

Book

Responding to HIV/AIDS: beyond science and statistics

I have cared for young children with HIV infection in South Africa since 1995. Looking back, it strikes me how positive clinical developments in HIV/AIDS care have transformed the demeanour and optimism of parents and the general mood in our outpatient waiting room. In the 1990s, it was a quiet, sad space, punctuated by the persistent cough of patients with bronchiectasis, and filled with desperately ill, emaciated, and dying children and adults. Today the waiting room is a happier, more lively place, frequented by alert and healthy babies, children, and parents, who enjoy each other's company, munch away on snacks, and contribute to a much improved—albeit at times excessive—noise level. This change reflects the steps we have taken since the 1990s in responding to the HIV/AIDS pandemic. Yet despite this progress, the inpatient care of children with advanced HIV infection in resource-limited settings remains a neglected issue.

The care of children younger than 6 months with advanced HIV infection is one of the most technically demanding clinical challenges that I face. At our tertiary referral hospital, 50–60% of our clinical practice focuses on this patient group. Refining care for these children requires innovation beyond published knowledge. It has been particularly gratifying that our inpatient HIV-related mortality has declined by more than 50% in the past 5 years as a result of establishing a comprehensive infectious diseases consultation service, early introduction of antiretroviral therapy, improved interventions for opportunistic infections, and appropriate access to intensive care. Yet more still needs to be done and so I welcome the new perspectives to be found in *From the Ground Up: Building Comprehensive HIV/AIDS Care Programs in Resource-Limited Settings*.

These three volumes contain a wealth of knowledge and a blend of useful facts, technical information, research findings, programmatic perspectives, and experience-based and anecdotal observations. The first volume addresses the building blocks of treatment programmes, including human resources, laboratory and

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pharmacy capacity, training, effective monitoring, evaluation and quality systems, and human rights. The next volume focuses on the scientific aspects of the infection, treatment, management of opportunistic infections, tuberculosis, a broad range of preventive strategies, as well as counselling and testing, prevention of mother-to-child transmission, paediatric and adolescent care, and youth-friendly services. The final volume addresses the challenges of scaling up care and treatment, community-based care, effective leadership, and cross-sector collaboration and partnerships. As the contributors in *From the Ground Up* make clear, if we are to progress beyond the status quo and close outstanding prevention, care, and treatment gaps substantial additional resources, coordinated multisector collaboration and integration, and effective national and global leadership are needed.

An important factor limiting the response to HIV/AIDS in resource-limited settings is the dearth of adequately trained health professionals, particularly in sub-Saharan Africa. Global estimates indicate that of 39 million health-service providers

worldwide, only 3% are based in sub-Saharan Africa, home to nearly 25% of the world's disease burden. Systematic deficiencies of adequately trained laboratory technicians and pharmacists are particular challenges that severely compromise the implementation and scale-up of prevention and care. In resource-limited settings, there is a strong correlation between the quality of trained staff and the relative distance from capital cities. A recent survey in Ghana in 205 laboratories showed that only 25% of staff had professional qualifications. A technical and training initiative for laboratory staff by the National Health Laboratories Service in Johannesburg, South Africa, has assisted many laboratories in Africa to improve the quality of their HIV diagnostic and monitoring services. The limited availability of qualified personnel has forced programmes to shift clinical, laboratory, and pharmacy functions to less qualified staff members, after appropriate training, thus re-engineering the job descriptions of many service providers.

Another key issue that features in *From the Ground Up*, is the health needs of HIV-infected women that include interventions to prevent mother-to-child transmission of the virus and the diagnosis and management of sexually transmitted infections. Women infected with HIV are at increased risk of cervical dysplasia and cancer, and cervical cancer presents at a much earlier age in these patients than in women without HIV. Visual inspection of the cervix with acetic acid is an effective alternative to Pap smear for identifying cervical dysplasia in resource-limited settings. As this book shows, nurses can be trained to administer an effective screening service, and the example of a project in Zambia is described. However, more frequent screening should be offered to HIV-infected women. Although



**From the Ground Up: Building Comprehensive HIV/AIDS Care Programs in Resource-Limited Settings**  
Richard G Marlink, Sara J Teitelman, eds.  
Elizabeth Glaser Pediatric AIDS Foundation Publication, 2009.  
Three-volume bookset with CD-ROM. Pp 1935. No charge.  
ISBN 978-0-9817577-0-4.  
<https://ftgu.pedaids.org>

vaccines may potentially prevent dysplasia and cancer, they have yet to be adequately evaluated in HIV-infected women.

