The BMA guide to quack remedies, p 1083

A dent in our sobriety

PERSONAL VIEW **Debbie L Shawcross**

REX ARGENT/ALAMY

It began at last year's conference of the British Association for the Study of the Liver. As I contemplated during the "symposium on alcohol" on how alcohol has ever so stealthily resulted in 4% of global deaths and disability I couldn't help but chuckle to myself as I pondered the original meaning of symposium: a forum for men to debate, plot, and boast; in simple terms, an excuse to drink wine and have a party.

It was difficult to understand why the audience all felt distinctly uncomfortable. After all, rarely a day passes by when, as hepatologists, we don't see a patient whose psychological or physical wellbeing has been marred by alcohol. We know that the death rate from alcoholic liver disease has doubled in the past 10 years in the United Kingdom and that its incidence has risen eightfold in the under 35s as a culture of binge drinking has evolved among young people. We have all projected that the incidence of cirrhosis will increase exponentially and that there will be a 500% greater need for liver transplantation in the next decade. We have heard it all before. Yet as our anxiety was gradually eased by a glass of wine at the end of the symposium, a dent was left in our sobriety.

A few days later I sat with a glass of red wine in my hand and pondered on this dent. I recalled patients I had seen early in my career and several recent experiences. Firstly, I thought about the two young girls I had seen walking past my house on the way to school. It was only 7 30 am, yet both girls were swigging from bottles of bright blue "alcopops." I gauged them to be aged 13 or 14, and more than likely they had missed breakfast. Cigarettes are unfashionable now among the under 16s, and the implications of being caught with illicit drugs is too great a burden for a diligent schoolgirl to entertain. But a sweet blue fizzy drink that doesn't taste of alcohol: surely that is OK? Did they drink at lunchtime and after school too? At one and a half units per bottle, what was their weekly intake? And does a "safe" limit of 14 units for an adult female apply to a young teenage girl who is still growing? What effect would the alcohol have on their ability to concentrate in the classroom? If I had a teenage daughter who chose to take up a vice, I wondered whether I would prefer her to smoke or drink. What would cause the least harm in the long term? I resolved on the side of smoking; at least this is now banned in public places.

I dread the day when the schoolgirls drinking alcopops will be referred to my clinic or, worse still, present with multiorgan failure

I then moved on to thinking about Jamie. He was in his early 20s. He came from a respectable family, had good qualifications, and had a well paid job. He presented with severe alcoholic hepatitis, and we gave him only 50% odds of leaving the hospital alive. His story began with binge drinking as a teenager at weekends and then moved to drinking holidays to Spain with his friends. It was part of his job description to drink and entertain potential clients after work, and long boozy lunches were compulsory. "Surely that couldn't have done me any harm, doc?' he exclaimed. "I hope you are not insinuating that I'm an alcoholic. I just enjoyed drinking with my mates when I was younger. It was a bit of a laugh. Now that I'm older I just drink wine and champagne with clients. It's not like I drink spirits." I think the humour was lost when he underwent a liver biopsy, which confirmed cirrhosis. Jamie made it out of hospital, but only just.

Ansal, just like Jamie, was admitted to hospital with alcoholic hepatitis. He wasn't so lucky, and I remember how my communication and diplomacy skills were tested when his family asked why he was bright yellow. Before Ansal drifted into a hepatic coma, I asked him if he drank alcohol. He denied it vehemently and told me proudly of his Muslim upbringing. It was only as his alcohol withdrawal syndrome was reaching its terrible crescendo that he finally admitted to his alcohol addiction. He had learnt the art of stealthily consuming the intoxicating liquor, hiding all evidence from his family and his faith.

Recalling Yonas, I contemplated how alcohol is not just a problem of the developed world. Yonas and his family lived in a village in east Africa, where Yonas's baby son succumbed to malnutrition and dysentery, and his wife was raped by a soldier in front of him. He escaped endemic hepatitis B and HIV and successfully attained asylum in the UK in 2000. Only then did alcohol beat him. Yonas found it too painful to tell me about the reasons why he couldn't stop drinking alcohol, but the all consuming drive to numb his pain and the haunting nightmares of former atrocities and torture in East Africa must have been overwhelming. Sadly, alcohol turned out to be his greatest enemy.

