A rollicking romp around an NHS hospital of the late 1960s, p 1275

Silent night

PERSONAL VIEW **Paul W Keeley**

A notice in a hospital proclaims, "Noise disturbs sick people. Quietness assists recovery." This should perhaps be written somewhere on the person of every new doctor and nurse at induction.

No longer working in an acute specialty I have forgotten, perhaps, exactly how busy acute medical and surgical wards can be, but I know they can be unpleasantly noisy. Of course, in communal bays the moans of patients in pain may be inevitable, but the main sources of noise on the ward are iatrogenic (or nosocomiogenic, if you like).

Junior doctors, it seems, are no longer issued just with pagers that go off with shrill regularity but also with walkie talkies through which shrewish voices can bark orders to the already harassed doctors to come and write up fluids or rewrite records. Through long night shifts nursing staff and doctors may try to keep up their spirits with voluble conversations. Among the patients, however, the sleep deprivation that may be induced can lead to intense frustration.

It seems that every trolley in the NHS sounds wonky; every ward door slams with the solidity of a medieval drawbridge. Every pump, every monitor is pitched to set the teeth on edge. They are indeed alarming—issuing an urgent Morse code of illness, dooming all the inhabitants of the wards to insomnia and anxiety.

I once witnessed a faintly bizarre ritual one night involving a particularly strident monitor. Every time it sounded an alarm, a member of the nursing staff would turn it to mute. They knew that the patient was ill; they were collecting the poor soul's observations every 15 minutes, and they didn't look good. But still the alarm kept going off every five minutes or so. Quite what its purpose was in the circumstances I can't deduce, but the more I think about it the more useless it seems. If the instant response to the noisy monitor is to switch it to mute, what on earth is its point? If you're monitoring something or measuring something, fine; if you're not then turn the thing off. I can only imagine the effect that such an intermittent, high pitched, ear splitting sound might have on the heart rate of the unfortunate patient who was attached to the monitor. Such a sound going off close to your head is likely to be counterproductive in the already tachycardic.

I imagine the revenge fantasies such situations may instil in patients. How difficult would it be for a patient to get home or mobile telephone numbers of night shift staff members and call them every half hour through the day, shouting, "How d'ya like them apples?" when they blearily answer the phone.

White noise, excessive heat, and unnecessary light all conspire to deprive people of sleep. Of course, such techniques have been used by the secret police of heaven only knows which unpleasant autocratic regimes. It is a travesty that they are employed unwittingly, or perhaps witlessly, by the NHS.

In an age when we mute our phones or allow them to vibrate rather than ring, and when wifi allows us to transmit messages silently through the ether, why do we allow the shrill midnight chorus to skewer the silence of the slumbering sick? How much nocturnal confusion in elderly people is purely environmental, resulting in unnecessary prescriptions of sedatives and antipsychotics? How much cortisol and adrenaline do we cause to pump through the vessels and brains of patients, impeding their path to healing?

The pattern of some of our hospitals can be traced back to the infirmaries attached to the medieval religious houses. I spent some of my otherwise misspent youth in the great Benedictine monasteries of England. There I learnt of the great silence that falls across such monasteries from the last office that completes the day until after dawn, when the monks raise their voices in praise and thanks that a new day has come. Is it too fanciful to believe that, to facilitate the healing of patients, such a great silence may be allowed to fall across hospital wards?

I spent some of my youth in the great Benedictine monasteries of England. There I learnt of the great silence that falls from the last office that completes the day until after dawn

ROB WHITE

Competing interests: I like a good night's sleep.
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WELLCOME LIBRARY, LONDON

Various fungi, some psychoactive, lithograph, 1827

REVIEW

Our chemical romance

Humans have used recreational drugs since time immemorial. **Ike Iheanacho** marvels at an exhibition and book that consider our history of getting high

High Society: Mind-Altering Drugs in History and Culture
A book by Mike Jay
Thames and Hudson, £18.95, pp 192
ISBN 978-0500251720
An associated exhibition is at the Wellcome Collection, London, until 27 February 2011, admission free (www.wellcomecollection.org)
Rating: ★★★★

Alcohol, a professor of pharmacology used to declare, "is a food not a drug." His argument was that the effects on the central nervous system occur only with high doses, which supposedly precluded classifying alcohol as anything other than a source of energy. This lame, unscientific reasoning buckles under its own contradictions. But in a sense far removed from that intended, he was right.

