Surgical techniques to repair hernia in the abdominal wall have evolved. Repair with suture alone is associated with a high risk of recurrence, and use of mesh has become routine in contemporary practice. Advances in molecular biology and tissue engineering have furthered the development of surgical meshes. Many types of mesh are available, including pure synthetic, pure biological, and composite and tissue separating meshes, and no single mesh is perfect for every situation. Many new products are entering the market, the origin and composition of which are not always obvious. Biological and composite meshes may contain porcine or bovine tissue. In my experience colleagues, including surgeons with a special interest in hernia surgery, are generally unaware of the constituents of these meshes.

The UK General Medical Council gives guidance to doctors about patients’ freedom of thought and their right to choose treatment according to their beliefs and personal and religious practices (www.gmc-uk.org/static/documents/content/Personal_Beliefs). As a principle, it says that clinicians must work in partnership with patients. As a part of good medical practice doctors must listen to patients and respect their views about their healthcare, share with patients the information they want or need to make a decision, and respect patients’ decisions (www.gmc-uk.org/static/documents/content/Consent). To obtain informed consent, a doctor has to discuss the options for treatment, and we know that the practice of obtaining informed consent for hernia surgery is not consistent (Hernia 2009;13:73-6). The onus is on the surgeon to provide adequate information about the constituents of a potential implant and to discuss the options to avoid patients’ distress and possible litigation.

Patients’ religious or other beliefs may be fundamental to their sense of wellbeing, and they have a right to know what prosthetic material will be used for their hernia repair. Acceptance of xenogeneic mesh among patients from different cultural and religious groups varies. Knowledge of these attitudes would help surgeons when obtaining informed consent. Absolute or relative restrictions of the dietary consumption of porcine and bovine material among various religious groups are relatively well known. However, there are no clear guidelines about the non-dietary use of animal products in the treatment of patients with particular beliefs. A doctor should not assume that patients would accept an implant that contains products of animal origin (J Am Coll Surg 2010;210:402-10 and Arch Surg 2008;143:366-70). For people of Muslim and Jewish faith, for example, dietary consumption of pigs is prohibited in ordinary circumstances, but use of pigs for other purposes is controversial. And some patients may want to practise pure vegetarianism, for religious reasons or otherwise.

I wonder what the reactions might be from patients who have already received such an implant were they to find out about its contents—for example, a patient who is a practising Muslim having received a mesh that contains porcine products, or a patient who is a strict vegetarian and practising Hindu having received a mesh that contains bovine products. I am not aware of any litigation claims made for these reasons. However, with the current trend towards increasing claims against malpractice, doctors should be fully aware of the products they use in patient care.

Information from the manufacturers about any animal content in surgical meshes would allow doctors to choose treatment according to patients’ wishes and priorities. To this end, mesh manufacturers should label their products if they contain porcine or bovine products, or otherwise mark them as “suitable for vegetarians.” Including this important information in the list of characteristics of each mesh would help us achieve the best physical and mental outcomes for our patients.

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Competing interests: The author provides services to J & J company (Ethicon) as an adviser for their products, which include mesh and mesh fixation devices, for which he is paid. He also teaches courses on laparoscopic incisional hernia repair run by the same company, and he receives payment for services as a faculty member.

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BOOK REVIEW

Our obsession with immortality

The knowledge that we will die is at the heart of the human experience. Julian Sheather enjoyed a book that tells the stories of those determined to avoid the inevitable.

The Immortalization Commission: Science and the Strange Quest to Treat Death

A book by John Gray

An idea Lane, £18.99, 288 pages

ISBN 9781846142192

Rating: ★★★★☆

Recently my eldest son woke from a troubled dream seized by a fear of death. “How is it that I will die?” he cried, shaking with terror. “Why must my heart stop?” Repeatedly he took hold of his flawless skin. “Why will this grow wrinkled and loose? Why?” So genuine was his anguish, so badly was he in need of consoling that, secular minded as I am, I ran through some of the more familiar consolations. There are those, I said, who don’t believe that death is the end: we may die to this life but awake to another.

The philosopher John Gray’s latest book, The Immortalization Commission, takes as its theme an entire generation’s struggle to come to terms with something like my son’s anguished arrival of knowledge: the knowledge that death is final and without appeal. To the 19th century, Gray writes, “Science had disclosed a world in which humans were no different from other animals in facing final oblivion when they died and eventual extinction as a species.”

