Soundings

Seize the day

It's great to be alive. If any of us had true insight, a true understanding of what this gift of life means, every morning we would wake up and rejoice and shout and laugh, bubble and effervesce and radiate with joy, sing and dance and go hippity-hop up the street. Because to be healthy, sound of wind, and clean of limb in a world of such coruscating beauty, where the birds are singing like angels and the morning stars still faintly glowing, is but a transient privilege. So seize the day: the best time to be is now, the best place to be is here. It will not always be thus, and each and every one of us will one day become ill and die.

I'm sorry to be the one to break that bad news, but if it upsets you excessively just go ahead and deny it: that's what the rest of us do.

Our lives today are immeasurably richer than in previous generations; we live longer and live better than ever before. We lack the beggars or cripples in the streets that are seen in the Third World and were seen world wide till the last century, but still we do not appreciate our good fortune. When we are well we have no comprehension of what it is to be sick.

Yet our century has its own dark hidden secret. Being elderly used to be a thing of comparative rarity, and elderly folk accordingly were prized and celebrated and venerated both for their vigour in living so long and for the wisdom they had gained along the way. But old folks have no such novelty value any more, and they are the 20th century version of the beggars in the streets. The pain and suffering are still there, in colossal amounts, but today they are not exposed to us every day in the streets, continually confronting our consciences. Instead they are locked away from public view in nursing homes. And our older folk still have so much to teach us and so much to give.

Bob Hope was asked why he hadn't taken up angling after his retirement. "Fish don't applaud," was his reply. A little red herring, perhaps, but the insight was revealing: to have a whale of a time he still needed the succour of the crowd, the laughter and adulation; without them he was in the wrong plaice.

When I am over 75 I intend to make the most of it, join the over 75 ski club, buy a pair of good walking shoes, sit enthroned amid the joyful chaos of my grandchildren in the happy knowledge I'll be handing them back shortly to their real parents, get some more tattoos and an earring for my other ear; and avoid doctors as much as possible.

As the Bible says (though I may be interpreting this incorrectly), "Eat, drink, and be merry, for tomorrow we die." And my last words will definitely not be, "I wish I'd spent more nights on call."

Liam Farrell, *general practitioner, Crossmaglen, County Armagh*

Personal view

When should a specialist retire?

In 1844 an editorial in the *Lancet* (1844;i:486-90), presumably by Thomas Wakley, excoriated the eminent William Prout as a man who had outlived his reputation and exerted a stultifying influence on progress in his field:

"[H]is main researches have been superseded by others .... [He] has retained in the text of his last edition his own account of the process of digestion without taking proper cognisance of the digestive principle *pepsin* .... [His] pathological notions ... have the appearance of closet speculations, and are diametrically opposed to the opinions of the soundest and most experienced men of the day .... [He has] total disregard of numerical and statistical details ... [and offers] hypotheses which are unsubstantiated either by facts or arguments .... Dr Prout's name and authority exercise an influence that is detrimental to the cause of science in this country .... Time was when our schools stood foremost in the ranks for originality and discovery, but that time seems to have passed away .... The fault lies [in] the authority of those who, having earned a reputation for themselves, cast unfounded doubts upon the labour of others, neglect and repudiate, without sufficient cause, the methods followed by their competitors, and deny them that honour to which they are justly entitled by their discoveries. We regret to find Dr Prout in this category."

Charles Mayo, after visiting Britain in 1907 also found superannuated specialists.

"Men who occupy the chief positions in the London hospitals, have gained them ... through long years of patient waiting and working in subordinate positions. By the time they became leaders, their work is more or less crystallized; and unfortunately, in many hospitals there is no machinery ... whereby these men may be retired .... [In] Edinburgh ... [it] is unfortunate that there is no age limit for the retirement of division heads, since the present system leads to their retention after their usefulness has departed, and the consequent delay in the advancement of the younger men."

Both Osler and Sir Ian Fraser had insight. Osler had two "fixed ideas: The first is the comparative uselessness of men above forty years.... The ... vitalizing work of the world is done between the ages of twenty-five and forty ... the anabolic or constructive period .... My second is the uselessness of

men above sixty . . . and the incalculable benefit it would be in commercial, political and professional life if, as a matter of course, men stopped work at this age."

Fraser "told one senior colleague that I was going to retire; he said very kindly, 'We will miss your mature judgment.' I hope he meant it. On the same day I ran into a much younger man and I told him the same. His reply was, 'High time,' and I know he meant it."

