**A hymn to health: John Wesley's medical classic**
**p 605**

# Let's not turn elderly people into patients

PERSONAL VIEW **Michael Oliver**

Many older people, often retired, are summoned by their general practitioner for an annual health check. They may feel reasonably well, but the NHS does not always permit such euphoria. They may be told that they have hypertension or diabetes or high cholesterol concentrations; that they are obese; that they take too little exercise, eat unhealthily, and drink too much. The quality and outcomes framework (QoF), the scheme that rewards NHS general practitioners for good performance, awards points, with related payments, for each documentation. Many of these patients are told to have more investigations. Eventually, most are started on pills. Few seem to be considered not at risk for something. Thus, of those who thought themselves healthy, a number will return home as patients. And they may be scared and no longer comfortably aging.

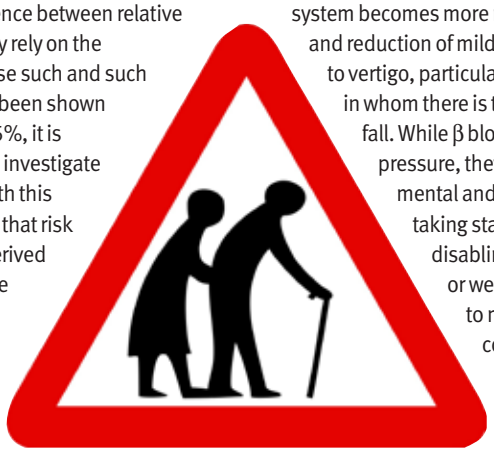
What kind of medicine is this? It is politics taking preference over professionalism, obsession with government targets superseding common sense, paternalism replacing personal advice. It seems that many Western governments regard all people aged over 75 as patients.

This trend has many causes. These include overenthusiastic and uncritical interpretation of various guidelines, the payment of GPs by NHS trusts for ticking boxes, the demands of government health economics and of insurance companies, and the relentless pressure from the drug industry.

Many busy family doctors seem not to understand the difference between relative and absolute risk. They rely on the reasoning that, because such and such a pill or way of life has been shown to reduce risk by 25-35%, it is mandatory for them to investigate and treat all people with this apparent risk. The fact that risk reduction is usually derived from comparison of the treatment in question with no treatment, placebo, or another pill (relative risk) is overlooked. The same treatment may have reduced the absolute risk by only 1% or 2%. This is not taken into account and is particularly relevant in advancing age, when longevity is limited. And the fact that the numbers necessary to treat in order to reduce either relative or absolute risk may be very high seems not to be widely understood. For example, about 75 mildly hypertensive elderly people may have to be treated to prevent one from having a stroke. Therefore, the other 74 will be committed to treatment for life. How many Department of Health economists comprehend this?

Guidelines should be regarded as just that. They are not commandments to investigate and treat. Some of these are so long winded that a busy GP does not have the time or the will to digest it all. The limits of supposed normality vary from one set of guidelines to another, and some derive from populations very different from that which the individual represents. For example, the isolated finding of a systolic blood pressure of over 140 mm Hg may be a warning sign in someone aged 40, but the evidence that it is bad news for a 75 year old is tenuous, and the finding should be assessed along with other features. Furthermore, the reliability of cuffs to measure blood pressure is often unchecked, and the optimum position of recording blood pressure is not heeded. Instead of making several measurements or investigating possible causes, the conclusion is to tell the person that he or she has raised blood pressure and that it must be treated.

Often, scant attention is paid to potential side effects. For example, the cardiovascular system becomes more rigid with advancing age, and reduction of mild hypertension can lead to vertigo, particularly in elderly people, in whom there is the added hazard of a fall. While β blockers may lower blood pressure, they can also slow activity, mental and physical. Many people taking statins seem to complain of disabling muscular discomfort or weakness, not amounting to myopathy. Of course, drug companies and their all pervading representatives do not encourage close consideration of minor side effects, even though they may be listed in the handout accompanying the pill package.



