"Questioning—let alone stopping—interventions like breast screening is met with anger"
Des Spence, p 592

Ask blood donors about practice, not just partners

PERSONAL VIEW **Matthew Sothern**

Richard Titmuss's seminal study of blood donation, *The Gift Relationship*, concludes that the central question for ensuring safety is, "What particular set of conditions and arrangements permits and encourages maximum truthfulness on the part of donors?"

Despite advances in the epidemiological modelling of risk and the screening of blood, truth telling and trust remain pivotal. The National Blood Service uses a "donor health check" questionnaire to identify would-be donors whose "lifestyle and medical history" puts them at greater risk of having contracted a transfusion transmittable viral infection (http://bit.ly/pMUFof). This triage of potential donors is designed to limit infected blood entering this fallible system.

Donors are trusted to answer a range of questions, including whether they have recently had a tattoo, travelled from a region of high HIV prevalence, or had sex with someone known to have HIV. They are also asked, "Are you a man who has ever had oral or anal sex, whether or not a condom was used, with another man [MSM]?" Answering "yes" to these questions currently results in a six month, 12 month, or lifetime deferral. Permanent deferral of MSM is controversial, and the government has announced a change to 12 months.

The blood service presents the questionnaire as gauging donor behaviour, but its principal function is to sort people into groups with epidemiologically defined risk profiles. The questionnaire elides relevant sexual practices: it is not the "lifestyle" of the donor but rather the donor's contextual association with an aggregate high or low risk profile that determines whether or not his or her blood is accepted.

A recent US government report described this approach as "suboptimal" because it prevents donations from MSM at low risk while permitting donations from heterosexual people at high risk (http://1.usa.gov/asx6Eu). We concur, and suggest that the 12 month deferral of MSM (effectively still a lifetime deferral for sexually active MSM) does little to tackle over-reliance on the logic of risk group profiles. To illustrate, compare the deferment periods for three subsections of the UK population with different HIV rates, as given by the Health Protection Agency—MSM (5.3%), black African people (3.7%), and the general heterosexual population (0.09%).

Although deferment for MSM and black African people is now ostensibly the same, MSM must be abstinent for 12 months, whereas African migrants who have been resident for 12 months can be sexually active as long as their partners have been similarly resident. This continued asymmetry is explained by the role played by context, rather than specific practice, in the way risk is calculated. For MSM, risk is imagined as endemic and proximate, with 82% of HIV transmissions estimated to occur within the UK and most assumed to be recent. Because MSM draw partners from within a population category of high prevalence, they are calculated as always at disproportionate risk—regardless of their practice.

The long standing calculation that a 12 month deferral is sufficient to avoid donations during the "window period" in African migrants is not based on any effect that assimilation may have on sexual practices. Because 68% of HIV transmission among black African people occurs abroad and is predominately historical, HIV among black Africans in the UK is imagined to be primarily imported. After 12 months, migrants can donate if they draw partners only from the low risk "general" UK population category.

ROB WHITE

Sexual networks within and between segregated communities are overlooked

We worry that substantial levels of transmission within the UK are de-emphasised, partner chains are imagined to only one degree of separation, and so complex sexual networks within and between segregated communities are overlooked.

Despite recent changes, the logic of deferral remains flawed because of its focus on population level risk groups and not practice. Current donor selection criteria trust that domestic heterosexuality is a protected context in which to harvest blood, even while heterosexual people represent the greatest absolute number of individuals living with transfusion transmittable viral infections in the UK. Risk is diluted by inadequately differentiated surveillance data that amalgamate subpopulations associated with higher risk of such infections—for example, people who live with deprivation (www.nwpho.org.uk/10yearhiv/HIV_10years.pdf), have low educational attainment (*Sex Transm Infect* 2010;86(suppl 3):S45-51), have alcohol problems (*Int J STD AIDS* 2007;18:810-3), or are migrants with 12 months' residency. The failure to assess actual sexual practice compounds the problem by obscuring multifarious high risk behaviours within the heterosexual population: multiple partnering and casual, anal, and unprotected sex (*J Sex Res* 2010;47:123-6, ; *Sex Transm Dis* 2010;37:369-76; *Sex Transm Dis* 2010;37:425-31).

This is not a call for more subtle epidemiological profiling but rather an attempt to highlight the limits of using population based epidemiological categories as the primary means to determine donor selection. Risk profiles are a function of mapping of surveillance data, not an accurate description of actual sexual practice or the risk presented by an individual donor. Subsuming most donors within the aggregate heterosexual "low risk group" fails Titmuss's concern about encouraging maximum truthfulness and drives a wedge between blood collection and sexual health education.

