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Television medicine again

Our editorial¹ and the article by a special correspondent² have provoked a spate of letters (25 February, p 503, and p 713 of this week's *BMJ*). Nothing that has been said so far, however, has answered the case for more responsible treatment of medicine on television. Medicine is different from politics, gardening, physics, and sport in that a woman who finds a lump in her breast or a man with suicidal depression who is misinformed by television may die as a direct result. Television people cannot escape responsibility for being in charge of the most powerful single influence on public opinion and behaviour. We share the views canvassed in the *New England Journal of Medicine*³ that the obligation lies on those working in television to show, for example, that violent plays do not encourage violent behaviour rather than there being an obligation on critics to prove that television can be harmful. A few words may be profoundly damaging: for example, recent news bulletins announced that doctors in Russia have "cured" a girl with retinitis pigmentosa. The Russian remedy is no secret: it is still being evaluated in careful trials, but Western ophthalmologists are profoundly sceptical. In June 1976⁴ we commented: "Equally the publicity that the treatment has engendered should be condemned. False hopes are cruel deceptions"—and nothing has changed since then. Perhaps the BBC believes the news value outweighs any risk of raising false hopes in hundreds of families (though certainly on this occasion the news bulletins did mention the doubts of British experts on the Russian claims), but we know already of blind people not suffering from retinitis pigmentosa who have had their hopes cruelly raised.

None of our correspondents have satisfactorily answered our main points: that one-sided presentation harms patients; that participants have no knowledge of how their contributions will be used; and that there is no way of correcting false or meretricious information. No better illustration of these points could be provided than the handling of cancer in two other BBC television programmes screened since we published our special correspondent's article² and the editorial.¹

In the first, a *Tonight* feature, the producer chose to give prominence to a "debate" between Dr Thurstan Brewin, a cancer specialist who has written on talking to patients,⁵ and a psychiatrist. Both had made their contributions separately (in Dr Brewin's case at least without any idea about how it would be used). Dr Brewin emphasised that not all patients wanted the actual word cancer to be used, though there was often an unspoken understanding between patient and doctor.

The psychiatrist stated equally reasonably that many psychiatrists and social workers thought that doctors treating patients with cancer often did not bring the facts into the open enough. In the event, their conflicting views were expressed in a series of cuts from cancer specialist to psychiatrist, giving the false impression of an actual argument between an old-fashioned conservative and a radical reformer. What was wrong with getting the two participants into the studio together and letting them have a civilised conversation? Do those responsible think that such a programme would have been boring—if so, they are surely confounded by the current series of television interviews of philosophers—or are they afraid that there might have been so much middle ground that any chance of a confrontation, however artificial, would have been lost?

The *Tonight* programme trivialised an important issue: its important lesson is that doctors should not take part in television programmes unless they know exactly how their contributions are going to be used. Professor Halnan and Dr Brewin (p 714) state that the deletions made slanted the programme in a pessimistic direction. The implications in the *Tomorrow's World* programme on breast cancer were even more pessimistic, because the facts in it were all too accurate. Observing that cancer of the breast was the commonest cause of death in middle-aged women, this went on to emphasise the relatively poor prognosis, with the underlying theme that women could not consider themselves cured until 10 years had elapsed—depressing facts that in the past doctors and producers or their advisers have rightly thought were more appropriate for professional discussion than for an individual woman who may just have had a breast lump removed. Even more serious, however, was the implication that without adjuvant chemotherapy treatment was incomplete. Since the studies of Bondonna *et al* were challenged there has been enough evidence on both sides to show that only random controlled trials (which are at present in progress) will produce the answer. In the past doctors have rightly been accused (by the media among others) of uncritically adopting new drugs or methods, such as anticoagulants or intensive care units for myocardial infarction. For a television programme to weight the debate on the need for chemotherapy so heavily might well make such a trial impossible, to say nothing of its effect on the woman who has been told that chemotherapy is unnecessary in her case.

We repeat that we are not against medicine on television—

only against the way it is sometimes presented. The paramount need is for balance, and to those who suggest that that is a dangerous, or unenforceable, concept we would reply that the parliament enforces it on television programmes in Norway (surely no less democratic than Britain). Much more use needs to be made of medical advisers, whose brief should be extended to cover all medical television programmes. There is also a good case for establishing a small committee to monitor programmes, as in Scotland.

Starting this summer, the *BMJ* hopes to introduce a long-planned feature—a new column “Medicine and the Media”—to review the best and the worst of the features on television and radio and in the press. Nevertheless, such reviews are unlikely to alter the attitude of the invincibly ignorant or prejudiced. In his article our special correspondent quoted Cromwell, and possibly the attitude of the *BMJ* may be entirely wrong. One thing is certain, however: mere debate is unlikely to settle the issue. So may we suggest a return to scientific method? Sir Michael Swann, FRS, the chairman of the BBC, is a distinguished man of science who understands the need for freedom and open discussion on the one hand, and for accuracy and fairness on the other. Let him collect a panel of, say, 20 uncommitted people and show them videotapes of the *Horizon* programme on induction of labour, the *Panorama* programmes on practolol and ECT, and the *Tomorrow's World* programme on breast cancer. Then let him ask them what conclusions they drew from the programmes. He will find that there is a striking gap between the impression given by the programmes and a consensus of reasonable medical opinion.

