Red = entered elsewhere

ANECDOTES AND WHIMSICAL OBSERVATIONS

1. INTRODUCTION

I retired from the NHS after 26 years as a consultant, having done most of the right things and concealing most of the wrong things. This section contains a motley collection of anecdotes designed to provoke thought or to amuse.

All readers are entitled to know something of the author whose works they are about to read. As it happens I had my personality assessed by a clinical psychologist 20 years ago. I had previously turned down offers of a personality test by the Church of Scientology on the grounds that I had no personality.

The first test was the Adult Eysenck Personality Questionnaire authored by Hans and Sybil Eysenck, both prominent psychologists. Thankfully I scored zero for pyschoticism. My extraversion score was 14, the average for male doctors being 12.78, so I am a bit more sociable than average. My neuroticism score was 4, the population average being 10.71.

So far so good but my measure of dissimulation was 10, the population average being 6.82. And dissimulation scale was the lie scale. I had taken a personality test and had failed! However I went back to the questionnaire manual to discover my lying characteristics and discovered that I am a liar because I claimed to have the following virtues. If I say I will do something I always keep my promise no matter how inconvenient it may be – but I take great care not to commit myself to doing what I do not think I can achieve. I have never taken praise for something I know that someone else has really done. I have never blamed someone for doing something I knew was really my fault. I never talk about things I know nothing about – I may know little and confess it), but I never know nothing, I have never cheated at a game. I have never taken advantage of anyone, I would not dodge paying taxes (even if I were sure I would never be found out). I do not put off until tomorrow what I ought to do today – mind you what I judge ought to be done today and what you think I ought to do today are two different things. Finally I am always willing to admit I have made a mistake.

I was horrified that this questionnaire assumed that incorrect behaviour should be so common that a denial of it is evidence of dissimulation: seemingly dishonesty is assumed in this questionnaire. However I did lie when I denied that I had ever taken anything (even a pin or button) that belonged to someone else. In 1984 I do recall that, with malice and aforethought, purloining a paper clip from the Lothian Health Board.

For all of the above virtues my lie score was worse than the average score of those who are psychotic, neurotic, prisoners, drug addicts, those with personality problems and much worse than the lie score of alcoholics who, interestingly, have the lowest lie score of all. A decline into alcoholism was not possible but there was a let out - the lie scale also measures some stable personality factor which "may possibly denote some degree of naïveté." It seems I may have told lies or be a fool, or both. Undoubtedly by the criteria of Hans and Sybil I sank.

Undaunted by the above revelations I had my attitudes assess by the Wilson- Patterson Attitude Inventory. I was graded as very liberal, indeed towards the liberal end of pop musicians and university students.

Subsequently my leadership style was assessed. Some are task rather than people orientated (an extreme would be executioners) and others are people rather than task orientated “all talk and no action” (the extreme would be gossip columnists). I scored highly on both. I would be an understanding executioner.

Another questionnaire revealed that I was more conscientious than graduate teachers at training college and art students. I scored low on dogmatism (119, communists typically score 148, Cambridge students 141, and nuns 164).

So I have no strongly held views and am less than decisive, I think.

So this is what I am. I am also a lateral thinker because I have a mild degree of dyslexia, which impairs straight thinking, especially about complex matters. Occam's razor is help here – the most simple explanations often are correct – but I favour Welsby's Sledgehammer – ignoring complexities and focusing on simplicities often reveals major flaws in conventional wisdoms.

2. Words of Wisdom?

At the age of 19 I had two experiences that encouraged a gentle skepticism that has proved to be a lifelong benefit. Firstly, I, a male, was accepted by what was then Royal Free Hospital School of Medicine for Women. Secondly, in the first week at this school of medicine for women an anatomy tutor informed me that the female breast was "a conical eminence on the front of the female chest." I did not believe it then and experience has confirmed this to be correct. However it was a male tutor who told me this so he must have been so far distanced from real life that his reading might have also caused him to think that all women had staples across their middle. Clinicians, in particular, general practitioners, are ideally placed to write about human behavior and motivations. Only they can ask questions of deep personal significance and confidentiality and expect to get relatively truthful answers. 3. A novel idea? When did a bank manager last ask a customer "how many sexual partners have you had in the last year and how many were "higher risk" contacts (without the HIV protective benefit of condoms)? Clinicians, unless blinkered, should gain more insights than other professions and perhaps explains why the profession of doctoring seems to contribute a disproportionate number of novelists.

3. Straight thinking

Doctors, and their precursors, medical students, have been reported to have superior intelligence. My IQ could not be measured accurately and probably lies somewhere indeterminate between 88 and 90 I have been simultaneously impressed and depressed by colleagues who seemed to possess a greater IQ and memory capacity than I, but these attributes seem in many instances to militate against a sense of humour or the capacity to generate ideas. Such high intelligence and an above average memory might make it more difficult for their minds to operate on the verge of illogicality that seems to be required to produce ideas "outside the box." Also my mild dyslexia (the more severe form presumably is known as lesdyxia) interferes with straightforward logical thinking. I was and am condemned to be a lateral thinker because I cannot think straight. Those are my excuses. What are yours?

4. Post-retirement

I am now retired. Although exciting and stimulating at the time, being a fulltime NHS consultant was stressful. I was at everyone's beck and call with exponentially increasing interruptions from telephone calls, pagers (as a clinician I believed that I had to carry a pager), e-mails, and mobile phones from staff and patients that conspired to produce an uneasy combination of infinite availability with continual interruptions. I once had my pager interrupt an interruption, which had been interrupted by an interruption. Occasionally patients interrupted ward rounds by becoming acutely unwell. The only way for clinicians to have uninterrupted thoughts is to leave the hospital and switch off all electronic devices (pacemakers excepted). This stress was the price willingly paid for an interesting life. For some reason my clinically active colleagues report it unhelpful when I counsel "Stress is the price you have to pay for having an interesting life."

5. Keep on working

All non-retired doctors should all work hard; get well paid, and pay taxes. Paying your taxes will help pay my pension, will keep me in the manner I would like to become accustomed. Who could wish for more? Sadly the retired are a gravely neglected resource. Few retired colleagues, non-academics with experience of "real medical life," are recruited to teach students. Once the time pressures of medical practice are removed we are, for a few years at least, in an ideal position to teach than your younger more stressed working colleagues. I derive great satisfaction in

teaching medical students two days each week.

My advice to colleagues, particularly clinicians whose medical roles define their life, is to prepare for retirement by continuing or developing an interest to replace medical interests before they retire. Endoscopists and gynaecologists should take up potholing, cardiologists fitness training, neurologists internet networking, neurosurgeons safe breaking, radiotherapists shooting, dermatologists painting, surgeons carpentry and family planning doctors should become security guards. Some retirees embrace golf, primarily a social disease (surely there is no pleasure derived from delivering a ball down holes in a field?) whereas others embrace gardening, delivering bulbs into holes in a field.

6. Does the NHS have a future?
The future of the NHS still concerns me because I may be a patient in future. There is the possibility of mortality. I used to ask of medical students "What must I do to live forever?" Choosing parents with care, no smoking, a small amount of alcohol daily (known to be beneficial but doctors cannot prescribe it), a statin a day, an acceptable Body Mass Index and no dangerous activities were all reasonable answers. But now for me the question has changed. "At what age should I abandon my quest for immortality and embrace activities that in my responsible youth I had eschewed such as car racing, smoking, and surfeits of sex, drugs and rock and roll?" Sex? I was a student in London in 1987, the famous summer of love, and I had not noticed. Drugs? I was too sensible. Rock and roll? I had been brought up 30 miles from Liverpool during the greatest focal outpouring of musical talent for decades and again I had not noticed. Surely I cannot be expected to be respectable all my life? Sadly I fear it is too late to recoup the lost possibilities of my youth.

It might have been appropriate for my career to be brought to an abrupt and dramatic close by being struck off the Medical Register. This has not yet occurred but I live in hope.

Towards the end of my NHS career I affected an amiable grumpiness but discontinued this affectation when it started to become autonomous.

6. Twig 'n' Berries
In the olden days junior hospital doctors were allowed to do GP locums and I spent a few happy months as a locum in a small town in County Durham. Medically there were no problems but I took some time to appreciate the local terms for various conditions. For example when mothers brought in children who were "twisty" it was clear that there was some minor, almost always undiagnosable, malaise. I was blissfully unaware that the local euphemism for the male genitalia was "twig and berries."

When the wife of a local market gardener came to see me with a complaint that her "husband's twig and berries were not working" I was mildly irritated that I was expected to solve problems that had nothing to do with medicine. What did I know about horticulture?

Nevertheless I was polite, if initially dismissive, "I'm afraid I cannot be expected to know much about this." Her look of disappointment made me realize that I had been a bit abrupt and unhelpful. A moment's reflection made me realize that even a little advice might be of disproportionate help, and remembering how my wife had recently resuscitated her failing pot plants I added "When my wife had this problem she found that pouring on cold tea was beneficial." The effect was dramatic: the effusiveness of her thanks was a miracle to behold.

When I later discussed this curious consultation with the senior partner I learnt two things - the local meaning of twig and berries and that people's jaws really do drop when told surprising information!

Sadly I never heard what the result of my advice had been.

7. Doctors a miracle workers

Some think that there was a Golden Age of Medicine during which doctors (?wrongly) were perceived to have the god----like abilities and to be able to perform medical and pastoral miracles for lesser mortals. Times have changed and now there is an increasing tendency for patients to treat us as though they had a divine right to demand miracles.

Accordingly a return to the Golden Age of Medicine is required using as an inspiration the great liberal thinker Colonel Gadhafi (not those thoughts contained in his famous green book in which he opined that "women are like blossoms which are created to attract pollen and produce seeds") but by the fact that he once made a British Ambassador wait, apparently with great expectation, for hours before granting an audience at which numerous valuable insights were seemingly to be imparted. For the occasion the Colonel wore a hat of such bizarre configuration that could only be worn by a madman, an eccentric genius, or both.

Adapting the Colonel's modus operandi the first steps in the long awaited Reformation of Medicine will be initiated. Out-patient clinic staff will be instructed that, from this day forth, patients are not to be given appointments. They were to be allocated times at which they should attend for an audience. Patients are to wait, in kneeling position, for at least for several hours, in a Spartan atrium (previously known as a waiting area) until their existence was acknowledged and admission to the inner sanctum, which would be referred to in hushed tones as the Medical Oracle, was imminent. Patients will not be told "the Doctor will see you now" but rather "The time has now arrived for you to be ushered into the presence of the illustrious magnificence."

GP referral notes and other requests for consideration would be written by hand in blank verse and proffered at convenient moments. Alternative medicine principles would float like a miasma across the incense-laden air. Masterly inactivity would be used as a diagnostic tool. "All will be revealed to those with patience." The infinite wisdom of the doctor will be distilled in a few judicious, if not judicial, incantations featuring mystical internally and externally contradictory outpourings that would make the declarations of non-medical journalists seem scientific in comparison. Hidden truths would be revealed in mystical terms "You are adrift on the sea of diagnostic uncertainty and you will soon come to a port, where you will disembark." Illegible grains of wisdom (previously known as prescriptions) will be written on tablets of stone. The practitioners of this arcane new medicine would often demand that the patients' feet should be washed - this is not so silly an idea as first appears given the malodorous feet of some current supplicants. Indeed in certain cases doctors should assume the role of the Good Shepherd and insist that some supplicants had to experience total immersion in a sheep dip before they could enter the Kingdom of Medicine. Patients would not know what was implied and what they would have to infer and thus no appeals to higher authorities would be possible in principle, even if it were postulated that higher authorities were theoretically possible. Authoritative instructions about use of tinctures, succussions and anointments would be given with words no shorter than five letters, no sentences shorter than 10 words and no paragraph shorter than five sentences. Discussion of such edicts would be thus unlikely. How can you have an ultimate authority if it can be questioned?

