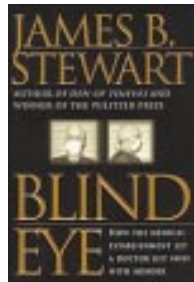


reviews

BOOKS • CD ROMS • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS • MINERVA

Blind Eye: How the Medical Establishment Let a Doctor get away with Murder

James B Stewart



Simon and Schuster, £17.91, pp 334
ISBN 0 671 04421 4

Rating: ★★★

There is ample precedent for physicians flouting the Hippocratic admonition, “First, do no harm,” and, directly or indirectly, accounting for multiple deaths. Dr Joseph Mengele’s handiwork has been much documented; more vicariously, Dr Joseph Guillotin’s invention did away with a fair number of folk, as did Dr Richard Gatling’s gun, which fired 350 shots a minute.

But Dr Michael Swango, the subject of this meticulously researched and highly readable book, was a fully fledged psychopath

who killed for the sheer thrill of it. And even though as many as 60 fatal poisonings could be attributed to him, his charm and glib persuasiveness allowed him to move on with impunity from one medical institution to another. As a medical student at Southern Illinois University, he became known as “Double-0 Swango—licensed to kill” after five patients under his care died mysteriously.

At each hospital, the huge cloud of suspicion that enveloped Swango was wafted away by physicians and administrators fearful of litigation and sullied reputations. Even today, he’s serving a jail term not for murder but for possession of narcotics and fraud—and could be at large again soon.

That a blind eye could have been turned to Swango’s persona and record is remarkable and somewhat chilling. He was fascinated by Nazism, the Holocaust, and serial and mass killers such as Jim Jones, the charismatic leader of the People’s Temple, whose thousand-odd followers he persuaded to commit mass suicide in 1978. Swango kept a scrapbook of pictures of gory car crashes and collected an arsenal of weapons and an assortment of poisons in his apartments.

The cover up was worst at Ohio State University, the prestigious medical school where Swango was admitted to an internship. Despite a number of suspicious deaths

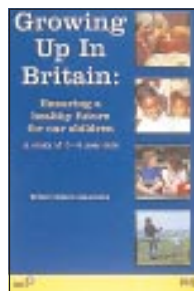
reported by nurses who had seen Swango enter the patients’ rooms with a syringe, the administration dismissed the concerns as gossip and overreaction. Fearful of the public relations damage and possible loss of funding, they closed ranks ... and later refused any cooperation with Pulitzer Prize winning author Stewart. In 1986 Swango’s license to practise medicine was suspended when he went to prison for attempting to poison his coworkers, yet when he was released in 1987 he was able to enter a residency in internal medicine in South Dakota. Even though his past caught up with him there, he went on to secure a psychiatric residency in New York state, before fleeing to Zimbabwe, where he was again suspected of poisoning patients—and again dismissed. Incredibly, he moved on to practise in Zambia, where he was suspected and fired once again.

Stewart’s is a cautionary tale calling for urgent and stringent legislation and improved reporting mechanisms so that checks on rogue physicians won’t continue to be thwarted by fear of litigation and bad press, and by a closing of ranks and a suspension of belief by fellow doctors.

David Woods *president, Healthcare Media International, Philadelphia, USA*

Growing up in Britain: Ensuring a Healthy Future for Our Children

BMA



BMJ Books, £19.95, pp 221
ISBN 0 7279 1433 2

Rating: ★★★

“The Chancellor has a much greater impact on health than the Secretary of State for Health, a thought that may well not cross the minds of either.” This quote from Quick and Wilkinson dates from 1991, when a Conservative government was in power—one that produced the document *The Health of the Nation* with its emphasis on individual health behaviours. The present government exhibits more

“joined up thinking” (its own jargon) and acknowledges the connection between poverty, inequality, and poor health. Its green paper *Our Healthier Nation* (1998) rightly placed much greater emphasis on social inequality. But will Labour deliver?

