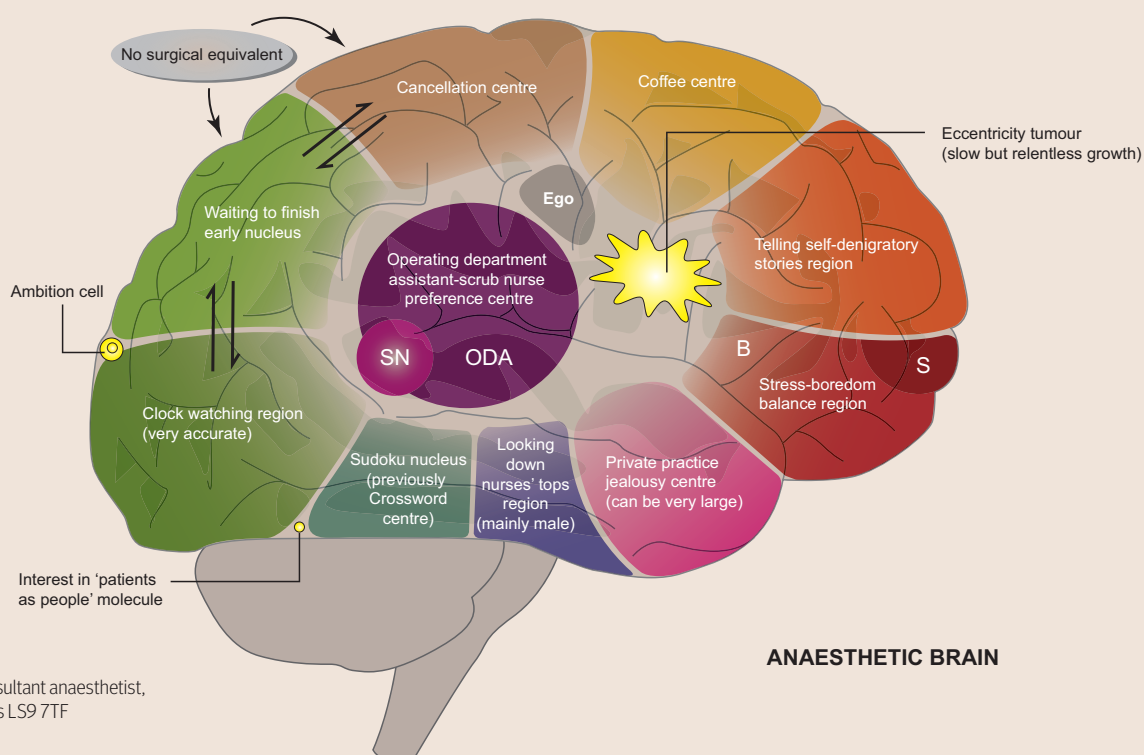
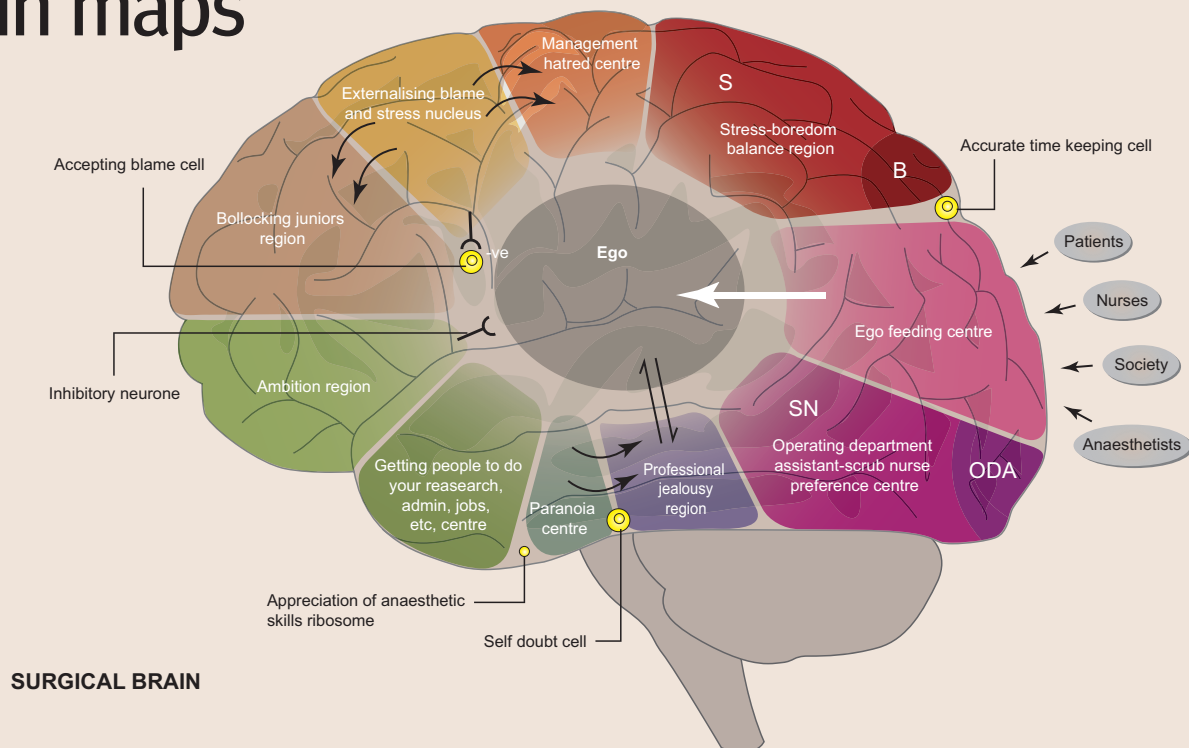