Clinical Directors will be instructed to upgrade clinic rooms to opulent chambers suitable for audiences with plush carpets, wall hangings, and caged songbirds. There will be fans waved by Nubian slaves (the dismay of female members of the staff when informed that such Nubians were traditionally eunuchs will be ignored). All the above is nonsense of course, but I have a horrible premonition that patient satisfaction measures would increase.

8. Guideline about guidelines

Clinical information is increasing exponentially and we are finding it difficult to cope, especially with increasing complexity of patients and treatments (I had one 80 year old with seven conditions on 23 medications). A thriving guideline producing industry is trying to help us. Sadly guidelines are mostly counsels of perfection rather than

statements of what is reasonable, and are derived from studies which have strict entry criteria so that their conclusions only apply to simple, well-defined limited situations. Attempted implementation of multiple single situation guidelines may be dangerous if their recommendations interact. It is dispiriting and all I can suggest is that we should return to stable ward teams with a wide spread of knowledge but there are stable clinical teams no longer. In hospital practice junior doctors have less time for formal and on-the-job training and often rotate at three or four monthly intervals – just as you have trained and got to know them they are off elsewhere.

Medicine is increasingly driven by guidelines that remove the need for thought. I have a series of silly guidelines that are designed to make students think. Such thought provoking guidelines include treating alcohol withdrawal symptoms with alcohol (how would you want your alcohol withdrawal symptoms treated?)

Guidelines are often political as they sometimes contain cost effectiveness judgments that, I believe, should only be made by those elected to make judgments. There are problems for elected governments because there are opportunity costs for any expensive innovation. If a new treatment costs N thousand pounds for each patient each year then, unless specifically funded by the government, other patients will not receive what could be bought with that amount. If new treatments are specifically funded then taxes go up, people become unhappy, and the government will not be re-elected. The NHS is a classic example of the "Common Ground Problem." Common ground, owned by no one, tends to be overused and deteriorates because everyone thinks they have a right to as much as they want. Or, if many individuals own portions of the same land then overall management is well-nigh impossible. A succession of authoritative nice overall owners may achieve a degree of management but this cannot be assumed. The only workable solution is an elected overall owner who has to operate on "greatest good for the greatest number" principles, and this, in the absence of infinite resources, implies that some will not, and should not, get what they want and need. Those inside the NHS should not relieve governments of their responsibility to govern.

9. Legal work

Towards the end of my full time career I was asked for medicolegal opinions as an expert witness and found the work interesting even though it involved ploughing through numerous files relating to a patient's misfortunes. It was my job to assemble the relevant facts and state my impartial opinion.

I became aware that one had to operate very much "on expertise." When giving evidence in Court it was essential to be as succinct as possible and only express an opinion when you really knew everything about the subject on which you were giving an opinion. Medicolegal judgments were often based on "the balance of probabilities" and this might well involve statistics, a mathematically complex minefield even for those who are professionals, never mind simple----minded doctors.

One example, based on a real life situation and, a warning, I will be asking you to make some judgments.

The risks of unexplained cot deaths are about 1 in 8,000. Two such deaths had occurred in one family and the chances of two such deaths occurring the same family are about 1 in 64,000,000 (8,000 x 8,000) and therefore the parents had almost certainly had killed their babies. That was what an expert in cot deaths told the Court. Why is this wrong? Obviously both babies might have had a predisposing inherited condition that caused them to die prematurely, or their might have been some unknown environmental factor, and infection perhaps? That is of course true, but probably only reduces that chances of double cot death to a still less-than-believable statistic and thus the parents still had almost certainly killed their babies. What had basic statistical point had everyone, including the expert witnesses, the lawyers, and the judge missed? Do take some time to think very hard. To help concentrate your mind I inform you that the mother of the two babies was imprisoned and eventually committed suicide and the expert witness was arraigned before the General Medical Council. What had been missed was the fact that i seems likely that the chances of one baby murder in a family would be at least 1 in 8,000, making the chance of double baby

murder at least 1 in 64,000,000 and, using similar logic, the likelihood of double murder was so remote that the babies almost certainly had died because of cot death. The chances of either could and should not have been used as they are of no help in deciding what had happened.

10. Computer Love Song
Written using Wordsworth for Windows (No need for encryption,
It is, by the way, a fiction).

My name was Mac, yours was Adell,
Supplanting the abacus that we knew well.
Our previous lives as stand-alones was hated
Our Internet linking was thus fated.

A search engine gave your address
Not my first visit there I confess.
I'd had few previous links in reality,
And I'd never had a virus or a (D)VD.

When we signed on together
Little did we wonder whether
It were possible to find love on-line,
But our experience turned out just fine.

Whilst drinking electrons in a cyberspace café
Whilst resting from the information highway.
A bit led to a lovebyte,
Your interface smiling. Quite.

You cast your web and I was Internetted
Entrapped, but not for one moment regretted.
We docked and set up a joint domain,
In order our love to contain.

Interesting high-level programmes we had to share
After mutual exchange of data, I do declare
Never again will we have to be lonely,
A scan shows we are about to have a little Sony!

11. Genetic engineering: the human gnome project
Conservatives of all persuasions worry themselves about the implications of the exponentially adventurous exploits of modern genetic engineers. They are right to worry. History suggests that, if something can be done, then someone, somewhere, sooner rather than later, will do it, no matter what anyone else thinks. Inevitably human attributes will be modified. But who shall take the lead? It might as well be me.

There are many simple design faults in humans (which should show creationists that the creator was not a good designer) which should be corrected. Here are a few.

The airway and food swallowing tubes cross over in the neck. This will be corrected. No more inhaled peanuts!

The retina has the nerve tissue in front of the light detecting tissue. This will be reversed.

Hair on the head is mostly useless (although I am told that, for depressed ladies, a perm is as good as ECT). Insert a few plant genes and hair could photosynthesize. Eyebrows will be incandescent to enable reading in the dark.

The upright posture is associated with low back pain. A bit of genetic engineering and, hey presto, future generations will be quadrupeds.

Bodily fluids will be flavoured. Perspiration will be perfumed. Other fluids could be chocolate flavoured, enabling President Clinton… Oh never mind.

Metabolism and excretion of alcohol will be made proportional to the blood levels such that blood alcohol levels cannot exceed safe limits.

The genital and reproductive tracts would be better geographically separated and childbirth will be made less painful. In fact females will be genetically engineered to lay eggs which, naturally enough, will be hatched by midwives genetically modified for this specific purpose.

Stomach size will diminish in proportion to the body weight, in order to reduce the current epidemic of obesity.

What will the genetically modified committeemen (GMC) have to say about all this? Your guess is as good as mine.

12. Health clubs: exercise and hot pants?
Regular attendance at the local health club is essential to keep me in trim. Usually I do not wear headphones, preferring to read the subscripts below the pictures which are obviously computer generated translations. Evidence for same? A weather report which, so I read, informed me that "There were to be Gaels in Northwest Scotland and the wind chill factor would be so great that wanking would be dangerous unless appropriate equipment was being worn."

A recent visit to my health club, a modern Temple of Health, revealed that there is a lot of energy being expended. People were running on treadmills getting nowhere at their inclination of choice. One treadmill machine I tried asked me my age and weight so I could be given a target heart rate. I entered 99 years and 9 kilograms and to my consternation was given a numerical reply rather than an automatic 999 call. Brave souls were cycling furiously without moving an inch. There are machines for running whilst in the horizontal position and rowing machines that could increase the gradient (of water?). Most unnatural. There is a machine that appears designed to develop muscles that squeeze the knees together. Its ultimate purpose is unknown but autocastration seems a possibility. Some of my fellow seekers of health were training for agility, some for strength. Some of the latter group, no doubt attempting to emulate Samson, push against pillars, seemingly in an attempt to bring the house down. Calories eaten are obviously not going to waist.

Personal exercise programmes were kept in a rack (one machine that was lacking was a proper medieval inquisitional rack) and there was a temptation to surreptitiously upgrade everyone – "Today you run a four minute mile, tomorrow you cycle to the moon."

There was a list of requirements before entry to the sauna "You must not have become pregnant, or have eaten a meal or ingested alcohol within the previous 90 minutes." Sadly the sauna was not classical. There were no blond eyed, blue haired Scandinavian ladies on hand to deliver gentle beatings with birch twigs before rolling you in the

snow. There was a suggestion box but I am not hopeful.

Is fitness training dangerous? Richard Adams, the author of the Hitchhikers Guide to the Galaxy, dropped dead in a Californian Health Club. A study in the New England Journal of Medicine confirmed the paradox of exercise – exercise increases the short-term risk of sudden death particularly in those not accustomed to regular exercise. So don't start suddenly, but if you have started don't stop. The latest news is that an aspirin a day plus half a bottle of whisky reduces the awareness of heart attacks.

So why do people exercise? After 45 minutes or so, in the absence of cardiac arrest, there is a feeling of intense wellbeing. This seems to be the endorphin high similar to the "rush" apparently experienced with intravenous heroin. So what is the difference between exercisers and heroin users? Probably both are addicted, but if the effort that exercisers makes involves some (hopefully not too much) pain, and if we accept "No pain, no gain" then exercisers gain. But heroin is of course an analgesic so for heroin abusers there is no pain and thus no gain.

Incidentally my resting pulse was 58 even when taken by the young nurses in out-patients

13. telephone etiquette: a masterclass
If someone is on the phone and you wish to contribute to the exchange do not speak to them. No one can hold a conversation whilst listening to a third person. Pass them a brief note.
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Hardly any people who say that they will phone you back actually do so. To encourage them find out their name and ensure that they know you know "I'm sorry I did not catch your name." (I imagine this is a perfect way to irritate an ex-wife). Give a deadline. "If I have not heard from you by 4pm can I ring you back? At what number?"

Telephones provide irresistible interruptions. You can be discussing vitally important topics such as the state of the world, patient care, or the latest atrocity in Big Brother and a ringing telephone takes precedence. Why? There is obviously some deep psychological reason. Perhaps some unconscious memory of times long past when church bells demanded that you attend church? Anyway, someone always answers the phone and thus two conversations have to take place simultaneously but it is psychologically impossible for two people to talk simultaneously for longer than a few seconds. The person answering the phone should cup his or her hand over the phone mouthpiece so that they can talk inaudibly and allow the pre-existing conversation to proceed without interruption. The corollary to the impossibility of simultaneous conversation is that, when rudely interrupted, keep talking.

On the telephone, as in life, people don't listen when they are talking (we only have one mouth but two ears, presumably in an attempt to rectify this). Accordingly do not interrupt until the caller has finished their account. But sometimes you have to interrupt. Never interrupt when someone is in mid-sentence. This is very rude. Interrupt when they are taking a breath, usually at the end of a sentence. This is less rude. To avoid interruptions some politicians take breaths mid-sentence. Mrs Thatcher did this a lot.