Because of the ways that alcohol is marketed, bought, consumed, and cherished in Western society it is far closer to foodstuffs than to other substances taken primarily for their consciousness altering effects. Indeed it's often not considered a drug at all, even in medical parlance. Who, for example, on hearing the term "drug addict" thinks immediately and spontaneously of the inveterate boozer? The risk of such oversight presumably accounts in part for the popularity of the phrase "drugs and alcohol," a tautology that is both a helpful reminder and a nod to the special status afforded to one of society's sacred cows.

Too much of current debate about non-medicinal/recreational/illicit/illegal drug use is a stalemate slanging match between closed minds expounding from entrenched positions in the absence of context

The myriad consequences of culturally sanctioning or censuring substances that are (or that contain) psychoactive drugs are key themes in the book *High Society* and the Wellcome Collection exhibition of the same name. Arguably these couldn't have come along at a better time. Too much of current debate about non-medicinal/recreational/illicit/illegal drug use is a stalemate slanging match between closed minds expounding from entrenched positions in the absence of context.

On the one hand are people in the extreme liberal/libertarian wing, who, in pushing for wholesale legalisation of currently controlled drugs, state unoriginally that, were alcohol to be discovered today, it would be instantly outlawed in light of its dangers. Occupying the opposite position are those who will brook no other solution than outright "bans" of any products even suspected as having potential for misuse. *High Society* represents a gentle poke in these blinkered eyes through its straightforward and engaging storytelling and cool headed analysis of use of, and attitudes towards, mind altering drugs.

Early on the book makes and substantiates the key point that the tendency to use substances to produce desired (not necessarily pleasant) psychological effects is an intrinsic feature of the human condition, recognisable down the ages and across all cultures. The same message is conveyed simply and effectively in the exhibition, in which the very first display comprises 50 or so juxtaposed items that exemplify the wide diversity of psychoactive agents, the ways and means by which they are taken, and the social circumstances surrounding their use.

The sceptic could, of course, try to draw hard and fast distinctions between, say, the injecting drug user and the coffee junkie; the devotee of amyl nitrite and the chronic tobacco smoker; the ritual-observing drinker of the narcotic kava and the wine buff. But, in reality, many of the obvious differences are culturally determined rather than being reflections of immutable pharmacological fact. This is not to say that all drug taking is or should be regarded as equal or automatically deserving of toleration, acceptance, or endorsement. The book certainly doesn't fall into this trap when detailing what it calls a "universal impulse" to use chemicals to change mental function. But neither does it shy away from highlighting the failures to understand or take account of common factors that have triggered or sustained the development, use, and trade of drugs of which mainstream society disapproves.

The book deserves high praise for rendering a complex, controversial topic with clarity and elegance. It's also good looking: every double page spread in the main text has at least one illustration, and the content and sensitive placement of these enhance an already lively text. The exhibition is also excellent but suffers a tiny bit from direct comparison with the book. It covers the same ground, but the inevitably restricted amount of linking narrative makes for a slightly disjointed presentation, in which some of the book's subtlety is lost.

And although the exhibition has potential advantages through incorporation of real life objects and installations, one or two of these are, frankly, duds. A particular offender is an overlong, dreary film in which an artist, having taken a dose of LSD, cycles tediously around Berlin, apparently in homage to a similar trip (in every sense of the word) taken by Albert Hofmann on discovering the drug 58 years before.

