A practical approach to an old problem

PERSONAL VIEW **Ben Moore**

A spell of gynaecological work in central Africa provided a reminder of major problems still existing in many parts of the world, including the morbidity and mortality from neglected cervical cancer. Tzhe African experience was followed almost immediately by an medical attachment in southern India that gave insight into how this problem might be tackled.

The first move was to a general hospital in eastern Zambia, a job involving three surgical and two outpatient sessions per week. At the clinics some complaints were ever present, including infertility (always the largest group) and pelvic and abdominal masses, plus two smaller groups: young women with urinary incontinence (mostly from obstructed labour) and older women with pelvic pain and foul vaginal discharge—a combination almost invariably heralding a cervical neoplasm. Of the last two groups the latter was more to be pitied. Fistula surgery was available but for advanced cervical cancer there was nothing. Over a two-month study period there were 18 such cases, a high incidence similar to that noted a year previously when working at a district hospital in Tanzania. (Tanzania, unlike Zambia, did have a radiotherapy unit providing free treatment for those able to get to the capital, Dar-es-Salaam.)

In time, pre-pubertal vaccination may be the answer to cervical cancer, but such a method will require years to prove its worth

The second journey was to Andhra Pradesh in India, where the Institute for Rural Health Studies (IRHS) a charity with links in the United Kingdom, ran projects south of Hyderabad. One was a primary care clinic staffed by two paramedics and five ancillary workers (supported occasionally by a volunteer doctor). This, despite its small size, attracted patients from a wide surrounding area, partly due to its modest charges and partly due to its reputation for giving impartial advice.

Among gynaecological complaints, infertility problems were rare, there were few pelvic masses and—during a study period comparable to that in Zambia—no urinary fistulas and only one obvious cervical cancer.

Another IRHS project was the Cervical Cancer Screening and Treatment Programme, a small group providing a peripatetic service based at the local district hospital. The group, supervised by a gynaecologist, was engaged in a survey comprising visual inspection, colposcopy, cervical biopsy, and cryotherapy. It was staffed by four or five locally trained, female health workers who travelled with their equipment (including a small petrol generator), the usual venue being a vacated classroom at the village school. Before screening (which was free) women were registered, counselled, and consented, and afterwards medication prescribed and follow-up arranged as required. The itinerary involved about 25 villages in three months.

Observing the group in action provided a possible explanation for the lower number of cervical cancer cases noted at the Indian location. It also demonstrated the positive impact made by a health team visiting a rural community: the buzz of excitement surrounding the team's arrival, the banner draped across the narrow street proclaiming its health protection work, the surge of interest when wives of village dignitaries attended for examination, the pretty young health workers in flowing white saris—all helped bring cervical cancer to the public's attention and encourage participation.

Cervical cancer is the commonest form of cancer among women in virtually all developing countries and is globally responsible for approximately 300 000 deaths per annum. In recent years it has received sporadic attention, principally through screening—the aim being to identify pathology at an early stage when available treatment can still be effective. Ideally screening is accurate, simple, cheap, reproducible, safe, and acceptable to the target population. Such perfection is rarely attainable and the procedure represents a compromise between accuracy and affordability; that is, if too simple it is not sufficiently accurate to achieve its purpose and if too complex accuracy may improve but it becomes too expensive. The service given by IRHS—good diagnostic accuracy, "screen and treat" for minor problems, and an efficient referral system for more complicated cases—seemed to provide a satisfactory balance between these extremes. Unfortunately, many areas lack such advantages. Nevertheless, if mortality from cervical cancer in developing countries is to be reduced some form of mass screening—appropriate to local circumstances—must be involved. In time, pre-pubertal vaccination may be the answer to cervical cancer, but such a method will require years to prove its worth. In the interim screening represents the best approach.

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REVIEW OF THE WEEK

Ministering to the Fatherland

Why did a trauma surgeon with an interest in humanism become Hitler's personal physician? **John Quin** reviews a fascinating new biography of Karl Brandt

Another day, another appointment panel. You make the decisions and then the lay chair passes some references for your attention: "An enthusiastic and intelligent student," "Fulfilled all his duties with skill and speed and has shown a good understanding of the duties and responsibilities of the medical profession in every respect," and "Worked with great zeal and conscientiousness."

Déjà vu—when was the last time you read references like these? When was the last time you *wrote* references like these? Last month, last week, yesterday? Those hackneyed phrases that promise everything and nothing. Read them again and tremble for these are the words spoken in support of Karl Brandt, Hitler's Reich Commissioner for Health and Sanitation, the man behind the notorious T4 euthanasia programme. Ulf Schmidt from the Wellcome Unit for the History of Medicine in Oxford has given us a timely reminder and explication of "how a rational, highly cultured, literate young professional…came to instigate and become responsible for mass murder…on a previously unimaginable scale."