PROFESSIONAL MATTERS

Brain maps



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Provenance and peer review: Not commissioned;
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Wards of the roses

With increasing numbers of hospitals banning bedside flowers from wards, **Giskin Day** and **Naiome Carter** investigate the pros and cons of floral bouquets

Cut flowers form an important part of rituals surrounding celebration and consolation in a variety of cultures. Blooms are brought to the bedsides of the sick as tokens of care, but concerns about infection control have caused many hospital wards in the UK to ban, or at least discourage, bedside bouquets. Is this anxiety justified? What do patients feel about flower policies? We talked to patients and staff at the Royal Brompton Hospital and the Chelsea and Westminster Hospital about their attitudes to flowers.

Stemming infection?

Most hospitals have longstanding and uncontroversial policies of not permitting flowers in high dependency units. Press reports of flowers also being banned from general wards started appearing in 1996, when an Aberdeen hospital introduced a “no flowers” policy on an orthopaedic ward.¹

The impetus behind the trend was that hospitals needed to show they were taking hospital acquired infections seriously. Banning flowers was a visible sign that bedside protocols were being revised. Hospitals tended to justify their actions by claiming that flower water harboured potentially deadly bacteria. Indeed, a 1973

study had found that flower water contained high counts of bacteria.² However, subsequent research found that there was no evidence that flower water has ever caused hospital acquired infection,³ and the authors of one study concluded, “Banning flowers is not popular with the public and is unnecessary according to the evidence available.”⁴ Yet hospitals continue to introduce “no flower” policies, in spite of the Department of Health acknowledging in 2007 that it was “not aware of any instance of health care associated infection being traced to cut flowers in the hospital ward setting.”⁵

Other negative effects have been ascribed to hospital flowers. In the late 1900s it was common to remove flowers from bedsides at night as there was a widespread belief that the blooms competed for patients’ oxygen. But this was dismissed as a myth when studies showed that the impact of flowers on air composition in wards was negligible and did not justify the labour involved in moving flowers to and fro.⁶

A blooming nuisance

Hospitals introducing “no flower” policies have met with local resistance. Recently Southend University Hospital imposed a blanket ban on flowers, in spite of intense lobbying from the local press and a campaign by James Dudridge, the MP for Rochford and Southend West. The hospital claimed its own survey found that patients supported the policy, on the grounds that flowers posed a health and safety risk because of high tech medical equipment around bedsides.⁷ However, as Humphreys points out, “Accidents arising from spilled water or broken vases are just as likely to occur with crockery containing drinks or food as with vases or jugs containing fresh flowers.”⁸

A study by Gould et al found that 80% of 39 nurses interviewed from a wide range of clinical settings were not in favour of flowers. They found some evidence that this attitude was related to the amount of work generated, with infection and other risks used to justify it.⁹ Indeed, interviews we conducted with staff at the Royal Brompton Hospital and the Chelsea and Westminster Hospital confirmed that

staff were more concerned about the practical implications of managing flowers than risks of infection.

At the Chelsea and Westminster, senior staff nurse May Wesley said, “I love flowers myself, but they can be a hazard at the bedside.” She told us that the biggest problem was curtains catching on vases, sending them crashing to the ground in a shower of water and glass. “We’re lucky to have wide windowsills though, where flowers can be appreciated by everyone on the ward rather than having them on bedside lockers where they get in the way.”

