The writing is on the wall for UNAIDS

PERSONAL VIEW **Roger England**

The creation of UNAIDS, the joint United Nations programme on HIV and AIDS, was justified by the proposition that HIV is exceptional. The foundations of exceptionalism were laid when the "rights" arguments of gay men succeeded in making HIV a special case that demanded confidentiality and informed consent and discouraged routine testing and tracing of contacts, contrary to proved experience in public health. But exceptionalism grew—to encompass HIV as a disease of poverty, a developmental catastrophe, and an emergency demanding special measures, requiring multisectoral interventions beyond the leadership of the World Health Organization.

The exceptionality argument was used to raise international political commitment and large sums of money for the fight against HIV from, among others, the World Bank, through its multi-country AIDS programme, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the US Presidents' Emergency Plan for AIDS Relief. With its own UN agency, HIV has been treated like an economic sector rather than a disease.

The proposition of exceptionality is now under stress. The poverty argument has been exposed as baseless. The country surveys carried out by Measure DHS (Demographic and Health Surveys) of, for example, Ethiopia, Kenya, and Tanzania show that prevalence is highest among the middle classes and more educated people. Although HIV can tip households into poverty and constrain national development, so can all serious diseases and disasters. HIV is a major disease in southern Africa, but it is not a global catastrophe, and language from a top UNAIDS official that describes it as "one of the make-or-break forces of this century" and a "potential threat to the survival and well-being of people worldwide" is sensationalist. Worldwide the number of deaths from HIV each year is about the same as that among children aged under 5 years in India.

Why a UN agency for HIV and not for pneumonia or diabetes, which both kill more people?

MIKE HUTCHINGS/REUTERS

Is the global HIV industry too big and out of control?

Similarly, multisectoral programmes were misguided and have got nowhere slowly and expensively. Some small projects of non-governmental organisations (NGOs) have successfully integrated sectoral efforts, but government ministries such as agriculture and education have not succeeded in the HIV roles imposed on them. Vast sums have been wasted through national commissions and in funding esoteric disciplines and projects instead of beefing up public health capacity that could have controlled transmission. Only 10% of the $9 billion (£4.5 billion; €5.8 billion) a year dedicated to fighting HIV is needed for the free treatment programme for the two million people taking those treatments. Much of the rest funds ineffective activities outside the health sector.

It is no longer heresy to point out that far too much is spent on HIV relative to other needs and that this is damaging health systems. Although HIV causes 3.7% of mortality, it receives 25% of international healthcare aid and a big chunk of domestic expenditure. HIV aid often exceeds total domestic health budgets themselves, including their HIV spending. It has created parallel financing, employment, and organisational structures, weakening national health systems at a crucial time and sidelining needed structural reform. Massive off-budget funding dedicated to HIV provides no incentives for countries to create sustainable systems, entrenches bad planning and budgeting practices, undermines sensible reforms such as sector-wide approaches and basket funding (where different donors contribute funds to a central "basket," from which a separate body distributes money to various projects), achieves poor value for money, and increases dependency on aid. Yet UNAIDS is calling for huge increases: from $9 billion today to $42 billion by 2010 and $54 billion by 2015. UNAIDS is out of touch with reality, and its single issue advocacy is harming health systems and diverting resources from more effective interventions against other diseases.

Steadily, the demand is increasing for better healthcare systems, not funding for HIV. Mozambique's health minister stated: "The reality in many countries is that funds are not needed specifically for AIDS, tuberculosis, or malaria. Funds are firstly and mostly needed to strengthen national health systems so that a range of diseases and health conditions can be managed effectively."

HIV exceptionalism is dead—and the writing is on the wall for UNAIDS. Why a UN agency for HIV and not for pneumonia or diabetes, which both kill more people? UNAIDS should be closed down rapidly, not because it has performed badly given its mandate, which it has not, but because its mandate is wrong and harmful. Its technical functions should be refitted into WHO, to be balanced with those for other diseases.

