# Diagnose and be damned

Doctors who have exposed child abuse are being hounded. Harvey Marcovitch, editor of *Archives of Disease in Childhood*, believes that the media are making matters worse

A few years ago, I found a neat roll of documents tucked behind a radiator outside my office. It contained letters, minutes of meetings, and suggestions on how to run a campaign to combat doctors' diagnoses of child abuse. Most were reasoned, but some were written in crude language and bristled with anger. The package had been planted where I would find it. I think it was meant to frighten me.

Last year, sitting in the editorial office of *Archives of Disease in Childhood*, I was handed some letters, headed with a private address, asking whether we had ever received for publication, but subsequently rejected, papers from the North Staffordshire Hospital on continuous negative pressure ventilation. My explanation that we did not keep records of rejected submissions beyond one year met with incredulity. The correspondent wrote again complaining that she knew I was covering up the existence of unethical experiments on newborn babies.

## The anti-doctor website

This week, I logged on to www.msbp.com and found a bulletin board for "Mothers against Munchausen syndrome by proxy." It was full of attacks on named paediatricians and child psychiatrists, and diatribes against two judges, a member of parliament, and various social workers. The accusations included perjury, conspiracy to defraud, attempted blackmail, and child abuse. More than one contributor claimed that judges and an MP in the Lord Chancellor's department had connived to prevent legal aid being granted to sue doctors who had diagnosed abuse. One message, to a neurologist, stated: "I promise I will make it my life's work to finish you for good."

Another message attacked David Southall, professor of paediatrics at the University of North Staffordshire: "Why I compared David Southall to Joseph Mengele: Joseph Mengele experimented on Jewish children in a concentration camp in Nazi Germany. Gloria's two children were named Joshua and Aaron. Need I say more? Penny."

These events are connected. They are some of the activities of a network of individuals whose aim seems to be to discredit, humiliate, and punish doctors, and others, who diagnose child abuse. Although primarily concerned with factitious illness, the website conflates this with allegations of unethical research on newborn infants, negligent paediatric intensive care, and, just lately, how some children with chronic fatigue syndrome are treated.

## Television fuels the fire

On 20 October, *Channel 4 News* joined in. It invited into its studio the prime target of this group, David Southall. Southall states that *Channel 4 News* producer, Jessica Salmon, invited him to discuss with newscaster Jon Snow the many attempts that have been made to frustrate his work in child protection and charitable aid for victims of war. Aware of the triple pronged attack on his work (the third involves research into the effects of high altitude on infant respiratory physiology), he told Salmon he was willing to take part but could not discuss his department's work on continuous negative pressure ventilation (CNEP) as it was subject to an NHS inquiry. As he watched the film preceding his live interview, Southall was horrified to find he had been ambushed, as much of it was about CNEP and contained a specific allegation of negligence from a parent of a child treated in his hospital's intensive care unit. Like all doctors in this position, he could not defend himself without breaking patient confidentiality.

The child in question had been transferred to Southall's unit after a stay in an intensive care unit elsewhere, a fact ignored by Channel 4. Staff at the referring hospital have stated that there is plenty of evidence to refute the allegation made in the programme, but, again, confidentiality forbids them saying more. Jim Gray, editor of *Channel 4 News*, justified the programme on the grounds that parents "are clearly in an excellent position to know about their own child, and everything we said in the report accords with what [they] told us. Whether or not Professor Southall has consent to comment on her case is clearly not a matter for us." Does this comment mean that *Channel 4 News* accepts what it is told without properly checking if it is true? And is it happy to set up a target for a live interview, caring little that he is unable to defend himself because of the paradox that he does not have his accuser's permission to do so?

On 8 November BBC's *Panorama* performed a hatchet job on Dr Michael Prendergast, previously a child psychiatrist at Great Ormond Street Hospital. Prendergast uses active rehabilitation as a treatment for chronic fatigue syndrome. It also criticised Dr Alan Stanton, a community paediatrician who had intervened in a case where parents' views and those of the local medical team were in conflict. This child's case had already led to www.msbp.com targeting Stanton for his stance in this case, and he has had to deal with complaints to his hospital trust and the GMC.

