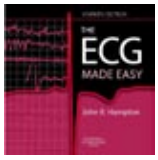

Explaining the "three Rs" of the electrocardiogram, p 301

The key to effective whistleblowing is interprofessional collaboration

PERSONAL VIEW **John Roddick**

Professionals of all disciplines are indebted to the *BMJ* for having opened up the issue of whistleblowing and for it being summed up so well by Peter Gooderham (*BMJ* 2009;338:b2090). As he points out, much more could be done by official bodies to help overcome the culture of silence and fear in many working environments. However, the time has come for those professionals who feel strongly about the problem to take matters into their own hands and lead the way towards a reassertion of true professionalism appropriate for the 21st century.

Faced with all the demands of the modern working environment and often inappropriate media coverage, to say nothing of career and family concerns, it takes a very special professional to go "out on a limb" and make a stand about something he or she believes not to be in the public interest. When the constraints of corporate endeavour, team spirit, and workplace friendships are added, the problems of speaking out become just too burdensome for many. As we have seen, these and other constraints also tend to make in-house arrangements for confidential reporting less than satisfactory; indeed, it would seem that they can even apply within a whole professional institution. Bearing in mind the origins of the present financial crisis, it is instructive to note that the UK Securities and Investment Institute had its own confidential reporting arrangements. Clearly, the restraints on responsible speaking out are mainly due to constraints generated in house.

Those who have incontestably risked or forgone lucrative commissions or immediate career prospects in upholding professional integrity will be honoured

There is no doubt, therefore, that unresolved problems of this kind need to be encouraged to move out of the "one against all" atmosphere of the workplace and into the climate of disinterested objectivity that a confidential, multidisciplinary, professional grouping could offer. Knowledge and experience could be pooled and a consensus reached on the most appropriate action. Such action could be a decision to do little or nothing, to provide ongoing support, or to enter into a mutually agreed direct engagement with the responsible authority, with the use of judicious publicity if and when necessary. But if this proposal is to succeed, if true professionalism is to be revitalised, if professionals are "to speak truth to power" fearlessly and honourably, such a change can be achieved only with the backing of a completely new, properly constituted, multidisciplinary professional grouping.

I have proposed a new body, the Centre for Professional Integrity, to serve as a powerhouse for professionals concerned about what is perceived to be a crisis in trust, the very essence of true professionalism ("Safeguarding professional integrity," *Structural Engineer*, 2007;85(15):22). For example, were you outraged by those professionals who must have been complicit in or who turned a blind eye to the likes of Robert Maxwell, Equitable Life, Shipman, miners' compensation, the Hatfield rail crash, and the lead up to the invasion of Iraq? If so, I urge you to play a part in helping to create and shape the Centre for Professional Integrity. This call is directed towards those professionals who take (or took, if retired) a very special pride not only in their expertise but in their professional integrity and who are prepared to help create what I hope will become a powerful new multidisciplinary professional body.

The centre's sole purpose will be to uphold all our learned bodies' common obligation towards the professional integrity of their members. It will extol those who have demonstrated their fearlessness in upholding their professional integrity in the public interest. Such exemplars, who have incontestably risked or forgone lucrative commissions or immediate career prospects in upholding this principle, will be honoured. At the centre's heart will be a confidential support and advisory service for fellow professionals who face an issue that appears to compromise their professional integrity. Its proceedings and publications will shine a light on actual examples, positive and negative, so that the professions can learn from each other and revitalise this vital principle they hold in common.

Of course, the quid pro quo for the sacrifice a professional makes will not be simply in the intangible moral value of professional integrity. It will be in its market value. Inevitably, demand for professionals who are identified with this reassertion of true professionalism will grow, just as, in the commercial domain, there is and will be demand for genuine corporate social responsibility. These quite separate but interconnected developments could have the most profound of implications.

Together they could contribute to a revitalisation of business ethics, which in turn will have a favourable influence on moral standards in society as a whole. And how fitting that members of two of our oldest and most respected professions, medicine and engineering, with their science based judgment and life enhancing disciplines, are taking the lead in helping to make a start on this reshaping of the future.