At the Royal Brompton Hospital, charge nurse Dermot Richards-Scully is adamantly opposed to the floral offerings of visitors. “I hate them,” he says. “My staff don’t have time to change stagnant water; spillage is responsible for slips, trips, and falls; and they cause hay fever.” If visitors turn up with an armful of flowers, Richards-Scully politely asks them to take their flowers home. “The trust guidance specifies that flowers should be avoided in critical care areas, but we have wounds on our wards as well.”

Procedures for dealing with flowers tend to vary from ward to ward. Some wards we visited had a cupboard full of vases, usually donated by patients. Often healthcare assistants were responsible for flower maintenance. Occasionally wards were fortunate to have hospital volunteers who helped with changing water, although these arrangements were often ad hoc. Other wards made no provision for flowers, and some patients resorted to using their water jugs as vases.

Good flower guide

Check that a particular ward accepts flowers before you send them

If you are a regular visitor, take responsibility for changing the water

If a friend is in hospital for a short stay, have the flowers sent to his or her home, as carrying and transporting bouquets can be an added complication to leaving hospital

Bouquets are more likely to be accepted if they are

- Not too big and unwieldy
- Arranged in florists’ foam rather than in a glass vase or in no vase at all
- On a firm base that is unlikely to tip over
- Composed of flowers that do not shed pollen
- Not too heavily scented





JOHN SHELLEY

Brightening effect

On private wards, staff tended to be more receptive to flowers. Sister Susan Bunce, in charge of the Sir Reginald Wilson ward at the Royal Brompton Hospital, said, "We welcome flowers in patients' rooms, as long as there are not too many, and they are not too smelly." Unlike the other wards we encountered, here it was part of the cleaners' jobs to change the water. "Maintaining flowers doesn't take up any nursing time, and they have a positive effect on the patients," says Sister Bunce. "Patients here have the luxury of space so flowers rarely get in the way."

We visited Mandana Tew, who was recovering from open heart surgery. At her bedside were some African violets and bright begonias. She invited us to take a peek into her bathroom, and there, floating in the bath, were more than a dozen long stemmed, apricot coloured roses. "I keep them in a cool bath during the day, and they stay fresh," she explained. A keen gardener, Mrs Tew is enthusiastic about the effects her flowers have had on maintaining a cheerful atmosphere: "My flowers smile at me and make me feel better."

Certainly, Mrs Tew and many other patients smile back at their flowers. Haviland-Jones et al found that flowers presented to women always elicited the Duchenne or true smile (which requires zygomatic muscle activity as well as orbicularis oris movement) and reports of positive moods three days later.¹⁰ Another study used a randomised clinical trial of 90 patients to measure therapeutic effects of plants. Patients in hospital rooms with plants and flowers needed

significantly fewer postoperative analgesics; had reduced systolic blood pressure and heart rate; lower ratings of pain, anxiety, and fatigue; and had more positive feelings than patients in the control group.¹¹

Men are usually the givers rather than the receivers of flowers, but sometimes a stay in hospital is a good excuse to reciprocate. Haviland-Jones et al found that flowers have immediate and long term effects on emotional reactions, mood, social behaviours, and memory for men and women alike.¹⁰ Robert Orbach at the Chelsea and Westminster Hospital, recovering from knee surgery, was delighted to receive two bouquets of chrysanthemums. "I'm a romantic at heart," he said, "and I like to give flowers, so it is very nice to receive them." He felt they had enhanced his experience of his hospital stay.

Making arrangements

Florists need to be aware of the practical implications of providing flowers for patients. Theresa Johansson, florist at the Flower Stand in Chelsea, often provides bouquets for visitors to the several hospitals that are within walking distance of her stall. "People tend to ask for bright and cheerful arrangements," she says. "Sunflowers, gerberas, and dahlias are always popular." Although many of the Victorian superstitions are no longer widely observed—for example, that bouquets of red and white

flowers on the wards foretold death—Theresa told us that lilies tend to be avoided for their funereal connotations, "and it is also not advisable to give bouquets that are too large or that include flowers that shed lots of pollen."

Patricia Law, a GP and keen gardener, feels that choosing flowers is a very personal process: "When I cut flowers from my garden to give to a friend, I try to match the flowers to the person. When someone is critically ill, it's often hard to know what to say. By giving them flowers or a cutting from your garden, you are letting them know that you are thinking of them." Dr Law points out that flowers take us back to our elemental connections with nature. This can be comforting in a hospital environment in which we are inevitably reminded of our own mortality.

