A city on the verge of a nervous breakdown, p 894

Chaplaincy services are not only for religious patients

PERSONAL VIEW **Mark Newitt**

At the age of 25 Adrian Sudbury, a local newspaper journalist, was given a diagnosis of acute myeloid leukaemia. I first met Adrian in early 2007 in my role as a hospital chaplain and worked with him over the next 18 months, ending up helping him plan his funeral and memorial service. Many of the particulars of my work with Adrian related to wider themes about the role and value of chaplaincy in the NHS. Adrian was not religious, yet he was certain that chaplaincy interventions greatly contributed to his wellbeing. His case typifies a new generation of patients who require a shift in knowledge, skills, and practice by all those involved in the holistic care of patients.

In the early months of Adrian's chemotherapy we met on several occasions for general conversation. When I visited in May 2007 he told me he was now in hospital for a stem cell transplantation, and I spent time listening to Adrian express mixed emotions about the transplantation. He was glad there was a donor but was concerned about being in isolation and was, unsurprisingly, worried about the unknown outcome and future. During Adrian's five weeks in isolation I visited him nine times. When Adrian was feeling the effects of the treatment, my visits tended to be short, of the "hang in there, I'm still thinking of you" sort. As the effects of the treatment wore off, and the effect of isolation increased, my visits became longer, sometimes lasting over an hour. During his time in hospital I did not undertake any religious functions with him.

Adrian's case highlights the fact that asking whether a patient is religious or not is an inappropriate way to discern whether chaplaincy support would be of benefit to them

Describing his experiences on a blog that he began as his transplantation approached, Adrian had written: "Interestingly, it was a hospital chaplain who was one of the greatest helps to me through these difficult times. He would pop in at least once a week and chat with me about anything and everything. We would have a laugh together, and I can't tell you how wonderful it was to converse with someone who wasn't medically or emotionally connected to me or [who would] make inquiries as to how many times I had 'opened my bowels' that day." After the transplantation failed Adrian lobbied the government to ensure that all 17 and 18 year olds are educated about blood, bone marrow, and organ donation.

My visits to Adrian were typical of much chaplaincy work. Some might be classified as pastoral visits, where we spent time in general conversation. Other times are better described as pastoral counselling. Working at a deeper level, my aim was to help Adrian make sense of what was going on, in relation to himself and his understanding of the world, and to find sources of strength and hope. As is often the case, the first type moved rapidly into the second as Adrian and I built a relationship of trust. The aim of my involvement was to support him through times of transition. Initially this meant helping him through the changes associated with his treatment and then, later, the move from life to death. The task of helping people through times of transition is, I believe, a key role of the chaplain. This view is supported by other practitioners and commentators (*Journal of Religion and Health* 2001;40:205-12; *Scottish Journal of Healthcare Chaplaincy* 2007;10:4-10).

As part of his admission to the unit Adrian was asked what his religion was. With his thoughts focused on a potential leukaemia diagnosis, Adrian said that he had indicated none and thought no more of it. It would seem that, at this stage, the ward thought no more about it either. This is concerning. Here was a young man who faced having his world turned upside down by a life threatening diagnosis, and yet because he did not fit a neat religious category, his spiritual wellbeing was potentially ignored. A narrow understanding of chaplaincy, restricted to religious care only, would suggest that a chaplain had no reason to visit Adrian. Yet it is clear that the visits were greatly beneficial.

The skills used in chaplaincy—listening, building relationships of trust, and using intuition, compassion, imagination, and creativity—are irreducible to numerical terms and not easily measured. Although numbers are necessary to manage large organisations, they must never become the final word. This is beginning to be understood in the NHS. Ara Darzi's final report of his review of the NHS, High Quality Care For All, states that, alongside effective treatment, patients "want care that is personal to them, and to be shown compassion, dignity and respect by those caring for them." These values, and a patient centred approach, are embodied in the work of chaplains.

