reviews

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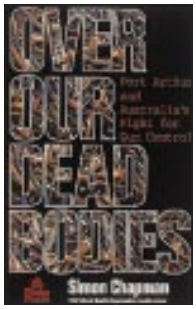
Over our dead bodies: Port Arthur and Australia's fight for gun control

Simon Chapman



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Rating: ★★★

On Sunday 28 April 1996, 23 year old Martin Bryant entered a tourist complex 100 km south of Hobart, Tasmania, and shot dead 35 people, wounding 18 others. The media described it as "the worst massacre by a single gunman in Australian history," although Chapman points out on page 1 that the wholesale slaughter of aborigines in the 19th century often involved far higher individual tallies.

Before this watershed tragedy, Australia's eight states and territories had different laws. In practice, they operated on or below the lowest denominator (ironically, that of Tasmania). For years, attempts to limit gun ownership had floundered in political backwaters, fobbed off by politicians cowed by vocal pro-gun lobbyists. After the massacre, obfuscation was cut through and a practical national gun agreement put in place. This included a ban on semiautomatic and pump action rifles, a compensatory buy back scheme, a register of all firearms, shooter licensing based on a "genuine reason for owning a firearm," safe storage requirements, and uniform national laws.

Myths surrounding gun control abound. "Guns don't kill people, people do" has had a successful run in the United States, but the Australian public simply did not buy this argument. I cheered when the epidemiological arsenal of sensitivity, specificity, and power was used to knock the stuffing out of arguments for a prohibited persons register; to prevent 570 assaults yet miss 30 each year in New Zealand alone would entail locking up 150 000 Kiwis.

Chapman sticks to his area of expertise and writes knowledgeably and well. He lays bare the bones of advocacy on both sides of the gun control debate and shows that understanding the opposition and getting the facts right are key to any public health change. If he ever wants a new career he could star as a general; until then I am glad he is wearing the white hat. Three years on, there have been no further Australian massacres (the previous average was one a year), and the core of the agreement remains intact. Japan, Britain, Canada, and Australia lead the world in gun control, while the United States lags a long way behind.

This book is really about the workings of the media, the use of lobbying, and the skills of advocacy. So pick a day when you are tired of dealing with the aftermath of ignored public health issues and read this ripping yarn, arm yourself with the tools it offers, and be ready to go into battle.

Mary E Black, *professor of public health, University of Queensland, Australia*

Pluto Press can be contacted at its website (203.4.212.185/pluto/).

Performing Arts: The Consulting Room

The Royal London Hospital,
9, 10, 11 July

For the past 10 weeks, patients at the Royal London Hospital have been persuaded to take part in an ambitious arts project presented by the IOU theatre. While perhaps not kicking off their shoes and dancing, both staff and patients have participated in singing workshops and interviews conducted by the members of the theatre in an attempt to explore notions of illness. The resulting presentation, named "The Consulting Room," incorporates these interviews into a 40 minute show and is the third in a series that will culminate at next year's Greenwich and Docklands international festival in a major show entitled "Cure."

When we enter the theatre, an area set up in the gardens at the centre of the hospital, a carbolic-soaped nurse—the model of professional efficiency—asks each of us for our name and directs us to a seat, telling us that "The doctor will see you shortly." Perched on white benches, we watch as names are called out one by one and our neighbours stand up and are led away. Some disappear completely, but others are led into strange machines that capitalise on the public's persistent belief that medicine is magic. The contraption resembling a mis-marriage of washing machine and motorised umbrella looks as terrifying to the medically trained eye as most of the medical equipment in daily use looks to patients.

Drip bags filled with horrifying liquids are handed out, and we are cheerfully asked to place the bags next to our ears as the speakers inside begin to broadcast the recorded interviews with patients talking about their illness and planning their recovery. Our names, meticulously noted down on our entry, are then called out, and we are given a surgical mask and led out of the theatre and across the courtyard into another set. Queen Alexandra, set in stone above us, stares disapprovingly as we are herded through plastic sheeted corridors. Climbing the stairs that lead up to the roof of a shed inside the second theatre, we stand back as the top lifts off to reveal a patient in bed. Nurses scuttle around and tidy pillows as the patient levitates off the bed and performs a deliberately rambling monologue about his life.

