The film *The King's Speech* is reviewed on bmj.com (2011;342:d456)

Should the spectacle of surgery be for sale?

PERSONAL VIEW **Simon Chapman**

Recently my band, the Original Faux Pas, donated its services to a cancer fundraising event. The event was a huge success, raising more than $A50 000 (£30 000; €37 000; $US50 000), with about 260 people digging deep for auctioned items donated by local businesses. Among the items was the opportunity for two to attend an operation being performed by a neurosurgeon.

Bidding was spirited as the auctioneer barked out the virtues of this exclusive opportunity, and the winning bidders paid something like $A1600, presumably to watch someone having brain surgery. I once bid for an opportunity to have dinner with a senior politician so I could get in his ear. For good causes sports stars often offer games of golf or tennis, and musicians give backstage passes. But somehow this seemed rather different. Two medical members of my band pulled perplexed faces as the item appeared between autographed football jumpers.

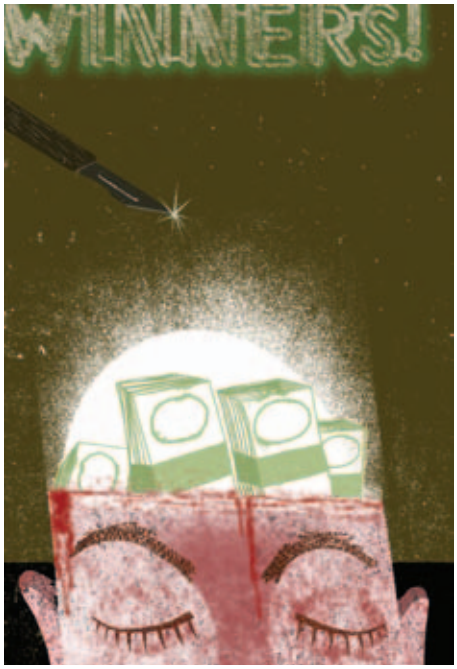
In the 19th century surgeons performed their tasks in rooms where limited seats were available for the public to watch. But many things have changed since then, not least the emergence of bioethics as a discipline that is relevant to every branch of medicine. Let's assume that in tapping the value of his prominence to help in funding cancer research the surgeon had obtained full clearance from his hospital ethics committee to have paying strangers sit in on his operations. This clearance could be conditional only on the observed patient giving full consent. But here, important considerations would arise for any ethics committee.

A person about to have brain surgery will often be desperate and vulnerable, fearful that the operation may fail. Imagine yourself in such a circumstance and having your surgeon say, "Oh, by the way, would you be willing to allow a couple of people who've paid big money to raise funds for cancer research to sit in and watch what happens to you?" Plainly, in offering the opportunity the surgeon and any ethics committee who supported him think that no coercion would be involved, that any patient would be absolutely free to say no.

But vulnerable patients are in very different circumstances from those of patients who consent to take part in a study where personal questions might be asked by researchers whom they have never met before and will probably never see again and who are offering them nothing in return. Here, a surgeon whose skills may literally mean the difference between life and death invites a seriously ill patient to think twice about turning down that surgeon's request.

An obvious parallel is with reality television surgery programmes, such as Channel Nine's *RPA*, which shows the everyday work at the Royal Prince Alfred Hospital in Sydney. Instead of two paying customers witnessing the travails of surgery in the operating theatre, hundreds of thousands of faceless viewers witness patients' journeys, their indignities, hopes, and anxieties—and sometimes their last days of life. Viewers can talk to anyone they like about it. All the patients filmed in *RPA* fully consent to participate. So what's the difference?

One critical difference is that, at any time after the *RPA* filming and before the segment is broadcast, if any of those who gave consent chose to withdraw it the segment would not be shown. If a patient who consented died, their relatives may well wish not to have the world witness their grief. But with paying spectators at an operation the witnessing will have taken place and could not be withdrawn. Two strangers will have been temporarily admitted as paying spectators.