There is an art to terminating phone calls from irritating callers (there seem to be more as I get older) who phone up with trivia (the definition of trivia has expanded as I get older). A direct or indirect suggestion that you are in the middle of something more important either seems rude or doesn't work. The answer is simple – cut yourself off! Do this when you are talking. Never do it at the end of one of your sentences (this is too obvious). Cut yourself off mid-sentence. And then make yourself unavailable to take attempted reconnection that, strangely enough, occurs less often than you might anticipate. The master technique when such a phone call interrupts your discussion with colleagues is to discretely cut yourself off and continue talking - "I can understand why you might think this but in fact you are a blithering idiot whose opinions are not worth listening to and I think you ought to jump off the Forth Road Bridge. Look to the left as you go, the views better." Put the handset down and enjoy the electrifying effect on

your colleagues whose mouths will be hanging open (Yes, it is true people who are gob smacked do let their mouths hang open). It is only fair to then tell them you had cut yourself off.

Abusive telephone calls threatening official complaints (my classic was a drug user enraged that I would not provide extra methadone which his "dog had drunk") can be neatly misdirected to waste their time by inventing a euphonious non-existent organization, such as the Senior British Physicians Trust, and stating "You can report me to anyone you like as long as you don't report me to the Senior British Physicians Trust."

14. Appendicectomy!
(Published in Edinburgh Medicine October 1986)
I would like to report on a personal loss, that of my appendix.

I am accustomed to taking showers and so a bubble bath purloined from my wife is a welcome change. Whilst metaphorically contemplating my umbilicus, my eyes drifted downwards through the bubbles and my gaze fell inevitably upon a distinctly unattractive part of my anatomy, a veritable blot on my escutcheon. I refer, of course to my appendicectomy scar.

Although my appendicitis occurred many years ago whilst I was a first year pre-clinical medical student at a Center of Excellence outwith Edinburgh (yes, they do exist!), it, like most once in a lifetime experiences, is still vividly recalled. Whilst I cannot comment on the actual extraction of the offending organ — in those days an anaesthetist had to be used to ensure my absent mindedness I feel my experiences worthy of description.

First symptoms were classical: a drive in the country disturbed by vague fever and diffuse bellyache (a symptom not described as such in most standard texts), latterly with focalization to the right lower quadrant.

As a pre-clinical student my thoughts then reflected what I have subsequently found to be true: the detailed biochemistry that I had been taught by academic enthusiasts bore little relevance to clinical diagnosis. Anatomy and physiology gave me the diagnosis (surely the biochemistry that most clinical doctors need to know should be encompassed by physiology and hardly needs teaching as a separate subject). In the absence of a twisted ovarian cyst or purulent vaginal discharge I had appendicitis. To my loss this diagnosis was correct.

After tea and cake (the pre-clinical and clinical courses were not then integrated) my general practitioner was called to prod my abdomen and perform what at the time seemed to be an eternal rather than internal examination. A brief murmuring to concerned parents in the next room, and then a trip to hospital.

A right sided limp from trolley to bed. A surgical consultation, another inner probing and my diagnosis was confirmed, although no one had actually asked my opinion. A time was set and the surgeon departed, no doubt for tea and cake.

A nurse arrived and approached me dispassionately wielding a razor like a well-practiced Rabbi and proceeded to shave the area concerned, but also included a certain contiguous area where I had felt no symptoms and upon which I had not envisaged surgical attack!

The anaesthetist had red wavy hair or the premed had been mighty strong. Despite my attempts to prove that mind could combat anaesthetic matter, my consciousness was dissolved by what I was later disconcerted to learn was a fat soluble compound.

I awoke knowing my body had been visited and violated; physically there was a diffuse inner pain and malaise such

that I could only await the passage of time which I knew would be the ultimate healer. I was aware enough to grope downwards to confirm that the nurse's shaving preparation had indeed been over extensive.

Pain crescendoed and the first injection of a colourless liquid, probably also fat soluble, was appropriately injected into my buttock. I noted that the
injection seemed painless in comparison to the pain in my abdomen, and thereby realized my first clinical truth that patients who wince whilst having an intramuscular injection probably do not have sufficient pain to require an analgesic by that route, and much more importantly, patients who do not wince have sufficient pain that they should have received adequate analgesia prophylactically. There is no doubt that PRN (Painful Rump Needling) analgesia is analgesia given too late.

Soon after my return to the land of the suffering I (quite correctly) was made to sit out of bed despite my gut feeling that I would be better left to thrombose or die peacefully from pneumonia.

Despite a satisfactory fluid balance the bowels remained obstinate, and, despite Sigmund Freud's claims concerning the subconscious joys to be found in retaining one's primordial possessions, action was plainly required. A suppository was administered to monumental effect, unfortunately just before visiting time. Perhaps an enlightened drug company will develop a perfumed preparation for use in such circumstances?

Towards the end of my stay a pleasant staff nurse confided to me that I had been delirious after return from theatre and had been thrashing about whilst delivering a soliloquy containing obscenities. My conscience (and hopefully my exposed subconscious mind) was sorely troubled by this knowledge, and to this day I do not know whether I should have formally apologized for this behavior, especially as a crusty night sister had to be called to help hold me down until a sedative could be administered and I had apparently told her that it was seduction and not sedation that I required.

Recovery progressed uneventfully and I returned home about one week later, only to produce a sharp fever. The surgeon came out on a domiciliary visit
(known to those in the trade as a DV) but when experienced from the left lateral position a D.V. appeared to be a euphemism for direct violation of my rectum's right to decline a rectal examination. I recovered from the fever and violation.

After complete recovery at any rate conscious recovery as many unconscious no doubt still suffers - I could honestly say that I benefited from the
experience.

Being medical I was given my appendix in a formalin pot which for a very brief time (due to my future wife's disgust) graced my flat in a prominent position as a conversation piece. My wife-to-be was not impressed with this and neither was she impressed by my suggestion that she ought to have been grateful that the surgeon hadn't followed the shaving nurse's implied advice and, as an encore, given me a sexchange operation. Now that would have provided the ultimate in conversation pieces.

15. Vasectomy
Edinburgh medicine April 1986 written under pseuonym of Dr TN Berries
When writing an article about mutilation of my apogee of amatory apparatus I would not wish to shock sensitive souls so I will use a County Durham euphemism I learnt whilst I was doing a GP locum. A young housewife complained that "her husband's twig 'n' berries were not working". Noting her horrified reaction to my suggestion that pouring on cold tea had helped my plants I soon realized the true nature of her problems. I can think of no better

euphemism than twig 'n' berries.

My wife and I were both certain that we would not want any more children no matter what circumstances appertained and thus some form of contraception was indicated: after contributing to the world population and becoming older and more irritable, it seemed the sensible thing to do. Another reason, left unsaid at the time, was that my wife had told me many years ago that she "would bring me up with the children". She has failed so far and I did not want to give her further ammunition with which to try.

We therefore considered the available options and their efficacy. I wondered what exactly was meant in contraceptive terms by "X per cent effective". My wife, who knows about these things, provided clarification. For a form of contraception to be 99 per cent effective means that, of 100 sexually active women using that method, one will fall pregnant each year. (I wish to state that I am "just good friends" with the other 99.) Celibacy has a guaranteed 100 per cent success rate, but is quite literally only for non-starters. The combined pill is almost 100 per cent effective but perhaps would be best reserved for younger patients.

The "minipill" is 98 per cent effective but there were relative contra indications. The diaphragm or cap + spermicide are 97 per cent effective but is messy and inhibiting to my mind. Some find the safe period 85-93 per cent effective but this method is temporarily inhibiting. Male and female sterilization are both almost 100 per cent effective but the male operation seems preferable. Given the traumas my wife had been through producing children I thought it was my turn to volunteer.

A major problem was the children. What should we tell them about my forth-coming vasectomy? If we told them the truth I shudder to think what version would circulate around school after it had been relayed several times! In the end we didn't go into details on the grounds that if I go into the garden to deal with the horticultural twigs 'n' berries I do not bother them with the details.

On the morning of the operation I shaved the berries as instructed. This is more difficult than it sounds: a preliminary coup de grass so to speak.

The momentous decision to have a vasectomy is akin to the equally momentous decision to get married and, by illogical extrapolation; I somehow expected a somewhat similar ritual to be enacted at the time of the operation. As I walked into the operating theatre I thought I was not going to be disappointed.

The high priest was there fully gowned with all the pomp and splendour associated with this particular kind of theatrical performance. But no incantations. No "dearly beloved we are gathered together in the sight of Theatre Sister Bloggs and Porter Jones to witness the sundering apart of the togetherness of the vasa deferens of this miserable mortal who presents himself today". Rather "Good Morning. Jump up. Bit of cold antiseptic (Oooh!). Spot of local (Aarghh!). Jolly good! Knife please."

I was quite expecting a brief period to recover my composure whilst the local took effect but to my horror the berries were attacked straight away! But before I could protest that local dental anaesthetics take several minutes to take effect the incision had been painlessly accomplished: I now realize that the two situations are very different, both anatomically and emotionally. Lignocaine diffuses rapidly round the periberricular tissues and their skin, taking effect almost instantaneously.

Throughout the twenty minutes of the operation analgesia was (thank heaven and thank you for your interest) complete and one needed distraction which was partially provided by discussion of various medical topics with the surgeon.

The operation was over before I realized. A handshake for the surgeon and off I went. It is strange that I was not aware of exactly what was being done as the operation proceeded, but whilst confessing this ignorance I would have turned down the offer of a mirror: no video nasties for me thank you.

The whole procedure was surprisingly discomfort free, even after the local anaesthetic had worn off. I could even laugh at the Two Ronnies but the Horse Show at Olympia was too much to watch impassively. Apart from the local tenderness, which was more severe and persisted for longer than the conventional advice had suggested, the most discomfort was at day five when there was a severe irritation as the absorbable stitches dropped out. Other problems arose: expansive gestures with the outstretched hand being followed by an (almost) irresistible desire to clutch the relevant parts!

How long is one, so to speak, hors de combat? About two weeks give or take
a night or two.

One of the unexpected benefits of a vasectomy was the recommendation of several daily hot baths which has led to my rediscovery of the joys of lazing in a hot bath whilst listening to Brahms. It must be Brahms: his music, like hot baths, is full of warmth, and is both supporting and relaxing. Bartok would be like a cold bath, whilst Ravel's Bolero could evoke physiological responses not in keeping with the immediate post-vasectomy state!

A word of advice, if you are a Scotsman and wear a kilt do not, under any circumstances, have a vasectomy in the wintertime. When Bertrand Russell described cold as being "scrotum-tightening" he was describing a physiological reflex of great post-vasectomy relevance.

There are several other features to a vasectomy of general interest but to ensure a crop failure from the berries at the three month test it is advisable to test the functional integrity of the twig (although not the berries) as often as is reasonable, so if you will excuse me…

17. Early morning call

I was not pleased when my bedside phone rang at three in the morning. A new casualty officer was foreign and anxious to please. "Good evening, I hope you slept well" – that boosted my adrenaline no end – I have five patients for you to see. A road traffic accident I think. A lamp post has crashed with a minicar. Could you come quickly to advise?

