



**How to navigate
your way to
paradise after
death in ancient
Egypt, p 1106**

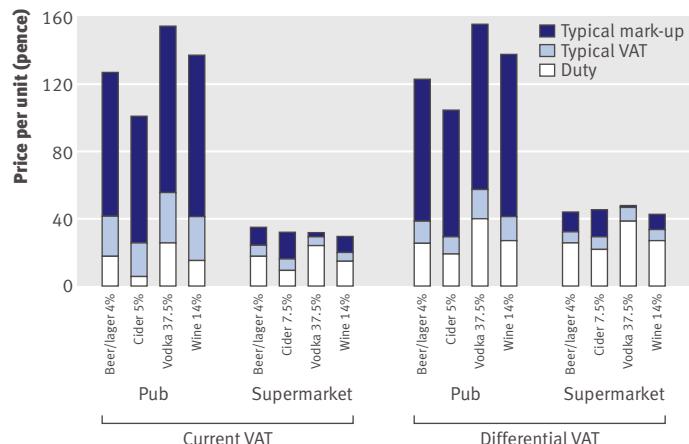
IEWS & REVIEWS

Vary VAT on alcohol to achieve minimum pricing

PERSONAL VIEW **Nick Sheron**

The House of Commons Health Select Committee report early this year placed the overall cost of alcohol to the UK in the region of £20bn-£55bn (€24bn-€65bn, \$32bn-\$88bn), with perhaps 30 000 to 40 000 deaths and 863 300 admissions to hospital each year (<http://bit.ly/bpoekd>). The report recommended that the government set a minimum price for alcohol of about 40-50 pence a unit, following a lead set by the independent Scottish Health Action on Alcohol Problems (SHAAP). SHAAP developed the policy in response to spiralling death rates as a clever workaround to the fact that the Scottish government did not have powers to increase duty on alcohol. The Scottish government then put forward legislation to introduce a minimum price per unit, but this proposal received a setback when the Scottish Parliamentary Health Committee split along party political lines to reject it.

In June of this year the National Institute for Health and Clinical Excellence published its long awaited guidance on the prevention of alcohol use disorders and again recommended the introduction of a minimum price per unit (<http://guidance.nice.org.uk/PH24>). It used evidence from a modelling study commissioned by the Department of Health that showed that a minimum price of 30 pence per unit would prevent 300 deaths a year, 40 pence about 1000, and 50 pence more than 2000 (<http://bit.ly/9SK8x7>). Tackling the cheapest alcohol is an effective public health policy because people who drink very large amounts of alcohol tend to drink the cheapest possible. For someone consuming 15 units



a week, the difference between 30 and 40 pence a unit is £1.50, whereas my patients with alcohol related cirrhosis consume a mean of 100 units, and in some cases up to 400 units a week—a difference of £10 and £40. This would have a substantial impact.

So minimum pricing works, but the UK government is not keen on the concept. It is sometimes difficult to decipher the reasons why governments don't like certain policies, but civil servants have suggested that it may be related to a misunderstanding by the media and public that a minimum price would be a new tax on alcohol. In fact the increased revenue goes not to the Treasury but to the big supermarkets; not surprisingly Tesco is in favour of a minimum price. From the Treasury's point of view it would get the blame but no financial gain. A view highlighted in a recent report by the think tank the Institute for Fiscal Studies, which accepted that the policy effectively targeted households that consume the most alcohol, but it also made the point that a minimum price of 45 pence could redistribute £700m from consumers to the drinks and

retail industries (www.ifs.org.uk/publications/5286).

The UK coalition government's proposals on alcohol include a ban on the selling of alcohol "below cost," but it is not clear what "below cost" would mean in terms of price per unit. The drinks industry suggests that it means no selling below the cost of duty plus value added tax (VAT), which would give a minimum price for industrial white cider of 5.4 pence a unit. This beverage can be made from fermented corn syrup and the residue left over from pressing apple juice; the current mark-up is about 15-30 pence a unit and presumably includes a profit. No form of "below cost" ban can deliver a price of 40 pence a unit without swingeing increases in duty on alcohol.