The first part of Gray’s fascinating study traces the impact of this excoriating knowledge on a small, high minded coterie of the late Victorian élite, including the Conservative prime minister Arthur Balfour; the great moral philosopher Henry Sidgwick; and William James, US psychologist and brother of Henry, the novelist. So intolerable was the new knowledge that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seized the hope, that, according to Gray, they seize... 

Again though, the book’s charm lies not in the anti-humanist philosophy that Gray teases from his tales, but in the characters and struggles that enliven them. The collision between H G Wells and Maria Ignatyevna Zakrevskaya (or Moura, as she was widely known), a woman of such sexual charisma and so many personas that she seems almost singlehandedly to have destroyed Wells’s faith in the mind’s ability to know the world, is flamboyantly novelistic.

In the final, meditative section, Gray moves from the Russian slaughterhouse to the present day. And in case we feel moved to look down on our mistaken forebears, he reminds us of a few of our contemporary death defiers. There is Ray Kurzweil, a so called techno-immortalist who will have us uploading our minds into computers and dispensing with the body’s corruptible shell, or there are those whose faith lies in cryogenics and future bodily resurrection.

“Science,” concludes Gray, “continues to be a channel for magic—the belief that for the human will, empowered by knowledge, nothing is impossible.” Although thankfully Gray seems sympathetic to our human folly, the book’s final message is implacable: it is time for us to stop panting after sunshine in the fall of a leaf.

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See FEATURES, p 238
In Manchester earlier this year, I happened into a shop that specialised in remaineder books and in resold review copies. The stock was small and miscellaneous; I picked up a slim paperback volume with the title *Making Sense of the NHS Complaints and Disciplinary Procedures*, published in a series called “The Business Side of General Practice.” It was edited by David Pickersgill and Tony Stanton, and it had a foreword by Sir Donald Irvine, then president of the General Medical Council.

It was not a title that normally would have attracted me much, even if, having been published in 1997 (an eternity ago in terms of NHS reorganisation), it were not likely to be already completely obsolete. Moreover, it was written in bullet point prose, and I am afraid even a small number of bullet points causes my mind to glaze over immediately; the effect of 240 such points in the compass of the 111 pages of this book can easily be imagined. As to numbered paragraphs, further subdivided, I have not counted them. A few flow charts completed the anaesthetising effect.

The enumerated desiderata of a complaints system were enough to induce a state of suspended animation in my brain: responsiveness, quality enhancement, cost effectiveness, accessibility, impartiality, simplicity, speed, confidentiality, and accountability. One could just hear the droning voice in a stuffy lecture theatre in one’s mind’s ear: blah, blah, blah. The proliferation of this well meaning and high minded cliché provoked a need for subversion, and to escape from the instantaneous boredom I began to imagine the advantages of a system that was unresponsive, expensive, ineffective, slow, complex, incomprehensible, and completely unaccountable.

In his foreword, Sir Donald Irvine wrote, “Patients today are seeking better protection from poorly performing doctors . . . The early recognition of dysfunctional doctors, adequate public protection, and the chance of effective mediation before damage is done to patients or the doctor with a problem, is critically dependent on sound local self-regulation in which doctors know what their duties and responsibilities are, and how to make the system work. Readers of this book will receive an invaluable grounding in key aspects of our new approach to professional self-regulation.”

I bought the book at a cost of £5, not so much for the book itself as for the strangest and eeriest of juxtapositions that it contained; for inside its pages was a printed slip from the Small Practices Association (mission statement: “To improve the quality of care provided for patients in small practices”) asking for a review of the book, to be completed by 2 February 1998. The person from whom the review was requested was Dr Shipman, almost certainly GP and serial killer Dr Harold Shipman, because the association’s office is just a stone’s throw from where he used to practise.

The book, though in good condition, had clearly been read from cover to cover (I recognise the marks that fingers make on the edges of pages). Of course, it might have been someone other than Dr Shipman who read it, but I doubt it. What was the trajectory of this book in finding its way to the shop? And, more interestingly still, what can have been Dr Shipman’s thoughts as he read it? Perhaps nothing out of the ordinary, for the human mind is a complex, subtle, and polyphonic instrument.