This request did not meet with my usual enthusiasm but I raced down to casualty wondering how five people had managed to fit themselves into a minicar, whatever that was. I found three portly Middle Eastern gentlemen and two, disproportionately young, women all needing urgent attention. Several colleagues and I assessed the situation and I dealt with the man who seemed to be the most injured. He had pallor and cyanosis (a very worrying combination). The major possibilities were that he might have a pneumothorax (burst lung) or massive internal haemorrhage possibly from a ruptured spleen. The situation looked desperate. He must have thought so too because he made it obvious that he wanted to say something to me. I moved my ear closer to his mouth so I could hear what I was sure would be his last whispered message to his loved ones. "Don't, don't" he gasped "Don't tell my wife."

17. Clap trap

The art of confrontation negotiation at its most sophisticated is to accede to all your adversaries demands and then to convince them they do not want what you offer. I came across a perfect example of this art form.

A colleague, a community medicine specialist working many miles from Edinburgh, was called to an emergency

meeting at a power station called by local unions after it had been revealed that one of the workforce had developed Legionnaires Disease, and the Union had (correctly) gathered that others of their members might have been infected.

As my colleague arrived he could hear a union spokesman on the other side of a smoke filled room demand that the whole site be sterilized. After an explanation the spokesman grudgingly conceded that this was not required, this was just as well because it would have been impossible. His climb down made him make his next request much more forceful. "We demand that the Union be informed of the names and diagnoses of each one of our members seen at hospital in the last month."

My colleague realized that releasing such information would be outrageous and in total breach of patient confidentiality. Nevertheless, being a realist and not wanting to precipitate a confrontation, he chose to capitulate.

This unexpected total victory gained the complete confidence of the assembled workforce and the spokesman complemented my colleague for his sensible cooperation with their demands. However their demands were abruptly withdrawn without the need for any ballot after my colleague announced "I'll start by getting the names and diagnoses from the local Sexually Transmitted Disease clinics."

18. The Irish problem

It was obvious, to me at least, that I was good at communicating with patients. I had been a consultant for 29 years and my peers had thought fit to appoint me to organize communications skills teaching for the third year medical students.

My only problem was that I was not skilled at getting the recording apparatus to work to video students conducting interviews with simulated patients (but then neither were the students – operation of such devices is a skill limited to teenagers).

My vainglorious self-assessment was diminished when I experienced what must be a unique distinction of being the subject of a complaint by a simulated patient who had been asked to portray a rather taciturn lady from whom the history had to be drawn out.

Immediately after the interview had concluded (we had not succeeded in recording it on video), I was discussing with the student the various gambits to help deal with this situation and remarked " Some patients seem strangely reluctant to volunteer their story and have to be assisted by providing menus of symptoms that they may have had."

The simulated patient, whom I thought had captured brilliantly a taciturn dour lady, had regarded herself as portraying her real self!

My self-opinion was lowered further when I had to break bad news to a jaundiced Irishman with a grossly abnormal liver who had been admitted because of an intensive episode of propping up a bar while seemingly requiring to be propped up himself by the number of empties he had accumulated.

It is conventional communication skills teaching that it is best to help patients realize and address their own problems rather than the doctor adopting a judgmental magisterial approach.

Accordingly I assisted the patient "We both know that the Irish have a reputation for what could be best termed certain overindulgences and we all know that too much of a good thing can be very harmful, as it has been in your case, and it is essential that you reduce your intake to zero and keep it there."

He said he very much appreciated my approach and that he would address “His Irish Problem” forthwith.

I was pleased with the outcome of this considerate, yet forceful and effective way in which I had communicated with him. I had done a good job. Oh Yes.

This self-congratulation persisted until I was halfway out of the room, when his concluding remark was “Thank you for that doctor. You can rely on me. I will never touch a potato again.”

19. Clinicians in management?

Some clinicians accept management roles and budgets (those without budgets are administrators). Those who have successfully combined clinical and management roles are an atypical breed, often doing the equivalent of two jobs. Inevitably they are highly energetic and highly admired workaholics who gain power and enhanced self-importance. It may be counterproductive and demoralizing to expect the majority of typical clinicians to emulate this minority. It may also be dangerous because clinicians and managers should have contrasting roles. Clinicians should try their best for each of their patients whereas managers have to deliver the greatest good for groups of people. It should be managers (ultimately the government) and not clinicians who should tell the public “In the financial circumstances we cannot afford treatment X.” The recognition of the conflicting but equally legitimate roles of clinicians and managers would help the public, who pay for the NHS, to decide priorities at the ballet box. Conflicting stances can be overt and constructive (iv): indeed acceptance of opposition is at the heart of democracy. As ever the system in fact works by multiple fudges.

Clinicians who also manage are treading a dangerous path and may become more familiar with spreadsheets than bed sheets. I quote the Health Service Journal. “You stick the buggers in clinical directorates, teach them how to count, and tell them to make cuts.” The journal commented that this viewpoint was probably the norm among managers rather than the aberration of a single macho type (v). The NHS gives people health care free at the point of need and inevitably there will be escalating demands with escalating costs. Enoch Powell, when Minister for Health, realized that this would occur and concluded that the only way of limiting expenditure was by having waiting lists which, paradoxically, we are told to shorten. Clinicians will inevitably tend to overspend. Let me put this more strongly. Clinicians should attempt to get maximum funding for their patients, as well as being maximally efficient etc. Managers will transfer responsibility for overspends by giving clinicians the poisoned chalice of budgets. Keeping within budgets often demands “efficiency savings” which are the euphemism for cuts in service that some clinicians in management deliver rather than rocking the boat.

20. Private finance: pay as you go downhill?

The Private Finance Initiative instructed that Trusts were obliged to consider whether private funding were better value than traditional (government) funding routes. If private management can finance health care building and make profits why cannot governments do the same and use the profits to enhance patient care?

Governments always claim the NHS should have taken action earlier to avoid overspendings “as would occur in any other business organization” thereby failing to make the crucial realization - overspent budgets in business are acceptable if monetary profits result. In a national health service only patients should profit. In the event cost containment efforts have usually adversely affected quality of health care provision and competition of the market does not contain costs (vi).

I speak from NHS premises and opine that a national health service should not be allowed to wax and wane under market forces and that clinicians with budgets are a Bad Idea.

21. Think about skepticism

Skepticism is an essential attribute in medical practice. Skepticism involves doubt which involves asking questions and making up your own mind when presented with possible answers. We are all fallible (an eminent neurologist informed me he had 12 cranial nerves, an opinion with which I half-heartedly agreed (we have 24). Sadly, some doctors regard themselves as Fountains of Wisdom and often have a manner that discourages questions by projecting an unspoken "Has anyone any foolish questions to ask after my masterly exposition?" Anyone confronted by such a doctor should destroy such silent accusations by a pre-emptive confession by enquiring "Can I ask an idiot question?" followed by the question. It is amazing how often those who should answer idiot questions dry up.

22. Moralizing medicine.
The most common example is our precipitation of alcohol withdrawal syndrome by withholding alcohol when alcohol dependent patients are admitted. The ideal drug to prevent alcohol withdrawal syndrome should offer a predictable response, abolish withdrawal symptoms without affecting conscious level, have a predictable patient response, have a predictable half-life, have a wide safety margin, have easily measured blood levels, allow administration by several routes, be cheap, and have effects appreciated by patients. I have asked the idiot question "Why not give alcohol?"and have only received idiot replies.

23. Inconceivable units or measurement.
We now measure blood levels, particularly of hormones, in inconceivably small units. Who can visualize a nanogram of anything? We need help. I recall a WHO Guideline for the developing world which referred to cupfuls per bucket. Now that I can visualize.

24. Difficulties in integrating molecular with clinical medicine.
Biochemists, as is their job, focus on molecules, but I sometimes wonder if they are making it up. Did anyone actually see Hans Krebs peddling along the Embden-Mayerhof pathway on his citric acid cycle? Molecular medicine is now increasingly like magic. Only wizards can understand it.

26. Meaningless sentiments.
We read at the hospital gates "Hospital X welcomes you." But at the same time managers tell us we should be formulating discharge plans. Full marks for technological patient management but low marks for understanding the emotional motivations of those who provide care to individual patients.

29. Therapeutic pain.
I asked a member of my health club why he exercised to the point of pain and he replied "No pain, no gain. At the end I feel refreshed and totally alert." Why not develop a user-controlled painful stimulus pad that could be applied, say, to a leg? People could make themselves refreshed and alert. Especially useful during postprandial committee meetings.

29. Some recommendations.
Get a non-medical life! Meet "normal people"when you are not "in charge." I am fortunate in that I have had a non-medical social activity (playing in orchestras) that will continue to ensure humility. Consultants are rarely criticized and thus humility is not encouraged (being criticized by one's spouse does not count). Occasional comments by conductors along the lines that "Not even Stravinsky could have conceived that rhythm" after I rendered a waltz in 4:4 time ensured that I was continually kept humble. Equally a comment "That was truly amazing" promotes introspection and self-assessment. Was it amazingly good or amazingly bad?

30. Some surprising information
Three things. Firstly, if anyone tells you anything that surprises you the most sensible response (which conceals your surprise, defers the need to comment, and enhances your reputation as a perceptive individual) is to reply "I am not

surprised at all" and change the subject. Secondly, if you have to ask a question that might upset or provoke a violent reaction you can minimize these by asking the patient's permission "Could I ask an awkward/embarrassing question? Thirdly, when things go wrong, as they occasionally do, it does no harm at all so say that you are sorry. Expressing sorrow is not an apology and does not imply guilt.

31. Clinicians and managers

The public should be aware of the contrasting roles of clinicians and managers (ultimately the government). The NHS is under threat. Some say the NHS should not be a political "football" but it (like education, defense, and maintenance of law and order) are the four major footballs that politicians are elected to kick around. Bevan bludgeoned doctors into the NHS against their will. He would be depressed by our half-hearted defense of the NHS. When politicians push our backs to the wall and insist on cuts in service for financial reasons we should turn round and fight. Observe what has happened to the NHS dental services if you need help to imagine a future business-like NHS.

Although retired the future of the NHS will affect me. I may be a patient in future. You should all work hard, get well paid, and pay taxes. Paying your taxes will help pay my pension, will keep me in the manner I would like to become accustomed. Who could wish for more?

32. Punitive medicine a new specialty?

We all have wished that certain patients could be assisted to see the error of their ways (as judged by us, given our infinite wisdom). Examples of such patients include those who are spontaneously rude, are violent, couldn't be bothered to take malarial prophylaxis and then present with malaria, swim in African Lakes when they know that they are at risk of Schistosomiasis (better be careful about this - medical students do this too), or continue to drink or smoke after receiving a transplant because of alcohol or smoking damaged organs.

It could be said that doctors should accept patients as they are and not attempt the positive actions required for punitive medicine. But this is a council of despair. Such patients cost the NHS. So what then is to be done to provide metaphorical pedal *vis a tergo*? A Society for the Promotion of Punitive Medicine should be created with a few dedicated doctors to found a committee, to appoint officials, and to seek members. This will be followed by the traditional sequence of issuing guidelines, consensus statements, launching of a journal, requests for the journal to be included in Index Medicus, acceptance of the subspeciality by the Royal Colleges, occupation of sumptuous premises and finally a breakaway movement with suggestions of even a Royal Charter. There are dangers to be faced. A doctor's job is to do the best he can for individual patients and therefore it would be essential that all punitive medical procedures are approved by our political masters. For individual doctors to even think about making such decisions independently are a first step down the road that leads to fascism and/or Shipman.

