Ninjas to the rescue, p 600

An unusual visit to court

PERSONAL VIEW **Anonymous**

I've always viewed myself as a law abiding citizen, but before I knew it I was sitting in the local county court, alone in the defendant's position, with my hospital's barrister, a trainee barrister, and three witnesses on the claimant side. Apart from one visit to the coroner's court when I was a senior house officer 18 years ago, I had never been to court before. This time I was a defendant, a witness, and my own counsel.

It all began 12 months ago when my hospital trust fined me £10 (€11; $15) for parking in a space reserved for outreach nurses when I was attending a sick patient while on call. I had parked there at around 6.30 am and then after seeing the patient had carried on with my ward round, followed by my usual daily duties. I admit I could have moved my car after the ward round, but this was the last thing on my mind when all my routine duties were crammed into a shorter day.

The receptionist at court warned me that the trust had sent a barrister, a trainee barrister, and witnesses. He reassured me by saying that I "shouldn't be intimidated" and that the judges are very fair. I put on a brave face and told him that I would be fine. In reality, I wasn't.

I got off to a reasonable start, addressing the county court judge with a hearty, "Good morning, sir." We were asked to be seated. I had a glimmer of hope when the judge, shaking his head disapprovingly, said, "So, Mr Brown (not the real name of the trust's barrister), this is St Elsewhere University Hospital taking one of its consultants to court over a £10 parking ticket?" A pregnant pause followed, before this was confirmed.

Just occasionally we have to stand up when we believe we have been unjustly treated

Proceedings started with the barrister putting the trust's case to the court. I was partly relying on the fact that the trust's parking policy was published only in September 2008, nine months after the incident. I then had to put my case, managing to remain composed while doing so. The judge put some questions to the barrister, and we were then asked to take a break for 10 minutes while the barrister took instructions from his client.

On our return it was time to examine the witnesses. The judge explained that the barrister would be asking some questions and that so would he (to assist me, given that I had no legal representation) and that I would also have an opportunity to ask questions myself. I cross examined one of the trust's witnesses and pointed out that one exhibit was in fact a photograph of a sign (I assumed) that was erected after the parking incident took place.

ALAMY

Are hospital parking regulations a law unto themselves?

It was then my turn in the witness box. The trust's barrister tried to establish that I could have moved my car after I had dealt with my emergency—apparently failing to take into consideration that it would have been difficult for me, as the duty consultant, to ignore 20 patients admitted over night who were ready to be seen. The trust's case also seemed to be belied by a lack of understanding that time would have been of the essence if routine duties started at 10.30 am instead of the usual 9 am because of on-call commitments. I defended myself to the best of my ability.

Finally, it was time to sum up. The barrister summed up for the trust, followed by me. The judge then summarised the case in around 15 minutes and delivered his verdict, dismissing the claim. The point he emphasised was that I had arrived at 6.30 am to fulfil a duty that the hospital required of me and that the trust couldn't penalise me for trying to attend to a sick patient as soon I could possibly have done so. Needless to say I was delighted and sighed with relief after my nearly three hours in court.

However, I have since reflected on the experience and become increasingly angry. Whereas I understood that the point of bringing the case was that the trust did not want to be seen to condone consultants and other staff parking in restricted areas, this was my first offence and I had a good reason; I wasn't a habitual rogue or villain. I had appealed and re-appealed internally at the hospital, saying that I parked where I did in an emergency, but the appeals were rejected twice by a committee. At no point in these internal appeals was I invited to appear before the committee to give my version of events. The trust's committee undertook a trial in my absence. Moreover, there was no fact finding investigation.

Although I was impressed by the judge's common sense, the whole saga meant that four trust employees (the trust's witnesses and me) wasted a morning in court when we could have been doing our jobs. There was also the expense of appointing a legal team to the case and of course the judge's time used on a relatively trivial case.

More importantly, for me, the case has left me feeling bitter. Common sense says that I should just have paid the £10 and avoided the trouble, but just occasionally we have to stand up when we believe we have been unjustly treated.

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REVIEW OF THE WEEK

The ninjas are with you

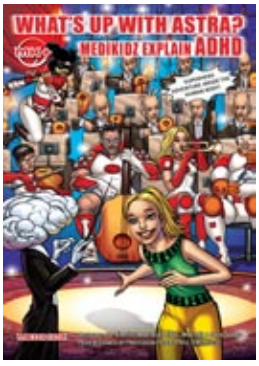
A set of comic books aimed at children seek to demystify various illnesses and conditions. Schoolboy **Joe Knight** finds them empowering

What's up with Matt? Medikidz Explain HIV; What's up with Paulina? Medikidz Explain Food Allergy; What's up with Astra? Medikidz Explain ADHD; What's up with Jasmine? Medikidz Explain Swine Flu

Comic books cowritten by doctors and the graphic novelist John Taddeo

Medikidz (www.medikidz.com), £6.99 each

Rating: ★★★★



Being a massive hypochondriac, I was apprehensive about reading what are basically detailed outlines of diseases I might get. Having convinced myself already this month that I have bowel cancer, diabetes, stomach cancer, tuberculosis, and malaria, I was wary of adding another four potential illnesses to my already abundant roster of life threatening conditions.