Much of the media, it would seem, has little interest in distinguishing news from propaganda. Which sections of newspapers and television programmes are the more reliable, news or advertising?

## A lesson from the *Washington Post*

In the 1970s I was a resident in a Massachusetts children's hospital. Week after week the local newspaper published brief news stories about odd and seemingly trivial events involving politicians connected with the Nixon administration. The stories added up to no more than what Bostonians call a hill of beans. But just as I returned to Britain the whole Watergate scandal finally broke, ending Nixon's presidency. Years later, I watched the film *All the President's Men* and understood what I had been unable to comprehend. The film detailed the policy of the *Washington Post*—that news was something that had to be corroborated. As long as there was only innuendo and gossip, the correct approach was to keep the story ticking over in a low key way on the inside pages, perhaps to flush out witnesses. Only when the same facts came from two unconnected sources, with no discernible conflict of interest, could the editor blow the whistle.

There's a lesson for *Channel 4 News* in the importance of independent corroboration, preferably by someone with no axe to grind. As one journalist said to me, if you make that extra telephone call you might just hear something that ruins your story.

## Southall's work disrupted

In a largely ignored press release—except, to its credit, by the *Guardian*—Southall detailed his 13 years of work in child protection. In it he claimed that, since 1992, Brian Morgan, a freelance journalist, and a group of parents accused of child abuse, have conducted a campaign against him. He says this has interfered with his work to protect children at risk, damaged his research, frustrated the work of his charity Child Advocacy International (which has provided financial and medical help to Bosnia and elsewhere), and led to wasteful hospital trust and NHS inquiries. One individual, Sharon Payne (also known as Wraxall), has been convicted of perjury after infiltrating the charity in the guise of a volunteer and removing confidential medical documents from its office. Another individual has been charged with conspiracy to abduct a child. The National Union of Journalists paid costs of £25 000 when it funded Morgan in his failed attempt to have Payne's purloined documents made public. Morgan states there is no formal organisation, merely a "loose network of contacts" and "a grapevine."

Southall says that he has received threats of violence, and that his charity's equipment has been destroyed. There is, however, no evidence to link this darker side of campaigning to Morgan or the public faces of the movement.

Surely *Channel 4 News*, the *Sunday Times*, the *Independent*, and others have been barking up the wrong tree. The real story is what drives Morgan and others like him, how the "loose network" is funded, the backgrounds of its supporters, and whether its campaign has destroyed some children's protection.

## Doctors may fear diagnosing child abuse

Unsurprisingly, Sir Roy Meadow, a pioneer in the description of Munchausen syndrome by proxy, has been the group's target for many years. He has been more fortunate than Southall in that when one of the "loose network" applied for a job in his unit the person was unmasked in time. However, like Southall and others, he has to put up with poison pen letters and telephoned and written threats to himself and his family. Meadow's concern is that the campaign could encourage doctors, particularly the young and relatively inexperienced, to turn a blind eye to possible cases of child abuse when it can cause them much trouble.

Peter Milla is a paediatric gastroenterologist. I was surprised to see him demonised on the website hit list, but he told me that in his specialty a few children are referred with factitious symptoms, and the consequent involvement of a child psychiatric team can lead to being targeted. He believes a prime reason for the present spate of accusations against doctors is the failure of some social service departments to understand and get to grips at an early stage with problems presented by families in trouble.


One respected medical journalist who has written about the tribulations in the University of North Staffordshire is Jeremy Laurence of the *Independent*. He has known about the various allegations against Southall's group for a long time and had dismissed most as rumour mongering. However, he considered that the suggestion that consent might not have been obtained for entering newborn babies into a trial was something he could not responsibly ignore, especially as ministers had ordered an inquiry. Southall is unimpressed, pointing out that the inquiry was provoked by reaction to an article in the *Independent*'s sister Sunday paper cowritten by Morgan, and that Laurence's article "effectively accused me of killing 28 babies and causing brain damage to a further 15." Laurence says: "Writing for a newspaper is a high wire act where you have to balance fairness with the need to sell the paper."

