"This debate is simply too important to be left to lawyers and politicians"
Des Spence on assisted dying, p 1426

The demise of cultured doctors is bad for everyone

PERSONAL VIEW **Theodore Dalrymple**

Many doctors have been famous writers, many famous writers had a medical parent, and many doctors appear as characters in novels and plays: but this is not enough to establish a special connection between medicine and literature, at least for those pedants who will not countenance a statement without the strongest possible evidence in its favour. Before a connection can be honestly asserted, our pedant will say, we need to know that there have been more doctors who were writers, more writers with a medical parent, and more doctors as characters in literature than could be expected by chance.

There are obviously problems here with both numerator and denominator. Who is to count as a writer? Any doctor who has published a book in any literary form or on any literary subject? Even more difficult is the question of who doctors are properly to be compared with. The whole of humanity? Bricklayers? Fishmongers? Lawyers? These difficulties notwithstanding, I am convinced that the connection between medicine and literature is and has been a real one. But will it survive?

In the past, the connection between medicine and literature was spontaneous or natural, arising from the general education that all doctors had received, combined with their experience of human existence, an experience that was necessarily wider, deeper, and more varied than that of most people. Doctors are privy, after all, to their patients' deepest secrets, but at the same time retain an attitude of objectivity. No situation could be more propitious for a writer.

However, with the increasing technical demands made upon medical students, it is possible that they are more narrowly educated than their predecessors were. Some medical schools now attempt to remedy this putative narrowness by teaching medical humanities as part of the course. But the spontaneous link between medicine and literature has been broken.

Does this matter? Is there any evidence that broadly educated doctors are better doctors precisely because of the breadth of their education? I suspect that there is not. In any case, it is clear that high artistic and literary cultivation does not by itself necessarily translate into fine moral qualities. For example, in his famous wartime memoir *Kaputt*, the Italian journalist and writer Curzio Malaparte describes a man who speaks perfect Italian though it is not his native tongue; discourses learnedly on Plato and Marsilio Ficino; has spent days and days studying the paintings in the Pitti Palace and the Uffizi; loves Chopin and Brahms; and plays the piano "divinely." This man is none other than Hans Frank, head of the general government of Poland at a time when some of the worst atrocities in the history of the world were committed there, a man in short who was among the very worst of the very worst. His intellectual and aesthetic refinement did not prevent him from believing that the Führer's will was the highest source of law or from seeing nothing wrong with the mass extermination of his fellow beings.

Furthermore, there is no reason why a doctor should not be highly accomplished in a severely technical discipline without being cultivated in any other sense. A doctor who can discourse beautifully on the sonnets of Shakespeare but who cannot operate is no use to someone with a surgical condition. And because medicine seems destined to become ever more technical, with knowledge and technical procedures increasing exponentially, there is no reason to suppose that our eminent doctors of the future either can or ought to be like eminent figures of the past, such as Geoffrey Keynes and Russell Brain, who were able to straddle the two worlds with almost equal distinction.

If no one is broadly educated or cultivated, that is the end of broad education and cultivation itself. We will be reduced to a society of technocrats, each absorbed in their own narrow specialism

For all this, I cannot rid myself entirely of the idea that doctors should be broadly educated. The time is surely still far in the future when doctors will have to be technicians and nothing else; and it does not follow from the fact that not every doctor needs to be broadly educated that no doctor does, any more than it follows from the fact that not every doctor needs to know intimately the biochemistry of hepatolenticular degeneration means that no doctor does. Yet I remain bothered by the still small voice of my inner pedant, who demands evidence that even in the non-technical sphere of medicine the broadly educated doctor is better than the narrowly educated one.

Perhaps things should be approached differently. Let us grant for a moment that it is not necessary for a doctor to be broadly educated or cultivated in any way. If it is true of doctors, it is likely to be true of every other group you can think of: lawyers, accountants, teachers, engineers, and so forth. In other words, there is no need for anyone to be broadly educated or cultivated.

