reviews

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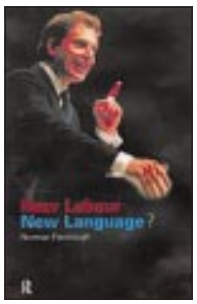
New Labour, New Language?

Norman Fairclough



Routledge, £9.99, pp 178
ISBN 0 415 21827 6

Rating: ★★★★

"I can suck melancholy out of a song," says Shakespeare's Jaques, "as a weasel sucks eggs." Hence the phrase "weasel words," coined for political purposes in the United States at the end of the 19th century and used (most famously by Theodore Roosevelt, criticising President Woodrow Wilson) to describe rhetoric that sounds as if it has substance but is actually empty of specific meaning, or is at best ambiguous and vague. All competent politicians know, often purely instinctively, how to coin weasel words, or at least how to use them. But none is as good at it as Tony Blair and "new Labour," according to Norman Fairclough in this penetrating disquisition, refreshingly free of sociolinguistic jargon and bolstered by linguistic evidence and analysis.

Some short words make superb weasels. Like "we." Not much ambiguity there, you might think. But "we" can be completely exclusive (the royal we, the authorial or editorial we) or completely inclusive (everybody). And in between are all shades of grey—I, you and I, the Cabinet, the government, parliament, the country, the world, the solar system, the universe. The trick is to make the meaning slide ambiguously from clause to clause, from sentence to sentence. Don't specify who "we" is, and everyone feels included. Inclusion, after all, makes you part of new Labour's "one nation," what John Major less successfully described as a classless society. It also means that you can participate in "public-private partnership"—in other words, privatisation. And it contrasts with "social exclusion"—what we once called poverty. The Tory party used to call itself the natural party of government; now, by pandering to our desires to be included, new Labour tries to claim that unrealistic role for itself.

Some other weasels also bare their teeth ambiguously: "values" (economic, political, or moral?) and "reform" (destruction or transformation?). Some are undefined: "work" and "change." And some involve shifts in meaning: "trust" (defined as the "recognition of a mutual purpose") and "dialogue" (which means not discussion but diatribe). Even "the" is not exempt—it is used to give verisimilitude to non-existent entities ("the international community"). Other weasels need no gloss: "quality," "evidence," "governance"—we have all come to know what they mean, or think we have.

But some of this subtlety subverts itself. When Blair evokes "joined up government" has he forgotten that joined up writing is what children aspire to but adults consider trivial? Probably—politicians are too often fooled by their own rhetoric (remember Mrs Thatcher's famous pronouncement that "we are a grandmother"?). And when he talks about the "third way," does Blair really want to raise echoes in our minds of the Third World—countries that we used to call underdeveloped? Or even the Third Reich?

Some of the rhetoric is even derisory. "The Tories stand only for the privileged few," says Blair. "We stand for the many." Now this is just a rehash of Mr Spock's *Star Trek* dictum that "the needs of the many outweigh the needs of the few." But in the hands of new Labour's rhetoricians, such trite sentiments are intended to catch votes, not to express real policies. The rhetoric creates the policies, not the other way round. Indeed, the rhetoric hides the absence of policies. Although Professor Fairclough curiously fails to note this fact, he does point to what he calls the reality-rhetoric dichotomy, exemplified by the contrast between rhetoric about open government and the restrictive reality of the Freedom of Information Bill.

Lest you doubt his interpretation, Professor Fairclough presents the evidence—an analysis of word counts and collocations in two bodies of writings and speeches, one from new Labour and one from the old left. He shows how words like reform, business, values, and work are no longer used to mean what they once did—that the weasels have got more weaselly. Disappointingly, he fails to compare these two bodies of texts with a comparable body of right wing texts (although he does occasionally cite Mrs Thatcher and President Clinton for comparison). Nor does he point to the rhetorical device of talking about "the old left," which is pejorative, rather than "old Labour," which has a resonance of its own.

But the message is clear. If you don't want to be too weaselly misled, look out for the weasel words and structures in everything you read. Look for them in the political manifestos, in executive directives, in the next letter from your friendly consultant. Oh yes, and even in book reviews.

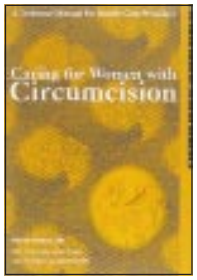
Jeff Aronson *clinical reader in clinical pharmacology, Oxford*

IAN STEWART/AP PHOTO

"Britain deserves better." But did it deserve New Labour?

