My surprise at fallout over dispatches from Israel

PERSONAL VIEW  A Mark Clarfield

Despite the fact that I like to write, I have never before thought of publishing a blog anywhere. But when the BMJ asked me to write about my experiences in the recent war in southern Israel and Gaza, it all came pouring out.

I wrote about the heavy responsibility I had felt in trying to look after my frail elderly patients in a hospital that Hamas had targeted with sophisticated Grad missiles. I wrote about watching friends and colleagues being called up to serve in the army and how we coped, psychologically and clinically, with this sudden absence. I wrote about Matan, my son’s friend and our friends’ son, whose task it was in the army to neutralise explosives in an endless number of homes (yes, civilian homes) that Hamas had boobytrapped in the hope that they would kill our soldiers—and hang the possibility that innocent Palestinian civilians might be hurt. I wrote about the careful instructions that he and his mates had received throughout training and during combat to minimise civilian casualties. Owing to the fog of war, they could not always succeed, but I have personal knowledge of the type of instructions received. I only tangentially alluded to the terrible fear I had felt whenever the air raid sirens went off. During those attacks I painfully counted the seconds, awaiting the boom that meant Hamas had missed me, again.

I wrote about other things. For example, I asked why many people in the world were so seemingly enraged by Israel’s attempts to defend its civilians but how we had not heard from these same critics before the recent hostilities.

I considered my BMJ mandate to be to provide a description of my medical experiences on the southern front. And this I tried to do, despite the frequent presence of other more intrusive thoughts.

To my surprise, some people actually read my four postings. Each blog sported a number of responses. 10 to my story about the tragedy of innocent children being hurt on both sides; 14 to my piece on how, despite being immersed in this terrible crisis, Arab and Jewish Israeli professionals in my hospital pulled together and were able, at least on the clinical level, to function quite well; nine responses to my account of how the hospital planned and modified its services during the war and how we coped with caring for the wounded, both military and civilians; and 11 to a more personal account of how, despite my own fears during one of the missile attacks, I had attempted to calm a petrified women with whom I suddenly found myself taking shelter.

I enjoyed seeing every one of these replies, even those from correspondents who hardly seemed to have my welfare uppermost in their minds. They were of several types, some supportive, others less so. Despite my attempts to concentrate in the blog on medical matters, a number of responses actually had little or nothing to do with the content of my postings. Some were vituperative, blaming Israel for all kinds of purported war crimes and misdemeanours. Curiously, these authors never seemed to address the fact that Israel was responding to the breaking of a ceasefire that had just preceded eight years of unprovoked missile attacks on its southern and sovereign territory. C’est la vie, I suppose. Nor did they concern themselves with the fact that, according to Hamas statements themselves, each of its rockets was actually aimed at civilians. Why? Because, said Hamas, all Israelis—men, women and children, old and young, sick and well—are “in the Zionist army.”

Most correspondents signed their names, but one of my staunchest critics, who weighed in a few times, signed off as “Anon Emous.” A particularly avid respondent was a “Mark Struthers,” who, if it is the same chap, is apparently no stranger to other targets in the BMJ. He actually took the time to pen five responses, each less a model of restraint than the previous. One early example: “Look at the young people of Israel who laugh as the bombs rain down on Gaza . . . and the extermination of the Palestinian people. I can only pity the nation . . . and the monster that Israel has become.” Odd, I thought. I hadn’t seen anyone laughing around me, young or old. As to the outrageous term “extermination,” no comment I could make would suffice to respond to this kind of hysterical charge.

Others, such as “Salim,” were upset that I had not covered both sides of the conflict. Perhaps he thought that I was a kind of war correspondent rather than just a doctor trying to keep his patients up and his head down.

Responses were certainly varied. One reader felt the need to correct me when I mentioned the red kaffiyehs (men’s headdresses) worn by some patients at my hospital: Ms Catherine Richmond, also something of a serial responder but a bit less enthusiastic than Mr Struthers, pointed out that these could not be Israeli Arabs, as they always wore only black and white ones. This is odd, because when I subsequently asked one where he was from, in flawless Hebrew he told me that he came from an Israeli village just a few kilometres from the hospital.