On that note my private symposium came to an end. The wine bottle from which I had been drinking was looking distinctly less full, and I wondered how alcohol would shape our future. I dread the day when the schoolgirls drinking alcopops will be referred to my clinic or, worse still, present with multiorgan failure, as happens to many with the "silent cirrhosis" that creeps upon them without their realising it. Governments across the globe must unite and act now to develop a worldwide treaty on alcohol to reduce the growing burden of alcohol related harm.

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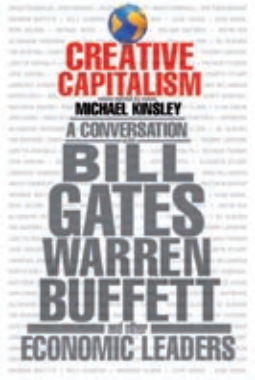
Patient consent not required (patients anonymised, dead, or hypothetical).

Cite this as: *BMJ* 2009;338:b1737

REVIEW OF THE WEEK

A capital gain for the world's poor?

The world's biggest philanthropist wants other capitalists to follow his lead. But experts are quick to pick holes in Bill Gates's idea, finds **Trish Groves**



Creative Capitalism
Edited by Michael Kinsley
Simon and Schuster, £16.99, pp 315
ISBN 978-1847374103
Rating: ★★★☆☆

At the World Economic Forum in Davos in January 2008 Bill Gates, founder of Microsoft, argued that many global problems are just too big for philanthropists or governments to solve alone. A new system called creative capitalism is the best way, he said, for "governments, businesses, and nonprofits to work together to stretch the reach of market forces so that more people can make a profit, or gain recognition, doing work that eases the world's inequities." Such work can, for instance, let the world's poorest buy vital drugs and useful computers and can free up patents for treatments for neglected diseases.

Is this a no-brainer? Not necessarily. So two political journalists, Michael Kinsley (who's married to the former chief executive officer of the Bill and Melinda Gates Foundation) and Conor Clarke, invited around 40 economists, policymakers, and analysts to debate the concept on a private website and thereby contribute to a self creating book, *Creative Capitalism: A Conversation with Bill Gates, Warren Buffet and other Economic Leaders.* Kinsley and Clarke also posted these commentaries and blogs at http://creativecapitalism.typepad.com/creative_capitalism/ so that the public could join in, with this proviso: "Comments to the effect of "capitalism is evil and Bill Gates is a fool" probably won't be used. But we're genuinely open to opinions of all stripes."

It worked, mostly. Because the book arose from blogs, the ideas and opinions ebb and flow through it like a real conversation, with everyday language and no references. The quality of debate and the use of real corporate examples—many of them about health—give necessary depth. And although it fizzles out at the end it's then redeemed by some great appendices, including economist Milton Friedman's classic critique "The Social Responsibility of Business" from the *New York Times Magazine* in 1970.

Most of these commentators find fault with Gates's big new idea. Firstly, it goes far beyond setting up a foundation with your own money. It means spending other people's (shareholders', employees', and customers') money on things they may not really want to support. And it's a bit rich, some say, for Gates to be so generous now. Microsoft made so much money and quashed so much of the competition that few of its shareholders or customers would or could have gone elsewhere, even if they didn't like the way the company chose to fund affordable technology in poorer countries.

Moreover, they complain, creative capitalism is an unnecessary and redundant concept. It's just a mishmash of existing forms of enlightened self interest in business, such as sustainability, corporate philanthropy, corporate social responsibility (or, more cynically, "corporate scandal response"), and social entrepreneurship (for instance, selling useful products and services to people at the bottom of the wealth pyramid and still profiting because there are billions of them). And they really don't like the implication that standard capitalism isn't creative.