I practically lived in Great Ormond Street Hospital from the ages of 4 to 6 after I was given a diagnosis of the bowel condition Hirschsprung's disease. It's fair to say that dealing with illness has not been my forte: the false calmness of the hospital waiting room and any word ending in "osis" still send a fearful shiver down my spine. The hysterical media coverage of the recent swine flu pandemic has not helped, and after many sleepless nights filled with routine forehead temperature checks I was glad to see those now familiar words on the cover of one of the four comic books I had received for review.

As soon as I heard the words "medical comics" I expected them to be little more than science books with a few sheepish drawings of swords and ninjas peppered across the jargon rich page in a vain attempt to engage children with words they can't even pronounce let alone understand. I also expected the "dumb kid" stereotype to be used, and I was not wrong, with the title "Medikidz" indicating that whoever the big shot doctor person was behind these books clearly thought that a disregard for spelling would attract children. It's not cool—or should I say kewl—or clever to change an "s" to a "z"; and as I fall in the age bracket (9 to 15 years) that these comics are aimed at, I was annoyed that they hadn't even been able to write the title without patronising already sick kids.

Despite these early misapprehensions I found the comics (there are now more than 30 in the pipeline, illustrated by the graphic novelist John Taddeo of Marvel Comics fame) fantastic. The characters had big, hilarious personalities, and the illustrations wouldn't have looked out of place on Pixar's drawing boards. More to the point, I learnt a lot from reading them. The language wasn't in the slightest bit condescending, and the larger than life medical superheroes taught me a lot about HIV, attention deficit hyperactivity disorder, allergies, and, of course, swine flu. The comics expertly mixed scientific terms with simple analogies and achieved a superb balance of seriousness and bright humour. I didn't feel as though the heroes were undermining the seriousness of the illnesses.

As I expected, there were ninjas, but they were used to symbolise white blood cells as part of the outstanding personification of the immune system that was one of the books' major virtues. Made into an army, the immune system was always going to be a key component in a book about illnesses, and this metaphor was empowering, putting into context the complex job of the immune system while making readers feel secure in the knowledge that they command deadly legions of crack soldiers, always ready to defend the body against evil pathogens. I'm sure that the perceived companionship of the immune system would help a sick child no end.

Thanks to a complex array of drugs and other treatments I remember little of my own medical experience. An x ray here, an injection there are all that is left of an experience I'm glad to have left behind. What I do remember clearly, though, was how meaningless my illness seemed. All it was to me was a strange name and a list of painful symptoms. I don't ever recall anyone explaining to me what was happening inside my body and why my stomach always felt like it was on fire—it was just "Eat this" and "This won't hurt" or "Inject this and you won't feel that." It made my illness seem undefeatable, like an invincible behemoth of horrible twinges and feelings.

These comics really show their worth in explaining what is actually happening, making the illness seem 10 times less daunting and, ultimately, manageable. To explain ADHD "your message cells are on strike" seems a lot less frightening than "You won't ever be able to sit still or concentrate." As Sun Tzu says in *The Art of War*, "If you know both yourself and your enemy you can win 100 battles without a single loss."

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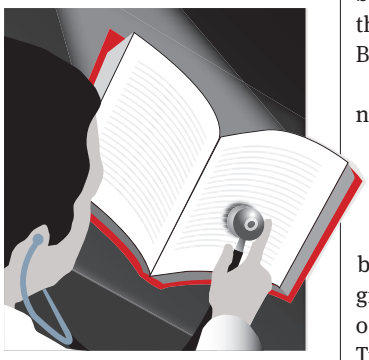
See ANALYSIS, p 574

The expert witness, or God's locum

BETWEEN THE LINES
Theodore Dalrymple



"A simple newspaper report of Sir Bernard's attendance at a mortuary or a churchyard is enough to condemn an accused man to death, even before criminal proceedings have commenced"

I once asked a Dutch professor of law who had experience of the English system whether she thought the inquisitorial or adversarial system was better from the point of procuring justice. She said she thought they were about the same but that the English system was vastly more fun for lawyers.

It is true that a good cross examination can be a thing of beauty, one example of which occurred during the trial in 1925 of Norman Thorne for murder. (The classic account of this trial is in *The Trial of Norman Thorne* (1929) by Helena Normanton, who was the first woman to practise as a barrister in the United Kingdom.)