## Fighting back

Can we persuade journalists that it is a matter of serious public concern when 11 consultant paediatricians and child psychiatrists have had to respond to letters of complaint to their employers and the GMC couched in virtually identical language? I have spoken to most of them, and most were prepared to respond only if I did not name them, because the publicity is interfering with their everyday work and because of the threats to their families. Presumably the GMC knows who they are. Sir Donald Irvine is rightly concerned about not ignoring whistleblowers and insisting on thorough airing of patents' complaints. But when complaints follow a pattern that suggests a campaign the GMC should consider changing tack towards protecting those on its register.

Jane Wynne, a Leeds paediatrician who is a leading expert in child abuse, became so frustrated with the GMC's handling of cases that she wrote suggesting she help its members understand what it was all about. Perhaps Sir Donald should take up her offer. Incidentally, Wynne isn't targeted on the website. Could it be because the *Mail on Sunday* had to settle for a substantial sum a few years ago when she pursued a libel suit against it?

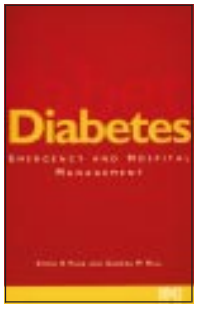
Many of the doctors I have spoken to have been defamed publicly, certainly on the website and possibly in the press and on television. None is wealthy enough to launch a personal libel action. Medical defence societies have traditionally avoided entangling themselves with actions for defamation, citing the excessive cost and the undoubted fact that most libels are quickly forgotten, except by the victim. This campaign is different from the spontaneous angry or distressed comments of a parent whose child has suffered. It should be dealt with differently. Most defence society members would be happy to see their subscriptions used to nip this activity in the bud by some well placed libel suits.

Trust managers may not realise the complaining letter they receive is based on a pro forma. They should adopt a more vigorous policy of rebutting unjustified demands and involving the police if they believe their employees are being harassed. It's about time the profession hit back at those who are vilifying our colleagues in Stoke, Great Ormond Street, Oxford, York, Sheffield, Cardiff, Glasgow, and now, presumably, Banbury as well.

**Harvey Marcovitch** *consultant paediatrician, Horton Hospital, Banbury*

# Diabetes: Emergency and Hospital Management

Simon R Page, George M Hall

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Rating: ★★★

What a pleasure to read a two authored work that doesn't equivocate and expresses a consistent viewpoint (as opposed to standard multiauthored texts or dry consensus statements). Better yet, it is light and well written and admirably addresses important aspects of emergencies in diabetes care and hospital management.

Several unique and attractive features of this publication warrant comment. It's obvious that the authors have extensive hands-on experience with many of the problems dealt with. Accordingly, their clinical vignettes are associated with practical management gems at every turn. Their coverage of surgery and the approach to planning for investigations in diabetic patients are exceptionally well thought out and presented.

Readers in North America may find aspects of care that do not conform with current practices there. For example, for almost every US patient with diabetic ketoacidosis (and with the hyperosmolar-hyperglycaemic state), arterial blood gas would be measured at the start of treatment, and probably serially during treatment, with little attention paid to the serum ketones. Diabetic women who are pregnant, especially in urban areas, will almost all be seen and followed up by a specialist or team of specialists.

In my area of interest—hyperglycaemic emergencies—I disagree with several of the authors' statements. For example, they advocate using urea to calculate osmolality and then relating the result to the level of consciousness in a hyperglycaemic patient, but this does not address the more physiological use of the effective osmolality (the osmolality excluding the diffusible urea fraction) or tonicity, which best correlates with level of consciousness. The authors advocate the use of normal saline in treating diabetic ketoacidosis and the hyperosmolar state despite the frequent development of hyperchloraemia in diabetic ketoacidosis and persistence or worsening of hyperosmolarity (especially the hypernatraemic variety) in the hyperosmolar-hyperglycaemic state. I also dispute their figure of 50% mortality associated with the hyperosmolar-hyperglycaemic state in current practice; we long ago achieved a mortality of 10-15%. Furthermore, although it has crept into many texts and protocols, I am unaware of any controlled studies to support the authors' recommendation of low dose heparin in diabetic ketoacidosis and full heparinisation in the hyperosmolar-hyperglycaemic state.