If the National Blood Service is to do all it can to ensure the safety of blood it must develop a more rigorous predonation questionnaire that focuses on actual practices. Such a change of emphasis presents challenges but because donors are also potential recipients, they should understand the need to focus on practices directly related to risk.

I thank Mike Kesby, senior lecturer, University of St Andrews

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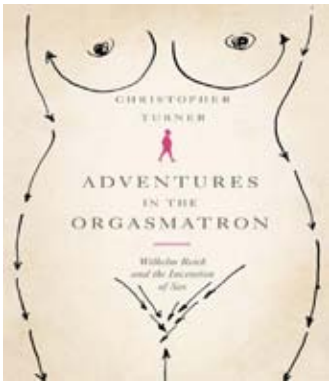
- The Gift Relationship (*BMJ* 2011;342:d2078)
- Research (*BMJ* 2011;343:d5604)
- Feature: Bad blood (*BMJ* 2009;338:b779)

See NEWS, p 557

REVIEW OF THE WEEK

Come again?

Sex, science, and repression. **John Quin** liked this story of Wilhelm Reich and his part in the sexual revolution



Adventures in the Orgasmatron
A book by Christopher Turner
Fourth Estate; £25; 532 pages
ISBN 9780007181575
Rating: ★★★★

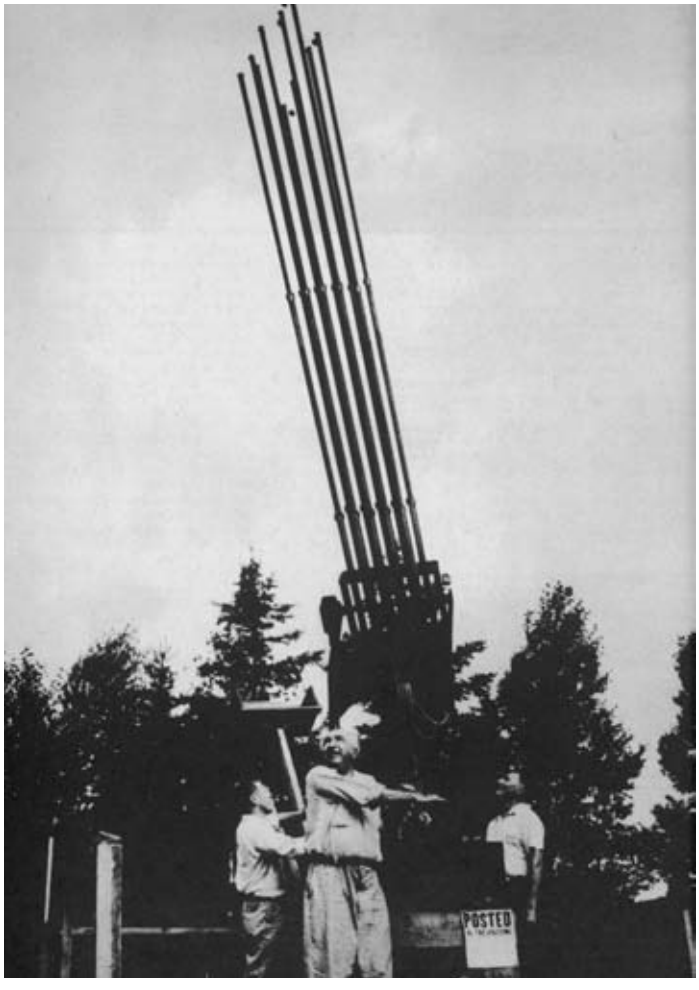
In Vienna in 1919, Wilhelm (Willy) Reich, after three years at the Italian front, was a medical student aged 22, when he paid Sigmund Freud a visit. They clicked, and soon Freud regarded him as his "fair haired boy" and began referring patients to the *wunderkind* for analysis. Despite the laughter of the medical school, Reich was groomed to be Freud's successor, and he was regarded as the best diagnostician of the younger generation of therapists. As a student Reich wondered if his restlessness was a result of his lack of sexual gratification. Reich had psoriasis, and Christopher Turner, the author of *Adventures in the Orgasmatron*, asks if he gave birth to a sexual revolution as a result of his uneasy relationship with his own body. Aged 12 he was bullied by his father into admitting that he knew his mother was having an affair. She subsequently poisoned herself, and Reich vowed, "May my life's work make good for my misdeed."