Putting HIV in its place among other priorities will be resisted strongly. The global HIV industry is too big and out of control. We have created a monster with too many vested interests and reputations at stake, too many single issue NGOs, too many relatively well paid HIV staff in affected countries, and too many rock stars with AIDS support as a fashion accessory. But until we do put HIV in its place, countries will not get the delivery systems they need.

Roger England is chairman, Health Systems Workshop, Grenada roger.england@healthsystemsworkshop.org

A longer version of this article with references is available on bmj.com

Rembrandt's chronicle of 17th century anatomy dissection p 1075

REVIEW OF THE WEEK

Observations from on high

A new book of medical musings on topics ranging from basic science to cheese will help clever doctors pss the time, **Colin Douglas** finds

This collection of medical musings comes with a veiled warning in its foreword: the pieces first appeared as columns in the *Quarterly Journal of Medicine*. Not in the *BMJ* or the *Lancet*, and definitely not in any of the cheery throwaways whose columnists are the medical equivalents of *Private Eye*'s immortal Phil Space and Polly Filler. No, they first appeared in the *QJM*; and the *QJM*, we are reminded in the foreword, has a core readership of fairly senior and fairly academic physicians. So, the usual stuff of the lesser sort of column—the week's odd case; the easy dig at management; the facile reflection along the lines of "aren't our patients sometimes dim"—simply will not do. Fairly senior and fairly academic physicians have their standards, which we must assume are fairly high.

I hope these 50 pieces lived up to them. They certainly show evidence of serious effort. After a few hundred words of a piece about bed wetting, our attention is drawn to the relevance and utility of the theory of logical types first proposed in Bertrand Russell and Alfred North Whitehead's *Principia Mathematica* almost 100 years ago. Helpfully, for the less senior and less academic of us, its essence is summarised before we move on to learn of its relevance to Bateson's theory of humour. Its relevance to bed wetting is, of course, the main point, and eventually we get there too; although after all that foreplay the outcome is anticlimactic—a sensible, even obvious, course of action is neatly justified. But thinking like this no doubt helps clever doctors pass the time in a mundane 10 minute appointment.

The author—at various times a GP and an analytic family therapist and on occasions a patient and a family man too—ranges widely. The collection has pieces on evolution, on basic science, on history taking, on postmodernism, on travel medicine, on personal illness, on teaching and supervision, on cheese and choice and health care, on some failures of our NHS, and on much else besides. There is observation well done and scholarship that reaches into odd and sometimes interesting corners.

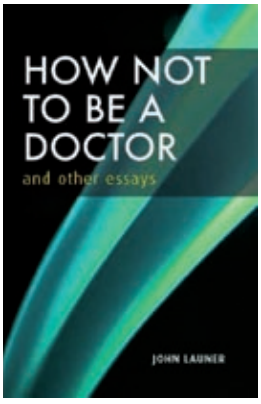
If the collection has a general problem it is that too much of it comes mulched with a rich psychoanalytic compost: glosses, reflections, and assertions that to the broad agnostic church of British medicine today might seem nothing more than the quaint disputed orthodoxies of a dwindling sect. And in these circumstances two and a half pages of quite small print on the case of Anna O and her hundreds of hours with Breuer might be a real risk. How quaint and distant it all seems now, and wherever did it take us?

But there are high points. A piece entitled "Weasel Words" begins with a better than average NHS jargon word game around those toe curling job advertisements decked out with goodies such as "exploring new realities" and "promoting sharing risk through integrated delivery." Firstly the author amiably mocks such nonsense, then he skewers it for what it is: "this pervasive deceit in the public services" with its "corruption of language, corruption of thought, and corruption of action." Ouch. Now he's almost as good and as tough as Orwell. People might reply to those advertisements, but have they any idea what they might end up doing if they got the job?