But this is a minor irritation, given the wealth of other illuminating exhibits. These include a breathtaking film of endless poppy fields that is both haunting and beautiful. And another gem is the snippet from a *Panorama* programme (recorded in 1955) in which a doctor called Humphrey Osmond interviews Christopher Mayhew, an MP, before and after Mayhew has taken a dose of mescaline. The hallucinogenic drug clearly scrambles Mayhew's concentration, but he also reports his colour vision as becoming "quite marvellous." Overall that's a fair summary of *High Society* too.

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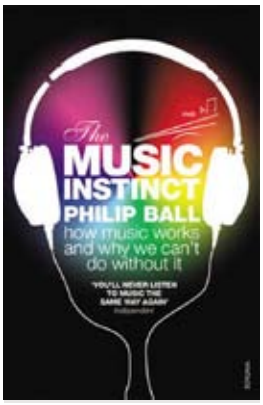
REVIEW

Music and the art of being human

The "neurology of music" has long been a mutual interest of doctors and musicians. **John Mathews** is impressed by a book that takes what we know about music and the brain to a new level



The Music Instinct: How Music Works and Why We Can't Do Without It
By Philip Ball
Bodley Head, £20, pp 464
ISBN 978-1847920881
Rating: ★★★★

Music and medicine have an association as long as recorded history. In the past few decades clinical research and a revolution in brain scanning techniques have enabled neurology and psychology to break through the previous boundaries of knowledge. The time is ripe for a modern, all encompassing, and challenging text on this subject.

Retirement takes several forms. My NHS post in rheumatology ended a decade ago, allowing more time for playing music, listening, attending courses on music history and theory, and also seeing musicians with their rheumatological problems. The twice monthly musicians' clinic at St Thomas' Hospital attracted hundreds of players—with their instruments (and was also popular with the BBC television documentary *City Hospital*). Retirement also provided time for me to do clinics for the British army in Germany and, serendipitously, to visit the prestigious Institute for Music Physiology and Musicians' Medicine in Hanover.

Until the 1990s virtually my only book on this topic was *Music and the Brain: Studies in the Neurology of Music*, which R A Henson coedited with Macdonald Critchley and was published in 1977. This book's 24 chapters emanated from the Danube symposium, a meeting in Vienna in 1972 on the topic "neurology of music"—"the first occasion when the subject had been submitted to serious discussion." I had thought, perhaps wrongly, that this kind of book was directed at specialists, and by the time I had taken the reviewers' advice to heart to read it it was out of print, hence my gratitude to Dr Henson, who posted me a spare copy in 1993. This volume prompted Lord Platt to write a eulogistic review article entitled "The neurological aspects of music," published in the *BMJ* the same year (1977;1:888-9), soon to be followed by a remarkable and perceptive paper by Dr Henson, "Further observations on the neurology of music: musical notation and pitch discrimination" (*BMJ* 1977;1:1121-5).

Recently two exceptional series of articles on music have appeared in the general medical press. In February 2008 Jason Warren initiated a sextet of essays on music in *Clinical Medicine*, and in May 2008 Philip Ball introduced a 'nonet' in *Nature*. It seemed natural to invite them to speak in the first session of a meeting on "Music and the Mind" in London at the Royal College of Physicians. I recollect Philip Ball's comment in accepting the invitation that this engagement would prompt him to write his "book on music."

The result, an up to date volume aimed at the musically interested public and written by a master in communication and explanation, poses all the questions and more that have been passing through my mind over the years and provides responses in the form of searching discussions.

The book has a "prelude" and a "coda"; between are 12 chapters arguing the case that music is fundamental to the human condition and that it is built in to the mind and telling all of us who are interested why this is the case. The text does not confine itself to classical music, although this features strongly, being the best studied; it also covers popular and "world" music.

