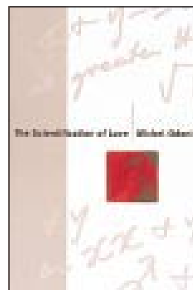
# reviews

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

## The Scientification of Love

Michel Odent





Free Association Books, £12.95, pp 130
ISBN 1 85343 476 0


Rating: ★★★

Michel Odent, who is perhaps best known for introducing birthing pools to obstetric wards, has written a slim but provocative book on the subject of love. Why write a scientific book about a subject best left to poets and songwriters? The answer, according to Odent, is because it's about time: "At a time when people are focusing on violence and the roots of violence, I am convinced that we can go a step further in our understanding … by turning the question on its head and looking instead at how the capacity to love develops."

With flair and considerable originality, Odent then proceeds to meditate on the scientific aspects of love. Each chapter, just five or six pages long, illuminates a different aspect of what scientists have come to understand about human love. Because of the brevity of the material, parts of the book can seem superficial, speculative, or even whimsical—but it is never boring. Consider the startling challenge posed in one of the later chapters, wherein Odent invites readers to recast the history of civilisation from the perspective of a newborn infant. From a baby's viewpoint, a turning point in the history of humankind occurred about 3000 years ago when the modern nuclear family structure evolved, and with it cultural practices such as the substitution of mother's milk with wet nurses', animals', and eventually powdered milk. Meanwhile, civilisation perfected its skills to dominate nature and master the potential for aggression. As Odent sees it, the instinctive drive for aggression and domination has resulted in the withering of our capacity to love, and with it the neglect of love as subject for scientific inquiry.

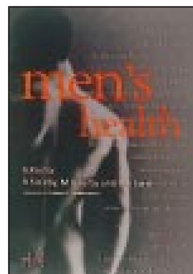
As a pioneer used to thinking outside the box, Odent demonstrates familiarity with a formidable range of subjects, from ethnography to endocrinology. His meditations draw on a diverse literature, which includes esoteric references to the *Journal of Near Death Studies*, Tantric Buddhism, and even the *BMJ*. Drawing on our emerging understanding of the role of the hormone oxytocin, Odent weaves a coherent and plausible story about the interconnected and health promoting processes of childbirth, breast feeding, and sexual attraction. One of the central themes of his book is that our capacity to love is primed during intrauterine development and the moments immediately after birth.

There is food for thought here for scientists engaged in life course research. Whether or not you subscribe to the idea that intrauterine and early life environments are important for later health, the premise that love is critical for human survival is a lesson that none can ignore.


**Ichiro Kawachi** *associate professor, Harvard School of Public Health, Boston, USA*


## Men's Health

Eds Roger Kirby, Michael G Kirby, Riad N Farah





Isis Medical Media, £39.95, pp 300
ISBN 1 899066 92 6


Rating: ★★★★

This morning I was told that one of my urological colleagues died on New Year's eve. He was 46, fit, and at the peak of his career. Such a story is all too familiar to Roger and Mike Kirby, two of the editors of *Men's Health*: their father died aged 49, just a few months after becoming a professor in cell biology. Left behind are young children who will not get to know their father and wives or partners who will have to cope with the loss for their remaining lives.

On average, men die five years younger than women do. The causes are age dependent: trauma in early life, cardiovascular disease and cancers later on, and suicide from the teens right through to old age. Dave Hill's parody of the "gender gap" summarises many of the issues: "As girls do better and better at school, boys trail behind; as women secure more and better jobs, men become more intimate with the schedules of daytime TV; while men kill themselves with increasing frequency, women lead lives that are not only longer, but also sweeter."

The importance of Hill's description lies not only with his assertion that the future is female but with his explicit prediction that this will be increasingly so if current trends continue. Books such as *Men's Health* signpost the start of a reversal of such trends. In what other kind of book would you find contributions from urologists, family doctors, colorectal surgeons, psychiatrists, cardiologists, epidemiologists, and genitourinary physicians as well as experts in health promotion and risk taking behaviour? Each of these disciplines is concerned with a disease process or trait that is more prevalent in men than in women.