But if no one is broadly educated or cultivated, that is the end of broad education and cultivation itself. We will be reduced to a society of technocrats, each absorbed in their own narrow specialism. Notwithstanding the horrible example of Hans Frank, this is not a state of society to which I look forward. Apart from anything else, some among us will be specialists in the exercise of power, against whom the rest of us will be defenceless.

Theodore Dalrymple is a writer and retired doctor

This is an extract from a lecture given by Dr Dalrymple at the Royal Society of Medicine on 4 May 2011.

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bmj.com/blogs

- Julian Sheather: Does art make people better doctors?
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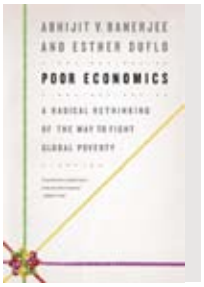
ROB WHITE

BOOK REVIEW

Does foreign aid work?

This is the wrong question, thinks **Gavin Yamey**, after reading a book that considers how a scientific approach can identify the development programmes worth investment



Poor Economics: A Radical Rethinking of the Way to Fight Global Poverty
A book by Abhijit Banerjee and Esther Duflo
PublicAffairs; 2011; 303 pages
ISBN 9781586487980
Rating: ★★★☆

Over the past decade, the global health enterprise—once a marginalised area—has experienced a remarkable turnaround, energised by new global partnerships and a substantial rise in funding. Aid for health grew almost fivefold, from $5.6bn (£3.4bn, €3.8bn) in 1990 to $26.9bn in 2010. This increase in aid must be good news, right? Well, it all depends on your perspective.

Proponents of foreign aid, particularly the health economist Jeffrey Sachs at Columbia University, New York, say that aid is crucial for providing the initial investments in health, education, and agriculture that help poor countries escape their poverty trap. In contrast, so called aid sceptics, led by the economists William Easterly at New York University, who writes the Aid Watch blog (http://aidwatchers.com), and Dambisa Moyo, author of the bestselling book *Dead Aid*, say that aid is harmful because it fosters corruption and interferes with local market based solutions.

The right question is not whether aid works but whether funding a particular intervention will help to solve a specific problem of poverty in a sustainable way. For example, can deworming improve poor children's cognition? Do cash incentives given to poor families increase the likelihood that they will take up health services? Can microfinance loans boost the income of poor women?

Poor Economics, by Abhijit Banerjee and Esther Duflo, cofounders of J-PAL, the Abdul Latif Jameel Poverty Action Lab at the Massachusetts Institute of Technology, considers all of these narrower questions. Poverty, say the authors, is "a set of concrete problems that, once properly identified and understood, can be solved one at a time." Instead of obsessing over the big questions—what causes poverty? Can free markets help the poor? Does aid work?—we should focus on these individual problems and then devise ways to solve them.

Banerjee and Duflo draw upon behavioural economics to paint a vivid picture of the problems that the poor face. Chief among these are a lack of information, such as on the benefits of vaccines or safe sex, and a lack of institutions, such as banks, that are willing to provide business loans.

Too often, they argue, the interventions used in global development to tackle the problems of poverty are based on tired dogma. These interventions fail because of "three Is": ideology (the intervention is based on beliefs, not evidence); ignorance (the intervention is designed without knowing the conditions on the ground); and inertia (the intervention lives on because nobody cares enough to stop it).

CMF, INDIA

A small loans scheme in Andhra Pradesh; a controversial trial in Hyderabad found that microfinance had only a modest impact, with no effect on health or education outcomes

Luckily, we have a tool that is proved to help avoid these traps: the randomised trial. Banerjee and Duflo are doing for global development what the evidence based medicine movement did for clinical practice: they are taking out the guesswork by using randomised trials. The 271 trials in the J-PAL database have considered an extraordinary range of questions, from whether eyeglasses improve academic performance in rural Chinese schools (they do) to whether teaching teenage girls in Kenya about the hazards of having sex with older men reduces the teenagers' risk of unprotected sex (it does, and costs just 80 cents a student).