**Few elderly people are allowed to enjoy being healthy. A bureaucratic demand for documentation can lead to overdiagnosis**

Rigid interpretation of guidelines can lead to superficial diagnosis. Overinterpretation of the normal range of laboratory results is common. A raised fasting blood glucose concentration often seems to be sufficient to label someone as having diabetes. Often such individuals are later shown to have a normal $HbA_{1c}$ (‹6.5%), but the diabetes box has been ticked, and they are stuck with the label. A total cholesterol concentration of ›4 mmol/l or an LDL cholesterol concentration of ›2 mmol/l is not a death sentence for elderly people. The actual evidence for the benefit of treating any risk factor in those aged over 75 needs much more careful consideration when applied to an individual. Are those people who have now been turned into patients warned sufficiently about side effects? Are minor side effects, which can be debilitating in this age group, reported to health authorities? More importantly, are doctors willing to discontinue treatment and permit these patients to return to their previously unencumbered and reasonably fit lives? The benefits and risks of treatment and of remaining untreated need to be explained fully to individuals, as it is they who should make the final choice. It may be difficult for doctors when individuals decline to be treated, but this is their right.

Primary prevention among young and middle aged adults should be encouraged and supported. But should this apply equally to fit elderly people? Few elderly people are allowed to enjoy being healthy. A bureaucratic demand for documentation can lead to overdiagnosis, overtreatment, and unnecessary anxiety. Preventive action may be irrelevant and even harmful in elderly people. More than 30 years ago Ivan Illich called this trend "the medicalisation of health."

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REVIEW OF THE WEEK

# The roots of our obsession

A new book traces the evolution of obsessive behaviour from social fact to medical phenomenon, **Iain McClure** finds


**Obsession: A History**
Lennard J Davis
Chicago University Press, £19, pp 290
ISBN 978-0226137827
Rating: ★★★☆

We have existed in our current evolutionary form for at least 100 000 years, and it's fascinating to consider to what extent, during this time, our ancestors thought the same kinds of thoughts as those we think today. For example, have we always had obsessive thoughts, and if not why not? Lennard J Davis, professor of medical education at the University of Illinois, enters this complex territory with admirable vision. He explores the history of obsessional thought as far back as sources allow (less than 2000 years). He then expands the history into a debate about how such knowledge should be used in the current medical understanding of obsession. In so doing he throws up many fascinating insights and ideas about where medicine might now be going wrong in its identification of an ever increasing number of "lifestyle" disorders.

In psychiatry an obsession is defined as a thought that is subjectively distressing. To the psychiatrist, people who have persistent ideas (and resulting behaviours) that are not unpleasant to them are simply focusing on their enthusiasms (such focusing is often present in autism, for example). Only if such enthusiasm becomes so intense that the person ceases to function normally would the psychiatrist consider it to be an obsession. However, Davis, who isn't a medical doctor, perhaps rightly doesn't feel the need to constrain himself within this "ego dystonic" understanding of the word. To him an obsession can be trapping, but it can also represent any ardent idea, pleasant or not; and he therefore covers a whole raft of material that psychiatrists might consider tenuous.

Davis begins by making it clear that our earliest notion of obsession involved the idea of being besieged by an idea from without (as opposed to possession, which was from within). This less intense form of mental preoccupation involved, to a sufferer in the third century, an awareness of their thoughts. Over the next 1500 years a shift occurred in thinking that allowed 18th century doctors to reconceive obsession as a condition that involved, in the words of the pioneer of modern psychiatry Philippe Pinel, "partial insanity." Partial madness meant partial cure, which meant money for doctors. Around this time, doctors feared losing control of the management of madness to other professions (such as the philosophers, as advocated by Kant). Davis makes the fascinating claim that the emergent psychiatry of the early 19th century and the disorder of obsession were codependent for their survival. So, he says, early psychiatrists, championing the idea that mental illness could include "monomania" (the notion that the mind could be imbalanced by a single idea), began to humanise the mentally ill, removing their chains and depraved conditions and welcoming the partially mad in through their asylum doors.