Bridging these fairly fixed interdisciplinary boundaries with a coherent theme is not easy, which is probably why so few have attempted to do it before. This book provides the male oriented specialist—whether a cardiologist, urologist, or traumatologist—with two valuable areas of expertise that are otherwise difficult to acquire. The first is an update on other male oriented specialties. When I'm talking to a man about measuring his prostate specific antigen I sometimes hear the question, "Why don't you check my cholesterol at the same time?" The chapter on lipids means that I can now answer with a degree of authority—something I couldn't do before.

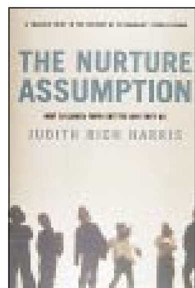
The second and possibly more important reason why this book should be of use to those who advise men about their health is the information on maleness. The chapters on men's as opposed to women's attitudes to health in particular and risk in general are essential reading for those with an interest in male prevalent disease. I would encourage the editors to expand on this aspect of the book in subsequent editions and perhaps include sections on drug concordance, self management, and self efficacy as applied to men.

The book is touchingly dedicated to Roger and Mike Kirby's father. If further poignancy were required, two of the male contributors to the book (Brendan Devlin and Ian James) died prematurely in the short time between submitting their final copy and the book going to press. Next to their names, in brackets, is the word "deceased."


**Mark Emberton** *senior lecturer in oncological urology, Institute of Urology and Nephrology, University College London*

## The Nurture Assumption: Why Children Turn Out the Way They Do

Judith Rich Harris



Bloomsbury Publishing, £9.99, pp 473
ISBN: 0 7475 4894 3

Rating: ★★

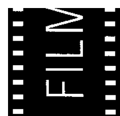
In an age when it is virtually impossible to browse in a bookshop or pass through a supermarket checkout without being bombarded by various types of literature on how to parent your children, it is indeed timely and to some extent refreshing to read a book dedicated to propounding the theory that what parents do doesn't matter. What matters, according to Judith Rich Harris, other than any genetic influence, is a child's peer group. She postulates that the role of parental upbringing has no influence on a child's personality or, in her words, "how the children ultimately turn out."

Much of the book is dedicated to challenging the traditional notions and theories relating to the parental influence on a child's development from various theoretical standpoints such as psychology, anthropology, behaviour genetics, and sociology. Notions such as that the early attachment patterns of a child, propounded in Bowlby's classical theories, will form a pattern of interaction that will be a template for later relationships, and the Freudian psychoanalytical theories regarding childhood development come in for particular scrutiny and criticism.

While it seems that many of Judith Rich Harris's early notions for wishing to challenge the "nurture assumption" have come from her thoughts about situations and anecdotes from her own childhood and experiences as a mother, there is disappointingly little rigorous scientific justification for her assertions regarding the fundamental importance of peer relations in being the crucial factor in a child's later personality characteristics.

This book is entertaining and thought provoking, although its style is somewhat irritating at times. It is unfortunate, however, that one set of views that has been so important in our society's current thinking about child development—that parents have a crucial role in formulating their children's personality—should apparently have been replaced so readily by another set of assumptions. Perhaps it would have been more judicious not to totally throw out the parents with the bath water.

**Marian Perkins** *consultant child and adolescent neuropsychiatrist, Park Hospital for Children, Oxford*




## American Psycho

Directed by Mary Harron, Lions Gate Films, on general release worldwide

Rating: ★★★

Adapted from the novel by Bret Easton Ellis, *American Psycho* stars Christian Bale as the notorious Wall Street financier Patrick Bateman. It follows his apparent decline from a cynical misanthrope, idly spinning out his time between appointments to dine, pose, and philander, to a bloodied psychopath, unable to control a compulsion to dismember his victims while they are still breathing. The film has the gloss of pornography and the glamour of fashion photography. Perhaps this is appropriate, as psychopathy and pornography have much in common. They treat the "Other" as an object, a means to an end. Psychopathy is to empathy as pornography is to love.

