Brando's first film—and a medical classic, p 1201

It could happen to you: why 20 mph limits matter

PERSONAL VIEW **Nick Foreman**

This is what happens and this is how it feels. I was driving along a well lit suburban street with my two small stepchildren in the back of the car. We were on the way to pick up my wife who had been working away for a few days, and we were all excited about seeing her. At the last minute we had arranged to meet at a different station from usual. It was 18.35 on a dark February evening.

In an instant, a few yards in front of me was a small child. He was followed by an adult. I remember thinking "WHAT THE..." and then reflexly hit my brakes. The car skidded and I ran into both of them. The child flew through the air, caught in the beam of my headlights. I didn't see the adult.

I got out of the car. Traffic had stopped behind me and on the other side of the road ahead of me. For a few seconds everything was still. The child, who looked about 3 years old and was wrapped in an anorak, was crying in a heap a few yards in front of my car; the adult had been thrown further. Neither seemed to have any obvious injuries. Already a crowd was appearing.

I realised that I needed to phone the emergency services and I went back to my car and got my phone. I couldn't bring myself to address my children in the back seat. Ringing 999 seemed to takes ages. There was a dislocation between the absolute panic now enveloping me and the calm voice on the other end.

By now a large crowd had gathered. My victims were local with lots of family and friends in the vicinity. They surrounded the bodies on the road and after a few false starts at trying to be a doctor I gave up. I couldn't do anything beyond making sure that nobody was moved. I felt incompetent and could only think that I had done this act.

It became clearer what had happened. The child had just got out of a car in a side street and had run towards the main road; his aunt had screamed and run after him. Both had run into my path.

Somebody tapped me on the shoulder. "Are you all right mate? I saw everything. The kid ran out in front of you – there was nothing you could have done." These were kind words.

I remembered my children. I put my head back into the car—both were crying. I said everything was going to be all right, but I had no idea whether this was the truth.

No faster

On the road nothing had changed. I rang my wife, incoherent. "Something awful has happened..." She was calm and calming. She established where I was and said she'd be there shortly in a taxi. The traffic was well backed up on either side of the car and neither the police or ambulance had appeared. It must have been about seven or eight minutes after the accident when an off duty ambulance paramedic appeared and quickly took control of the scene.

After a further five minutes or so the police arrived—lots of them. I was identified as the driver and was told to switch of my engine (still running) and to sit in my car. At this point my autonomy had been decisively removed.

Then a rapid response team arrived in an ambulance car and another five minutes after that, thank God, an ambulance. The police seemed to keep on getting me in and out of the car. They were polite but firm and they started to appeal for witnesses, who they began to interview as the ambulance men got out support stretchers to carefully move the bodies.

A man tapped on my car window. I got out. He said he was the child's father. He asked me if I was all right. He said he thought his son was going to be OK. The paramedic then came over. He told me not to be frightened about the stretchers. He didn't think there was any major injury.

The ambulance then sped off and a police sergeant appeared. He was less friendly and spent a long time inspecting my car—particularly the front of it. He ordered his colleagues to chalk the road identifying my car position.

My wife appeared walking along the road with her luggage. We kissed and she checked that I was as well as could be expected. The sergeant then allowed the car to be moved and one of the officers said he would take me home later. My wife drove the car and the children home.

The police then explained that I would need to accompany them to the police station where I would be breathalysed and they would take a statement. They asked me if I had been intimidated by the crowd (I hadn't). The police were now friendly and sympathetic. All the witnesses corroborated my story. Slowly my autonomy was returning. The ride in the police car was short and the police station was cold. I couldn't stop shaking. The breathalyser test was carefully explained and I passed it. I was led through my witness statement by one policeman as another checked my car insurance and tax on their databases.

I was then told that no action would be taken against me because the incident was clearly an accident. I was taken home by a young police officer who was supportive and chatty. He gave me his name and phone number and told me to ring him if I needed to talk

He rang me a day or two later and told me that the aunt and the child had no broken bones and were both at home nursing some bruising. The aunt then rang me to tell me that she and her nephew were both well and to thank me for not driving fast. I told her that it was brave of her to try to save the child and she laughed.

