



A torrid struggle with alcohol and severe blepharospasm, p 1166

VIEWS & REVIEWS

What the white paper might mean for public health

PERSONAL VIEW Anthony Kessel, Andy Haines

This winter, in the wake of the new plans for the NHS, the UK government will publish a white paper on public health.^{1,2} We are promised a new Public Health Service for England, and there is a sense of anticipation in the public health world. This is tempered, though, by anxiety about changes to the public sector; suggestions of an influential role for the private sector in shaping public health policy; and the current economic climate.^{3,4}

For some years local public health teams have been based in primary care trusts. These teams might move into local authorities, although at what tier remains to be decided. Director of public health posts have already been moving in this direction through joint appointments with local authorities, although their teams have not necessarily followed. Aligning the directors with their departments therefore seems sensible. This also provides a chance to even out some of the inequities in public health skills and resources that have developed between localities.

A further advantage of placing public health directors and their teams in the council architecture is the closer relationship with those involved in the distal determinants of health—for example, environmental health, housing, and transport.⁵ These are traditional domains of public health, and notwithstanding academic debates about the notion of historical progress⁶ there is a sense here of “historical circularity.”

The first post of medical officer of health in England was created in 1848, and in the second half of the 19th century such appointments spread through the country. Based in municipalities—precursors of local authorities—medical officers of health built their teams and their influence.⁷ Through the 20th century their responsibilities changed, but the role was not abolished until the 1970s, with the creation of community medicine and the shift of public health into health authorities and health service work.⁸ The proposal may seem regressive, but there is a sound underpinning logic, and the plans may benefit the agendas of health improvement and health inequalities. The proposed move must be adequately supported—otherwise the potential will not be realised.

The planned transition leaves a gap in providing technical support to general practitioners with their new commissioning role; how this will be provided remains unclear.⁹ Closing the gap in commissioning expertise in the new primary care consortiums is essential if they are to have credibility in negotiating with a range of NHS trusts, which may have vested interests in resisting change. Public health needs to retain influence within the NHS, to complement the individual focus of clinical medicine with a population perspective.¹⁰

The health protection function was separated from mainstream public health with the establishment of the Health Protection Agency (HPA) in 2004, on the back of health security concerns after the 11 September 2001 attacks in the United States.¹¹ The functions of the HPA (currently a non-departmental public body) will move into the new Public Health Service, with the secretary of state for health accountable.²

This may strengthen its influence on national policies; but retention of scientific impartiality is important, and maintaining independence and a separate identity would have value. Whether to keep communicable disease control at community level under specialist health protection or to move it back under local directors of public health will require careful consideration. The determining factor, however, should be what is best in terms of the wellbeing of the public.

The organisation of public health functions in the United States is a possible model for England. The Centers for Disease Control and Prevention

(CDC) is part of the US Department for Health and Human Services, so moving the HPA's functions into government would mirror this.

However, there are big differences. CDC is responsible for communicable and non-communicable diseases and has a substantial health improvement commissioning role; the HPA does not.¹² There is also a discrepancy in the US between the seemingly well resourced scientific high end of public health at CDC and the teams on the ground. Also, although CDC is strong in field epidemiology, there is no formal universal system of public health training in the US, unlike programmes in the UK and other Western countries.⁵

Public health in the UK has a well recognised professional role, and national health and social service systems facilitate the delivery of public health functions. Once again the opportunity exists to improve the system and the public's health further. If the new Public Health Service is to fulfil its potential, a more cohesive set of arrangements must be



Public health doctors never forget

complemented by adequate resources and a commitment to tackling public health challenges at individual, local, and national levels.

Competing interests: AK is also director of public health strategy and medical director at the Health Protection Agency. AH will shortly take up a part time appointment with the Health Protection Agency. These views, however, are personal and do not represent the views of the HPA. References are in the version on bmj.com.

