Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

The most pressing issue

The editorial by Professor Malcolm Potts (January 2000 *JRSM*, pp. 1–2) is an affront to readers and humanity itself. That the 'population explosion' is a bad thing is debatable. Malthus 200 years ago, and demographers in the early part of the 20th century, did not believe that the world could support its present numbers, but it can. We really have no idea how many people the world will be able to support in the future, nor how many there will be in 100 years' time, but if we do not accept human life as good, it is difficult to see how anything can be good, or indeed why we are in medicine. Fertility is also good, and stable loving families are the backbone of a stable society.

Without doubt, contraception and abortion are intimately connected, and it is good that the article at least makes that clear. Contraception trivializes sex, separating it from both love and procreation, and thereby destroys families and leads to the very division and violence which the author himself suggests should be avoided. Abortion is of its nature violent, deliberately causing death, not preventing it, and to suggest 'manual vacuum aspiration' as an alternative where abortion is illegal is the most blatant hypocrisy.

As for global warming, destruction of forests and depletion of fish stocks, these can hardly be blamed on the developing nations, but rather on the small-family nations who are, in the author's words, surging forth economically. Is Korea a happier or healthier country than the Philippines? Is Rwanda's dependence on western aid really due to overpopulation, rather than tribal and post-colonial warring?

Changing Professor Potts' words only slightly, may I suggest that, in the new millennium, the medical profession could indeed make a difference by promoting three strategies:

- Lobbying to sustain and expand budgets for education in fertility awareness in developing countries—not for contraceptive supplies
- Delegate most (natural) family planning instruction to lower-level providers, on the basis of scientific evidence
- Help society accept the reality of what abortion is.

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Professor Potts summarizes his view of family planning by warning 'if we choose to do nothing, we may bear responsibility for division and violence in a world that fails to adjust human activities to biological limits'. The Population Division of the United Nations Department of Economic and Social Affairs convened a meeting of fourteen world renowned demographic experts in Toronto, Canada in November 1997 and reached a different conclusion. They confirmed that the decrease in fertility which has affected most of the industrially developed countries—Northern and Western Europe, Canada, the United States, Japan, Australia, New Zealand—is extending to an even greater number of developing countries in Southern and Eastern Europe, Asia and the Caribbean.

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Pulsating veins

Dr Barnett and colleagues describe a patient with pulsatile varicose veins who was originally thought to have an arteriovenous fistula but proved to have tricuspid regurgitation (January 2000 *JRSM*, pp. 29–30). Veins do not have to be varicose to pulsate[1]. Moreover, intracardiac pulsations may propagate not only to leg veins but also to arm veins[2], as encountered in tricuspid regurgitation in drug addicts who develop infective endocarditis on the tricuspid valve. Users of intravenous heroin are prone to thrombophlebitis of the arm veins and this process can destroy valves so that the arm veins pulsate in the manner of right atrium and jugular veins. The reason why pulsating arm veins are not encountered frequently in drug addicts is that they often have no patent arm veins left on account of phlebothrombosis and scarring.

In the case reported by Dr Barnett and colleagues a raised jugular venous pressure was a clue to the correct diagnosis; however, a normal right atrial pressure does not rule out tricuspid insufficiency[3]. Just as a normal left atrial pressure may exist in the presence of severe mitral insufficiency due to a dilated left atrium with increased compliance[4], so tricuspid insufficiency may exist without an elevated right atrial pressure.

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Biblical origins of placebo

Mr Conway (January 2000 *JRSM*, p. 53) presumes an error in Dr De Craen and colleagues' citation of the word placebo in the Vulgate (October 1999 *JRSM*, pp. 511–15). In fact

the citation *Psalm* cxiv verse 9 was correct[1]. The Vulgate is the Latin translation of the Bible by Jerome (342–420 CE). He translated the Psalms three times. His first translation is known as the Gallican version—the version accepted by the Catholic Church[2]. It is only in this version that the word placebo occurs. This translation was based on the Greek Septuagint which divides the Psalms differently from other Bibles, which have this verse as part of *Psalm* cxvi.

Mr Conway questioned the accuracy of the translation of the Hebrew *ethalech* (usually taken to mean 'I will walk with') as 'I will please'. Others[3] suggest that the Vulgate is in error here. However, the Greek origin of this version of the Vulgate explains the difficulty.

