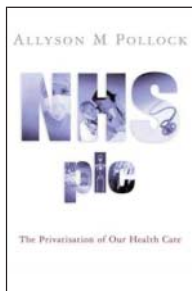


reviews

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NHS plc: The Privatisation of Our Health Care

Allyson M Pollock



Verso, £15.99, pp 271
ISBN 1 84467 011 2

Rating: ★★★★★

Forty years ago, when on a gap year in a remote secondary school in post-colonial Ghana, I was summoned by the headmaster and informed that we had in our library a book the government didn't think we should read. It must therefore be taken out into the bush and burned. Curiously, he suggested the boy for the job, a junior member of the library committee. So I handed both our dog eared copies of *Animal Farm* to young Kwesi, who nodded thoughtfully and took them away. I never saw them again, but somehow Orwell's fable of Soviet Russia became instantly famous within the school: a cultish clandestine "must read," passed in secret round the dormitories and quoted and laughed over at breaks—a powerful and brightly topical polemic in a darkening political landscape.

Of course such things could never happen here, but the most gripping section in *NHS plc*, Allyson Pollock's defence of an NHS under political onslaught, describes her experience in November 2001 at the hands of the House of Commons Health Select Committee, then just refreshed by an influx of New Labour ultras, including one Julia Drown MP, a former health service manager. Against the advice of the committee's chairman and clerks, Ms Drown tabled a rant aimed at undermining Professor Pollock and her Health Policy and Health Services Research Unit at University College London. In the chairman's view such an attack on an individual witness was unprecedented and wrong, yet it nevertheless (by virtue of a nasty but neat little bit of committee footwork) appeared in the final report of an inquiry into the implications of the private finance initiative (PFI) for the NHS.

Such official displeasure and venomous over-reaction from the governing party

are easily understood. Uplifting messages about falling waiting lists, record building programmes, patient choice, and diversity are not to be questioned from the sidelines by academic onlookers, however numerate, articulate, and well documented their concerns about the shrinking services, the financial and moral costs of turning the NHS into a marketplace, and the ever more rapid erosion of its founding principles of comprehensiveness, universality, and equity. Such views are, in this best of all possible NHS worlds, simply unhelpful.

But if you are old enough, or even just curious enough, to wonder whatever happened to the British NHS as first conceived, you might find *NHS plc* a useful little book. An excellent early reputation—for cost effectiveness and equity based on integrated services, minimal management costs, and a vast and intensely practical pooling of risk—dwindled slowly. This was firstly because of chronic and insidious underfunding, later because a notional internal market began to take it apart, and finally (though the word may still be slightly premature) because of the current assault: a burgeoning, divisive, sometimes mendacious for-profit marketisation of a health-care system that was once an admired public provision and a right of citizenship in the United Kingdom.

Since it was Pollock's views on the PFI that so upset its proponents, it is worth summarising them briefly. Costs are now intrinsically higher, because of capital borrowing at higher rates than those available to government, because of cash hungry consultancies and the vast transactional and monitoring costs of countless contracts, and because—for the first time on a large scale in the NHS—commercial profits must be made. To accommodate all these new costs clinical services have been scaled down, while matching assumptions about increased efficiency are only variably delivered. All this, along with the rigidity of a trust based strategy for building hospitals and the locking in effect of contracts fixed for decades, seems to Pollock and many others at best a bad bargain, at worst a naive betrayal that opens the NHS to piecemeal destruction and the eventual abandonment of its founding principles. And all over the country PFIs—greedy, noisy, alien cuckoos in the NHS nest—gobble up its finances and will do so for the next 30 years. Yet this we have come to call progress.



PUBLIC HEALTH POLICY UNIT

Allyson Pollock: a brave, necessary book

There are other concerns. Foundation trusts ("public benefit corporations"—what?) will further disrupt any attempts to build effective local health services, drive the balance of care in the wrong direction, and almost certainly get choosy about the patients they treat. All this will least benefit elderly patients, whose care as our population ages ought to be explicitly identified as the core commitment of our NHS. Will elderly people be surprised? I doubt it. Their long term care was totally abandoned by the NHS in England long ago, and given the direction of current reforms any priority for their acute care would be astonishing. And meanwhile, under the Orwellian rubric of choice and diversity, all manner of dubious, expansionist corporate players, many from the United States, where these things are managed so much worse, are circling, scenting opportunities for private profit in a once great public service.