The government in Westminster, unlike in Scotland, has the power to increase duty on alcohol and could deliver a price above the public health threshold. But this would increase the price of a pint in struggling country pubs. The ingenuous benefit of minimum pricing is that it would not affect prices in pubs; the average unit of

alcohol in a pub already costs more than £1 and much more in many cases. Pubs are expensive to run and have to charge more for alcohol. As a result they pay more VAT, which puts the price of drinks up even further, but this also suggests a novel solution. There is a policy that would increase the minimum price of alcohol above the public health threshold; deliver all the increased revenue to the Treasury, where it can be used to help towards the £20bn-55bn annual cost of alcohol to UK plc; and would not increase prices in pubs.

VAT is already levied differentially on food and drink; more VAT is charged to drink coffee on the premises than to take it away. If this policy was applied to alcohol but was reversed—say, for example, reducing the VAT for on-sales from 20% to 12%—it would be possible to increase the rate of duty to compensate for this without increasing the price of alcohol in pubs. The figure shows the effect of such a change on typical pub and supermarket prices. When this proposal was suggested to the Treasury at a recent meeting they were not immediately keen on the concept of changing VAT but produced no concrete reason why it could not work.

Competing interests: See bmj.com.

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► News: Minimum price for alcohol in Scotland (*BMJ* 2010;341:c5267)

► Lobby Watch: The Portman Group (*BMJ* 2010;340:b5659)

► Analysis: Failure of self regulation of UK alcohol advertising (*BMJ* 2010;340:b5650)

REVIEW OF THE WEEK

Die like an Egyptian

The ancient Egyptians believed that beautifully illustrated spells would guide them to paradise after death. The British Museum provides a unique opportunity to see these fragile papyruses, some more than 3500 years old, explains **Wendy Moore**

Journey through the Afterlife: Ancient Egyptian Book of the Dead

An exhibition at the British Museum, London, till 6 March 2011; tickets £12
www.britishmuseum.org

Rating: **★★★**

Spell 87, papyrus of Ani, circa 1275 BC



TRUSTEES OF THE BRITISH MUSEUM

As if the ancient Egyptians did not have enough to contend with in daily life—marauding crocodiles, venomous snakes, and locust plagues—they were convinced that after death they had to negotiate a perilous journey to reach paradise.

Surviving this gruelling voyage through an underworld populated by vengeful gods and terrifying demons required all the ingenuity a wandering spirit could muster. And so the resourceful builders of the pyramids armed their deceased with a handy pocket-sized scroll that contained all the spells and guidance that might conceivably be needed to attain eternal life.

Combining map, passport, and travel guide—a kind of *Rough Guide to Hell*—these papyruses became known collectively as “the book of the dead.” Skilfully inked in black and red hieroglyphics, lavishly illustrated in vivid colours, and lovingly personalised to suit each individual’s likely passage, these exquisite artefacts provide a key to understanding the rich belief system of ancient Egypt.

Because of their extreme fragility and sensitivity to light, the papyruses are rarely viewed except in small portions by dedicated Egyptologists. The current exhibition at the British Museum therefore provides a unique opportunity to see these remarkable manuscripts together and in full for the first time.

The exhibition showcases treasures from the museum’s own collection of book of the dead papyruses, which is the most comprehensive in the world, alongside others from around the world. They include the vibrantly colourful papyruses of Ani and Hunefer as well as the 37 m long Greenfield papyrus, which is displayed in its entirety for the first time. Winding a dimly lit, labyrinthine trail through the museum’s Reading Room, the exhibition both reveals and replicates the mysterious journey that the ancient Egyptians envisaged from last breath to paradise.

For the wealthiest families these papyruses, dating from about 1600 BC, were long, ornate, customised scrolls commissioned from scribes working outside the temples. If the later Christians would suggest that it was easier for a camel to pass through the eye of a needle than for a rich man to enter heaven, then the ancient Egyptians thought that a judiciously prepared book of the dead could give them a helpful shove. The less well off could buy shorter, off the shelf versions, with blanks where they could insert the name of a deceased relative. And the poorest had to rely on an amulet or two to wrangle their passage to the other side.