Growing up in Britain provides the ammunition to pressure the government to do so. This broad based and wide ranging book is a combination of the general and the specific matters covering many aspects of children’s health, not just health care. It is a source of information and references not easily available elsewhere. Statistical relationships, causal relationships, and examples of projects and interventions are explored together with the evidence for their effectiveness.

Why do children from poor families consume such a lot of sweets, chips, fizzy drinks, milk, and white bread? Penny for penny, a chocolate bar provides more calories than carrots, even from a market stall. If the child refuses what is offered there may be no money in the budget for an alternative.

Effective programmes to improve children’s diets are needed. If individual health education advice such as that offered by specially trained health visitors to increase

children’s iron intake makes no difference, then there may be a case for follow on formula to be routinely supplemented with iron or for a US style WIC (women, infants, children) welfare programme to be introduced here. We need to know both what is the most appropriate target—perhaps reducing salt or fat intake is more important medically in the long term—and what can be successfully implemented.

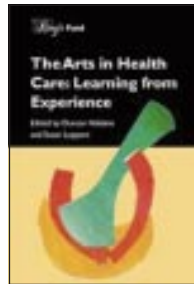
A separate chapter about the health problems of children from ethnic minorities would have been welcome. As well as suffering disproportionately from poverty, they may face particular problems of racism, language barriers, and certain diseases. Refugee children may have witnessed or been subjected to horrific violence. The newly fashionable “joined up” approach to support them might be just the ticket.

This is a wonderful source book, which is excellently referenced and should be read and referred to by all those concerned for the health and wellbeing of children in this country.

Sarah Thurlbeck *consultant paediatrician, St George’s Hospital, London*

The Arts in Healthcare: Learning from Experience

Eds Duncan Haldane, Susan Loppert



King's Fund Publishing,
£14.99, pp 164
ISBN 1 85717 246 9

Rating: ★★

Siting the arts in the public domain is often a contested practice. The specific and particular demands of the healthcare environment make this no exception. This publication of presentations delivered to the conference "Arts in Healthcare," held at the Roehampton Institute in September 1997, follows other attempts to collate and validate the expansive and constantly diverging practices that occur under the generic term "arts in health care." As Duncan Haldane acknowledges in his introduction, one of the recurring issues in any debate on the arts in health care is that of how such projects might be evaluated and expenditure on them justified.

This book documents projects in Britain, Australia, and the United States. It covers many aspects of arts interventions,

including those where the boundaries become blurred, involving the usually discreet areas of architecture and interior design. Some chapters contrast the benefits where the arts are involved in an integrated fashion at the developmental stages of a new building against others where they are used to enhance an already established setting. The book presents informed original research from 14 contributors, each of whom clearly advocates the application of the arts to the healthcare environment. Despite the strengths of these endorsements and the status of those providing them, this evidence in measured terms is usually classified as anecdotal and not afforded much scientific credibility. It is a pertinent debate, but one where we may have to look at the appropriateness of the measuring stick. The benefits of arts in health care may only be made truly tangible in analysis by taking a qualitative approach. The many interpretations of its value may be beyond the scope of quantitative methods.

In her chapter "Painting Versus Vending Machines," which describes her current research into the practical issues surrounding the location and survival of artwork in hospitals, Linda Moss recognises the difficulties of evaluation and stresses the need for the application of critical analysis as the debate surrounding the arts in healthcare matures.

After more than 25 years of distinctive practice, there is a need to move the debate

forward, to consolidate the whole gamut of arts practice within this context, and to provide identities and clarification to the many different genres and the roles they fulfil, as promoted by the 12 point plan endorsed by the Nuffield Trust conference of 1998, which recommended the creation of a taxonomy of the field. This book outlines descriptions of a cross section of individual projects, the range and variety of these providing a rich resource for any potential archiving and classification of the subject.

Michaela Crimmins' chapter describes some new initiatives exploring the relationship between artist and healthcare environment in which artists were involved in producing a response to a particular hospital environment. Some of the outcomes from these sensory audits provide insight into how the environment is viewed, enabling those institutions involved to decipher the hospital environment visually, raising awareness of people's perception of its atmosphere and purpose.