Brandt was about as far away from the demonic image of a Nazi medical thug as one can imagine. He was no Mengele, no scary psychopath we can quickly label and file away in some dark cupboard of the mind marked "Bad." Qualifying in 1929 Brandt specialised as a trauma surgeon. He "developed his career in a methodical and competent manner by gaining theoretical knowledge and practical experience . . . and clearly possessed significant expertise and skills and developed a good rapport with patients, patients' relatives and colleagues." Now where have you read that sort of endorsement recently? In 1932 he flirted with the idea of going to Africa to work with the great humanist Albert Schweitzer—such are the ironies of the individual and history. Instead, somewhat in the manner of the doctor in Giles Foden's novel on Idi Amin, *The Last King of Scotland*, Brandt came to a dictator's attention by his medical intervention at a car accident. His ascent at the court was swift; he was popular with Eva Braun and the ladies; socially skilled he counted fellow professional Albert Speer as his friend. He was tall, handsome, polite, charming—they thought he was a delightful young man, a wonderful doctor.

By 1939 Hitler, in a written statement, charged Brandt "with the responsibility of enlarging the powers of specific physicians, designated by name, so that patients who, on the basis of human judgement, are considered incurable, can be granted mercy death after the most careful assessment of their condition." Today Hans Scharoun's wonderful 1963 Philharmonie building, where the great and the good come to listen to Sir Simon Rattle's mighty orchestra, sits close by Tiergartenstrasse 4. However, in the early 1940s this address was the headquarters of Aktion T4, the euthanasia programme, which would claim the lives of an estimated 70 000 people.

With the war going badly for Germany after Stalingrad and the RAF bombings the pressures on the medical services mounted. Brandt then found himself giving agreements to swathes of nightmarish policies—experimentation on camp victims without consent on the effects of starvation, phosphorous burns, hepatitis contaminated serum, bullet wounds, then on to championing research into biological and chemical warfare.

Brandt believed that delivering the patient from pain at all costs was the doctor's task, even if the patient lost his life as a result. This nihilism intensified: the death of the mentally ill or the physically handicapped for the likes of Brandt, so Schmidt explains, "freed society from a financial, emotional and even aesthetic burden." They "eliminated sickness by eliminating the sick." Even after his arrest and trial at Nuremberg, Brandt was determined to paint himself as an idealist, a doctor at ease with his conscience that he was only doing his best for his patients. "I was motivated by absolutely humane feelings." Judge Harold L Sebring exposed how individual morality and responsibility had been totally abandoned or corrupted. The inviolable dignity of the individual had been trampled upon. In his defence Brandt gave the game away by saying this—*it was never meant to be murder.*

Before he was hung, Brandt offered to submit himself to a medical experiment offering no chance of survival. Even at this late stage he still failed to comprehend the basic issue of consent that he had blithely ignored in his ignominious self serving career. Brandt obeyed, he did as he was told, Brandt was *the* anti-contrarian of medical history, and Schmidt's account of his life has, in our own troubled time of doctors as terrorists, of market driven "health reform," and of the New Genetics, many, many disturbing reminders of the abyss we bestride.

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Karl Brandt: The Nazi Doctor—Medicine and Power in the Third Reich
Ulf Schmidt
Hambledon Continuum, £25, pp 480
ISBN 978 1 847250 31 5
Rating: ★★★★

TOPHAM PICTUREPOINT/TOPFOTO

Brandt was about as far away from the demonic image of a Nazi medical thug as one can imagine

Pass it on?

FROM THE FRONTLINE
Des Spence

It was 3 am and the six of us had been playing Dungeons and Dragons, a fantasy role-playing game. We were nerds, one and all. She passed the joint. I inhaled and passed it on. We laughed and munched on packets of crisps.

I smoked cannabis about a dozen times at university. I am not the home secretary but I am a responsible professional. Is it inappropriate for a doctor to admit to having smoked cannabis or can this be seen as tacit acceptance and normalising of drug use? My rationale, however, is honesty, without which there is only hypocrisy and the stifling of any meaningful debate. Drug use by the young is, perhaps, the widest schism between the generations.

Age comes at a cost but it has a great gift—experience. My young life was a conveyor belt of predictable and clichéd mistakes—I was 18, so of course I knew best. But many of these wrong choices were my most important ones. Scalded and scarred by our mistakes we limp into middle age, weary but a lot wiser. Seeking to spare our young some pain we proffer them some unsolicited advice but omit the story behind the lecturing. Every single generation of the young happily jump onto the old conveyor belt full of bold and contemptuous certainty, smiling and waving at a despairing family, heading for the check out marked "Ten stupid things you must do before you grow up and admit that your parents were right and then apologise." So what should be done about the young and cannabis?