Still others viewed this terrible conflict as just some kind of childish schoolyard squabble. One writer, describing herself as a “pacifist,” helpfully suggested that both sides should just stop.

Of course, there were a few who seemed to understand the situation and sympathised with Israel’s position. For example, Michael Gordon pointed out that Hamas “rockets are not crude in their lethal effect or intent.”

Perhaps the most heartwarming response was the one that seemed to reflect an understanding that in my blog I had been trying to show what it was like as a doctor, not as a political scientist, to experience this conflict. And how as a doctor I hoped with all of my heart for an end to the hostilities and fighting. Matiram Pun had this to say about the description of our work at Soroka Hospital: “Thank you for bringing the situation so lively and vivid!!! This is very very scary. It is beyond imagination how narrow the grey area is there between the green area of life and the red zone of Death there!!! Hopefully, there will be no more civilian casualties.”

My only thought in response was, “Amen.” A Mark Clarfield is head of geriatrics, Soroka Hospital, Ben Gurion University of the Negev, Beer-Sheva, Israel markclar@bgu.ac.il

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

Cite this as: BMJ 2009;338:b722

See EDITORIAL, p 491, ANALYSIS, p 509

PODCAST

Mark Clarfield talks about life as a doctor in southern Israel, and reactions to his blog, at podcasts.bmj.com/bmj

“Let’s get the teenagers with heavy metal T shirts off their computer games and give them a three week deadline” Des Spence on how to fix the NHS computer project, p 548

PODCAST

Mark Clarfield talks about life as a doctor in southern Israel, and reactions to his blog, at podcasts.bmj.com/bmj
The very model of a vampyre

To those of literary ambition but modest talent the company of writers of genius can be discouraging. No quantity of self-deception is sufficient to disguise the gulf between their own productions and those of the geniuses in question; it has the same effect as coming too near a flame.

John Polidori (1795–1821) was the son of an Italian refugee in England. He attended Ampleforth College and then Edinburgh University, where he received his medical degree at the age of 19. Lord Byron selected him as companion and personal physician for his journey to the Continent that started in 1816 but discharged him after a few months because he found him bumptious, tiresome, and opinionated. Byron was not a man to take kindly to the opinions of others, especially those of a commoner.

Before they set out Dr Polidori had an agreement with John Murray, Byron’s publisher, to write an account of their agreement with John Murray, Byron’s best work to date. The main character of the story, which is only a score of pages long, is Lord Ruthven, an aristocrat of chillingly distant mien, who was capable of fascinating people by the magnetism of his eyes. He is the “vampyre” of the story’s title, who sucks the blood of young maidens and transforms them into vampires in their turn.

It is universally agreed that Dr Polidori’s model for Lord Ruthven was Byron himself; and since Polidori’s vampire was the model for that in Bram Stoker’s Dracula . . . Lord Byron was the ultimate inspiration of the vampire industry.

The coroner’s verdict was death “by sympathy.” No doubt this was the model for that in Bram Stoker’s Dracula. It follows that not Prince Vlad of Transylvania but Lord Byron was the ultimate inspiration of what might be called the vampire industry.

Having been discharged by Lord Byron, Polidori attached himself briefly as personal physician to another British aristocrat before returning to England to try to practise in Norwich. He soon gave up, however, and read for the bar instead; a gambling debt, it is said, caused him to commit suicide by swallowing prussic acid at the age of 26.

The coroner’s verdict was death “by Visitations of God.”

Theodore Dalrymple is a writer and retired doctor.

BETWEEN THE LINES

Theodore Dalrymple

It is universally agreed that Dr Polidori’s model for Lord Ruthven was Byron himself; and since Polidori’s vampire was the model for that in Bram Stoker’s Dracula . . . Lord Byron was the ultimate inspiration of the vampire industry.

To those of literary ambition but modest talent the company of writers of genius can be discouraging. No quantity of self-deception is sufficient to disguise the gulf between their own productions and those of the geniuses in question; it has the same effect as coming too near a flame.