This chronicling of the emergent possibilities of the arts in health care is a particular achievement of this book. Its concluding afterword presents an optimistic vision of future developments. "Learning from experience" may mean learning to recognise the sustainable position the arts have achieved in the healthcare environment. A claim that this publication adds credence to.

Joan Beadle *senior lecturer, Department of Fine Arts, Manchester Metropolitan University*



Epilepsy: A Comprehensive Textbook on CD-ROM

Eds Jerome Engel Jr, Timothy A Pedley, Jean Aicardi, Marc A Dichter, Uwe Heinemann, Solomon L Mosh, Roger J Porter, David C Taylor

Lippincott Williams and Wilkins, \$379
ISBN 0 7817 1840 6

Rating: ★★★★★

Despite its antiquity, epilepsy remains an intricate clinical entity. This is reflected in the many disciplines involved in epilepsy care, ranging from allied health services to general practice, emergency intensive care, and multidisciplinary epilepsy units. Moreover, knowledge in epilepsy is changing rapidly thanks to research involving molecular genetics, diagnostic and therapeutic interventions, and patient centred outcome measures. The editors of this CD Rom have succeeded in capturing such breadth and depth of infor-

mation in this electronic, revised version of its three volume, text predecessor.

Of the roughly 160 epilepsy related books published in English and aimed at health professionals, this multiauthored treatise is the most comprehensive. It is also the first to appear in electronic format, making it highly portable. Its 289 chapters are parcelled out into 12 sections. Standard topics are addressed in depth, and unique chapters deal with topics such as "co-registration," healthcare delivery, resource allocation, and many others. It is gratifying to find that most chapters are adequately supported by relevant references. These can be accessed instantly with one click of the mouse button—a pop up window shows the citations, some of them complete with Medline abstracts.

The software is easily installed, requires only 2 Mb of disc space, and runs largely from the CD. Access time was satisfactory even with a 2x (slow) CD drive. The image viewer is equipped with a zoom facility that provides good access to the many figures. Other useful features include highlighters, bookmarks, notes, and a print facility. Navigating and searching is tricky initially and requires frequent visits to the help menu. First time users are strongly advised to review the tutorial.

How does the CD work in practice? The following examples should illustrate its performance. Say you need to know about the significance of epileptiform discharges

found in the electroencephalogram of a non-epileptic person. Typing "epileptiform" and "non-epileptic" in the queries box yields 26 hits. A quick glance at the entries shows a section on this topic, complete with an adequately referenced table summarising the results of the most relevant evidence. Search time: 20 seconds. Alternatively, you may need to review the role of ion channel disorders in epilepsy. Typing "channelopathies" in the search box yields five hits. One entry has seven relevant references, one with a Medline abstract that you decide to print out for closer analysis. Search time: 45 seconds, including a peek at the abstract.

Overall, this is an outstanding resource. My wish list for the next edition includes adding a good old fashioned index with hypertext links, more intuitive navigation, more Medline abstracts, enhanced graphics, and the ability to download references into a reference manager programme.

S Wiebe *assistant professor in clinical neurological sciences, University of Western Ontario, London, Canada*

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(4=excellent)



Sultans of spin

Panorama "Spin doctors," BBC1, Monday 13 March at 10 pm

"Saving the NHS" was one of the key planks of the Labour party's election campaign, so convincing the electorate that this is happening has emerged as one of the main priorities of the government. This television programme argued that separating the substance of the government's claims about the NHS from the spin applied by its propaganda machine has become almost impossible.

Statements about spending on the health service have been the slipperiest. In 1998 a spending increase of £21bn over the following three years was announced. Later it emerged that half this sum resulted from triple counting—a practice decried by the Treasury select committee. It said that, for the sake of transparency, the government should refer to annual increases over the previous year rather than to cumulative totals—advice since ignored by the prime minister no fewer than 30 times.