Music stimulates more parts of the brain than any other intellectual activity. Although only some of these are shared with other activities, such as language, music is hardly likely to have developed merely to satisfy hedonistic temptation and could hardly be there by chance. Ball starts by discussing the perplexing problem of music's origin. We don't know how or why music started, what the predisposing factors were, or even the form in which the earliest manifestations evolved (rhythm, melody, dance, communal singing, and so on). For example, was there perhaps a selection advantage operating through musical activity that improved community bonding? We are left surmising. Among many factors involved a likely background is genetic.

Ball examines the ways in which the brain processes and organises auditory input. Recent technology, such as functional magnetic resource imaging and positron emission tomography, has shown a plethora of brain responses to music. When we listen to music our "general" mind activity seems to be stimulated. The brain is sorting out a multitude of inputs, involving sections of it known to process language but also other sections associated with emotion and reward and others that connect to muscle movements. It is suggested that when music arouses emotion an important mechanism is violation of a natural hierarchical sequence. It is not known how the particular emotions come to be related to music, but my own thought is that it is at least partly through previous associations. Physical accompaniments of these emotions are well documented and have been used as indicators of the potency of the music. Could it be that the difficulties with atonal music are related to the fact that it is not easily memorable?

This is an engagingly colloquial book for everyone interested in music of all varieties and its deepest ramifications. Has Ball made his case that music is a fundamental part of being human? I enjoyed being persuaded by the arguments.

When we listen to music our "general" mind activity seems to be stimulated. The brain is sorting out a multitude of inputs, involving sections of it known to process language but also other sections associated with emotion and reward and others that connect to muscle movements

JAM is glad to relate that the musicians' clinic in the Department of Rheumatology at St Thomas' Hospital thrives under his successor, Frances Williams.
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BETWEEN THE LINES **Theodore Dalrymple**

Doctors in the valleys

Rhys Davies (1901-78, born Vivian Rees Davies) was once known as the Welsh Chekhov, not because he was a doctor but for his short stories. And for a reason that I cannot fathom—because he was a very fine writer indeed—he is now all but forgotten except by specialists and thesis mongers.

He left his native Rhondda very early in his adulthood, but much of his writing is nevertheless about south Wales. He was accepted straightaway into the bohemian London of his day, and when he went to the south of France he befriended D H Lawrence, accompanying him from Bandol to Paris when he sought treatment for his tuberculosis.

His early work was published by small publishers in tiny editions. His first hardback collection of stories was called *A Pig in a Poke* (1931). It depicted the people of the Rhondda in a not always flattering light, though always with understanding, compassion, and the kind of affection that you often have for what you have left behind.

In the valleys there was a tiny middle class, which was also the local upper class. The doctor naturally belonged to this group and was more or less above criticism. The story *Evelyn and Ivor* is about the unhappy wife of the local butcher. She humiliates her husband by dressing up a whole pig in his window as himself. We learn that one of the butcher's drinking companions is a doctor, "who was fortunate in having got himself the reputation for being ten times more a doctor when drunk." I remember as a child my relatives, including my father, claiming in all seriousness that they drove the better for a few drinks.

JULIAN SHEPPARD/NATIONAL LIBRARY OF WALES

Rhys Davies, the Welsh Chekhov

"[He] was fortunate in having got himself the reputation for being ten times more a doctor when drunk." I remember as a child my relatives, including my father, claiming in all seriousness that they drove the better for a few drinks

The story *The Doctor's Wife* is very daring for its time. Dr Morgan is 36 years old and "was admired as a clever man." The reasons for this make interesting reading in an age of patient autonomy. "He had a pleasantly bullying way with patients, gruff and hearty with the men and domineering with the women, so that everyone had confidence in him."

He captures exactly the feeling I had about my general practitioner when I was a child: "His rough didactic manner as he talked boldly and energetically to them [his patients] made their illnesses seem more important. It was nice to have such a large influential-looking man bothering in so masterful a way about them."