But whether they were rich, poor, or middling, the basic idea of a magical combination of images and text to steer spirits through the treacherous underworld remained the same. In death, as in life, the Egyptians believed that a mixture of magic and practical skills could protect against perils and ills. Embalming the corpse to deter decay was a

vital first step, as it was held essential that the body remain intact while the spirit roamed. But, just to be on the safe side, a spell was dedicated to the god Anubis to protect the bodily remains from harm.

**Put one foot wrong
 and the hapless
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 with the digestive
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 eating excrement
 and drinking urine**

With the body secure, the spirit could embark on its hazardous journey. Although no agreed map of the underworld existed, the general consensus was that its terrain featured a series of gateways, caverns, and mounds that harboured demonic terrors in human and beast-like form, infinitely more terrifying than anything Harry

Potter might encounter. Only by possessing divine knowledge could a spirit charm its way to safety. So spell 32 could repel crocodiles, spell 33 protected against snakes, and spell 148 listed the requisite names of the divine bull and his seven cows.

Put one foot wrong and the hapless spirit might find itself upside down; with the digestive system reversed it could spend eternity eating excrement and drinking urine. Luckily spells 52 and 53 protected against such mishaps. And, once the spirit was past the trials and pitfalls, the ultimate test lay ahead: the hall of judgment, where the heart was weighed against a symbolic feather.

Well aware of the central function of the heart in mortal life—several millennia ahead of the Western world—the ancient Egyptians believed the organ to be crucial to immortality. With its fate literally hanging in the balance the spirit had to make a “protestation of innocence” to the 42 gods standing in judgment. The handy papyrus provided the names and proffered a sturdy defence. If the scales tipped the wrong way the heart was consumed by the Devourer, a nightmarish beast with the head of a crocodile, front legs of a lion, and rear of a hippopotamus. The Greenfield papyrus, belonging to Nositanebisheru, the daughter of a high priest, shows Anubis coolly weighing the heart while the Devourer greedily eyes its prize.

Success at the scales opened the door to paradise. And because the ancient Egyptians believed that writing or depicting an event guaranteed that it happened, all the papyruses culminate in joyful scenes of rebirth in an idyllic version of Egypt. The ancient Egyptians maintained a childlike faith in the power of the written word. And their beautiful papyruses, depicting superstitions and beliefs both wildly alien and astonishingly familiar in symbols and pictures so vivid they seem freshly inked, retain a power that speaks to us still.

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BETWEEN THE LINES **Theodore Dalrymple**

Who are the sane?

Doctors are said to make very bad patients. Two stories are known to me in which psychiatrists become inmates of their own asylum. The first, *Ward 6*, by Chekhov, is very well known. The second, by the greatest Brazilian writer, Machado de Assis (1839-1908), was written a few years before *Ward 6* and is less well known in the English speaking world. It is the novella *O Alienista*, *The Alienist* or (as it is usually translated) *The Psychiatrist*.

A doctor, Simon Bacamarte, returns to Brazil after his studies in Coimbra and Padua and settles in the small town of Itaguai. With a deep passion for science and a complete faith in its powers of redemption, he wants to penetrate the secrets of madness and persuades the municipal council to open an asylum under his direction, called the Green House, so that he can unravel those secrets.

What follows reads like a prescient satire on the *Diagnostic and Statistical Manual* of the American Psychiatric Association. The first thing for Dr Bacamarte to do is to classify the mad, in the style of the DSM: "first two great classes, then sub-classes, then sub-sub-classes into which cases, ever more aberrant, were increasingly more difficult to place."

Unsurprisingly, more and more of the people of Itaguai are admitted by force into the Green House until four fifths of the entire population of the town are lodged there, including Dr Bacamarte's own wife, who he realises is mad when she cannot decide whether to wear her sapphire or her garnet necklace to a forthcoming ball and gets up in the middle of the night to try them on in front of the mirror.

The increasing number of people admitted to the Green House eventually causes a revolt, in the course of which 11 people are killed. This gives Dr Bacamarte pause: perhaps his theory has been wrong all along. Perhaps it is the sane, those with perfect mental equilibrium,

Perhaps it is the sane, those with perfect mental equilibrium, the small minority, who should be admitted ... to the asylum



Machado de Assis: a tale in madness

the small minority, who should be admitted to the asylum. Dr Bacamarte gets the municipal council to grant him powers to admit all the well balanced people (excluding members of the council, of course) to the asylum.