Apparently, it is now Downing Street policy to announce the same good news several times over, as if for the first time. The

£30m being spent on the modernisation project for accident and emergency services and the £20m being spent on the instant booking system were both announced four times. Deciding what's genuinely new money requires an economics PhD and a team of research assistants.

Some of the measures of success that are selected for publicity tell only part of the story, if anything at all. Waiting lists are a case in point. Which tells you more about the state of the NHS—that waiting lists for treatment have fallen over the lifetime of this parliament or that patients wait a year to see an orthopaedic surgeon after a general practitioner's referral and then another 18 months for surgery?

It's for its war against cancer that the government really wants our attention. Women anxious about breast cancer were originally guaranteed an appointment with a specialist within two weeks of referral—"ludicrous" if its aim was to have an impact on cancer survival, said the director of a breast service. Figures published on the *BMJ*'s website on the day of the programme showed that delays in initiating treatment dwarfed the time to specialist referral (www.bmj.com/cgi/content/full/320/7236/DC3).

Last May, the government pledged to save 60 000 cancer deaths by 2010 and organised a highly publicised cancer summit in Downing Street. According to Karol Sikora, a cancer expert at the World Health Organization, it was "clearly orchestrated hype." The prime minister had written about his mother in that morning's *Daily Mail*; the summit included a photo opportunity, and



Blair: the extra £21bn is "real" money

during the first presentation the prime minister left, leaving the assembled cancer experts to talk among themselves.

Four months later, the second cancer summit took place, and the 60 000 potential lives saved had jumped to 100 000. The two week referral limit for breast cancer was "already having an effect" and was extended to all cancers. A "cancer czar" was appointed. The serious issue of how much money was needed to address the chronic shortfall in cancer services has hardly been addressed.

Moved by the plight of a patient whose cancer became inoperable as her treatment was repeatedly cancelled, the prime minister announced on a television programme this January that UK spending on health would rise to the European average over the next five years. *Panorama* called it "the most important statement in the history of the NHS," with profound implications for public sector spending (www.bmj.com/cgi/content/full/320/7236/DC2). Since then, Downing Street has said the pledge was in fact "an aspiration"; the Treasury has downgraded it further to "a long term challenge."

Such wild prime ministerial utterances fuel the belief that there are no claims that the government won't make about its current and future stewardship of the NHS if it thinks the public will swallow them. Unfair, of course, but the government has only itself to blame given the yawning chasm that now separates rhetoric from reality.

Yet when voters return to the polling booth they are likely to reflect on the reality as they and their families are experiencing it—13 months on an urgent waiting list for coronary artery bypass grafts, eight months' waiting for a specialist appointment for incapacitating back pain, the inoperable tumours that might have been operable had the NHS been able to respond in time. The government might consider forsaking its smoke and mirrors and beating a path back to reality, while there's still time.

Tony Delamothe *BMJ*



WEBSITE OF THE WEEK

Error in medicine The consensus this week is that medicine lags behind other industries that are safety critical. The principal remedy will be to change from a culture of blame to a learning culture, in which the focus of inquiry shifts from the individual to the system in which errors were made. In other words, make the system work, and the individuals will take care of themselves.

Computer programmers make errors too, and the systems that programmers use to deal with them are interesting because the tools that they use today will be ours tomorrow. In the open source model of development (www.opensource.org) databases of software bugs are maintained on the internet: users can contribute to them freely, and as the software is modified and fixed, so the bugs fall off the end of the database (www.chiark.greenend.org.uk/debian/Bugs/).

Setting up a similar system for medical errors would be a radical notion but would cut down on the number of intermediaries involved in communicating sources of error that the present systems require. Of course, the great difference between software and humans is that once the software is "stable" it requires no further effort. Back in the real world, the best place to start looking for material specifically oriented to the medical domain on the web seems to be www.smi.stanford.edu/people/felciano/research/humanerror/.