Adrian died on 20 August 2008. Given the high profile nature of Adrian's blog and campaign, it would be difficult to pseudonomise the details of this case, as would be normal. Adrian is named and personal correspondence used with the full permission of his parents. Further details of Adrian's story and campaign can be seen by visiting http://baldyblog.freshblogs.co.uk

I am not suggesting that every patient would find value from a chaplain's visit, nor that every hospital patient has deep spiritual needs. However, chaplaincy is clearly important in the care of some patients; and some who would benefit from chaplaincy support end up without it. Adrian's case highlights the fact that asking whether a patient is religious or not is an inappropriate way to discern whether chaplaincy support would be of benefit to them.

I leave the last word on the value of the chaplaincy service to Adrian, written in an email from him to me on 12 July 2008: "It's difficult to quantify exactly how I was helped but I will just try and briefly explain. For an hour or so we could talk about football, running, the state of the church, world politics, faith, local and national news, emotional issues and hope. There is no one else who could have provided a service, or range of conversations, to match this—given my unfortunate circumstances. I loved these chats, and they were always something that left me feeling better and with a renewed determination to keep battling on. It was a service that made one of the most difficult times in my life substantially more bearable."

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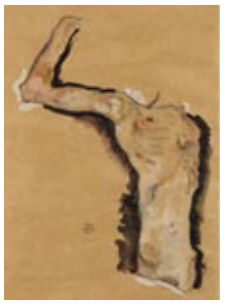
REVIEW OF THE WEEK

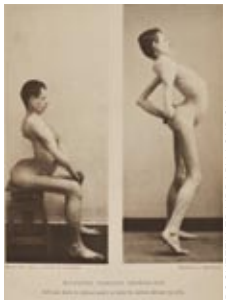
City on the verge of a nervous breakdown

An exhibition looking at the relations between mental illness and art and architecture in Vienna impresses **Trevor Jackson**

Madness & Modernity: Mental Illness and the Visual Arts in Vienna 1900
An exhibition at the Wellcome Collection, London, from 1 April to 28 June 2009
www.wellcomecollection.org/madnessandmodernity
Rating: ★★★☆



COURTESY OF RICHARD NAGY LTD, LONDON



ROCKEFELLER LIBRARY, LONDON

PHILLIPS COLLECTION, WASHINGTON DC

Above: Male Torso (Body and Arm) by Egon Schiele. Were his figures influenced by images from Salpetrière? Right: Oskar Kokoscka's portrayal of Lotte Franzos as mentally ill horrified her

Vienna in 1900 was one of the most conservative cities in the Western world. It was also the home of Sigmund Freud, the artists Egon Schiele, Gustav Klimt, Oskar Kokoschka, and Max Oppenheimer, the architects Adolf Loos and Otto Wagner, the philosopher Ludwig Wittgenstein, the writer Robert Musil, and the composers Gustav Mahler, Richard Strauss, and Arnold Schoenberg. The city that was the capital of the crumbling Hapsburg empire was also a centre of radical innovation and was on the brink of far reaching social and cultural changes that would usher in a new sense of modernity.

The Wellcome Collection's latest exhibition is an ambitious and impressive venture that looks at the interaction between madness and Viennese radicalism in art and architecture—at how creativity and mental difficulty shared the same space—and at the belief that modern architecture could transform people's lives. Vienna in the early 1900s was in the grip of an epidemic of what were described as nervous ailments (what we would nowadays identify as depression, stress, and anxiety), and the city's wealthy described themselves as living in a "nervous age."

In 1906 Josef Hoffmann, a student of Otto Wagner, designed the Purkersdorf sanatorium in the Vienna Woods on the edge of the city specifically to treat these ailments. It was a Modernist architectural masterpiece of clean lines and hygienic spaces that functioned more as a hotel than a hospital. Purkersdorf's doctors believed that nervous ailments were bodily afflictions and tried to convince their patients that what they needed was physical, not mental, therapy, recommending, for example, a regimen of gentle electrotherapy (a world away from electroconvulsive therapy), although there was no hard scientific evidence for any of its treatments.

Nowadays when we think about mental illness at the beginning of the 20th century it is Sigmund Freud who is likely to come to mind, but the exhibition argues that Freud, who was moving away from the notion that mental ailments were bodily in origin and were instead to do with patients' psychological and emotional past, was very much on the margins of Viennese developments in the treatment of mental illness. However, the exhibits include a re-creation of his famous couch, along with statuettes from his desk (*BMJ* 2006;332:613) and a portrait by Max Oppenheimer.