Norman Thorne was a 24 year old man who ran a small and unsuccessful chicken farm in Crowborough, near Tunbridge Wells. He was engaged to Elsie Cameron, a slightly unstable young woman from Kensal Rise, where he had previously lived. Unfortunately he was also in love with a local girl; Elsie claimed to be pregnant, a sure way in those days to get the man to marry.

She went unexpectedly one day to see Thorne. He left her in the hut in which he lived to go to a previous appointment, and when he returned (he said) he found her hanging. He panicked, cut her up, and buried her in the garden.

In the trial a character witness testified that Thorne was not the kind of man to be violent. The prosecuting counsel, Henry Curtis Bennett KC, asked him only one question, which completely destroyed the value of the witness's previous evidence: "I must ask you this: could you have imagined, from your knowledge of the defendant, that he would be able to dismember a body?"

The whole trial hinged on the medical evidence. The theory of the prosecution was that Elsie died from shock caused by bruising; that of the defence that she died from shock consequent on hanging. There were obvious deficiencies in both theories, but the first was believed because of the identity of the medical proponent: Bernard Spilsbury.

For a long time Sir Bernard (1877-1947) was held up, even after his suicide, as the model of scientific infallibility. I remember the bestselling biography, or hagiography, of him by Browne and Tullett among my parents' books.

More recently a biography by Andrew Rose has suggested that he had feet very much of clay and that his reputation for infallibility sent many innocent—or at any rate doubtfully guilty—people to the gallows, among them (in my opinion) Norman Thorne. Sir Bernard once said, "I have never claimed to be God—but merely his locum on his weekends off."

The dangers of too great a reputation were pointed out at the time, though not heeded. The KC defending Thorne, J D Cassels, said in his closing speech, "We can all admire attainment, take our hats off to ability, acknowledge the high position a man has won in his sphere, but it is a long way to go if you have to say that because that man says one thing there can be no room for error."

Of Sir Bernard, one of the pathologists called for the defence, Dr R M Bronte (1880-1932)—of the famous literary family—said, "A simple newspaper report of Sir Bernard's attendance at a mortuary or a churchyard is enough to condemn an accused man to death, even before criminal proceedings have commenced."

Thorne's sensitive last letters before his execution are unbearably poignant. But the shade of Sir Henry Curtis Bennett asks me, with a cynical smile playing on its mouth: could such a man have dismembered a body?

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

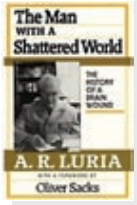
The Man with a Shattered World

By A R Luria **Published 1987**

The subjective experience of dementia is a difficult reality for doctors and lay people to grasp. This absorbing and brief monograph by the great Russian neuropsychologist A R Luria is short (and compelling) enough to read in one sitting and invites immediate rereading and reflection. Although it is based on a case study of a different illness—brain injury—the lessons and insights from this astonishing narrative have enormous relevance for those affected with dementia. Luria presents and comments on the diary of one of his patients, Sublieutenant Zasetsky, a soldier in the Soviet army whose severe left sided brain injury from a bullet wound in 1943 left him with profound perceptual, memory, and language problems.

Covering a process of rehabilitation lasting over 25 years, the journal arose when, growing impatient with attempts to regain speech and relearn writing letter by letter, Zasetsky was encouraged to write spontaneously, and it was discovered that he had an automatic ability for writing—even though he could not read what he had written. The writing process was therapy as well as story telling and is a remarkable early example of ability based rehabilitation: focusing on what a patient can do rather than on what they can't do. The book evinces a remarkable lack of self pity, and we share Zasetsky's aspirations, juxtaposed with his sense of bereavement over what he has lost.

Some parts of the book should be compulsory reading for all professionals dealing with people with memory and language problems. In one sequence Zasetsky outlines with heartrending effect how, noticing discomfort in his abdomen, he could not immediately tell that this was due to the need to defecate. Then, slowly realising that he could not utter a verbal plea for help, he decides to gesture for assistance. As the nurse passing the end of the bed ignores him, he comprehends that he has forgotten how to gesture in a way that will attract attention: how often have we been the person passing the end of the bed of a patient with dementia who was trying to tell us something. Equally touching and thought provoking is the scene where he leaves hospital. He recounts how his mother and sisters were overjoyed to see him and hugged and kissed him. He, although also overjoyed, has forgotten how to kiss. A feeling of loss of affection and relationship from the person with dementia can hugely affect carers, and such insights as this book offers can help us to discuss with relatives whether what they are experiencing from their loved one may be not so much a loss of affection as inability to express it and to explore other ways to enable these emotional interchanges.



An added richness of this classic is the inspiration that clinicians can gain from Luria's extraordinary engagement and persistence over several decades with what many would have deemed to be a helpless case. He unintentionally reiterates to us that a deep sense of humanity can be combined with intellectual curiosity and rigour and that the most vulnerable patients are precisely those on whom we should focus our attention.