Over on the east coast of the United States a team of managers and accident and emergency doctors has devised a scheme for looking at error in their own workplaces and minimising it (http://teams.drc.com/powerpoints/Jim/ACEP_1207_site/index.htm). They've made use of Powerpoint's natty feature for converting proprietary files to HTML, which makes turning a talk into a website very easy indeed. The downside of the approach is that the resultant files of text plus graphics are comparatively large—downloading the whole talk (94 Powerpoint slides) takes 2 Mb. Alternatively, for a case study from a British intensive care unit, download www.dcs.gla.ac.uk/~bussed/HECS/HECS.html.

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NETLINES

- The drug and therapeutics committee of the Greater Glasgow Health Board may not have produced the flashiest of websites at www.show.scot.nhs.uk/gghb/adtc, but it has some good content. From a plain but functional home page, you can access useful resources, including a formulary and newsletters. Overall, it is a laudable effort from a small organisation that has something useful to contribute to the internet community.

- If you are interested in health informatics on the web then look no further than www.imbi.uni-freiburg.de/medinf/mi_list.htm from the University Hospital of Freiburg, Germany. This neat offering comprises links to websites grouped by country. Navigation is text based, and, while there is nothing wrong with that, a map with hot links to databases might be easier to use. Thankfully, on the bottom of the home page there is a guide to all the acronyms that are used.

- The trauma information site at www.trauma-pages.com does not look at the physical aspects of trauma but at the emotional factors involved. A good review of the whole site can be achieved by scrolling down the home page. The site has a nice homely and welcoming feel about it. It is a useful contribution, and the author has thoughtfully made available an onsite translator just in case English is not your first language.

- For a slick general practice website go to www.warders.co.uk. This Kent based practice has made a fair effort to produce a user friendly and informative site. All the usual features that you would expect are there—such as patient information, newsletter, links, etc—but the gem is a superbly written history of the practice, which has been well adapted to the web. It is broken down to specific segments and is of interest to all students of medical history, not just the local population.

- A website that specialises in HIV infection and AIDS and carries the claim that it is the largest of its kind in the world, as well as being updated every hour, is worth a look. In fact, *Aegis* (www.aegis.com) is knee deep in information from an impressive array of resources. It is of interest to both specialist and generalist doctors as well as lay people. This convergence of interest means that this site is a central resource for all concerned. Some of the claims made about the site may be open to debate, but there is no doubt that it is a key site with oodles of material that is easy to find.

Harry Brown *general practitioner, Leeds*
DrHarry@dial.pipex.com

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

PERSONAL VIEW

Looking back ...

It was an emergency—not life threatening, but something needed to be done. All the monitoring equipment was attached, and, with words like, “Don’t worry, everything will be fine,” we began. But everything was not fine, and it got worse, and after half an hour my patient was dead. At my hands.

Immediately after the event I was a wreck. I vaguely remember talking to the family; I don’t know if I was much use to them. The best advice I was given was to write down as much as I could remember as soon as I could. Doing this made me realise how much was just a blur. I remembered impressions, images, emotions much more than a cool sequence of clinical events.

That night I got drunk. It was the only way I could sleep. A sensitive colleague came and sat with me. I didn’t realise until later that this was to ensure that I didn’t go and kill myself. By the next day I had reassured myself that it wasn’t “my fault.” It was a normal complication, and these things do happen. I even managed to go through a family conference, detailing what happened and why. With time, more details emerged from my memory.

Then the medical examiner rang. The necropsy did not absolve me from blame. Perhaps I might have been at fault. Perhaps my patient should be alive. Armed with the written report I visited the family. Patiently, I explained what went wrong and why. As understanding dawned so did anger. All I wanted to do was cry out, “It wasn’t my fault—I did the best I could.” Instead I listened to the anger directed at me. It was probably justified. It was also the hardest thing I have ever done.