Flowers and herbs have been used as remedies in the earliest hospitals, and as a means of cheering up the hospital environment for at least 200 years. It seems remarkable that flowers still tend to be treated in an ad hoc fashion in hospitals. The

Flowers have immediate and long term effects on emotional reactions, mood, social behaviours, and memory for men and women alike

design and arrangement of most wards make little or no provision for flowers. Surely bedside lockers could

be better designed to hold vases in such a way as to prevent spillages? Hospital art programmes have done a great deal to transform corridors and waiting areas, but wards tend to remain frenetic environments for staff, but passive and monotonous ones for patients. Although flowers undoubtedly can be a time consuming nuisance, the giving and receiving of flowers is a culturally important transaction. Hospitals are humane places, and, as John Ruskin said, "Flowers seem intended for the solace of ordinary humanity."¹²

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See EDITORIAL, p 1388

Selling patients

The way hospital departments “sell” patients to each other has been parodied but seldom studied. **Peter Nugus, Jackie Bridges,** and **Jeffrey Braithwaite** explore the rules of the game

“Since...gomers [Get Out of My Emergency Room] don’t die...the term [intern] had to find other ways to turf them...The problem with the turf was that the patient might bounce, i.e. get turfed back...The secret of the professional turf that did not bounce, said the Fatman [a supervising Resident], was the buff... ‘Because you gotta always remember: you’re not the only one trying to turf. Every term and resident in the House of God is lying awake at night thinking how to buff and turf these gomers somewhere else.’”

“[That doctor’s] so scared of missing something by sending the patient back home that he admits them all. He’s a sieve... he lets everyone through...Be a wall. Don’t let anyone in.’...A mind-boggling thought: the delivery of medical care consisted of buffing and turfing the seeker of care to somewhere else. The revolving door with that eternally revolving door always waiting in the end.”¹

Introduction

Everyone’s got something to sell. Retailers sell products. Workers sell their labour and skills. Everyone sells their status and knowledge; academics and clinicians are prone to this.

Emergency clinicians sell patients. Why? Emergency departments the world over are under pressure to diagnose and treat patients efficiently, and move them on as quickly as possible.² There are always new patients arriving in the queue. Who’s the buyer? The rest of the hospital. In the UK, in particular, GPs package patients for the hospital, too.

The novel *House of God* by Samuel Shem¹ satirises the games and strategies that characterise the transfer of patients. With similar irony, Innes³ wrote about “Successful hospitalisation of patients with no discernible pathology.” Innes prescribed 11 “admission techniques” variously appropriate depending on the particular type of “difficult consultant”

encountered.

So, the concept of selling patients has been parodied. Studies have examined case shaping for organisational relevance⁴⁻⁶; patient disposals⁷; interdepartmental identity and communication⁸; mutual alignment of goals in referring patients⁹; and how consumers communicate emergencies.¹⁰ We wondered why the game of selling to, from, or within the hospital had not been seriously studied.

Methods

The way to understand behaviours as they happen is to observe them and the people who enact them.¹¹⁻¹³ This study draws on observations and interviews in two tertiary referral hospitals in Sydney, Australia, from a larger study examining the organisational work of emergency clinicians. We examined interactions between and within departments, drawing on structured observations and staff experiences derived from 28 semi-structured interviews that were audio-recorded and transcribed. Nurses and doctors from the emergency departments and four inpatient departments across the two hospitals were interviewed. Observations included accompanying junior, mid ranked, and senior emergency doctors and emergency nurses for a full shift each in each emergency department, comprising 24 full shifts and about 110 hours of structured observation, generating approximately 800 pages of field notes (box).

Data were categorised in an inductive, grounded process,¹⁴ in which themes were compared and contrasted in a series of cycles to produce interpretations.^{15 16} The core analytical codes of “selling” or “mutual persuasion” were distilled, and exemplified below.

Findings

Telling and selling

Selling emergency patients involves sorting



them into categories appropriate for potential inpatient admission. Patients admitted to the hospital are ultimately transferred to a specialty ward in the hospital if they require more than 24 hours in hospital. To transfer the medical care of the patient out of the emergency department, emergency doctors need to persuade an inpatient medical or surgical team to admit the patient formally under the care of their department. In the following excerpt a registrar, an intern, and a nursing unit manager (team Coordinator, TC) discuss which inpatient team to approach for review, telling, and selling:

Reg [registrar]: “What’s her age?” Intern: “72. How old does she have to be to go to gerries [geriatrics]?” (looking it up in a booklet). TC: “It’s a bit soft. You mightn’t sell them.” Reg: “Gastro’d [gastroenterology] be even better” (JDB: 18).¹

This exchange demonstrates that one of the roles of emergency clinicians is to decide, from a range of specialty teams and departments, where and under whose care to transfer the patient. They have to figure out who is most likely to consummate the deal and purchase the product.

