medicine have trained as GPs, the philosophy of care, of which Fordham and colleagues are rightly proud, is disseminated in secondary care to the benefit of patients.

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Dr Fordham and colleagues make some important points about palliative care that should not be dismissed simply because of the extremist tone of their writing or the internal contradictions of their argument. Shorn of its pejorative impedimenta, the article claims that palliative medicine has not kept its promise. The specialty undertook to deliver symptom control to all patients, irrespective of their underlying condition, but in practice usually serves best the needs of those with cancer. We undertook to empower other professionals in their management of dying patients, but the result of our involvement can be to marginalize other carers. We recognize in principle the importance of general practitioner experience, but at least one GP (Dr Fordham) feels his skills are not valued. We undertook to provide an alternative to fast-paced, thoughtlessly invasive, acute hospital-style medicine for patients with incurable disease, but modern palliative care offers a wide range of symptom-relieving procedures some of which may themselves be highly invasive. These are all real issues, and it is helpful to be made to consider how far they are true in our own practice.

Dr Fordham sees these as symptomatic of the evolution of palliative medicine into a specialty. In doing so he unwittingly reveals his own world view. That a doctor may be an expert or caring, but not both, is a fallacy that seriously endangers the seamless care of patients. A compassionate, holistic approach to medical management is not the invention of, nor is it unique to, general practice. Neither is a dismissive and thoughtless approach to patients confined to specialists. There are good and bad doctors in teaching hospitals and GP surgeries alike.

Palliative medicine is likely to continue as a specialty despite Dr Fordham's reservations. We should use his criticisms to help ensure that we do not forget our role in providing a model of care that draws on and develops specialist expertise without abandoning principles of compassion.

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Professor Higginson's editorial 'Who needs Palliative Care' (November 1998 *JRSM*, pp 563–564) is long overdue. In our area the Macmillan Nursing Service is far from satisfactory. The public perception of a nurse is a person who provides care at the bedside, and many patients and their carers are sadly disillusioned. The service is Monday to Friday 9 am to 4.45 pm. Outside those hours the telephone is answered by a machine, which advises the caller to refer urgent calls to the general practitioner. I am a general practitioner as well as the medical director of a hospice. In our practice callers after 6 pm are referred to the deputizing service.

The average general practitioner has seven patients per year with cancer. Of these between two and three die at home. The experience a practitioner has of the management of terminal illness is limited. Macmillan says that it is addressing the problem—but my understanding is that their proposed solution is to provide more nursing auxiliaries. This of course would be helpful but does not provide expertise. Palliative care is a 24-hour commitment. The county of Devon provides this service and does it admirably. Why is this service not available throughout the UK?

What I have written about the community applies to the district general hospital. At the hospice we frequently take calls from ward sisters who are seeking advice on the management of terminal illness. We are happy to provide this information and guidance but properly this is the function of the hospital itself.

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Psychopharmacology and the human condition

If one was to accept the views put forward by Dr Bruce Charlton (November 1998 *JRSM*, pp. 599–601) psychiatrists would become purveyors of happiness in addition to therapists for the mentally sick.

It is not the function of the psychiatrist to give life more meaning; that is the role of the priest. Thomas Szasz once wrote, 'The fundamental error of psychiatry is that it regards life as a problem to be solved instead of as a purpose to be fulfilled'. Thus the problem with modern-day psychiatry is that all too often there is a failure to clearly differentiate between an understandable reaction to life's circumstances and clinical illness. That is the reason why vast amounts of antidepressive drugs are prescribed and, where there is a claimed benefit by an unhappy and distressed subject, it is not because of the antidepressive action of the drug but because of the tranquillizing effect of the medication.

Bearing in mind the side-effects of antidepressive medication and the fact that it only benefits those who are actually clinically depressed, there can be no possible

justification for the indiscriminate prescription of antidepressants to those who, for whatever reason, find life a burden. As often as not, this is the result of a personality defect and not a reflection of disordered brain metabolism likely to respond to medication.

It is, of course, possible that Dr Charlton is not being serious; after all the Notes for Contributors state 'Solemnity is not compulsory'.