Dr Morgan marries Phoebe Pryce, 12 years his junior and an accomplished amateur harpist. "Now, Phoebe," says Dr Morgan, "you're going to be a new woman. I shall take you to pieces and build you up again. A doctor's wife must be an example to the place."

Things do not turn out like this. When a social worker called Agnes Wright comes into the valley and starts an amateur dramatic group, Phoebe turns away from Dr Morgan.

He mistakenly believes that she must be having an affair with a young man in the cast of *The School for Scandal*. "He had no real proof that she had been faithless to him. But he had an unbounded belief in his own perception and keen instinct for fathoming guilt and secret behaviour; his success in the world had been partly due to that talent in him."

At the end of the story Phoebe leaves Dr Morgan to live with Agnes Wright. Dr Morgan writes to her and asks her to come back to him from her lover. "But I warn you I'd thrash his life out if only I could lay my hands on him!"

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

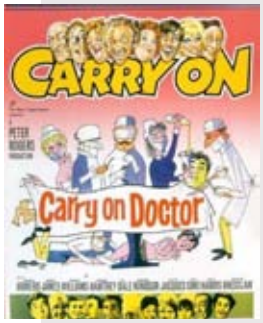
Carry on Doctor

A UK film released 1967

Carry on Doctor is the second and, arguably, the best of four hospital based films in the long running *Carry On* series. Shot in eight weeks, it teams the regular cast with the superb Frankie Howerd for a rollicking romp around an NHS hospital of the late 1960s.

In the opening scene we see Howerd as the confidence artist and mind over matter healer Francis Bigger ("Think power, think positive, think Bigger!"). Promoting his healing powers on stage with his assistant, he announces, "For many years this poor creature has suffered from loss of hearing or, in technical terms, Mutt and Jeffness." He claims to an apathetic crowd that positive thinking is all that is necessary to remain healthy, before falling off the stage and being rushed to hospital.

There we meet the rest of the gang. Bernard Bresslaw limps off each day with a pot on his foot for a tryst in the women's ward, while Sid James plays a malingerer who puts his thermometer in his cup of tea to make sure that he isn't sent home to his wife.



But Howerd is undoubtedly the star of the film, with all the best lines. When he is admitted the nurse marches in and barks, "We must get our clothes off and get into bed." He replies in inimitable faux shocked Howerd style: "We? Madam, I have an affliction!"

The main plotline starts about halfway in. Barbara Windsor is Nurse May, who has come to the hospital to meet Dr Tinkle (Kenneth Williams). She has been obsessed ever since he treated her for a minor ailment, and a narrative arc of sorts ensues. But that's not really the point; the film is essentially a mishmash of larger than life characters who exist solely to showcase the comic abilities of the cast.

Despite all the silliness the film touches on one issue that still makes headlines today, often in the context of a fitness to practise hearing. Sid James's malingering is dealt with brutally by Dr Tinkle, who maliciously prescribes him daily ice baths to try to get rid of him. In fact Tinkle is a pretty bad doctor all round, having told Nurse May while she was a patient that she had a "cute little tibia" and "beautifully enlarged glands."

Carry on Doctor also gives an insight into popular opinion of the NHS, which was less than 20 years old at the time. As today it is clear that quality of care was an issue. "Oh, a slight bruising, certainly, yes," says the doctor examining Francis Bigger's injured backside. "No bleeding. Good." To which Bigger rolls his eyes and says, "Just like the service round here."

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The problems of controlling controlled drugs

FROM THE FRONTLINE
Des Spence

Medicine has endured much regulation and intervention: now even teachers look at us with sympathy. This regulation takes the form of annual appraisals (and of course revalidation, when it arrives in 2050) and new contracts that dictate much of our day to day activity—medical micromanagement. Professionalism is mistrusted.

One area now more closely regulated is controlled drugs. Many general practitioners once carried one or two vials of diamorphine, which was given very occasionally on house calls. Rules on the storage and recording of controlled drugs existed but were widely flouted because they were impractical and because general practitioners carried only small amounts. Today these regulations are being strictly enforced.