Caring for Women with Circumcision: A Technical Manual for Health Care Providers

Nahid Toubia



RAINBO, $17.95, pp 94
ISBN 1 893136 01 9

Rating: ★★★★

A 19 year old Somali refugee woman presented in labour. She spoke no English. Examination of her vulval area showed a long scar in place of her external genitals, with only a tiny opening. The senior resident called to advise thought that he remembered hearing about ritual cutting, and managed to track down a colleague who had worked in Somalia. Over the telephone, she explained that the woman was infibulated and needed defibulation in the second stage of labour. Instructions were faxed over from another state, and the baby was delivered successfully.

This case history from Toubia's book illustrates some of the difficulties encountered both by affected women and by doctors. Toubia writes as an African woman and a physician, and her manual provides concise and accessible coverage of the cultural, physical, and emotional complexities of female circumcision. This is also, more controversially, termed female genital mutilation; Toubia considers that both terms have their place, with "female circumcision" being more useful in the clinical setting.

Female circumcision affects about 100 million women and girls worldwide. Their risk of dying in childbirth is doubled and of having stillborn babies trebled, and other physical, sexual, and relationship problems are common. Although female circumcision is now illegal in many countries, the practice continues in much of sub-Saharan Africa, among various religious groups, as a rite of passage into womanhood or a way of preserving virginity until marriage.

The extent of physical damage ranges from a clitoral nick to complete infibulation, when the external genitalia are removed and the vaginal opening narrowed by stitching. The different types are clearly described in the book, supplemented by a laminated sheet of illustrations and diagrammatic instructions for defibulation. Although the classification of circumcision is precise, Toubia comments that the performance of the surgery frequently is not, as it often involves a traditional circumciser, poor lighting, and an unanaesthetised child who is screaming and wriggling.

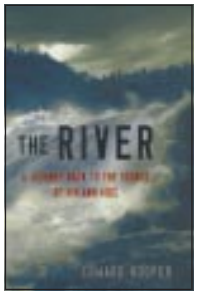
The practicality of this book extends not only to the medical, gynaecological, and obstetric needs of those circumcised but also to the section on communication. This is masterly, with cogent advice on topics such as asking about past circumcision, giving information (use pictures for women with low literacy), and employing interpreters (avoid using patients' children). The section on the law has been written for the US market but also summarises the position elsewhere.

This is a valuable reference for a topic poorly covered in mainstream textbooks and is a compelling read for clinicians who wish to develop the skills to manage affected women capably and sensitively.

Jan Welch *consultant, Department of Sexual Health, King's College Hospital, London*

The River: A Journey Back to the Source of HIV and AIDS

Edward Hooper



Penguin Press, £25, pp 1070
ISBN 0 713 99335 0

Rating: ★★★

Does it really matter how AIDS started? Not long after AIDS was described in the United States, Europe, and Haiti, it became evident that several countries in sub-Saharan Africa had far greater proportions of people already affected. The belief emerged that the human immunodeficiency viruses arose in Africa. Thanks to molecular technology, the HIV-2 virus, mainly limited to west Africa, was found to be identical in genome organisation to a simian virus (SIV) in the local sooty mangabey. Evidence accumulated about the close relation between the now pandemic HIV-1 and chimpanzee SIVs in central Africa.

How did the viruses transmit from monkeys and apes to humans, to cause the most important zoonosis yet known? And when? The earliest identified isolate of HIV-1 comes from an unknown male in Kinshasa, Congo, in 1959. The first identified patient with HIV infection and AIDS was a Scandinavian man in the 1960s, who had visited west-central Africa. Then came sporadic cases among gay men in the United States and among Haitians in the 1970s, leading to the global explosion in the '80s and '90s and the literal decimation of peoples in several tropical countries. Did the transmissions of SIV across species—and there were two or more some time earlier last century—come about through close contact between human hunters and their primate prey (dissecting or eating), or might the pandemic have arisen from a medical accident?

The hypothesis of this book is that the drive to conquer another scourge, polio, is the crux. The preparation of live attenuated oral polio vaccine originally used cultures of monkey kidney cells; there were monkey laboratories in Africa devoted to testing these vaccines and providing kidneys for the vaccine factories; the kidney cells (or associated lymphocytes) could have been infected by SIVs that could adapt to humans and cause disease (which they do not in their natural hosts); then administration of oral polio vaccine infected adults and children with SIV during the mass trials in the late 1950s.