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Swift's pocky quean

I was interested in Dr Bewley's article on Jonathan Swift's health (November 1998 *JRSM*, pp. 602–605), since I postulated that creativity in nineteenth century composers and some poets was mediated by otosyphilis[1]. Syphilis might explain many puzzling aspects of Swift's life.

Bewley queried the meaning of 'This woman [Betty] my mistress with a pox, left several children who are all dead'. In the *Oxford English Dictionary* (*OED*), under *mistress=substitute wife*, the only quotation from 1694 to 1819 comes from Swift's *Works*. For *pox=syphilis* the only unambiguous source before Joyce's *Ulysses* was Swift's *Gulliver*. Not noted was *Tale of the Tub* where the narrator, Swift, reported diseased nose, shins and 'body spent with poxes ill cured by trusting to bawds and surgeons'. From 1642 to 1771 *bawd=procuress*. In *Journal to Stella*, he dined with his cousin Leach, 'with a pox'; he often used *pox* as imprecation (e.g. 'Pox on these ministers'—in this personal sense, *OED* nil 1647–1941). *Small pox* marked the face of Biddy Floyd, to whom he wrote an ode: he escaped smallpox, but constantly complained of sore shins. From 1600 to 1800, none of the ten quotations for *smallpox* nor the twenty-nine for other words on that page were Swift's. The only source for *great pox=syphilis* 1608 to 1819 was Swift ('Has the small or greater pox Sunk down her nose or seam'd her face?'). The first *OED* source for *pox=to infect someone with syphilis* is Swift ('The dean be pox't'). The only quotation for *pocky=syphilitic* 1640 to 1822 was Swift's 'pocky quean'[2] (*=whore*).

Syphilis explains Swift's later reluctance to marry. Curious marriage problems also occurred in three composers with probable otosyphilis: Beethoven never married; Schumann's father-in-law objected violently to his marrying Clara; Haydn's marriage was childless and bitter. Like Swift, Haydn died from dementia, probably syphilitic[3].

Swift attributed giddiness to 'eating a hundred golden pippins at a time'. Such overeating is not plausible nor a recognized cause of Menière's disease. Perhaps Swift meant surfeit of tarts, just as *coffee* meant having sex. *Pippin* was 'a word for which Swift had an odd fondness', a give-away word, allowing attribution of doubtful poems[2]. *Golden pippin* (*OED* 1718) occurs in two 1712 poems and figuratively in *The Fable of the Widow and her Cat* ('Your golden pippins, and your pies/ How oft have I defended?').

Finally, Swift independently confirmed all this in *To Betty the Grisette*. The *OED* says *grisette=shopgirl*, noting two usages before 1768, both Swift: Webster also gives *part-time prostitute*. It starts:

> Queen of wit and beauty, Betty
> Never may the muse forget ye:
> How thy face charms every shepherd
> Spotted over like a leopard:
> And, thy freckled neck displayed,
> Envy breeds in every maid.
> Like a flyblown cake of tallow,
> Or, on parchment, ink turned yellow:
> Or, a tawny speckled pippin,
> Shrivelled with a winter's keeping.

Syphilis derives from Fracastoro's poem about the shepherd Syphilus. Fracastoro held that the French disease (in the English vernacular 'the pox') was spread by seedlets and by direct contact, by analogy with closely packed rotten apples[4]. In short, Swift was obsessed with syphilis and admitted having it, probably from cousin Betty, whose children had a high death rate consistent with congenital syphilis.

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Hernia audit in private practice

Congratulations to Mr Drew and his colleagues for having the courage to compare a personal series of hernia repairs with results from specialist centres (November 1998 *JRSM*, pp. 583–584). The accompanying editorial (p. 567) is an unfortunate one, damning by faint praise.

Bassini-like repairs are painful, with months of convalescence before return to work, and have a national recurrence rate of up to 15%[1]. The Shouldice layered repair was a considerable improvement, the use of local anaesthesia eliminating the small mortality and substantial morbidity in elderly and cardiorespiratory patients, but demanded meticulous technique. The non-tension repair with prosthetic mesh combines the considerable advantages of local anaesthesia and day-care surgery with early return to work and recurrence rates of under 1%[2,3]. Laparoscopic repair involves higher hospital costs, specialized equipment and training and general anaesthesia. It is correct to say that this approach gives less pain in the first few postoperative