The whole theatre piece is clinically surreal: while feeling uncomfortable at stepping into other people's lives, your conscience vies with an equally natural sense of curiosity. As we leave The Consulting Room, we are given our "notes," a booklet of medical thoughts compiled by Lou Glandfield, a founder member of the IOU theatre. Inside is a quote by Voltaire: "The art of medicine consists in amusing the patient while Nature cures the disease."

Siân Knight, *editor, Student BMJ*

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

In the grip of spin

"Congratulations, Mr Blair, you have managed to alienate the whole profession," stormed Dr Ian Bogle, chairman of the BMA council, in Belfast on Monday 5 July. The lack of consultation over NHS structural changes, low morale, the private finance initiative, and the enduring crisis over junior doctors' pay and working conditions were enough reasons for delegates to reward Dr Bogle's attack on the government with a standing ovation at the BMA's annual representative meeting. But the subtext of his opening day speech was anger at New Labour's doctors of spin. "We don't want spin with a grin. We don't want smile with guile," fumed Dr Bogle, who even managed to look a picture of glumness in the following day's newspapers. Ironically, it was the first blast in the war of spin that reached its height in the middle of the week.

On 6 July, Dr Bogle's speech had seized the initiative. "BMA's dire warnings must not be ignored," warned the *Express*, "The worst thing the government can do is fail to listen to the doctors." The *Sun*'s health correspondent, Lisa Reynolds, was more blunt: "Doctors yesterday launched a scathing attack on Tony Blair's handling of the health service and rammed home this message: The PM is bad for your health."

On the contrary, that same day the government was launching a campaign for wellbeing—the delayed white paper on public health. The suspicion was that, as the government was expecting a lukewarm response, the white paper had been rescheduled to coincide with the BMA meeting, to be buried amid the abundance of health news that week. Even so, it would deflect some attention from the expected discontent in Belfast, especially over junior doctors' working conditions. While health minister Frank Dobson was launching the white paper, on the same day in Belfast, junior doctors' leader Dr Andrew Hobart was emotionally telling colleagues that they would even strike to improve their lot.

Meanwhile, the government published its response to former chief medical officer Sir Donald Acheson's report *Independent Inquiry into Inequalities in Health* as a supplement to its white paper, unannounced and largely unnoticed. Whether this was intentional or a blunder is unclear.

Would the next day's (7 July) press give the limelight to the plight of junior doctors? With the government keen to divert attention, Tony Blair decided to weigh in, obviously piqued at the BMA's criticism of NHS initiatives like NHS Direct, walk in clinics, and the private finance initiative: "People in the public sector are more rooted in the concept of 'If it has always been done this way, it must always be done this way' than any other group of people I have come across."

His office also released advance briefings of a speech he was due to give later on Wednesday. "'The BMA, like any trade union, is there to represent and promote the interests of its members. The government is here to govern for all the people,' Mr Blair will say on a visit to the site of a hospital in Greenwich," reported the *Daily Telegraph*. The next day, however, the paper noted that the prime minister had toned down his actual speech, perhaps in response to a robust defence of the public sector by the deputy prime minister, John Prescott. But Downing Street's spin doctors had done the trick: heart-wrenching stories about downtrodden junior doctors were given less prominence than Blair's frustration at the public sector.

Both, however, were outdone by the controversy over a kidney donated for "whites only" and accepted by the transplant authority. That story was on the front page of four national newspapers on Wednesday, while Tony Blair's outburst hit three front pages, and the junior doctors came in last with only one front page appearance.

The "whites-only" kidney was actually donated in July 1998, so how was it that the scandal broke a year later? Doctors and journalists at the BMA conference were suspicious that it was another diversionary ploy by the government, while some columnists suggested that the story was put about by the BMA to focus attention on its debate on presumed consent.

In the weeks leading up to the BMA meeting, Matthew Hill, health correspondent for the BBC's *Newsnight* programme, was alerted to the situation by members of the trade union UNISON working at the headquarters of the UK Transplant Support Services Agency in Bristol. *Newsnight* planned to run the story on Thursday 8 July, the day of the BMA's debate on presumed consent, and Matthew Hill contacted Frank Dobson on Tuesday 6 July to arrange a comment from him on the day of the programme. He didn't have to wait that long, however. By the Tuesday evening, the Department of Health had contacted the Press Association with a statement by Frank Dobson deploring the incident and ordering an immediate inquiry.