Reich was, in a word, dodgy. He copped off with his patients, using what Turner terms the "slippery logic of his newly acquired psychoanalytic reasoning." After serving as an intern at the Steinhof State Asylum in Vienna he became the deputy medical director of the city's Ambulatorium clinic. There he would teach his patients to have regular orgasms. Like Charcot, like Freud, he thought hysteria had a genital origin and went on in 1927 to write *The Function of the Orgasm*, according to Turner the first full length book on the topic. If as an orgasm addict himself Reich hadn't had one for two days "he felt physically unwell and saw black before his eyes."

Reich was "deliberately provocative and confrontational with his patients"—they called him the "character smasher," and yet some praised his tenacity and inspirational qualities as a teacher. He was a fan of discharging patients if he couldn't help them—truly ahead of his time. He operated a mobile clinic in a van dishing out sex education and contraceptives motivated by trying to counter "the sexual misery of the masses under capitalism." He railed against something called the "Fiasco of Bourgeois Morality." Aged 30 he came into conflict with Freud largely it seems over Communism and was rejected by Big Daddy. His daughter Lore tells us that "he had lots of affairs, and he felt that if you didn't go along with that you were just clingy and neurotic. This was totally different if women cheated on him."

By 1933 we learn from Turner that "as a psychoanalyst, a Communist, and a Jew, Reich was thrice-marked in Nazi eyes." His books were burned but he got out of Hitler's way at some cost: soon his peers were labelling him as paranoid, a schizophrenic, a manic depressive, and a syphilitic. Lore again, inadvertently hilarious, said, "They're dealing with crazy people all the time and the worse thing you could say about another analyst was that they're crazy." Reich began talking about something that he called "orgone," an energy force, a kind of sexual electricity. Turner tells us that by now Reich is "depicted as a bogus alchemist and fraudulent guru," which seems the correct diagnosis. By 1939 he's in dream bright America, and attention is paid. He builds a box he calls an orgone accumulator, which sounds like a walk-in cupboard that you might pick up from Ikea. The idea was that you sat in it and then you'd hope that something good was going to happen. Many fine minds like Saul Bellow, Norman Mailer, and William Burroughs bought into the idea; even Einstein met with Reich. In *The Mass Psychology of Fascism* (1933) he postulated a link (made more explicit in Orwell's *1984*) between totalitarianism and the suppression of the orgasm.

Ever loopy, he began to link "sex starvation" with cancer and to make "cloudbusting guns"



MARY EVANS PICTURE LIBRARY/ALAMY

Reich shows Einstein his cloudbusting gun

But then, ever loopy, he began to link "sex starvation" with cancer and to make "cloudbusting guns." The *enfant terrible* of the Vienna Institute turned out to be a genius only, in Fritz Perls' words, "to eclipse himself as a mad scientist." The Food and Drug Administration got on his case thinking that the orgone box was "less a scientific implement than his own personal piggybank." In 1953 the FDA asked Dr Frank Krusen of the Mayo Clinic to test the orgone box. He concluded that "this quackery is of such a fantastic nature that it seems hardly worthwhile to refute the ridiculous claims of its proponents." The FDA nailed Reich, and he was jailed in Lewisburg Penitentiary, Pennsylvania, where he died in 1957.

Nowadays a man like Reich would be a performance artist. An obstinate figure, you couldn't push Willy where Willy wouldn't go. Turner's biography is an entertaining romp through the mind of a genuine medical *meshuggah*.

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BETWEEN THE LINES **Theodore Dalrymple**

Moon Tiger and Mr Smith

Books evoke memories unpredictably and therefore all the more powerfully. The *Moon Tiger* of Penelope Lively's novel of the same name is the brand of mosquito coil that the protagonist uses while she is in Egypt during the war; it brought to my mind the years when I never slept without such a coil by my bed to keep the mosquitoes—culicine rather than anopheline—at bay. (I still caught dengue.) The brand was Double Happiness rather than Moon Tiger, but no one has ever described with more loving accuracy than Mrs Lively the slow smoulder of a mosquito coil as it leaves its delicate spiral of grey ash.

