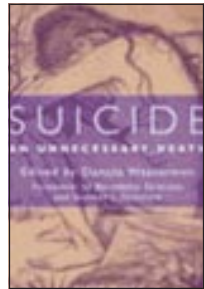


reviews

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Suicide: An Unnecessary Death

Ed Danuta Wasserman



Martin Dunitz, £29.95, pp 286
ISBN 1 85317 822 5

Rating: ★★★

Around the world, approximately one million people a year take their own lives, but of greatest concern is the recent rise in suicide rates among young people. The largest proportion of suicides now committed relates to those below the age of 45. This “ungreying” of suicide, traditionally associated with later life, acquires a dramatic aspect when one considers that the proportion of elderly

people in the total population is increasing at a greater rate than that of younger people.

As a result of the sensational rise in the global suicide rate since the 1950s, the World Health Organization predicts that by the year 2020 the rate will increase by approximately 50% and that 10 to 20 times more people than this will attempt to kill themselves.

The lowest suicide rates around the world are found in the eastern Mediterranean, comprising mostly countries that follow Islamic traditions. The highest international rates are found in Europe—particularly eastern Europe in a group of countries that share similar genetic, historical, and sociocultural characteristics, such as Estonia, Latvia, and Lithuania. Outside Europe, curiously high rates tend to be found in island countries such as Cuba, Sri Lanka, and Mauritius. Also, why does Canada, which consistently gets into the top three countries for quality of life in international league tables, still have twice the suicide rate of India?

Although unable to provide satisfactory answers to these and many other oddities, this is a comprehensive, if somewhat dry,

account of the state of suicide research today. It is perhaps the most authoritative account of its subject currently available, produced as it is by a collaboration between the network of WHO experts on suicide, and edited by a professor of suicidology whose clinical experience derives from Sweden—a country with traditionally a high rate of suicide.

Beyond the epidemiology, there is also much of use here to the clinician trying to detect genuine suicidal tendencies. For example, the book confronts the dangerous interaction between suicidal patients’ ambivalence—swinging from wanting to die to wanting to live—with the ambivalence of the doctor performing the assessment. After all, psychoanalysts argue that many employees in the healthcare services choose their occupation out of fear of death, dependence, and helplessness—suicidal patients’ self destructive behaviour runs counter to the instinct for self preservation and the desire to cure and to alleviate that are so strongly developed in healthcare staff.

Raj Persaud *consultant psychiatrist, Maudsley Hospital, London*

Women and Schizophrenia

Eds David J Castle, John McGrath, Jayashri Kulkarni

Cambridge University Press, £18.95, pp 164
ISBN 0 521 78617 7

Women and Mental Health

Dora Kohen

Routledge, £16.99, pp 250
ISBN 0 415 18885 7

Rating: ★★★

Research in medicine is often, in practice, research in medicine for men. Doing research on people who have regularly fluctuating hormone levels is regarded as too tricky unless, of course, those hormones are themselves seen as the cause of the problem. And those hormones are often regarded as the most likely culprits when sex differences are observed in the incidence and prevalence of disease, or response to treatment. These issues are writ large in both of these books.

Women and Schizophrenia is at its best when addressing the impact of schizophrenia

on women’s lives and the ways in which treatment regimes can help to alleviate problems which are often secondary to the illness itself. Other areas are covered less satisfactorily. For example, the chapter on brain sex differences devotes a large section to the neurodevelopmental effects of testosterone on male brains. The limitation of the authors’ explanation of sex differences in behavioural symptoms of schizophrenia to differences in neurodevelopment ignores work on cultural effects showing that judgments about acceptable or abnormal behaviour are often gender rather than sex based.

On the whole, this is a clearly written and well presented book, but, in an area fraught with methodological problems, the authors could have been more critical of the

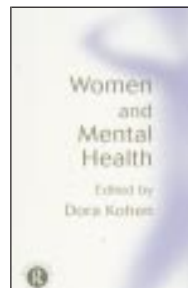
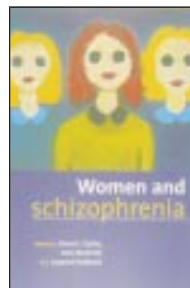
findings they report and cast their net more widely.

Turning to the chapter on schizophrenia in *Women and Mental Health*, we find much of the same material as above, but here it is dealt with in a more parsimonious and critical fashion. The other chapters on particular conditions—depression, perinatal disorders, eating disorders, and substance misuse—are similarly impressive.