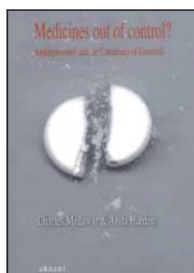
Professor Pollock, with the help of many colleagues acknowledged in a list that reads like a roll of honour for services to the real and now threatened NHS, has written a brave, necessary book. And because you know the government thinks you shouldn't read it, you probably should.

Colin Douglas *geriatrician and novelist, Edinburgh*

Items reviewed are rated on a 4 star scale (4=excellent)

Medicines out of Control? Antidepressants and the Conspiracy of Goodwill

Charles Medawar, Anita Hardon



Aksant,
£19.25/€27.50/\$34.50,
pp 260
ISBN 90 5260 134 8
www.iisg.nl/publications/
aksant.html
www.socialaudit.org.uk

Rating: ★★★

The treatment of depression has seldom been more controversial. The safety of new antidepressants is subject to radical reappraisal, while an unpleasant question looms: can we really trust scientific evidence? Medawar and Hardon give a detailed analysis of this quagmire, massively annotated with footnotes and verbatim quotations.

It is understandable that the references sometimes get lost or the argument wanders, for the problem is not focal but pervasive. Theirs is an indictment of “big pharma” (the drug industry), doctors (both as prescribers and researchers), the regulatory authorities, politicians, and, ultimately, the values of society itself. Building on the evidence that earlier treatments of “distress” (such as opium, barbiturates, and benzodiazepines) initially seemed benign, only to wreak havoc later, the authors locate a similar optimism among early accounts of some antidepressants (particularly the selective serotonin reuptake inhibitors or SSRIs).

However, they suggest that there is something different about the current debate—something that is about precision, semantics, or sleight of hand, depending on your viewpoint. The authors argue that SSRIs elicit “dependency,” as evidenced by withdrawal phenomena, but that this has been obfuscated by terminology. If feeling worse or experiencing adverse reactions when stopping a drug constitutes dependence, then SSRIs produce it. However, an alternative vocabulary describes such withdrawal phenomena (note the connotation of addiction) as “discontinuation” reactions, a softer sounding term. Furthermore, classically dependence requires euphoria and tolerance (increasing the dose to get the same effect). SSRIs evoke neither of these phenomena, but the authors see this as special pleading.

They extend their critique to the failure of post-marketing surveillance procedures. Relatively few prescribers report adverse reactions, and low levels of reporting can foster the assumption that little is wrong. The authors term this the NERO (no evidence of risk equals evidence of no risk) fallacy.

Again, their question is whether the people monitoring the unwanted effects of SSRIs knowingly or unknowingly minimised the drugs’ drawbacks. If these drugs encour-

age suicidal acts among some patients then calling such acts “non-accidental” really matters. The authors suggest that the classification of suicidal acts as non-accidental obscured the problems with paroxetine in particular. Here, much depends on the attribution of motives to others.

Throughout the book the authors describe detailed paper trails: naming names and meetings, quoting what the regulators said, who gave evidence, who declared an “interest” and left the room, who had shares in drug companies. A number of psychiatrists are named. A dilemma emerges. A committee needing an expert opinion will need someone who has worked in the area. Yet a psychopharmacology researcher may well have received grants from industry. If the expert leaves the room when the science is discussed (declaring a competing interest), then the level of discourse is diminished. Few recognised experts in psychopharmacology have ever interacted with big pharma. This critique sees all such contact as evidence of potential collusion. Yet we know that clinical research would be a long time coming if it depended only on scarce “blue chip” funding such as the Medical Research Council or Wellcome.

All the major players can be seen as compromised. The drug companies are massive organisations that need reform (see *BMJ* 2004;329:862) yet are struggling to innovate. Most new compounds are variations on a theme; and, paradoxically, most research occurs within the public sector.

Elsewhere, the academic research community needs money to survive. Universities encourage entrepreneurship, and research income is a major determinant of esteem. Commerce is not confined to psychopharmacology; some genetics presentations are based on data that cannot be shown because of patent issues. It is not inconceivable that the pursuit of truth might eventually be constrained by the bottom line and science “deprived of its epistemological character” (R Horton, “The dawn of McScience,” *New York Review of Books*, 2004 March 11:7-9). And prescribers are no better. Social psychological research has repeatedly shown that doctors misjudge the influence exerted on them by big pharma’s gifts and representatives. We are all fallible.