See FEATURE, p 1132, OBSERVATIONS, p 1135

Anthony Kessel is honorary professor (anthony.kessel@lshtm.ac.uk) and Andy Haines is professor of public health and primary care, London School of Hygiene and Tropical Medicine
Cite this as: *BMJ* 2010;341:c6623

SSPL/GETTY IMAGES

REVIEW OF THE WEEK

On the blink

A novelist's frank account of her struggle with the torment of alcoholism and severe blepharospasm offers a definitive gaze at a damaged self, writes **John Quin**

What to Look for in Winter:

A Memoir in Blindness

Candia McWilliam

Jonathan Cape, £18.99, pp 482

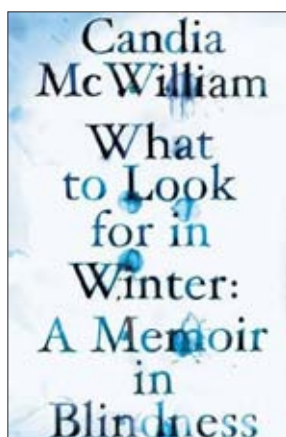
ISBN 978-0-224-08898-5

Rating: ★★★★★

Candia McWilliam published her first novel in 1988, drawing praise both for her polished prose and her striking looks. Not since Truman Capote had an author's photograph provoked such a torrent of chatter. Sixteen years have passed since her last novel—so what happened? Here we find out: a torrid struggle with alcohol and the excruciating torment of severe blepharospasm. For 22 hours a day she couldn't open her eyes. She was thus functionally blind, prone to accidents and "functioning" only fleetingly, describing her odd appearance thus: "In order to gain sight, I grimace, stretch, peer and . . . hold taut and high my already rather camel-like head with the result that I look . . . like the caricature of a snob."

Marinating in self disgust she sees herself as "a monstrous dowager with Tourettian facial tics and the creep-and-lurch gait of a not sufficiently surreptitious drunk." Pithily she acknowledges that "something has gone wrong in High Command, up here in my head." This candid memoir then is an "account of many kinds of light denied." We learn that "I do feel dead sometimes. I feel like a fat ghost." She sees in "stroboscopic clatters of vision." On learning the diagnosis she is "relieved that I had not been making all this up."

As for her nuanced view of the medical profession: "I had run dry on doctors. My condition's intractability either exasperated them or baffled them." She sees seven professors of neurology, one neuropsychiatrist, and four ophthalmologists but doesn't give up on us. "I am not on the attack against conventional medicine." Alternative therapies aren't much help



either. A hypnotist tells her, "You are very sympathetic . . . you could be in my line of work." Which earns him this rejoinder: "So now I know. I could talk rubbish to desperate people and be paid for it." She tries Botox and medieval sounding bits of metal known as Lundy Loops, then endures something called a Crawford brow suspension, which sees her "face pegged up like washing." She defends her GP: "How frustrating that his skills—common sense, empathy, compassion, practical doctoring—are undervalued."

In hospital she observes a fellow patient who "railed against the fact that because she had 'Doctor' before her name, other doctors presumed she had no feelings." And later she pleads, "Why cannot doctors be kinder to doctors." She is wryly amusing about those of us who foist their own writings upon her.

McWilliam's mother killed herself. This is Scotland in the 1960s, "where speaking was less the done thing . . . of dramatic personal matters, or personal matters at all." Of her bereavement now she says, "I have looked away from it for a long time while pretending to look at it . . . I want the emotional truth, so I can make her better. And that I cannot

have." Her recall of the trauma is moving: "I did become rigid with fear that my skinny father would slip away too, and I took, in the coming weeks, to waking him, shaking him awake, like a first time mother with a baby."

Her own diagnosis: "I don't think I'm depressed at all; I am sad." And so she turns to the bottle, with predictable results. "I had aged suddenly, become a dead weight on those I cared for, a bore, ugly, terrified and alone; and I deserved it."