With the city seemingly in the grip of mental ailments, many of its artists were interested in portraying them. Schiele is perhaps most famous for this, with his contorted, uncontrolled figures, including a famous image of masturbation. Next to reproductions of some of Schiele's work (it is a pity that the Wellcome was able to obtain only two Schiele originals) are pages from the *Nouvelle Iconographie de la Salpêtrière*, a journal produced at Jean-Martin Charcot's Paris clinic for disorders of the nervous system. These show the contorted bodies of patients with conditions ranging from a funnel shaped thorax (pigeon breast) to hereditary myopathy with refractions. The curators are keen to suggest that Charcot's journal was specifically aimed at artists such as Schiele, as well as doctors, and that the word "iconographie" in the title underlines this. The juxtaposition of pages from the journal and Schiele's works seems to imply that the photos were used as sources for artists searching for new ways to represent the body, although evidence for this idea is lacking.

Soon Vienna's artists extended their iconography of mental illness to include images of friends and patrons. Kokoschka shows Lotte Franzos with her fingers held rigid, her arms pulled across her abdomen, and her face downcast, a representation that upset his sitter, who wrote to him expressing her dissatisfaction and enclosing an image of what she thought she really looked like. Other sitters, however, such as Thomas Mann's brother Heinrich in a painting by Max Oppenheimer, were said to be happy to have themselves portrayed as mentally ill. Heinrich is shown with flickering eyelids, rigid limbs, and splayed fingers.

"Vienna 1900" in the title is perhaps misleading, as the focus ranges from 1784—in the exhibits relating to the infamous prison-like asylum in Vienna known as "the Tower of Fools"—to an impressive collection of stunningly beautiful "outsider art" (a term generally applied to art by psychiatric inpatients) found among the rubbish from an asylum in 1950. But the exhibition, which brings a number of important Viennese works to Britain for the first time, convincingly identifies the early 1900s as a time when psychiatry began to influence early modernism in architecture and the visual arts. It gives an overwhelming sense of a city living in "nervous times"—one that foreshadowed our fast paced modern cities, with all their anxieties.

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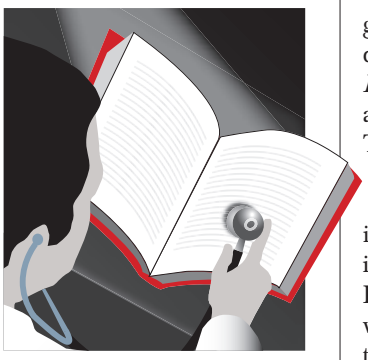
The surgeon's prayer

BETWEEN THE LINES
Theodore Dalrymple



"I believe in surgical treatment for duodenal ulcer, cerebral abscess, pyloric stenosis, aneurism and all forms of endocrine disturbance"

W H Auden's father, like Marcel Proust's, was a professor of public health. Auden developed an abiding interest in medicine, and also in psychoanalysis, from reading in his father's library. When Auden was 20 his father published an article on autoerotic strangulation. Proust's father also published in the field of psychopathology.

In 1935 Auden wrote a play, *The Dog Beneath the Skin*, in collaboration with Christopher Isherwood, in which appears a surgeon, remarkably like Sir Lancelot Spratt in the 1954 comedy film *Doctor in the House*, called Sir William Spurgeon. It is not easy to summarise the plot, except to say that it is a satire on the state of Britain and, to a lesser extent, of Europe in the 1930s, and it ends with a peroration by the vicar of an English village, in which he addresses the young people in the manner of a fascist leader. Great poet as Auden was, I do not think this was an acute political observation.

Sir William is a surgeon of the old school: a caricature, in fact, 17 years before Sir Lancelot. When he enters the operating theatre he makes the students recite a credo:

Sir William: I believe . . .

Students: In the physical causation of all phenomena, material or mental: and in the germ theory of disease. And in Hippocrates, the father of Medicine, Galen, Ambrose Pare, Liston of the enormous hands, Syme, Lister who discovered the use of antiseptics, Hunter and Sir Frederick Treves. And I believe in surgical treatment for duodenal ulcer, cerebral abscess, pyloric stenosis, aneurism and all forms of endocrine disturbance.