Matt Miller, senior fellow at the liberal US think tank the Center for American Progress, makes an unusually left wing criticism—for this book at least—of Gates's concept. He argues that "business's greatest potential contribution to the global poor has nothing to do with how companies operate. It lies instead with the broader public policies that capitalists support or oppose." If only the US public and government agreed to tax the wealthy more heavily and overcame their anxiety about the proper role of government in providing health care and pensions (thus relieving US businesses of that burden), he says, they'd have less reason to protect their jobs and trade to the detriment of poor countries. Meanwhile Lawrence Summers, formerly Bill Clinton's treasury secretary, warns that one major attempt at creative capitalism in the US—federal assistance for poor Americans to buy homes—has just gone badly wrong. He's not the only commentator to mention the global economic crisis, although it was only just beginning to unfold as this book was taking shape.

Unsurprisingly the book does have some good things to say about creative capitalism. Matthew Bishop, chief business writer for the *Economist*, quotes the profitability of companies such as Google and Salesforce that donate 1% of equity, profits, and employees' time to good causes. The returns—particularly in the recruitment, retention, and productivity of staff who like working for overtly responsible companies—exceed the costs, he says. And in markets where other firms have bad reputations—for exploiting workers in poorer countries or refusing to reduce prices there, for instance—working for and buying from the good guys can be very appealing.

In the end *Creative Capitalism* is about the individual good guys, even if they're acting for corporations rather than their own foundations. As Abhijit Banerjee, professor of economics at the Massachusetts Institute of Technology, puts it, "The creative capitalist has a real advantage; he knows how to put pressure on governments and how to market his ideas to the man in the street. He has credibility, he does not need anyone else's money, and he knows who to call."

I'd add that he or she has decided, as Google has, that "you can make money without doing evil."

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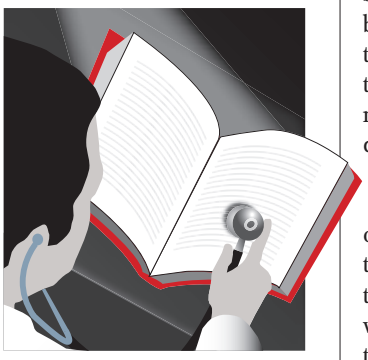
Cite this as: *BMJ* 2009;338:b1774

Bill Clinton's former treasury secretary warns that one major attempt at creative capitalism in the US—federal assistance for poor Americans to buy homes—has just gone badly wrong

Deafening silences

BETWEEN THE LINES
Theodore Dalrymple



My mother was a refugee from Nazi Germany, arriving in Britain in 1939. She never saw her parents again, who escaped to Shanghai; she never spoke a word about her life between 1933 and the battle of Britain

Are there any depths of cruelty and absurdity to which bureaucracy cannot plunge? It seems unlikely, an impression confirmed by reading Jean-Claude Dreyfus's short and laconic *Souvenirs lointains de Buchenwald et Dora, 1943-1945.*

Dreyfus was a young doctor in Paris when the second world war broke out. After the war he was to become a distinguished professor of biochemistry. During the first period of the occupation he worked in Parisian hospitals where, as a Jew, he experienced neither hostility nor sympathy.

Eventually it became too dangerous for him to remain in Paris, and he went to Lyon, where he assumed the identity of Raymond Leclerc, pretending to be a travelling salesman but actually working unpaid in the laboratory of Professor Gabriel Florence. When Florence was arrested as a leader of the Resistance, however, Dreyfus/Leclerc removed to Annecy, where he was himself arrested, not as a Jew but at random, as one of 40 people taken in reprisal for the killing of two German soldiers by the Resistance.

He went first to Buchenwald and then to Dora, where, to improve his living conditions and increase his chances of survival (in Buchenwald he had undergone several operations without anaesthesia on his leg for an abscess that left him weak and unable to do physical labour) he admitted to being a doctor. Although people were dying from malnutrition and epidemic diseases, Dreyfus was obliged to undergo an academic examination by other doctor prisoners in the camp, to establish whether he really was a doctor. At the end of the examination he was granted entry to the camp's medical fraternity.