So what has this experience done to me? Suddenly a few speeding points on my licence don't seem quite so innocent. If you have any you should also feel ashamed. It is easy to exceed the speed limit and thank God on this occasion I wasn't. Nor was I fiddling with my mobile phone, sat nav, or CD player, all of which I do do or have done. I think I was probably going at 20 miles per hour at the point of impact, and maybe now you will agree with me that that should be the speed limit in built up areas.

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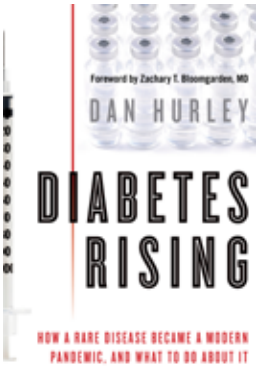
- Research: Effect of 20 mph traffic speed zones on road injuries in London, 1986-2006 (*BMJ* 2009;339:b4469)
- Editorial: Traffic speed zones and road injuries (*BMJ* 2009;339:b4743)

REVIEW OF THE WEEK

Life is Sweet

There was great optimism about diabetes in the 1980s, but a new polemic from the USA sets out a grimmer, more complex future, finds **John Quin**



Diabetes Rising—How A Rare Disease Became A Modern Pandemic, And What To Do About It
Dan Hurley
Kaplan, $26.95, pp 312
ISBN 978-1-60714-458-8
Rating: ★★★☆

"To each age its defining disease . . . diabetes is the defining affliction of modern Western civilization"—so says Dan Hurley, an investigative journalist who has type 1 diabetes. Here he matches Michael Moore's anger at institutional dither. This is not a self help guide; this is a counterblast of polemic from a man who knows the price he and we are paying. The Centers for Disease Control now projects that 33% of all American boys and 39% of all girls born in 2000 will develop type 2 diabetes in their lifetime. Hurley's message is stark—America is killing its youth. So what are we to do?

There was great optimism about diabetes in the early 1980s. We had a bounty of new developments—laser photocoagulation to treat proliferative retinopathy, home blood glucose monitoring, pancreatic transplantation, early insulin pumps ("dumb as a brick"), and talk everywhere of cure within a decade. But now we face a grimmer, more complex reality—diabetes has "more tricks up its sleeves than a vaudeville magician." Hurley is good at tracking the key developments since then, underlining the fiendishly difficult problem of insulin resistance. He is not slow to identify and snicker at well meaning clinicians from the past who have been proved wrong in advocating a *laissez-faire* approach to glycaemic control. The prophetic Elliott P Joslin, founder of the world's largest diabetes centre, was caricatured as "the crusty New Englander who simply couldn't lighten up and adjust to the freedom that insulin should have permitted," but 60 years later he would be vindicated by the Diabetes Control and Complications Trial (DCCT). But there is a price to be paid for tight control—hypoglycaemia: "a cupcake away from a coma . . . when you recognise the paramedics in your ambulance, you know you have a problem."

Diabetes has "more tricks up its sleeves than a vaudeville magician"

Hurley is brutally honest about the new methods of glucose monitoring: "the greatest weakness of the continuous glucose sensor proved to be its greatest asset: its *continuousness*. The darn thing is always at you, beeping, vibrating, beckoning you to check it, like a Blackberry—it's maddening." Candid opinions from others are faithfully reported, some of which will raise adrenalin levels among a few diabetologists. Hurley wants to stir it up, insist on debate. So we learn that David Nathan, of DCCT fame, thinks that islet cell transplantation programmes "should be stopped." And Kenneth Sells, a primary care physician, informs us that "endocrinologists can't live on what Medicare pays." Meanwhile, back in Britain, Professor Terry Wilkin drives his orange 1976 Volkswagen camper van and gives us the accelerator hypothesis, subject of the first of five chapters, where current aetiological thinking for the explosion of diabetes today is summarised.