Given that Bateman lives in the best parts of Manhattan, it seems hard to believe that his loud activities go unnoticed. The film suggests that his money and privilege elevate him beyond scrutiny or suspicion. Indeed, the world in which he lives is so cynical and devoid of authentic communication that even when he confesses to his murderous acts, his confessions are not heard. His interlocutors are as mask-like as he is, all preoccupied by their urge for acceptance at exclusive restaurants, the design features of their business cards, their ties, their suits, their trophy girlfriends. Indeed, they recurrently mis-identify each other on the basis of their clothing, such is the superficiality of their relatedness.

Why is this film nauseating? Probably not for the violence it contains, which is mostly

Bateman's "mask of insanity"

indirect and implied. Indeed, it is possible that the story might prove nauseating even without knives, hatchets, chainsaws, or blood. I think it is the unremitting cynicism of its characters that leaves the work without any hope of resolution or reparation. Bateman cannot "fail," though he might want to, because no one will listen to him. He cannot be punished, though he might provoke nemesis, because no one is prepared to accept the truth in his words. The camera work plays with perspective as it jumps between objective and subjective views of the world, as Bateman realises, toward the denouement, that his world is as sick as he is.

But Bateman differs from other film psychopaths. He lacks any moral framework, so does not see his own fall from grace. And he does not enjoy his villainy in the manner of Anthony Hopkins's Hannibal Lecter in *Silence of the Lambs*, or Malcolm McDowell's Alex in *A Clockwork Orange*. Bateman does for the music of Huey Lewis what Alex did for Beethoven, in appropriating it for carnage. The lightest moment in *American Psycho* is Bateman's monologue attributing meaning, significance, and musicological development to the work of Phil Collins. Surely a case for treatment.

**Sean A Spence** *senior lecturer in psychiatry, University of Sheffield*

## Hit parade

These articles scored the most hits on the *BMJ*'s website in the last week in March

*MARCH*

1. **ABC of arterial and venous disease: Chronic lower limb ischaemia**
   2000;320:854-7
   38 275 hits
2. **For and against: The male menopause—does it exist?**
   2000;320:858-61
   31 604 hits
3. **Recent advances: Dermatology**
   2000;320:850-3
   24 996 hits
4. **New clinical guidelines for stroke published**
   News 2000;320:823
   11 919 hits
5. **Plant sterol and stanol margarines and health**
   Education and debate 2000;320:861-4
   10 944 hits
6. **Healthy people 2010: objectives for the United States**
   Editorial 2000;320:818-9
   8834 hits
7. **Relation between infants' birth weight and mothers' mortality: prospective observational study**
   Paper 2000;320:839-40
   7576 hits
8. **Total knee replacement: the joint of the decade**
   Editorial 2000;320:820
   5361 hits
9. **Cohort study of birth weight, mortality, and disability**
   Paper 2000;320:840-1
   4515 hits
10. **Saliva test could diagnose cancers**
    News 2000;320:825
    4326 hits

# A cry of pain and anger

It was the *Times* that broke the story. Under the headline "Struck off doctor elected to GMC" (1 May), it carried the first account of what, by any standards, was a major electoral upset. Just as Tony Blair was about to receive a bloody nose from London voters, and William Hague from those in the Romsey byelection, Britain's doctors were making their opinion felt of efforts by their leaders to reform the General Medical Council.

At first glance, the result seemed simply perverse. In a byelection for the GMC last month 50 candidates stood for one place on the disciplinary body, whose slogan is "Protecting patients, guiding doctors." Over 45 000 doctors voted, 23% of the total on the medical register. The result suggested that many who completed their ballot papers would prefer to see the GMC's slogan reversed to read "Protecting doctors, guiding patients."