The centrality of this activity was inadvertently demonstrated to the first author



Game playing and strategies to sell things to others are ubiquitous human phenomena. There are elaborate clinical and organisational pressures on clinicians to discharge or transfer patients

ROB WHITE

by an emergency registrar:

Emergency registrar (*to researcher*):

"Are you a med reg [medical registrar]?"

Researcher: "No, I'm not." Registrar: "Oh well, I won't try and sell you a patient"

(SDA2: 30).

Another registrar noted to the observing researcher that "the GP patients were well packaged today" (MDB1: 37). This meant that the patients sent to the emergency department by GPs were presented using a clear and well crafted narrative of the symptoms and potential for inpatient admission. Packaging emergency department patients involves recognition of the need to advertise patients and market them to inpatient teams.

A medical ward round in one of the emergency departments typically focused on inpatient admissions. A resident, referring to a particular inpatient service, said: "[They're] a bit of a wall." An emergency staff specialist responded: "Good luck." Other doctors laughed. In a field interview after the shift the registrar, citing terms from *House of God*, explained that a "wall" asks a lot of questions and is reluctant to admit patients even when the relevance of the condition to their speciality is "obvious." She believed that "sieves" were very rare (MDA2: 42). Similarly, an inpatient registrar was in the emergency department, asking other registrars from other inpatient

teams to review his patients:

Inpatient registrar: "I'm selling a lot of patients."

Emergency staff specialist:

"Number two's getting a lot better." Inpatient

registrar: "That's good. Hopefully by the

time I get to him he'll be ready to go home"

... Emergency registrar (chuckles): "[You're] turfing to [each other]!" (MDB1: 26).

Teaching the new sales force

The need to progress patients' journeys makes patient marketing an inherent part of emergency department work, and part of the craft of emergency medicine. Emergency interns often have difficulty persuading inpatient team doctors to become involved in the care of emergency department patients. They often fail to appeal to the organ-specific requirements of doctors representing particular inpatient teams. Frequently, interns described at length the history of the patient, which did not provoke a commitment from the inpatient registrar to become engaged in the sale.

There are hard lessons to be learnt in fulfilling the needs of inpatient teams. Selling patients usually requires minimising and maximising various aspects of the case to target a particular medical or surgical speciality. The excerpt below involved a call made by an emergency intern to an after-hours medical registrar. The intern's supervising consultant listened eagerly. The

responses of the registrar and the consultant epitomised the technique of persuasion that emergency doctors are required to learn:

Intern *to researcher*: "I'll ring the med reg [medical registrar]". Phoned: "Hi, it's 'Trudy' here from emergency. I have a patient that needs admitting...He's got a history of acute appendicitis [Consultant behind—looks exasperated]...OK. Bye." [Consultant]: "What did he say?" Intern: "He said call the surg reg." [Consultant]: "Of course he did. You don't tell him he's got a history of appendicitis. That's an easy bounce straight to surgery" (FNA: 185).

The emergency specialist was explicitly teaching the intern to package the patient into an acceptable category to suit the particular sub-specialty. The game was to use marketing techniques on those whom they wished to persuade.

Discerning customers

The responses of receiving doctors combined resistance and on-selling. An after-hours medical registrar explained to the observing researcher his expectations as a receiving doctor:

"Emergency doctors have one of two philosophies: the 'us versus them' philosophy and the 'you need to help

us because you provide specialty care' philosophy. The first one never works. That's when emergency doctors say, basically, 'You must take the patient.' The second approach is to say: 'Here's the evidence.' Selling is the proper way—not demanding. The burden of proof is on emergency. They have to prove that the patient is worthy of your care. They have to 'buff' the patient [another *House of God* metaphor] to make it look good. I've been told they lie in this [emergency department]. I've never experienced that, but I have had [the message] distorted inadvertently...It's normal to expect intervention but please do it properly... Give good info and give the right info that adds up to my specialty...You can't cry wolf" (TCB2: 24-7).

A cardiology registrar, in a field interview, explained the apparent reluctance of receiving doctors to become involved:

"We're overloaded. I mean, I'm a human being...We're just so...short of time what are you going to do? An older person with a heart problem?...You try not to come down unless you're convinced there's a good chance it's one of ours...A young person with a heart problem—now that's interesting! I'm just being honest" (Cardiology registrar, Interview 81).

An aged care registrar acknowledged that they were sometimes in a similar position to emergency doctors. After criticising emergency doctors the registrar said:

"But you know I do the same thing. When I ring [the consultant in charge] in the morning after a night shift, or when I ring the boss on an evening shift, if I said that they've got a primarily respiratory problem, I'll tell them a primarily respiratory story and then if they've got other problems as well you sort of downplay the other problems and tell them the respiratory problems. Everyone does it" (Aged care registrar, Interview 21).

