A poster poser—doing it in tiles

PERSONAL VIEW Adesh Shrivastava

It was a scene familiar to many a doctor travelling to make a conference presentation. Dr Kotkar smiles as he remembers the episode at Mumbai airport: “As I boarded the aircraft I saw many anxious faces staring at me. Soon I realised that it was my long tube-like poster holder, which made me look as if I was carrying a rocket launcher. And then it would not fit inside the overhead locker even after a joint effort by me and the air hostess. I had anticipated such embarrassment but had no other option.”

Doctors and researchers often have excellent ideas for designs for illustrated posters to use in presentations at meetings and conferences. But then, to avoid situations such as Dr Kotkar’s, they ruin the effect by resorting to the conventional A4 sized landscape printout for ease of carrying, especially when long distance travel on aeroplanes is involved.

Dr Desai, who enjoys painting as a hobby and whose ideas for poster designs are appreciated by his students and colleagues, is irked by this problem. “It’s really annoying that you cannot present your best, particularly at the international level,” he said. “But it is still better than causing inconvenience to others and being frowned on by fellow passengers.”

Folding posters that are printed on paper makes them look messy. One solution could be the foldable “flex prints,” the polythene sheets used in roadside hoardings. But images on this medium do not have sufficient sharpness for viewing at short distances.

Last summer, when I faced a similar situation, I decided to put up with the embarrassment rather than compromising on quality at my first international presentation. But then to my displeasure I received a letter rejecting my application for a travel grant. It was just a month before the event, and I had been all prepared. The organisers asked me to send my poster with my senior colleague Dr Kapoor, who was also invited. And then came the moment I had feared. She asked me to redesign the poster in a small format to make it easier to carry.

I had been sitting in front of my PC for hours trying to recompose the design in the smaller format when I spotted the box of an old jigsaw puzzle kept on a shelf at the side of the desk, with a few pieces showing through a half open cover. The idea struck me: I had found the solution to the problem. And even before experimenting with it for the first time I baptised my newly born idea the “tiled poster.”

As I switched on my inkjet printer I decided to use normal A4 sized printing paper for each tile, because the overlapping edges of thick glazed sheets would make the poster look uneven after assembly. I printed the poster, dividing it into a stack of “tiles” by using the “tiled printing” option in Adobe PageMaker. This produces a section of image on each sheet of paper with an area of overlap (the width of which can be set by the user), so that the edge of each image is duplicated on the adjacent sheet. Tiled printing can also be done in other popular software such as Corel Draw and Adobe Photoshop. Then, with a commercial paper cutter from a local bookbinder, I trimmed off the blank unprinted strips on each side. You could also do this by running a sharp blade alongside an appropriately placed ruler on the stack. Avoid using scissors, though, as the edges won’t cut cleanly. So now I was ready with my tiled poster to present the conclusions of my study in the way I had wished.

After handing over the tiles to Dr Kapoor we discussed how to put up the poster on the display board. We could think of two options. To make the poster reusable we used adhesive putty, available on the market under various brand names, such as Blu-Tack. This sticks well and can be removed from any surface without damaging it. The other option, which means the poster can be used only once, requires you to stick the tiles together at the venue before mounting the poster on a display board. Liquid glue leaves wrinkles on the paper after drying, so it is better to use non-wetting glue sticks.

I explained to Dr Kapoor that to assemble the poster she should place the tiles in order from left to right in a row and then move downwards to begin the next row. And not to forget to position the overlaps correctly each time. But even before she said anything I could see she was concerned by something. And then her question made my own brow pucker with worry. “What if the order of pages in the stack got disturbed?” Her immediate reply to her own question relaxed me: “Just number the tiles and put them in sequence in a document file.”

I numbered the tiles and placed them in a large file to prevent any edges from hanging out and getting creased or curling up. I also sketched a grid on the file cover with instructions on mounting the tiles. Thus I was confident that the poster would be mounted easily and successfully.

On the evening of her return Dr Kapoor congratulated me. “Your idea worked well,” she said. “People were impressed by this interesting technique. Besides discussing your research findings, they were eager to know how you made your poster.”

Do think about this option. It’s better than overhearing a kid remarking to his mother: “Look, Mummy, there is a terrorist in the plane!”