The protagonist, a former war correspondent of fiercely independent mind called Claudia Hammond, who goes on to write successful books of popular history, recalls her life as she lies dying slowly, aged 77, in hospital. It is common wisdom that your life passes before your eyes like a video as you die, but I am not sure how this can be verified. My life certainly did not appear before me in this fashion on the only occasion I was ill enough to be thought close to death; but I was still a young man who perhaps did not really believe that he was dying. Alternatively, I wanted to protect myself from seeing the expense of spirit in the waste of shame that so many lives can be made to seem.

The author of *Moon Tiger* manages brilliantly to convey from the inside, as it were, Claudia Hammond's fluctuating level of consciousness, which varies between complete lucidity to a hallucinated immersion in scenes of her past life, among which is a reliving of the only love of her life, a young army captain killed in the battle of El Alamein. After my mother's death, I discovered that she had kept the letters, tied in fading red ribbon, of her first fiancé, a fighter pilot killed in the defence of Malta.

An acquaintance of mine became Mr Smith rather than Bill the moment he crossed over from being an NHS patient to being a private patient, which suggests that modes of address still mean something even today

REX

From time to time, nurses intrude on Claudia Hammond's deathbed reveries, treating her with insensitive condescension. They assume that someone who does not or cannot talk cannot hear or understand. Even when they know that she is conscious, they speak to her in an infantilising way: "Upsy a bit, dear, that's a good girl—then we'll get you a cup of tea."

Because it was written a quarter of a century ago, there is one humiliation that the nurses do not inflict upon their patient. Although when her visitors arrive they will say in front of her that, "it's one of her bad days, you never know, with her," they still never call her by her first name. They always address her respectfully as Miss Hampton. Nowadays it would be by the first name or, worse, a diminutive of the first name.

We are told, and even taught, that this informality is friendly and patients like it. But an acquaintance of mine became Mr Smith rather than Bill the moment he crossed over from being an NHS patient to being a private patient, which suggests that modes of address still mean something even today. Unsolicited informality is therefore an expression not of friendliness, but of power and a desire to keep people in their place.

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

The Adventures of Roderick Random
A novel by Tobias Smollett

First published in 1748

For the most vivid account of naval surgery, nothing beats Tobias Smollett's comic novel *The Adventures of Roderick Random* (1748). A ribald romp in the best traditions of bawdy Georgian humour, Smollett's first novel drew on his experience as a surgeon's second mate during the ill fated British expedition to the West Indies during war with Spain in 1740-1.

Scottish born Smollett (1721-71) served five years' apprenticeship to two surgeons in Glasgow before heading to London to take the examination in surgery that qualified him to enrol with the navy. But after his gruesome experience on board the battleship *HMS Chichester* he practised for only a few years before permanently swapping his scalpel for a pen.

Although he would retain high regard for surgery and surgeons, in *Roderick Random* Smollett ridiculed blundering physicians and lampooned the corrupt Company of Barber-Surgeons with an incisive eye for detail and a cutting wit. Smollett's eponymous hero quakes before a "dozen grim faces" when he takes his oral examination at Barber-Surgeons Hall. He flounders desperately as one examiner asks how he would treat a man "with his head shot off" and another inquires how he would help a patient with a "plethoric habit." As the examiners squabble over fine points of surgery and anatomy, Roderick escapes with his prized certificate.

But Smollett saved his sharpest irony for his excoriating description of life at sea. Failing to obtain a naval surgeon's post through official means, Roderick is pressganged onto the battleship *Thunder*, where he finds himself surgeon's third mate on a mission to the West Indies.

Beset by tropical diseases under a beating sun, with poor provisions and filthy conditions, the roll call of sick and dying mariners inevitably climbs. Confronted by the sight of 50 sailors suspended in hammocks in the airless sick bay, Roderick confesses, "I was much less surprised to find people die on board, than astonished to find any body recover."

But the tyrannical Captain Oakhum and his brutal chief surgeon, Doctor Mackshane, have a cunning plan for reducing the number of sick. Ordering all the patients to be brought on deck, Oakhum declares a man with malaria fit for work only for him to expire the next day. Mackshane prescribes exercise for a consumptive patient, who promptly collapses in a "deluge of blood."

As battle wounds compete with rampant disease to despatch the remaining crew, the dead are thrown to the sharks and the wounded consigned to hospital ships devoid of medical care. "Their wounds and stumps being neglected, contracted filth and putrefaction, and millions of maggots were hatched amid the corruption of their sores," notes our hapless hero. Succumbing to fever, Roderick only survives by refusing all medicine. Once home Roderick—like Smollett—swiftly abandons surgery.