ROB WHITE

What guarantees are there that winning bidders would not pass on full descriptions of what they saw to enthralled dinner party guests?

What guarantees are there that winning bidders would not pass on full descriptions of what they saw to enthralled dinner party guests? What if interesting biographical details slipped out about the patient? Unlike hospital staff, paying guests are not subject to the same ethical requirements of confidentiality. It would be unimaginable that the spectators would be allowed to film what they saw, because of the potential for gross invasion of privacy. So what is it about merely watching that makes it all right?

Medical ethics recognises that some things can never be done with patients, regardless of any question of consent. Health professionals and teachers cannot have sex with their patients or students, even if they might consent, because of the understanding that the imbalance of power between patient and doctor or teacher and pupil rules out the possibility of a mutually consenting arrangement.

The surgeon was doing a noble thing by trying to contribute to cancer research. But should his patients really be put in a position to have to surrender their privacy? In important respects the same concerns about undue influence also apply to *RPA* and other reality medical programmes. Patients should be told that the deal between the hospital and the *RPA* programme provides much needed dollars for the hospital, to enable it to continue to do important things.

Simon Chapman is professor of public health, University of Sydney simon.chapman@sydney.edu.au

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REVIEW OF THE WEEK

Reality bites

Cynicism, racism, and how to tell a colleague that he has cancer: **Kinesh Patel** is impressed by a refreshing play that is unafraid to portray the gritty reality of hospital medicine

Tiger Country
A play written and directed by Nina Raine
Hampstead Theatre, London NW3 3EU
Until 5 February 2011; from £22
www.hampsteadtheatre.com
Rating: ★★★☆

ROBERT WORKMAN

The last time I heard the words "tiger country" was when I was navigating my way with a colonoscope through a rather tricky sigmoid colon affected by severe diverticulosis. "Be careful," the consultant said to me, adding for effect, "This is tiger country."

Thankfully Nina Raine's new play *Tiger Country* is much more pleasurable and a good deal more insightful than a difficult colonoscopy. Stage or screen productions that are based on medical material usually glamorise medicine to such an extent that they become more a simple form of entertainment rather than an accurate depiction of reality.

And although there is nothing wrong with simple entertainment, it can become a little tiresome when what I call the "Karl Kennedy effect" takes over a production, after the one man who acted as general practitioner, gynaecologist, surgeon, radiologist, and oncologist to keep the storyline moving in the Australian soap opera *Neighbours*.

Raine has made no such concessions in the script of this play. Researched meticulously—she spent three months in hospitals shadowing doctors—the small, often innocuous details we all note in our everyday lives are brought to life with panache in the amphitheatre-like setting of London's Hampstead Theatre.

One such scene involves a doctor unsuccessfully trying to eat his lunch, a rather tired looking sandwich, but being thwarted at every turn by the incessant bleeping from his pager. Each time the bleep sounds he indifferently places the sandwich back onto a clinical surface, answers the telephone, and picks it up again after the call is complete, seemingly unaware of the untoward organisms that could be transferred to his food. We've all seen that casual disregard for infection control when our colleagues are harassed.

The controversy reaches much deeper than breaching infection control, however. The play illustrates the dichotomy of modern medicine superbly: the overarching story is that of a young doctor keen to do her best for all her patients and frustrated by the resistance and cynicism of those around her when she struggles. Her efforts have predictably adverse consequences on her personal life with a fellow doctor. This part of the plot is a little formulaic, but the other strands bring out themes not usually seen in medical dramas.

The somewhat cavalier racism that does still occur in the NHS at the expense of staff is mentioned. One male doctor talks to another about finding a new girlfriend: "Nurses aren't sexy any more; they're all Filipino," he says in matter of fact tone, adding, "Physios are the new nurses."

Raine must have based these lines on what she heard during the time she spent in four hospitals in southeast England. That such comments were made with an external observer present shows how racist attitudes are entrenched in mess banter and highlights some doctors' lack of insight into their wider social unacceptability.

