

The assumption that morality is rooted in the functioning of the stand-alone brain, itself shaped by genes that are concerned only to ensure their own survival, raises difficult questions about how we should judge psychopaths and others whose behaviour causes suffering. Many of these questions arise precisely because of a determinism that is fostered by genetic and/or neural and/or evolutionary accounts or morality. Michael Penn and his co-authors develop a twin track approach to understanding individuals who have ethical disability: they invoke an aetiology that combines dysfunction in neurobiological processes necessary for an adequate perception of the mechanism of reward and punishment and experiences with injustice. While they relate anti-social behaviour to neurally based insensitivity to the normal facilitatory and inhibitory stimuli of traditional upbringing, in the case of individuals brought up in many inner-city and poor rural communities, they also suggest that 'the loss of hope has resulted in the eclipse of fear' – the fear of disgrace, punishment or pain that would normally give pause to someone about to commit a felony. This sounds both plausible and is a long way from neutralisation, genetic determinism or the 'Darwinitis' that I had anticipated from the title of this book.

The history of attempts to naturalise morality has not been a happy one for the fundamental reason that morality is normative and natural processes are not. Nature is about what happens and not about what ought to happen or ought to be made to happen. Evolutionary theory, as we have noted, may be able to explain patterns of behaviour that are altruistic and why (as Sean Spence argues) truth telling is the default state of the human mind, but it does not really cross the boundary between the 'is' of nature and the 'ought' that lies at the heart of human life. An adaptive pattern of behaviour is not the same as conformity to a moral principle. Principles are explicit. They are acknowledged, assented to, embraced. We deliberately respect or flout them.

Human beings are the only items in nature that appeal to the better nature of others. (And it is interesting in this respect that no other creature teaches its young, except incidentally by example.) Morality is articulated, inculcated, argued over, contested, defended and so on. Its principles have been forged at a great distance from nature, within the spaces that are made available by power relationships, by institutions, by the law and by world-pictures, religious and secular. The laws of the land, unlike the biological and physical laws that operate in the soil, are formulated in the collective and individual self-consciousness of human beings. The self-consciousness of human beings, what is more, has a temporal depth for which there is no evidence in other animals. We feel bound by our past promises (it was not for nothing that Nietzsche described man as 'the promising animal') and we draw on our remembered past and imagined future to give the sense of identity and of the meaning of our lives which both underpin and are reinforced by behaviour we regard as moral. Our explicit obligations make sense of our lives and our lives make sense of our obligations.

The science of morality is beautifully written and commendably succinct. Walker is either a brilliant editor or very lucky in his contributors or, as I suspect, both. I argued with this book from beginning to end. More significantly, it has left me arguing with myself about whether the increasingly sophisticated biosciences of

the human body bring us any closer to a science of human morality and whether we can close the gap between physical laws and ethical principles.

RAYMOND TALLIS
Emeritus Professor of Geriatric Medicine
University of Manchester

Prof: The life of Sheila Sherlock
'The liver queen'

By Om P Sharma. Royal College of Physicians, London
2007. 228 pp. £20.00.

To a generation of physicians Sheila Sherlock was an icon – the pioneer of liver disease as a clinical discipline, a polymath in its intricacies, and a formidable presence at any national or international hepatology meeting. Few, particularly at the sharp end of one of her comments at such a meeting, would have paused to wonder how and why she developed to such a towering figure.

Om Sharma, a family friend and professor of medicine at the University of Southern California, tackles this question in a wide-ranging, discursive and pretty idiosyncratic fashion. He weaves the various strands of personal and professional life into a backdrop of social history. We actually go back to Becket blood (St Thomas à Becket that is) as a forebear – naturally on the female side. And it is from the female side that – to the amateur psychologist – the fascinating background to Sherlock's personality and drive begins to emerge. Central to that is the story of her own mother's drive, both before and after marriage, coupled with the account of Sheila's father, a would-be cavalry officer drafted to Ireland in 1916 at the time of the Easter Rising, and subsequently an absent and unforgiven parent. Genes from the female side and the environmental struggles in a one-parent-family must have made a potent contribution.

