**Developing a safe way to use digitalis, p 1393**



# Improving healthcare services for men

PERSONAL VIEW **Ian Banks**

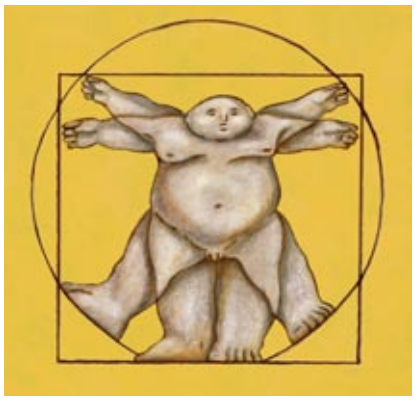
As a GP, journalist, spokesman for the British Medical Association, and, most significantly, president of the Men's Health Forum (www.menshealthforum.org.uk), an independent body working on issues relating to the health of men and boys in England and Wales, I have for many years been campaigning for greater recognition of the specific health issues of men and the need to develop sex sensitive health services. Until recently there has been too little interest, knowledge, or understanding of the term "men's health."

Well into the early 2000s policy makers continued to overlook the need to develop an inclusive approach to men's health. And although appreciation of sex sensitive approaches to healthcare provision has now grown, men's health in the United Kingdom remains astonishingly poor. But I'm hopeful that recent developments will bring positive change—namely, the government's gender equality duty, introduced in April 2007, which applies to all public bodies. However, closing the gender gap can be achieved only if policy and advice on best practice can be successfully implemented at a local level.

The gender equality duty demands that public authorities put gender equality into the mainstream of all functions and policies, by carrying out "equality impact assessments" (tools for public bodies to identify the effects of a policy or function). The duty requires the NHS to tackle men's low level of access to GP services, men's underuse of particular services (such as smoking and weight management programmes), the lack of health information aimed at men, and men's lower life expectancy.

**How men deal with their health is not going to change overnight, yet ignoring their underuse of existing services is condemning them to unnecessary suffering**

Nationally we are moving in the right direction, and progress has been made to put men's health needs on the map. However, transforming national policies into local services remains a problem. National legislation is not filtering down to the local level in a consistent or strategic way, and research endorsed by the Equalities and Human Rights Commission concluded that compliance is disappointingly poor. Services are often inconsistent, temporary, and underfunded.



ALBERTO RUGGIERI/GETTY IMAGES

What is more, little monitoring or reviewing of health outcomes exists. The largest men's health project in England (Bradford Health for Men) is an example. The scheme, introduced in 2002 and partly funded by local primary care trusts, is coming to the end of its five year programme—with no indication of how the knowledge gained will be implemented in future provision of men's health services.

Knowledge is a key factor in translating national policy into local services. Currently, local staff are ill equipped with the tools and knowhow needed to implement change effectively. Staff need to feel empowered and supported to embrace men's health initiatives; it is not a question of chastising primary care trusts for failing to comply with the duty but of educating them on how best to do it.

To develop effective services we must first understand the barriers that prevent men using services. We must understand an area's demographic profile in terms of sex but also how sex interacts with ethnicity, social class, and employment status—and must have a clear view of who is not using services as well as who is.

Although long term health education programmes in schools will influence the behaviour of men in future generations, immediate changes to current services will improve health outcomes today. Making health services more male friendly through extended opening times of general practices and introducing outreach services that target men in safe, familiar environments are just a couple of the ways this can be achieved.

One project that has shown how to engage with men and promote simple ways to achieve healthier lifestyles is the "Go" campaign at Halton and St Helens Primary Care Trust. In response to poor health statistics among men in Halton's deprived neighbourhoods, the trust developed a way to engage with men aged over 40 years through the delivery of free health checks. A dedicated service was built around the needs of local men, involving flexible times for health checks, non-clinical settings, and accessible venues. Motivating the target audience to attend the health checks was a key challenge, given that men in the most deprived areas are often disengaged from services and, in some cases, socially isolated. Provision of what they asked for—"a service just for us"—provided an excellent motivational tool.