And he's good too at the personal. We are mortal, and first we get ill. Launer does it in style. His account of an electrocardiography technician's best efforts variously to control, ignore, and diminish him while confidently confusing him with another patient is a model of its kind: both as NHS worst practice and in the description of it. If only it could have been included in the offender's annual appraisal folder, much good might have come of it. On fatherhood too he shines. Twins are a complex and rewarding challenge, and he covers it well: from the first exposure to well meaning gratuitous nonsense from strangers, through the early literature (Shakespeare had twins, which explains a lot), and on to the intricate science of zygosity, by then, in the context, fairly painless.

But in one or two pieces the art overwhelms the matter. One in particular struck me as intriguing, if only because its ideal audience might be small or minuscule. How many devotees of the sonorous paratactic rhythms of the Old Testament might also be fans of the majestic force of evolution? Aren't these interest groups much at odds these days? But perhaps Launer, with his account of phylogenesis in a pastiche of Genesis ("And the deuterosomes are also in the likeness of worms. And we are of the deuterosomes, because when we are newly formed in our mothers' wombs, yea, our anuses are open even before our mouths . . .") has happened upon an unlikely means of at least getting them to sit down and reason together. I hope so, but I won't hold my breath.

Colin Douglas is a doctor and novelist, Edinburgh



How Not to be a Doctor
John Launer
RSM Press, pp 108, £24.95
ISBN 978 1853157523
Rating: ★★☆☆

His account of an ECG technician's best efforts variously to control, ignore, and diminish him while confidently confusing him with another patient is a model of its kind

The bland bombshell

FROM THE FRONTLINE
Des Spence

I try not to be judgmental, but I do struggle with society's fastest growing group—the terminally dull. This presents a problem in medicine, as patients actively avoid the tedious doctor.

People didn't used to be so bland and timid. A generation ago people enjoyed salt on their chips, deep fried everything, and filled their tea with sugar. There was more social diversity and a great number of different musical and fashion factions (rockers, mods, hippies, new romantics, goths, reggae Rastas, and punks). People actually had political and religious views that they didn't keep to themselves for fear of offending others: Trotskyites, Anarchists, Unionists, Syndicalists, various Christian schisms, one-nation Tories, and the Thatcherites. At weekends only—as that was all they could afford—they all enjoyed low strength (by today's standards) beers and sweet table wines and engaged in blazing rows.

For most people back then the only drugs were the occasional passed joint. There was little scope to self medicate with a plethora of drugs merely to make them "seem" more interesting to others; they just were. Jokes were told to each other in person, not passively passed through email and texting. Society was inventively rude, not just crude, today's lowest common denominator. And like a good wine, character became more pronounced with age—doctors became ruder and were unashamed of their shuffling gaits from untreated osteoarthritis.

So, for all our supposed sophistication now, people just seem duller. Perhaps it is a distorted Darwinian effect of social evolution, or the state has been conducting charisma bypass procedures without our knowledge. Or, more likely, it is a reflection of today's protocol driven childhood in which parents seek to produce "perfect" homogeneous children. Few now suffer the complexes arising from resentment at being the oldest child, the anguish of being the forgotten middle children, or the perpetual disappointment of the spoilt youngest child. "Character" has been reduced to the stuff of pompously titled self help books and "personality" added to the finished product, like the fake rips and patches added to modern jeans. I fear that the drug industry is working to make dullness a definable syndrome with drugs in the pipeline.

Doctors need charisma. We should screen medical applicants for dullness and offer remedial lessons in humility, wit, sarcasm, timing, rudeness, stoicism, and behaving disgracefully (but not antisocially). If not, we will see the extinction of the bow tied, hunched, monocle wearing, cigar smoking female chest physician.

Des Spence is a general practitioner, Glasgow **destwo@yahoo.co.uk**

The Royal College of Lay People

IN AND OUT OF HOSPITAL
James Owen Drife

We are pleased to announce a new royal college, the first for almost three months. The Royal College of Lay People (RCLP) aims to bring together all those who make decisions on health care in the United Kingdom. Opinion polls tell us that the public still believes that such matters should be left to doctors and that quangos are less trustworthy than medical colleges. The RCLP has been founded to correct these misperceptions and invites applications for the following faculties.