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Doctors on the dole

FROM THE FRONTLINE
Des Spence

I felt something snag. I lifted up the pitchfork to find my brother's hand attached to it. We looked at each other and both started screaming. "A scar to impress the girls," Mum comforted, as she cleaned the hole in his hand and smeared on antiseptic cream. She seemed to know what she was doing, and I made my mind up that I was going to be a doctor. This was the 1980s, a decade of big hair, miners, and yuppies. Smoking was compulsory at state and private schools, snooker and darts were considered "sports," and binge drinking was merely a logical approach for the cash strapped poor. Professional footballers ate greasy pies at half time and saved enough to retire and buy a pub, only to drink it dry and return to a career as a painter and decorator. The reaper strolled the littered streets, arbitrarily taking people in car crashes, accidents at work, sudden vascular events, lung cancer, or infections—a nation happily but obliviously unhealthy.

At medical school the wards heaved with pathology: acute cardiovascular diseases, severe chronic obstructive pulmonary disorder and asthma, and bacterial infections. Even rheumatic heart valve disease was common. And in general practice in the 1990s I often saw acute myocardial infarction, heart failure, strokes, appendicitis, pelvic inflammatory disease, and quinsy. The fear of acute illness sizzled and burned constantly in the foreground of your working consciousness, because the consequences of a missed diagnosis lived with us for ever. The diagnosis of serious acute illness through acumen and judgment was what we were trained to do.

Times change. Now I can go for months without seeing acute major illness—and this in Glasgow, number one in the hall of infamy for fatal health statistics. I ask colleagues, who shrug their shoulders in bemused agreement—acute illness is in decline. I trawl national diseases statistics, and there is indeed a steady sustained downward decline in illness, and these are reported trends so they lag many years behind the real situation.

Perhaps it's vaccination and better nutrition and housing, but whatever it is I am truly glad. What is left, though, are the modern illnesses of affluence or invention that somehow just seem less like real illness. Also, modern medical management requires neither judgment nor acumen. So perhaps doctors are redundant, to be replaced by vending machines full of pills with the appropriate guideline taped to the wall. Seemingly we have become a nation unhappily but obliviously healthy.

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Royal insights on smoking

PAST CARING
Wendy Moore

COLIN CRISFORD

Monarchs and their heirs are not always noted for their rational medical advice. But James VI of Scotland, who became James I of England in 1603, certainly earnt his nickname as "the wisest fool in Christendom" for his visionary insights into smoking.

Published anonymously in 1604 but immediately credited to the king, *A Counterblaste to Tobacco* flew in the face of prevailing medical opinion by outlining some of the chief health risks of smoking more than three centuries before scientists made the connection. Possibly the first official antismoking campaign, the royal pamphlet highlighted cost and passive smoking as two of the most powerful arguments against tobacco, while it lamented that addiction, peer pressure, and fashion were among the most difficult obstacles to overcome.

Introduced into Europe in the previous century, tobacco had already gained an enthusiastic following with the zealous encouragement of the medical establishment. The Spanish physician Nicolas Monardes listed 36 illnesses in 1571 that smoking either cured or prevented, including toothache, halitosis, and cancer. Since the plant had arrived from North America at the same time as syphilis, tobacco was frequently prescribed, with the scientific logic of the age, as an antidote to the infection.

James I was having none of it. Employing the xenophobia he knew was one of his strongest propaganda weapons, he argued that just as the English disdained the customs of the French and Spanish so they should not mimic the "barbarous and beastly maners of the wilde, godlesse, and slavish *Indians*."

And with impeccable rationality the king speedily dismissed medical claims that tobacco had cured illnesses ranging from gout to ague. Just because a sick man got better after smoking did not prove that tobacco caused his recovery, he argued. This was like an "olde harlot" attributing her long life to "harlotrie." The "natural course" of a disease and the "apprehension and conceit of the patient" were more likely to have effected the cure, he explained.

The habit of smoking enslaved men who could no longer "forebear the same," cost up to "foure hundred pounds a yeere," and pervaded public places with its "filthy smoke and stinke," the king argued. Furthermore, the custom was so prevalent that people felt obliged to smoke rather than seem "peevish and no good company" or, like those who ate garlic, so as not to be disgusted by the smell of it on others.

Rising to a crescendo, James I condemned tobacco as a "custome lothsome to the eye, hatefull to the Nose, harmefull to the braine, daungerous to the Lungs, and in the blacke stinking fume thereof, neerest resembling the horrible Stigian smoke of the pit that is bottomlesse." He should have saved his breath. Medical professionals would blithely advocate smoking for health for the next 350 years.

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Sources are available on bmj.com