After that, contact with the family ceased. But life continued. I was able to see patients again, but not concentrate. I began to “enjoy” alcohol. It would have been easy to go down that route. My family was wonderful—I don’t know how someone without a caring partner would have coped. Reactions from colleagues were mixed. One valued friend went through the whole event with me—carefully going over each step without passion. Slowly we made some sense of the

events. I received lots of telephone calls. Some support was clumsy: someone asked me how I was getting on in the middle of a crowded room at a conference. Others simply offered useful support—such as locum assistance if I needed to get away. Others just ignored me—as though I might taint them with my failure.

As the days stretched into weeks, people ceased to be interested. I realised that for

them it was now old news, despite the fact that I still dreamt about it. It was time to move on. My thoughts about the incident changed with time. Regardless of the actual events, I realised that it was my fault. I could not avoid the fact that I was responsible for the patient’s death. But did

responsibility mean that I was negligent? Interestingly, suicide never entered my mind. If it had, however, would it have been an inappropriate response? I’m not sure. Surely there is a price for the responsibility we handle.

It was two months before the dreams stopped. It was three months before I spent a day and did not think about the events. It was six months before my heart stopped leaping at letters marked “private and confidential.” I was over it. Life returned to normal. That is, of course, until my partner suggested that my behaviour was erratic and asked what the matter was. Within minutes I was in tears, hopelessly out of control. I realised then that “getting over it” was not the issue—living with it was.

So I adjusted, and gradually life did return to normal. On the first anniversary, I had several procedures booked. This was a mistake. Everything that could go wrong did go wrong, and I was a mess. But I and the patients survived. Interestingly, the day after, I coped with several extreme emergencies without anxiety.

It was as though a milestone had been passed.

So where am I now? As I write this, the memory still makes my hands shake. The emotions are always there. But I am okay. I can function and be an effective doctor and spouse. I no longer need the forgiveness I craved at first. I can live with my fallibility. I continue to try to do my best for the patients. But now I truly understand the consequences of failure.

I do not presume this to be a blueprint of what to do in these circumstances. But I know that this will happen again to someone else, and they should know that they are not alone.

The best advice I was given was to write down as much as I could remember

It was three months before I spent a day and did not think about the events

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

Plane speaking

I have always had a fascination with plane crashes. For years I have read every detail of newspaper reports, mentally filing each incident by cause, airline, and warning signs. But the Qantas 747 that careered off the runway and crashed at the airfield perimeter while landing at Bangkok on 23 September last year was of particular interest. This is because I was on it.

Afterwards, despite the darkness, every passenger claimed to have noticed something wrong as we landed—too fast, too far up the runway, not enough reverse thrust, or was it too much? The truth is, none of us had any idea of what was coming, not even the copilot who was making his welcoming announcement when it happened. Certainly there was no sign of a recent tropical storm in which, according to most media coverage, we were trying to land. There was a light drizzle, but it was no more a tropical storm than the showers that fall on Manchester every week.

Suddenly the plane braked sharply, then rolled on, bumping and grinding over ground that felt nothing like runway. Lights, luggage, and overhead lockers fell around us. In my section of the plane the ceiling collapsed, giving us an enviable view of the dark vault above the cabin. When we stopped I could hear the crew still yelling "Brace!" Outside, the nose and both wings had been dented and warped. An engine on the right looked almost detached. The left wing was resting on trees. The front wheel had snapped off. The jumbo was flat on its belly, a traditional posture of surrender.

For a moment we stared at the wrecked interior. Next to me was a young couple with whom I had exchanged no more than a few grins and grunts in the previous nine hours from Sydney. I asked them if they were okay, though it was clear that I was the one with the urge to bolt for the exits. Then in a quintessentially English moment they said, "By the way, we're Dominic and Fiona," and we shook hands.

The lights of the rescue team took quarter of an hour to appear—it later emerged that the control tower did not know where we were. The cabin crew kept us seated, assuring us that there was no fire. People began to take photographs. One woman got out her camcorder—the footage was used by Australian television. Finally, we were evacuated down the emergency chutes. It was a long wet slide, the kind of thing that would have you queuing for hours at Disneyland.