Placebo Domino in regione vivorum (I will please the Lord in the land of the living) is a direct translation of the Septuagint's Ευαρεστησω ἐνωπιον Κυριον ἐν χωρα ζωντων. In fact, it is a meaningful interpretation of the Hebrew. While the simple Hebrew form *elech* means 'I will walk', the reflexive grammatical form *ethalech* implies something more purposeful such as 'I will be in step with' or 'I will please'. The Septuagint consistently avoids translating Hebrew anthropomorphism literally, and translates this form of 'walking' as 'pleasing' in *Genesis* v verse 22 and likewise in *Genesis* vi verse 9[4].

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Red jackets and red noses

In his analysis of the drinking habits of the British Napoleonic soldier (January 2000, *JRSM*, pp. 38–41), Dr Howard perhaps should have laid even more emphasis on the distrust that was placed on the safety of the water supplies overseas—or, in the case of the Royal Navy, that had been kept in casks for several months. (This distrust lingers on, even in areas where it is not applicable; might it account for the behaviour of some British holidaymakers abroad?) Metropolitan water supplies in Great Britain were also not greatly trusted, hence the incorporation of a brewery in many 18th century city hospitals to provide patients (and indeed staff) with a supposedly uncontaminated fluid for internal consumption, with water used for external hygiene if at all.

As Dr Howard notes, alcohol rations for the armed forces fell after the Napoleonic campaign. Past practice may even have had a beneficial effect; in the Crimean war, the Russian General Liprandi had concluded that the only explanation for the charge of the Light Brigade at Balaclava was that all the cavalry were drunk, and was startled to find that this was not the case[1,2]. Whether this surprise hindered Russian strategy in that war thereafter is hard to prove in what was a very confused campaign. At the postprandial evening Cabinet meeting to agree orders to be sent to Lord Raglan for the invasion of the Crimea, held at Pembroke Lodge in Richmond on the evening of 28 June 1854, most of those present were asleep, waking up once when someone knocked over a chair and then dozing off again[1]. Perhaps, in those days, excess alcohol consumption influencing military capability was not just confined to the armed forces.

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Accountability, clinical governance and the acceptance of imperfection

Dr Neville Goodman (February 2000 *JRSM*, pp. 56–58) asks for the acceptance, by implication, that the doctor knows better than the patient because of extensive medical training. This is a self-evident truth for lay patients when the whole gamut of medical knowledge is considered. However, the patient is concerned only with the one aspect of medical knowledge that involves his or her own predicament. When accompanied by dedication and intelligence this special interest can create a focus of enquiry that no uncommitted practitioner could hope to match, especially in the limited time allocated for general-practitioner consultations. The Internet has made 'library' research on any subject so much easier, but there remains the danger of a lack of perspective for the layman. When this source becomes truly interactive, enquiring patients will have the potential to become better informed on their illness than their GP.

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Dr Goodman's worry that improvements in healthcare through NICE, CHI and medical reaccreditation are mere presumptions, unscientific in design and with detrimental side-effect potential, is echoed in many clinical service

corridors. His argument that medical expertise is best judged by experts would be common sense in the NHS if such judgments were made by expert medical consensus rather than by government ministers. Instead, doctors lean on ropes with hands tied by red tape, while the press and media hit the profession, sometimes above and sometimes below the belt.

It was disappointing to read Dr Goodman's conclusion that politicians should rein back public expectations of the NHS, with media support. Patients' expectations are important stimuli to medical advancements. At any time, the NHS inevitably has boundaries, but they constantly change. They are supposed to be defined financially by a government that reflects popular priorities. In my view, government could better serve healthcare by empowerment of the professions to police clinical and professional standards using 'carrots and sticks', which are standard legislative tools. This would serve society better than having doctors ration other than by urgency of clinical need. Roles have become muddled.

I suggest that to believe politicans should or would wish to rein back public expectations or ever would obtain support from the media to do so is naïve. The medical profession must regain the initiative regarding medical practices. Our passivity has cost us dearly in public respect. We entered this arena to protect patients. If we don't come out fighting we should expect to be knocked out. Professionals allied to medicine are emerging as diagnosticians and independent practitioners, climbing into the ring before we hit the canvas. According to Dr Goodman the public trusts doctors more than politicians. We should take advantage of our popularity while it lasts.

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A national database of medical error

I share the enthusiasm of Dr Sheikh and Professor Hurwitz for a database of medical error (November 1999 *JRSM*, pp. 554–555). Like many doctors, I am aware of several medical errors that have occurred that should be publicized to help other doctors avoid the same pitfalls. Issues of patient consent and confidentiality, as well as medicolegal factors, make it difficult to publish details of such mistakes so that others can learn from them. At present, the only way of circulating clinical information about these errors, which may well be due to organizational failure rather than individual incompetence, is via the defence societies' annual reports.