In an amnesty doctors turned in ancient incomplete registers and out of date vials and confessed to not having 10 kg strongboxes in their bags. Now we have regular and rigorous inspection of our registers. Controlled drugs are kept in lockable containers at all times; the locked boot of a car is not enough. And we are asked to meet an inspector regularly.

However, these days there are many fewer occasions when general practitioners need to give drugs such as diamorphine. Patients with myocardial infarction are whisked straight to hospital by competent paramedics who provide an extended role of care. In palliative care, forward planning means that drugs are prescribed to the patients before they are actually needed, and controlled drugs registers are held in the house. This is all for the good: it limits the opportunity for doctors themselves to misuse the drugs and limits their potential to harm patients, as Harold Shipman did.

However, this regulation generates an air of suspicion. Doctors worry about the consequences of losing the register or, worse, a vial of diamorphine. They fret over what to do with out of date stock or simple errors in recording. And the situations in which we would normally resort to using controlled drugs are points of crisis, occasions not given to filling forms and fumbling for tiny misplaced keys. Because of these concerns many doctors, especially those who do not work out of hours, have stopped carrying injectible controlled drugs, electing to carry tramadol instead. Even district nurses refuse to collect or carry scripts for patients. This is all just a natural avoidance response.

But addiction is primal, so those doctors intent on misusing controlled drugs will find other avenues, legal or otherwise. Likewise, those doctors who are intent on malevolence will find new ways to do harm. The rule of unintended consequence means that soon few general practitioners will carry controlled drugs. Will this be in the best interests of patients?

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How many miles to Bethlehem?

IN AND OUT OF HOSPITAL
James Owen Drife

The closest I've got to Bethlehem was a medical workshop in Beirut last month. Or was it earlier, at a conference in Damascus or Amman? Distances in the Middle East can be deceptive. Are we talking geography, politics, or psychology?

As the crow flies from Jerusalem, Beirut is 145 miles (230 km) northwards and Amman is 44 miles to the east. On a map of England, if Oxford is Jerusalem, then Beirut, Damascus, and Amman are Leeds, Hull, and Welwyn Garden City.

What different images these names conjure. Beirut still suggests violence, despite the beauty of the American University's clock tower, rebuilt after the 1991 bombing. Damascus reminds Christians of Paul's conversion, though it long predates the New Testament. And Bethlehem, especially in December, is an icon of sentimentality, evoking images of shepherds bathed in starlight.

Today Mary and Joseph would have a tough time reaching that stable, let alone fleeing to Egypt. Nazareth is in Israel, or the "Occupied Territories," as it was called during our workshop. Whatever name I use I must brace myself for emails. Bethlehem is only six miles south of Jerusalem, but miles are irrelevant because the town is in Palestine (or, if you prefer, the West Bank), and a wall separates them.

Our workshop was organised by the World Health Organization through its tactfully named Eastern Mediterranean Regional Office. I learnt that WHO does not provide estimates for maternal mortality in the West Bank (or Palestine Northern Governorates), which has its own maternal mortality survey initiated by the United Nations Relief and Works Agency and run by the Ministry of Health.

In 2009 the rate in Bethlehem, based on four deaths, was about 60 per 100 000 births.[1] In Israel in 2008, according to WHO, the rate was seven per 100 000.[2] You or I might think a way could be found to allow pregnant women prompt access to Israel's world class medical facilities, but not even the United Nations Human Rights Council, which regularly discussed this problem, has worked out how to do this.[3]

Until recently women gave birth in cars at checkpoints and sometimes died.[1 3] No maternal deaths at checkpoints were reported in 2009. This may be because of an initiative by Palestine to establish its own hospitals or because families have stopped trying to take women to Israel for help. Either way, women are still dying. It makes you weep.

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