The annual trend of new HIV infections shows that the pandemic has been slowly declining for more than a decade. However, large numbers of new infections continue to occur, fuelled mainly by heterosexual transmission. HIV/AIDS is gender-based, mediated by factors largely out of the control of women. *From the Ground Up* highlights how HIV prevention efforts have been inadequate, constrained by underfunding, and have not kept pace with the expansion of antiretroviral programmes. Several additional factors undermine prevention efforts, such as the lack of an effective vaccine, cultural, religious, and social resistance, poor leadership at all levels, and lack of activism focusing specifically on

prevention. Scaling up antiretrovirals can only be sustained if the number of new infections is dramatically reduced. A renewed emphasis on HIV testing and prevention is urgently needed. It is, therefore, appropriate that this publication addresses several aspects of prevention, such as male circumcision, the importance of herpes simplex virus type 2 infection, and HIV counselling and testing for couples.

The dynamic nature of HIV research means that parts of *From the Ground Up* may quickly become outdated. Indeed, global treatment guidelines are in the process of being changed. Nonetheless, my brief overview cannot do justice to this magnificent publication. Through a large collection of essays *From the Ground Up* explores many contemporary aspects of the HIV/AIDS pandemic, encompassing the biology of the virus, the intricacies of

antiretroviral therapy and prevention of mother-to-child transmission, infant feeding, tuberculosis, hepatitis B and malaria co-infections, and much more. Importantly, aspects of the disease in children are given adequate space. Diagnostic tests are thoroughly reviewed, providing clinicians with detailed laboratory insights. The publication is replete with examples of successful projects, which will be invaluable for programme managers and lead clinicians.

Books about HIV-related scientific and clinical advances abound, but *From the Ground Up* is unique in imparting concern and compassion for those affected by HIV/AIDS, alongside invaluable science, statistics, and policy issues relating to this pandemic.

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**First Do No Harm: Being a Resilient Doctor in the 21st Century**

Leanne Rowe, Michael Kidd.  
McGraw-Hill, 2010. Pp 180.  
£16.99. ISBN 978-0070276970.

## In brief

### Book Finding our resilience

As we develop our skills as good doctors, do we potentially neglect the need to develop skills at being good people? Leanne Rowe and Michael Kidd recognise the great malady common among doctors, which I often see brandished across the exhausted faces of many of my senior colleagues: "The medical profession has had a long and admirable, but often unhealthy, tradition of self-sacrifice. The culture of the medical profession is such that the signs of burn-out are worn as badges of honour."

As doctors we can find ourselves failing to manage the minor facets of patients' care and struggle to graciously approach the mundane: interactions with disgruntled nurses; dealing with the brunt of relatives' anger; and frustration at a lack of work-life balance. Rowe and Kidd urge us to attend to our basic needs

in order to deal emotionally and physically with the draining situations we are frequently subject to. With a few basic principles (which should have been a staple of our medical school curriculum), they provide a foundation from which to embrace the repetitive challenges that confront under-supported, stressed-out health professionals.

Yet *First Do No Harm* does not encourage us to put our career aspirations on the back burner of a less-demanding lifestyle, instead Rowe and Kidd recount stories from the highest achieving medics and surgeons of the century, appealing to us to identify the patient who drives us on to practise our discipline with commitment, integrity, and passion. As the theologian and physician Albert Schweitzer observed "I don't know what your destiny will be but one thing I know. The only ones among you who will be really happy

are those who have sought and found how to serve."

Each doctor may look back on medical school interviews with nostalgia and their first set of on-calls with a sense of belonging and pride. Sadly, and increasingly commonly, life as a doctor is becoming less inspiring and, if we're honest, is eating away at the dream that first called us to medicine. This book reminds us of the age-old traditions we long to feel part of amid the modernisation, bureaucracy, and challenges of our working lives. I exhaled a long sigh of relief as I closed the final pages. I felt re-energised about why I want to be a doctor, recalling the promise in the Declaration of Geneva: to consecrate my life to the service of humanity and to practise my profession with conscience and dignity.

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## Historical keyword

### Degeneration

Degeneration derives from the Latin *degenerare*; a falling off from the generic or natural state. It entered the English language in the 15th century, but was first used as a secular theory of nature in the 18th century by Georges-Louis Leclerc, Comte de Buffon who considered that the climate of the New World produced weaker, sterile species of animals and human beings. Around 1850 it began to appear in medicine; first in pathology. In that year James Paget published *On Fatty Degeneration of the Small Blood-Vessels of the Brain and its Relation to Apoplexy*. From then on, its use proliferated in pathological texts and became the term applied extensively to damaged nerve cells and tracts. But by 1900, degeneration had been discovered as a ubiquitous state of Victorian nature. Why?