Was this merely damage limitation or was it pure opportunism, to wrench the health agenda away from the BMA and deflect criticism from the government? In view of their renowned proficiency in the art of spin, it is difficult to imagine that New Labour's media managers weren't pulling the strings. Colin Brown and Jeremy Laurence explained to their readers in Wednesday's *Independent* about Tony Blair's attack on the public sector: "Senior government insiders said last night that the offensive was part of a strategy by Downing Street to get a grip of the domestic agenda after setbacks in the European elections and damaging speculation of internal division. One senior source said Peter Mandelson's hand was behind the strategy. 'It is classic Mandelson stuff. You create conflict to get your own agenda in the papers,' he said."

Behind the headlines are the men who create the news, usually doctors of spin rather than medicine, although sometimes both. The goal is simply to win public support and influence the debate, but the route is often tortuous, murky, and secretive. The rest of us are caught in the web of spin, hunting for the truth—if we can be bothered.

Kamran Abbasi, *BMJ*

WEBSITE OF THE WEEK

Digital imaging Diagnostic radiologists are enthusiastic proponents of the digital era (see p 168) but most hospitals in Britain still immediately convert the digital information generated by those phosphor screens into film for storage. Chasing, sorting, presenting, and filing *x* ray films occupies so much medical time that you can't help yearning for a fast forward button to an era when images are presented in order, weightless, and in the blink of an eye.

Image files are big and need lots of bandwidth, but if you have a fast connection there are a host of resources on the web that let you see the possibilities of retaining and transmitting images in digital form. The BrighamRAD radiology teaching resource of Brigham and Women's Hospital Department of Radiology (brighamrad.harvard.edu) presents radiographic materials in a searchable database on the web. The material is well presented for learning: you can choose a diagnostic view with no help or a teaching view with arrows. The images have been optimised for transmission over a network, and there are clinical case scenarios that gently chide you if you suggest a non-cost effective investigation strategy.

Academic networks are encouraged to mirror the resource locally if they recommend it to students: one of the best ways of economising on bandwidth is to ensure that frequently used files travel only short distances. In theory, the end user shouldn't have to think about this, but you might as well have something to occupy your mind as your Progress Bar makes no progress. And while you're there, check out the business plans for providing radiology opinions all over the globe. (www.partners.org/pw-cgi/dbml.exe?template=/pweb-view/dept/news/article-details.dbml&item_id=6922&dept_id=4)

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PERSONAL VIEW

Making a mark

Six years ago I completed my post as general surgical registrar in England and left for a remote rural hospital in Uganda. I took up a job as a general surgeon. The job description entailed tackling any surgical problem of any specialty which I felt able to cope with. The huge need and the lack of resources are overwhelming. I was the only surgeon in a district of 450 000, and in all the neighbouring districts of similar populations there were no surgeons. In neighbouring Congo the position was even worse.

Most of the conditions which presented to my clinic were new to me. In Uganda there are few surgical specialists other than generalists outside the capital. I attempted to send some patients to Kampala—a boy with a bean in the trachea made it to the referral hospital but died while waiting for the doctors to assess him. Other patients returned untreated, having lost all their money on the bewildering journey to the capital. Most patients would not even contemplate travelling. Therefore, I was often faced with the hard decision of either operating or discharging the patient with no treatment. Clearly, when the patient was dying—for example with a ruptured uterus from prolonged labour—there was no choice. So from the book I rapidly learnt how to perform an emergency hysterectomy and many other procedures.

> I wish that the urologist could have seen those happy women … I would have gladly passed on the chicken

In an elective case, however, the decision was more difficult. Do I attempt to repair a cleft lip, or correct a clubfoot? Do I put in a shunt for a hydrocephalic child? Do I internally fix a fractured forearm? How do I best manage carcinoma of the cervix? There are few guidelines to help in these situations.