That everyone does it suggests that marketing and packaging patients might be a dimension to clinical care that needs to be taken seriously. But it's not in any undergraduate or postgraduate teaching programme of which we are aware.

Discussion and conclusion

Selling patients—packaging and marketing them—is an under recognised component of clinical work. Is this life imitating art or art imitating life? Shem, a psychiatrist, parodied much about the lot of young doctors. As

How excerpts are coded

Interview and observational field note excerpts are coded according to the primary participant being observed or recorded, whether a senior doctor (staff specialist) (SD), junior doctor (intern) (JD), team coordinator (nursing unit manager) (TC) or senior nurse (SN). FN signifies general field notes observed in unstructured observations. References also indicate whether the data were derived from Hospital A or Hospital B, which of the first or second shifts contributed the data in the case of structured observations, and the page number of the original field notes in which those particular data were recorded. For instance, "SNB2: 21" indicates that the excerpt of evidence was taken from page 21 of the field notes recorded during the second shift of the senior nurse of Hospital B. Names of participants have been changed to protect their identities.

satire, his book trades on exaggeration. Our study shows that selling does occur, and that concepts about marketing and knowing the rules of "the game" are integral to clinical work.

Game playing and strategies to sell things to others are ubiquitous human phenomena. There are elaborate clinical and organisational pressures on clinicians to discharge or transfer patients, such as the "four hour rule" in the UK.¹⁷ Clearly, the policy and organisational environments influence clinical practice. Selling may be widespread, including GPs selling patients to hospitals. Undoubtedly, they are mediated by knowledge, skills, seniority, experience, and interpersonal relationships.

Different hospital departments provide specialised services. It might not be a bad thing for clinicians to defend the boundaries of their department and put their interdepartmental colleagues to the test to see that patient transfers are appropriate. Selling strategies by well intentioned doctors might work well most of the time, because they are designed to ensure that patients receive the right care from the most relevant team at the right time.

Some patients might be transferred on the basis of quality of selling rather than patient need. How will we know? Bringing the politics of patient journeys to the surface might engender clarity, as might fair bargaining practices.¹⁸ The rules should be out in the open.¹⁹ One troublesome thing is that such skills are learned on the job rather than explicitly taught, with the benefits of business school research. Might we be only half jesting when we ask if there is a place for teaching *Selling, Marketing and Packaging 101* to future emergency department physicians and GPs, and *Negotiating, Resisting, and Reselling 101* to everyone else?

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Contributors: PN, a sociologist of health care, conducted his PhD research on the organisational work of emergency department clinicians from which this paper was produced. JB is a registered nurse and has considerable experience in researching emergency departments and the impact of organisational processes on patient care. JB is an international leader in health services research, and in researching and publishing on health institutional structures and processes. He also supervised PN's PhD. All three authors were involved in the design, planning, and writing of the paper. PN is the guarantor.

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H-index pathology

The h-index has quickly become the standard method by which medical schools judge the impact of medical researchers. **Rob Horne, Keith Petrie, and Simon Wessely** describe a cluster of potentially pathological behaviours associated with the index

In 2005 Jorge Hirsch proposed the h-index as a means of measuring the productivity and impact of a researcher.¹ A researcher's h-index is determined by the highest number of papers they have published to receive at least that many citations (figure). So a scientist with an h-index of 40 has written 40 papers that have received at least 40 citations. The h-index can be obtained through the subscription databases of Web of Science and Scopus,¹ or through using Publish or Perish software, which is based on the Google Scholar database, enabling brave (or reckless) authors to check their own h-index.

Although the h-index is not without its drawbacks, it has quickly become the standard measure by which medical schools judge the value of academic staff.² The process of observing or assessing performance can influence behaviour and the h-index is no exception. The increasing importance of citation rate as an index of success has led to an increase in self citation (where the author's earlier work is cited in their new publication).³ We have also noted the emergence of a range of socially undesirable behaviours associated with the h-index. We outline the behaviours and discuss their implications for medical researchers and practitioners.

H-index behaviours

Home-ophobia—Irrational hatred of people with similar names who may dilute or diminish your h-index. The name of this syndrome derives from the fact that having a less h-endowed namesake also reduces the likelihood of a Google search revealing the subject's personal home page at the top of the search result. The fear of h-index dilution, coupled with home page obscurity within the Google search, creates the state of home-ophobia. Particularly prevalent among academics named Smith, Jones, Cohen, and Patel.

