The person in the patient

PERSONAL VIEW **Alastair M Santhouse**

"The care of the human mind is the most noble branch of medicine" Aloysius Sieffert

"Psychiatrist—a man who asks you a lot of expensive questions your wife asks you for nothing" Sam Bordell

My opinion of the branch of medicine that I have given my career to, psychiatry, veers unsteadily between two extremes. At times I am carried away by the nobility of my calling, while at other times I am left wondering at the validity and usefulness of modern psychiatry. I am talking about the vast bulk of mental illness largely ignored by psychiatry but that forms the greatest burden of mental suffering in the population: depression, anxiety disorders, conversion disorders, somatoform disorders, and a variety of other similar disorders. Why are these disorders becoming more prevalent? Is our treatment effective? Is our understanding of the illnesses adequate? Surely the context influences the development of mental health problems; and perhaps understanding the context of our patients and the society in which they live is crucial. After all, we spend enough time taking this into consideration in transcultural psychiatry. Why not for the indigenous population? And what of the environment the doctors work in? Is this not also worthy of exploration?

Our society is a reductionist society. As the Austrian psychiatrist and Holocaust survivor Victor Frankl said, our nihilism is not a belief in nothing but a belief in "nothing but"—in other words, that we are nothing but a series of neural inputs and outputs, nothing but a function of our genes, nothing but sophisticated apes. Inevitably, the effect on society is corrosive. Worse still, the effect on individuals is to foster a notion that they are unimportant, a biological accident, thrown into a survival of the fittest in terms of wealth and prestige, youth and beauty, with no higher purpose or goal.

The direction that medicine is going in further accentuates the problem. In hospitals the fragmentation of specialties means that doctors see only their part of the "machine," a situation that edges us ever closer to veterinary practice. Psychiatry, in its unending yet sadly unrequited love affair with hospital medicine, imitates the model. If this biological machine is broken, it needs to be fixed. Somewhere along the way we have forgotten the person, a ghost in the machine.

A growing number of patients I see who have gained a diagnosis of depression, or who have failed to respond to treatment, are not really depressed at all. More detailed questioning reveals a familiar pattern in which the patient lacks a sense of purpose in life, with no higher goals or aspirations. Naturally this is accompanied by symptoms associated with depression, such as sadness, pessimism, or hopelessness—but identifying these symptoms simply as a biological depression misses the point entirely. Antidepressants do not help to give the patient a sense of purpose. We must speak to the person behind the symptoms and discover what will give their lives meaning. This applies in many branches of medicine, in which we should be able to move beyond the unexplained pain or physical symptoms. Everyone has a drive to imbue their lives with a sense of purpose, in what Frankl referred to as a "will to meaning."

What has become of psychiatry? Tick boxes and risk management protocols dominate the agenda, and these address only the very lowest and crude notions of what makes the patient safe from committing suicide or homicide. Inevitably, psychiatric assessment becomes an exercise in risk management and does not allow time to focus on the person. Worse still, psychiatric patients start to see themselves only in terms of risk and not for what they may be able to contribute to society. Centralised diktats impose on us treatment algorithms to provide a homogenised and very basic standard of care. Yet unlike in almost any other specialty, a psychiatrist could have flawless paperwork and entirely fail to understand a patient's problem or treat them properly. And indeed this is what I observe.

RICHARD TUSCHMAN

A growing number of patients I see who have gained a diagnosis of depression, or who have failed to respond to treatment, are not really depressed at all

So what is to be done? The first point, although it may sound fairly obvious, is to leave psychiatry to the psychiatrists. The second would be to encourage psychiatrists to focus more on psychiatry. The collective wisdom of our specialty is being eroded. The way some patients think of themselves ("nothing but"), the way some managers think of patients (risky cost pressures to be managed), and the way some psychiatrists think of their patients (complex computers) are leading to a dullness of thought and practice. The undeniable advances in molecular psychiatry are of enormous benefit to our patients yet can, paradoxically, exacerbate the problem of forgetting the person.

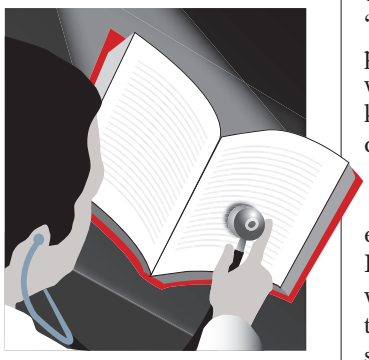
The choice is ours. We need to start again to truly understand the patient and engage in the noblest calling or else continue to ask a barrage of questions to no great purpose, which the patient's spouse could do better and more cheaply.

Alastair M Santhouse is consultant in psychological medicine, York Clinic, Guy's Hospital, London
alastair.santhouse@slam.nhs.uk

Cite this as: *BMJ* 2008;337:a2262

Counting our blessings

BETWEEN THE LINES
Theodore Dalrymple



We soon feel wretched if we have nothing to complain about

It is an old adage that we should count our blessings, and it is an equally ancient failing of human beings that they should fail to do so. For we are as much problem seeking as problem solving creatures, and we soon feel wretched if we have nothing to complain about.