As a GP, my working life now includes delegation to other health workers, an increasing amount of telephone advice and extensive use of computerized systems. All these are ripe areas for failures in communication and misunderstandings. Sharing errors, mistakes and mishaps in an anonymized, nationally accessible way, as happens in other professions such as aircrew, can only help prevent them.

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There are arrangements in aviation which might, if applied to medicine and surgery, help to answer Dr Bratman's dilemma: '. . . hospital people will find all sorts of reasons for not wanting to report adverse incidents . . . ' (February 2000 *JRSM*, p. 106). Pilots and others involved in general aviation submit details of hazardous incidents and accidents on a voluntary basis for anonymous publication in the *Flight Safety Bulletin*, published quarterly by the General Aviation Safety Council. For incidents associated with human factors (fatigue, health and emotional and team problems), voluntary contributions are published, also on an anonymous basis, by CHIRP (Confidential Human factors Incident Reporting Programme) in a regular news-sheet. Air Accident Investigation branch bulletins cover the commercial sector. The debate is open, generates an airing and sharing ethos, and is widely respected.

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Postmortem and perimortem caesarean section

Ms Whitten and Mr Irvine (January 2000 *JRSM*, pp. 6–9) address a highly emotive issue. This distressing dilemma is most likely to be managed in the casualty department, by junior staff working to ATLS guidelines[1]. These advocate that there is little or no place for perimortem caesarean section in the context of maternal arrest due to haemorrhagic hypovolaemia. Placental circulation is compromised early in haemorrhagic shock, and fetal perfusion will be inadequate by the time maternal decompensation has occurred. The evidence presented by Whitten and Irvine does not contradict this view.

If postmortem or perimortem caesarean section is to be reconsidered as a valid option, the context must be that of Whitten and Irvine's best scenario, with immediate availability of appropriate staff and equipment for caesarean section and neonatal resuscitation in the casualty department. We suspect most hospitals are currently unable to provide such support.

Whitten and Irvine mention the surviving partner, but infrequently. Surely the view of the partner or next of kin is more valid than that of a consultant obstetrician who may never have met the patient or her family. They consider the

tragedy of leaving a bereaved partner with a severely handicapped child. The emotional trauma of managing even a healthy new baby alone, coupled with the devastation of bereavement, has not been considered. An additional dilemma is whether to attempt perimortem delivery of a single mother.

The article appropriately emphasizes the need for clearer guidelines in this area. The authors conclude: 'the decision not to deliver the fetus may leave many unanswered questions'. Unfortunately, the decision to deliver must leave at least as many.

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Intracranial hypertension

Dr Patton and colleagues report a case of intracranial hypertension with bilateral IV and VI nerve palsies (February 2000 *JRSM*, pp. 80–81). In this case the condition was judged idiopathic. Intracranial hypertension with normal cerebrospinal fluid (CSF) can occur also after ear infections. There may or may not be manifest lateral sinus thrombosis, the obstruction to drainage of the CSF being in the Pacchionian bodies of the superior longitudinal sinus. With the rarity of mastoid infection nowadays, it may be missed. CSF pressure must be reduced, medically or otherwise, to prevent damage to vision.

I saw an odd example when the lateral sinus was blocked off by packing during a saccus operation for Ménière's disease, the sinus being forward. Unknown to the surgeon at the time and shown only by postoperative brain scan, the lateral sinus and internal jugular vein were absent from the other side.

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James Ewing

This month in history

In an era when oncology was yet to emerge as a specific discipline of medicine, James Ewing (1866–1943) predicted that the struggle against cancer would be more a marathon than a sprint. Ewing's first account of the tumour that now bears his name bore the title, 'Diffuse endothelioma of bone', and was published in 1921. This tumour was unlike any myeloma he had encountered and his personal experience convinced him that it was extraordinarily radiosensitive. A 14-year-old girl had been treated by a local physician for nasal discharge and bleeding. In November 1918, she suffered a spontaneous fracture of the ulna. Soon a tumour was apparent in the upper part of the arm, which led to an initial consideration of osteogenic sarcoma. On 12 April 1919, under Dr Ewing's care, a radium pack of 12 760 millicurie hours was applied to the arm, to be followed by two other packs at intervals of two weeks. The results were dramatic—the tumour receded and no swelling remained after five weeks. The patient returned in October 1920 with a recurrence. A biopsy showed distinctive features, leading Dr Ewing to advocate the term endothelioma. Ewing, as director of Memorial Hospital, New York, remained a strong advocate of radiation therapy, and was vehemently opposed to surgery for surgery's sake.

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