A few omissions also merit comment. There is no mention of commercially available pre-mixed insulin (such as 70/30); no discussion of "contact casting" in the management of neuropathic foot ulcers; no comment on the explosive increase in type 2 diabetes among teenagers in the Western world (typically associated with obesity); and no warning that during labour and delivery before separation of the placenta, insulin requirements may fall to zero because of the extraordinary muscular activity associated with labour. In addition, an important error occurs in Table 3.1, where electrolyte losses in diabetic ketoacidosis are incorrectly recorded as per litre. This will confuse readers.

This being said, the authors' approach remains coherent and, if followed, will improve current practice in many centres. Not only will this readable, practical text provide the hoped for "guide for . . . the non-specialist," but it will also be slipped into the pockets of endocrinologists, diabetologists, and internists to be plumbed for pearls of wisdom and practical suggestions.

**Robert Matz** *professor of medicine, Mount Sinai School of Medicine, New York*

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

## WEBSITE OF THE WEEK

**The ageing population** In the future there will be more old people than there are now. How do we know? Because the Government Statistical Service tells us so (*www.statistics.gov.uk/misc/sitemap.htm*). Government statistical reports were notoriously dusty paper publications, but being able to download the actual data in electronic form from a website does make them more interesting. So if the information in this week's *BMJ* on the future demographics of ageing is insufficient—perhaps because it does not discuss a particular condition in which you are interested—you can download the relevant data to make your own calculations. The fact that searching the site seems somewhat clunky probably reflects the vast quantities of data, but when you find what you want you can download actual numbers as a "comma separated values" (CSV) file and import them into your spreadsheet or database application.

The demographic age shift has been creeping up on us for so long that media fatigue seems to have set in: even the webmasters of the Debate of the Age site (*www.age2000.org.uk/*)—the organisation that has prompted the current round of discussion—has less than compelling content that seems to be little to do with an ageing society.

There is general consensus about the rise in morbidity that is likely as a result of this shift. The social consequences of the demographic shift are perhaps more interesting still. A general search on ageing displays the usual gaudy mix of sites promoting cryopreservation, Viagra, and special interest groups advertising their 24th congress. Pass these by to an interestingly comprehensive review of social gerontology by a Texas academic at www.trinity.edu/~/geron.html—a remarkable coalescence of knowledge on all aspects of ageing.

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PERSONAL VIEW

# Should age based rationing of health care be illegal?

Age based rationing of health care is part of daily life in the NHS. As Graham Sutton writes, "Ageism seems to be embedded in the NHS culture" (*BMJ* 1997;315:1032-3). I have argued elsewhere that the concept is morally indefensible (*BMJ* 1995;310:1179-82). My suggestion is that it should now be made illegal. It might be thought impractical to involve the law. However, the 1976 Race Relations Act and the 1975 Disability Discrimination Act have made discrimination illegal in other areas, and it should be possible to take a similar statutory approach to protect the healthcare requirements of elderly people.

Under the terms of the 1976 Race Relations Act, "A person discriminates directly against another in any circumstances relevant for the provision of the Race Relations Act 1976 if on racial grounds he treats that other less favourably than he treats or would treat any other persons." Could "on grounds of age" be substituted for "racial grounds?" I believe it could. Surely no one would dispute that in age based rationing the elderly patient is being treated "less favourably" than "other persons." The Race Relations Act has afforded protection to those who might previously have been the subject of racial discrimination. Is it not reasonable to assume that if age based rationing were made illegal elderly patients who might previously have been unfairly discriminated against in terms of healthcare allocation would be protected from such discrimination?