Theodore Dalrymple is a writer and retired doctor.

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**MEDICAL CLASSICS**

**Hons and Rebels**

A book by Jessica Mitford, first published 1960

Jessica Mitford might have been surprised to learn that her memoir, *Hons and Rebels*, was being dubbed a “medical classic.” The book, first published half a century ago, describes the life of her large (she was one of seven children), eccentric, aristocratic family in the years between the first and second world wars. The Mitford family spawned Nancy, a novelist who chronicled the so called Bright Young People of the inter-war period; Diana, wife of British fascist Sir Oswald Mosley; Unity, who was infatuated with Hitler; Deborah, the current Duchess of Devonshire; and Jessica herself, who embraced communism and went to Spain to support the republican cause during the civil war. The narrative includes, however, fascinating vignettes describing beliefs about health, medical practice, and a particular form of doctor-patient relationship.

Jessica’s uncle campaigned against the pasteurisation of milk, under the slogan “Freedom, not doctordom.” He also wrote pamphlets on the benefits of manure, of slowly smoked bloaters (herring, smoked whole), and of homemade bread. Jessica’s mother, Lady Redesdale, withheld vaccination from her family (“pumping disgusting dead germs into the Good Body!”), forbade the use of tinned foods, and upheld Mosaic dietary laws—no pork, shellfish, or rabbit.

A visiting doctor anaesthetised the two year old Nancy with a handkerchief soaked in chloroform, to lance her infected foot. Nancy’s father, observing the procedure, noticed that she seemed to have stopped breathing, and “seized the doctor by the neck and shook him like a rat.” Clearly, Nancy survived. The doctor’s fate is not known.

Jessica developed abdominal pain and rang the doctor to ask if he would mind coming over to take out her appendix (while her mother, unconcerned, went out to feed the chickens). The operation was performed in the nursery, its furniture covered in white sheets, again using the chloroform soaked handkerchief for anaesthetic, and it apparently left an eight inch (20 cm) scar. Jessica’s mother subverted medical advice by mobilising Jessica as soon as the anaesthetic had worn off and the doctor had gone (perhaps not altogether a bad idea). On another occasion she took the splint off her broken arm equally quickly. Lady Redesdale rejected the germ theory of disease: Nancy’s débutante ball went ahead despite Jessica’s having typhoid at the time, and the children were taken to weddings and parties with chickenpox and whooping cough. On return from Spain, Jessica, somewhat estranged from the family and living in the east end of London, found herself amid an epidemic of measles. Nurses at the free health clinic set up by the Labour party (some years before the inception of the NHS) assured her that breastfeeding protected babies from measles.

Unfortunately, Jessica had never had measles, and both she and her four month old baby caught it. The baby died.

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FROM THE FRONTLINE

Margaret McCartney

A medical mole

A few health professionals have turned their hands to ferreting out and exposing secrets. The consummate mistress of the dark arts was a nurse, Elizabeth Alkin, who doubled as a spy during the English civil war.

Little is known of Alkin’s private life beyond the fact that her husband Francis was hanged by royalists. Under the codename Parliament Joan, Alkin sought revenge in the service of parliamentary generals by sniffing out royalist sympathisers. She received her first payment in 1645, of £2, for “several discoveries,” including “discovering George Mynne’s wire”—not a prototype bugging device but a mystery. She may have smoked out divers necessities about the sick and wounded men here,” she wrote from Harwich and added, “It pities me to see poor people in distress.” She died destitute in about 1655.

Once civil war was succeeded by the more usual practice of fighting foreigners, during the Anglo-Dutch wars, Alkin volunteered as a nurse. She tended wounded soldiers landed at Portsmouth and accompanied the invalids in wagons back to hospitals in London in 1653. The next year she ministered to nearly 1600 casualties in Ipswich and Harwich. Her petitions to parliament for payment for food, medicine, accommodation, and assistance reveal that she organised nursing services in tandem with surgeons in the manner of a 17th century Florence Nightingale.

“I have laid out my monies for divers necessaries about the sick and wounded men here,” she wrote from Harwich and added, “It pities me to see poor people in distress.” She died destitute in about 1655.

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Sources: see bmj.com

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