We should reform libel laws in light of Singh victory

PERSONAL VIEW A C Grayling

When three senior Court of Appeal judges came down on Simon Singh’s side in his libel tussle with the British Chiropractic Association, they did so by ruling that the right to state an “honest opinion” is essential to free speech and that Singh was entitled to claim this as a defence to the association’s action against him (BMJ 2010;340:c1895). And they thereby lent great weight to the now almost universal criticism of English libel law—namely, that it has a deeply chilling effect on legitimate debate and criticism, illustrated by the fact that the association’s suit against Singh silenced discussion. This, the judges said, “might otherwise have assisted potential patients to make informed choices about the possible use of chiropractic.”

The judgment, which the association might yet appeal, concerned one crucial aspect of Singh’s case: whether he can rely on a defence of fair comment. It is this decision that the appeal court has cost £200 000 (€230 000; $300 000) so far—cost capping has to lie at the centre of reform. But it cannot be the only reform. Dealing with costs has to stand beside a robust “honest opinion” defence to enable more discussion, challenge, research, comment, and investigation. Now that the appeal court itself has said as much, there can be no excuse for parliament not to legislate accordingly. Peer reviewed scientific and other academic research should have even stronger protection: the status of “privilege” should be extended to it, affording the same insulation as is enjoyed by what is said in parliament or the law courts.

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In saying that Singh is entitled to such a defence the appeal court has also placed a major weapon in the hands of those calling for statutory overhaul of English libel law. The current law has earned London the unenviable reputation of “libel capital” of the world. The result has been to make money and corporate bodies are among the quickest to sue to silence criticism, libel cases are highly lucrative for lawyers.

But another and, in its own right, more serious obstacle is the need to preserve what is right in libel law, which is to provide a remedy for those whose reputation—and as a likely consequence, therefore, livelihood—has been wrongly or unfairly damaged. There has to be a resource for individuals—especially individuals—and organisations to resist wrongful defamation and to be compensated for any harm done. The question is: how is this to be achieved without the huge downside of the current situation?

The obvious answer is cost. Cost is a function of process—the cumbersome process of the great machinery of legal endeavour, with solicitors’ and barristers’ fees on both sides increasing multiplicatively with the passage of time. Because the mere threat of expense is the chief factor causing the mere threat of libel actions to stultify debate in our society—Simon Singh’s road to the appeal court has cost £200 000 (€230 000; $300 000) so far—cost capping has to lie at the centre of reform.

Without question there is everything to be gained by a thorough reform of English libel law, and between them Simon Singh and the Court of Appeal have shown the way.

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Cite this as: BMJ 2010;340:c339

See NEWS, p 777
Do you think everything you do is determined by you and you alone? What influence might those around you have on your mental wellbeing? Can a friend of a friend have an effect on your physical health? These are some of the questions tackled in Connected, a new book that addresses the meaning and impact of social networking on our lives.

Co-authored by Nicholas Christakis, an American physician, professor of medical sociology at Harvard Medical School, and one time BMJ columnist, this is a compelling and highly accessible book, although it covers a wide range of complicated topics. Stories, diagrams, and case studies are used to good effect, with examples from past outbreaks of hysteria to more recent customer panics over the near collapse of the Northern Rock building society. And while some discussions of how individuals and groups may influence each other are fairly familiar—for example, in voting behaviour—others are far more intriguing. Peanut allergies, for example, are examined in the book in the context of public panics about child health that expand across communities in a cloud of social anxiety.

Epidemiologists are used to tracking infection, but this book places these activities into a wider social context. Topics as wide ranging as suicide contagion and sexually transmitted infection are looked at visually with maps, charts, and diagrams and in terms of sociological and psychological impact. Without medicalising, the book also focuses on how obesity can be related to proximity—friends, family, and wider communities can be the place where your physical health is supported or limited and where you identify with norms and values that drive food consumption.

Although social networking is a hot topic, this aspect of our online lives is not a main part of the book, but is covered at the end of it. This is the part of the book most likely to date quickly, but what is discussed is very important. The authors provide a clear and entertaining overview of the history of mediated social networks, beginning with print and moving to the telephone before tackling the internet. Given the current moral panic around the dangers of social networking sites, voiced in the media and endorsed by some practitioners (although not clearly evidenced), it is refreshing to see a more nuanced conversation about this issue. The discussion may well help those wanting to work in this area to find clearer and calmer explanations for social networking phenomena.

Physical and psychological health issues are at the core of the book, although the authors do not suggest how the ideas shared could be used in practice—that is left for the reader to interpret.

Some readers may appreciate this challenge, but others may feel that direct instruction on how to apply the findings to health and social care would be more helpful.

Although the book is concerned with social science its interpretative framework is largely evolutionary. Although this angle is interesting, it is limiting and not representative of social science as a whole. Exciting critical or applied approaches that could have been used to good effect here are absent, which is a shame. There are parts of the book that are still heteronormative and in places judgmental—for example, the description of swinging communities is outdated and could have benefited from more current research.

