protective genes have evolved which have a survival advantage at times when calories and salt are less abundant, but are disadvantageous when there are unlimited or increased supplies. This goes some way to explaining the marked weight gain and trunkal obesity, insulin resistance and diabetes seen in South Asian immigrants to the UK. Alternatively, building on the Barker hypothesis of intra-uterine growth and its impact on adult health comes the second explanation, the 'adaptation–dysadaptation hypothesis', which investigates the mismatch between 'foetal thrift' and 'postnatal plenty'.

The book also aims to identify areas for treatment and strategies to reduce the epidemic and improve cardiovascular health in this population. The reasons for a higher prevalence of tobacco smoking and a lower quit rate in some ethnic subgroups have been examined well with innovative and culturally-appropriate public health strategies suggested.

TUSHAR RAINA
Specialist Registrar, Royal Hallamshire Hospital

KEVIN S CHANNER
Consultant Cardiologist, Royal Hallamshire Hospital

The good doctor

By Damon Galgut. Atlantic Books, London 2004. 240pp. £7.99.

This novel is an enthralling, all-consuming and intense read right up to the last page. The two main characters are doctors and many of the sub-plots have a medical slant, but one certainly does not have to be a medic to appreciate and be profoundly moved by the book.

The scene is post-apartheid South Africa and the focus is on the lives of two totally contrasting doctors who find themselves working closely together, indeed sharing a room in a hopeless, run-down hospital. The hospital is 'managed', so to speak, by an incompetent female surgeon and is in one of the old Bantu homelands not far, I suspect, from the Angolan border. One of the two is young, new, energetic, full of ideas and thoroughly enthused about and committed to the 'new' South Africa and what can be achieved. The other is older, has been there a long time, lacks ambition, is not very successful in the eyes of his traditional upper middle-class family, and his marriage has failed. This tale relates the tensions that develop between them and the catastrophic consequences.

The main plot and the various sub-plots deal with violence, corruption and desperation, and are weaved in and out of each other with great skill. There are many unexpected twists and turns; every page is compelling, and many are disturbing and shocking, but the writing is always horribly plausible. The story is brilliantly narrated in its discomforting way, and it was no surprise to learn after I had read it that it had been shortlisted for last year's Booker Prize.

It is a short book, just 200 pages. It is now in paperback and is to be thoroughly recommended.

JM HOLT
Emeritus Physician, Oxford

letters TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by email to: Clinicalmedicine@rcplondon.ac.uk.

The 2001 guidelines on cardiopulmonary resuscitation

Editor – The 2001 guidelines on cardiopulmonary resuscitation (CPR) emphasise patient participation in the CPR decision-making process.[1] However, two recent articles in your Journal highlight the difficulties in doing so (*Clin Med* July/August 2004 pp 424–6; *Clin Med* July/August 2004 pp 471–2). Over the past five years several studies have shown similar trends, thus exposing the huge gulf between the guidelines and common medical practice. On one hand, the medical profession has been vocal in their disapproval of these guidelines[2] and on the other, patients have shown no enthusiasm for discussing these issues.[3] Even the national press has admitted their ignorance on the subject by linking euthanasia to the 'do not resuscitate' order.[4]

The time has come for policy-makers to listen to the profession and revisit guidelines on cardiopulmonary resuscitation. Emphasis should not only be on political correctness, but also on practicality and improving patient care. Ambiguity surrounding existing guidelines should be rectified by clearly stating that patient engagement in discussing CPR should be at the discretion of the medical team. Models of engaging patients, where appropriate, in end-of-life issues must be an integral part of any revised guidelines.

Policy-makers have the responsibility to present a clear and balanced view, which increases the patient's confidence in the system and is acceptable to doctors and nurses who provide front line care. Failure to do so will harm the very heart of patient care, which these guidelines are intended for.

References

1 British Medical Association, Resuscitation Council (UK), Royal