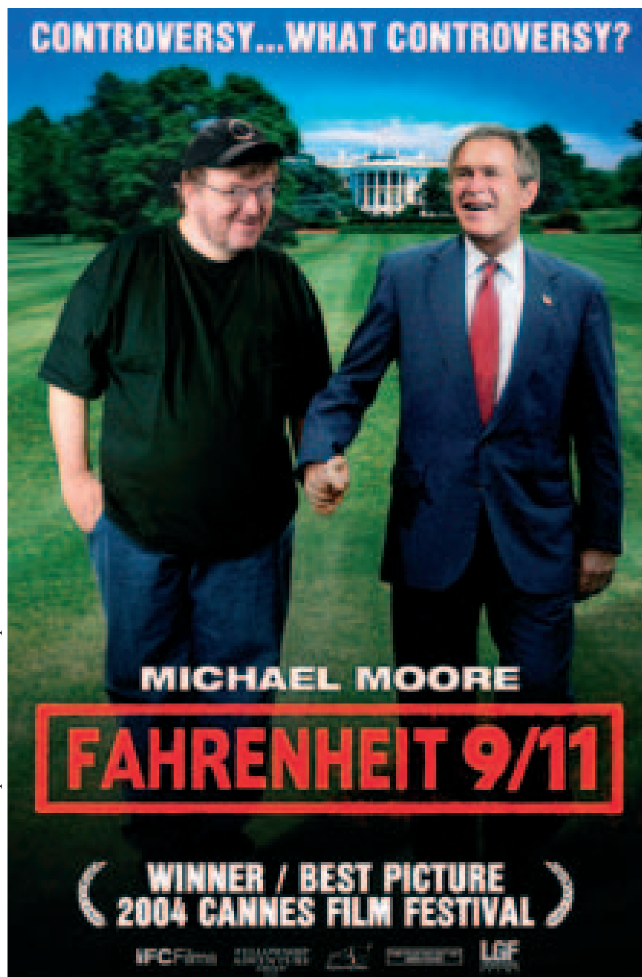
Fahrenheit 9/11
directed by **Michael Moore**
Lions Gate Films, 2004

THE political messages in Michael Moore's film are framed like the game where one connects dots and pictures emerge. The pictures are ones that have, in part, been supported by the reports from the 9/11 Commission about ineptitude, at best, and incompetence all round in foreseeing and then dealing with the events prior to the World Trade Center destruction. The dots also connect the deceit, double speak, and disinformation that preceded and have continued right along in the US/British war in Iraq. And don't forget oil, the lubricant of world money and power, and of the Bush family's longtime financial relationship with the Saudi ruling family and the Bin Ladens, who, it seems, were whisked back home to Saudi Arabia on the only planes in the sky, other than US military planes, 2 days after 9/11.

But I can't let go of the reality that I see the world as a doctor, and the scene that was most important and moving for me was a brief one in the rehabilitation unit of a Veterans' Administration (VA) hospital. A US serviceman who had lost both arms below the elbow tells the camera of the phantom pains he was experiencing and how upsetting they were to him, but how the docs gave him enough morphine to help the pain and he was grateful for that.



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For 3 months in the fall of 1969 I had one of the best posts any medical student from the Midwest could imagine — a well-paying job as a research assistant for a VA clinical study, based at the VA hospital in San Francisco. One day, in the cafeteria, I met a quadriplegic army veteran who was a patient in the rehabilitation unit of the hospital. He invited me over to see where he lived and to meet some of his friends. Larry introduced me to a generation of soldiers who felt forgotten and shelved, from their families and from society. Like so many people one meets in a lifetime, especially a clinical lifetime, I was changed forever, and they are gone and I am left telling stories 35 years later. That scene from *Farenheit 9/11* took me back to that desperate ward of disabled, angry, struggling vets from another war, Vietnam, which would affect my generation forever in ways that are again being acted out on the international stage. I didn't know what to do or say 35 years ago and I still don't today.

After Vietnam, the term PTSD (post-traumatic stress disorder) became a more common part of the medical lexicon. I have taken to asking men of a certain age, as part of a routine medical history, whether they have served in the military and if they had been to Vietnam. If they have, I ask them whether they have ever needed or received help with dealing with their experiences. Men being men, most have not. The doctor part of me realises that these denying Vietnam veterans left with their nightmares and depression will soon be replaced by the strutting, confused, scared American troops who Moore interviews in Iraq and the US. So, my new question for my 20-something patients and their 40-something National Guard age colleagues will be, 'were you in the service, and if so, have you been in the Middle East, and if so, have you gotten help dealing with it?'

Farenheit 9/11 also shows the family-doctor viewer the next generation of patients and their families who will be part of our practices. The family that Moore focuses on in the film is from his home town of Flint. One of the things I respect most about Moore is that, despite being lionised at Cannes, he remains a man of Flint, Michigan, the industrial town abandoned by industry, but more an 'all-American city' than all the glitzy book-and-latte, or well scrubbed suburban towns that carry that label. When Moore speaks on campuses, he talks about Flint more than he does about

his films. He seems to have been radically changed, at some point along the road, by a seminal encounter with unfairness toward his friends and neighbours, which continues to motivate everything else he has done since.

The family whose mother loses a son, and who sits and reads his last letter from the field, is a family of working people, mixed race, and with true grit, who have been believers, despite evidence to the contrary all around them, in the resilience of American communities. The mother works in a job training programme, having risen from unemployment and welfare to being a supervisor. And she, like many parents around the world, encouraged her children to join the military as a way of paying for an education and gaining skills and experience while being of service. Neither she nor her family expected that service would include a downed helicopter in Baghdad.