Hurley attends a conference on the cow's milk hypothesis, which ends up being "the scientific equivalent of a schoolyard rumble." Confusingly, he refers to this as the Rodney Dangerfield of theories, a reference to the now deceased US comedian. Feminist readers might struggle with the oleaginous descriptions of various academic wives, uniformly beautiful, "younger looking than her 42 years" and so on. There follow romps through evidence supporting a role for persistent organic pollutants and the vitamin D story. Epidemiologist Frank Garland tells us that "in Boston you cannot make any vitamin D from November through March, even if you were standing naked in the middle of the city." Of the hygiene hypothesis we hear immunologist Li Wen say "I don't think it's bad to be a little dirty." And we learn a new *mot juste* for our times—videophilia—"a preference for indoor media activities over outdoor recreation."

Potential cures are reviewed. Of the artificial pancreas there's much talk on "moving horizon algorithms" from mathematics geeks. Deterministic linear model predictive control algorithms will embrace uncertainty—the quotidian trials of life itself. At the first world congress on bariatric surgery there is much "defending of turf" and "tossing scientific turd bombs." Hurley admits "I loved it" and that "watching doctors fight is more entertaining than pro wrestling."

Hurley concludes with swipes at subsidised farmers and exploitative food companies. He demands "something more is needed . . . united action is necessary to face down what is a public, and therefore a political, danger to our well-being." The corollary of this demand is that we need a new sustained critique of excess, and you don't need to be Noam Chomsky to doubt this will ever emerge from America. And yet it has to. Advanced boosterist consumer capitalism is the Lesch-Nyhan of ideologies; it mutilates itself. The triumphant West with its Coca-colonisation has marinated in success; its peoples have become caramelised. The solutions are not ones we want to face up to because they go against what we adore. We cannot stop driving or playing with computers. We are encouraged daily to gorge. To change is a fundamental political issue that few hypercapitalist governments intend to tackle because to do so undermines their *raison d'être*, their will to make money. Hurley's arguments inadvertently point right back at the heart of what his country stands for. We must pass on another slice of the devil's pie.

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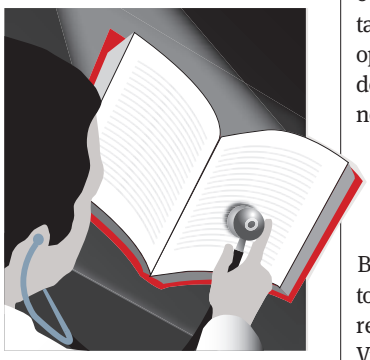
Ill at ease

BETWEEN THE LINES
Theodore Dalrymple



Morse wanders the corridors of the hospital or completes the *Times* crossword in 10 minutes. Today, the ability to turn to the crossword page, let alone answer any of the clues, would be taken as evidence of fitness for discharge

Anticholinergics, bottles of peppermint scented aluminium hydroxide, liquorice tablets, milk diets, and vagotomy and pyloroplasty—all the things that I remember from my childhood as treatment of peptic ulceration because my father tried them all without success (indeed, the V and P very nearly killed him)—were rendered redundant first by new pharmacological treatments and then by the discovery of the role of the *Helicobacter*.

Things have changed dramatically in other respects too. For example, in 1989, in *The Wench Is Dead*, Inspector Morse (Colin Dexter's hero of the Oxford police) was admitted with haematemesis, via the emergency department, to the John Radcliffe Infirmary. In those days, everything was done manually and thermometers still had mercury in them. Doctors wore white coats and the nurse in charge of a ward was a sister rather than a ward manager. However, change was in the air: the sister of the ward to which Morse was admitted, the old fashioned dragon-type, had left by the end of the book to become not the matron of another hospital, but its director of nursing services.

Once in the ward, Morse finds himself opposite an old colonel who promptly dies from septicaemia. The dead man's wife arrives later and hands round to the patients, *in memoriam*, her late husband's great work, an account of a Victorian murder. Dissatisfied with the verdict he finds in the book, Morse sets out to solve the case from his hospital bed.

The astonishing thing (from our current perspective) is that he seems to have plenty of time in which to do so. The only medical procedure to which he is ever subjected during his stay is endoscopy; whereafter he is allowed to vegetate in the ward for more than a week, and then discharged with no very great sense of urgency! Most of the other patients vegetate likewise; the man opposite him (after the death of the old colonel) seems to have little wrong with him, but his daughter who visits him is a librarian at the Bodleian who is able to help Morse with his researches into the Victorian case.