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Cite this as: BMJ 2008;337:a2923

See also VIEWS & REVIEWS p 56
The new ethics of research into terrorism

PERSONAL VIEW

Edgar Jones, Kamaldeep Bhui

The recent terrorist attacks in Mumbai have increased pressure on authorities not only to discover ways to prevent such attacks but also to undermine the appeal of radical groups set on violence. However, in May 2008 a postgraduate student studying Islamic terrorism at Nottingham University was arrested for possessing a copy of the “al-Qaida handbook.” Although the student was released without charge after six days, Colin Campbell, the university’s vice chancellor, warned researchers that if they accessed terrorist material they “run the risk of being investigated and prosecuted on terrorism charges.” This incident marks a change of attitude towards those who undertake research into the psychology behind criminal acts of violence and terrorism. Academics should be mindful of infringing antiterrorism laws and may need to protect themselves when applying for ethical permission by setting out a process to balance research activity, confidentiality, and public safety.

The introduction of wide-ranging legislation designed to identify and detain terrorist suspects raises new ethical questions. In the past no medical school academic studying murder or paedophilia would have feared that contact with perpetrators of such crimes might prompt their own investigation and possible arrest. Research into criminality did not carry an implication of sympathy or involvement. In the short term, however, there is no way to distinguish between the enthusiastic researcher, a potential recruit to terrorist activity, and the terrorist concealing his or her plans. Because an interest in terrorist material may be a marker for support and possible engagement in violent acts, all researchers, it might be argued, should be treated as suspects. Furthermore, UK universities, including medical schools, are known recruiting grounds for radical Islamic organisations. Indeed, Omar Sharif, the British man who was arrested in April 2003 in Tel Aviv while trying to detonate an explosive device strapped to his body, had been recruited when studying mathematics at King’s College London. The failed bomb attacks in London and Glasgow in June 2007, together with earlier evidence gathered in the Middle East, indicate that doctors may be disproportionately represented among the ranks of the terrorists (N Engl J Med 2007;357:635-7).

Thus, to ignore the behaviour of staff and students in institutions of higher education would open antiterrorist organisations to a charge of negligence.

The nature of the threat of terrorism, in particular the absence of social and behavioural markers, makes it essential that detailed studies are undertaken of those who may be vulnerable to recruitment. Britain is currently targeted by a “third wave” of terrorists, that is, those recruited and radicalised in the United Kingdom without direct access to al-Qaeda training camps in Pakistan or Afghanistan (Peace and Conflict: Journal of Peace Psychology 2007;13:293-312). No link has been found between the 7 July bombers and an al-Qaeda leader. Radical groups are generally composed of second-generation immigrants who have received a mainstream secular education. We can also be fairly certain that most of these individuals will not meet international diagnostic criteria for mental or personality disorders. They are not drawn from a particular socio-economic group and are certainly not limited to the unemployed or the least educated elements of the community (Terrorism and Political Violence 2004;16:795-814).

These findings raise a crucial question: what is it during the acculturation process that goes wrong for radical activists such that apparent integration is not accompanied by a sense of belonging? We know little more about potential terrorists other than that they are largely men under the age of 30 and that second-generation immigrants are at higher risk. However, the number in this group who are engaged in terrorist activity is so small that targeting the group is unlikely to yield any meaningful results until further social and behavioural research is undertaken of young men in general—and specifically second-generation immigrants—involved in criminal or radical activity.

A central goal of terrorism is the disruption of normal patterns of work and play through fear and intimidation. Attempts to clamp down on terrorist acts can in themselves serve the aims of terrorism by generating inhibitions and legislation that restrict activity and undermine resilience (J Risk Res 2006;9:57-73). If our society becomes so concerned with safety that it restricts the capacity of researchers to investigate valid questions, then it serves the purpose of radical extremists who in the pursuit of a single overriding truth plausibly discourage debate and diversity.

Legislation that inhibits research into terrorism may delay the design of strategies to counteract radical appeals to violent acts. Any intervention of lasting impact has to be grounded in a thorough understanding of culture, personality structures, and the belief systems and desires of vulnerable groups. Even if such work is permitted, perhaps through licensing and ethical and security clearance, the issue of the status of such findings remains. Sensitive results may be censored and retained within the security community. Alternatively, if released, findings may be misused by groups to generate fear among the public or to inform terrorist methods. Engaging people and groups who are driven by radical thinking carries responsibilities of confidentiality to those individuals, responsibilities that have to be balanced against the safety and health of the public. Given the potential for moral panic and damage to social cohesion, a new ethics of research into terrorism is needed, but it risks becoming a radical response to a conventional ethical dilemma.