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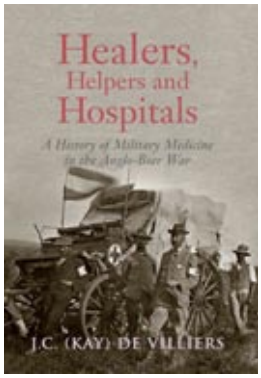
See FEATURE, p 264

REVIEW OF THE WEEK

Bullets come first

Can a medical history of the Anglo-Boer war teach us anything about today's conflicts, asks **Gerry Shaper**



Healers, Helpers and Hospitals: A History of Military Medicine in the Anglo-Boer War
J C (Kay) de Villiers
Protea Book House
Vol 1 (pp 772), ISBN 978-1869191832
Vol 2 (pp 348), ISBN 978-1869192303
Slipcase ISBN 978-1869192777
R600. Available through various South African online bookstores
Rating: ★★★☆

Functional and psychiatric disorders were recognised during the Anglo-Boer war. Neurasthenia, hysteria, disordered action of the heart ("service heart"), self inflicted wounds, and malingering were all recorded

"You want pills, I want bullets, and bullets come first"—Lord Kitchener

Think of a war being fought by small, highly mobile, semi-autonomous units in difficult terrain with problems of heat, dust storms, and water supplies and with considerable limitations in external sources of manpower and equipment. In the event of wounds, accident, or illness the combatants rely heavily on their fellow fighters, friends, and relatives in the immediate vicinity. Add to this the civilian casualties (who may well be your family), the problem of your opponents identifying who is and who is not a combatant, the handling of prisoners of war, and transgressions of the Geneva Convention and you may well think of Afghanistan before you think of Boer commandos. Every war has been fought before, if we would only remember it.

The Anglo-Boer war (1899-1902) was predicted to be a "little war," fought in a remote corner of the British Empire; but the United Kingdom eventually deployed 450 000 men, and its death toll was 22 000, of which two thirds were due to disease or accidents. Boer volunteer forces numbered about 87 000, of whom more than 7000 died. The British medical services of that conflict have been fully described, but little is known about the medical services of the two Boer republics and virtually nothing about medical services in the guerrilla phase of the war after President Kruger fled to Europe in 1900. This lengthy, asymmetrical war was associated with a "total war" policy by the British, including a "scorched earth" programme, martial law, and the removal of women and children to concentration camps. This book, by intention, does not deal with the well covered issues of the concentration camps, nor does it deal with the involvement of the indigenous population.

The British had learnt a great deal from the Crimean war and the Nightingale inspired overhaul of army medical services, and the Geneva Convention of 1864 had set down guidelines for behaviour towards hospitals and the wounded. Despite all this, communication and agreement among British politicians, the military, and voluntary organisations was almost totally lacking with regard to the organisation and supply of medical services.

The British were aided by the Colonial Medical Services (Cape Colony, Australia, New Zealand, Canada, and India—the book has a photograph of Gandhi and his ambulance men) and were not greatly helped by the "lady hindrances," an assortment of "non-nursing nurses" of high social standing who shared the attributes of "wealth, boredom, and frivolity" and whose attendance led to bedside posters proclaiming "I am too sick to be nursed."

The Boers had hospitals in a few major cities, but they had no formal military medical organisation, considering that there was "no need for such refinement." There was no medical registration in the two Boer republics, no medical or nursing training, and doctors and ambulances were treated with contempt by the Boer leaders. The Red Cross and other voluntary organisations were regarded as "foreign," and the Boers were highly dependent on help from the United States (Chicago Irish Americans), Russia, Switzerland, Germany, Belgium, the Netherlands, and even the Dutch East Indies. This was a measure of strong international support for the Boers in their struggle against the might of the British Empire.

The second volume of this monumental work focuses on clinical and public health topics. Like each new war the Anglo-Boer war extended the knowledge of what new missiles could do to the human body and allowed the emerging disciplines of anaesthesia and radiology to be tried out under extreme and primitive conditions. Typhoid, endemic in the Cape Colony, became a major hazard among the British troops, spreading northward as they advanced. It took a redoubtable and emotional British MP, William Burdett-Coutts, reporting for the *Times*, to expose the gross inadequacies of the sanitary regimes and medical care. The scandal was suppressed by the War Office (nothing new there) and then whitewashed by a royal commission (nothing new there either).

It is of interest that functional and psychiatric disorders were recognised during the Anglo-Boer war. Neurasthenia, hysteria, disordered action of the heart ("service heart"), self inflicted wounds, and malingering were all recorded. Acute combat stress reactions may not have been part of the language, but "general nervous shock" and the "going home" syndrome were registered, the second occurring among men who did not go to the war as paid soldiers and had wives, children, land, and livestock to return to, not unlike in the American civil war.

With 64 pages of previously unpublished photographs, this book is a remarkable achievement, and although the detail may overwhelm those unfamiliar with this particular "little war," the lessons of history are writ large in our understanding of the medical aspects of asymmetric warfare. We would do well to recognise that "plague and war take people equally by surprise" (Camus) because they are one and the same thing.