The Punitive Medicine specialty will require close supervision. Trials will have to be performed (nocebo controlled of course). Audit will be required with the mark of success being the number of unjustified complaints not received from those undergoing punitive medical procedures.

Obviously some steatopygious (look it up) readers with no sense of humour will take the above seriously. If they could write and give their home telephone number I would be prepared, in the spirit of punitive medicine, to phone them appropriately to discuss their immediate complaints of interrupted sleep.

33. Criminal tendencies

Once the HIV problem in Edinburgh had been identified I, as a Consultant in Infectious Diseases, had to deal with intravenous drug abusers (IVDAs), the most numerous group infected in Edinburgh at the time, and gay men. I became aware that there were covert subgroups within society that mainstream society was largely unaware. The

IVDAs usually came from multiply disadvantaged backgrounds and often both genes and environment had conspired against them. Sadly lying is often part of the pathology of drug abuse, and I learnt that drug abusers were totally sincere when they stated their future intentions, the problem being that they were equally sincere when they changed their minds. Some IVDAs were intelligent "The best way to get heroin into prison is to use a dead pigeon (don't ask), pack it full of heroin, and catapult it over the prison wall, having arranged for a public----spirited inmate friend to keep the exercise yard clean – in the interests of keeping the prison environment pleasant. Others were less intelligent. One was arrested whilst robbing people at a Cash point. Superficially quite an intelligent move? No, he was robbing those who were waiting to use the Cash Point. Another IVDA of less than normal intelligence had appeared before the Court after stealing a lorry load of apples. When asked why, he threw himself onto the possibly charitably minded members of the Court "I was 'ungrey yer 'onour." He, as they say, got sent down - the apples concerned were cooking apples. I was also told a story, possibly apocryphal, of a prisoner who had complained that his prison food had contained a hacksaw blade.

34. A patient complains

A home visit as a locum General Practitioner prompted me to write a compliant as if it were emanating from a particular patient who had asked me to unblock the toilet whilst I was there.

I write to protest concernin' industrial action to which I have recently been subjected.

Fer years now we have had a regular visitation from our GP, 'bout once a month when pills run out or are eaten by the cat (wot fractured his tail on the catflap after eatin' Dad's high hope hormone tablets). It used to be easy for us to get the doc in. All we did was to phone surgery when Dad got back from the pub, and explains a problem.

Usually I suggested that the doc comes now at this instant but after discussion he agrees mostly to come on the morning, a decision that is always to Dad's mutual satisfaction. Come next day, we get the family together, attempting to get Dad up and outa bed which always makes 'im look suitable unwell, switch on the telly and wait. Usually the whole family gets a lookover cos of Dad being unwell. We owe this to Mum, who turns the charm on and ain't half pervasive when she has a mind to "And whilst your'e 'ere doctor…"

But now this time-honoured ritual has been perverted to abuse. It all started when the doc came in with oil on his hands and grime on his fingers. I ask you. Blood OK, Sweat OK. Vomit perhaps. But oil and grime! Dad took umbrage and asked why it were so. The reply were shocking.

"Home maintenance evening course, I'm afraid. I can't afford to hire tradesmen these days because of the present price of labour."

Dad were right 'umbled and said me brother Tony would've helped out but he'd broken his foot whilst out shootin' grouse, and me other brother were out on picket duty – he bein' a car gearbox worker now puttin' a cog in the works to maintain the differentials and 'at. And again he couldn't be a scab for the doc, could he now?

Anyroad, same again on the next visits after. "Car maintenance course" next time "Home plumbing course" and so it went on.

About six call since this situation, up drives the doc for his regular session, but he comes in a van, big and blue it were, with a great brass plate t' side "Hire-a-doc. ALL systems repaired." Up he went to see Dad, then Mum gets 'im to see the kids and to give our Gert a supply of little torpedoes for summat and then, with a twinkle in his eyes, the doc he says "Oh, and whilst I'm here, the colour television needs tuning, the lavatory ballcock is not descending into the cistern and from the sound of it your car ignition is not firing on at least one of the eight cylinders."

Cheek, I thought, but afore I knew whot he were about, the black bag was out, the 'ospital rubber gloves were on an' he'd set to. No complaints 'ere, he were a hard worker, did jobs well. That were Tuesday. Cum Thursday a bill arrives.

"I have much pleasure in presenting my account" (you betcha bleeding life he did).

Car service, parts and labour £97
Callout fee for home visit £35 Television adjustment, plus labour £42 Repositioning of ballcock £37 Home visit. Medical attention. No fee permissible Bloody nerve. An' that's why I writing to protest. The prices are too much even for a professional guy like the doc to charge. The price of 'is labour is summat awful, especially for adjustin' the undescended lavatory ballcock. When our Paul had a similar trouble in the personal private way he goes to 'ospital and it were put back in place free, not strings attached like. Me, I don't want no General Medical Cowboys round 'ere no more.

35. A pickpocket's guide to the NHS
Whilst working in London I became aware of several of patients who had come to the Britain specifically to obtain free medical care. I wrote this piece, which was published in World Medicine, a wonderful but now defunct publication. This attracted a lot of attention and one MP was encouraged to ask questions in parliament.

The sole requirement to exploit the NHS is the price of an airline ticket to Britain and the knowledge of a few basic rules.

Rule 1. If you can pay the airfare to Britain and if you are fit enough to climb the plane steps you are fit to travel. Do not be deterred by the possibility that you have an infectious disease constituting a risk to your fellow traveler. Altruism can be fatal.

Rule 2. On arrival at a British airport present yourself as an emergency illness requiring attention. Use statements like "started to feel unwell during the flight" or vomited blood during the flight" or jaundiced am I doc? Gettaway" or "Felt faint and had black motions. Huge knobbly liver have I doc? Must have been the in-flight drinks." So–called emergency symptoms likely to ensure prompt admission to hospital include diarrhoea (mention a friend who has cholera), or haemoptysis (put some blood from a cut into your handkerchief in preparation). An ability to collapse for several hours is a useful attribute and, in enhanced by chest pain and shortness of breath, guarantees hospital admission. At all cost be too ill to answer questions from anyone save a doctor: an administrator might question your entitlement to free treatment if the doctor decided you were not an emergency. Over-reliance on Rule 2 raises a slight risk of repatriation. Rule three is safer.

Rule 3. Struggle from the airport and present yourself at an NHS hospital casualty department. With luck you will be seen by an over busy doctor who will not question your entitlement to NHS care. If he does question it he or she probably won't know what action to take. If he does know what action to take he or she probably won't take it anyway because it would take up too much time. I have and it does.

If, as occasionally happens, you see a British Casualty Officer it is unwise to tell him that you came to Britain specifically for medical care: misguided patriotism and a feeling of National exploitation may override his sense of humanity and natural justice.

Teaching hospitals are recommended because their enthusiasm for potentially unusual imported diseases will ensure admission "A possible case report here." In this connection if you have a fever and have just returned from West

Africa mention Lassa fever and no one will think to question your speedy placement away from the casualty department.

A warning. Avoid hospitals with private patient beds. An interfering administrator may insist that you be treated as a private patient and you might have to foot the bill. If however you are in an NHS bed, and if private placement is not feasible for any reason, you cannot be charged. Enlightened socialism is removing beds from the NHS hospitals and you future free treatment "as of right" will thus be less at risk.

The next rule applies to patients with serous non-emergency conditions that would prove expensive if treated privately.

Rule 4. Obtain a British address, a British GP, and his referral letter. Fly to Britain on your visitor's visa to see relations or friends. You have a British address. Ask them to arrange for you to see their GP. Although you are a temporary resident, he will probably refer you to for an outpatient appointment or for admission. As you now have a British address and a British GP it is unlikely that anyone at the hospital will question your entitlement to NHS treatment. Come to think of it, how many patients are questioned about this routinely? You may even profit from Rule 4. I have looked after non-entitled patients receiving NHS care who were also claiming the expense of their illness from insurance companies abroad.

Rule 5. Avoid central London hospitals. Many of these hospitals are aware of what could be described as "overuse of NHS resources." The administrative staff of provincial hospitals are less likely to question your entitlement.

Rule 6. Become unfit to travel while in Britain. This rule is of potential use to those with sick relatives whose condition is deteriorating and who require better and/of cheaper treatment than may be available locally. Fly the patient ostensibly for private treatment (it is truly amazing what pathologies certain airlines will transport). Arrange for admission to a small private nursing home and arrange for a private consultation by a consultant who has NHS beds. If your timing and estimate of disease progression is good, and the consultant does not feel he can take the responsibility (which you have lumbered him with) of repatriating the patient at the patient's expense, or at the expense of the patient's embassy (he 'as no number, wee do not know of heem, wee are soree but cannot 'elp)) and no one is available to provide 24 hour cover at the nursing home, what can the consultant do? (Your thinking is faster than my writing). Admit under the NHS.

Other less clear-cut abuses occur. A rich man comes to Britain for treatment of his terminal condition. With private care his condition is palliated and deterioration is slow. Private care has a defined cost and riches are relative. The patient becomes pre-terminal (therefore an emergency) and bankrupt and cannot stay in private facilities that, after all, are not charities. What happens? Is there any charitable organization that can spring to the rescue? No prizes for the solution.

I have seen each of these six rules in action. I hope that by delineating them I can encourage administrators to pay more attention to this NHS abuse.

I wrote a parable to go along with this:
A man fell ill in a far off land and local medical care was dubious. Symptoms failed to respond to self-medication with local panaceas. The illness progressed. A passing doctor thought the patient not worth his attention. A passable doctor examined him, but found little money and no credit card and after a brief course of psychotherapy "Good luck" departed for his private clinic. A third doctor, a Good Samarian, observed the man's distress and noted the potential expense of the condition. He raised his eyes to the sky as if in search of assistance, and saw an aeroplane. He advised the patient "Spend what money thou hast to gain a seat within a silver bird, and take thyself off to Britain,

wherein there are many institutes of healing and the good people of that land will succor and cure you and demand naught in exchange.

36. Are you competent?
"The trouble with the world is that the stupid are cocksure and the intelligent are full of doubt." Bertrand Russell.

Most of us have had the experience of having to deal with people who seem intelligent but prove to be disproportionately stupid. Such people are much more difficult to communicate with than those who have lower intelligence and are proportionately stupid. This disproportionality has been studied by psychologist and is known as the Dunning Kruger effect which describes, rather obviously once it is pointed out, that those who are incompetent often lack the competence to realize that they are incompetent (Dunning and Kruger received an Ig Nobel prize for their paper "Unskilled and unaware of it. How difficulties in recognizing one's incompetence leads to inflated self-assessment. Journal of Personality and Social Psychology 1999:77;1121-1134). One evidence for this is that over 50 per cent of people think they are above average. Additionally, people competent at low levels can, justifiably, be promoted until they reach a level at which they are incompetent (Parkinson's second law).