There he classifies them as he once classified the mad: the modest, the loyal, the wise, the patient, and so on. He devises a scientific method of disequilibrating them—for example, he gives the modest a tail coat, a wig, or a cane, and they at once become full of themselves. Those refractory to the treatment are given diamonds to wear or an official decoration.

Before long, everyone is "cured" of being normal, and Dr Bacamarte discharges them from the asylum. But he is still an enthusiast to know more, and in the end he admits himself to the asylum, where he dies 17 months later. The rumour then spreads that there had never been a madman in Itaguai other than Dr Bacamarte himself. "Be that as it may," the story ends, "his funeral was conducted with great pomp and rare solemnity."

Surely anyone who has worked (at least as a doctor) in the NHS in the past few years cannot but have wondered who are the mad and who the sane?

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

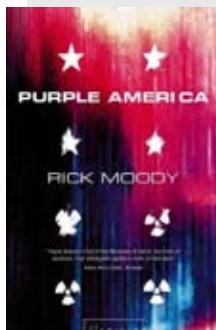
Purple America by Rick Moody

First published 1997

The relationship between an elderly woman in the final stages of progressive multiple sclerosis and her alcoholic son is probably not the most immediately appealing subject for a film, which may be why this, Rick Moody's third novel, has yet to be adapted for the cinema. The two screen adaptations of his work (*The Ice Storm* and *Garden State*) are certainly more widely appreciated than the books from which they were derived.

Hex Raitliffe, the central figure of *Purple America*, is a stammering, physically awkward alcoholic who returns to his family home. His mother, Billie, has multiple sclerosis and has developed the physical and cognitive impairments associated with the progressive phase of the disease. She has been deserted by her second husband, and Hex is unexpectedly and suddenly expected to assume the role of her main carer. His mixture of disgust and curiosity with the physical reality of washing and dressing an incapacitated adult who happens to be a close family member is vividly illustrated. The paraphernalia of chronic disease and disability become integral to the functioning of the household, such that the "Dear John" letter left by Billie's departing husband is composed on her machine that converts text to speech.

Events unfold over 24 hours and are described from the point of view of four principal characters. Billie's first person narrative manages to compellingly convey a stream of consciousness framed by impairments in concentration and memory. Her disjointed thought processes have a naturalistic and unforced feel, giving a real sense of the experience of cognitive disturbance.



It is easy to sympathise with the neurologist involved in Billie's care: given the lack of therapeutic options in ameliorating her disease, he flits in and out of the story rather ineffectually, unable or unwilling to intervene in improving her quality of life rather than struggling to treat her disease. The difficulties experienced by Hex in taking his mother out for a meal or bathing her are obvious and yet could be overcome in the real world with some lateral thinking and the provision of appropriate support.

Whether tackling these problems would make any difference to Billie's quality of life and hence her wish to end it is debatable, given her diminishing awareness of the world around her. As professionals we would probably talk about her "capacity." There is no melodrama or agonised introspection in the final passages but a calm acceptance that generates an almost incongruous optimism, given what has gone before. Family, disease, death, memory, decay, and hope are some of the broad themes deeply mined. I'm not aware of another novel that so poignantly captures the pervasive nature of one person's chronic disease in modern society. This complex and rewarding little book deserves wider exposure.

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We welcome submissions for Medical Classics. These should be no more than 450 words long and should focus on a book, film, play, artwork, or piece of music that sheds light on the practice of medicine or the role of doctors in society. The work under review should be at least 10 years old.

Please email ideas to Richard Hurley (rjhurley@bmj.com).

Bad medicine: paediatric ENT surgery

FROM THE
FRONTLINE
Des Spence



When I was 6 years old I once woke with pus and blood on my pillow. Concerned, my mother took me to our doctor, who sent me to the local hospital. There they physically pinned me down and suctioned out my discharging ear. I can still feel the pain of that event and now reflect: why did they do this procedure? Current common paediatric ear, nose, and throat operations include grommets, tonsillectomy, and adenoidectomy. But why operate?