In the second half of the 19th century, biological theory was increasingly used to explain the dangerous nature of “the poor”. Identified by their unrestrained reproductive capacities, hereditary diseases, and criminal propensities, the poor would, many declared, swamp the intelligent middle classes and bring an end to civilisation. This “degeneration theory” was framed as a variant of Darwinian evolution. Human intervention through welfare was inhibiting nature’s weeding out of the unfit and the result was—in the words of the US degenerationist Eugene S Talbot, in 1898—a proliferation of the “pauper, hysteric, epileptic, prostitute, criminal, born-blind, deaf-mute, paranoiac, recurrent lunatic and idiot”. All were “buds of the same tree of degenerate heredity”, to which anthropological theory added Jewish people, effete aristocrats, artists, the Irish, and all non-European people. Degeneration existed as a continuous chain from the nerve studied down the microscope in the laboratory (“Wallerian degeneration”), through the syphilitic in the clinic, to the urban population of the “outcast poor”.

After World War I, the eugenic theory that these fears gave rise to was implemented in the segregation and sterilisation of “degenerates”, culminating in Nazi Germany’s “Final Solution” in World War II. But as degeneration theory became politically vicious in the interwar years, most mainstream biologists distanced themselves from it. After the war, distaste for the idea returned its use largely to pathology—as in macular degeneration. Shadows of its previous sinister life still exist in fiction: degeneration is the subtitle that describes the zombies in the biohazardous world of *Resident Evil*.

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## Lifeline

**Sunetra Gupta** was born in Calcutta in 1965, graduated in 1987 from Princeton University, received her PhD from the University of London in 1992, and is now Professor of Theoretical Epidemiology at the University of Oxford, UK. She lives in Oxford with her husband and two daughters, and is also the author of five novels.



### What has been the greatest achievement of your career?

In my scientific career, advancing a new theory for pathogen evolution that helps us understand why so many of them exist as antigenically distinct strains. In my literary career, my third novel.

### And the greatest embarrassment?

Not knowing, while appearing on the television show *Saturday Review*, in 2002, who George Clooney was.

### What inspired you?

My father, who made me aware of the enormous capacity to redeem ourselves through feeling and thinking and deriving satisfaction from making small differences to other people’s lives rather than seeking posterity.

### What is the best piece of advice you have received?

Rather paradoxically, it was a family friend—a renowned neurosurgeon in Calcutta—telling me not to study medicine.

### What is your greatest regret?

Not realising the extent to which my father was ill and needed my help before he died.

### What is your favourite film?

Stanley Kubrick’s *Barry Lyndon*, for its exquisite and unrelenting dedication to irony.

### What are you currently reading?

John Banville’s *The Infinities*. I am addicted to his prose.

### What is your worst habit?

Rearranging furniture—my family live in fear of it.

### In which other country would you like to live and why?

In Italy, especially Rome, to be surrounded by beauty.

### What was your first experiment as a child?

I kept a cockroach and an ant in a jar, gave them food, and faithfully recorded their indifference to each other.

### What was the most memorable comment you ever received from a referee?

This is not the sort of “truth” that *Nature* publishes.

### If you knew you had a week to live, where would you be?

In a beautiful Italian villa with my daughters and my husband (provided he does not bring his Blackberry), silently staffed and with an exceptional cook.

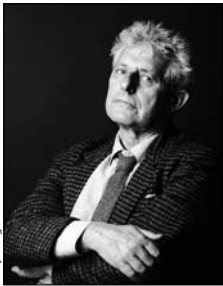
### You can have dinner tonight with a famous person of your choice, who would it be?

F Scott Fitzgerald—I think we’d have a lot to talk about and he might actually drink more than me.

## The art of medicine

### Poetry, medicine, and the International Hippocrates Prize

The 2010 International Hippocrates Prize for Poetry and Medicine and the associated International Symposium on Poetry and Medicine are supported by the Fellowship of Postgraduate Medicine and the Warwick Institute of Advanced Study.