Randomised trials have challenged many of the dogmas of clinical medicine. The Women's Health Initiative trial, for example, led clinicians to radically rethink their views on hormone replacement therapy (*JAMA* 2002;288:321-33). The J-PAL trials are having a similar impact on development dogmas. Microfinance, for example, gets hailed in the development community as a miracle for alleviating poverty. Yet J-PAL's trial in Hyderabad, India found that microfinance had only a modest impact: it was associated with a small increase in the proportion of poor people starting a new business but had no effect on health or education outcomes. Microfinance advocates took to the blogosphere to denounce the trial's results but cited only weak case studies to argue their point.

Poor Economics injects much needed rigour into the debates on global development, but suffers from two weaknesses. Firstly, it tends to assume that generating evidence will naturally lead to better policies. Yet policy making is a messy process, influenced by an array of sociocultural and political factors, and the book says little about these. Secondly, given the risks of basing decisions on a single trial, rather than all of the evidence, it is surprising that there is no mention of systematic reviews. It is easy to cherry pick an individual trial to show that deworming improves education outcomes—yet a Cochrane systematic review found no effect on cognition or school performance (*PLoS Negl Trop Dis* 2009;3:e358).

Caveats aside, *Poor Economics* makes a compelling case for carefully isolating the components of poverty and rigorously testing interventions. It documents how tiny changes can have a huge impact. In a randomised trial in India, when parents were offered a small incentive to immunise their children—just a bag of lentils and some metal dinner plates—the immunisation rate increased more than sixfold (*BMJ* 2010;340:c2220). If the book had a motto, perhaps it would be "don't think big; think small."

Competing interests: See bmj.com.

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BETWEEN THE LINES **Theodore Dalrymple**

Till death do us part

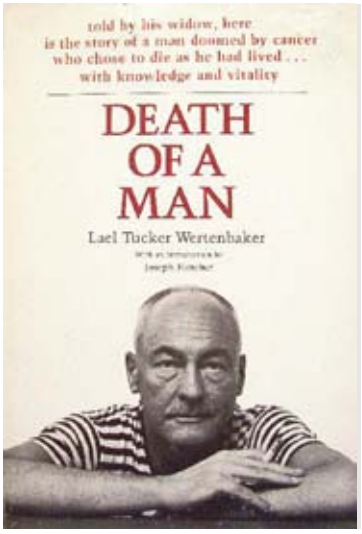
Perhaps the greatest, because unintended, tribute to the triumph of modern medicine is the number of detailed literary accounts now published of illness experienced by patients or witnessed by their relatives: for writers choose as subject matter what strikes them as out of the ordinary or worthy of note. Where illness rather than health is quotidian, therefore, accounts of it will not be frequent. Only where good health is assumed to be normal, the default setting of the human frame, as it were, will the experience of illness be thought worth writing about.

It is not surprising, then, that illness memoirs were less frequent in the 1950s than they are now. Among the most striking of them, however, was *Death of a Man*, by Lael Tucker Wertenbaker, published in 1957, about the death aged 53 from cancer of the colon of her husband, Charles Christian Wertenbaker, whose father was a doctor and whose son is an ophthalmologist.

Both the Wertenbakers were war correspondents and novelists (their daughter, Timberlake, is a well known playwright), who gave up regular jobs to live in the French Basque country. Their fiction is not much remembered today, and the obituary in the *New York Times* of Lael Tucker Wertenbaker, who survived her husband by 43 years, suggested that her memoir of her husband's death was her most significant work (http://nyti.ms/iNxmd0).

If Charles Wertenbaker was not a writer of the first or even of the second rank, he was appreciated, as a man, by those who were. Among his friends were Ernest Hemingway and John Hersey, the author of the famous account of Hiroshima and also of one of the most perfect short novels in English, *A Single Pebble*.

On the back cover is a photo of Wertenbaker dressed in a hooped T shirt. He has the face of a man for whom health and safety were not uppermost: rather, he has the face of a man who likes a drink (he did). Not coincidentally, he has a cigarette between his fingers, literature and tobacco being then inseparable. Close to death from his colon cancer, and still smoking 60 a day, he rejoiced



He cut his wrists in front of his wife, running the blood into casserole dishes to forestall a bloody mess

that he had "certainly fooled the hell out of the lung cancer boys." I suspect that he would not have had much time for QALYs.