I sent a questionnaire to gastroenterologists around the world asking the usual age of retirement. In 34 countries 19 required retirement at 65. Retirement age ranged from 58 in India, 60 in seven countries and 63 in Finland up to 67 in Norway and 70 in Brazil, Denmark, and Spain. Australia and the United States had no fixed age limit. Four countries allowed academics, department heads, or professors to retire later, while in 10 employment could be prolonged for a few years.

I have suffered from gerontocracy, and was pleased to be forced to retire at 65 from both my health service and university sessions in Britain. I retired from editorial boards and committees, and told journals, funding bodies, and universities that I would not write editorials, referee scientific papers, or grant applications, nor examine. I no longer see patients or direct research, and limit my competence to the history of medicine, science, and healthcare arts, where I do not lock out younger people. Most British private hospitals and NHS private wings stop consultants working after 70 except by annual extension by their medical committees. Some private health insurers will not pay specialists after their 70th birthday.

"We will miss your mature judgment"

The Wellcome Trust told me their choice of "most of the referees used are still active in research. However, there are circumstances—for example, when we need advice on academic or strategic scientific issues, when we seek advice from more senior individuals who can contribute some of the wisdom which accrues from a lifetime of research."

I work half the year in New York, which, as in my stay in 1961-2, has no mandatory retirement age for hospital or academic specialist staff, because it has no national health service and because by law no one can be forced to retire at any age except for incompetence. Instead each institution adopts its own policy. Few impose mandatory retirement ages on individual doctors, but many require retirement at specified ages for department or division heads. It will be interesting to see whether the changes in the delivery of specialist health care in the United States lead to a compulsory retirement age.

I thank those who answered my questions and improved my text.

Jeremy Hugh Baron, *honorary professorial lecturer, Mount Sinai School of Medicine, New York*

Medicine and the media

Failed publications: the medical model

Why are so many medical reports and newsletters written in pseudoscientific gobbledygook? Tim Albert considers these sad creations

Next time you see a newsletter or an annual report from a distinguished medical body, look for the anodyne bureaucratic phrases and the pseudoscientific gobbledygook, the pompous initial capitals, and the photo booth "repertory company" photographs. Then reflect that in all probability a lot of highly paid academics put in a lot of expensive hours making the publication that bad.

Earlier this year I gave up that part of my business which produced newsletters for medical and academic organisations. While most of my clients were charming, stimulating, and able, they were working within a culture that encouraged a type of behaviour that has serious implications for the relation between medicine and the media.

The story invariably goes something like this. Someone decides that it is time the organisation had a newsletter or glossy annual report. A middle manager (rarely a doctor or a scientist) is nominated to do the work, and she (almost invariably a she) brings in outside professionals to help. Together they carefully define the purpose of the publication; describe the readers they wish to reach (usually influential lay people); and commission designers, photographers, and professional writers. The first draft is completed within the deadline; it looks handsome and is (for the target audience) reader friendly.

Now the trouble begins. Instead of the document being shown to one person at the top of the organisation to say whether the organisation can live with it, in the name of democracy and the spirit of scientific inquiry (also known as peer review) it is sent round to all the major players in the institution for their opinions.

This is invariably disastrous. Paragraphs are removed or (worse) added for reasons of institutional and professional politics. Well produced photographs are replaced by those more flattering to the subjects. Words like department, doctor, and division become Department, Doctor, and Division (although patient always stays as patient). Sentences that were short and simple become converted into the worst kind of medical journal speak: "About two thousand people die each year from asthma" becomes "It has been demonstrated in the literature that 1986 men and women in England and Wales die from asthma and related disease." Instead of being focused on persuading outsiders of the merits of the institutions, the document becomes a series of compromises, each intended to serve the interests and attitudes of the main political players rather than those of the target readers.

And, yes, it does matter. One of the most powerful influences on media messages is what organisations and individuals say about themselves. If a large part of a large sector—in this case the scientific medical establishment—is putting out messages that are less effective than those from other organisations then they will be misunderstood or ignored. For evidence, compare the publications of medical organisations with those put out by successful commercial organisations, and then ask yourself which ones are likely to attract, and keep, uncommitted readers.

There must be a major change of attitude. If scientists and doctors want good documents they must learn to accept plain English (and the strong messages that go with it) and hire and then trust good professional communicators. Those at the top of these institutions must be more explicit as to what they want their documents to achieve, more robust in the way they handle internal critics, and more exacting in the way they evaluate the document's success. Others in these institutions must learn to be less touchy. In particular, doctors and scientists must realise that, although they may be good judges of good science, they are not necessarily good judges of good communication.

Tim Albert, *trainer in written communication and visiting fellow in medical writing at the Wessex Institute for Health Research and Development*