Grommets are used in otitis media with effusion, more commonly called glue ear. Caused by mucus in the middle ear after a viral infection, this produces a conductive hearing loss. The rationale for surgical intervention is that the hearing loss affects learning and speech. This theory has resulted in many and repeated operations in small children in the past few decades. Anecdotal evidence is that this is an operation (like tonsillectomy) of private practice, in middle class children of families whose standard mantra is "something has to be done." But the clinical diagnosis is wholly subjective, with wide variation among surgeons, and is often driven by parental expectation, not science.

The hearing loss of glue ear is transient, resolving despite intervention. Secondly, grommets are ineffective, with no evidence of improved educational outcomes (www2.cochrane.org/reviews/en/ab001801.html). Lastly, and worse still, grommets cause considerable and lasting harm—from scarring of the drum and recurrent infections

to cholesteatomas and potential long term hearing loss. For those intent on intervention, the temporary use of hearing aids is an alternative to surgery.

Tonsillectomy is still common for recurrent tonsillitis. But what is tonsillitis? Clinical diagnosis is highly unreliable; indeed it is estimated that only about 5% of patients with sore throats ever seek medical attention, and seeing a doctor is dependent on cultural, social, and aberrant health seeking behaviour rather than the severity of disease.

The traditional operative criterion for tonsillectomy—seven episodes of tonsillitis in one year—is completely arbitrary and is fundamentally flawed by self reporting and health seeking behaviour. It is not just the diagnostic uncertainty surrounding tonsillitis: tonsillectomy doesn't prevent complications of streptococcal disease, quinsy, or even recurrent sore throat (www.sign.ac.uk/pdf/sign117.pdf). Finally, tonsillectomy has the potential to do real physical harm, and surely tonsils must have some evolutionary purpose.

Paediatric ear, nose, and throat surgery is an example of the power of a medical belief system over common sense and evidence of harm. General practitioners should stop referring patients, and surgeons should stop doing the operations, for this is bad medicine.

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Torture: the bright side

THE BEST MEDICINE
Liam Farrell



"She preferred the timid touchings of the eunuch to the ponderous bollocks of the Roman Emperor," said Gibbon's *Decline and Fall of the Roman Empire*, a metaphor for the empire's descent from barbarian virility to effete decadence. And we are learning nothing from history, because MI6 recently admitted that it regards torture as illegal and abhorrent, and I've been left yearning for those golden days of redneck vigour and bigotry, when *Ad extirpanda*, a papal bull promulgated in 1252, authorised the use of torture by the Inquisition, and when George Bush approved waterboarding.

But despite Pope Innocent and Dubya being cool with it, torture gets a bad rap from the liberal media. The term itself is pejorative, and I prefer "inhuman and degrading treatment," as suggested by the European Court of Human Rights.

One method, used in Guantanamo Bay, involved putting prisoners in a box with an insect—after first reassuring them that the insect had neither a venomous sting nor bite. I'll bet the terrorists were shaking in their shoes: "Please don't throw me in that briar patch, Br'er Fox," they'd be singing. Could there be a more instructive symbol of the feebleness of the West? If it was up to Barack Hussein Obama, when the terrorists attack we'll all be sitting around in a circle, holding hands, and singing *Kum bay ya*. The Yanks could learn from the British army; those chaps know a thing or two about extracting enthusiastic confessions.

Joe told me how, during the Troubles, when they were interning people for being called Paddy or Seamus, the army blindfolded him, took him up in a helicopter, then pitched him out. Only when he landed did he realise that the

helicopter had lifted just a few feet off the ground. He sprained his left pinky and was lame for hours, another "martyr for old Ireland."

"That was real torture," he said, misty eyed. "We might have been enemies but, dammit, we respected each other, more substance in our enmity than in our love." Taking a degree was quite de rigueur among the internees. Joe had read English lit and never flinched from displaying his scholarship. "You'd have told them anything, just to see their smile; great people, the British."

"But those were hard times," he added. "The memories haunt me at night, the world more full of weeping than you can understand."

"You're still not getting any sleeping tablets," I said. Liam Farrell is a general practitioner, Crossmaglen, County Armagh
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