He also believed that he had the right to die when and how he chose. Towards the end he tried several times to kill himself with morphine, with tragicomic effect. The first time he tried, he said to his wife, "I love you, and I've had a damn fine life." He closed his eyes, and soon after opened one, saying, "Purple haze coming as promised." Closing his eyes again, and then opening one once more, he said, "A gentleman should know when to take his leave." He seemed then to sink but finally opened both his eyes and said, "I'm not going to die."

After a couple more failed attempts, he said with rueful irony that he was running out of last words. Finally, however, he succeeded. He cut his wrists in front of his wife, running the blood into casserole dishes to forestall a bloody mess. His wife said that she "started pumping morphine into him," having accidentally cut herself on the glass phials, so that his and her blood "mingled for an instant, symbol of all love." There were no legal consequences.

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

Portrait of Doctor Boucard

A painting by Tamara de Lempicka, painted 1929

Never has a career founded on fighting diarrhoea been depicted so glamorously. Tamara de Lempicka's portrait of Dr Pierre Boucard shows the French bacteriologist who in 1907 isolated *Lactobacillus acidophilus* from the human stool and developed Lacteol, an antidiarrhoeal drug still widely used in France and elsewhere. His company, Laboratoire du Lact ol du Docteur Boucard, on the outskirts of Paris, was highly profitable (and acquired by a Canadian pharmaceutical manufacturer in 2002). Boucard's subsequent wealth enabled him to indulge his love of art and lead a life of leisure. He was a friend of the photographer Jacques Henri Lartigue, who snapped him occasionally, sipping cocktails or driving his Rolls Royce. In the late 1920s Boucard became Lempicka's patron, commissioning portraits of his family and taking first refusal on other work. This picture is from 1929.

The deal transformed Lempicka's finances. Born to a Polish-Russian aristocratic family in Warsaw in 1892 (or perhaps Moscow in 1898 or 1902—she was vague about her age and birthplace), Lempicka fled Russia with her tsarist husband after the revolution, when their luxurious lifestyle attracted the attention of the Cheka, the secret police. The couple arrived in Paris in 1918, and Tamara took painting lessons when her husband was unable to find work. By 1925 she had established herself as a renowned art deco painter. Boucard's patronage enabled her to acquire a lavish modernist studio in glass and chrome.

Lempicka's portrait of Boucard is subtly ambiguous. He appears elegant and sophisticated, with the suavity of a matin e idol. He is a cosmopolitan man of the world and a celebrity scientist, posing in a dynamic half turn with professional accoutrements to hand. Boucard's dual personality is neatly suggested by his clothing, rendered in sweeping, razor sharp lines: at first glance he could be wearing a humble laboratory coat, but it is in fact a flamboyant white trench coat more suitable for a rendezvous on the Champs Elys es than for medical research. Theatrical lighting and a dramatic backdrop of abstract architectonic planes borrowed from cubism complete the picture.

Yet Boucard exudes other, less heroic qualities. The manicured moustache and square shoulders lend him the caddish air of a spiv. He stares suspiciously over his shoulder as if disturbed in some furtive act. What sinister chemical might be signified by the malignant ochre secreted in the test tube poised for inspection? The portrait perhaps captures a distrust of science and the menace that it could represent in the wrong hands. About the same period, W H Auden evoked fears of biological terrorism in his poem *Gare du Midi*, in which a passenger disembarks in Paris "clutching a little case" and "walks out briskly to infect a city." In her portrait of Dr Boucard, Lempicka has produced an oddly compelling painting.

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Assisted dying: are doctors in denial?

FROM THE FRONTLINE

Des Spence

bmj.com/archive

- Review: Assisted dying: we are not alone (*BMJ* 2011;342:d3772)
- Head to Head: Should the law on assisted dying be changed? (*BMJ* 2011;342:d2355 and d1883)
- Obituary: Ann McPherson (*BMJ* 2011;342:d3424)

Every aspect of what doctors do has an ethical dimension, generating real angst and anger. The BMA currently opposes doctors' involvement in assisted dying, but is this the right position?