If I had worked in isolation for the past six years I wonder how many new procedures we would be doing well. Our work was transformed, however, by surgeons who gave up a week or two of their holiday to visit and train us. Those brief visits were tremendously instructive for us doctors who had been struggling with difficult problems. Many visiting surgeons provided textbooks or instruments to enable us to continue the operations they had taught. I have appreciated the value of this training.

In 1997 a paediatric orthopaedic surgeon and I performed eight corrective procedures for talipes of varying severity. I then went on to perform a further 50 talipes corrections and taught a Ugandan doctor the same procedure; he has since performed 21 corrections. A urologist donated cystoscopic instruments and taught us how to perform transurethral resection of the prostate. We were then able to treat old men who had been struggling with an indwelling catheter for years. When a plastic surgeon visited we decided to concentrate on clefts and gathered enough patients to keep us busy repairing clefts for a week. With this training we have since performed over 400 cleft repairs and taught five other doctors to repair them.

Other advantages have been the workshops and teaching sessions, where the instruction is less personal but more staff can benefit. The most active specialty for teaching in Uganda is anaesthetics. The anaesthetic officers often work in isolation and are kept informed with literature and regular training courses usually run with the help of visiting anaesthetists from Britain. Our anaesthetic officer always returns with renewed enthusiasm from these workshops, keen to use his new knowledge. Even after these specialists have returned home they continued to advise us from a distance. With the arrival of email our patients have benefited rapidly from these expert opinions.

The structured training and competition make it difficult for doctors to break from their chosen career and spend time working in developing countries. This is a great shame. At whatever stage in their training, doctors can make a large contribution in underresourced countries. Though most doctors do not feel able to live and work in a developing country, many are able to give up one or two weeks to help in training. Many specialists wonder what good they can do in such a short visit. In my experience the benefits are numerous. One afternoon, four smiling women sat in my house drinking tea while a fine cockerel they had presented nervously eyed us. They had all developed complex urinary fistulas following childbirth. For years they had lived with the incontinence and the offensive, humiliating smell. They had all had numerous operations with no success. They were finally cured by a new procedure which I had learnt from a visiting urologist. I wished that the urologist could have seen those happy women, and witnessed the dry odourless chairs. I would have gladly passed the chicken on to him.

Andrew Hodges, *surgeon, Kagando Hospital, Kasese, Uganda*

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

In England now

In his daily school run slot throughout May and June, a radio disc jockey dedicated tune after tune to the million or so unfortunate students taking examinations. This month, the line has changed. "And let's all spare a thought for poor Fred B, chief examiner for the Open University module X, who has 462 papers to get through by next Monday morning. And for Charlie Y, schoolteacher, marking 1500 scripts in GCSE Latin. Here's some Mozart to keep your spirits up, gentlemen."

A protected prime time slot on the Henry Kelly show has probably done more to raise public awareness of the dismally timed and uniquely tedious task of marking summer examination papers than either of two recent reports in the *Times Higher Education Supplement*. One of these (18 June) suggested that the annual fee paid to university external examiners (around £350) converts to an hourly rate that is substantially below the national minimum wage.

The other (2 July) reported the resignation of the external examiner at one university after his recommendation—that two students who had admitted to serious plagiarism in assessments be expelled—was dismissed by the internal board. The *THES* had a field day quoting senior university officials justifying the decision.

Why, asks an accompanying leader, do any of us volunteer for the task of checking other universities' assessment procedures and confirming or challenging their standards? It is particularly puzzling since this thankless activity counts virtually nothing towards the two performances that are now supposed to rule the lives of all self respecting academics—the Research Assessment Exercise and the Teaching Quality Assessment.

The fact that neither press nor public picked up on these stories confirms that examiners are ranked in the popular imagination alongside traffic wardens and customs officers. Long hours poring over scrawl and filling in structured marking sheets in which a maximum of two per cent may be awarded for having legible handwriting or presenting arguments in a logical order is precisely what we loathsome creatures deserve.

And so, as the sun casts long shadows across a perfect cricket pitch and the other mums and dads relax in the bar, here I sit in a quiet corner of the pavilion with my back to the window and a huge pile of scripts in front of me. My sole companion is a new red pen.

Trisha Greenhalgh, *general practitioner, London*