The association of an addictive product with images of cowboys, virility, and the American West has made Marlboro the brand of choice children worldwide.

In the United States Marlboro is preferred by 60% of 8th, 10th, and 12th grade boys and girls (14-18 year olds) who smoke. Among white 12th graders, Marlboro's share of the market is even higher at 70%. Between 1988 and 1997, the Marlboro campaign was responsible for convincing 1.4 million children to try smoking. If current trends continue, about 200 000 of these new smokers will die prematurely from smoking related disease. If Philip Morris was truly serious about stopping the alarming spread of teenage smoking, it would start by dropping the Marlboro Man and changing its marketing practices that influence children, such as advertising in magazines with high youth readership.

BETH A KEISER/AP PHOTO

Marlboro man: flavour of the century?

In reality, Philip Morris is getting maximum public relations value out of its teenage antismoking campaign while achieving little in results. The tobacco industry has a long history of diverting attention away from its true motives. The release of internal documents in recent years has shown how tobacco companies have misled the public about the dangers of smoking and how they have directed marketing at children. As previously, the industry responds to threats of legislation or litigation with public relations campaigns. A 1995 internal Philip Morris document quoted Ellen Merlo, Philip Morris's senior vice president of corporate affairs, warning her colleagues, "If we don't do something fast to project the sense of industry responsibility regarding the youth access issue, we are going to be looking at severe marketing restrictions in a very short time. Those restrictions will pave the way for equally severe legislation or regulation on where adults are allowed to smoke." Does that sound like a company concerned about children smoking?

Another aspect of Philip Morris's strategy is to try to enhance its image by attracting credible health, education, and youth organisations as partners in its teenage antismoking effort. So far, only one group has agreed to participate: the National 4-H Council, a respected group that fosters partnerships between young people and adults, has agreed to take $4m from Philip Morris. The council claims that it has been given assurances that Philip Morris will not try to control how the money for antismoking programmes is spent. Still, there has been considerable dissension within the organisation, and many of the council's state level programmes have refused to be associated with Philip Morris. California's 4-H advisory council wrote to the president of the National 4-H Council, admonishing him that "4-H does not belong in Marlboro Country." Many in the organisation believe that any association with Philip Morris will damage the reputation of 4-H.

It is clear that Philip Morris is trying to buy respectability, and little else, with its $100m. From past events, it's easy to conclude that Philip Morris wouldn't have it any other way.

William D Novelli, *president, Campaign for Tobacco-free Kids, Washington DC, USA*

@ WWW

WEBSITE OF THE WEEK

http://www.monash.edu.au/informatics/index.htm The internet began in universities, and asking what use it is for education is a bit like asking what the role of the telephone is in communication. But there are better and worse ways to transmit educational messages, and the Monash site has useful guidelines for those assembling materials for learners on the internet, from basic pointers such as keeping web based text short—people read more slowly on screen—to digitising audio and video teaching materials.

Once you have assembled the materials to be available on the web, how do you go about building a community? As things settle out in cyberspace the system is starting to reflect the system: the organisations with the resources and the vision are starting to implement these on the net and, slowly, virtual representations of the usual suspects become available online. Further ahead than most is the Royal College of Surgeons of Edinburgh. Behind its neoclassical facade lurks an internet cafe (http://www.rcsed.ac.uk/fmi/cafe.asp) where aspiring and qualified surgeons can hone their internet skills with support from the college staff, one of the better medically oriented gateways to the internet (http://www.rcsed.ac.uk/fmi/gateway.asp), and SELECT: the beginnings of an online package for basic surgical education, already reviewed in these pages (*BMJ* 1998;317:1532).

Another useful gateway for all matters related to information technology, teaching, and medicine is the GHIFT project (http://www.chime.ucl.ac.uk/GHIFT/), which is partly sponsored by the Department of Health's information authority.

The correspondence course has come a long way, and this is only the beginning. Last week I saw a demo of a distance learning course in primary care, which even included a virtual student bar, though you'll have to pay your fees for an MSc in primary care if you want to "drink" there. And beware: the log files on the server mean that your tutors know when and what you've been reading.

Douglas Carnall
BMJ

PERSONAL VIEW

I don't believe in excellence

"Who's a nice chimp, then?"

It has been several years coming and is not fully worked out. But it is continually gnawing away at the back of my mind. Now I have been pushed over the edge by the British government's two new initiatives for the English NHS: National Institute for Clinical Excellence (NICE) and Commission for Health Improvement (CHIMP). It seems a wondrous coincidence that these initiatives tie in so well with my weft: "I don't believe in excellence," and my weave, "I don't believe in progress."

I have been involved in AIDS related development projects in South East Asia for the past four years. I left medicine after my house jobs in the United Kingdom six years ago. It has gone far beyond "a refreshing change." It is hard to describe the passion I now feel towards life. Not like before. Not like the NHS. Not like being screwed by management. Not like the shattered dreams I had woken up with by the Christmas of my first clinical year at medical school. Not like the migraines of society's scream for a golden calf: "Make us a graven image, make it like unto perfection in health." Not like that pavement pizza of a word: vocation.