H-bomb—Where disclosure or discovery of an individual's h-index has an immediate,

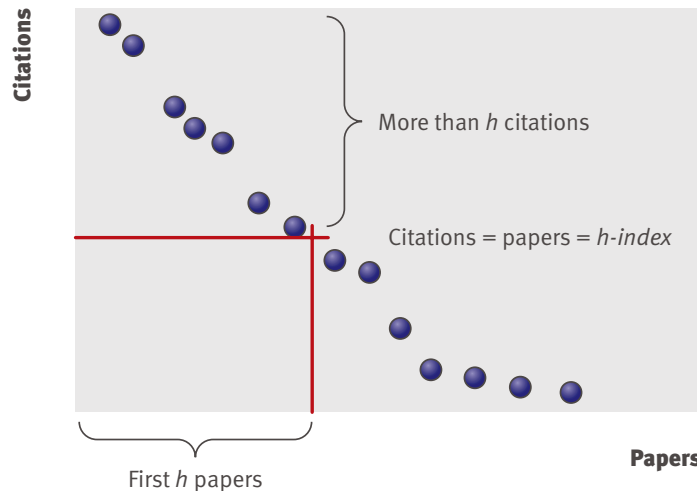


Illustration of h-index calculation

catastrophic effect on career aspirations, professional standing, and sense of self. Often manifested in the short term by an explosive venting of emotion, sometimes accompanied by fainting (H-ysteria) followed by chronic psychosomatic illness (post traumHatic stress disorder), and occasionally by psychHosis (see below).

PsychHosis—A delusional state in which the sufferer perceives their h-index to be much higher than it really is and behaves accordingly (for example, with understated academic swagger).

Retaining a dignified aloofness to the h-index is difficult for those with scores of less than 30

Sometimes linked to a failure to appreciate the influence of having a common surname, it is, in this respect, the reverse of home-ophobia. Unlike home-ophobia, psychHosis can also affect people with uncommon surnames, who can succumb to the delusional belief that they have authored a *Nature* paper.⁴

One h-manship—Surrounding oneself with individuals with a lower h-index in order to boost self esteem. This may involve attending meetings which would ordinarily be avoided,

such as seminars in cultural studies and general practice conferences.

h-indexism—Appointing people to academic positions based on their h-index rather than the traditional factors of appearance, high school attended, or whether they are Chelsea Football Club season ticket holders.

h-Cite—Self citation of a paper based solely on the fact that more citations of this particular paper will raise the author's h-index.⁵⁻⁷ This should not be confused with general self citation³ where any one of an author's papers is shamelessly referred to in the author's own article.^{8,9}

HAART (highly articulate angry response to teaching)—Reaction exhibited when, on the basis of a low h-index, the academic is "invited" by the head of department to make the provision of undergraduate teaching his or her "core mission." Not to be confused with highly active antiretroviral therapy.¹⁰

Dropping your h's—Letting one's h-index slip in social company in order to boost social standing. Sometimes causing arguments with *h-eretics* who question the validity of the index. For those with a low h-index, this can take the form of a *h-istory* (story fabricated to explain a low h-score).

Comment

We believe that the cluster of behaviours described here has implications for medical researchers and practitioners. An awareness of the existence of these behaviours in others may help medical researchers to avoid any h-index linked professional embarrassment. However, retaining a dignified aloofness to the h-index is difficult for those with scores of less than 30. For this reason, researchers may also wish to increase their h-index as quickly as possible by publishing innovative work or through cunning self citation.¹¹

There are also implications for medical practitioners. Beliefs¹² and behaviour¹³ can influence health and we anticipate that general

Researchers may wish to increase their h-index as quickly as possible by publishing innovative work or through cunning self citation

and specialist physicians will see a large increase in the incidence of h-index related presentations, perhaps taking on new psychosomatic forms like those discussed above.¹⁴ Some cases may be managed by education¹⁵ and cognitive behaviour therapy¹⁶ but many will require medication.¹⁷ Prescribing creates a further challenge because many h-index patients will not perceive themselves to be ill, and consequently doubt that they need medication, leading to nonadherence.¹⁸ Moreover, being academics, they are likely to be dissatisfied with standard information¹⁹ demanding more detailed explanations and discussion about the condition and treatment.

There are also important considerations for medicine as an academic discipline. The h-index is typically calculated for an individual. However, it can also be applied to groups of researchers.^{20,21} It could, in future, be applied to compare the research contribution of medical specialties in a medical school or of medical schools in universities with implications for the wellbeing of deans and editors of medical journals.