Dannie Abse



John Keats



John Milton



William Carlos Williams

In November, 2009, we launched the annual Hippocrates Prize for Poetry and Medicine, with the inaugural 2010 awards to be presented at an international symposium in early April. Why this focus on what may seem at first sight an unlikely pairing? If we think of medical matters as they are reflected in literature, it is likely that our minds turn first to the doctors who appear in prose fiction, such as Tertius Lydgate, who struggles so valiantly to become established in George Eliot's *Middlemarch*, or Charles Bovary, who disastrously tries a new surgical approach in Gustave Flaubert's *Madame Bovary*. Or we may think of the comic mileage in medical matters discovered by Molière in *The Hypochondriac* or *A Doctor in Spite of Himself*, in which he shows us a man whose reputation for working miracles goes before him, so that he finds it easy to slip into a medical role in which he can deliver delightfully absurd pronouncements such as: "She mustn't die without a doctor's prescription".

From the physician who observes the distressed Lady Macbeth sleepwalking, to the doctors who turn to homicide in the pages of Agatha Christie, and television hospital settings from *Emergency Ward 10* to *ER* and *House MD*, medicine and the medical profession have steadily emerged in the modern era as objects of profound fascination to writers, readers, and audiences. Nonetheless, an initial scepticism is often evident when medicine and poetry are mentioned in the same breath. In part this arises from lingering preconceptions concerning the proper subject matter of poetry. Love, the contemplation of beauty, and expressions of grief and loss are imagined to be the major provinces of the poet, from Ovid, the Romantic poets, and Nobel laureate Seamus Heaney in the western tradition, to delicate haiku in Japan. We also tend to think of poetry as dealing with grand philosophical and historical themes, such as in Homer's *The Odyssey* and Dante Alighieri's *Inferno*.

However if we believe that "the proper study of mankind is Man", as stated by Alexander Pope in the 18th century, then we should also agree with the ancient principle that the writer's province is anything within human experience. Indeed, to the Roman Lucretius, engaged in the first century BC in philosophical and scientific inquiry into natural phenomena, it did not seem unnatural to write about these themes in verse in his *De rerum natura*. Poetic themes may also have a medical resonance beyond the imaginings of the poet. Ovid's *Metamorphoses*, for example, provide metaphors and names for a wide range of psychiatric disorders, from narcissism to the Oedipus complex. Among the Romantic poets, the writings of John Keats most obviously illustrate the effect on poetry of both medicine as a profession and the personal experience of illness—in

Keats' case tuberculosis which led to his death at the age of 25 years. There are echoes of William Harvey's *Exercitatio anatomica de motu cordis et sanguinis in animalibus* in Keats':

"...thou would wish thine own heart dry of blood  
So in my veins red life might stream again"

His "Ode to a Nightingale" refers to the place "Where palsy shakes a few, sad, last grey hairs" and he reflects on his own intimations of mortality in his cameo "When I have fears that I may cease to be".

In the 20th century, eminent physician poets come to mind. The German Gottfried Benn was the doctor in attendance for Edith Cavell when she was executed as a spy by the Germans on Oct 12, 1915, near Brussels. Benn later specialised in dermatological and venereal diseases. 2 years before the outbreak of World War I, he had published his first volume of poems, *Morgue*, in which his point of view was often not only detached but ostentatiously shocking:

"Come now, go ahead, lift the blanket.  
See, this lump of fat and rancid juices  
was once magnificent to some man or other  
and was bliss to him and meant home."

In the USA, William Carlos Williams, a general practitioner in New Jersey, frequently drew on his professional experiences, both in his prose writings (*The Doctor Stories*) and in verse. In his poems of death, sickness, and frailty, Williams strikes us as a medical man more likely to show compassion and understanding of the patient's perspective:

"Oh, oh, oh! she cried  
as the ambulance men lifted  
her to the stretcher—  
Is this what you call

making me comfortable?  
By now her mind was clear—  
Oh you think you're smart  
you young people,

she said, but I'll tell you  
you don't know anything."

Keats' allusions to melancholy and mortality, Benn's cancer ward, and Williams' dying grandmother all illustrate some of the vast terrain open to poems influenced by medical knowledge and experience. This includes experience of disease, accident, and death from various points of view; it includes medical science and its history; it includes everything from the Renaissance theory of the humours to the contemporary routine of the ambulance driver.

Recent years have seen extraordinary growth in the use of poetry for therapeutic purpose. What led to this use of poetry to help in treatment of clinical disorders? Here too it is necessary to begin by recognising that poetry may serve many ends and come in many forms. We are more accustomed to the use of music and painting in therapy. Ideas that passive experience of poetry may reset abnormal mood—comedy for the depressed, tragedy for the manic—go back at least two millennia to the Greek doctor Soranus. As early as the 18th century, the US physician and psychiatrist Benjamin Rush pioneered active engagement in writing poetry for his patients. There is now increasing interest in exploring the idea that by unlocking the doors of depression or denial of serious illness, reading and writing poetry may bring understanding and coming to terms with illness, through encouraging expression of mood, feelings, concerns, expectations, and insights.