The case against is very strong. Our professional duty is to preserve life; physician assisted dying would compromise our position in society and runs against our ethical duty. There are impassable religious objections focused on the sanctity of life and against doctors "playing god." There are wider concerns: patients might be pressured by their families to end their life. Disability groups fear that society's most vulnerable would be at risk, with changes in the law becoming the thin edge of a wedge to widen assisted dying. Also, the definitions are fraught. Should only those with a terminal illness or those with an incurable illness be eligible under the law? Logically this might extend to people with mental illness. Finally, opponents suggest that palliative care currently offers relief from suffering, so there is no need for assisted dying.

The case for assisted dying is also strong, focusing on personal autonomy. Proponents assert that people suffering unyielding pain or without hope of cure should be free to end their own lives. Indeed, many people have witnessed end of life care, even in a hospice, that involves pain, suffering, excessive medical intervention, and loss of respect and dignity. Modern medicine may be able to prolong life, but that doesn't mean that we always should.

There is, however, a third, pragmatic position. Currently UK patients are electing to travel abroad to die, often prematurely, because of fear that their illness will overtake them and leave them unable to travel. We are simply exporting this issue. We know this is happening, yet we do not stop them. But there is a more fundamental fact: assisted dying is happening every day throughout the NHS. The doctrine of double effect means that doctors give large doses of morphine near the end of life. We know that this will hasten death, but we square this moral circle by accepting that we are relieving suffering. Doctors also widely withhold and withdraw treatment knowing that this will hasten death. Isn't the reality that we are already actively engaged in assisted dying?

Shouldn't we be honest and accept the principle of assisted dying? Then we can actively engage in the debate about what assisted dying is and what it is not, because doctors are the only profession with the experience to ensure proper safeguards and oversight. This debate is simply too important to be left to lawyers and politicians.

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Doctor Doctor

OUTSIDE THE BOX

Trisha Greenhalgh

Here's a milestone. Last week, I examined my 41st PhD and my ninth PhD student handed in a final draft. This means I have read more than five million words of more or less hopeful scholarship and am approaching my half century in real or mock viva examinations.

The student generally assumes that the purpose of the PhD viva is for you to cross question them on the finer points of epistemology and humiliate them with a long list of typographical errors. Actually, the viva is an opportunity to (a) confirm that the student rather than their supervisor wrote the most impressive passages in the thesis; (b) confirm that the student rather than a ghost writing agency wrote the least impressive passages; (c) visit your mate Bruce in Salford to pursue mutual research interests over a lunch for which neither of you is paying; and (d) catch up on your email backlog on the train.

In the UK, the PhD viva is held in private—typically in the hastily smartened-up office of the aforementioned Bruce, with a jug of tap water, some Jaffa cakes, and a sign in felt pen on the door saying CAN EVERYONE PLEASE SHUT UP IT'S SALLY'S VIVA TODAY. After you and your fellow examiner have finished going pedantically through all the illegible sticky notes you've slapped on the thesis, you send the candidate out to quake in the corridor for a quarter of an hour before announcing "minor corrections" and cracking open the bottle of cheap champagne that you all knew was chilling in the common room fridge.

In most countries in mainland Europe, the viva is replaced by a "public defence," which is an order of magnitude more fun for all stakeholders. You (the "opponent") and the candidate face each other from your respective lecterns in front of a packed lecture theatre and engage in up to six hours of parry-riposte-counter-riposte until one of you (or, sometimes, the audience) enters a phase of terminal exhaustion. Permissible rhetorical devices for both parties may include humour, melodrama, Socratic dialogue, pregnant pauses, and PowerPoint. Then everyone, including the candidate's mum and dad, piles into the nearest pub and dances till the small hours.

Following this rite of passage, the candidate may henceforth dress in flowing red robes and call themselves Doctor Doctor. Or—recalling some of the more impressive of my 41 encounters—Doctor Nurse, Doctor Librarian, or Doctor Secretary.

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