Excellence. I look at a world where the "haves" are leaving behind the "have nots." A world of geopolitical rhetoric, followed up by little positive action. Perhaps some tinkering here and there. Still most of the poorest countries in the world have a net outwards cash flow—to service our loans. In these countries the standards of living for many are going down and some people advocate abandoning the demographically entrapped. I see the rich countries trying to isolate themselves from the poor. I see tightening immigration becoming a vote winner. I see new barbed wire erections along the borders of Spain's north African enclaves. I see the General Agreement on Tariffs and Trade sucking dry the poorer nations for the sake of middle class Western bank accounts, which must make a profit each year for us depositors. It all reminds me of segregation under apartheid.

Then, with entrenched (and often unrealised) money, patronisation, and power, I see rich Western institutions (and emulators) pushing excellence models on to the poor. These they sometimes swallow gladly until most of their health budget has gone into mediocre hospitals in urban areas. Primary health care is regarded as second class care, lamely pushed about like a pooper scooper: necessary but a bit nasty.

Why is "appropriate" such a little used word? It could take account of so many things such as income and infrastructure differentials. Look how South Africa has approached its healthcare differentials. Firstly, it desegregated—voluntarily, with some fear, but no less commitment and courage. Secondly, it acknowledged the differentials and has not (yet?) tried to snatch away the goodies. Thirdly, a new model is being promoted: appropriateness. Primary health care is being more adequately pushed; sometimes apparently at the expense of excellence based tertiary services.

> "I would like to see the poor handed the means to stand up to us"

What about progress? To tell the truth, I would like to see a general moratorium on advanced technological research and development. I would like to see basic, appropriate technology made universally available first. I would like to see a process of catching up to occur globally. I would like to see operations research, networking, and community development initiatives to be dramatically spurred. In other words, disseminated consolidation. I would like to see Western medicine reflecting on global health when developing national (home) initiatives, not wasting money and time on NICE CHIMPs. I would like to see the poor handed the means to stand up to us.

Like South Africa, it will take courage and commitment on behalf of the West to take steps in this direction. It will knock our pride, our control, our bank accounts, our economies. Of course it will. I guess it will never happen. I guess the Southern poor will never threaten the Western rich, as occurred in South Africa. At least, not if we keep them out and down.

We can accelerate two key global developments of the past two centuries: rising health indicators and growing freedoms. But this will not be best served by excellence, or progress, or by turning the indicators into gods.

I believe in appropriateness and empowerment. We need to stop the world and get off. Enjoy the view. Stretch a bit. Have a coffee. Then get back in and drive a little more carefully. Or even let someone from the back seat drive.

"Ditch" Townsend, *AIDS technical adviser, South East Asia*

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email **editor@bmj.com**

SOUNDINGS

… a joy forever

Andrew Lloyd Webber musicals, drugs reps personally demonstrating thixotropic nasal sprays; the world is full of unattractive things, and vomiting is reckoned among the worst of them.

Vomiting and the presence of a vomiting centre in the brain seems like yet more arguments against the existence of a benevolent God. There are other physical activities with better public relations which perhaps seem more deserving of a centre of their own, and in Thomas More's *Utopia*, all other methods of elimination were recognised as being among the pleasures of the flesh; he seems to have specifically excluded vomiting, perhaps to further annoy Henry VIII.

I can understand this attitude, however misguided it is, as I myself have vomited once or twice, and it wasn't pleasant. But to a physiologist, vomiting is actually an exquisitely elegant and fascinating manoeuvre, and there are irrefutably positive aspects to driving the porcelain bus.

Vomiting, like Gaul, is divided into three parts; first of all nausea, you feel you want to vomit; then comes retching, all the sound effects and tumult and all the unique sensations—but nothing comes out; sound and fury, signifying nothing. Finally, the real thing … the vomit. The stomach starts to dance, the valves open, and whoop, up it comes, a wild trumpet blast on the unfortunate palate, and you think, "I don't remember eating that."

But no pain without gain, and vomiting is in fact a protective mechanism to get rid of poisons in a determinedly unforgettable manner; you might forget your birthday or anniversary, even your last columbine kiss, but nobody forgets their last vomit, or the circumstances which caused it. Such a complex activity requires part of the brain all to itself; the vomiting centre is devoted to coordinating the messages coming in from the stomach and the blood, and to sending them back to the stomach telling it to throw up immediately and damn the embarrassment. It's coincidently a great way of getting rid of unwanted company.

So the next time you get on the great white telephone to God, transcend the misery and remember that your body is presenting you with a most precious gift; emerald and ruby, amethyst and amber, a liquid bird of paradise, a spectacular, technicolour yawn, only Cecil B DeMille could direct the movie. A thing of beauty is…

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