The future of psychiatry as an emerging science was thus firmly rooted, and Davis argues that the notion of obsession as an acceptable form of madness began to permeate the whole of 19th century intellectual and creative thought. Indeed, the book claims, 19th century endeavour became increasingly about "science, specialisation, overwork, and obsession." Furthermore, medical attention to the constituent disorders that made up "monomania" (hysteria, neurosis, neurasthenia, and obsession) itself became obsessive—in terms of its exhaustive subcategorising, for example. This is indeed a significant idea: that a mental disorder influences a shifting culture, which in turn solidifies that disorder's prominence. Some might say this observation has contemporary relevance—for example, that attention deficit hyperactivity disorder is a prodigy of an attention deficit society.

Davis's broad concept of obsession allows him then to explore the history of how an increasingly obsessive culture (Western society) delved into many areas of human activity, including areas hitherto hidden from scientific enquiry, such as human sexuality. It is therefore no coincidence, Davis argues, that at the start of the 20th century Freud was poised to champion the obsessive psychoanalysis of obsession as the key to unlocking the secrets of the human mind.

The remainder of the book explains how 20th century psychiatry continued the categorisation of mental disorder, at first influenced by Freud but then increasingly informed by technology and pharmaceutical advances.

Davis infers that this obsessional process within medicine and in psychiatry in particular has toxic potential. In his conclusion he asks doctors to stop, reflect, and redefine our understanding of illness in a way that is "biocultural." By this Davis means, among other things, that we should use "narrative medicine" to give ourselves and our patients "a historical and social context into which they can place a disease entity" such as obsession.

In its effort to cover such a vast field (effectively the history of modern psychiatry and aspects of Western culture to boot) in relatively few pages, this book has a patchy feel. Certain areas are covered in great depth, but others (such as the overlap between obsessional and autistic thinking) are never mentioned. However, its key new idea—that obsessional thinking generated a whole new field of medicine, which in turn affected the way we now all think—is fascinating and will hopefully stimulate any psychiatrist into some non-obsessive reflection on the significant influence, for good or ill, of our profession.

**Davis throws up many fascinating insights and ideas connected to where medicine might now be going wrong in its identification of an ever increasing number of "lifestyle" disorders**

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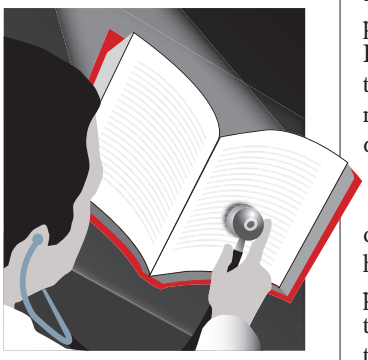
# Rhyme and reason

BETWEEN THE LINES
**Theodore Dalrymple**



**A contemporary Pound would be given antipsychotics: does that mean that there are many mute, inglorious Pounds in our midst?**

A connection between genius and madness has long been a romantic cliché and is no doubt responsible for a lot of wilful waywardness. If geniuses are eccentric, then perhaps eccentricity is a sign of, or might even result in, genius. Bad logic is, one might say, hardwired in the human psyche.

But can the mad write good poetry? Christopher Smart wrote his peculiar but very moving and beautiful religious poem *Jubilate Agno* (Rejoice in the Lamb) while a patient in St Luke's Hospital in the late 1750s, while he was in a state of manic excitement.

Some of Ezra Pound's *Pisan Cantos*, written nearly two centuries later, resemble Smart's poem in tone. Smart wrote: "For Resistance is not of GOD, but he hath built his/works upon it./For the Centripetal and Centrifugal forces are GOD-/SUSTAINING and DIRECTING./For Elasticity is the temper of matter to recover its/place with vehemence." And Pound wrote: "With a smoky torch thru the unending/labyrinth of the souterrain/or remembering Carleton let him celebrate Christ in/the grain/and if the corn cat be beaten/Demeter has lain in my furrow."