When he is not thinking about the case, Morse wanders the corridors of the hospital or completes the *Times* crossword in 10 minutes. Today, the ability to turn to the crossword page, let alone answer any of the clues, would be taken as evidence of fitness for discharge. How luxuriantly slow paced, then, were hospitals only 20 years ago.

Was it inefficiency or humanity that made them so? I recall with nostalgia a deliciously peaceful seven days in hospital in the late 1970s on my return from abroad where I had suffered heart failure from presumed viral myocarditis. I was in for investigations, but was left largely undisturbed. The ward was half empty, spotlessly clean, delightfully calm give or take the irruption of the tea trolley, and endowed with a wonderful bath of gargantuan proportions. The nurses were a sadomasochist's dream, all starch and black stockings.

Morse felt almost sad on being discharged from hospital, as I did. His stay had been a spiritual refreshment to him, as mine had been to me. True, spiritual refreshment is not what hospital is for, which perhaps is just as well since you can't measure it. In the event, also, I never got a firm diagnosis; but at least I had a personal relationship with the man who didn't make one.

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MEDICAL CLASSICS

The Men Directed by Fred Zinnemann

Made in 1950

The Men is a film still worth watching. Historically, the prognosis of spinal cord injury was appalling. Harvey Cushing cited 80% mortality in the first two weeks for men who sustained spinal cord injuries during the first world war. These injured young men were seen as incurable and untreatable. Hidden away, they were left to die, avoided by healthcare staff and forgotten by the public. O H Gotch's 1923 *BMJ* article on traumatic paraplegia reflects the prevailing therapeutic nihilism at the time: "his progress cannot be other than gradually downwards . . ."

In the 1930s things began to change. Herbert Everest and Harry Jennings invented their portable self propelled wheelchair (Everest had received a spinal cord injury in a mining accident in 1919; Everest & Jennings remains one of the world's largest wheelchair suppliers), and Donald Munro in the US pioneered a multidisciplinary approach toward treatment and management of paraplegia. Bladder irrigation and antibiotics meant that death from renal failure, septicaemia, or both was no longer inevitable, if still horribly frequent. And then there was the second world war.

The Men was Marlon Brando's first film, made in 1950, with a screenplay by Carl Foreman, shortly to become "un-American" and self exiled to Britain. It tackles the subject of paraplegia head on, recognising that spinal cord injury sufferers are fully human, alive, and furious. Unashamedly educational at times, details about bowel and bladder function, bedsores, and sexual function are not spared, and dramatically presented.

Ernest Bors (the neurologist on whom the character of Dr Brock in the film is based) and A Estin Comarr (the urologist who later wrote extensively about recovering sexual function) both worked at the Birmingham Veterans Army Hospital at Van Nuys, California, where the film was mainly shot, and went on to eminence. Built hastily, the hospital opened in 1944 and closed in 1950, and housed 220 men with spinal cord injuries.

Marlon Brando in *The Men*

The film's stars spent time living (and drinking) with the paraplegic patients before filming, using the same wheelchairs and facilities. Marlon Brando reportedly came dramatically out of role at one point when stopped in a bar by an evangelical Christian who exhorted him to believe and walk; he got up, danced, and ran off, applauded by his companions. Arthur Jurado, "Angel," was the most prominent paraplegic actor, but opening credits simply cite "45 men of the Birmingham Veterans Army Hospital." Medical details were accurate and sometimes chilling; the patients are human, die, and are exploited, and everyone smokes. Dr Brock shouts "what gives you the right to ruin good surgery with complete indifference?" at a patient without being struck off—the staff get almost as angry as the patients do.

The ending, with Marlon Brando's character swallowing his pride and accepting help, seems sadly disempowering and would, I hope, raise an outcry nowadays. But *The Men* was radical enough in its time, and the bitterness, frustration, and pain of war injured young men and their families continues.