As another Scottish writer, James Kennaway, wrote, age was chasing sex from her face. Like her own author heroes Malcolm Lowry and Hans Fallada she became bloated on whatever she could get: "household cleaners, disinfectant." Some senses are preserved; she has a "greedy obsessive recall of trivial detail," and olfactory references abound: railings that smell of iron, rust, coally rain, and lead paint.

Candia McWilliam: "In order to gain sight, I grimace, stretch, peer and . . . hold taut and high my already rather camel-like head with the result that I look . . . like the caricature of a snob"



Culzean Castle she recalls as a "gracefully parodic masterpiece," a description that would equally suit this Jamesian memoir. Ironically she earlier was approached by Kubrick to write the screenplay for, you guessed it, *Eyes Wide Shut*.

McWilliam was "unpersoned by blindness," because "I was my eyes, my eyes are how I got to being me." She reveals that "I would have thought it narcissistic to be so in touch with the body; my mistake, my very Scottish mistake." She realises now that she was pretty. The saddest, the most Beckettian line here, perhaps, is this: "But I never knew that I was, sometimes, beautiful"—recalling Krapp replaying tapes at his most maudlin.

So why write about such a fresh hell? "I want to pass it on, to pass the shiver that comes when we read and know for a time what it is to live, think, feel and be inside the mind of another." This then is a definitive gaze at a damaged self that had me concluding—as the youth of today have it—see ya; wouldn't wanna be ya.

John Quin is consultant physician, Royal Sussex County Hospital, Brighton

John.Quin@bsuh.nhs.uk

Cite this as: *BMJ* 2010;341:c6072

BETWEEN THE LINES Theodore Dalrymple

Lacking moral fibre

It is strange how a phrase that you have not heard used for several decades can, like Proust's madeleine, stir the deepest, though not necessarily the fondest, memories. I happened recently to be leafing idly through Sir Charles Symonds's *Studies in Neurology*, a selection of his papers published in 1970, when he was 80 years old. The book begins with an autobiographical introduction, and on page 18 three words, followed by their acronym, stood out from the rest of the page as if in pink neon lights on a pitch black night: "lack of moral fibre"—or LMF.

How, I wonder, do the eyes, guided by the mind, home in so unerringly on such a phrase among all the others on the page? The fact is that lack of moral fibre (often reduced to its acronym) was precisely what I was so often told as a boy that I was suffering from, among many other defects. Since then, of course, LMF has gone the way of floating kidney, chlorosis, neurasthenia, and other doubtful diagnoses, but I am not sure that it didn't have its use or describe something real. In other words I am not convinced that, even now, I have

LMF has gone the way of floating kidney, chlorosis, neurasthenia, and other doubtful diagnoses, but I am not sure that it did not have its use or describe something real



Sir Charles Symonds: psychology in combat

overcome it. Those who spotted it all those years ago might have been right after all.

"Lack of moral fibre" was an expression invented in the second world war by senior officers of the Royal Air Force, not as a diagnosis but rather as an antidiagnosis or as a deterrent to diagnosis. For, at a time of the direst national emergency, air crews were in short supply, and it was feared that doctors would have diagnosed among them real conditions such as flying stress, aeroneurosis, and aviator's neurasthenia, which would have entitled them not only to a passage out of the force but to a pension on the grounds of invalidity. By contrast, a reprehensible lack of moral fibre would mean not only that they could be dismissed from the service without compensation after the humiliation of reduction to the ranks but also that they could be stigmatised among the general public as cowardly and pusillanimous. With the threat of being designated as LMF hanging over them, they would much prefer the 67% chance of being killed by a first tour of duty or 84% by a second, if in Bomber Command.

It was Symonds who, although a neurologist, carried out the most detailed psychological studies of the stresses of air combat, and he was promoted to air vice marshal in recognition of his work. It was he who recommended the number of missions that airmen should fly before they were granted a period of leave.