How can one recognize those affected? I find that those affected try to dominate discussions, by talking a little bit louder than is required in the circumstances and tend to make statements that they seem to think require no justification. My experience is that grossly overweight women in their twenties who have this syndrome are irritating to the extreme. I suspect most women will report that they experience thin over intense men with beards their twenties to be similarly irritating. My cure for the former is lighten up, both mentally and physically to enhance their chance of getting laid and for the latter is to get a sense of humour to enhance their chances for the same reason.

One other supporting observation from a GP colleague is that patients who start consultations by declaring "I'm not stupid" usually are. My addition to this insight is that patients who start by saying "I hope I'm not being stupid but…" usually are far from stupid. They have the insight to realize that, medically speaking, they might be naive.

A problem for those with insight is that they are often reluctant to ask questions that might reveal their lack of understanding or ignorance. Some teachers enhance this fear by turning back questioning in a patronizing fashion on the questioner in an attempt to drag the answer (that the questioner does not know) out of them. I recommend a technique used by an assistant general manager at the Lothian Health Board. He used to pre-empt all suggestions that he was stupid or ignorant by a full frontal confession prefacing some simple questions. "Please could I ask an idiot question?" Over half of such questions he asked never received a competent reply.

Some examples of idiot questions. I have asked blood transfusion service doctors "How long does it take for stored blood to start carrying oxygen after it is transfused?" Obviously the answer will vary with the duration of storage but I have only received general answers "a few hours" or "less than 24 hours."

The result is that the incompetent rate their abilities as above average and the competent rate their abilities below average. The competent incompetently assume that the others have at least similar or perhaps greater competence.

37. My ravishing prose raped by subeditors!
This is based upon an article I wrote for the British Medical Association News Review in response to the subediting that I had experienced. Surprisingly, and to their credit, they published it. I put in two deliberate errors hoping that I would get a response to which I had replies awaiting.

In Greek mythology Procrustes tied his victims to his bed, and cut short their legs if they were too long for it. Today subeditors now perform the literary equivalent on author's writings.

Fowlers' The King's English states that "anyone who wishes to become a good writer should endeavour, before he allows himself to be tempted by the more showy qualities, to be direct, simple, brief, vigorous, and lucid." Unfortunately subeditors seem to concentrate on these latter attributes at the expense of the "showy" qualities that include style.

The scientific style of writing – direct, simple, vigorous, and lucid – is appropriate when communicating facts but lacks the crucial attribute of memorability unless the facts have dramatic impact in themselves. Writing opinions, when the aim is to ensure a memorable impact, requires a more personal and artistic style inevitably requiring more words than are scientifically necessary. Subeditors often fail to differentiate between artistic and scientific styles, reflexly opting for brevity, especially when print space is expensive.

The annihilation of verbosity and prolix pomposity in scientific writing is desirable, but subeditors should not tamper with logically unified and comprehensive flow of opinion or contentious thoughts. Have they no respect for Gestalt Principles – the whole being greater than the sum of the parts – when they are decimating such writing?

When writing original or contentious thoughts in a comprehensive, basically logical, linear progression it often necessary to pause the progression temporarily to explore implications of certain aspects of the argument. Subeditors just love cutting out these important asides leaving the hapless author to reply to numerous correspondents who, after publication, suggest that he hadn't thought through the peripheral implication of his ideas.

Some subeditors are slavishly adherent to outmoded conventions: I am outrageously irritated when my deliberately split infinitives are unthinkingly unsplit: the way in which something is done may be more relevant that what is done, and thus the adverb merits first mention.

It has been said that critics are like eunuchs in a brothel – they know what should be done but don't have the ability to do it themselves. I suggest that some subeditors function like Brothel Madames who know what should be done, have the ability to do it, but instead only supervise. There is however one difference between Brothel Madames and Procrustean subeditors: the former (apparently accept variation of style.

What were the two deliberate errors? As expected some wrote to say that there was only one Fowler. In fact initially the authors were the Fowler brothers. Only one person took the bait and wrote in to say that it should have been Brothel Mesdames instead of Brothel Madames. I was able to respond by conceding his likely greater familiarity with such establishments.

Some notable examples of subediting?
Thomas Gray's Elergy in a Country Churchyard subedited to "Dead but not Forgotten."
William Shakespeare's sonnets returned to author with comment "14 lines is too long, please cut by half."
Bertrand Russell's History of Western Philosophy returned by subeditor asking him to "think again."
Encyclopaedia Britannica returned by subeditor "too long." Index subsequently published.
Hansard script returned to Parliament by subeditor with comment "Don't waste my time with this rubbish."

38. A trip to Libya
I was invited to teach in Libya just after President Reagan had bombed Libya and direct flights from the UK were not available. We had to travel via Frankfurt and the late arrival of a BA flight meant that we only managed to board the air Libya flight at literally the last moment by running half a mile in under two minutes. Sadly out luggage did not travel this fast and it was only available on the day of our return. It was then I discovered that, thanks to Mr Reagan's recent intervention, my American Express Card was of no use. I had no Libyan currency and was only able

to buy small items – swimming trunks had to serve as washable underwear. The teaching was a success and, unlike my colleague, I had taken the obvious sensible precaution of taking all my teaching material with me as cabin luggage. I had booked my seat in the rather old Libyan Airways plane and had specifically requested a no smoking seat and was relieved my seat had been specifically designated as a no smoking seat, but was relieved of my relief by the realization that all other surrounding seats were smoking seats. Landing a Tripoli Airport was a shock. Colonel Gaddafi, no doubt fearing that his airport might be bombed, had positioned rusty wrecks of old planes immediately adjacent to the runway. It was like landing in a scrap yard.

The evenings were hot and humid and after sun fall darkness was profound. I decided that a cold shower was in order and thereafter decided to practice my clarinet in the nude. It seemed a good idea at the time. However I was unaware that my balcony was shared with adjacent rooms. I was half way through the Mozart Concerto when I noticed a seemingly disembodied pair of teeth outside my window. It turned out that the owner of the teeth was a Sudanese who was as "black as night which had concealed the rest of him. To my befuddlement he commented "It is all most wondrous." I never discovered whether it was the whole presentation or just the music to which he was referring.

Colonel Gaddafi' face was on nearly every wall with the sobriquet "Great Man, River Builder." It later turned out that the river was a water pipeline from the interior that provided water for the coastal area. There were free copies of the Colonel's Little Green Book that explained, or to be more accurate, stated his numerous outlooks on life. I was most struck by his revelation that "A woman is like a flower, it is her purpose to be fertilized." Just thought you ought to know.

Even then I thought that he, like most dictators, would be lucky to survive in the medium to long term. The most worrisome dictators are those that take control during a revolution and believe that they are acting for the good of all the people. The problem then arises of what to do about those who oppose their well-meaning initiatives. Well, they have to be persuaded of the error of their ways, if this fails, they have to be suppressed, and if suppression is not working, they have to be removed from the debate. There is a slow progression from persuasion to intimidation, torture and death. Once entering this progression dictators have no choice but to continue because there is no way in which they could retire when there would always be those with a score to settle. So they continue and their tyranny becomes more marked. They cannot groom anyone as their successor because those they groom would then be in the best position to depose them. That is why most dictators need to have a son in waiting – it is unlikely that your son would try to depose you. What can be done? Outside countries will close their physical and financial borders and utilize sanctions which only make the lot of the common man under a dictatorship worse, more likely to revolt, and to require more suppression, all of course in the interest of the people as a whole. Despots have to hang on to the bitter end, using more and more violence to remain. I have only one suggestion – the rest of the world should designate an isolated area- ideally a small island – as a place of early voluntary exile. Dictators would be able to afford to buy security as they all have money stashed away in Swiss bank accounts. It is not justice but at least fewer people would die.

Revolutionaries who take power on behalf of the people almost routinely find that the people don't wish their insights and to keep power, selflessly you understand, on behalf of the people they almost inevitably end up being tyrants. There is a slow decline into tyranny. Starting out with gentle suppression of those obstructing your innovations, then intimidation, then imprisonment, and finally killing some people "for the benefit of the people." As this stage is approached a tyrant cannot retire to his own country and he will be lucky to find a country willing to take him (even though his Swiss bank account may be overflowing). He has to continue. Worse he cannot trust anyone other than his immediate family, and even this may be risky. Anyone else he grooms for succession might wish to assume power prematurely by deposing the tyrant.

39. Medical fundamentalism?

Few readers will guess the identity of the most famous doctor of the last fifty years. A clue. He was an alternative medicine enthusiast with Marxism-Leninism as his medicine and he had a lot of sugar at his disposal to help this particular medicine go down. A further clue. How many doctors have gazed out from a poster put on walls by literally millions of ill-informed teenagers? The answer is Dr Ernesto "Che" Guevara, a revolutionary freedom fighter, armed insurrectionist, terrorist, and guerrilla, all euphemisms for someone who increased morbidity and mortality, and which are not usually associated with doctors. Those of a curious mind will wonder, quite literally, how a doctor developed a career opposed to such conventional medical aims.

The facts are simple, even if the consequences were complex. Dr Guevara was born on the 14th May 1928 in Argentina. Of a middle class family, he went to medical school in Buenos Aires in 1948, and obtained a medical degree in 1953 when aged 25. During his medical training he managed to travel, read and think and developed a fundamentalist conviction that Marxism/Leninism was the key to existence and that this conviction of his justified any of his means. In particular armed insurrection and guerrilla warfare, which including sacrifices of innocents, was the way forward in pursuit of his revolutionary cause. Dr Guevara arrived in Cuba in 1956 and, along with Fidel Castro, deposed the dictatorial government. They then suppressed counter-revolution using similar strategies as had been used by the deposed dictator, including the abolition of elections – since the people ruled Cuba already there was no need to cast votes.

Dr Guevara had certain convictions which ultimately did not prove helpful to him or, presumably, to those he killed. Whilst convictions help make decisions when there is insufficient information available there are dangers in convictions "a belief of the correctness of untestable theories" because they are not susceptible to scientific investigation, proof or disproof. Dr Guevara, like many humans regarded his convictions as a justification (which minimized his personal responsibility) for taking action against others. Indeed the responsibility for conviction-driven actions can only be shared with those of similar convictions whilst, in contrast, actions taken on scientific evidence should receive general support from everyone, no matter what their convictions). Dr Guevara's conviction was Marxism-Leninism and, being intelligent, he must have realized the fallible nature of convictions in general and apparently developed a specious ploy – defeating capitalism and attaining socialism through armed struggle was tantamount to a scientific discovery!

Later he tried to manage Cuban economy and, finding this less than fulfilling, departed (yet again) to fight someone else's fight for them, first in the Congo and then, in prospect almost suicidally, in Bolivia where in 1967 he was killed, thereby achieving a temporary form of immortality.

Perhaps his self-precipitated premature death was a means of avoiding ontological disillusion associated with a partial insight that his convictions were not shared with those he thought were fellow travelers. He had become disillusioned with bourgeois tendencies in Russian communists and because the Russians had tried to use the Cuban Revolution for their own strategic interests. Finally the communist parties in Latin America he wished to revolutionize did not wish his interventions. According to Dr Guevara "One of the fundamental objectives of Marxism is to remove interest, the factor of individual interest, and gain, from men's psychological motivations." Given his naïve conviction that all humans could be so selfless, he probably was also disillusioned by the failure of pigs to fly.