20th-century interest in poetry as therapy has inspired a substantial body of poetry written about serious medical disorders, including psychiatric problems, HIV/AIDS, and terminal illness, especially cancers. Since these subjects tend to be the very opposite of beautiful or uplifting, poets, while foregrounding the distressing features of illness, often contrast upsetting clinical experiences with inappropriately elegant or jolly poetic styles. In these lines from his long sequence on cancer, entitled *C* (1984), Peter Reading disarmingly includes ironic comment within the poem:

“My fistulae ooze blood and stink,  
I vomit puce spawn in the sink,  
diarrhoea is exuded.  
Do not be deluded:  
mortality’s worse than you think.

You find the Limerick inapposite? Try the pretty Choriamb?

Bed-sores without; swarm-cells within.  
Rancified puke speckles my sheets.  
Faeces spurt out quite uncontrolled  
into my bed, foetid and warm.  
Vomit of blood tasting of brass,  
streaked with green veins, splatters my face.”

Self-evidently this is not poetry for the faint-hearted; neither for those who demand their daffodils in verse. To ask what the function of such verse might be entails inquiring into the essential nature of poetry. Those who want poetry to consider the facts of our physical existence as unflinchingly as the surgeon will want to defend Reading’s approach. Those who want poetry to impart consolation or courage may turn from Peter Reading in disappointment or anger; yet may be uplifted by “light deny’d” in John Milton’s “Sonnet XIX On his blindness”. Milton encourages readers under the “yoak” to value modest achievements, greatly understating his own highly productive 22 years of blindness, supported by gifted amanuenses, including Andrew Marvell.

For the Hippocrates Prize, we wished to draw together national and international perspectives on three major historical and contemporary themes uniting the disciplines of poetry and medicine: medicine as inspiration for the writings of poets; effects of poetic creativity on the experience of illness by patients, their families, friends, and carers; and poetry as therapy. The Prize has an international open category eligible for unpublished poems in English by any poet; and separate awards for UK health students and NHS-related staff, including clinical teachers, researchers, and biomedical scientists and their supporting staff. Has our vision been justified? At this stage it is already clear that initial interest has been remarkable, with over 1600 entries from 28 countries and six continents. The inaugural 2010 awards will be judged by physician and poet Dannie Abse, broadcaster and Man-Booker Prize trustee James Naughtie, and National Health Service Medical Director Sir Bruce Keogh, with awards presented during a Symposium on Poetry and Medicine on April 10, 2010. Within both the Hippocrates Prize and the associated Symposium, contributors are encouraged to explore medicine as a theme in its broadest sense. Themes could include the nature of the body; the history, evolution, current and future state of medical science; the nature and experience of tests; and the experience of patients, their families and friends, and of doctors, nurses, and other staff in hospitals and in the community. In this spirit, the first Symposium will include discussion of the influence of doctor poets, from Williams to our Australian keynote speaker Peter Goldsworthy, alongside discussion of poetry as an aid to understanding illness, as well as early anatomy as inspiration, poisoning in Shakespeare, and poetry as passion for creative health professionals.

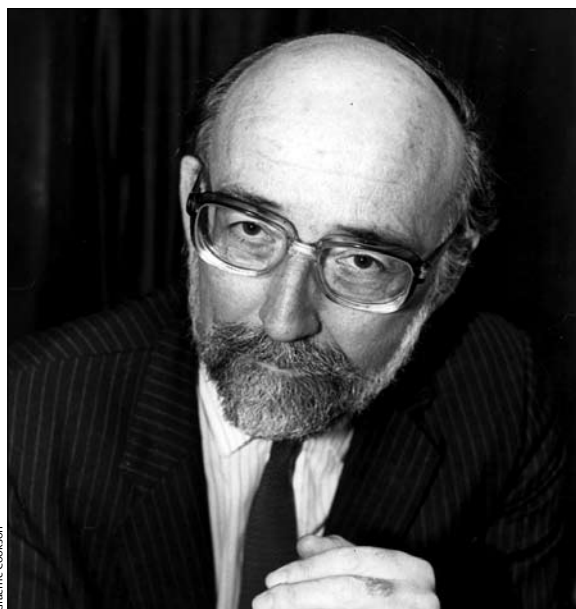
The response to the Prize and Symposium confirms our sense that the meeting of poetry and medicine is attracting growing national and international interest. Among the reasons for that interest is the widening understanding of the therapeutic value of words. We are creatures of language, and finding words for critical experiences helps us to cope and find the way forward. Today, in the practice of the medical community, poetry is increasingly joining music and the visual and plastic arts as an aid to recuperation and convalescence. At the same time, professional poets have increasingly written candidly of painful illness and death. Poetry and medicine—with all the beauty and all the harsh reality that either discipline can bring into our lives—are too big to belong to the “experts”, and must be shared by us all.