What is most unsatisfactory is the separation of these chapters from those on physiological, sociological, and psychological factors in women’s mental health. This can lead to unnecessary repetition but more often leads to a lack of integration of material crucial to the understanding of the aetiology and epidemiology of psychiatric disorders.

These books show that mental health researchers and clinicians are developing more sophisticated explanations of the ways in which women’s physiology interacts with the ways women live and the roles we play to produce particular patterns of mental health and mental illness. Clearly, however, there is still a great deal of research to be done.

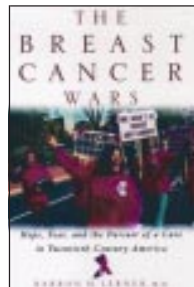
Helen Pattison *senior lecturer in psychology, University of Birmingham*



Items reviewed are rated on a 4 star scale
(4=excellent)

The Breast Cancer Wars: Hope, Fear, and the Pursuit of a Cure in Twentieth-Century America

Barron H Lerner



Oxford University Press,
£19.99, pp 383
ISBN 0 19 514261 6

Rating: ★★★★★

If you wonder why American women pin pink ribbons to their jackets and go in their thousands in “runs for the cure,” this book will give you the history.

In a readable style with realms of research, Barron Lerner, an associate professor, medical historian, and practising physician in New York, outlines the history of the diagnosis and treatment of breast cancer in the 20th century.

Lerner describes the first battles: over surgical treatment for breast cancer, then

over statistics versus clinical experience; over the biology of individual cancers; over randomised controlled trials; and over the patient’s role in deciding treatment.

Surgeons such as William Halsted of Johns Hopkins tried to remove every bit of tissue that might have been invaded by cancer. Did the surgery improve survival? Lerner explains the problem of comparing studies. At first, women presented with large tumours. The American Cancer Society urged women to see their doctors if they found a lump: earlier detection meant better survival, but the reward was a grossly disfiguring operation. Breast cancer survival statistics remained about the same.

Lerner describes the revolution when breast cancer treatment, along with society, changed in the 1960s. Barney Crile, a surgeon at the Cleveland Clinic, questioned whether drastic operations saved women’s lives; he listened to British, Canadian, and European investigators, and he spoke to the public in a book, articles, and on television, when previously doctors had kept their doubts in professional circles.

Lerner explains how Bernard Fisher of the University of Pittsburgh promoted randomised controlled trials, which revealed the importance of chemotherapy if a cancer became systemic early. Biology determined survival.

Women’s involvement became incendiary in the early 1970s, when well informed women journalists developed breast cancer, challenged their doctors, and wrote about it. Other prominent women—the president’s wife, Betty Ford, the vice-president’s wife, Happy Rockefeller—went public with their breast cancer.

Lerner reports that the only randomised controlled trial of mammography screening in the United States showed that screening saved lives. To see benefits for younger women, doctors had to rely on overseas trials. The better mammography became, the more suspicious findings it turned up. Genetic testing brought new questions.

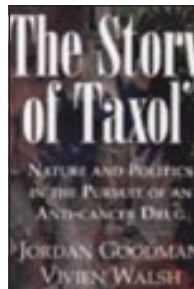
Lerner notes that when women demanded to be involved in decision making, state laws required doctors to describe all options for treatment. Women demanded greater funding and got support from American corporations, many of whom were involved in breast cancer treatment. A curious situation: the more breast cancer, the greater corporate profits.

In the last century, surgeons offered a quid pro quo, Lerner writes—come early and we will cure you. Today, he concludes, there is no quid pro quo.

Janice Hopkins Tanne *medical journalist, New York*

The Story of Taxol: Nature and Politics in the Pursuit of an Anti-Cancer Drug

Jordan Goodman, Vivien Walsh



Cambridge University Press,
£18.95, pp 282
ISBN 0 521 56123 X

Rating: ★★★

In the 1950s, the United States government set up a programme to look for cancer cures in the natural world. The US Department of Agriculture, in conjunction with the National Cancer Institute (NCI), sent researchers off into the wilds, and over the next 30 years 15 000 plants were collected and analysed from around the globe.