The 20th century was full of novels and films of lives shattered by wars, since there were so many wars and so many individual and family lives that had been affected by them. Sadly, rather than making serious ongoing efforts to open communities to the physical and psychological needs of survivors, society seems to pay tribute to disabled veterans with a yearly parade, and, in the US at least, discount rates on automobile licence plates.

It is not because the VA health system doesn't try to address the needs of veterans, but because, like so much of public sector healthcare in the US, it is grossly underfunded and looked on by mainstream medicine as a venue for doctors who couldn't quite make it in the real world. The wealthy can get virtual colonoscopies and Botox on demand, but there are not enough rehab centres in the downsized VA system for the new 'consumers' coming back from the Middle East. Those with physical damage will undoubtedly get care, since the VA system has waiting lists and capacity issue. Those who come back 'whole' will return to their 'usual source of care' and that means us in the community. I will start seeing these guys at some point. I am glad to see them, frankly, since it is one way that I can help and apologise to myself for the insanity that we in the US have, once again, brought on ourselves. This time, I will be with the veterans for the long haul and maybe feel a bit less embarrassed about how relieved I felt, in 1969, to be leaving the San Francisco VA and shutting it out of my memory.

John Frey

Medical records: use and abuse
Heidi Tranberg and Jem Rashbass
Radcliffe Medical Press, 2004
PB, 173 pp, £24.95, 1 85775 604 5

IN the beginning the patient told the doctor a secret. And, behold, the doctor kept the secret in his head until he died or forgot it. Later on, the patient told the doctor a secret, and the doctor wrote an aide mémoire for himself in cryptic handwriting, abbreviations (or in Latin), and destroyed it when he retired. Later again, the patient told the doctor a secret and the doctor wrote it out clearly in a record folder shared with his or her partners and a nurse or two, which the receptionist saw but couldn't talk about outside on pain of losing her job, and which followed the patient about like a bloodhound for the rest of their life. And now, the patient tells the doctor a secret and the doctor can do one of two things: she can type it into a practice computer system, soon, under the government's *Information Strategy for the Modern NHS 1998–2005* to be amalgamated into a national electronic health record, or — she can keep the secret in her head until she dies or forgets it.

Entering the names Heidi Tranberg and Jem Rashbass into Google told me two things relevant to this matter. One was that the authors of this book have exactly the right qualifications: Tranberg is a solicitor with experience in medical record cases, now researching the field in Cambridge; Rashbass is a medically-qualified information technologist and educationalist, an executive director of the NHS Information Authority and a government adviser. The second lesson was how incapable any of us is of comprehending the power of the mechanism that can chose exactly the right web link, in less than a second, out of the 4.6 billion webpages, covering the whole of knowledge, currently indexed by Google.

Tranberg and Rashbass point out the urgent need for an open and informed debate on the possible consequences of storing personal details on such an unprecedented medium, and here they have provided us with the definitive primer for that debate.

'The protection of patient information is the cornerstone of effective health care,' they say, 'medical records contain some of the most personal and private information known about individuals, though this must be balanced with the need to use information in other contexts.'

Yet the impossibility of achieving this balance in a way that satisfies the interests of all parties, on every occasion, is a recurrent theme of their book.

Governments are now taking the issue of the confidentiality of personal data very seriously. But their attempts at legislation have led to new difficulties as well as progress. The Data Protection Act of 1998, for all its merits, has had negative effects on medical research, and although it has given patients the right of access to their records, again with many benefits, it remains unclear what rights, if any, they have to change them. The unofficial shredding of an offending letter, which I remember occasionally happening, is probably now impossible.

The Freedom of Information Act of 2000, which comes into full effect next year, will open the way for any member of the public to access information held by government bodies, including the NHS. Will that include anonymised and pseudonymised patient data? Probably yes. Tranberg and Rashbass explain the difficulty of ensuring that individuals remain impossible to identify when these techniques are used. If identities are concealed behind an encrypted NHS number (the British government's preferred option) who will hold the key to the encryption? Will they always guard it wisely?

The complexities surrounding the issue of consent — historically the mainstay of confidentiality — are detailed clearly. And the authors do not duck the difficult truth that consent cannot be valid if people can only obtain essential services by providing it. Whether you agree with their conclusion: 'introducing medical privilege [that is, giving medical records the same status as legal records] is not likely to be beneficial', will depend on your point of view.

Tranberg and Rashbass point out that in 1997 the Caldicott Committee (of which I was a member) concluded that there was a culture in the NHS of breaching patient privacy; 31 out of the 86 different flows of identifiable patient data identified were not found to be justifiable. They go on that there is: 'an overriding belief within the NHS that the sharing of information benefits many, harms few and is essential for efficiency and expediency.' At the same time, 'The UK public is concerned about medical privacy' (96% of people in a survey by the UK Information Commissioner said it was very or quite important) 'but generally trusts that doctors and the NHS will keep their medical records confidential'.

It is that fragile trust that is at risk if we conflate the personal relationship, in which integrity is still assumed, with the mediated relationship we have with corporations and governments, in which it so notoriously is not. At the moment when we encourage patients to tell us their secrets we are close to doing so on false pretences. We must not wait to be pushed into action by litigation or by patients starting to routinely withhold sensitive information. The current situation is in unstable equilibrium and cannot be sustained. GPs have a central contribution to make in furthering the debate, which this book has so ably begun.

James Willis