It doesn't end there. Comments about "vacuous black nurses" make uncomfortable listening; it would be naive, however, to try to disregard them as theatrical licence when they probably represent a school of thought. Patients also do not escape vitriol: a doctor irreverently refers to a particularly large woman's derrière as a "double Whopper with cheese."

All this sets the play apart from the modern medical drama that has become so familiar. Imagine hearing such lines broadcast on the BBC: it would never happen, because it would be politically unacceptable. What makes *Tiger Country* so refreshing is that it doesn't seek to shock or provoke controversy but merely mentions these issues almost as an aside, which, paradoxically, seems to give them more weight.

A doctor irreverently refers to a particularly large woman's derrière as a "double Whopper with cheese"

Raine doesn't miss the chance to probe the weaknesses of the NHS and its staff. One character discovers a lump in his neck. Watching a colleague trying to break the bad news to him in the mess that he has lymphoma is cringeworthy but probably a damning indictment of how bad we are at handling illness ourselves and when it afflicts colleagues.

But perhaps the most interesting part of the play was when Thusitha Jayasundera, a hardnosed Asian surgical registrar, has a moment of introspection concerning the sacrifices she has had to make to fit into the surgical establishment, admitting to a colleague that she is forced by an unwritten surgical culture to act, dress, and talk like a white, middle class male.

Her attitudes are tempered when her relative becomes unwell: she moves from the role of doctor in charge to the lowly rank of patient's relative and finds herself impotent when dealing with the situation, a situation that most of us can relate to. Ultimately she surrenders her chances of career progression to save her relative, provoking the immediate question: would you do the same?

Tiger Country is an accomplished theatrical work. For doctors it provides a combination of vivid authenticity with the added benefit of insight into our day to day lives. Most of us are too busy to examine how and why we do what we do, but this rare beast allows us a valuable opportunity to do so.

Kinesh Patel is junior doctor, London kinesh_patel@yahoo.co.uk

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BETWEEN THE LINES **Theodore Dalrymple**

Hiding and hauntings

Hans Keilson is 101 years old. For many years he practised as a psychiatrist in Amsterdam, particularly among orphans whose parents had been deported and killed—as his own had been. He qualified as a doctor in Berlin but after 1936 was forbidden to practise, because he was Jewish, and so he moved to the Netherlands. His degree was not recognised there, so he became a sports and music teacher. During the Nazi occupation he was hidden by a couple, and after the war he requalified in Holland.

HERMAN WOUTERS/NEW YORK TIMES/REDUX/EYEVINE

Hans Keilson: survived Nazi occupation

He published his first novel in 1933, but it was banned in 1934. He has published a clinical study of the repeated traumatisation of children orphaned in the war and another of Freud's view of art. His novella, *Comedy in a Minor Key*, was first published in 1947 and has recently been republished in England.

This was dedicated to the couple who hid him during the war. In the story a young married couple, Wim and Marie, consent to hide a Jewish man, Nico, during the occupation. They are, of course, frightened, having had no experience of leading a double life or of having to conceal things from their neighbours (who may, of course, equally be concealing things from them).

Unfortunately Nico dies of natural causes, if contributory debilitation by hunger can be called a natural cause. This dashes Marie's dream of proudly walking in the street with Nico after the war to the amazement of the neighbours. The problem that now faces the Dutch couple, however, is how to dispose of the body without being observed. A doctor, Dr Nelis, helps Wim remove the body, by now very stiff, under cover of night to the nearby park, where they put it under a bench. It is found the next morning and becomes the subject of a police inquiry. The couple also have to remove any traces of his having lived in their house.

His novella, *Comedy in a Minor Key*, was dedicated to the couple who hid him during the war

Then the young couple realise that they have made a terrible mistake, their first such mistake in all the months of their vigil. Just before he died they dressed Nico in Wim's monogrammed pyjamas, which have on them a laundry label by which they can easily be traced. They themselves have to go into hiding. Later they learn that the policeman in charge of the case is "good"—that is to say a passive resister who destroys the evidence against them—and they are able to return to their house. But their house has changed for them.