My wife and I once visited a missionary doctor in Haiti called Dr Hodges. I had met him there 10 years earlier, when he told me that he wished to retire soon in Haiti and concentrate on archaeology. (He had discovered the place where Christopher Columbus had first landed and founded a small museum.) But when we met him again the medical needs of the population had grown so much that, though well into his 70s, he had not been able to retire. We found him, exhausted, in the middle of triage, surrounded by hundreds of patients. We resolved thereafter, whenever either of us complained of some trivial frustration in the NHS, to say to the other, "Remember Dr Hodges!"

Our resolution lasted about two weeks, but I experienced the same sense of shame about my own thinness of skin recently when reading Primo Levi's first published work, "Auschwitz Report," which he wrote in partnership with a fellow inmate of Auschwitz, Leonardo de Benedetti. Dr de Benedetti was a general practitioner from Turin who, with his wife, was turned back at the border when they tried to reach Switzerland and were later deported to Auschwitz, his wife being killed immediately. Levi and de Benedetti were among the thousand inmates remaining in the camp when the Russians arrived.

"Auschwitz Report" was written at the request of the Russians and published in 1946 in the Turin medical journal *Minerva Medica*. It concerns the medical conditions and "services" in that part of Auschwitz where inmates were kept who were still capable of working for the artificial rubber plant established there. De Benedetti, who was 21 years older than Levi—that is to say 45 when he was sent to the camp—survived four "selections," the process by which those who were deemed too ill to work were sent off for extermination.

De Benedetti returned with Levi to Italy, where he worked as a doctor until he was 80 years old. When he died five years later, Levi wrote two brief and moving encomiums to him. De Benedetti had looked after Levi when he had pneumonia, Levi wrote, and "his kindly and indomitable character, his infectious capacity for hope, and his zeal as a medical practitioner with no medicines were invaluable not only to us, the very few survivors of Auschwitz, but to thousands of other Italian men and women on the uncertain journey back from exile."

De Benedetti, who never remarried, "did not enjoy solitude, and at first he lived with relatives and then with a family of friends: Dr Arrigo Vita and his two sisters. They passed away one after another, and Dr de Benedetti was left on his own. Until he was 80, he had been the hard-working and highly esteemed doctor of the rest home, where he decided to take up residence in the serene sadness of one who knows he has not lived in vain."

How many of us will be able on our death beds to say the same? From now on, I'm definitely counting my blessings.

Theodore Dalrymple, writer and retired doctor

Cite this as: *BMJ* 2008;337:a1791

MEDICAL CLASSICS

La Bohème By Giacomo Puccini

First performed 1896

Paris, Christmas Eve. A bohemian trio of philosopher, artist, and writer (Rodolfo) are shivering hungrily in their garret flat, burning the pages of a play to keep warm. They come across some money. The philosopher and artist go off in search of food, drink, and bonhomie. The writer says he will follow. Enter Mimi, a beautiful but consumptive seamstress whose candle has gone out. The writer is immediately smitten and is soon exchanging arias with his lovely but frail neighbour.

Mimi moves in with Rodolfo briefly, but the couple quickly splits. His possessive jealousy is, apparently, incompatible with Mimi's coquettish behaviour towards other suitors. But all the characters know Mimi's true motives: she is sick and needs warmth, medicine, and nursing care. And seeing her grow weaker by the day is breaking Rudolfo's heart. After a heartrending farewell on a freezing snowy night, Mimi takes up with a rich count, who will offer her the best chance of survival.

But silk blankets and expensive potions are a poor substitute for the arms of the man you love. In the last act Mimi returns to the garret, coughing violently and clearly close to death. Her hands are frozen. The bohemians welcome her fondly, and Rodolfo's friends go off to pawn their clothing and jewellery to get money for a muff and a doctor's visit. Soon after, Mimi dies the standard death of the tuberculous heroine: wilting quietly away while Rodolfo and his friends watch helplessly.

The link between tuberculosis and poor living conditions was certainly no mystery at the time of the opera's première in 1896. Fourteen years earlier the pathologist Robert Koch had demonstrated his famous postulates in relation to the tubercle bacillus. It would be another half century before Austin Bradford Hill conducted the world's first ever placebo controlled randomised trial to demonstrate the efficacy of the new antimicrobial streptomycin. Yet, as every GCSE biology student knows, the dramatic fall in the incidence of tuberculosis is associated more closely with the rise in living standards and quality of general public health measures than the discovery of any specific treatment.