Two of the three doctors who topped the poll had themselves been found guilty of serious professional misconduct by the GMC in the past. Jennifer Colman, who won with 5719 votes, was struck off the medical register in 1987 for neglect of a patient and racial abuse of a colleague. She was restored to the register two years later when the GMC accepted that her behaviour was linked with ill health caused by two head injuries for which she had been treated. She has since given up medicine and now works as a medically qualified barrister.

Not far behind in third place was John Studd, with 4653 votes, who was admonished by the GMC in 1997 for removing a woman's ovaries without her consent during a hysterectomy operation.

Both comprehensively beat Professor Michael Baum, the internationally respected breast surgeon, whom most outsiders would have selected as a certainty to win. He was hoping to take over the mantle from his brother, the equally distinguished Professor David Baum, president of the Royal College of Paediatrics, whose untimely death from a heart attack during a charity cycle ride caused the byelection. But it was not to be. He polled 3872 votes to take fourth place. And there were another 46 candidates behind him.

So what are we to make of this? Why do doctors select from among a field of 50 candidates the two with, how shall I put it, chequered pasts over the one with the international reputation? None of the newspaper reports—the *Times*' scoop was followed by the *Guardian*, *Telegraph*, *Mirror*, *Express*, and *Independent*—offered an explanation. But, as I wrote later in the *Independent*, a clue may be found in Dr Colman's election statement. "I am concerned," she wrote, "that doctors should, regardless of alleged misconduct, be dealt with fairly and with courtesy ... Patients must not needlessly be deprived of doctors trained at great expense."

When I telephoned Dr Colman, she expanded on her views. "[The GMC] is a quasi-judicial body that has its own way of interpreting its own rules behind the scenes. This has upset a lot of people. It is no good getting hysterical about it, but we have got to address what is wrong and put it right," she said.

John Studd is of a similar opinion. In a call to me after my piece appeared in the *Independent*, he confirmed that he had stood on an "anti-GMC platform." He told reporters in March that he regarded the GMC as a "useless organisation" that had done a "great deal of harm" to the image of medicine by attacking "high profile internationally respected doctors." He was incensed by the Bristol heart surgery case, which had destroyed "three good, hardworking doctors" who had been made scapegoats for a "rotten, underfunded health service." Second place in the election was taken by a consultant in intensive care from Bristol Royal Infirmary, Sheila Willetts, who gave evidence on behalf of the GMC in the Bristol heart surgery inquiry and whose popularity appeared to buck the trend.

This, then, is the kickback—a cry of pain and anger from beleaguered doctors who feel betrayed. The outcome of the byelection is the clearest possible signal from a section of the profession that it is sick of being criticised and shoved around and has little appetite for Tony Blair's programme of modernisation and still less for that of the president of the GMC, Sir Donald Irvine.

I wrote in the *Independent*: "These are the 'dark forces of conservatism' to which the prime minister referred—a minority, maybe, but one significant enough to swing a vote at the GMC." That remains, for me, the chief message of the vote. Medicine is a broad church, and medical organisations have difficulty representing all shades of opinion within their ranks—witness the fierce battles fought over general practitioner fundholding in the BMA in the early 1990s. But the stakes this time are at an all time high—the next four years could break the NHS. If the profession's leaders cannot carry the grassroots with them the battle is as good as lost.

An interesting question is whether voters knew of Dr Colman's and Mr Studd's past GMC convictions. GMC rules do not require them to be declared on the principle that once the sentence, if any, has been served, the offence is deemed expunged. Stories about their candidacy, and their past misdemeanours, did appear in the London *Evening Standard* and the *Independent* in March, so some doctors must have known. But now that the votes are counted it seems possible those stories increased their popularity, rather than reduced it.