The idea is not new, having been proposed in 1992 (and rubbished or deflected by the scientific community). What Hooper has done is to show a striking geographical and temporal correlation between the earliest known and probable cases of AIDS and the sites of administration of polio vaccine in central Africa. He presses for a major review of the vaccine hypothesis and the testing of any remaining stocks of those vaccines for infection with HIV or SIV.

Whether the proposition is true will become clear as more primate SIVs are genetically sequenced and correlated with HIVs over time and place. My personal feeling is against the hypothesis on the grounds that it is too simple an account of the evolutionary complexities of these lentiviruses, and the fact of more than one introduction of SIV or HIV into humans. However, it is possible in principle, and finding out the truth is important because of the implicit threat to vaccine programmes in the future.

This magnum opus from a non-medical investigative journalist should stand for other reasons. It is the best yet historical description of AIDS. It is a detailed examination of a great episode of medical endeavour (the polio vaccine), and also shows how we can cut corners when it suits and fail to document much methodological information (it is not certain whether cultures of chimpanzee kidney cells were used in the final stages of vaccine production).

Yes, it does matter how AIDS started, and this book is a contribution to the debate.

Sebastian Lucas *professor, department of histopathology, Guy's, King's, and St Thomas's School of Medicine, London*

Reviews are rated on a 4 star scale (4=excellent)

Vilified for tackling tobacco

An organisation dedicated to "imposing its will" on people across the world and "undermining property rights" met in Switzerland last week. It was criticised in the *Wall Street Journal Europe* as undermining individual choice and in the *Scotsman* as "leading to a version of 1984." So what was the name of this sinister body? Was it the Mafia? Or the Freemasons? Or a new socialist terrorist organisation dedicated to the overthrow of the capitalist system? No. As it turns out, it was the World Health Assembly, which was meeting in Geneva.

Why did the assembly (the annual general meeting of all the member states of the World Health Organization) provoke such ferocious criticism, prompting a leader in the *Times*, a long feature in the *Wall Street Journal Europe*, and a half page article in the *Scotsman*? Its crime, according to these distinguished newspapers, was that it had decided to "take on" the tobacco industry, instead of confining its activities to the legitimate task of combating malaria, tuberculosis, and other infectious diseases.

It would be convenient to assume that the authors of these articles were all in the pay of the tobacco companies, but no such evidence exists. But it is still worth addressing the arguments of people who attack the WHO for taking on the tobacco industry, because the debate is bound to run and run.

The main opponent of the World Health Assembly's actions is Roger Scruton, the libertarian writer and philosopher who was until recently a professor at Birkbeck College, London, and now makes his living as a writer and runs an experimental farm. Scruton has produced a paper for the Institute of Economic Affairs (a right wing British think tank), entitled "WHO, what and why," which is cited in the *Times* leader and which is the basis of the *Scotsman* article. Moreover, many of his arguments are repeated in the *Wall Street Journal* piece.

In his paper, he argues that transnational institutions are increasingly exercising their legislative powers, in order to bypass the constraints to which national legislatures are subject. The situation is made worse by the habit of conferring leadership of these institutions on former politicians, such as Dr Gro Harlem Brundtland, the former prime minister of Norway who is now the director general of the WHO. Such former politicians tend to be more responsive to the concerns of vocal but unrepresentative interest groups, Scruton claims.

"The dangers of this are illustrated by the WHO's 'Tobacco free' initiative, and its current attempt, eagerly pursued by Dr Brundtland, to secure a draconian convention against the tobacco industry." Scruton claims that the grounds for this are largely spurious and will lead to massive legislative and policing powers being given to unaccountable bureaucrats and to the trade in tobacco going underground.

Although Scuton's arguments hang together logically (as befits a former philosophy don), some of the statements on which he bases his arguments do not stand up to close scrutiny. He claims, for example, that although smoking is a risk to health, "it is perhaps less of a risk than eating junk food." What evidence is he using to reach such an outlandish conclusion? And when he claims that the numbers of deaths from smoking have been exaggerated, what statistics is he using to counter the powerful collection of figures produced by Richard Peto and others in such books as *Mortality from Smoking in Developed Countries 1950-2000*?

He also claims that tobacco is of no relevance to people in developing countries, because smoking related disorders affect people only in later life, and average life expectancy in many such countries is only 45. Yet he fails to recognise that this life expectancy figure is low because of the high number of infant deaths, and that plenty of those people who survive into adulthood live quite long enough to be affected by the diseases of smoking, such as lung cancer, emphysema, and heart disease.