Dr Guevara was a fundamentalist. Everyone has convictions but some of the convicted are fundamentalist of which there are two types, benign and malignant. Dr Guevara was one of the latter.

Benign fundamentalists are easily recognized. They are usually male, devote themselves to a single issue or activity which dominates all other aspects of their life, view the world through fundamentally restricted inputs and,

inevitably, their interpretations and outputs are similarly restricted. They are driven by their personal agenda, are viewed by others as workaholics or obsessive, tend to socialize almost exclusively with those of similar persuasion, and are often able to rise to high positions because they are less distracted by full worldviews. To those outwith their restricted circles they are often perceived to be boring "Ought to get a life." No doubt you recognize some colleagues.

Malignant fundamentalism is a progression from benign fundamentalism in which there is an additional conviction of the correctness of their restricted views, which they then seek to impose on others. Because others usually do not agree, malignant fundamentalists characteristically surround themselves exclusively with the like- minded, tend to isolate themselves from the displeasing outside world and also want to change the world to fit in with their convictions "their historic duty," (which in practice implies elimination – a word which covers a wide range of potential actions) of any opposition. They often alienate those of similar but moderate views leading to declining support, which encourages them to fight even more violently for their convictions. Frequently they see their convictions as more important than themselves or their close ones. (Dr Guevara voluntarily left four of his children fatherless and an uncertain number of fatherless children of those he helped kill). Sooner or later malignant fundamentalists show signs of wanting to extend their principles outwith their area of knowledge or expertise and justify any means by the ends that they are convinced will occur in future. Dr Guevara, a perfect example of malignant fundamentalism in action believed "the blood of the people is our most sacred treasure but it must be used in order to save the blood of more people in future."

Malignant fundamentalists can be very attractive. They know the answers. Even the intelligent can be deceived. Dr Guevara was "The most complete human being of our age" (Satre) and "We were witnessing happiness that had been attained by violence" (de Beauvoir who, as her name suggests, must have seen violence through fundamentalist rose-tinted spectacles). This account is rather critical and balance is important, so it behoves the author to state Dr Guevara's good points. Dr Guevara showed that dictators with large resources can be deposed by men of strong convictions. Dr Guevara was a dedicated man who was prepared to die for his convictions. But this is not necessarily a good thing and it certainly does not make a conviction true. He believed in violent revolution and showed that this could be effective at a certain time in a certain place. But surely violence as a principle should be as a last resort. World history suggests that the human race has not yet realized that using violence is too easy an option – have you not seen those who espouse peace killing each other – without achieving much? The problem with revolutions is that those who were at the bottom of the wheel come out on top, but the underlying problems remain the same.

Fortunately Dr Guevara was only a minor malignant fundamentalist. Leaders like Hitler (dead score at least 6 million with 125 individuals dying for each word in Mein Kampf) was a malignant fundamentalist who used fascism as his conviction system, Stalin (dead score 22 million) used communism and bin Laden (dead score about 3,000) used Islam. However we were lucky. Dr Guevara's "universal prescription" could have precipitated a world (nuclear) war so that socialism would then triumph over capitalism. There is little doubt that if the Soviet nuclear missiles based in Cuba had been under his control he would have dispatched them. At least that would have achieved the desired equality for most of mankind – who would be equally dead.

What should people do when confronted with what they perceive as injustice which does not yield to non-physical persuasion? The range of options is from Lennon and McCartney "When in times of trouble…. let it be, let it be" to armed insurrection. Medical principles must surely apply. Hippocrates would have suggested "First do no harm." However if there is truly no alternative to violence and individuals take power for themselves "on behalf of the people" (never of course for their personal aggrandizement) they should give it back without delay. This is precisely what the Cuban revolutionaries and other malignant fundamentalists do not do. Why should they – they are the prophets of the New Order.

How are middle of the road, full of doubt, moderate people, whose modest ambition is to leave the world a better

place than they found it, to combat malignant fundamentalist believers who are inaccessible to scientific approaches or to approaches from differing beliefs? Moderates of the conviction system concerned have to do the job. No one else can. Moderates have to identify malignant fundamentalists in their midst, and deal with them. They have to firmly isolate them to the periphery whilst ensuring that they are not totally excluded.

Dr Guevara failed. The way things have turned out he almost certainly did more harm than good. He smelt both after and before death (his personal hygiene was notorious) and he enabled a lot of capitalists to make a profit by selling posters. He was a distinctive, almost unique, individual but by this definition, abnormal. He, like all those who had his picture on their walls, lacked insight. Ultimately education has to be the weapon of choice to achieve insight.

Facts here presented were derived from many sources, but notably Che Guevara. A Revolutionary Life. Anderson JL. Bantam Books. 1997. London. The thoughts about fundamentalism are my own and were evoked by the events of 11th September 2001.

39. Is there an alternative? prove it!
I have no problem with complementary medicine (CM) but alternative medicine (AM) should be judged like any other medicine.

Alternative medicine practitioners should do for their treatments what the rest of us have to do. Prove it – there should be no shortage of money – in the US AM is a $32 billion a year industry. Instead what we have (all from a reputable Sunday newspaper):

“Candida may cause general depression, loss of energy, odd feelings after eating certain foods, and irritability.” Or may not.

“It is estimated that 50 percent of the population have a weakened lymphatic system.” More than 50 percent would seem to be one definition of normal.

“I am travelling to India and do not want to take conventional anti-malaria drugs. Are there alternatives?” Well yes. “Malaria is a potentially fatal disease so consult your GP before dismissing the idea of taking prophylactics. If you still decide to avoid standard anti-malarials then more “natural” alternatives include vitamin B12 tablets and garlic capsules.” They may be “natural,” but alternatives they aint.

“Did you know that 90% of your bodies energy is created by oxygen?….aerobic oxygen (£17 a bottle) is a liquid supplement that you add to water which, the manufacturer claims, increases the oxygen content of a glass of water by 400%.” In most people the oxygen saturation of haemoglobin is 98% and an extra 2 % saturation would achieve, well, not a lot.

“I have terrible cellulite on my legs and bottom. Are there any alternative treatments?” Apparently skin brushing works by boosting the lymphatic system.

Are we for evidence-based medicine or not? If not, how much do we go along with AM practitioners and how much should we let it cost the NHS? My NHS Trust had allowed a complementary Therapy Open Day with aromatherapy, stalls (not finger stalls I hope), Reiki massage, Shiatsu, reflexology, spiritual healing, crystal healing and Indian Head Massage. I kid you not. At least we were not treated to an exhibition of colonic irrigation which, to my mind is the ideal treatment for taurofaecalosis.

Is it good enough to put forward suggestions defined as "Alternative" and, at the end of the piece, to put "Before following any medical or dietary advice in this column, please consult your GP if you suffer from any health problems or special conditions, or are in doubt as to its suitability." An example of this art form. "My two-year old grandson has just spent his second three-night stay in hospital with a severe asthma attack. He now has an inhaler. Are there alternative treatments you can recommend?" Well yes. "A natural remedy called Oralmat, containing ryegrass has been shown to help sufferers reduce the number and severity of attacks." Pity the two year old can't read the instruction about seeing his GP.

I can provide a similar form of alternative advice "If you are feeling depressed you could jump off the Forth Road Bridge but remember to look to the left. The view is better. With a bit of luck you will be in the company of a GP ("moral has never been lower") with whom you could have a very brief consultation." So that's all right then.

The medical profession has to sit down hard and think about AM. Are we really interested in evidence-based medicine or is evidence-based medicine just another gimmick in the cycle of perpetual change in the NHS which serves to guard against stagnation?

Homeopathy seems to meet with popular approval and is advocated by one influential member of the Royal Family (who also talks to flowers). Despite the lack of evidence that the homeopathic practice of diluting something can potentate its actions, I do espouse homeopathic principles. I wish to attend homeopathic conferences in exotic locations would only involve diluting my attendance to an undetectable proportion of the time. Do not criticise homeopathy – one of the world's great religions reports the turning of water into wine, whereas homoeopathists can turn water into money.

40. The consultant and the call girl

I was doing a post-take ward round with the medical students in attendance. The patient was female, young and attractive. My history revealed that she had a flat in a highly desirable area but no apparent means of financial support. I continued my inquiries with tact that proved totally superfluous.

"I'm a call girl." A statement of fact without shame expressed or apparently required. Amorality, not immorality.

Further conversation rather than questioning revealed that her flat cost "A hell of a lot." And the next question seemed entirely appropriate "What is your call out rate?"

"I'm high class, £250 basic plus £100 for each extra. In advance. I did not question whether VAT was charged and I did not question what the extras were. I have an imagination

Later I discussed with the medical students her illness (hepatitis caught by sex with someone infected with the hepatitis B virus or from using needles during drug abuse which she denied but you never know) and remarked "Miss X earns an untaxable £250 per visit. Is it right that she earns more than a Consultant would earn if I were asked to do a domiciliary visit?"

One of the female medical students put me right "I doubt if a Consultant would provide as much satisfaction."

41. Doctors

Of course doctors have influence over people and because we can answer some important questions and advise on significant health decisions, we are often, possibly wrongly, perceives as having significant power and this exerts some allure.

Mr X even as a medical student was able to offer the desirable benefits of his bed to members of the opposite sex. Whilst most of us could pick up girls, he seemed to have an extraordinary ability to lay them down. One of the benefits of being on call was that we had our own living quarters and the services of a rather endearing elderly Greek lady who would generally look after us and this included bringing us tea in bed at 7am. X benefited from this too but his opinion was greatly altered after the Greek lady entered his room as usual and, accepting the presence of an extra person, asked the question to which there could be no correct answer "Does this one take sugar?" Rumour had it that he left his room rather rapidly with his tail between his legs.

Whilst some questions cannot be answered correctly there are rhetorical questions for which there is an answer. A lecturer in statistics was explaining the logic behind research questions "Two negatives constitute a positive, but is there anyone here that can provide any instance of two positives making a negative?" His pause for effect was concluded when a voice from the back of the lecture theatre interrupted the silence with a sotto voce "Yeah, yeah."

Doctors may become so specialized that they become separated from mainstream medicine and indeed society in general. A Royal College once mounted a Symposium entitled "Organ Failure. What to do in the middle of the night." The potential for misunderstandings was exacerbated by the renal physicians who were to advise on how to treat an episode of rejection.

Doctors may have high self-regard, some believing that the definition of a Centre of Excellence referred to their geographical situation such that they advised juniors that there was no need to travel elsewhere to gain further knowledge. To be fair, many such doctors possessed many professional virtues, except humility.

Doctors may be more boring than many of their patients, who often have life experiences far outwith those of their doctors, and who provide doctors with "experiences by proxy." No doubt this explains why doctors historically have contributed many novelists. There is no other profession that can ask their clients deeply personal questions and usually receive truthful replies. I once caught myself asking a gay man "Where are you going, what are you going to do there, and do you intend to take precautions?" I was referring to malaria but the replies I got were not relevant to that particular infection.

These day patients have to thwart their doctors if they wish to die in peace without the benefit of all the possible interventions. I used to ask medical students what I should do to live as long as possible but now I ask at what age I can start to enjoy those things that I had denied myself because I had previously wished to prolong my life. Once a certain age is reached certain activities like smoking, drinking, car racing, or free fall parachuting, will not affect my prognosis overmuch.