In 1988 the Court of Appeal stated, "The suitability of candidates [for employment] can rarely be measured objectively; and subjective judgements will be made. If there is a high percentage rate of failure to achieve promotion at particular levels by members of a particular racial group, this may indicate that the real reason for refusal is a conscious or unconscious racial attitude which involves stereotyped assumptions about that group." "Age groups" could easily be substituted for "racial groups" here. The great worry is that elderly people may be refused treatment because they are subject to unfounded "conscious or unconscious … stereotyped assumptions" in the same way as racial minorities sometimes are.

Of course, there will be grey areas. There may well be some cases where deciding what is age based rationing of health care and what constitutes good medical practice is difficult to decide. For instance, some clinical decisions which might seem to be based on a need for rationing are actually based on other criteria. Often a treatment will be withheld because it has a low chance of success, or because distressing side effects outweigh any possible advantages. A doctor, for example, might choose not to use cardiopulmonary resuscitation in a severely ill elderly patient and may have no thought at all of another patient's need for a bed. But to refer once again to the 1976 Race Relations Act, no doubt there are grey areas here as well. But this has not stopped the act being useful in curtailing racial discrimination in employment.

The legislation I propose would not result in elderly patients being given treatment that was of no benefit, or in the treatment of them against their will. The role of the legislation would be to ensure that genuine cases of age based rationing were prevented. In the same way that an employer has to think carefully before refusing employment to a member of a racial minority, or to someone with a disability, doctors would have to think a lot harder than they do now before refusing treatment for an elderly patient.

> The legislation … would not result in elderly patients being given treatment that was of no benefit

In drafting legislation I accept that there would be a problem in deciding who is old. However, as age based rationing of health care happens to younger patients as well as those who are old—I was told of a health authority which refused to treat a 37 year old with anorexia because it preferred to use its limited resources to treat younger patients—the law would ban age based rationing at any age. In any case, the fact that it may be difficult to define "disability" has not prevented the implementation of the Disability Discrimination Act.

There is no doubt that age based rationing is being practised. By using the law to prohibit it, we can indeed go a long way to ensure that the concept does not become accepted medical practice, or even an option to be considered when choosing who to treat. Although involvement by the courts may not be welcomed by doctors, it is possible for the law to be used effectively to prevent age based discrimination in health care.

This paper is adapted from my PhD thesis, *Is age-based rationing of health care morally defensible?*, submitted in August 1999.

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SOUNDINGS

## *Quackery, flummery, and fleas*

"I've been to my cranial osteopath and she assures me that she can cure my asthma. But then, you won't believe any of that, anyway."

I make no comment, as always. It is assumed that I, a member of a conservative profession, will hold a bigoted opinion about any form of alternative treatment.

But I do not respond. I fear the branding of intolerance. As though I, like some religious zealot, hold an intransigent belief that I proclaim through a megaphone, inciting fear and loathing with a rising cadence.

And yet, when my patient leaves, I find myself wondering at the widespread distrust of conventional medicine.

I suspect that the answer lies in the wider question of the distrust of science. We seem to be living in the backlash of the technological age. People were led to believe that science, through technology, was the route to untold riches. But what they fail to realise is that the aim of science is not to open the door on everlasting wisdom or wealth: it is to set a limit on everlasting error.

And yet these strains of antirational and quasireligious movements are unquestionably a rising tide of our times. We are witness to an alienation of people from a scientific movement that seems to them to be nihilistic. They are confronted with a scientific world view, by polemists such as Richard Dawkins and Lewis Wolpert, which presents mankind as merely a rather tragic epiphenomenon of Darwinian theory. And so we see the public desert in droves to the ranks of crystal gazers and astrologers. And yet surely this nihilism itself can be seen as the result of an extrapolation of a theory beyond the realms of its legitimate domain.

I am reminded of the professor of logic who wished to establish a link between cause and effect. He placed a flea on the table in front of the auditorium.

"Jump!" he commanded. And it jumped.

Next he produced a scalpel and chopped off the flea's back legs.

"Now, jump!" he commanded. The flea remained stationary.

He rounded triumphantly on the audience.

"My dear friends," he announced, "we have conclusively proved that when a flea's back legs are amputated the creature is rendered completely deaf."

**Kevin Barraclough** *general practitioner, Painswick, Gloucestershire*