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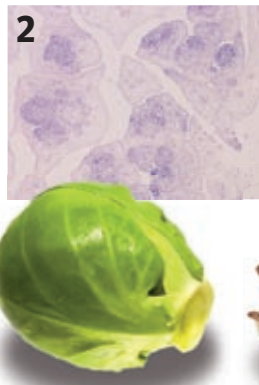
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Christmas quiz: Answers The five figures combined show Christmas lunch.



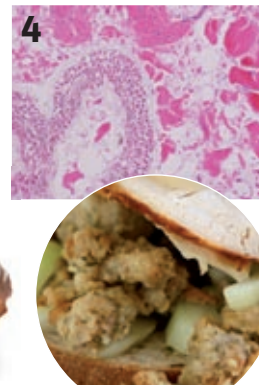
Macroscopic: Two legs, two wings, weight 3 kg
Microscopic: Abundant skeletal muscle fibres with their peripherally placed nuclei
Diagnosis: Christmas turkey
Comment: Ice crystal artefact reveals author as a user of frozen turkey



Macroscopic: A multilayered green, oval lump with a distinctive aroma
Microscopic: A complex swirling arrangement of vegetable matter is seen
Diagnosis: Brussels sprout



Macroscopic: Cup shaped tan material 7x7x5 cm; crispy outer texture, soft inside; a liquid brown substance on the surface
Microscopic: Amorphous material with alveolar-type spaces
Diagnosis: Yorkshire pudding



Macroscopic: Multiple rounded balls of tan material with a varied texture
Microscopic: A complex intermixture of vegetable matter, skeletal muscle, and fat
Diagnosis: Stuffing



Macroscopic: An elongated, tan coloured cylinder wrapped in dark red material.
Microscopic: Two distinctive adjacent areas, with skeletal muscle surrounding amorphous material
Diagnosis: Sausage in bacon
Comment: Note the complete absence of muscle fibres from the sausage compared with the bacon.

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Evidence based merriment

Medical humour has a long history, but is short on evidence, say **David Isaacs and colleagues**

The ancient Greeks introduced the world to bodily fluids called the four humours. You would think that a philosophy based on blood, choler, phlegm, and melancholy was no laughing matter.

What is the evidence that medical humour benefits staff or patients? We performed a systematic revue, but it was not funny. We propose a randomised controlled trial of medical humour.

Pilot study

The Royal Flying Doctor Service funded a pilot study. Hospital staff completed a standardised questionnaire about the role of humour in their department.

The department of surgery expressed an interest in side-splitting jokes.

The ophthalmology department insisted that all patients should have a slit lamp examination for aqueous and vitreous humour.

The gastroenterology department wanted to ban sick jokes and toilet humour.

The allergy department warned of the hazards of severe joke allergy. At least one child has suffered a severe allergic reaction to a shaggy dog story, while cat allergy predisposes to cataplexy. However, the most feared condition is anaphylaxis to puns, which can only be treated with outrageously expensive adrenaline syringes, called Epipuns. The State Department of Allergy and Over-reaction has recommended that all children with pun anaphylaxis carry Epipuns and that jokes are banned from nursery schools. The child must also bring to school a letter from their parents guaranteeing that they have not been told any jokes at home in the last 24 hours.

The hospital administration warned that black humour contravenes health department policy on racial discrimination and punchlines are forbidden under department guidelines on bullying in the workplace.

Study design

Doctors will be randomised to an intervention group who will tell random jokes to children on the paediatric wards or a self control group who will be asked to save their jokes for their own long suffering children at home. Here is a random joke. "Two cannibals ate a clown doctor. One cannibal asked the other, did that taste funny to you?"

The responses of joke recipients will be screened. Their facial contours will be exam-



ined for increases in creases. Mirth will be measured in grins per milli-titter, gigglebytes, or smiles per hour. Belly laughs are expressed in units called Hertz. Laughter delayed for greater than 30 seconds is not classified as humour. He who laughs last, thinks slowest.

Statistics

The data will be massaged and tickled and subjected to a Student's *t*-hee test with a funnel plot to see if the jokes come out funnely.

Ethics approval

The proposed trial will be submitted to the Institutional Ethics and Deforestation Committee, which requires 47 double spaced, single sided copies of the trial protocol. The protocol must be on the ethics committee application form, which can be completed in less than a month by anyone with an IQ over 130 and

advanced degrees in information technology and communication.

The ethics form needs to be countersigned by the Head of Department, the Head of Department's Head of Clinical Stream, the Clinical Superintendent, the Chief Executive Officer and the Minister for Health.

Conclusion

We call for a randomised fairly controlled trial of humour. Humour is a serious matter and should not be taken lightly.

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Improvement works may affect your journey, particularly for on-call, nights, and weekends. Check before you diagnose. Look for important symptoms and signs: keep updated at www.bmj.com

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