Smollett would never forget his medical experiences, and when he died in 1771 he bequeathed his body to science: for him at least the pen was mightier than the scalpel.

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Herd mentality

FROM THE FRONTLINE

Des Spence

Until 2008 the mantra was, "You can't lose on housing." Everybody became a property developer. The chatter was always "location, location, location." House prices kept rising. Remortgaging to release capital for cars, holidays, and school fees was common. But did it make sense that house values could double in a short period? Economics is behavioural; we follow the herd. Our vested interests in the rise blinded us to this asset bubble.

James Penston's book *Stats.con: How We've Been Fooled by Statistics-Based Research in Medicine* challenges the numbers in current medical practice. As a card carrying sceptic this plays to my prejudices because I believe that we are in the middle of a medical bubble. Risk factors such as blood pressure and cholesterol have morphed into monster diseases. Medical corporations, the pharmaceutical industry, and doctors have grown rich on the back of these interventions. Newspapers, television, and news programmes have unquestioningly and simplistically accepted these conditions because medical stories sell. The polypill is the latest media darling, and reports suggest it will halve cardiovascular disease. Yet the polypill hasn't actually saved one life, and all of these claims are based on the flimsy science that is medical disease modelling.

And in the real world, millions take preventive drugs, but there is limited direct evidence that this policy has improved health outcomes. Even if these drugs do work, few appreciate the treatment paradox: the majority of patients never benefit directly, despite decades of treatment. Then there is seductive "screening." Intuition suggests that earlier diagnosis should lead to better outcomes. But breast cancer screening has had little impact on survival and has caused massive overdiagnoisis and overtreatment (*BMJ* 2009;339:b2587, doi:10.1136/bmj.b2587). Bowel screening, the new kid on the block, has not been shown to reduce mortality but is being rolled out irrespectively. And there is a screening paradox too: individuals screened will never directly benefit but have a high chance of iatrogenic harm.

How have we got here? There is vast financial, professional, intellectual, and institutional vested interest in promoting these interventions. Interests that underpin people's careers and livelihoods, so that questioning—let alone stopping—interventions like breast screening is met with anger and hostility. Just as with economics, change will come not from silly "nudge theory" but only after a catastrophic crash. Perhaps this will be a drug disaster, an overdiagnosis lawsuit, or, most likely, some unforseen event. Until then the media and doctors will, in a well intentioned but misguided and wilful way, continue to use relative risks over simple benefit and marginalise dissenters. The numbers might not stack up, but no one wants to listen; we are just a herd.

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When I'm 64

IN AND OUT OF HOSPITAL

James Owen Drife

Last weekend, the 1971 medical graduates met in Edinburgh. We've had reunions before but this one was special. With most of us retired, for the first time in our lives we felt relaxed. The hospital and medical school have moved to the suburbs, so we could admire the new site and reminisce among the luxury apartments that have replaced the old one.

But the real thrill was the rebirth of our student band, the Unbelievable Brass, complete with trumpets, trombones, sousaphone, rhythm section, and contingent of non-medical players. We drew heavily on Herb Alpert and the Tijuana Brass, who were big in the 1960s. What style we brought to those student parties and posh balls. Man, we were cheap.

Forty years on, an out of town rehearsal seemed a good idea. Village halls today are equipped with sound systems, spotlights, immaculate toilets, and almost enough parking for our rather nice cars. Our pianist, now director of music in a cathedral, brought the scores, reprinted on his computer. Concentration was intense as the jaunty syncopations re-emerged, occasionally juddering to a halt when the repeat marks were missing.

I loved that first run-through. After decades in medical politics and academia, it was bliss to be part of a gathering with no subtext. All that mattered was the music—and the logistics. Shifting a drum kit doesn't get any easier. My role was to play maracas, do introductions, and sing a little: mainly Beatles classics, added to our repertoire when they first appeared.

We were scheduled to perform after dinner in a historic library. When the university heard about this, their emails became tense. Evidently they had heard about bands from the swinging '60s. How loudly would we be playing? I shall treasure our reply, written by the sousaphone player, now professor of musical acoustics in the department of physics and astronomy.

Our playlist includes Lennon and McCartney's *When I'm 64*. Coincidentally the gig was two days after my 64th birthday. As a student vocalist I never really thought about the deeper meaning of the lyrics, but I think I expected still to be working. Of the boys in the band, it is the doctors and schoolteachers who have retired, beaten down by bureaucracy. Bit of a waste, maybe, but at least we have time for maraca practice.

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