The regulators work closely with industry; governments encourage this and often the same people rotate between sectors (poacher or gamekeeper by turns). Even patients’ groups may be financed by industry.

Medawar and Hardon also emphasise what will be familiar to those who attend journal clubs: that published research is often of poor quality, and data may be deployed creatively. As Richard Horton, the editor of the *Lancet*, says in the *New York Review of Books* article, “Journals have devolved into information-launders operations for the pharmaceutical industry.”

This is a depressing book, offering few solutions. The last pages invoke Ivan Illich and his thesis that medicine is bad for

society, fostering dependence on doctors and technology and robbing us of our autonomy—our belief in ourselves as basically healthy, capable human beings. My own view, for what it is worth, is that where national governments fund health care they have a legitimate interest in properly funding research into treatment. Until they do we will rely on committees sifting inadequate studies and meta-analyses of secondhand data.

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Competing interests: SAS has received honorariums from drug companies for chairing meetings and making scientific presentations (all income donated to department funds); has received research grant funding from Cephalon UK, and has been supported in attending conferences and scientific symposiums. SAS does not accept personal payments, does not give promotional talks, and does not own shares in drug companies. He holds an MRC career establishment grant.

Hit parade bmj.com

These articles scored the most hits on the *BMJ*'s website in the week of publication

OCTOBER

- 1 **News: Can country music drive you to suicide?**
BMJ 2004;329:817
11 926 hits
- 2 **Editorial: Selective serotonin reuptake inhibitors**
BMJ 2004;329:809-10
7258 hits
- 3 **Editorial: Lessons from the withdrawal of rofecoxib**
BMJ 2004;329:867-8
7254 hits
- 4 **Paper: Promoting walking and cycling as an alternative to using cars: systematic review**
BMJ 2004;329:763
6090 hits
- 5 **Editorial: What has evidence based medicine done for us?**
BMJ 2004;329:987-8
5823 hits
- 6 **Editorial: What causes chronic fatigue syndrome**
BMJ 2004;329:928-9
5739 hits
- 7 **Editorial: Aspartame and its effects on health**
BMJ 2004;329:755-6
5633 hits
- 8 **News: Pfizer criticised over delay in admitting drug's problems**
BMJ 2004;329:935
5322 hits
- 9 **Editorial: Placebos in practice**
BMJ 2004;329:927-8
5148 hits
- 10 **Editorial: The scandal of poor epidemiological research**
BMJ 2004;329:868-9
4978 hits

All articles cited are full text versions

Governing Medicine: Theory and Practice

Eds Andrew Gray, Stephen Harrison



Open University Press,
£22.99, pp 224
ISBN 0 335 21435 5
www.openup.co.uk

Rating: ★★★

I've a fantastic idea for a reality TV show. But it's one with a twist: the future of the NHS will be decided on the outcome. The show takes place in a hospital, and the contestants will be doctors and managers. The audience will be the patients, who vote on how to run the hospital. But they won't be told that the options are unworkable. The contestants know, given the equipment and information supplied to them, that the options are impossible. But they're out of the show (it's in their contracts) if they say

anything to try to influence the voting. There'll be plenty of crisis and angst. The contrast will be provided by the nurses: they'll exude calm while the protagonists argue. But peace won't break out; it's not good for ratings.

The game rules are that the doctors must do what they are trained to do: treat the sick to the best of their ability. But they also must prove it to the satisfaction of the managers, who aren't trained to know. Meanwhile the managers have to get the doctors to see certain patients when and how we tell them. And we'll change that from episode to episode ostensibly on the basis of audience voting. We all know that making doctors do anything against their will is like herding cats. So the managers can't make it work either. Brilliant, isn't it?

Governing Medicine shows the extent to which the NHS has become a cynical political game. Gray and Harrison have brought together an impressive list of observers of the health service who have produced a highly readable social commentary on clinical governance. I found the introduction and the first section to be riveting. The thesis is that clinical governance is really a means of controlling doctors, while the publicly

acceptable rationale is to drive up standards. The authors of the first six chapters provide ample evidence and cogent reasons for the likely failure of that rationale. The second section reveals practical faults in the bedrock of clinical governance: the use of randomised controlled trials to predict best practice, guidelines that don't allow for human nature, information systems that are judged in different ways by policy makers and practitioners, and circumscribed user involvement.