The initial results of the programme, which is being evaluated by the University of Liverpool, have surpassed all expectations, with the first sessions being oversubscribed. The programme has continued to meet its challenging targets. More than half (57%) of the men attending have since gone on to access other services, including diet and exercise interventions, smoking cessation programmes, and health trainer services. This success reflects ongoing engagement that will result in genuine improvements in health. This kind of approach, which takes practical steps to target those in need, will help to convert positive policy aims into improved outcomes.

How men deal with their health is not going to change overnight, yet ignoring their underuse of existing services is condemning them to unnecessary suffering. It is our responsibility to implement change and develop services that men feel comfortable using. Only then will we see improved outcomes and a closing of the gender gap.

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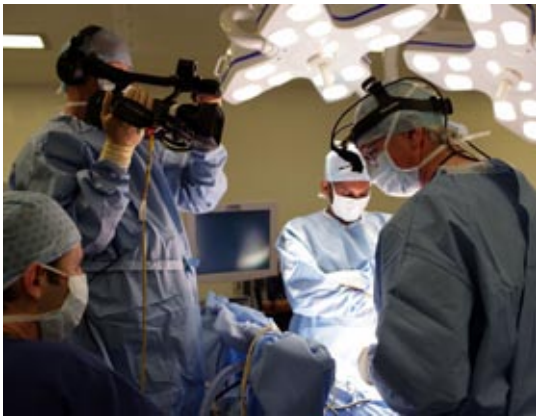
REVIEW OF THE WEEK

# Performing surgery

Public education or thrill seeking voyeurism? **Roger Kneebone** and **Rajesh Aggarwal** find last week's televised surgery a little bit of both



**Surgery Live**
A series of four television programmes, Channel 4, 25-28 May
www.channel4.com/explore/surgerylive
Rating: ★★★☆

In *Surgery Live* last week, four operations were televised on Channel 4. On consecutive nights expert teams carried out major procedures, which were relayed in real time. The four were highly complex—mitral valve repair, resection of a brain tumour, laparoscopic fundoplication, and removal of a pituitary tumour.

This was breathtaking theatre, in every sense. The operations themselves displayed stunning skill and technical mastery. And the sense of presence, of being in the same space as the surgeon, gave an immediacy that we have never seen on television before.

But if these programmes were about enlightening the public, an important concern surfaces at once. Seeing these procedures is one thing but understanding them quite another. Even for us as surgeons, watching operations from an unfamiliar specialty can be deceptive. The transnasal removal of a pituitary tumour through an endoscope, for example, was performed so expertly that the dangers of drilling between the carotid arteries and under the optic nerve were almost invisible.

The programme approached this in two ways. Firstly, by having two way contact between the operating team and the programme's presenter in the studio, Krishnan Guru-Murthy. Taking the part of a lay viewer, Guru-Murthy asked what was happening at every stage, relaying this to the studio audience at London's Wellcome Collection. Cleverly, there was another consultant surgeon in the studio each night who explained the operation as it unfolded and commented on events. This kept a sense of continuity even at tricky moments, when the operating surgeon had to focus entirely on what he was doing.

But this television was never intended to be a one way process where viewers just watch. The programme was billed as an opportunity for the public to get involved. Questions flooded in through Twitter and were fed to the team while the surgery was taking place.

So what did this programme achieve? In one sense, watching surgery live is nothing new. Early operating theatres provided just that—a theatre where students watched while surgeons taught. Today, surgeons routinely watch one another operate during conferences, and patients can see a wide range of procedures on YouTube. But this is the first time that these operations have been aimed at a more general public.

**At one point during the cardiac operation the surgeon asked that he be taken off the air, causing a palpable frisson in the audience. Had something gone dreadfully wrong?**

As theatre, the programme was successful, providing fascinating insights into a world of which most people are completely unaware. But live transmission of complex surgery on mainstream television raises some challenging questions. Where is the line between entertainment and public engagement? And what about the conflicting agendas of television and surgery?

The programmes emphasised that the patients were the most important people in the events. Yet we didn't hear how the patients felt about being broadcast live on air. Especially interesting might have been a discussion with the patient who had brain surgery while awake. How did he feel about being in front of an audience during such a serious life event?