He was deputed to the ward for moribund patients with tuberculosis. Right up to the end of the war, into the last three or four months of it, these patients were examined radiographically and their sputum examined bacteriologically, though of course there was no treatment. When they died their names and numbers were entered punctiliously into a book for the purpose; once there was a crisis when Dreyfus mistakenly entered the wrong number of a deceased person in the book. He could have been relieved of his duty because (it was explained to him) terrible suffering might result if relatives were wrongly informed of a death. It didn't matter, of course, that no such information was ever given out, and that by then the allies were only a few miles to the east and the west and all communication with the outside world had ceased.

Dreyfus's daughter said he never spoke of his experiences once he returned from Germany. His short memoirs were written at his family's request and not published until nine years after his death in 1995. The epigraph to the book is, "To remain silent is forbidden, to speak impossible."

My mother was a refugee from Nazi Germany, arriving in Britain in 1939. She never saw her parents again, who escaped later to Shanghai; she never spoke a single word about her life between 30 January 1933 and the battle of Britain.

After her death I found letters from her father, a doctor, written to her from Shanghai. In 1942 he wrote, "It is a beautiful spring morning and the sun is shining brightly, but there is no sun bright enough to penetrate the dark clouds that are covering the whole earth." Three years later her sister, also in Shanghai, wrote to her to ask in which language she wanted their parents' tombs, English or German.

Theodore Dalrymple is a writer and retired doctor

Cite this as: *BMJ* 2009;338:b1719

MEDICAL CLASSICS

Secret Remedies: What They Cost and What They Contain

First published 1909

Published by the BMA a century ago and priced at a shilling, *Secret Remedies* was a detailed scientific investigation of the contents of the quack medicines that were so popular at the beginning of the 20th century. Its timely publication coincided with changes in the law in the UK and in the US to increase the public's awareness of the outrageous claims made for the nostrums, specifics, remedies, and even "cures." The use of the word "cure" was very soon to be outlawed, but the book records some 15 preparations using this word in the title of the product—apart from the claims made in accompanying literature. Products were available by mail order or from the apothecary. Manufacturers even offered chemists bribes to supply them with the details of patients with ailments that matched their remedies. They then plied their wares directly to the potential sufferer. The book describes deception not only in the description of the treatment but also the claimed qualifications of the vendor.

Thoroughly detailed pricing of the contents of a treatment reveals the remarkable profit per bottle or pack. The profit margin was excessive, even taking into account production of attractively designed packaging, testimonials, booklets and almanacs, and decorative and colourful embossed bottles.

Products sometimes contained a small amount of vegetable or herbal material of very dubious effectiveness and would often be described as being sourced from native tribal recipes. This added an extra mystery or magical context, implying that the conventional doctor had failed to alleviate many complaints and that the inventors had found a solution through their own research. Unidentifiable chemicals were given ambiguous names unknown in pharmaceutical circles. Labelled preparations did not have to carry a list of the contents, hence secrecy was maintained. An authorised paper seal adhering to the product indicated the stamp duty paid to the government. This affected 33 million items and resulted in a tax gain of £2.5m (€2.8m; $3.6m) each year. For an extra fee the vendor's name or autograph could be included in the stamp, giving the product the government's apparent guarantee.

Trade card for Warner's Safe Cure

SWIM INK 2, LLC/CORBIS

A desire for profit often led to a cure-all treatment. The most widely traded product was Warner's Safe Cure. Blood purifiers, stomach cleansers, and nerve stimulators all staked their claim.

This book is a medical classic for its evidence that the quack medicines of the day were costly and ineffective, if not dangerous, and for its wealth of information for the medical historian. A second publication for the BMA in 1912, *More Secret Remedies*, continued to reveal manufacturers' exploitation of a gullible public.

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Cite this as: *BMJ* 2009;338:b1624

Stop! In the name of love

FROM THE FRONTLINE
Des Spence

In the last deep recession a friend and I washed cars. This was the days of Thatcherism; and as it was his business and buckets, we split the takings 60:40. I accepted this, as I was desperate for work to buy blank cassettes. In the days before teenagers downloaded a lifetime of music overnight from pirate websites we taped music from the radio chart show, because original LPs then cost a weekly wage. The only alternative was the "tribute cassette" found in loose bins in Woolworths: three redundant Cardiff steel workers "Sing the Supremes." What price quality?