The fascinating case studies are supported by evidence, but these references are not really explored or unpacked. This is disappointing, as some of the issues are complex and might well have different interpretations. However, I accept that further exploration might have overcomplicated matters, and as a general overview of social connections might well help those wanting to work in this area to find clearer and calmer explanations for social networking phenomena.

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I would recommend the book as a fascinating and enjoyable read and something that definitely makes you think again about your place in the world—and how you came to be there.

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Cite this as: BMJ 2010;340:c1851
Sophistcates and slobs

When I was a student a friend of mine (who has since achieved great eminence) said that one of the consequences of growing old was hardening of the concepts. It was therefore with relief that I discovered recently that I was still capable, despite my advanced years, of learning a new concept.

The notion in question was that of “gratuitous smoking.” I learnt of its existence in a newspaper article about a group of doctors who had called for a ban on smoking in private cars to protect the health of children. According to the report, the doctors also suggested that films with “gratuitous smoking” should be shown only to those over the age of 18.

Now if there is gratuitous smoking, there must presumably be justified or rational smoking. I am not sure whether gratuitous or justified smoking is intrinsically the harder concept to grasp, but it so happened that a crime novel I read soon afterwards gave me an insight into it.

One of its main characters is Slim Callaghan. As for chewers of gum—“sevenpence half-penny in his pocket and a heavy smoker’s cough.” This description reminded me of my childhood, when smoker’s cough was regarded not as a symptom of an actual or incipient disease, but as a mildly amusing eccentricity or character trait.

In the book, Callaghan and others light up or send for cigarettes no fewer than 84 times in the space of 222 pages. Blowing perfect smoke rings, or smoke out of one nostril, is a sign of the utmost sophistication. If that is not gratuitous, I don’t know what is.

The first page of the book reminded me of why I hate smokers even more than anti-smokers: “Callaghan felt in his raincoat pocket for a packet of Player’s, produced it, found it empty, threw it away.”

That’s precisely what smokers still do in the otherwise delightful road in which I live. Why should I have to go round clearing up after them? Smokers are incapable of putting their packets into wastepaper bins even when they are 15 inches away from them. I think they think that it is a sign of hard-boiled sophistication to fling them away like Slim Callaghan. As for chewers of gum—don’t get me started…

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Cite this as: BMJ 2010;340:c1889

MEDICAL CLASSIC

On the Death of Dr Robert Levet

By Samuel Johnson Published in 1783

One of Samuel Johnson’s greatest poems was an elegy for a physician and friend who for many decades cared for the London poor with grace and simplicity. Robert Levet was, according to Johnson’s biographer James Boswell, “an obscure practitioner of physic amongst the lower people” who collected minimal fees but had such an extensive practice that he walked daily on his rounds. “From Houndsditch to Marylebone.”

Johnson had a passionate sympathy for the poor, and called the silent and tireless Levet “a very useful and very blameless man.” When Levet died, Johnson was moved to write a poem that the critic W Jackson Bate has praised for its “deep, dignified, and accurate feeling directly engaged with real and daily things.” The poem is never sentimental and never overstated, and is, therefore, all the more powerful.

Although published in 1783, the poem has much to teach modern physicians and medical students about modesty, restraint, equanimity, and endurance. These are traits that have perhaps become undervalued in our era of technocratic medicine and self-promoting physicians.

“Obscurely wise and coarsely kind,” Levet was always there for his patients:

“No summons mocked by chill delay, / No petty gains disdained by pride; / The modest wants of every day / The toil of every day supplied.”

And despite the limited remedies of his time, Dr Levet seems to have been an effective practitioner:

“When fainting Nature call’d for aid / And hov’ring death prepared the blow, / His vigorous remedy display’d / The power of art without the show.”

The phrase “The power of art without the show” suggests strength through humility and restraint. “Show” here means an “ostentatious display” (one of Johnson’s own definitions from his Dictionary of the English Language), which brings to mind a physician flourishing his stethoscope and making dramatic gestures and pronouncements at the bedside. Dr Levet, on the other hand, just did his job simply and effectively, without the “show.” The simplicity and modesty of his practice added to the power of his art. Sir William Osler, the most influential physician of the late 19th century, also understood the importance of humility for a doctor: “With it comes not only a reverence for truth, but also a proper estimation of the difficulties encountered in our search for it.”

The idea of power through restraint resonates with Shakespeare’s 94th sonnet (“They that have power to hurt and will do none, / That do not do the thing they most do show, / Who moving others, are themselves as stone, / Unmoved, cold and to temptation slow . . .”), which seems to be about the paradoxical increase of strength and self possession that arises from the judicious withholding of force, the restraining of passion, and the containment of facile emotion. In world affairs, real and lasting power does lie in the use of restraint, as Gandhi and Martin Luther King have shown with their use of non-violent approaches.