He fails to address entirely Richard Peto's prediction that although smoking is likely to increase deaths in developed countries by only 50% in the next 25 years (from 2 million to 3 million a year), it is likely to increase deaths in developing countries by 700% (from 1 million to 7 million a year).

Finally, his claim that the WHO is not accountable to national governments is flattened in one sentence by Dr David Nabarro, an executive director of the WHO, who replied to Scruton's polemic in a counter article in the *Scotsman*. In it, he said: "WHO is directly governed by its member states and Dr Brundtland is an elected—not appointed—official . . . The WHO secretariat is responding to its member states," who said that they found it hard to regulate the tobacco industry. They found that tobacco companies could circumvent advertising restrictions, health regulations and taxation rules and exert tremendous pressure on governments, which are generally ill-equipped to deal with their wealthy marketing machines.

The ironic aspect of the *Times*' attack on the WHO's "political correctness" is how reminiscent it is of its earlier opposition to public health measures. When Edwin Chadwick tried to introduce clean drinking water and better sanitation into 19th century England, a *Times* editorial in 1854 thundered: "We prefer to take our chance with cholera than be bullied into health." Plus ça change.

Annabel Ferriman *BMJ*

WEBSITE OF THE WEEK

Urinary tract symptoms This week the *BMJ* publishes a paper (p 1429) and a linked editorial (p 1418) that show that lower urinary tract symptoms in middle aged women are common and that they relapse and remit. It's a salutory read for anyone who doubts the size of the overlap between "health" and "disease": from an epidemiological perspective, asking patients to list urinary symptoms seems to be an act of even less diagnostic sensitivity than was previously imagined.

If there can be such a thing as a classical field of inquiry on the internet, then urinary incontinence must surely be one: it's an embarrassing problem that many people would rather discuss in the safety and anonymity of the online environment. The *BMJ* has already published a paper that shows that much of the information and advice available online in this area is of good quality (www.bmj.com/cgi/content/full/319/7201/29). It takes more than good intentions to build the kind of online communities assessed in that paper though: the author of "A guided tour of self help in cyberspace" (http://odphp.osophs.dhhs.gov/confrnce/PARTNR96/ferg.htm) argues that such communities are contemptuous of the "shovelware" (material created for paper then converted uncritically to HTML and shovelled onto the web) that many health providers provide on their websites.

It may be unkind of me to suggest it, but www.incontinencenet.org/ falls into this category. A frames-based site that is paradoxically tricky to navigate, it has evidently been heavily sponsored by the pharmaceutical industry: all that fancy graphical design does not come cheap. But IncontinenceNet fails a crucial internet test—it has little evidence of community: one or two sad questions languish unanswered in its "chat" forums. Its British equivalent, the Continence Foundation (UK), has a useful basic site at www.vois.org.uk/cf/ but you'll have to write off to receive any of its publications in the post.

Meanwhile, if you want to point patients in the direction of some high quality resources, send them off to the US National Institute of Health (www.niddk.nih.gov/health/urolog/urolog.htm), where there is a collection of high quality, consumer level publications on many different urological problems.

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PERSONAL VIEW

Has humanity disappeared from the NHS?

It was Monday 27 December 1999, when I was the first on-call physician for the acute medical admissions unit at the Royal Infirmary of Edinburgh; it was to be the busiest day of the year.

There were heroic efforts from many staff in containing what seemed to be a tidal wave of patients—most of whom were seriously ill. Paradoxically, I enjoyed the 24 hour period, unencumbered by the usual other clinical commitments. It was like the "good old days" when doctors and nurses worked together rather than in parallel.

The next day there was a sense of elation: every patient was in a bed. But as I visited the new patients scattered throughout the hospital it became clear that many had not been clerked, many were not in appropriate beds, many had been moved on more than one occasion, and some of that boarding had been instigated by bed managers against medical advice.

I sense a climate of fear in the NHS, preventing the admission of inadequacies in the service

My experience was not unique, but what made that Christmas period so memorable was the collective failure of management to recognise or, perhaps more accurately, to admit that the NHS was in difficulties. It was the behaviour of directors, trying to defend the share price of their company ahead of the publication of poor results. Not only did such a stance undermine the efforts of the clinical staff, but it also concealed the true state of affairs from the public.

I sense a climate of fear in the NHS, preventing the admission of inadequacies in the service lest it is interpreted as personal failure with serious career consequences. And that fear has infiltrated beyond administrators. Journalists are frustrated by the "don't quote me" revelations of hospital doctors who are concerned about their financial promotion. There is just a danger that they will lose the independence which characterised doctors in the past—at times counterproductive to progress, perhaps, but a guarantee that patients had effective advocates.