Faculty of Campaigners—Sitting on the pavement with a placard is all very well, but you can reshape the NHS more effectively by joining a committee. Preference will be given to those with anecdotes from the last century about substandard care received by them or a member of their extended family. Please be assured that no professional will challenge your views.

Faculty of Health Economists—It has been suggested that this faculty is not needed because all NHS professionals are now more cost conscious than care conscious. Vigilance is essential, however, as outbreaks of nambypamby rule bending continue to occur.

Faculty of Chief Executives—CEOs! Do you still feel accountable to your board, council, chairman, or president? The faculty will help you lose those outmoded inhibitions. You will be enabled to wield power ostentatiously or discreetly, as you prefer.

Faculty of Media Editors—With so many medical organisations now employing public relations experts, stereotypes are an endangered species. The faculty offers regular get togethers (with refreshments) where you can reassure one another that all consultants live in London, work in Harley Street, and spend their afternoons playing golf.

Faculty of Statisticians—Bored? Let us show you how stimulating it is to investigate the bleeding obvious. Projects for 2010 to 2020 will address unsolved questions such as "Are rich people healthier than poor people?" or "Do asylum seekers receive above average care?" The results may lead to decisive government action as early as 2025.

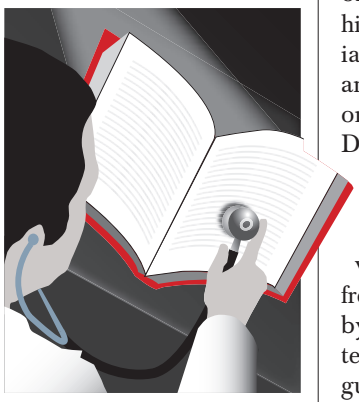
Faculty of Politicians—Attempts to form this faculty have been abandoned. During the pilot phase large numbers kept promising to turn up, but they all sent their apologies just before each meeting.

Stop press! Senior members of the medical profession are eligible to join the RCLP, provided that they have seen less than six patients in two years. Don't be shy. Coming out as a lay person is liberating.

James Owen Drife is professor of obstetrics and gynaecology, Leeds
j.o.drife@leeds.ac.uk

Dangerous, ignorant, fools

BETWEEN THE LINES
Theodore Dalrymple



A surprising number of doctors have been tried in Britain for treason or sedition

The wickedness, to say nothing of the incompetence, of doctors has long been the subject of monographs, memoirs, and anthologies. The medical murderer is a figure of perpetual fascination and horror, and many studies, of individual cases and of the type in general, have been published.

One of the first of the compendiums of doctors' brushes with the law, still in print 80 years after it was first published, is Leonard B Parry's *Some Famous Medical Trials*. Mr Parry was consulting surgeon to Brighton's Hospital for Sick Children, the Hove Cripples' Guild, and Barnardo's Hospital for Blind Boys (and a staunch member of his local branch of the BMA); he was also the author of histories of criminal abortion and the use of torture in England. His one truly medical monograph was his *Risks and Dangers of Various Occupations*, published in 1900. He died, aged 87, in 1958.

Among the famous trials Parry relates are those of the great medical poisoners of the 19th century, as well as that of Dr Smith, who murdered a man whose life he had previously insured for £2000 (about £120 000 (€150 000; $240 000) in our debased money). Of Dr Smith, Parry writes, "It is difficult to imagine an educated professional man carrying out this cold-blooded, carefully planned crime for such a paltry advantage." As Parry had previously given the history of the equally well educated Dr Lamson, who poisoned his stepson to gain the even more paltry advantage of £1500, his want of imagination seems rather odd.

But many of the trials he writes of did not involve murder at all; a surprising number of doctors have been tried in Britain for treason or sedition. My particular favourite, however, was a libel trial, brought in 1839 by one medical man against another.