And then there was the state of medical education in the late 1930s. English medical schools turned down her applications, leaving Sherlock to become Edinburgh's top graduate; but apparently the Scottish system could not stomach the prospect of offering academic training to a woman. The story of her rescue by some of her mentors, and by the Hammersmith Hospital, her pioneering investigations into liver disease, and her investigative zeal are well covered, as are the ethical controversy that her invasive tests and research-driven biopsies raised.

Sharma researched this book in a very personal way, with extensive interviews with friends and colleagues. Sheila's career achievements and honours are obviously well documented, but Sharma's approach also warmly documents her friendships with other clinical researchers, her devotion to her trainees, and the curious combination of private warmth with a formidable external persona probably developed as a carapace for shyness. There is of course also the story of her family life – as well as the love story – essentially in her husband's words. There is probably scope for a book on consorts, and Gerry James, together with Prince Albert, Denis Thatcher, and in the future possibly Bill Clinton – would fit into it aptly.

Could anyone develop such a career now? It's an interesting question at a time of work-life balance, performance indicators, and, in UK universities, some fairly rigid criteria for success. Sharma's book demonstrates that Sheila's opportunity arose against

the background of society's evolution in the 20th century – the most rapid period of social change in recorded history. Many things combined to provide the opportunity for Sheila Sherlock's success – the rise of academic medicine as a discipline in the US and its importation into the UK, and the opening of a new clinical discipline with fertile opportunities for innovation. The book's value, however, is the insight it gives into the personality who was 'Prof', how she responded to those opportunities, and how that personality and her success developed against the 20th century tapestry. Who should read it? Today – anyone whose path crossed Sheila's; in the future – social historians with an eye to the original.

HUMPHREY HODGSON

*Sheila Sherlock Chair of Medicine
Royal Free and University College School of Medicine*

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 sent by e-mail to: Clinicalmedicine@rcplondon.ac.uk

Inhaled insulin

Editor – my editorial on inhaled insulin was published almost the very day that Pfizer announced the withdrawal of Exubera[®] because of its failure to achieve sales targets (*Clin Med* October 2007 pp 430–2). As my paper should show, I have reservations about the usefulness of Exubera.[®] The concept of an injection-free insulin regimen has, however, attracted patients with diabetes and the professionals who support them for decades and it is sad that the first clinically effective non-injectable should have had such a very short existence in the market.

The message conveyed by the withdrawal of a novel and effective (whatever its problems, Exubera[®] certainly works as an insulin!) agent so soon after its release because it did not receive enough of the market share in the time available is enormously worrying. The imperative for industry to make major financial gains on new developments within a short time of their release runs totally counter to the dictates of good medical practice, which demand that a new agent, with its inevitable high cost and lack of long-term safety data, should initially only be used in patients in whom the conventional agent is failing in some way – in terms of efficacy, patient acceptability or side effects – with slow replacement of older agents as and if it proves its clinical worth. The conflict between the needs of industry to recoup drug development costs and to provide returns for their investors and good medical practice need to be reconciled. Only a change in the way the market operates can achieve this. Unless we can change the way industry funds its drug development programmes, however, potentially valuable agents will either never see the light of day or be lost to us shortly after their release.

STEPHANIE A AMIEL

*RD Lawrence Professor of Diabetic Medicine
King's College London*

Deep vein thromboprophylaxis in medically ill patients: poor compliance and limitations of guidelines

Editor – We could not agree more with Butt *et al's* recommendations on thromboprophylaxis for deep vein thrombosis (DVT) in acutely ill medical patients in the hospital (*Clin Med* August 2007 pp 418–9). Hospitalised patients account for about 25% of the cases of DVT with more than half of these patients being medically ill.¹ We also found a similarly poor rate of compliance in assessment and prophylactic treatment for DVT in an audit carried out at Maidstone Hospital, a district general hospital in Kent. This audit was done to assess practice following an unfortunate fatal pulmonary embolism (PE) in a 27-year-old female patient with immobility of seven days duration secondary to a psychogenic paraparesis. She had no other medical illness, had no history of DVT/PE and was not on an oral contraceptive pill.

We collected data from the case notes and drug charts of 100 acutely ill medical patients and stratified the DVT risk for each patient according to Thromboembolic Risk Factors (THRIFT) consensus group guidelines (Table 1).² The majority of patients belonged to the moderate-risk category (91%). Only four patients were in the low-risk category. Of the 96 patients in the mod-