The GMC is now reviewing its electoral procedure. But in the light of this vote, much more will require review. Ministers have been at pains to secure backing for their NHS modernisation programme—which includes revalidation of doctors and tougher monitoring of performance by the GMC—from the BMA, the royal medical colleges, and the GMC itself. Whether those organisations can swing their members behind the project now looks less certain than it did.

**Jeremy Laurance** *health editor of the Independent*

WEBSITE OF THE WEEK

**Head injury** A review in this week's *BMJ* (p 1308) concludes that the evidence for any of the treatments for head injury is thin, because the trials designed to assess potential treatments have been small or otherwise methodologically weak. The review's authors are also trialists, proud owners of the CRASH acronym (corticosteroid randomisation after significant head injury) and its attendant website (www.crash.ucl.ac.uk/).

It's a good example of how a quite simple website can be a powerful tool. The number of recruits to the trial to date takes pride of place on the index page, as well as links to the systematic review that led to the study and contact details so that clinicians who would like to enter their patients in the trial can telephone, email, or write to the trial organisers. More would be possible: you can't actually enrol patients in the study using the site, nor can you download the files for approval by local ethics committees.

Looking for more general information about a common condition means that even the best search engines let loose a torrent of mediocre information, but there are jewels to be found. The American Brain Trauma Foundation has assembled a set of guidelines with associated scientific evidence at www.braintrauma.org/guideems.nsf. You'll need to know some advanced browser tricks to free yourself from the frames if you want to provide a reference to any of it. (Hint: find the "Open this frame in new window" command by clicking your right mouse button, then copy and paste the URL into your own document). Apart from the abominable frames, the design is fairly nicely done, although its clinical recommendations are likely to be controversial because the evidence is weak.

**Douglas Carnall**
*BMJ*
dcarnall@bmj.com

PERSONAL VIEW

# The two tier syndrome behind waiting lists

The Labour government is making a serious effort to shorten the waiting times for specialist assessment and treatment. But if real progress is to be made it must tackle the two tier syndrome.

Past governments have formally sponsored private practice as a second tier by assuring long waits for NHS services and by writing contracts that provide consultants with incentives and ample time to induce patients to pay high fees for the treatments they should receive free.

Waiting lists have been attacked piecemeal and it is a pointless effort. Charges that lists are artificially reduced by pressurising general practitioners not to refer, or removing people from the lists, or by making more serious cases wait longer, are shuffling exercises that leave underlying causes untouched.

The two tier syndrome has six elements that have reinforced each other so well that the public and doctors think that long waits are as much a fact of life as waiting nine months for a baby to be born. The first element is the maximum part time contract. This is a government issued commercial licence, sold for several thousand pounds a year to consultants to build highly profitable businesses on the foundation of their NHS practice. Meanwhile, they keep a lifetime salary, six weeks' paid holiday, an indexed pension, and ready access to resources and networks with which to build their upper tier practice. The two tier syndrome is set up so that consultants can double their NHS salary seeing private patients for a day a week; surgeons can double it in half a day a week.

The second element is the minimal obligations that the government sets so that full time consultants have plenty of free time to build up private practices. Data collected by the Audit Commission and John Yates show that whole time NHS surgeons operate less than one day a week on NHS patients. Some patients are told "Mr G does not work for the NHS on Thursdays and Fridays." Yet if surgeons operated just one more day a week on NHS patients, waiting times would plummet to three weeks or less.

These two elements make up what I have called previously the "sweetheart contract." They are reinforced by a third element, to allow hospitals to set prices for extra theatre and other sessions well above their actual marginal costs, so that purchasers cannot "afford" to buy two to four extra theatre sessions a week. Marginal costs should be about a quarter of average costs, just as an extra night at a hotel costs only a fraction more, after all the fixed costs are covered by their break even occupancy at the regular rate.