Sir William: Let not the patient react unfavourably to the anaesthetic.

Students: But let it save him from pain.

There is then a satire in the form of the chants of the Church of England:

Decani: The surgeon is great: Let his name appear in the birthday honours.

Cantoris: I was in danger of death: And he delivered me.

Decani: I was in fever and could not sleep. The pain assailed me all day long.

Cantoris: I groaned in the darkness: I was in terror for my life. I took no pleasure in women, neither in the innocent pastimes of children, my food had lost its savour.

Decani: The physicians shook their heads: they consulted together in the next room and were perplexed.

Cantoris: They prescribed diets, cathartics, drugs and all manner of salves and ointments: but no one of them relieved me.

Unison: But the surgeon, he relieved me: he removed the emphasis of my trouble and I was healed.

In the course of the operation the lights go out: this is because other medical students, in the middle of their rag week, fuse the lights during their festivities. Sir William loses his temper and throws the instruments about; the patient dies, and he blames everyone else.

The play is also satirical about militarism and patriotism. It ends with a paraphrase of Marx, uttered by the chorus: "To each his need: from each his power."

It is all the more ironic, then, that my copy should be inscribed (in red ink—whether to show sympathy with the political ideas at the time of Auden and Isherwood?) with a name and date, "Anthony Patrick Benson Graham Sutton, March 1938," followed by a very neat print inscription: "Killed in Libya November 1941."

And on the page opposite, in yet another neat and cultivated hand: "For Jeffery R Pearson, With love from Helen and in memory of Pat."

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

Det Syke Barn (The Sick Child)

By Edvard Munch **Painted 1885-6**

Det Syke Barn (*The Sick Child*) was first exhibited in Oslo in 1886. It's not the artist's best known painting, that of a screaming figure with hands clasped to a contorted face, now debased in countless parodies and caricatures. But Munch's image of a mortally ill girl or young woman is important because it marks a definitive transition in his painting style, from traditional realism to a more abstract and subjective expressionism.

Initially exhibited with the unspecific title *Study*, the painting's unfinished state provoked controversy. It was ridiculed in the press, even though the exhibition selectors had emphasised its importance, hanging it in a prominent position. There is a biographical tendency to romanticise artists' early lives as heroic struggles for recognition; but *The Sick Child*, as it later became known, did receive some positive, contemporary opinions. It was not universally derided.

The painting broke with earlier 19th century representations of sick children, such as the sentimental photograph *Fading Away* (1858) by the English photographer Henry Peach Robinson, a stilted composition with a lateral view of a young woman slumped on her sick bed, surrounded by family members. The Norwegian painter Christian Krohg's *Sick Girl* (1881) depicts a seated, wan figure in full face, clasping a rose whose shed petals presage her own imminent death. Munch shows his sick girl in profile, her pale face silhouetted against a white pillow, across which strands of her red hair stream like seaweed. She seems resigned rather than anguished. Her already grieving mother, hunched forward with her head bowed clasping the girl's left hand in hers, contemplates her imminent loss.

NASJONALMUSEET/BØRRE HØSTLAND

Munch had personal knowledge of tuberculosis, which was rife in the 19th century. His father, Christian Munch, was an army doctor; and tuberculosis killed both his mother Laura (in 1868, aged 31 years) and elder sister Sophie (in 1877, aged 15 years). The artist often wrote about *The Sick Child*, as in this 1929 account: "I reworked the picture countless times in the course of a year—scratched it out—allowed it to infuse the paint medium—struggling again and again to recapture the first impression—its translucency—the pale skin towards the canvas, the trembling lips, the trembling hands."

Permanently on show at the National Gallery in Oslo, *The Sick Child* is currently the subject of an exhibition (from 16 January until 3 May 2009) examining its history. Included are the artist's five other painted versions and several lithographed and etched versions of his haunting image of a dying young woman and her despairing mother. To 21st century eyes, the roughness of Munch's original painting, although controversial when it was first exhibited, heightens the raw, inexpressible emotional content inherent in the artist's subject.