Despite my use of cannabis as a young man I question the logic of liberalising the law. Health worries to one side, the real issue is that looser laws would surely lead to increased consumption and availability. Our communities are already saturated with mind altering drugs, be they illegal, prescribed, or cheap vodka. Our society is greatly undermined by drug use; we simply do not need any more.

I have never denied my cannabis use to my patients, and rather than undermining my position I feel that honesty has made my advice more credible. Perhaps it is time that we are a little more honest as a profession and come out of that bulging and over crowded closet marked "medical drug use." Who knows, some of the young might even jump from the conveyor belt and be spared some pain.

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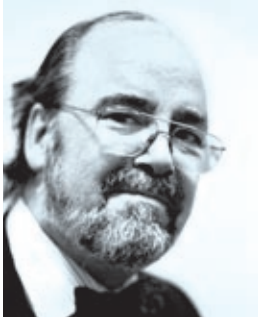
Doctor in the booth

IN AND OUT OF HOSPITAL
James Owen Drife



It's five years since we've been in the recording studios, but little has changed. Some gizmos have been updated and the photo of the producer as a member of a long-haired pop group has gone, replaced by a picture of his contemporaries, the Beatles. Still, the elderly sofa and scattered musical instruments are comfortably familiar.

Can it really be more than three decades since our first show in the Edinburgh Fringe? This time we've decided to break with tradition and learn the songs before the dress rehearsal. Recording helps. Oddly enough, it's hard to memorise your own words. You have to work at forgetting the ones you deleted during the agony of composition.

Performing to a microphone generates a special kind of adrenalin. On stage, after the preliminary rush of anxiety all that matters is that the audience has a good time. Mistakes sometimes help. Alone in the recording booth, you need to get everything right for the friendly but fastidious team listening next door. You can't relax.

Your long-time collaborator (once a fellow houseman) plays his music immaculately and then it's up to you. You put the headphones on and your brain immediately ceases to function. Your colleague sellotapes the lyrics to the glass and mimes encouragingly. When you finish, a voice invites you to come out and listen to your efforts.

Sycophancy is not part of the producer's repertoire. After the second take he compliments you on no longer imitating a wounded boar and asks if you can try to avoid sounding like a man about to be hung in the morning. He suggests that you sing across the beat and you feel it would be uncool to ask what that means.

Modern technology, he says, can correct small errors in tempo but it has its limits. It cannot insert raw emotion. Goaded, you return to the booth and give it some welly. You wave your arms. You pout. You smile coquettishly at the microphone. You emerge drained and find the team next door chatting about football.

The songs are supposed to be funny. As the tapes play you watch surreptitiously, hoping for a smile, but everyone is concentrating on musical minutiae. Suddenly someone notices a joke and gets a fit of giggles. Bless him. There's still hope.

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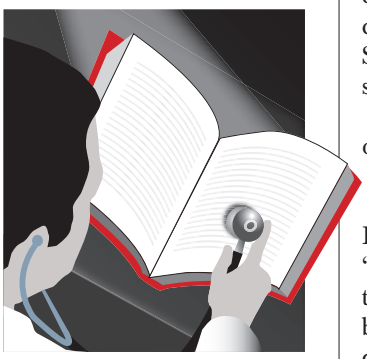
James Owen Drife will be performing in the Edinburgh Fringe in *The Secret Life of Robert Burns*, which runs from 21 to 23 August.

A bit of a doctor

BETWEEN THE LINES
Theodore Dalrymple



When someone is unconscious, he tries smelling salts first, and then an injection of strychnine, which revives the recipient no end

Pulp fiction is not literature, of course, but that of a bygone age is not without historical interest. It also tells us something of the popular medical conceptions of its period.

Edgar Wallace was the most famous author of his day. He wrote 175 novels, and 160 films were made of them. His publisher claimed in the 1920s that one in four books sold in Britain was "an Edgar Wallace." Quite often, when you buy a second hand copy of one of his books, a previous owner has ticked the titles he has read on the list of other books by Edgar Wallace that appears before the title page, as if reading them were in compliance with a religious duty. The desire for completeness sometimes takes strange forms.

Sanders of the River, published in 1911, is one of Wallace's most famous books. Sanders is a district commissioner in a British African territory (Wallace is very imprecise in his geography, and can hardly tell his east from his west and central Africa). I don't think you have to be politically correct to find Sanders' tendency to administer swift justice, in the form of the "scientific hanging" and "scientific flogging" of natives a little alarming, especially as it is obviously held up to the admiration of his readers, who probably pursued dull white-collar jobs and longed for something a little more exciting.