As it happens, an old woman in Paris whom I know quite well recounted to me how she was travelling in a bus there 60 years after the end of the occupation and started to speak to a woman of her own age. They became friendly, and the other woman asked the first where she lived. She gave firstly the address and then the number of the flat in that building. When she heard the answer, the second woman burst into tears. It was the very flat, opposite the local commander's office, in which she had spent the whole of the occupation, hiding in terror, never appearing anywhere near a window.

Ghosts certainly come back to haunt us—if they ever really go away.

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

The Yellow Wallpaper

By Charlotte Perkins Gilman

First published 1892

The short story "The Yellow Wallpaper" is a stirring, if exaggerated, account of the personal experiences of its author, the American writer and sociologist Charlotte Perkins Gilman (1860-1935). It has been repeatedly adapted for the stage and the small screen—most recently serving as the inspiration for a production at the Edinburgh fringe festival in 2009.

Written as a series of journal entries, "The Yellow Wallpaper" is set against the backdrop of recent childbirth. Shortly after the birth of her daughter the protagonist develops depression and fatigue. Her husband, John, himself a physician, determines that his wife has "neurasthenia" and, convinced by the work of Silas Weir Mitchell, a leading neurologist of the late 19th century, prescribes Mitchell's "rest cure" as a treatment.

Forced to retire for the summer to a colonial mansion the narrator finds herself confined to an upstairs room, which has previously served as a nursery. Forbidden from working by her husband, denied access to the rest of the house, and reduced to hiding her journal entries from him, what begins as a "temporary nervous depression" rapidly becomes a florid psychosis, with the wallpaper serving as a focal point. Relatively benign adjectives—its "yellow" smell, its "breakneck, scrawling pattern," its "missing patches"—soon become more sinister, with the eventual emergence of a "shadowy figure" from the wallpaper: "a woman creeping on all fours, trying to escape the bars from the shadows."

The story culminates with the end of their vacation, whereby her husband symbolically opens the door, only to find his wife circling the room, stroking the wallpaper. When she exclaims, "I've got out at last," her husband faints. The narrator continues to circle the room, stepping over her husband's inert body with each lap.

Gilman had repeated bouts of depression throughout her life, and there is a strong suggestion that "The Yellow Wallpaper" is a satirical take on the "rest cure" that had gained prominence in the early 20th century. Based on the premise that sufferers were overeducated malingerers, it often led to solitary isolation, forced feeding, and denial of intellectual stimulation. Yet Gilman's personal experiences led her to believe that these measures only accelerated the descent of a vulnerable mind into psychosis—a belief that did not make her popular with the establishment. In fact one critic wrote, "The story could hardly . . . give pleasure to any reader . . . to others, whose lives have become a struggle against heredity of mental derangement, such literature contains deadly peril. Should such stories be allowed to pass without severest censure?"

More recently feminists have argued that the novel is an example of early feminist literature. Although there is no doubt as to Gilman's feminist leanings and the probable diagnosis of postpartum depression for the protagonist, it is not this battle cry that should lead readers to its pages: the mettle of the story, the fluidity of the language, and the critical review of perceived wisdoms should more than suffice.

Omar Mukhtar, specialist registrar in clinical pharmacology and therapeutics, King's College Hospital, London om1979@hotmail.com

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Greed isn't good

FROM THE FRONTLINE
Des Spence

See EDITORIAL, p 237,
NEWS, p 247
FEATURES, pp 256, 257
OBSERVATIONS, p 260

I have realised that I am not middle class enough to call myself a socialist and that capitalism does work to drive production. Indeed there is plenty of scope for efficiency savings in the NHS's £100bn (€120bn; $160bn) annual budget without a loss of function. So should we welcome healthcare reforms that offer more competition? Soon general practice consortiums will commission services from any "willing provider," and foundation trust status will be given to all hospital trusts, willing or otherwise. All this will be overseen by a new economic regulator.