This all sounds like pretty swashbuckling stuff, yet the real drama of the programme lay not in the eventual discovery of Taxol—a powerful antineoplastic agent extractable from the bark of the Pacific yew—but in what happened next. If a drug is discovered by the government, who develops and markets it? If the drug can only be sourced from a rarity of the natural world, what happens when demand increases? This erudite page turner deals with every player, from the botanist who

first catalogued fruit, bark, and needle specimens from a 25ft tree seven miles north of Packwood, through to the executive who later transferred the drug and most of the tree’s rights over to Bristol-Myers Squibb. Admittedly, it does not dwell upon the major problems of solubility and tolerability that also slowed Taxol’s transition from lab to clinic, but so what? The authors are quite clear from the beginning that to them the most interesting Taxol issue is the strange inter-relationship that developed between potential wonder drug and humble woody host.

Nowadays, nobody would ever think of Taxol as a panacea. It is just another chemotherapy drug useful in treating breast, ovarian, and non-small cell lung cancer. At the peak of its fame, however, the Pacific yew was widely touted as the oncological equivalent of the goose that laid golden eggs. Indeed, as the bark stripping process inevitably killed the tree, for a while—just as with the legendary goose—the demand for Taxol seemed to threaten the Pacific yew’s very existence.

From original sources the authors shrewdly explore the resulting sensationalism in the press that pitted timber merchants fighting cancer against environmentalists saving forests. They claim that lower yielding but more renewable sources (such as yew needles or cultivars) could have been developed earlier but that these were overlooked by the NCI for short term financial reasons. Without the perceived dependence on bark for a source, Goodman and Walsh argue that much of the circus accompanying Taxol’s development need never



ED JENSEN, CORVALLIS

Tree of life: the Pacific yew

have happened. They’re probably right and yet, like all good circuses, it did produce some great moments of entertainment. Read this book if only to smile at the thought of the US Forest Service having to set up a sting operation to catch troublesome “bark poachers.”

There are always downsides, and the academic intrusions of Goodman and Walsh’s authorial voice to discuss the relevance of events within something called actor-network theory (or how it is possible to write the biography of an inanimate object representing different things to different groups at the same time) are uniformly annoying and unnecessary. Fortunately, there are not too many of these, making them a relatively small price to pay for an otherwise highly enjoyable and informative book.

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drcamidge@talk21.com

RC has been reimbursed by Bristol-Myers Squibb, the manufacturer of Taxol, for attending a conference.



Bringing up baby

Child of Our Time, BBC 1, Wednesdays at 9 pm, 27 June to 11 July
Life as an Infant, BBC Radio 4, Tuesdays at 9 pm, 19 June to 10 July

Robert Winston recently publicised *Child of Our Time*, his latest television series, on the radio, adding his preference for radio over television, because it gets “serious points” across more easily. He also explained his noble aim to deliver demystified “science” into our living rooms. Can television succeed here, or will radio always, quietly, reign supreme?

Child of Our Time boldly expands a familiar format—reviewing 25 babies over their next 20 years—but, instead of just surveying what has happened and how these individuals react, Winston attempts to explain why such reactions occur.

Alongside *Child of Our Time* the BBC has recently aired *Life as an Infant*, the second part of Connie St Louis’s large radio series, which, like its sister television project, analyses lifelong human development. The crucial difference between the two series is that, although they both set out to explain

human development, only the television series projects scientific theory onto real subjects.

Wittingly or not, therefore, the BBC has provided an opportunity to consider Professor Winston’s comparison of these two media and how the subject of child development can, and should, be tackled.

Compared with the radio programmes, the television series was over-reductive. In the first episode, which considered personality development, Winston explained that true character emerges after the first six months and that we are either “bold or shy.” Two of the sample children were thrown into some science (Ainsworth’s “strange situation” test), and we watched the results. This test elucidates four basic patterns of attachment—secure, avoidant, resistant, or disorganised. If pathological attachment styles persist this has implications for future development. Such science, I would have thought, is key to Winston’s project. However, he ignored it and reductively described the test as “a simple and well established way to measure happiness in children.” Dysfunctional avoidant attachment was elicited in the second child but was incorrectly explained as withdrawal “probably because she is unhappy, not because she is naturally shy.” Through oversimplification, Winston missed the point of the science, which is not designed to elicit character (that is, relative shyness or boldness) but attachment strategy. The lingering image of the unattached mother and her avoidant child was poorly explained and insufficiently explored.



Professor Winston: “reassuring moustachioed commentary”

How did radio tackle complex issues of child development? Each episode of *Life as an Infant* was half the length of those in *Child of Our Time*, but, despite this, I was struck by the amount of detail delivered. Whereas television was high-energy and bombarding, radio was relaxed and reflective. In the programme that considered how young children learn to communicate, I learnt a whole gaggle of new science. We heard about “Motherese” (the automatic communication mode of the “good enough” parent), the structures of pre-language, and why in some cases communication fails (with an expert explanation of autistic spectrum disorders). Another programme considered intelligence, again with stimulating detail, and even found time to present contrasting expert opinions—such as on the crucial question of whether an early infant can knowingly imitate its mother’s facial gestures.