However, I was disappointed by the third and final section. The authors seem to have learnt nothing from the analyses of the earlier sections and revert to the rhetoric of clinical governance and NHS politics. The premise seems to be that if only everyone would behave as they're supposed to then clinical governance would work, and doctors, nurses, managers, and patients would between them create the ideal health service. Unfortunately the anthropological critique in the first two sections shows that people don't always follow the script.

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ART

Robin Levy: Confronting Our Bodies

An exhibition at the Contemporary Arts Center, New Orleans, United States, until 19 December 2004
www.cacno.org

Rating: ★★★★★

The American artist Robin Levy is fascinated by the way that our bodies are changed by pregnancy, disease, and ageing, and by the way in which our bodies become "objects" when we undergo medical procedures. Many of the sculptures, installations, and photographs in her new show are snapshots of our bodily changes—as if Levy is trying to create a permanent record of something that is never quite static.

One of the techniques that she uses is to juxtapose or superimpose images of her own body with those of her son or her mother. *In Vein*, for example, is a series of digital photographs showing two legs that at first glance appear to belong to the same person. Look more closely at the varicose veins and you see that they are more advanced on one of the legs, which belongs to Levy's mother, and less advanced on the

other leg, belonging to Levy herself. In the sculpture *Self Portrait: Artist and Mother*, she pairs a casting of her right foot with her mother's left foot.

This sense of our connectedness and heredity is even more obvious in *Soft Spot*, a photograph of Levy's thumbprint—a potent symbol of her unique identity—superimposed on to her son's birthmark. The effect is initially unsettling—how odd to see a mole bearing the familiar whorl of a fingerprint—but once you realise what you are looking at, the overall sense is of tenderness (a mother's soft spot for her child).

Levy worked closely with health professionals to create the two most striking

images in the show, *Lifeline #2* and *Lifeline #3*. These are cross sections of umbilical cords that have been digitally manipulated to produce enormous prints, in which the pink cords are tiny against a huge white backdrop. The cords appear so delicate, yet the title of the pieces reminds us of their power and of their potential therapeutic use. David Rubin, the curator of the show, says that these large scale prints "quietly take a positive stance on the potential benefits of stem cell research."

Many of the works that deal with health and illness reflect the artist's personal experiences. Following her own pregnancy, she created *Birthing Sheet*, made of crisp white cotton. The piece captures the clinical and impersonal aspects of giving birth—the sheet is there to focus the obstetrician's concentration by removing intimacy with the patient.

In the mid-1990s, Levy discovered that a family member and several friends had breast cancer and she became a carer to many of them. She has turned her experiences into a series of sculptures, including *The Princess and the Pea*, in which a mammogram is displayed on a pillow as if it were a precious, highly prized object (the tassels of the pillow were made from strips of mammogram film).

Confronting Our Bodies is presented in a quiet, dimly lit space. Each artwork is individually illuminated, adding to our strong sense of awe as we gaze at these representations of the human body.

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In Vein #3, 2001



Ten troublesome trends in TV health news

A 2002 Gallup poll showed that many Americans consider television their most important source of news and information on health. It also showed that television is one of the least trusted sources of such news and information. I studied each of the 840 health news stories that appeared between February and May 2003 on four television stations (KARE, KSTP, KMSP, WCCO) in Minneapolis-St Paul, Minnesota, where I live. As I watched hours of health news coverage, 10 troublesome trends scrolled across the screen.

Too brief to matter—Brevity robs viewers of the chance to grasp the significance of health stories. TV stations often pay lip service to health news by creating segments (“Lifeline Minute” or “Health Headlines”). But as more than two thirds of the stories in this analysis lasted less than a minute, and more than half were 30 seconds or less, this is a shallow commitment.

No full time health journalists—In the four months the four stations used 58 different people to report on health news, not one of whom worked full time. How can excellence and expertise be achieved when so many journalists are asked to cover these issues and with none owning responsibility?

No data to back up sensational claims—Journalists not trained in the nuances of

covering health and medical news may be more likely to report stories that make unproved claims of research progress. More than bothersome, this is a potentially dangerous trend. It could promote a misconception: that participants in a research trial will certainly derive direct benefit from what is actually an experiment with uncertain benefits and harms.