But my favourite passage from Sir Charles's autobiographical introduction is, "In 1931 I had acquired a chauffeur and limousine. I had a roller blind to pull down over the partition, and thus without being distracted could read my journals, write notes for lectures, and eat my sandwiches. This meant a great saving in time and fatigue. I had a telephone line to my chauffeur." To which one can only ask, "Where are the chauffeurs of yesteryear?" I suppose that they have gone the way of lack of moral fibre.

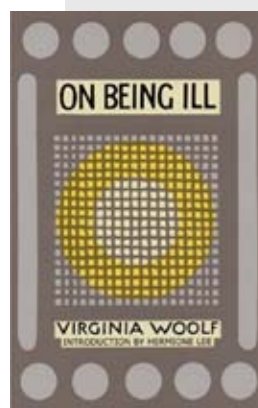
Theodore Dalrymple is a writer and retired doctor
Cite this as: *BMJ* 2010;341:c6635

MEDICAL CLASSICS

On Being Ill An essay by Virginia Woolf

First published 1926

In this essay Virginia Woolf examines the spiritual change that a minor feverish illness such as flu can bring, enhancing our perception of the world while normal society goes on without us. "Directly the bed is called for we cease to be soldiers in the army of the upright; we become deserters. Mrs Jones catches her train. Mr Smith mends his motor. Men thatch the roof, the dogs bark." Meanwhile the recumbent can study nature, indifferent but comforting, finding new beauty in "the interminable experiment with curtains of gold shafts and blue shadows in the sky" or the rich suffusion of colours in the petals of flowers.



For Woolf illness is also something to be experienced without expectation or wish for sympathy: "A world so shaped that it echoes every groan, of human beings so tied together by common needs and fears that a twitch at one wrist jerks another, where however far you travel in your own mind someone has been there before you—is all an illusion. We do not know our own souls, let alone the souls of others. Human beings do not go hand in hand the whole stretch of the way.

There is a virgin forest in each; a snowfield where even the print of birds' feet is unknown. Here we go alone, and like it better so. Always to have sympathy, always to be accompanied, always to be understood would be intolerable."

Many of us, I think, will recognise the sensations the author describes in our own experience of febrile illness but not her rejection of emotional support that she displayed so tragically before her suicide 15 years later. In that era patients usually didn't like to discuss their innermost emotions; nowadays the tabloids and magazines are full of people exposing their private medical experiences. Our patients come to see us not just to be treated but often in hope of sympathy and to be understood; and in the past 30 years consultation skills have been central to general practitioners' education and training, including the ability not simply to sympathise but to empathise.

But how well do we succeed in this? We may do our best to put ourselves in the patient's shoes and know we can bring comfort by such expressions as "I know how you must feel." But, outside our own experience, can we fully enter the experience of someone else?

Barry Newport, part time sessional GP (former GP principal), Wokingham, Berkshire barry.newport@yahoo.co.uk

Cite this as: *BMJ* 2010;341:c6633

We welcome submissions for Medical Classics. These should be no more than 450 words and should focus on a book, film, play, artwork, or piece of music that sheds light on the practice of medicine or the role of doctors in society. The work under review should be at least 10 years old.

Please email ideas to Richard Hurley (rhurley@bmj.com).

Unreadable codes

FROM THE
FRONTLINE
Des Spence



I love the internet: it is a useful tool to obtain music, films, and research papers and for sending messages. But I hate its latest manifestations, such as social networking, and I can't be bothered to tweet twaddle. As for Facebook, I am lucky, because I have three actual friends and no interest in 1000 virtual ones. Technology is now a weapon to assault traditional social interactions and to undermine the fundamental importance of eyes and ears to assess honesty.