The sound of the Maxim gun as it mows down African warriors with spears—the "ha!ha!ha!" of the gun, as Wallace puts it—also features quite frequently in the pages. As do medical matters.

Sanders' cook, Lataki, tries to poison him with ground glass in his chop, perhaps not altogether surprisingly, in view of Sanders' treatment of him: "Lataki was no stoic and when, tied to a tree, ten strokes were laid upon his stout back . . . he cried out very loudly against Sanders, and against the civilisation of which Sanders was the chosen instrument."

Sanders is visited one day by Professor Sir George Carsley, of St Mark's Hospital, London, "a great scientist and the author of many books on tropical diseases." (We must remember here that Wallace's definition of an intellectual was someone who had found something more interesting than sex.)

Sir George announces that he wants to study the witch-doctor, and anticipates, against Sanders' mocking scepticism, "making valuable scientific discoveries through my intercourse with them." This, of course, is strikingly in advance of his time.

Sir George goes missing in the bush, but later turns up having gone native, except for the fact that he is administering hydrogen cyanide to all and sundry.

Sanders himself is a bit of a doctor. When someone is unconscious, he tries smelling salts first, and then an injection of strychnine, which revives the recipient no end.

The most interesting medical incident, however, involves Claude Hyell Cuthbert, a thrusting young man who arrives in search of a mining concession in Sanders' district. Unfortunately, he becomes convinced that he has sleeping sickness because he feels very sleepy, and he knows that he has been bitten by tsetse flies. He crawls away to a hut to die, and spends several weeks there, but Sanders discovers the real reason for his apathy and sleepiness: a chief called Basambo has given Cuthbert a lot of Indian hemp to smoke. So Edgar Wallace discovered the amotivational syndrome.

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

The Doctor's Dilemma
By George Bernard Shaw

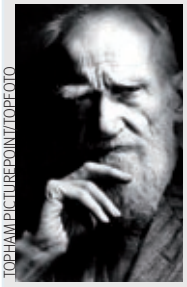
First staged 1906

George Bernard Shaw (1856-1950), Irish dramatist, arts critic, socialist thinker, and winner of the Nobel prize for Literature, had a bit of a problem with doctors. By the turn of the 20th century he had formed the opinion that the medical profession was in a terminal state, requiring urgent and heroic intervention. Shaw, one of the greatest British dramatists since Shakespeare, was quite happy to make the first of several subsequent incisions.

A high-school drop-out, Shaw had undertaken a massive programme of self education in his 20s, courtesy of the British Library's reading room. Following this, his subsequent combination of prodigious intellect and panoramic knowledge meant that few subjects intimidated him in his quest for fairness and truth.

By 1905, Shaw had reached the height of his dramatists' powers, with plays such as *Man and Superman* and *Major Barbara* enjoying international accolades. It was at this point that he decided to write *The Doctor's Dilemma*, a scabrous comedy that would come to be regarded as the greatest satire on the medical profession since Molière's *Malade Imaginaire*.

The protagonist of Shaw's ironically labelled "tragedy" is Sir Colenso Ridgeon, a recently beknighted, bachelor physician, troubled by unfulfilled matrimonial desire. Colenso has received his knighthood in recognition of his pioneering immunological research, specifically his discovery that tubercular patients can be cured—in the right hands of course—by inoculation with a miracle substance, Opsonin.



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Shaw: a problem with doctors

The play opens with Colenso holding court, firstly for an entertainingly observed spectrum of medical colleagues who come to pay tribute to him and, secondly, for a beautiful young woman, Mrs Dubedat, who consults in search of a cure for her moribund, consumptive, but divinely gifted husband. Now we see Colenso's dilemma. He has already promised the last slot in his forthcoming treatment programme to a consumptive colleague, the plodding but decent Dr Blenkinsop, who, after working all his days in a deprived, disease-ridden general practice, has eventually been infected by one of his hapless patients. The ensuing drama, brimming with high comedy and sizzling one-liners, brilliantly fillets Colenso's personal and professional ethical system, as he is squeezed into a decision that leaves him (as with all successful tragedies) reduced and chastened.

What constitutes a good doctor? How should medical services be organised? On what basis should doctors choose who is to be given the chance to live and who, in consequence, may die? All of these questions and more are tackled by *The Doctor's Dilemma*, a play that, while perhaps not the greatest of Shaw's works, is peppered with thought provoking argument and, crucially, is still highly relevant to our times. It is, in consequence, an undoubted medical classic.

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