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Additional references are in the version on bmj.com

Cite this as: BMJ 2008;337:a3069

Studies of those vulnerable to recruitment, such as the doctor convicted of the Glasgow bombing, are essential, but risk leaving researchers open to prosecution.
Nothing to be sad about

Within a radius of a few miles of the hospital in which I worked were a number of what were once called dossies. (We laugh at the Victorians who supposedly covered up the erotically suggestive legs of pianos, but we routinely disguise realities with euphemisms.) A certain specific kind of solidarity reigned in the dossies. The residents arranged for their social security payments to be paid on different days, so there was always money enough for the 3 l bottles of strong cider that were their main interest in life, the lack of which would cause them acute suffering. But that was the only real solidarity they showed.

Reading Maxim Gorky’s play The Lower Depths, first produced by the Moscow Arts Theatre in 1902, I am struck by how little has changed in the intervening century at this level of society. As in Gorky’s day not all the inhabitants of the lower depths started life there: in the play one of the characters is an aristocrat, and the rest of them were their main interest in life, the lack of which would cause them acute suffering. But that was the only real solidarity they showed.

In my career I’ve been called as a medical witness in several dossie murders. They could all have come out of Gorky’s play: arbitrary, sudden, sordid, and drunken.

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I’m not sure what conclusion to draw from the continuing accuracy of Gorky’s play. That people are irredeemably wicked? That society is to blame? Some combination of the two? The problem with human existence is that it is so hard to comprehend.

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BETWEEN THE LINES

Theodore Dalrymple

In my career I’ve been called as a medical witness in several dossie murders. They could all have come out of Gorky’s play: arbitrary, sudden, sordid, and drunken.

BMJ 2008;337:a3088

MEDICAL CLASSICS

African Highway: The Battle for Health in Central Africa

By Malcolm Watson

First published 1953

For most of the period from 1970 to 1986 I worked as a surgeon and health service manager in Zambia and in particular for the mining industry from 1975. In common with most of the residents of the Copperbelt mining district I rather took for granted the fact that we had no need to take malaria prophylaxis. On reflection this was not something we could have expected. My interest in the history of malaria control on the Copperbelt was first raised by sight of correspondence in 1936 from the directors of the Beatty’s mining company in London urging the chief medical officer at the Roan Antelope mine to put more effort into public health. For the times this seemed to me to be an enlightened approach.

This situation arose out of the interaction between two remarkable but different men, Alfred Chester Beatty (1875-1968) and Malcolm Watson (1873-1955). By 1911 Beatty had become rich from success in the American mining industry. In the 1920s he realised the potential of the copper deposits in Northern Rhodesia and was probably the single most influential investor in the new mines. He was aware that malaria presented a major challenge to any investment in central Africa, no previous control efforts having succeeded.

In 1929 Beatty turned to Watson for advice. Watson was deputy to Ronald Ross at his eponymous institute in London. By this time Watson had made his reputation as a world expert in malaria control. In 1901, just four years after Ross identified anophele mosquitoes as the vectors of human malaria, he initiated effective malaria control operations in the Klang and Port Swettenham regions of Malaya, where the annual mortality had been 170 per 1000 people. Working before the availability of insecticides such as DDT, Watson based his work on altering the habitat to prevent the breeding of the species of mosquitoes known to transmit malaria, a method that became known as species sanitation. The results allowed the development of a major plantation industry in Malaya and a successful career for Watson as an independent consultant to that industry and in other countries.

Watson’s African Highway describes the work undertaken on the Copperbelt that led to the successful control of malaria and the development of a major mining industry. Within three months of the first approach a team was assembled by Watson and despatched to the area. The incidence of malaria was rapidly reduced through the application of Watson’s species sanitation methods, such that the disease had little impact on economic activity, and this success was reinforced when DDT was added to the control armoury in 1946. Recent economic analysis has shown that the cost of Watson’s work was low and that without it the Copperbelt industry would most likely have failed.