Likewise I loved early medical computing software: legible, searchable, auditable, and then paperless. These quick small programs on dumb terminals were ugly but beautiful in their functionality. Today, however, once you eventually succeed in logging in with 40 different passwords, the new consulting software needs the power of a NASA computer to run even slowly. Our clinical systems are now hijacked by the "new GP contract," held hostage to endless flash reminders for a thousand futile points. Prescribing also is obsessed with safety, and multiple warning screens appear on every occasion; desensitised, we ignore them all. Everyone now sidesteps the NHS nanny net with our 3G smartphones, so tired of firewalls and connection speeds that sending a letter is quicker. But these are petty irritations compared with "Read codes."

Brought in at great expense in the mid-1980s these codes are used to record clinical data in a standard way. These codes are enormously important, if a little geeky, because they allow data transfer between practices and extraction

of information. Their potential benefit is to be able to follow the natural epidemiology of disease and focus treatments on particular groups. Intuitively good sense and simple enough, you might think. But there is a problem: these codes are so complex and illogical as to be useless. You cannot, for example, add "breast cancer" or "prostate cancer" to the computer summary. Type in "dog" and 12 possibilities are available; "bitten or struck by a dog occurrence at sport/athletic area" is my favourite (more ridiculous examples are welcome). Codes exist for every eventuality but the one you need, and I get so frustrated that I just give up. This is hindering the quality of care in the NHS.

Attempts have been made to rationalise codes, and recently a new coding system called SNOMED (Systematized Nomenclature of Medicine Clinical Terms) has been suggested, but it has a staggering 370 000 codes. It will never work. We need to change and revamp these codes to make them clinically usable by limiting them to a searchable simple few thousand. I reckon two interested doctors could do this work over a weekend. But this is a typical story of information technology in the NHS: decades late, promising everything to everyone but delivering nothing to anyone, and costing a sum equivalent to the Irish Republic's national debt. Information technology is just a tool; the blame for these problems is with bad NHS managers.

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

Cite this as: *BMJ* 2010;341:c6694

Who needs press releases?

IN AND OUT OF
HOSPITAL
James Owen Drife



Every morning I receive an emailed list of stories that are making the news in women's health. Clicking on links brings up the printed pages, but I rarely bother. Once you've read the précis you could write the headline yourself.

I used to be media spokesman for a royal college, hence the daily updates. It was exciting to be on the front line, facing salvos of questions whenever a story broke. Sometimes a platoon of us would be dispatched to various television studios to reassure the nation simultaneously on different channels.

Our role was to provide soundbites of common sense in response to the latest claims from campaigners, politicians, or researchers. Friday was our busy day, when the weekly medical journals appeared. Unfortunately for us, newsrooms had advance knowledge of what was to be published, and we didn't.

Responding to reporters used to mean dashing to the library and phoning them back. Today, with the internet, it can still be difficult to unearth the peer reviewed version of a breakthrough if the media have picked it up from a paper in an obscure journal—or, rather, from the accompanying press release.

Medical editors claim they have no control over what appears in the lay press, but a glance at my daily email shows non-random clustering of stories. As I learnt from my time on the front line, few reporters read medical journals. They rely on tip-offs in the form of press releases and then phone their contacts.

As editor of a specialist journal myself, I've thought of playing this game. Why not raise our profile by hyping one of this month's papers? Or maybe start a global scare, leaving it to today's spokespersons to calm

things down? I don't, but I can't prevent others from doing so. For universities and their press officers, media attention is an indicator of success.

Who benefits from press releases? Not the doctors who have to explain each false hope or needless scare to worried patients. And few scientists welcome the stress of talking to camera about their work. The beneficiaries are journalists, who of course say that openness is good. If so, why not let the rest of us in on the conversation and publish the press releases alongside the papers? The archive could make interesting reading.

James Owen Drife is emeritus professor of obstetrics and gynaecology, Leeds J.O.Drife@leeds.ac.uk

Cite this as: *BMJ* 2010;341:c6638

The *BMJ* has been publishing its press releases online since 1998. See <http://bit.ly/gvRL6m>.