The irony of these events is that the health service, in trying to improve the way it

handles "untoward incidents," is aiming to learn from the airline industry. I am a member of the Department of Health committee that will report in the next few months. The airlines know better than anyone how to detect and investigate things that go wrong. As it turned out, there were also lessons in how they handled those of us on the receiving end.

Within a few hours Qantas arranged everything we needed—a plush hotel in Bangkok, a relief flight to London, meals, telephone calls, and new toothbrushes. The airline's staff in Thailand did their best to keep us up to date on what was planned, though they also acquired a way of walking backwards when quizzed by exhausted and truculent passengers.

They couldn't be blamed for the lack of information about what had caused the incident, though in the absence of facts media accounts ran riot. One Australian paper described how we almost went off a cliff. Several said we landed on a golf course. Nor could they be held responsible for the bureaucracy of others. The Thai immigration authorities, for instance, at first refused to allow out of the airport anyone whose passport had been left on the plane. And the airline was not the cause of the constant queuing, herding, and hanging about that filled our time.

But there was the curious issue of saying sorry. In two letters handed out the following day and a talk from a senior official, Qantas apologised for the disruption to our travel plans. Our travel plans? As most of us were more concerned about the near disruption to our life expectancy, this seemed to miss the point. Perhaps sorry sounded too close to a confession. We imagined teams of lawyers working into the night, purging from all statements any hint of liability. It was left to the cabin crew on the flight back to offer regrets over what had happened and to double the champagne rations to show that they meant it.

As we took off from Bangkok, there was an awkward moment. This time there was a storm and the rattle of the overhead lockers as we picked up speed along the runway had us fingering our seatbelts as if they were rosary beads. To one side we could see yesterday's plane, stranded along with our luggage. When we finally dragged ourselves into the air there were sighs of relief in every row. After all, we now knew what no clinician can afford to forget—that even the rarest mishaps do sometimes happen.

Louis Appleby *professor of psychiatry, Manchester*

SOUNDINGS

Crisis in the air

I was flying across the ocean in a big metal box, quietly dozing in business class by courtesy of accumulated frequent flyer points and one of those wine glasses that automatically refill themselves, when my Oslerian *aequanimitas* was rudely shattered by a voice over the loudspeaker calling for a doctor.

Making my way through countless cabins of fellow travellers sleeping in various distorted positions, I reached a small lounge at the back of the plane bustling with agitated people, some 20 of them packed into that tiny area. On the floor a very heavy set young woman, white as a sheet, pupils dilated, was undergoing cardiac massage. She looked dead, or dying.

With great difficulty, some pushing, and some shoving, I managed to feel her pulse. It was slow and bounding. The cardiac massage was stopped, but an excited woman, clearly in command and towering over her patient, kept giving orders loudly in heavily accented English. She had two assistants, who were holding up the woman's legs so high that I feared they might dislocate her hips. She kept calling for vodka and oxygen and meanwhile was slapping her face and fumbling to open her mouth. "Are you a doctor?" I asked. "I am a dentist," she shouted over the din of voices.

I believe, if I understood rightly, that she wanted to do acupuncture of the tongue. I turned to the young woman on the floor, leaned over her face, and asked how she felt. "I am terribly hot," she said, "could you please take my sweater off?"

I motioned to the stewardess to stop fussing with that oxygen mask, and then the young ladies let down the woman's legs. She got up; the crowd dispersed. Later I found out that she had felt ill and might have fainted after taking an anti-nausea nostrum that contained atropine; hence the slow pulse and dilated pupils. Predictably, at New York they held up the plane; paramedics arrived with flashing lights and ringing bells. But they found nothing to do other than fill in forms—in duplicate, no doubt.

There has been much in the newspapers lately about defibrillators on board, and how they saved lives. But that night it was perhaps just as well that none was available in our flying box, high up over the great deep, for use by the excitable dentist and her unquestioning assistants.

George Dunea *attending physician, Cook County Hospital, Chicago, USA*