*\*Donald RJ Singer, Michael Hulse*

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**Further reading**

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- International Symposium for Poetry and Medicine. April 10, 2010. <http://www.warwick.ac.uk/cpt/poetry/symp>
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Gratime Cookson

## Ernest Donald Acheson

UK epidemiologist and Chief Medical Officer who dealt with HIV/AIDS and BSE. He was born on Sept 17, 1926, in Belfast, UK, and died on Jan 10, 2010.

One of the minor rewards of chairing a government working party is to be eponymously memorialised. Donald Acheson, UK chief medical officer (CMO) from 1983 to 1991, achieved this distinction twice. The first "Acheson report", published in 1988, considered the role of public health; the second, in 1998, reviewed inequalities in health. Both were well received and influential, but the latter is the more remembered.

Commissioned by the newly elected Blair Government the second report was intended to identify "cost-effective and affordable interventions to reduce health inequalities". Acheson and his colleagues itemised a list of potentially beneficial policies encompassing many social determinants of health from housing and employment to pollution and nutrition. They argued that all government policies likely to affect health should be evaluated for their influence on inequality. Professor Cyrus Cooper, director of the Medical Research Council (MRC) Epidemiology Resource Centre in Southampton, has known Acheson since the late 1970s. The report on inequalities, he says, had an effect not only on health policy but on the research agenda within the population sciences. "It pointed to the life course origins of health inequality. Not just when you're at the age when you actually suffer the common morbidities that lead to premature death, but to their origins throughout life, and perhaps even in the

generation before. And this led to a policy focus on the pregnant woman, infancy, and adolescence."

A New Labour Government was never likely to respond to work on inequality as dismissively as the Conservative Government had been towards a report on the topic published during its term of office. And so it proved. But this is not to suggest that Acheson's career had been free of strife. His period as CMO coincided with the emergence of HIV as a major problem, and with the advent of bovine spongiform encephalopathy (BSE). His response to the former was to successfully confront it. "I think what he did with HIV was truly impressive", says Professor Sir Michael Marmot, director of the UCL International Institute for Society and Health. "This was early days, and it would have been easy to underestimate it or do nothing. He was very impressive." He had to work hard to ensure that HIV/AIDS was treated with the seriousness it required. His handling of BSE was less sure-footed, partly because of conflicting interests of the health and agriculture ministries. In a subsequent enquiry into the BSE outbreak he publicly regretted having been too insistent in his claims that eating beef could be judged risk free.

Acheson's public responsibilities had been preceded by a distinguished academic career. The son of a public health doctor, he studied medicine at Oxford University, qualified in 1951, and subsequently worked at Oxford University for 10 years, latterly as director of the Oxford Record Linkage Study. A chair in clinical epidemiology took him to Southampton University, where he became the first dean of its new medical school, and then director of the MRC Environmental Epidemiology Unit before taking on the job as CMO. He was well suited to this task according to Cooper: "He was one of the few people able to span the range from discovery science through to policy implementation."

The late 1970s and early 1980s was a period of confusion and demoralisation for public health. Invited to chair a working party on its future, his findings (the first "Acheson Report") marked a new beginning for the specialty. In Cooper's view, "It served as the stimulus to put public health on a strong intellectual, practical, and academic footing."

The role of CMO may have been the high point of Acheson's career, but it was not his final job. No sooner had he left government service than he responded to a request from WHO to go to Bosnia to assess the public health problems of that war-torn country. The work was exhausting and occasionally dangerous. He later became chair of the then UCL International Centre for Health and Society: another peace-making role, albeit a less hazardous one. He acted as a sort of eminence grise, Marmot recalls, keeping control of the intellectual wrangling between his enthusiastic younger colleagues. He is survived by a wife and a daughter, and also by a wife, son, and four daughters from a previous marriage.

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