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Talking about a revolution

FROM THE FRONTLINE
Des Spence

Medicine is glamorous. Overheard hushed voices talk about how clever we are: white coats, serious expressions, high pay, and respect. So medicine can be a draw for the vain, motivated by status not duty. But medicine is harsh, full of late nights, uncertainty, doubt, and blame. Even evidence based medicine informs but the merest part of our work, just a plastic tarpaulin in the wild storms of clinical practice. Medicine is a job of attitude not bookish learning, of emotion not logic. We still select doctors on the basis of crude academic ability, with results utterly confounded by the educational tricks of the affluent, rather than ability to cope.

No more so is this an issue than when it comes to the taboo that is death. Talking about death is difficult—it requires strength to be honest and direct. But doctors are human and seek to avoid the uncomfortable and to protect themselves. Indeed modern medicine systematically fractionates responsibility with multidisciplinarism, with the unforeseen effect that everyone is accountable so no one is accountable. When it comes to end of life decisions which health professional is responsible?

Many of us are scarred by the experience, seeing dying patients overmedicalised, choking on polypharmacy, and given futile and destructive treatments, with many patients left needlessly to die in hospital instead of at home with their families. In this new era of being able to do so much, the most important intervention remains knowing when not to intervene at all. But medicine often pursues the thoughtless and easy option of the prolongation of life for life's sake, with doctors shunning the difficult and honest dialogue with patients on prognosis. Surely our duty is to preserve quality of life and to respect patients' wishes and above all their dignity. Doctors should have the emotional strength to hold aloft a torch to cast light, warm, comfort, and shelter to the dying. For something that is terrible can still be done well and this is a core responsibility of being a doctor. Death must be accepted because it cannot be defeated.

The wanton medicalisation of death has led to calls for assisted suicide in the United Kingdom. And the General Medical Council's response, new guidelines *Treatment and Care Towards The End Of Life: Good Practice in Decision-Making*, is welcome, if wordy. They enshrine for the first time specific rights for patients to refuse treatment and doctors' duty to respect advance directives and their obligation to talk about death. Will this transform end of life care?

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Good at what we know

STARTING OUT
Kinesh Patel

We're all good at different things. Eighteen months ago I had never picked up an endoscope. Now I spend 12 hours a week—10% of my waking hours—with one in my hand. And although there is undoubtedly an element of skill to it, I must admit that most of the ability comes with practice and repetition.

The same goes for understanding patients with gastroenterological problems, from irritable bowel syndrome to inflammatory bowel disease. We all learn by seeing and doing and are much better at dealing with the familiar than the unfamiliar.

Why is this relevant (apart from being a minor exercise in self aggrandisement)? Well it follows that we can't possibly be good at everything and that we should probably stick to what we know best, given our particular skill sets.

It's not just medics, of course, who are subject to this effect: ask a builder to build a small extension. There will be an architect, a structural engineer, someone to dig the foundations, bricklayers, plasterers, tilers, an electrician, a plumber, a carpenter, and a roofer. And each of them, while expert in their individual disciplines, will decline to do any of the other jobs because each requires a specialist.

Junior doctors are often better than managers or even senior doctors at identifying deficiencies in care by virtue of their moves from hospital to hospital and region to region. I have often discussed where I would send relatives with particular problems—and living in London we are spoilt for choice.

Say you had an acutely painful red eye. Where would you go in an emergency? Would you rather wait three hours and 45 minutes at your local emergency department to see a second year foundation doctor who has barely used a slit lamp before? Or would you prefer to go to the Western Eye Hospital and see an ophthalmologist in the same time frame?

The answer is obvious. And it is not just eyes that are affected by such discrepancies of care. Cardiac chest pain? The choice is to wait seven long days for an inpatient transfer to a hospital with a cardiac catheter laboratory or to go directly to the referral centre and be seen and treated within hours. Neurological problems? How many district general hospitals do not even have a full time neurologist? Or take yourself to University College Hospital and be seen by someone from the National Hospital for Neurology.

This is the NHS's guilty secret: although emotive rationing for drugs may date back to yesteryear, what no one is prepared to tell their patients is that chances are their doctor has been rationed too.

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