Both were practising in Rotherhithe. Dr Austin was medical officer to the Rotherhithe Poor Law Guardians, which received an anonymous letter one day alleging that Dr Austin had given insufficient care to a woman in labour. That Parry is of a very different epoch from our own is shown by the following sentence: "The board of guardians, instead of assigning the anonymous communication to its proper place, the waste-paper basket, decided to hold a court of enquiry into the allegations." The one place complaints are never sent these days is the waste paper basket, for that way bureaucratic underemployment lies.

Dr Austin was absolved, but he became convinced that the original letter was sent by a local rival, Charles Ventris Field. He therefore wrote a letter of his own to the board:

Now, sir, with respect to the individual who has considered himself called on to make this attempt to do me a serious injury in your estimation . . . In fact, my silence in the case of a murderous operation performed by him on a Mrs Mason . . . has been a means of screening him probably from criminal proceedings, from universal disgust and the opprobrium of every medical man, nor is this a solitary instance of his malpractice. Of his character I should say that he was shunned and avoided by every medical man as a dangerous, ignorant, presuming fool and cowardly poltroon. This animal answers to the name of Charles Ventris Field."

Dangerous, ignorant, presuming fools in medicine? No wonder Dr Field was awarded damages. But if £2000 is paltry, what are we to say of a mere £100?

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

The Anatomy Lesson By Rembrandt

Oil on canvas, painted in 1632

Rembrandt's famous painting *The Anatomy Lesson of Dr Nicolaes Pulp* was a group portrait commissioned by the Guild of Surgeons of Amsterdam. Rembrandt was only 26 at the time he painted it. The itinerant painter had travelled from his native Leiden to Amsterdam. Luck readily smiled on him.

Dr Tulp—the newly appointed reader of the Guild of Surgeons—needed a portrait to befit his new status. Rembrandt's genius was in transcending the limited appeal of a group portrait to become a chronicler of anatomy dissection of his time. What is the story behind this autopsy? Where did the body come from? As a surgeon I get easily drawn to the subject matter.

Rembrandt leaves us various clues to the life and times of his contemporary anatomist. The body looks too healthy to have died a natural death. Only corpses of executed murderers were allowed for dissection in those days; indeed, the corpse was that of an executed criminal. We don't see any dissecting instruments, but a textbook is open at the foot of the corpse. This voluminous tome could be Vesalius's anatomy treatise, which was published nearly a century earlier and proved wrong many Galenic assertions, laying the foundations for a scientific study of the human body.

Some of the painting's subjects are looking ahead. Are they looking at other spectators? Anatomy dissection in 17th century Europe was as much a social as a scientific event. Demonstrations were held in public theatres once a year and the display offered to students, high officials, and the public for a fee. Although the body remains intact, the left forearm is already completely dissected. Centre stage is the demonstrator, Dr Tulp. Dressed in a wide brimmed hat and formal outfit, his social standing is obvious.

He is busy demonstrating the actions of the long flexors of the hand to his amazed audience. With one hand he is lifting and pulling the flexors; with the other he is mimicking their function. This action is of obvious interest to the observers, at least two of whom are looking directly at Tulp's hand. The spectators are forever locked in a moment of rapt attention. This chronicle of anatomy dissection is also a subtle narrative of our continuing obsession with unlocking the secrets of the human body. Rembrandt draws the viewer in to a private demonstration of the unravelling of a mysterious secret.

My appreciation is that of a layman, yet I cannot but also comment on the painting's visual beauty. Rembrandt was a master of light and shadow, and his skill is evident even this early in his career. The faces are remarkably bright, giving a lighting effect, but death casts its dark halo on the corpse. In painting this humble commission, Rembrandt created a masterpiece that, centuries later, still evokes a vivid leap of imagination.

Munier Hossain, staff grade surgeon, Ysbyty Gwynedd, North Wales **munierh@doctors.org.uk**