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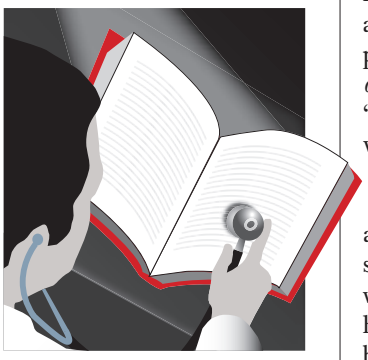
Mesmerising evidence

BETWEEN THE LINES
Theodore Dalrymple



She described sceptics of mesmerism as having "minds self-exiled from the region of evidence," a very good phrase that surely describes us all at times

Feeling slightly under the weather recently, I decided to go to bed with a book. I looked on my shelves for a suitable volume and alighted on Harriet Martineau's *Life in the Sick Room*.

My copy once belonged to Henry W Longfellow, the American poet who in his day was as popular as Tennyson but is now almost unread. Harriet Martineau (1802-76) was also popular in her day as a novelist, pamphleteer, travel writer, and social campaigner but is now even less read than Longfellow.

Always rather sickly and virtually deaf, resorting from an early age to an ear trumpet, Martineau spent the years 1839-44 as an almost bedbound invalid at Tynemouth, in the north of England. Her *Life in the Sick Room* (1844) was the fruit of her experience. It is not certain what was wrong with her: that she had an ovarian cyst is well known, but on the other hand she was restored to good health by a mesmerist, suggesting that in large part her problems were psychological.

During her period of invalidity she became dependent upon opiates. Nothing interested her except the next dose: "I observed, with inexpressible shame, that no details of the perils of empires, or of the starving miseries of thousands of my countrymen, could keep my eye from the watch before me, or detain my attention one second beyond the time when I might have my opiate."

Efforts to give up were unavailing: "For two years, I wished and intended to dispense with my opiate for once, to try how much there was to bear, and how I should bear it; but I never did . . . and I have now long given up all thoughts of it."

Then she tried Mr Spencer Hall, the mesmerist who happened to be visiting Newcastle. With nothing to lose she tried him and tells what happened in her *Letters on Mesmerism* (1845): "Various passes were tried by Mr Hall; the first that appeared effectual, and the most so for some time after, were passes over the head, made from behind,—passes from the forehead to the back of the head, and a little way down the spine. I became sensible of an extraordinary appearance, most unexpected, and wholly unlike anything I had ever conceived of. Something seemed to diffuse itself through the atmosphere,—not like smoke, nor steam, nor haze,—but most like a clear twilight, closing in from the windows and down from the ceiling."

The next day Mr Hall was ill (mesmerist, heal thyself?) and Martineau got her servant to imitate him. "Within one minute the twilight and phosphoric lights appeared; and in two or three more, a delicious sense of ease spread through me,—a cool comfort, before which all pain and distress gave way, oozing out, as it were, at the soles of my feet. I could no more help exclaiming with pleasure than a person in torture crying out with pain. I became hungry, and ate with relish, for the first time for five years."

She didn't miss her opiates and soon gave them up altogether.

She described sceptics of mesmerism as having "minds self-exiled from the region of evidence," a very good phrase that surely describes us all at times. But what counts as evidence? That, of course, is the difficult question.

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

The ECG Made Easy

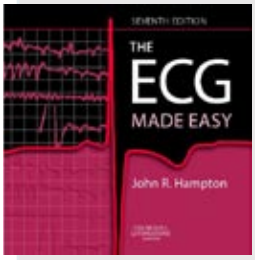
John R Hampton

First published 1973

A true medical classic should be novel, stimulate thought and discussion, transcend both specialty and experience, and most importantly be moreish. This pocket sized hero, the epitome of the medical classic, explains the "three Rs" of the electrocardiogram—rate, rhythm, and right (or left) cardiac axis—in plain English and with elegant diagrams. Hampton encourages the reader to consider this most complex of patterns as "amenable to reason." After first reading it in my fourth year at medical school during my cardiology attachment, I began to make sense of this bewildering cacophony of oscillations and amplitudes.

Apart from bedside observations such as blood pressure and temperature, the electrocardiogram (ECG) is the most commonly used non-invasive tool of investigation. The indications are manifold: chest pain, shortness of breath, collapse, loss of consciousness, before and after operations, on treadmills. Thus the taking and interpreting of the ECG is one of many essential skills needed not only for medical students to pass finals but to become a competent doctor.

Only by understanding the science of the heart can you make sense of the ECG. Indeed, this is one of the founding tenets of medicine: understand the anatomy and physiology, know the pathology. Yet how often do we allow our students time to understand first principles, as the undergraduate curriculum becomes increasingly crowded, forcing them to rely solely on rote and pattern recognition?



The author describes a further tenet: "It is the patient that should be treated, not the ECG." It is a lesson many of us would do well to heed. Indeed, here you could substitute any test for the ECG, as in this increasingly defensive and test heavy world we are forgetting to do the basics well, trusting seemingly infallible tests and distrusting our own eyes and judgment.