Hyperbole—Hyperbole threatens the credibility of television health news. One example: Botox, a drug that has been much in the news for its wrinkle removing uses, received enthusiastic coverage by one station for its use in pain control. The station called it a “new wonder drug for pain . . . nothing short of miraculous . . . what some consider a miracle drug.” The single doctor who was interviewed “says his patients are proof Botox is a miracle drug.” Science doesn’t work that way; it demands independent confirmation. So should journalists.

Commercialism—My analysis found many examples of reporting that contained elements of commercialism: statements from private companies with no balancing statements from competing companies or other sources; and stories mentioning a link to a private company’s website and links to the commercial website given on the station’s news website.

Single source stories—News stories that rely on only one source are not good journalism. Anyone with knowledge of the healthcare industry, of medicine, and of the scientific community knows that many vested interests reside among government health spokespeople, researchers, universities, drug companies, device manufacturers, providers, insurers, and so on. But single source stories were the rule, not the exception.

Baseless predictions from basic science—Many stories leapt from mouse studies to potential treatments in people or from phase I drug trial findings to imminent approval by the Food and Drug Administration (FDA).

FDA approval treated as a fait accompli—Stations often treat drug approval by the FDA as a mere formality, either not mentioning that a drug is still in an early phase of research or referring to FDA approval as something that “could” or “should” happen soon. Sixteen stories in the four months discussed drugs that had not been approved by the FDA without clear caveats about this early phase of research. Rather than reporting on a company’s hopes for its product or the potential sales, journalists could better serve their audiences by reporting on the evidence for and against a product, explaining the distinction among phases of drug trials, and including explanations of the hurdles, unknown factors, and potential problems in drug or device research.

Little coverage of health policy—Despite the occurrence of many national and local events to do with health policy (Medicare, Medicaid, managed care, health costs, insurance, access to care, and so on) the four stations had little coverage of health policy during the four months of analysis. There was almost as much coverage of stories on cosmetic health (wrinkle removing, liposuction, face lifts, and body contouring—some of which are not even covered by insurance).

No time for enterprise—Of the 840 health related stories only 77 (9%) were originated by the stations themselves. All the other stories simply followed scheduled events of the day, news releases, journal studies, local hospital announcements, or handouts.

Common practices?

Can these findings from Minneapolis-St Paul be generalised to the rest of the United States? Ours is the 14th largest television market in the country and is viewed by some people as one of the best in the nation. The mobility and turnover of television news personnel may mean that the practices found in this study are commonplace in other markets.

Local television news has tremendous reach and potential impact on Americans. But the many Americans who get their health and medical news and information from local television news are receiving a distorted picture. Remedies for these ills are well within reach: training, more time, and more effort. News directors may also be wise to consult a new statement of principles published by the Association of Health Care Journalists (available at www.ahcj.umn.edu/files/AHCJ_principles.pdf (accessed 12 Oct 2004)).

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REX FEATURES

Are television journalists putting viewers in the picture on health?

PERSONAL VIEW

The negligence of medical experts

I have just participated in a medicolegal exchange whose outcome was thoroughly unsatisfactory. The questions of negligence and causation were not publicly debated, and the decision was not based on evidence but reflected emotional issues and everyone's desire to stay out of court.

Medical negligence absorbs victims—patients and doctors—and disgorges them years later, often damaged and disgruntled, while its functionaries benefit. Despite the move towards closer regulation of clinical practice, medical negligence remains firmly in the dark ages that existed before the Kennedy report and the Bristol debacle. It is mostly secretive, unaccountable, and unregulated by audit governance or revalidation. Scant interest has been shown in it by our governing bodies, the royal colleges, the General Medical Council, or organisations involved in patients' safety.

The central players are the expert witnesses. The public assumes that they are in the forefront of their specialty, giving up to date, balanced opinions that are based on their own practice—honed by continuing professional development—and a detailed knowledge of the literature on their subject, to which they are major contributors. They are also supposed to be unbiased. In a number of well publicised recent criminal cases experts have been challenged on the factual quality of their evidence and sometimes on an *idée fixe*, which may amount to an obsession, on which their eminence may have become established. Are these notorious cases the tip of an iceberg of unsatisfactory professional activity?