These days, the affliction of the bohemian artist is typically AIDS, not tuberculosis. Exactly a century after Puccini published *La Bohème* Jonathan Larson rewrote its storyline as the rock opera *Rent*, set in eastside New York and featuring a near identical opening scene in which a writer burns his own manuscript to keep warm. There is also a candle that has gone out, but in the modern version Mimi (a stripper and prostitute) admits to needing the flame for her drug habit. Many of the characters in *Rent* are HIV positive and face a similar illness trajectory to the heroine, since none can afford the prohibitive cost of antiretrovirals.

The enduring message? Perhaps that although the proximal causes of poverty associated disease (specific bacteria and viruses) change with time, the distal causes (social exclusion, insecurity, lack of access to basic health care, and the sociocultural preconditions for casual and transactional sex) remain broadly the same from generation to generation.

Trisha Greenhalgh, professor of primary health care, London
p.greenhalgh@pcps.ucl.ac.uk

Cite this as: *BMJ* 2008;337:a2282

You can call me Des

FROM THE FRONTLINE

Des Spence

We all took turns introducing ourselves on the bus we were to be sharing on a two week trip around New Zealand. Scots, English, Irish, Canadians, Americans, and a smattering of confused looking Germans. An American with the usual unabashed confidence stood up. "Now, I know all you Brits will laugh, but my name is Randy." A brief pause—then those British eyes met. A giggle escaped, then weeping, choking, gasping, excoriating, contorted spasms of spontaneous and uncontrollable laughter rocked the bus. Names are funny.

Parents try to give their children a special and unique name only to find that everyone had exactly the same idea. So in my class all the boys were called David, John, Brian, or Kevin. Every man of my generation (not in a civil partnership) is married to a woman called Susan or Sarah. Those of us with unusual names (like Desmond) were teased by the homogeneously named majority. I prayed that I might wake up with the name John but I was never saved. Eventually I reinvented my name as "Des"—much to my parents' irritation. Names seem to matter.

But now, in these irreverent and irrelevant times, what should doctors call patients? My rule with patients is that if they're my parents age it is Mr or Sir and Mrs, Miss, or Ms, depending on their preference. If they are around my age it is just plain first name and second name. For anyone younger than me it's first names only. I have resisted the modern trend of calling everyone mate, double air kissing, and giving man hugs—perhaps I am just out of touch. This approach works well for me.

What should patients call doctors? I've never been comfortable with Dr Spence, perhaps a product of my misplaced sense of egalitarianism. So I give patients no direction on how to address me—they can call me what they will. I am also happy to be called Des by patients, because family medicine has many similarities to a friendship. Many doctors, however, are suspicious of overfamiliarity—comfortable with the distance titles afford and fearful of letting go of the mantra "Don't get too involved." I don't know the answer, and perhaps names don't really matter, but experience tells me otherwise.

Des Spence is general practitioner, Glasgow destwo@yahoo.co.uk

Cite this as: *BMJ* 2008;337:a2328

Model behaviour

DRUG TALES AND OTHER STORIES

Ike Iheanacho

Perhaps you blame yourself. Common sense warned you that the ridiculously easy credit couldn't last and was best avoided. However, if self criticism is inappropriate or too painful, don't worry: there are plenty of others to accuse.

What about the politicians who acted like they understood what was going on when, plainly, they were clueless? Then there are the "light touch" regulators, laughable watchdogs with neither bark nor bite. And don't forget the economics experts commentating after the fact who now claim, unconvincingly, that they knew all along the world's financial systems would combust.

This already crowded rogues' gallery would be incomplete without the bankers, traders, and brokers, who have been an obvious target for public anger. But guilty as these groups may be, it is simplistic to label them as the root cause of the problem. For example, many of them were only disciples to some of the true brains behind the operation: the clever analysts who invented and promoted the flawed risk models at the heart of the mess. The work of these individuals and the way it was accepted so casually are a timely reminder of the dangers of model making.

It's not that such instruments are bad in themselves. After all, medical science, like finance, has long depended on models to try to account for the present or to predict and plan for the future. Countless advances in the understanding of disease and treatment would have been slower or impossible without them.

What's easily forgotten, though, is that a model is merely a framework around which to build and test what might initially be a speculative idea. If rickety, the model will collapse under the gentlest of examinations. Other, more robust frameworks may still fall victim to sustained critique and negative data. Ultimately only the strongest should survive, so allowing the ideas they represent to develop and become established.

Inevitably, things can go wrong if an undertested model is regarded prematurely as an article of faith by its creator and fellow believers. Before long, these experts will have produced the fancy PowerPoint presentations and accompanying spiel on how their marvellous new toy fits with all the available evidence (very little) and explains everything (except its own validity). Other people may be beguiled or bamboozled enough to fall for this.

Such models may thereby get to direct thinking or practice in the real world. At that point their inadequacies may start to appear, possibly as unintended, harmful consequences. Something like this happened to the money markets recently. Stand by for the next episode in medicine.

Ike Iheanacho is editor, *Drug and Therapeutics Bulletin* iiheanacho@bmjgroup.com

Cite this as: *BMJ* 2008;337:a2268