And did these programmes need to be broadcast live? Like watching the Cup Final as it happens, this certainly heightens tension. At one point during the cardiac operation, for example, the surgeon asked that he be taken off the air, causing a palpable frisson in the audience. Had something gone dreadfully wrong? Was the patient in danger? It turned out that the surgeon had simply needed space to think, and the team was soon back on screen. But where is the line between voyeuristic thrill seeking and gaining a genuine understanding of the pressures of surgery?

Another tension is between the need for surgery to inform and for television to entertain. Simply watching an operation is not enough: the viewer needs to be involved, and this in turn must affect the surgery. Commercial television added an additional dimension. At intervals during the operations, the presenter would explain that a commercial break was needed, often asking the surgeon to slow down so that the audience would not miss a key step. It is an illusion that television simply opens a window onto a hidden world without affecting it. Any act of observation alters what is being observed. Like it or not, it is a two way street.

Was *Surgery Live* successful? As theatre, as education, and as entertainment it was. The programmes were handled with sensitivity and professionalism, showing skill, humanity, and restraint. But it remains to be seen whether these values will remain central if surgery were to become a television reality show. We started by thinking that this programme would bring the operating theatre to the public. We ended by realising that it also brought the public into the operating theatre. And that's a challenging thought.

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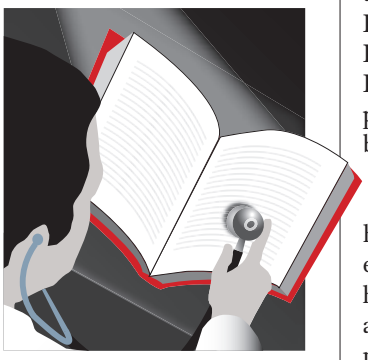
# Curing crime

BETWEEN THE LINES
**Theodore Dalrymple**



**"Perjury is a form of aphasia, leading a man to say one thing instead of another. Forgery is a kind of writer's cramp, forcing a man to write his uncle's name instead of his own. Piracy on the high seas is probably a form of sea-sickness"**

Even Homer nods, so Horace said, by which he meant that even the greatest poets sometimes write dud lines; or, as Somerset Maugham put it, only a very mediocre writer is always at his best.

G K Chesterton was a brilliant writer with an oeuvre so vast that it was inevitably of variable quality. Many of his aphorisms involved a reversal of terms, as in one that should be put up in neon lights in the office of every minister of health: "The reformer is always right about what is wrong. He is generally wrong about what is right."

In 1912, he published a rather strange and not altogether satisfactory metaphysical novel or fable called *Manalive*. It was an attack on the facile, optimistic notion, as common in his day as in ours, that science can tell us how to live, and that with enough technical advances we should all be able to achieve not just progress, but happiness. Chesterton also did not believe that science would help humankind to understand itself, in the sense of plucking out the heart of its mystery. For him, something would always remain inexplicable, which is why he was religious.

In this book, a holy fool called Innocent Smith arrives in a boarding house in Swiss Cottage and is soon apprehended by two doctors, one called Horace Warner, of Harley Street, famous for his treatise on "The Probable Existence of Pain in the Lowest Organisms," and the other Cyrus Pym, an American doctor expert in criminal psychology. They accuse Innocent Smith of various crimes, and hold an informal trial in the boarding house. It is important that Dr Pym should be American, for even before the beginning of the first world war, America was in the forefront of scientistic optimism.

They accuse him of repeated attempted murder. While Smith was at Cambridge, he discharged a revolver in the direction of the warden of Brakespeare College, Dr Wilfred Emerson Eames, a philosopher who had just been telling him how little life was worth living, and how death was preferable. Smith shot in his direction, deliberately missing him, to make him plead for his life, which he did, thus proving that his philosophy was so much sophisticated affectation in which he did not really believe.

He used the same method on Dr Warner, who had told him that he did not celebrate his own birthday because he couldn't see that being born was anything to rejoice about. Dr Warner's outrage at being shot at is supposedly a refutation of this belief.