Was their madness, as well as their poetry, similar? The *Pisan Cantos* were written while Pound was held in captivity by the Americans in 1945. (He was kept incommunicado in an iron cage, open to the elements, with only the writings of Confucius and later religious tracts for diversion.)

Pound, who lived in Italy before and throughout the second world war, broadcast anti-Semitic and anti-Roosevelt rants from Rome on shortwave radio and was transferred back to the United States to stand trial for treason, a capital offence. The government did not relish executing one of the most famous (though mostly unread) poets in the world; and fortunately four psychiatrists, three of them appointed by the prosecution, found Pound unfit to stand trial. He was paranoid and—as the lines quoted above may suggest—disordered in thought, and he could neither instruct his lawyers nor follow proceedings. He was therefore committed to a psychiatric hospital.

There a legal problem immediately arose. Much to everybody's relief, perhaps, he was incurable, for if he had got better he would have had to stand trial, precisely what the government wanted to avoid. But he was clearly not dangerous enough to require incarceration in hospital. His lawyer argued on his behalf, correctly I think, that because he would never be fit to stand trial, and because he did not need to be held from the point of view of public safety, he was being imprisoned indefinitely merely because he had been charged with a crime, which was unconstitutional. On the other hand, public opinion would not at the time have countenanced his release, which it would have regarded as his having got away with it.

The dilemma was only resolved 12 years later, by which time it would have been difficult to assemble the witnesses against him. A judge therefore ordered that the charges against Pound be dropped. He was released at once, still mad, and returned to Italy, where he died 15 years later.

The psychiatrists claimed that Pound had been mad for many years before his arrest, while he was writing the works for which he is best known. Of course, a contemporary Pound would be given antipsychotics: does that mean that there are many mute, inglorious Pounds in our midst?

Theodore Dalrymple is a writer and retired doctor

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# MEDICAL CLASSICS

## Primitive Physic: Or, an Easy and Natural Method of Curing most Diseases

By John Wesley **First published 1747**

John Wesley is of course well known as a founder of Methodism and writer of sermons; less well known is this medical work. His uncle was a physician; and his Puritan great grandfather had, on being thrown out of his parish after the 1660 restoration, studied theology and medicine at Oxford, thereafter retaining his independence by practising medicine.

Wesley's preface to the first edition of *Primitive Physic* is 14 pages, much of it of a religious nature. His purpose was to give advice, including on saving money, and it includes a diatribe on the expense of physicians and apothecaries. He finishes with some 20 rules for a healthy life that would not go amiss today.

The main part of the book records 287 conditions—from item 1, "Abortion (to Prevent)," to 287, "Wounded tendons"—and 824 remedies. His remedy for "Menses obstructed," to "take half a pint of strong decoction of pennyroyal every night at going to bed," did cause my eyebrows to rise.

He ends with a section on using and how to make elixirs, balsams, James powders, Scotch pills, emetics, and eye waters. He is very modern and is thoroughly taken in by the remedy of electrifying, which he recommends for 49 conditions, from St Anthony's fire (erisipelas) to wens (sebacious cysts). In true Hippocratic manner he says of this remedy: "Nor have I known one single instance, wherein it has done harm."

**Wesley: 20 rules for a healthy life**

The addition of asterisks to his preferred remedies, comments, and short case reports indicate that he was often asked for medical advice and freely gave it as a good Christian should. His part time practice of medicine is not recorded in any of the biographies I have read. He was subject to criticism, but not by the medical profession. The criticism came from fellow divines, who believed that some diseases were God's punishment for sin.

It is notable that the more recipes for remedies are given, the less likely is a cure; for "A consumption" he gives 18. Wesley sometimes adds, as a good GP should, "Consult an honest physician."

This little book can be counted as classic for the view it gives of 18th century medicine, the diseases it describes, and the methods of management. Naturally I first looked at it from the point of view of my specialty. I doubt that Wesley practised obstetrics, but his recommendations for bleeding, antenatally and postnatally, are what the recommended practice was at the time.