When *Child of Our Time* considered intelligence, in the second episode, the series came alive. Whereas the first episode had squeezed infants through inaccurate slots of reassuring, moustachioed commentary, this, and the third programme on gender, focused science onto the actual children shown. What emerged with television, which *Life as an Infant* did not attempt to convey, was the power of human predicaments. Movingly, one child, the only survivor of triplets conceived by in vitro fertilisation, heroically progressed from a near fatal condition at 25 weeks to relative good health by her second year. Through the infants’ natural, feisty reactions to the science that they engaged with, I learned nuggets of new facts, like how children’s (especially boys’) sexuality is garnered as much from their parents’ behaviour as from their genes.

I was left informed and entertained but confused. What about the avoidant child in the first episode? Will television leave such dysfunction untreated to serve future viewers’ appetite for disaster. Radio’s anonymity inevitably protects child subjects. Is such a television series fundamentally unethical? Time will tell.

Iain McClure consultant child and adolescent psychiatrist, Vale of Leven Hospital, Alexandria, Dunbartonshire



WEBSITE OF THE WEEK

Systematic reviews and the Cochrane Collaboration The *BMJ* likes systematic reviews and meta-analyses. Even though we are well aware of problems associated with this kind of research (see Sterne et al’s article on page 101), we are convinced that this kind of research is necessary to provide the best evidence for health care. In this week’s issue we publish a systematic review (p 81) that has already been published in the *Cochrane Library* recently. This is because, together with other journals, we recognise that publication is a continuum, and being published in the *Cochrane Library* ensures regular updates to include the latest evidence. Additionally, systematic reviews published in the *Cochrane Library* are usually of higher quality than those published in other journals only. Abstracts of Cochrane reviews can be found at www.update-software.com/cochrane/cochrane-frame.html, but, unfortunately, you have to pay a subscription in order to access full text articles.

The mission of the Cochrane Collaboration is “preparing, maintaining and promoting the accessibility of systematic reviews of the effects of healthcare interventions.” More detailed information can be found on www.cochrane.org, a truly rich website that does a lot more than provide information on aims, collaborators, and how to do a systematic review properly (www.cochrane.org/cochrane/resource.htm). It is also an apparently successful attempt to let the collaboration flourish and grow. In addition, the collaboration has taken an early but serious step towards doctor-patient partnership by providing a consumer website (www.cochraneconsumer.com). This site is easy to navigate, and the contents are excellent and well presented. In fact, www.cochrane.org and many other health related websites might benefit from adopting the friendly web design.

For those who would like to try a quantitative synthesis of trial data, epiweb.massey.ac.nz/meta_analysis_software.htm provides a convenient list of links to free software for performing meta-analysis. If you want to spend money on more powerful software you might visit www.meta-analysis.com or www.update-software.com/metaxis/metaxis-frame.html.

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PERSONAL VIEW

Conversations, observations, and exclamation

About three and a half years ago, I started to feel unwell. The following day—a Sunday—I took myself off to see the emergency GP. She suggested, rather forcibly, that I should go straight to hospital. From this point I have developed an interesting relationship with some of the doctors I have seen. The majority of the two dozen or so doctors have been professional, supportive, and amicable. My GPs have, without fail, been exemplary.

There have, however, been conversations with other doctors that provide alarming insights into the self perception of some members of the medical profession. As an ethnographer (a sort of psychologist) I relate some of the conversations.

The duty consultant (after a very brief examination) on being first referred as an emergency: “Young man, I can find no evidence whatsoever of what you are saying is so. I don’t know why you were sent here. Go home.”

Two days later my GP came to see me—I was now bedridden: “I think you need to see a consultant neurologist straightaway. I have arranged for you to go to his clinic this afternoon.”

Two hours later, the consultant neurologist at the local hospital: “I think we need to have you in the neurology centre now.”

Then, at the neurology centre: “I know they are not very pleasant, but a lumbar puncture would be useful.”

“You are not claustrophobic are you? MRI scans can be a bit enclosing. We will put you on . . . for the pain.”

“Doctor, can you give me some idea of what is wrong, how long am I going to be off sick?”