41. Codswallop?

Is any footballer worth a salary of one million pounds a year? I used to think so because I often heard that famous players had been laid low by what was called "Groin strain." It sounded very painful and I surmised that an opponent's foot had not connected with a ball other than the one intended. A million pound a year seemed like reasonable compensation for the most personal injury imaginable for a male.

I am now better informed and outraged. An orthopaedic colleague tells me that a groin strain is merely a strain where a muscle (*Rectus femoris*) is inserted into the pelvis.

42. Prenuptials

Prenuptial agreements for the rich marrying the poor are increasingly recommended to protect the pockets of the rich whilst lining the pockets of the lawyers. Would prenuptial agreements have altered history?

We, acting on behalf of Henry VIII, henceforth known as the King, wish to agree with Anne Boleyn that:
The King will acknowledge all his debts for her services, including her encouragement to found the Church of England (if refusing to have sex constitutes an encouragement). The King further acknowledges that the granting of prenuptial sex will be under the strict understanding that Mrs King (Catherine of Aragon) will be divorced. In the event of matrimonial dissatisfaction the King may have to sever relations with Mistress Boleyn (the event turned out to be the severing of her head from her shoulders). A permanent residence will be provided (in the event the Tower of London was only a temporary residence but her final permanent residence was a coffin. In fact Queen Boleyn was provided with two permanent residences, her head being buried separate from her body – centuries later they were reunited). Royalties from any "top-ten" romantic ballads the King may compose will be shared equally. Royalties from future presentations, books, films and television programmes will be shared.

43. Skepticism: a neglected but essential attribute in medical practice
Skepticism involves doubt, asking questions and then making up your mind. Sadly, some individuals regard themselves as Fountains of Wisdom and often have a manner that discourages skeptical questions by projecting an unspoken "Has anyone any foolish questions to ask after my masterly exposition?" Anyone confronted by such an individual should destroy such covert accusations by a pre-emptive confession "Can I ask an idiot question?" followed by the question. It is amazing how often idiot questions dry up Fountains of Wisdom. I once used this idiot question technique at a major conference involving transfusion medicine doctors and asked "Can I ask an idiot question? How long does it take for transfused stored blood to carry oxygen normally? I received no response except "a few hours." The most striking example of skepticism failure is the medical profession's precipitation of alcohol withdrawal syndrome by withholding alcohol when alcohol dependent patients are admitted. The ideal drug to prevent alcohol withdrawal syndrome should offer a predictable response, abolish withdrawal symptoms without affecting conscious level, have a predictable patient response, have a predictable half-life, have a wide safety margin, have easily measured blood levels, allow administration by several routes, be cheap, and have effects appreciated by patients. I have asked the idiot question "Why not give alcohol?"and have only received idiot replies.

44. Poem without words
This was written to see if it could be done

U and I. Two lives
A story in Word without words

8/1/46 DoB I ♂
6/2/47 DoB U ♀
1963 I 9 Os
1964+ I o o O O O♀
1965 I 3 As@A!
5/5/68 I BSc, U MA
30/5/68 I↑N, U↓S I ♀n ?
U ♂ n?
15/3/69 I c U, I P=100/min!
♀☿♀☿♀
♀☿♀
♀
U
16/6/69 U&I 2? I<–>U?
15/3/69 U&I?
I♥U

25/12/69 U+I, ←I ♂ →U♀? Y!!!!

I@U, U@I!

9pm – 2am

o oo ooo!

0 00 000!!

O OO OOO!!!

2am. U&I zzzzz

29/2/1972 U "U& I, 2=1?" I√!

8/7/72

☺=☺

1974 O OO OOO!!! +9/12= ♂☺ , DoB+ = waaaaaaa!

!970s+ = £nnnn

1972 O OO OOO!!! +9/12=♀☺ , DoB+ = waaaaaaa!

1972+ = £NNNN

1974- 2000 o oo ooo 3/7ly, 1/52ly, 1/12ly.10.30pm-10.35pm

1991 + o oo ooo/zzzzzz

1991&1995 UNI ☺☺ = £NNNN!

2000–2003 + o oo ooo/zzzzzzz?

2003+ zzzzzzz/o oo ooo

2004 + zzzzzzz

U 8/2/03 8.30am -4oC o═o >!< o═ o ITU ECG═══════

I 8/2/04 Aghh ECG═══════

45. GMC failings

The General Medical Council (GMC) is a body that protects the interests of patients and despite the many problems or any organization that is self-regulating, performs well with the maximal possible rigor. There are problems however. Doctors can be asked to provide "Reports to the Court" concerning possible instances where a doctor is being sued for negligence. Some cases are obviously unjustified and never get to Court. Some are borderline and stand a good chance of a public airing in Court and may come to the attention of the GMC. In contrast in cases where the claim of negligence is justified and irresistible almost always are settled out of Court. These more serious professionally unacceptable errors have no public airing and the GMC does not routinely interest itself in these cases. There is a worrying suspicion that out of court settlements might reflect a desire to "hush things up."

This leaves the Expert Witnesses in a morally uncertain situation. The claimants often do not want the extra stress of GMC involvement after they have received compensation. Should Expert Witnesses inform the GMC. The GMC answer is "No" "The threshold for determining whether a doctor's fitness to practice is impaired are different from those that apply in negligence cases…The GMC does not, therefore, routinely investigate all cases involving successful legal action or which are settled out of court… and it is likely that in a proportion of negligence cases, the doctor may also be referred to the GMC either by the party bringing the claim or by the employer." In addition Expert Witnesses have had access to privileged information and confidentiality issues arise. I am aware of one instance in which a prescription sheet had been altered after a drug had been given and an instance of a more senior doctor blocking a highly necessary intervention that had been initiated by a junior doctor without seeing the patient. Totally unacceptable, but apparently acceptable. Unacceptability is worrying but even more worrying is that the doctors concerned were not offered remedial advice.

Sometimes a doctor is accused and reported to the police and the GMC can be particularly bland. A male doctor well known to me was reported to the police for an assault of a sexual nature made on a patient in an outpatient clinic in the presence of a chaperone and a medical student. The doctor concerned, the chaperone, and the medical student

could not recall anything at all out of normal. The doctor concerned obviously had to inform his wife, who happened to work in a Family planning clinic, and who guessed the identity of the patient and was aware that the patient had a large psychosexual counselling folder. She was not aware of its contents. Could the accused doctor use this as part of his defense? The GMC was approached and their reply was a miracle of obfuscation. The Defense Union was uncertain. The doctor was on his own but happily the police decided that there was no case to answer. But doctors are vulnerable in this way.

46. Book review

I wrote this review of a book (Big Fat Lies. Is your government making you fat? Hannah Sutter. Infinite Ideas Limited. Oxford ISBN 978–1-906821–37–1), posted the review on Amazon and had a retort that I ought to reads Gary Taubes book "The Diet Delusion." I did so and changed my views and had some thoughts about why and how diets usually fail- see Calories are not fundamental to weight loss in the Reflections section

The author espouses the use of science, but then starts her account with an anecdote about two bankers (not even a series then) who had lost weight on a diet "Two fat men eat loads (not a scientific measurement) of calories and, without exercising, lose weight and inches fast" as the initial evidence for her views. Scientific controls and follow-up details are there none – presumably fat cats are difficult to follow up. Ketogenic diets were the cause of this weight and inch loss and "no exercise was required and they could eat unlimited amounts of food." There was no definition of unlimited amounts."

There were statements that were plainly incorrect. I have to advise the author (a lawyer) that mistakes are not necessarily lies, and that the negligent may not be liars. Apparently epidemiological studies "are not considered good evidence in a courtroom and will be dismissed by a judge if presented on either side" (Page 49). What? Expert witness doctors in court often base their opinions on epidemiological balance of probabilities and judgments have to be made on the basis of these. They are not dismissed.

The book is surprisingly devalued by inclusion of statements that are correct! I was distressed to read that the author was a self-confessed obsessive, gave up her day job, that her GP husband had a response that was hopeless such that "he wasn't too impressed, as it turned out that he had to go back to full-time work, and "she went into the kitchen to develop a range of products." The book was produced by a self- publishing company.

All of these facts could cause alarm bells to ring but, on scientific grounds, have to be irrelevant to my judgments about the scientific merits of the book.

The quantity "Some" was often coupled with strong assertions. "Some" can mean anything from just above zero to just below 100 percent. For example it is reported that a professor presented a paper reporting that a group (what proportion of the total?) were eating more calories than other groups, in some cases." Read this again: it is meaningless.

The word "significant" is used without any guide as to how scientifically significant. For example "We are eating less but a significant (how significant?) percentage of us are getting fatter more quickly." This sounded very worrying. I chased up the reference for this crucial statement. "Despite that fact that data from different years were not strictly comparable there was a general downward trend in eating. So far so good. But the "Some" is a 15% obesity rate in 1993 rising to 24% in 2007 (a 9% point change). Given we start at 1993 a 9% point increase in obesity might well represent this 9% eating more, giving rise to a 2007 obesity rate of 24% but with the rest of us of us (76%) eating a little less to allow the statement that "we are eating less" to be correct. This does not sound very worrying for 76% of us! The use of "we" was annoying when it was unclear as to whom the author meant. Every reader? Or some of us? Or just she and I?

The author does make some good points. Exercise is a relatively inefficient way to lose mass (rowing hard for 15 minutes only loses 100 Calories). Body Mass Index is not a perfect way of assessing body habitus – athletes (that's you and me obviously) are graded heavier than they should be for their height because muscle is heavier than fat. The government's advocacy of starch does seem inappropriate. Some Calories are not as available as other Calories.

The author espouses a return to the good old days when we were all hunter-gatherers. Sadly we are all still hunter-gatherers, but now hunting and gathering our mass and energy inputs more successfully than hithertofore using supermarket trolleys.

What are the "The Big Three Fat Lies" that our "criminally behaving" government advocate for everyone? These are that people should:
1. Eat less and eat fewer calories
2. Eat a diet according to the government's eatwell plate
3. Do more

And my assessment of these so-called" lies"?
1. Self evidently not a lie.
2. You can lose body mass on almost any "reduction" diet, including a ketotic diet that the author is promoting. If a ketotic diet is, as seems likely, relatively harmless (apart from causing halitosis) then "Why not?" no matter how it works (probably by appetite reduction with low mass and energy inputs. I subsequently changed my mind - the response to acidosis prompts carbon loss by increased pulmonary ventilation). So the government recommendation may be mistaken but it would be excessively critical to call it a lie.
3. Although good for us in a general sense, exercise is an inefficient way of losing energy compared to dietary interventions. As a general recommendation hardly a lie.

In conclusion, this book's weighty title is not justified by the content. Nevertheless a provocative book but, like many others, is not skeptical enough for the average scientist. Do diets work? Of course they do – Google diets and you will get innumerable websites that will indeed cause you to lose weight. Undoubtedly. Money from your wallet does have a weight.

47. A bitter pill to swallow?
A male medical student was asking a feisty 60 something year old stoke patient about risk factors. Because the contraceptive pill can be a minor risk factor for a stroke he thoughtlessly asked her if she was on the pill. "Young man I'm old enough to remember the 1960s when I was young and foolish and in those days such a question would be the prelude to a proposition. Times have changed but..." I intervened to change the subject at that point.