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Cite this as: BMJ 2008;337:a2940

Cite this as: BMJ 2008;337:a3088
Humbug?

Christmas is over. Woolworth’s entrails are strewn across the looted shop floor. Sofas heave with bad tempered children. Presents begin the slow march to the garage; novelty socks and jumpers head for the charity shop. Men stretch their ill fitting clothes, too idle (or relaxed) to take them back to exchange. Seemingly innocuous electronic games gnaw at the fabric of family life. A materialistic melancholy descends as we realise that we cannot spend our way to emotional prosperity. In truth, Christmas is haunted by the memories of those who we have lost, and at this time we revisit those few moments we shared with them in our otherwise largely forgettable lives.

Perhaps I am of the last generation of big families (six or more children). Children were materially deprived, their stockings filled with nuts and tangerines, and so were materially appreciative. I am grateful, for our real gifts were one another. But does having children make you a better doctor? No, though it certainly makes you a different doctor. Having children gives you insight into the minds of those infuriatingly over-anxious parents, allows empathy rather than just sympathy, and gives an authentic gravitas to our medical advice. Patients see us as people, not just doctors. On a personal level children liberate us from the tedious introspection of career and wipe away the foolish and cosmetic aspirations of youth. And at the end of our career, when they take down our name badges, dismiss out of hand the decades of work, and ignore us in the supermarket, what is left is our family. Choosing family over career is never a mistake.

These are uncertain times, and many might think to delay having children. But youth and fertility are not linked by chance, and parents need the energy of youth. As for that glittering medical career, the necessity of compromising is the very mother and father of invention. I respect that many people choose not to have children and that others, regrettably, can’t, but those who can should ignore all the ethically correct nonsense about limiting the numbers of children and invest in the security of family. One Christmas you too will wake at 5 am to the sound of fighting children, not knowing whether to smile or cry, and later shake your 3 year old upside down to dislodge the baby Jesus from his larynx. But you will at least know that you are alive.

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Cite this as: BMJ 2008;337:a3124

Sorry, you’re barred

And it was all going so well. You were in the right place at the right time, looked the part, and really wanted to do it. You’d met all the right people, who were keen to get you signed up and involved.

But then they spotted a detail that marked you as a non-starter and, well, a waste of their time, frankly. Suddenly you were out of the picture, dumped and forgotten. All your desirable qualities were irrelevant, as you no longer mattered. No right of appeal, no second chances—you were history.

Exclusion criteria are the executive doormen of clinical trials. Tough, blunt, and inflexible, their only role is to keep undesirables out. This might not seem a noble aim. But, as with human bouncers, the decision to exclude may increase the safety of the situation, even if it leaves those affected feeling victimised or disgruntled.

Where the reasons for barring people from trials are transparent and determined primarily by ethical considerations, evidence based judgments, and common sense, there’s no issue. Too often, though, that’s not what happens, and cynical pragmatism is a more plausible cause of the blocks to participation. Sometimes the intention seems less to protect vulnerable patients from inappropriate or potentially harmful interventions and more to guard trials against “contamination” by individuals who, it is thought, are inconvenient to manage or less likely than others to show the desired responses.

Exclusion criteria can come across as tedious small print: the stuff that ought to be studied and considered but is easily glossed over by people with inadequate time, interest, or experience in assessing and contextualising research findings. This is compounded by the lack of explanation many researchers give for their choice of criteria, typically in marked contrast to the words lavished on other aspects of studies. Convincing justification is especially important where the criteria would otherwise appear arbitrary or sweeping. Notorious examples include the rpy upper age limits for recruits and lists of supposedly “excluding medical conditions” that any claim dodging healthcare insurer would be proud of.

In theory, multiple mechanisms are in place to deal with such abuses. Non-industry research funders, ethics committees, healthcare regulators, and peer reviewers should all be capable of questioning the basis on which certain people are kept out of trials. The fact that the problems remain such a prominent feature of published research does not say much for the collective attention paid to this area.

In general, it’s a bad idea to challenge strong bouncers. Why do weak exclusion criteria get the same respect?

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Cite this as: BMJ 2008;337:a3086

BMJ | 3 JANUARY 2009 | VOLUME 338