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Save our souls

FROM THE FRONTLINE
Des Spence

What the hell is going to happen to all our recently qualified general practitioners? Locum work is drying up, out of hours rota sessions are full, the only permanent jobs are salaried positions, and GP partnerships seem to be coming to an end. Why is all this happening?

In the mid-1990s a doctor shortage led to an expansion of medical schools' intake; this expanded cohort of doctors is now completing specialist training. Furthermore, after the Modernising Medical Careers (MMC) debacle in 2007 many hospital doctors moved into general practice. So more GPs were produced. Also, the employment changes arising from the 2004 GP contract are now being felt. At one time there were no salaried positions, with regulations stipulating partnerships or nothing. And there were large financial incentives to take on new partners.

But now practice finance is completely deregulated, with just one big tempting pot of cash. So, for instance, why not make savings on reception staff and keep the money? If the practice needs extra clinical time, why not employ a cheaper salaried doctor or, better still, a specialist nurse and pocket the difference? Why retire? Or you could drop clinical commitments and "manage" a salaried horde. Few partnerships are being offered, because the current partners would be financially stupid to do so.

The result is increasingly resentful new GPs who are offered no career progression, are effectively disenfranchised from the GP community, and are left scrabbling for shrinking amounts of locum and out of hours work. Add in the recession's squeezing effects on use of locums, and the law of supply and demand will see locums' pay rates fall and the financial situation of new GPs become ever more dire. This is not a crisis yet, but it will be.

I propose a solution to which I am willing to put my energies. We all know that the quality and outcomes framework (QOF) is stupid, paper shuffling nonsense. So half of QOF payments should be used to encourage new partnerships, as real quality of care is born of continuity and access to well trained, committed doctors. Secondly, salaried contracts should be a "partnership with a view," with a defined run in of a year, giving proper career progression. Without young partners, traditional general practice in the United Kingdom will die.

GPs are becoming salaried zombies enduring an eternity of centralised polyclinic hell. This is wrong, and the time has come to protest. Picketing the conference of local medical committees in June might be a start.

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No going back

DRUG TALES AND OTHER STORIES
Ike Iheanacho

Forget the future; that's all in the past now. Referring to it just makes you look like a dinosaur and so out of touch that you're unaware how the world has moved on. Smart people wouldn't dream of using this F word, not when they can talk instead of "going forward."

This pesky phrase is everywhere, and its appeal is obvious. No longer is it the preserve of people who converse entirely in marketing speak and who believe, for example, that thinking can't be simply novel or creative but must instead be "blue sky" or from "outside the box." As something that combines notions of ambition, direction, momentum, and improvement, "going forward" lends a seductive sheen to the most suspect of plans.

But unfortunately all it ever really guarantees is change, often for change's sake and not necessarily for the better. It operates (if that's the right word) on the principle that doing something—anything—different inevitably trumps the status quo (which is typically caricatured as "doing nothing"). Consequently it's essentially a short termist philosophy, with little appreciation of difficult but helpful lessons from history.

This attitude abhors evolutionary change, mislabels targets as useful outcomes, and confuses frenetic effort with improvement. The NHS has, of course, been a prime victim of this type of mentality, particularly in recent years. It has been plagued with uncoordinated, shortsighted initiatives to restructure, reorganise, and reconfigure what it does, all supposedly to benefit patients. That many of these developments are a rehash of previously tried and abandoned approaches seems not to bother those who dream them up and drive them through. Nor do these individuals seem unduly troubled by the resulting bewilderment and frustration felt by the NHS staff who have to work through these questionable attempts at progress.

It's too much to hope for any fundamental alteration in this way of doing things. Successive governments have chosen to retain hands-on control of key aspects of the NHS. As such, the service itself, its management, and its long term f****e remain prone to the vagaries of the electoral cycle, the popularity and confidence of the governing party, and the interests and ability of ministers. All these elements fit more naturally with "going forward" than with the broader vision and independent mindset needed for truly sound planning.

Although it's small consolation, we can at least keep close watch on those who manipulate the language to disguise weaknesses in their proposals. "Going forward"? Blundering on, more like.

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