John Polidori (1795–1821) was the son of an Italian refugee in England. He attended Ampleforth College and then Edinburgh University, where he received his medical degree at the age of 19. Lord Byron selected him as companion and personal physician for his journey to the Continent that started in 1816 but discharged him after a few months because he found him bumptious, tiresome, and opinionated. Byron was not a man to take kindly to the opinions of others, especially those of a commoner.

Before they set out Dr Polidori had an agreement with John Murray, Byron’s publisher, to write an account of their agreement with John Murray, Byron’s best work to date. The main character of the story, which is only a score of pages long, is Lord Ruthven, an aristocrat of chillingly distant mien, who was capable of fascinating people by the magnetism of his eyes. He is the “vampyre” of the story’s title, who sucks the blood of young maidens and transforms them into vampires in their turn.

It is universally agreed that Dr Polidori’s model for Lord Ruthven was Byron himself; and since Polidori’s vampire was the model for that in Bram Stoker’s Dracula. It follows that not Prince Vlad of Transylvania but Lord Byron was the ultimate inspiration of what might be called the vampire industry.

Having been discharged by Lord Byron, Polidori attached himself briefly as personal physician to another British aristocrat before returning to England to try to practise in Norwich. He soon gave up, however, and read for the bar instead; a gambling debt, it is said, caused him to commit suicide by swallowing prussic acid at the age of 26.

The coroner’s verdict was death “by visitation of God.”

Theodore Dalrymple is a writer and retired doctor.

Cite this as: BMJ 2009;339:b801

MEDICAL CLASSICS

The Sea and Poison By Shusaku Endo

First published in Japan in 1958 and in English translation in 1972

“Doctors aren’t saints.” So says Toda, one of the doctors in Shusaku Endo’s novel that was based on actual human vivisections carried out in Japan during the second world war. “They want to be successful. They want to become full professors. And when they want to try out new techniques, they don’t limit their experiments to monkeys and dogs. Suguro, this is the world, and you ought to take a closer look at it.”

The Sea and Poison is a tale of the subjugation of patients’ care to doctors’ ambitions. It tells of medical error and its concealment and of war crimes carried out by medical staff. A power vacuum exists in the medical hierarchy of a university hospital, and different factions vie for control. Experimental surgery is planned on a poor elderly patient with negligible hope of recovery. A prestige gaining operation on a young relative of the previous dean goes catastrophically wrong. Their fortunes having faltered, one department colludes with the military to carry out lethal experiments on US prisoners, thereby bolstering their position in the power struggle. The principal vivisection, portrayed by the protagonists as crucial to thoracic surgery for tuberculosis, is carried out to measure how much of the bronchial tree can be cut before the patient dies.

What is startling about this novel is that it evokes not only revulsion and horror but also some understanding of the protagonists. Much of the book is devoted to exploring the formative experiences of the characters and the lifelong shadow cast over them by their involvement.

Suguro is an idealistic medical school graduate who becomes disillusioned by the realities of clinical practice and his colleagues’ cynicism. He passively acquiesces to help in the vivisections through a combination of inertia and fear of going against his superiors. The Old Man, a senior professor, is grasping his last opportunity to become dean and is left an empty shell of a man. Nurse Ueda has been rendered deadened and apathetic by a life dogged by misfortune. Toda, in a searing first person narrative, relates a life of detachment and apathy. Suguro asks, “Aren’t you too, deep down, unmoved by the suffering and death of others? Aren’t we brothers under the skin perhaps?”

This novel provides a stark reminder of one of medicine’s most abhorrent episodes and serves as a case study of research ethics, ambition, conscience, responsibility, and the difficulties of individual conduct in wartime conditions. The concept of personal integrity is, however, one of timeless importance. As Endo himself said, “If I had been confronted by the decisions faced by Suguro in The Sea and Poison, who am I to say that I would not have responded as [he] did?”