What price indeed. I have often challenged the quality and outcomes framework (QOF), the incentive system for NHS GPs. I am not an academic, just a working grunt, so surely I should be reassured by the constant assertions that the QOF is improving care? But let me bear witness to the indignity of obviously obese patients being shoved on to scales; the insensitivity of depression questionnaires sliding across a tear stained desk; the spectre that is chronic kidney disease, devoid of evidence of intervention; the pained silence of the review appointment, my only amusement the three smoking status entries that all contradict. The QOF is an upwards only escalator of prescribing. It is a pseudoscientific instrument on which any GP with wit can play a good financial tune. Real quality is a timeless classic: reassurance, commitment, continuity, communication, the power to do nothing, and, in this fading fake society, the ability to be honest.

But angry academics curse me. "What would you do, big mouth?" So I have an alternative QOF that gives points for limiting the use of antibiotics, antidepressants, benzodiazepines, and polypharmacy and stops prescriptions for ischaemic heart disease in low risk groups. Other points are given for enabling patients to die at home, and there are management points for using paperless systems (texting, email, and online booking). And points for reducing consultation rates and thus increasing access, and perhaps points for regular contact with children on the at-risk register. There will be points for the return of journal clubs and regular multiple choice question tests of doctors' knowledge. Doctors could even earn points for advocating locally to raise the price of alcohol.

Lastly, quality in primary care depends on our brothers and sisters in the hospitals, and so points will be awarded for feedback on referrals, reducing referral rates, reducing numbers of investigation requests, limiting hospital admissions out of hours, and instituting a system of two way secondments. The current QOF is NICE's cheap hissing copy of easy listening classics, but it is a sad tribute to real quality: independent, thinking doctors.

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Cite this as: *BMJ* 2009;338:b1757

Clearing out

IN AND OUT OF HOSPITAL
James Owen Drife

Retiring has its good side. The farewell party is fun, and the warm wishes of colleagues and patients are deeply touching. From now on, there will be no early morning hypertension as rush hour cheats whizz past me in the bus lane.

The downside is clearing the office. It's like an archaeological dig. The Mesolithic has letters written with golfball typewriters. Look! Here's one from 1994, protesting against the health authority's decision to disband a committee providing specialist advice. How quaint. Off they go for confidential shredding. Further down, though, is the Palaeolithic, with its nonbiodegradable lecture slides. Today's PowerPoint generation doesn't know how vital the medical illustration department once was to academic life.

Gosh, here's that slide from *The Listener*, the BBC's highbrow journal. (Yes, really—this was years ago.) In 1980 it published the Reith lectures, "Unmasking Medicine," given by Ian Kennedy, then a young barrister. I made a slide of one of his subtitles: "We must become the masters of medicine, not its servants."

It seemed ridiculous. Medicine isn't a master-servant relationship, for heaven's sake. How wrong I was. Rarely has a mission statement been so stunningly fulfilled. The state is our master now, and Sir Ian has been loaded with honours by royal colleges anxious to associate themselves with it. Some say that the profession brought this on itself by its overweening arrogance. Don't be so sure. I remember, on becoming a consultant in 1982, how uncomfortable I felt at being lifted onto a pedestal by the same public who took such delight in bringing us down in the 1990s.

Anyway, it's done now. The apparatus of central control covers everything from junior job applications to practice guidelines and appointments to the General Medical Council. We used to cite Germany in the 1930s or the Soviet Union as awful examples of how this can go wrong, but at least in those countries some doctors resisted. The British do things more subtly, and doctors seem to like it.

Discipline imposed by old fashioned consultants is now caricatured as a "climate of fear." Today's fear is not of the consultant's footstep but of the manager's email, as apparatchiks enforce targets set by the state. Doctors who once fought the system on behalf of patients are reduced to writing sad little articles. No wonder we're clearing out.

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Cite this as: *BMJ* 2009;338:b1717