On the Death of Dr Robert Levet is more than praise for a useful and blameless man: it celebrates the finest qualities of a physician. Look around the hospital, perhaps you’ll find a “Dr Levet”—that quiet but competent physician who arrives early and stays late, takes his time on rounds, keeps calm in emergencies, and grows old with his patients.

Cite this as: BMJ 2010;340:c1847

Dr Johnson: celebrating humility and restraint

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Published in 1783

On the Death of Dr Robert Levet

His vigorous remedy display’d / The power of art without the show.”
Bad medicine: depression

A fundamental question for society is: while we have become richer and healthier, why have we become unhappier? Self reported depression has risen steadily, and a leading charity claims that one in 10 of us is currently depressed and that the lifetime risk is one in four. Such figures have been splashed across the media, and depression is presented as a particular problem in young people, with a rising rate of self harm in this group. Medical pundits still claim that depression is underdiagnosed and undertreated. We have a prevailing reductionist approach to depression, suggesting that mood is a simple “chemical imbalance” and amenable to intervention by the chemistry set of modern drugs. Rarely these days is it suggested that depression is a social problem, merely a natural reactive adjustment to life events.

Some of the more paranoid see depression as a pharma conspiracy, with companies hitting the prescription jackpot. And in the United States—the Vegas of medical excess and overmedicated mayhem—there is a new vogue for multiple prescription of antidepressants, mood stabilisers, and even antipsychotic drugs in depressive illness. Yet the biggest gamble is in treating children, with drugs widely dispensed and a persistent “disease creep” of adult diagnosis into schools.

These trends continue despite conflicting evidence that antidepressants are little better than placebo. But none of this anti-pharma conspiracy theory is new. And indeed in Britain we are now betting on a new “counselling culture” in the NHS. This is certainly better medicine, but is it the right medicine? For counselling has strong potential to be unilateral, unconditionnal, and unsubstantiated—offering the potential for indulgence and dependence. Widespread talk therapy could just become another new type of medicalisation. All our current approaches reinforce the notion of depression as “illness.”

Decades of drug treatment and counselling have not defeated depression, and by some crude markers of mental illness perhaps we have made the situation worse. Has the time come for medicine to step back? Is depressive pain a reactive evolutionary process? Is teenage angst merely nature’s gauntlet to adult insight? Is our medicalisation of mood undermining self reliance and coping? Have we been peddling an unrealistic notion: that life is always happy? Lastly and fundamentally, does depression have purpose? It seems that the only possessions worth owning are the very things that can’t be possessed. The medicalisation of mild to moderate depression has not been bad medicine, but it is sad that it hasn’t worked. So maybe it’s unfashionable to say it, but we need some new interpretations of stoicism, acceptance, normalisation. Indeed, perhaps the cure for the pain of depression lies more with society than the individual.

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Cite this as: BMJ 2010;340:c1873

Hard decisions

“But my local hospital is so good.” It doesn’t matter where you are, with perhaps the exception of mid-Staffordshire: sentiments such as these are echoed up and down the country. Everyone loves their local hospital, just as everyone loved their local pub, post office, and shop. All of these occupy important parts in the heart of most communities.

But after the pub or shop or post office have long since shut down and are only footnotes in a local historian’s archive, the local hospital remains open. No one dares to suggest that it may be better to close it, for fear of vitriol and vilification, locally and nationally. MPs have lost their seats over such matters. The newspapers love it: scaremongering is a great way to sell copies. And there is usually a local bureaucrat or villain who can adorn the front cover—modern day sheriffs of Nottingham.

Well, let me say it. We have too many acute hospital beds. We have too many elderly people waiting—long after their initial illness has passed—either to go home or to a long term care facility. And what is really sad is that many do not make it to either; they die in hospital.

Where do doctors tend to stand on the matter? Unfortunately, it is usually with the nimbys. Thrown from bed crisis to bed crisis, we instinctively feel that shutting down our hospital must be a bad thing, and then there’s our inbuilt inclination towards self preservation.

But how many patients need to have a blood bank, nuclear medicine, and operating theatres on the same site? And how many just need some care and attention with physiotherapy, diligent nursing, and an efficient social services department? Even though it is sacrilege to suggest it, many patients do not even need daily medical input.

Unfortunately we are pretty hopeless at leading from the front when it comes to reconfiguration of services, preferring to criticise from the back. Those doctors who do put their head above the parapet are instantly pilloried for even trying to improve services.

Let’s put things a different way. If you look around the hospital ward today, surely what you see cannot be the answer to care in the 21st century? What we don’t need is more of the same.

So it is a real shame that as a profession we cannot advocate wholesale service redesign and instead leave it to managers, who close wards surreptitiously to avoid any substantial outcry. It is time for us all to get more involved in making the hard decisions—after all, we’re good at telling people things they often don’t want to hear.

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Cite this as: BMJ 2010;340:c1920