Most medical negligence work is handled in camera between the medical experts, the defence organisations, the NHS Litigation Authority, and a body of solicitors of varying expertise in the subspecialty. The litigant's case can be established at the outset only on the opinion of a medical expert. Therefore the object is more likely to be damage limitation and compromise rather than vigorous defence through a strong intellectual argument. This is understandable and even laudable when considerable expense can be expected in the uncertain process of judgment in court. Unfortunately court procedure provides the only opportunity for the experts to be challenged—and then only if a penetrating cross examination can be undertaken by a barrister who has some familiarity with complex medical issues and is prepared to put aside his deference for the opinion of a professional colleague. However, most cases never come to court, and the data are therefore unavailable for analysis. It is not surprising that there is little consistency in

the settlement of similar mishaps, sometimes even dealt with by the same medicolegal team, but it is not in anyone's interest to use this knowledge to shorten the legal process.

Medical experts may be offered a case for comment by solicitors for a variety of reasons other than their perceived expertise, including a reputation for prompt delivery of reports, familiarity with the legal process, and a good bearing in court. They may be selected from a register of experts whose membership signifies nothing other than the ability to pay the annual premium.

The quality of expert reports varies greatly. Events may be minutely chronicled, with little effort at critical analysis. Some experts may not be at all familiar with majority opinion, particularly if they are retired or inactive. Quoted source material often amounts to a page or two from a very ancient textbook. This seems to be acceptable in the legal process; they would not dare to offer such inadequate references to support a clinical presentation to their medical colleagues.

The terms "negligence," "breach of duty," and even "causation" are arcane, legalistic, and pejorative.

The distinction between probability and possibility is often ludicrous but still determines what is reasonable and what, on the other hand, is culpable.

Lawyers cannot be expected to remain informed on who is an expert when new techniques within the subspecialty develop quickly. However, they should set greater store on the quality of a report and its sources rather than quantity and presentation. The experts should surely exude the wholesome smell of the clinic rather than the conservative mustiness of the courtroom. Governance, audit, appraisal, and peer review should penetrate this area of medical endeavour. The process of medical negligence should be transparent, with all agreed settlements and their discussion published in the medical and legal literature. A nationally managed register of coded incidents and their outcome would be a great help in defence of claims and in the broader aim of learning from error.

It is unlikely that initiatives such as "no fault compensation" will replace the adversarial process that is based on the reports of medical experts working ostensibly for the court but in reality from a partisan standpoint. It is increasingly important that medical experts have real authority and expertise to retain the respect of their colleagues.

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The quality of expert reports varies greatly

SOUNDINGS

In captivity—at Lewes

The life of Dr Juhan Paasikivi has been closely linked to Finland's struggle for independence. His grandfather was Finland's prime minister and president in the perilous times following the second world war. His father was killed in the Russo-Finnish winter war of 1939. He became an academic physician in Stockholm and in the 1960s showed that tolbutamide lowered the incidence of myocardial infarctions in patients with abnormal glucose tolerance.

He had a country house in the Aland Islands, where during the Crimean war an Anglo-French naval expedition under Sir Charles Napier stormed the fortress of Bomarsund (few casualties, but 600 died later from cholera). They took Finnish prisoners (regarded at the time as "Russian"), who were then stranded for six weeks on the battleship *St Vincent* and later the *Devonshire*—without much food but on hammocks infested with lice, allegedly left over by the French.

In October 1854 some 170 emaciated "poor victims of the ambition and criminality of the emperor of Russia"—including 15 officers, six wives, and one child—were marched to a former jail in the "ordinarily quiet country town" of Lewes, England. Treated on the whole quite well, even taken once a week to the town's outskirts to breathe the fresh air, they were housed three in a room with no doors or fireplaces, kept on frugal rations of beef and cocoa, but weighed periodically to ensure they were getting enough food.

Several tried to escape and were recaptured; two escaped in civilian clothes with false beards, almost walked into the British embassy in Hamburg, but eventually made their way to St Petersburg. In November 1855 a "young Fin" was unexpectedly born to one of the wives and duly baptised. Altogether some 27 prisoners died—from "rheumatism and disease of the chest," "dysentery with ague and fever," "phthisis pulmonalis," and "extensive disease of the left orbit." Some of the officers were "in great favour with the young ladies," but thought that the English danced the waltz rather poorly.

All this is detailed in a large file of letters and newsletter clippings from the 1854-5 *Illustrated London News* and the *Sussex Advertiser* that Dr Paasikivi sent to me some 25 years ago. For many years we planned to meet in person. It never came to be. He died in October 2004, age 74.

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