Cite this as: BMJ 2009;338:b782
Error report

FROM THE FRONTLINE
Des Spence

Meatloaf blasted from the jukebox. Tears welled in her eyes as she looked down into her Lambrusco. I met my mate’s eyes and nodded. We left, heading for the arcade games—huge gaudy machines, with only two buttons and a simple joystick. “Rolling Thunder,” “Hang-On,” “Gauntlet,”—these monsters consumed my grant, time, and headspace. They were simple, intuitive, and fast, but the computer programs behind them were tiny. These days computing is big business, with the NHS spending £12bn (£14bn; $18bn) on a national integrated records system. London’s Royal Free Hospital is trialling this new system, but its recent crash blasted clinical staff back to the stone age of pen and paper. How can this be?

In primary care computer systems have evolved for 20 years from those set up by small companies started by practising doctors. We now have paperless systems, meaning an end to illegible handwriting (if not illogical content), no lost records, no Brownian filing, multiple access, up to date prescribing records, integrated laboratory results, and electronic transfers between practices. Some practices even offer online appointment bookings. These systems are stable, flexible, functional, and familiar. We have huge vested interests in making these systems work.

But in 2004 responsibility for our IT passed to the primary care trust, and we have lost local control. Increasingly we see an obsession with security; currently I need six passwords to access the full system, and these change constantly at ever decreasing intervals. New systems seem to need high spec hardware, only to run more slowly. Why is this? Because now commissioning is detached from the users. As a result procurement is overly ambitious, overly complicated, and driven by management priorities, not clinical ones. Also, trusts are addicted to the safety of big monolithic contractors whose creativity long ago became trapped in the mire of corporate hierarchy. These projects, devoid of accountability, always promise all things to everyone but deliver nothing to anyone.

We are always told health is different from other sectors. It isn’t. Why can’t we develop a secure, intranet based solution that is shared across the NHS with one common record, is simple and intuitive to use, and has the look of traditional paper records? This would be cheap and easy to develop. In 2004 a college student set up Facebook, which now has 175 million users. So let’s get the teenagers with heavy metal T shirts off their computer games and give them a three week deadline, because the current system simply isn’t good enough.

Des Spence is a general practitioner, Glasgow destwo@yahoo.co.uk
Cite this as: BMJ 2009;338:b798

“Paid for by the NHS”

Kinesh Patel

“There are four ways in which you can spend money. You can spend your own money on yourself. When you do that, then you really watch out what you’re doing, and you try to get the most for your money.

“Then you can spend your own money on somebody else. For example, I buy a birthday present for someone. Well, then I’m not so careful about the content of the present, but I’m very careful about the cost.

“Then, I can spend somebody else’s money on myself. And if I spend somebody else’s money on myself, then I’m sure going to have a good lunch!”

“Finally, I can spend somebody else’s money on somebody else. And if I spend somebody else’s money on somebody else, I’m not concerned about how much it is, and I’m not concerned about what I get.”

The Nobel prize winning economist Milton Friedman, who said these words, defined four different kinds of spending in a way most people could relate to. These words typify the fundamental problem with the NHS, in that it is the epitome of the fourth category.

Free car parking for everybody? Yes! More expensive drugs against cancer? Yes! A few more teenage pregnancy coordinators (a job that sounds like it would be best suited to a virile adolescent)? Why not?

Everyone likes something for free. And while it is easy to always ask for more—and hard to refuse without seeming cruel—it is impossible for the normal human brain to comprehend what the individual effect of an extra billion pounds here or there will actually be.

Even in these credit crunch times, when newscasters have given up talking about millions of pounds in favour of tens of billions, every penny spent matters and has to be paid for—by someone else. And the demands on the health service from patients are limitless.

When will it all end? Personal trainers for everyone? How much would that cost per quality adjusted life year? It would probably be more cost effective than many treatments already paid for by the public purse.

So, why not try to inject a touch of reality into the minds of the public? A bill, presented at the end of each hospital stay or procedure or scan with the amount spent and the words “Paid for by the NHS,” would go a long way to making people appreciate the value of the services they receive. For, as one of the consultants here sardonically observed last week: “It’s only when they go private they actually find out how much things cost.”

Kinesh Patel is a junior doctor, London kinesh_patel@yahoo.co.uk
Cite this as: BMJ 2009;338:b739