¹ *British Medical Journal*, 1978, **1**, 323.

² *British Medical Journal*, 1978, **1**, 348.

³ Feingold, M, and Johnson, G T, *New England Journal of Medicine*, 1977, **296**, 424.

⁴ *British Medical Journal*, 1978, **1**, 348.

⁵ Brewin, T B, *British Medical Journal*, 1977, **2**, 1623.

SI, moles, and drugs

Whether we like it or not, there has clearly been no relaxation in the determination of the World Health Organisation and other international bodies to secure the worldwide acceptance in the medical sciences of the *Système International d'Unités* (SI) and its corollary, the use of the mole, the unit of substance, in place of the gram, the metric unit of mass, for the reporting of concentrations in clinical chemistry. Last year the 13th World Health Assembly noted that “the change to the use of SI units in medicine has already taken place or is now under way in several countries.” The latest recruit is Canada, and there are signs that opposition may be beginning to weaken even in those countries, notably the United States, in which it has hitherto been most stubborn. Universal acceptance seems most unlikely for a few years, however, and in the meantime we must continue to live in a world of duplicate sets of values, conversion factors, and, at the worst, confusion. Fortunately the clinical disasters that were widely prophesied in our correspondence columns and elsewhere when SI was introduced into the NHS in 1974-5 do not seem to have materialised—or at least have not been reported—but undoubtedly the past two years have been a trying and exhausting time for clinicians, who have had to familiarise themselves with new normal ranges and new standards of abnormality, all to no obvious practical advantage.

Hitherto in Britain our main guide to the application of SI in medicine has been the recommendations prepared by a working party of chemical pathologists, haematologists, and others for the DHSS, the substance of which was published in a paper by Baron *et al* in the *Journal of Clinical Pathology*.¹ WHO has now produced² its own booklet, *The SI for the Health Professions*, which is described as “the most authoritative account of the subject that is available for the medical and allied professions.” Comparison of the two guides provides one or two interesting pointers to the ways in which medical SI has developed in the past three years and may be expected to develop in future. The newly agreed units of radiation are included, but how soon they will be generally adopted in clinical radiology remains to be seen; an increased emphasis on the kilopascal as the measure of blood pressure will hardly be welcomed, though the concession allowing the millimetre of mercury to be used is retained, albeit relegated to secondary position; while confusion will be caused by a change from the previously allowed expression of mass concentration of haemoglobin as g/dl to g/l and by a recommendation that “substance concentration (mmol/l) may be used provided it is specified whether the monomer—Hb (Fe)—or the tetramer—Hb (4Fe)—is used.”

More important, perhaps, is the failure to eliminate some of the more rigidly academic and practically unnecessary and irritating requirements. Foremost among these for the clinician is the insistence on the use of negative exponents in place of the familiar solidus (/) or “per” in complex symbols such as mg. kg⁻¹.d⁻¹. This sort of expression is ugly, difficult to comprehend, a nuisance to typists and printers, and intended to avoid an ambiguity that rarely if ever can arise in clinical medicine. It is one of the rules that can well be ignored—and indeed we already ignore it in the pages of the *BMJ*. Another absurdity is the rule that “concentration” must always be qualified by “mass” or “substance” even though the nature of the units that follow makes it obvious which is intended; the suggested abbreviations “masse” and “substc” are not ones that will commend themselves to medical writers, editors, or readers.

The greatly extended list of conversion units in clinical chemistry will be welcomed, but one serious omission from the new guide—as from the old—is a really clear exposition of the mathematics whereby a conversion factor that is not given in the table can be derived from the molecular weight (or “relative molecular mass”—another unnecessary change of traditional and well-understood terminology) of the substance concerned and of the necessity to know exactly which substance is concerned. Conversions from mass to substance concentrations may have to be undertaken by relatively junior laboratory or editorial staff, and a failure to understand the exact nature of the substance whose concentration is being measured may lead to a calamitous mistake. An unfortunate example of this possibility and the confusion resulting from it that has recently been experienced in this office is brought to light this week in our correspondence columns (p 716).

Linked with this is another serious omission—the lack of clear guidance on the use of SI units in clinical pharmacology. Drugs may be administered in the form of the base itself or of a salt or other compound of the base, but when assayed in the blood or urine the substance measured may be the base or its compound, a conjugate, a metabolite, or a mixture of these, so that it may be difficult or impossible to decide what the molecular weight should be for the purposes of calculation.

For this and other reasons, and because there is little likelihood as yet of drug dosages being expressed in moles,