It was Aldous Huxley who said that fear "casts out intelligence, casts out goodness, casts out all thought of truth … in the end fear casts out even a man's humanity."

How else, other than in terms of loss of humanity, can you begin to explain how we have come to accept, as the norm, mixed sex wards, with the delirious drunk adjacent to the elderly spinster in cardiac failure, her life ebbing away; boarding of patients in the middle of the night and possibly on several occasions during a hospital stay; and the inappropriate early discharge to relatives ill prepared to cope?

There would, however, seem to be some good news. The secretary of state for health has admitted that the reduction in hospital beds, at least in England, has been excessive. But what if, as is likely, there is a disparate perception held by doctors and managers of what is an adequate number of beds, and occupancy figures are nearer 100% than the ideal of 85%? It will be unfortunate not only for patients who will continue to endure all that is unsatisfactory with the present provision of health care, but also for medicine as a whole because of the intolerable burden of working at, or near to, full capacity throughout the year.

And what is the cost of this frenetic activity? Doctors will be increasingly forced to cut corners with the inevitable rise in cases of medical negligence. They will not have the time to attend the lunch time clinical meeting regularly, will give this year's specialist conference a miss, will fail to engage in research and audit, and their medical journals will remain unopened.

It is not that doctors are workshy, but they are frustrated that the system does not seem to recognise that time is necessary to reflect on your activities if a high standard of care is to be delivered. There is an increasing anger that they have become the whipping boys for the failure of an inadequately resourced service.

At such times doctors look to the medical royal colleges and the General Medical Council for guidance in trying to maintain a decent standard of clinical practice. However, these potential saviours are on the back foot, greatly exercised by how to counter the seemingly endless criticism of the medical profession. It is all very well to proclaim the merits of revalidation and of clinical governance, but most practising clinicians have little confidence that either of these projects, as yet unfunded and somewhat ill defined, will improve the lot of the patient, or indeed maintain confidence in the profession.

And these independent and potentially powerful bodies have been quiet, at least in public, over the issue of resources. Surely they, too, cannot have become as fearful as the individual doctor or manager of pointing out what has been glaringly obvious to anyone who has needed to be in hospital recently. There is within medicine an enormous talent and within management genuine commitment to the NHS. Think how much better the service could be if fear of failure and of sticking your head above the parapet were to be swept away and intelligence, goodness, truth, and humanity allowed to flourish.

Anthony Toft *consultant physician, Edinburgh*

SOUNDINGS

Be very afraid

"Beware the Jabberwock, my son,
The jaws that bite, the claws that catch …"

Danger can be obvious, something dark and wicked, easy to perceive and to shun. But, as any heartbroken lover will tell you, when it comes in the guise of something beautiful, something gentle and kind, it is hard to recognise and avoid, and then it is perilous indeed.

Two of my patients died last week. I'd looked after them for years, and they were good people and easy to be good to, but I can't pretend to have felt any great grief over their deaths. Over the years I've got pretty hardy, not one to blubber.

We are not made of rock, but of flesh and blood; we are not gods, just simple men and women doing our best. You can care deeply for your patients, like them, be their friend as well as their doctor, and that's as it should be, but there is a thin line to be crossed where we give too much of ourselves.

"Equanimity," according to William Osler, was what we should strive for, and most of us do manage to muddle through somehow.

No matter how exquisite the pain, we usually walk away after our shift and forget about it, watching a game of football, having dinner with our family, a few beers with friends. We go back to our own lives. Yea, tho we walk in the Valley of the Shadow of Death, once I'm out of the Valley it's not my problem anymore.

But we do have to care a little bit, and sometimes our profession can let us down very badly. A tribunal is under way in the Republic of Ireland at present to investigate the use of contaminated blood products which led to many people with haemophilia developing AIDS and hepatitis C, the cure devastatingly worse than the disease; don't trust me, I'm a doctor.

Whether this was a result of incompetence or laziness or bad luck or lack of resources is not yet clear. We have only heard the patients' side of the story, and no matter how stark the tragedy it is too simplistic to look for scapegoats; doctors are easy targets for blame.

But what has clearly emerged is a picture of an aloof, secretive, and unfeeling profession. Even after the mistake was made some of these patients were treated with an offhand discourtesy that seems barely credible.

Surely this picture can't be right; surely.

Liam Farrell *general practitioner, Crossmaglen, County Armagh*