The government's rationale on commissioning is simple. The greatest costs lie in the shale beds of the hospital sector, but successive governments have been poor at extracting any tangible savings. Indeed the Labour government pushed up labour costs and reduced productivity. So, bin the bureaucrats and get other doctors who know the tricks of the trade to drill out costs. This is a divide and rule policy—not nice professionally but a good political idea.

However, another agenda lies behind the political platitudes: the involvement of the private sector through "willing provider" status. The justification is emotive, with vague references to different countries' cancer survival rates, but these are of course so confounded by reporting as to be next to useless. And the private sector is not based on competition but on greed. This is no basis to provide healthcare—we are not making sausages.

We are offered the false reassurance of robust regulation, but historically the first sign of regulatory problems is spectacular failure. Consider also that in the land of far from free healthcare, the capitalist United States, healthcare costs are twice those of the United Kingdom, and 50 million US citizens have severely restricted access to care. Indeed the US's own public sector, Medicare and Medicaid, currently spend almost as much as the NHS does as a proportion of gross domestic product. The US also has the most bureaucratic system in the world, and "competition" there has delivered the world's most expensive drugs. The US system is defined by overinvestigation, overdiagnosis, and overtreatment. The world needs more nationalised healthcare to remove the shadow of profit from medical decisions.

Success in private care is measured by activity. But the best medicine is often no medicine, and mere activity is no measure of quality. Aggressive capitalist corporations would be a disaster for the NHS. With costs pushed up, the system would be intent on chasing and capturing the well in the name of profit. These corporations would become huge employers with the power to bully parliament and suffocate true competition. The NHS will change from a state monopoly to a corporate cartel. We have a once in a generation opportunity to protect the NHS from greed—we must resist private medicine.

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

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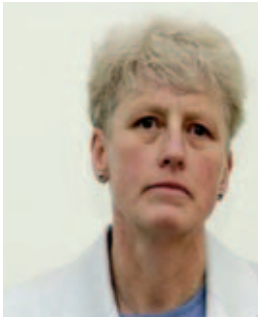
Continuity of care

OUTSIDE THE BOX
Trisha Greenhalgh



I've had the same hairdresser for 21 years. She recently took a career break of several months. I forgave her, of course, for having a life event, but what about my hair?

I had already fallen in with the salon's new system of interdisciplinary care pathways. On my arrival one staff member would check me in, another would wash my hair and get me seated before *my* hairdresser was summoned, and a fourth came round and offered me tea. I humoured this assumption that my personal haircut was really "teamwork."

I was assured by the manager of the salon that any of the other hairdressers would be aware of my needs—but the salon didn't seem the same, so I took my custom elsewhere. My first encounter was with a stout, middle aged lady in a tiny, singlehanded shop that had been on the high street for decades. She spurned the new polyclinc model and still did everything herself—including the accounts and washing the floor. She did a passable pudding basin cut with antiquated equipment and told me that gel was newfangled nonsense.

Next time round I found another salon with a gentle, skilful hairdresser who seemed to understand my needs. She allowed me to talk at length about the traumas of being nicknamed "Loo Brush" at school and asked how I felt about each layer as she snipped away. But her salon was miles away, and the waiting list to see her was nearly three weeks long.

Eight weeks later, bad hair day returned. I had my old hairdresser's email, so I contacted her to ask how things were and dropped just a tiny hint. Two days later she was round at my house with a portable kit, apologising for being off work and letting me down. She refused to charge me, and I felt guilty about not respecting her boundaries.

I decided to let it grow—but it did so sideways, as ever. At the end of our road is a unisex barber's shop occupied by a neat, taciturn man who displays a no haggling price list. I popped in on impulse this morning and asked whether he could do me a short back and sides. He gestured for me to sit in the chair, damped my mop down, and clipped away in silence for 10 minutes. He charged me half what my regular salon had charged, for the best haircut I've ever had.

Trisha Greenhalgh is professor of primary healthcare, Barts and the London School of Medicine and Dentistry
p.greenhalgh@qmul.ac.uk

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