While surgeons and anaesthetists are short changing the NHS, other specialists work hard without coming close to treating all in need, because they are in short supply. This is the fourth element, government induced shortages in most specialties that guarantee long waits in the lower public tier and a generous supply of private patients for the upper tier in Britain's two tier system.

These four elements are joined by a fifth, control by consultants of the waiting lists and over how long different kinds of patients will wait. This is a blatant conflict of interest, an invitation for mischief. Consultants have told me how other consultants exploit the NHS in many different ways. And some routine practices in the NHS help to drive patients into the upper private tier, such as notifying NHS patients when they have been given an appointment in ways that minimise the chances they can actually show up; scheduling theatre sessions to end an hour early; or allowing team members to take days off without careful planning for a replacement, so that sessions have to be cancelled.

> This is a blatant conflict of interest, an invitation to mischief

These practices are no accident. They would not exist if every cancelled session, every shortened session, and every patient who does not turn up meant less income to a unit and its members. But instead, these officially permitted practices mean less work at full pay and more patients ready to queue jump and pay large private fees.

The sixth element is that past governments have denied or obfuscated the government's two tier policies by focusing on just one or two elements and calling for yet more studies.

A heartening change seems possible with the new Labour government. But so far it is treating the symptoms, not the causes, and the current negotiations over a new consultant contract include a proposal to give a licence to all consultants to build up private practices. That would make the two tier syndrome even worse.

Will this government also perpetuate the two tier British healthcare system? Or will it demand that consultants see NHS patients three days a week as a minimum, set productivity goals, and reward specialty teams for exceeding them, allow purchasers to buy extra sessions at true marginal costs, and start training or importing more specialists? Ending government practices that support an upper private tier and long waiting times should be a major goal of Alan Milburn's newly formed leadership team.

**Donald Light** *fellow, Center for Bioethics, University of Pennsylvania Health System, Philadelphia, USA*

SOUNDINGS

# *Seven guidelines of wisdom*

Doctors are expected to be wise. Nowadays people can access knowledge without our help. They want more from us than just correct decision making, and we expect wisdom of one another. The commonest complaint about doctors in trouble is that they lack insight.

Yet we receive no training in wisdom. We assume that it is randomly distributed and partly genetic, like musical ability. Over the past six years the *BMJ* has published only 13 papers with "wisdom" in the title or abstract. Three of them were about teeth.

Here at last are some guidelines.

*(1) Mix the generations*: In modern Britain the only time that the generations mingle is at weddings. In hospital, consultants teach registrars, registrars teach juniors, and students teach one another. Intergenerational discourse should be reintroduced. Don't assume the flow of wisdom will be one way.

*(2) Take time for reflection*: "Reflective practice" is a cliché in nursing journals but not in ours. If anyone passing my door sees me sitting and thinking I feel guilty. The only place where you could stare thoughtfully through the window used to be the train, but modern electronics have stopped even that.

*(3) Converse with lay people*: This is hard. Many lay people have fixed attitudes to our profession, ranging from awe to resentment. Many doctors encourage these feelings. Concealing your calling is no help. We must converse as equals.

*(4) Dare to be unoriginal*: Today's NHS is constantly seeking novelty. Its jargon has a six week shelf life. In this context it takes nerve to point out the obvious. Wisdom is old fashioned though it can be repackaged under a snappy title like "clinical governance."

*(5) Move around*: This is increasingly difficult. Long ago undergraduates could move around Europe, but medical schools' seamless curricula now make this impossible. Regions are doing the same for specialist registrars. And consultants stay put.

*(6) Keep your sense of humour*: Seriousness belongs in the consulting room. Outside, be a jester, whose job is to deflate pomposity. Good jokes depend on insight. Think of all the books called *The wit and wisdom of . . . .*

*(7) Stop reading articles with "guidelines" in the title*: Whoever heard of a wise person reading numbered guidelines? Or writing them?

**James Owen Drife** *professor of obstetrics and gynaecology, Leeds*