His final advice: "I advise all in or near London, to buy their medicines at the Apothecaries' Hall. There they are sure to have them good."

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# Comic leadership

FROM THE FRONTLINE
**Des Spence**

The second world war cast a long shadow over my generation. Even our school janitor had been lifted off the beaches at Dunkirk, only to return four years later, still being shot at. I marvelled at the courage of the characters in my *Commando* comic. My toy Action Man doll did not blowdry his hair or play on a skateboard but had a general issue cropped nylon hair style and was armed to his plastic teeth. My embarrassed notion of leadership is both simplistic and militaristic: it is the vision of the sergeant carrying his wounded comrade while under enemy fire.

So when I am sent a circular for courses with names like "Reach for the Stars—Leadership in the NHS" my face flushes. In the past I was conscripted into attending. The courses were all flip charts, team building exercises, and propagandist slogans: "Communicate, motivate and innovate" and "Win hearts and minds." Normally I try to hit the sleep trance zone, eyes open and nodding occasionally but brain switched off, but this is impossible with the repeated intrusion of participation. Then there are presentations on "change theory" and "leadership styles" seeking to define the indefinable. Management consultants creep across the carpet, stating the bleeding obvious for £1500 a day. You want to ask why they aren't running their own international business from a yacht in Monaco rather than boring health professionals at a Travelodge in Swindon. The truth is that those who need to go on a leadership course will never lead.

When times are good, we are complacent about leadership—it just doesn't seem to matter. It is only in the hard times that we need real leadership. A storm is gathering, and this recession will squeeze the NHS like nothing seen for a generation. Many of the absurd health initiatives will be blown away (starting, I hope, with all the management and leadership courses). This is a time for new priorities: to battle against the dogma and emotional rhetoric that drives medicalisation and to sweep aside the invented, implausible, and impoverishing diseases of wealth. So, under fire, we need new leaders with determination, honesty, and vision but, above all, bravery to drag a wounded NHS back behind the lines of common sense and fiscal prudence.

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# The old dead white guys' room

THE BIGGER PICTURE
**Mary E Black**

The first black female South African minister of health was due to visit Harvard's School of Public Health in the 1990s. I got lost during an advance recce of the venue. A helpful black janitor put me right. "You mean the old dead white guys' room," he said.

There they were, portraits of the great and the good, all white men except for one small blurry photo of a white woman. The story told was one of eminence and exclusion, of generations where many potential US leaders of public health could get in the door only if they were cleaning staff.

Soon after that, I began my first professorship at the University of Queensland. My inaugural tour of the medical school took me past oil paintings of important white men, including a beaming, silver haired former dean fondling a pair of long obstetric forceps. Later two colleagues told me that this brought back memories of the traumatic forceps assisted deliveries of their babies.

The Royal College of Physicians of London, of which I am proudly a fellow, boasts 500 years' worth of valuable portraits of white men. Women were excluded from entry to the college until 1909. After further delays, Helen Mackay became the first female fellow in 1934. Women have been making up ground since then, and we even have two female presidents up in oils. But what about other women who have made a difference in medicine? Do we not think the first woman doctor or the first female member or fellow of the college achieved something worth noting? And what about colleagues of colour? Are they not part of our history too?

Black students do better in academic tests when they first see images of inspiring black leaders; the same happens with women. When I enter any old and famous building of medicine, of course I am inspired by the imposing display of men who made medical history. And of course I look for people with whom I can personally identify and who will also inspire me. I do not propose removing any of the old dead white guys; they have earned their place in history, but we need a wider range of icons and role models. It is time to shuffle the paintings.

Until we achieve portrait parity, in about 3017, I will subvert history. At the Royal College of Physicians my first stop is always Henry VIII, founder of the college. All powerful then, today he would be chased by paparrazzi. I imagine I am his personal physician and sign him up for family counselling and sexually transmitted infection contact tracing. Then I head to the Jacobean presidential portraits, with their long, lustrous curls, gorgeous dresses, and elaborate jewels and props. I have co-opted them as honorary sisters.

Hello, girls.

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