“Difficult to say, could be a while. Let’s sign you off for a couple of months and see how we go.” Still in pain.

“I know they can be a bit uncomfortable, but, a second lumbar puncture would be really helpful.”

“I had a fax from the emergency doctor. Sorry to hear you were in such a state after the last lumbar puncture. Don’t worry, I won’t ask you to have another.”

About nine months pass, lots more consultations, still in pain.

“Doctor, I feel I have aged 40 years, and I am still in awful pain, please tell me what you think the problem is.”

“As you have probably guessed, you have multiple sclerosis. I will refer you to the pain specialist.”

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

An aside from the head of the human resource group at the university where I taught: “Oh, MS, that’s yuppie flu isn’t it?”

At the first pain clinic: “Not having much luck with this pain issue. I will give you some pethidine. Come back and see me in six months’ time.”

Another doctor, another conversation: “Have you tried cannabis?”

Upon referral to another pain clinic in a centre of excellence: “Ignore those people (referring to four anonymous men sitting behind me), they are researchers, just look at me.”

Speaker at a conference for patients and families with MS: “As a doctor, those patients who I respect are the ones who will put some effort into their lives. Some just give in to it.”

Same doctor: “Pain is an indicator of neurological degradation.”

Another visit to another clinic, still in pain: “I see you are a psychologist. What did you do to get that?”

“A PhD”

“Good, good, well let’s see what we can do for you, Mr Levy.”

Second and (final) visit to the above doctor: “Oh yes, you’re a sort of doctor aren’t you, Mr Levy?”

Another conversation with another doctor: “You are coping very well, Gerald. I don’t know how I would handle it if I were in your situation. Thought about cannabis?”

Two years on, now referred to the local hospice. Doctor with stud in eyebrow: “We can get the pain under some sort of control, at least so you can have some quality of life and get some sleep. Don’t worry, we will just keep at it until we find an answer.” “I think I did mention that this may give you some hallucinations.”

And do we all live happily ever after?

To date the efforts and persistence of my studded doctor continue, with some improvements.

As a patient I demand an instant cure to all my ills. As a grown up I realise this is not to be. As a grown up patient, however, I am disappointed that some of my fellow humans who practise medicine fail to be aware of (or care about) the need to treat patients with the dignity normal in adult relationships. This is even more true when doctors can offer not clinical, positivist treatment, but rather advice on management of symptoms. The doctor and patient relationship becomes the medication; trust and respect become all. It seems that the irascible, pompous demagogue as portrayed by James Robinson Justice lives on, but his continued existence is paid for by patients and colleagues.

Gerald Levy former university lecturer, Chester (email: gerald.levy@virgin.net)

SOUNDINGS

Learning in boxes

Along with some colleagues from the more creative fringes of our discipline, I will shortly be running a conference on narrative in health care. My vision is that doctors, nurses, anthropologists, psychotherapists, literary critics, historians, linguists, and service users will spend two days sharing experiences of illness and healing through the simple, time honoured, and universal technique of storytelling.

I expect that the stories they tell and hear in formal, timetabled presentations may prove less valuable than the ones they will share in the more permissive environment of the lunch queue or the bar. The organisers’ declared aim of promoting discussion on research rigour and some small print qualitative techniques will no doubt appeal to an academically inclined minority. But from the applications I have seen so far, most people are coming because they have a story to tell—and a hunger for the stories of others.

For the benefit of my fellow general practitioners, I am seeking the Postgraduate Educational Allowance (PGEA) kitemark from the Royal College of General Practitioners—and I am mightily frustrated. The first question on my application form for PGEA is how I have assessed the needs of the intended learners. The second is whether this learning experience should be categorised as “disease management,” “service management,” or “health promotion.” And the last one—which I’m particularly stuck on—is what explicit and measurable learning objectives I have in mind for the punters.

I’ve picked up a thing or two about learning objectives in recent years. Indeed, somewhat ironically, I will be presenting a paper at the conference on how to set appropriate objectives for university courses in narrative techniques. But this conference isn’t a degree module—it is a rare opportunity for busy professionals to take time out, talk, listen, and emerge refreshed.

A few months ago I found myself exchanging stories of clinical practice with a small group of fellow GPs whose individual experience ranged from six months to some 40 years. As we parted, one of the more experienced GPs commented to me: “Stories are wonderful, aren’t they? You never know what you’re going to learn from them but you always learn something.”

I hope he’ll forgive me for spilling the beans, but my wise informant was the college president.

Trisha Greenhalgh general practitioner, London