My favourite part of the book is the pictorial representations of the heart and its conducting pathway, which, like the ECG, convey what it would take many words to describe. I also enjoyed Hampton's perhaps inadvertent use of black humour when describing ventricular fibrillation: "As the patient may have lost consciousness by the time you realise the rhythm is not due to a misplaced lead, the diagnosis is easy." Indeed.

He also says that "there is no substitute for the reporting of large numbers of clinical records for the development of clinical competence and confidence." Passing finals is merely a licence to drive, but becoming a competent driver comes from spending many hours behind the wheel—the ECG machine or whichever skill one wishes to master.

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Delirious

FROM THE FRONTLINE
Des Spence

A holiday in London. The children returned from *Billy Elliot* the musical, a sophisticated commentary on Britain's north-south divide. "What was it like?" I asked. "The swearing was brilliant, Dad." Next morning in Hyde Park we buzzed the gated play area. The local authority guard watched us with suspicion, for we bore none of the stigmata of class—no pinkie rings, pink shirts, or pearls—nor were we nannies. A fulltime "first aider" prowled the play area looking for grazed knees. A mother called out "India" and several girls turned round. Then we wandered through Notting Hill—personal trainers, cosmetic dentists, and counsellors dispensing common sense for £200 an hour. Expensive London boroughs seem different from our northern hinterlands. With large numbers of children without the measles, mumps, and rubella vaccination, they are testimony to health neurosis and sensitivity to the inflated risk peddled by the media.

So as swine flu kicks off in the capital, questions are asked in parliament, children wear masks in the street, mothers delay conception, and all the talk is of 60 000 dead. A fevered government response has been to launch a website. After the briefest of online tickbox assessments, oseltamivir is dispensed to low risk "healthy" flu sufferers. But is it a good idea to dispense such huge numbers of doses to the healthy?

Oseltamivir is a relatively new drug and has not been used on a population basis like this before. It has an effect in proved cases of flu to shorten the duration of symptoms and reduce complications (*Archives of Internal Medicine* 2003;163:1667-72) but has no effect on "flu-like illnesses" (and surely an internet algorithm, however "validated," cannot distinguish these from the real thing). Also, oseltamivir has no proved mortality data; and in otherwise healthy people it has not been proved statistically to reduce rates of hospitalisation. And what of side effects? In Japan, where oseltamivir has been more widely used, case reports have emerged of neuropsychiatric behaviour, especially in young people, and even suicide. It should also be remembered that rare serious adverse reactions to new drugs are not evident until they are widely used.

So if swine flu is no more virulent than normal seasonal flu, is treatment of otherwise healthy sufferers really wise or justified? I wonder if the motivation to dispense oseltamivir is more political than scientific. Already the Tories accuse the government of doing "too little, too late." As a cold northerner, however, I swear it is a case of "too much, too soon."

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When my daughter sailed home

THE BIGGER PICTURE
Mary E Black

At the European Optimist sailing championship in Strunjan, Slovenia, this June, 250 children from 40 countries competed for six days on the wide, wide sea. I was a proud "OptiMum" with two children in the Serbian national team. "Oppies" are the boats in which the world learns to sail. Children are captains of their own ship. Competing is about winning; but more importantly it is about gaining a love for sailing and learning life lessons.

There we were, of all nationalities, waving our children off from the shore. I thought of parents who have waved their children off as they embark on a desperate search to escape poverty, or after a family argument, or off to war, unsure if and when they will meet again, hoping they would meet kindness and help on their journey.Although sailing can never be totally safe, we were fortunate to know that our children would sail home to us.

On the last race my 14 year old daughter gave up her boat for her 12 year old brother; his rudder had fallen off, and as he was the leading sailor in the team she did not hesitate when the coach suggested it, even though her own points would suffer badly. She limped back alone for 2 miles in his rudderless craft using only a sail, until the shore team helped her out. "Finally," she said, her face shining and without a trace of regret. "I think I really learnt a lot about sailing downwind."

Humans collaborating constructively is a wonder. In Strunjan the systems were not fully in place, yet a mini-army of coaches, team leaders, judges, cooks, boat washers, boat measurers, photographers, and parents jumped into action for a week to get the fleet safely on the water. They made the regatta a huge success by pooling their skills, invoking past experience, filling in gaps in the system, and, above all, doing the right thing.

There is a satisfaction I have always found as a doctor and which we do not speak about enough. I refer to the quiet joy of teamwork, when the situation is messy and uncertain, but for the greater good of others we create a bigger sum from the parts. We can focus endlessly on getting systems right, on setting standards, on developing care pathways. But systems alone are not enough; they may not be invoked, or they may break down. For good health care we need people and not machines. People who will work hard to do the right thing, irrespective of how the systems are set up. People who will help others who journey on life's waters with a broken rudder.

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