One of the characters in the book ridicules Dr Pym's patho-physiological theory of crime (and, by extension, of all other human behaviour), to be cured by therapy of an unspecified, but medical, nature: "Perjury is a form of aphasia, leading a man to say one thing instead of another. Forgery is a kind of writer's cramp, forcing a man to write his uncle's name instead of his own. Piracy on the high seas is probably a form of sea-sickness."

Chesterton was an odd mixture of dogmatic faith with regard to religious truth and profound scepticism with regard to the empirical world. Asked by the editor of the *Times* to write on what was wrong with the world, he replied:

"Dear Sir,
I am.
Sincerely yours,
G K Chesterton"

Theodore Dalrymple is a writer and retired doctor

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# MEDICAL CLASSICS

## An Account of the Foxglove and Some of its Medicinal Uses

By William Withering **Published 1785**

William Withering, discover of digitalis, began practising as a doctor in Stafford in 1767. It was a small practice, and he found time to study flowers, which were painted for him by Helena Cook, who became his wife. He soon moved to Birmingham, where his first book, *A Botanical Arrangement*, was published in 1776. It went through several editions and was still in print 101 years later.

In 1775 Withering, whose father was an apothecary, was given a secret family recipe for the treatment of dropsy. Withering realised that the active ingredient was the foxglove. This he tried out on his patients over the years in different preparations until he had acquired 10 years of experience, on which *An Account of the Foxglove* is based. The book reveals a careful and observant author, fully aware of the dangers of digitalis. At first he tried every other possible diuretic in the physician's armamentarium, using digitalis as a last resort. As his experience increased and his confidence grew he used the drug at earlier stages until it became his first line treatment, with the aim of promoting a diuresis, repeating as necessary.

The book's introduction deals with the history of the use of foxglove and the serious symptoms that occur on ingesting it. Withering then describes how he developed a safe way to use the foxglove and records 163 of his own cases, together with 53 case records sent by colleagues.

In my analysis 106 of Withering's cases can be counted as successes; in 94 of them the patient definitely had cardiac failure, while the others have some evidence of it. In the few obstetric cases the patient would probably have had a diuresis anyway, although I suspect one patient had rheumatic heart disease.

Withering discusses the use of various parts of the plant and concludes that the best is the dried green leaf taken shortly after flowering, with the leaf stalk and midrib removed. The leaves rub down to a "beautiful green powder" one fifth the weight of the original. The dose is to be given, he says, until nausea, purging, or slowing of the pulse occurs. The dosage is one to three grains twice daily or, if "if a liquid medicine be preferred," one ounce twice daily of "a dram of dried leaves infused in half pint of boiling water, adding to the strained liquor an ounce of any spirituous water." Thirty grains of the powder, or eight ounces of the infusion, can be taken before nausea occurs, he states.

Withering gives a chapter on rules and cautions and the constitution of patients, and he describes the types of cases most likely to respond, which we would recognise as cardiac failure.

His inferences about the use of digitalis end with a view of the future: "That it has a power over the motion of the heart, to a degree yet unobserved in any medicine, and that this power may be converted to salutary ends."

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# Playing the numbers

FROM THE FRONTLINE
**Des Spence**

"No more bets, please" said the croupier at the roulette table. I was at a university reunion at a casino. It was like the old days; indeed, my friends were still wearing the same clothes and hairstyles as at university. We had £25 split on 33/36, £200 on red, and £100 as an outside bet—all our chips staked on one roll of the ball. "Red 36." We jumped and hugged, exchanging loud, poorly chosen expletives—heterosexual male love is strong. It wasn't the grade As at A and S levels that bound us together—it was that willingness to take a risk.

"Attempts are being made to make the public understand risk, for we are becoming a risk averse society." We strained to hear Radio 4 through the yells and banging of the normal morning melee. My wife used loud, poorly chosen expletives and a "hallelujah." For it is true that we are a disproportionately fearful society. I look on in a professional, non-judgmental way as parents decline the measles, mumps, rubella vaccine, as teenagers insist that a mole is removed, and as patients offer me the result of their full body scan.

Why are people so fearful? Much unease is down to marketing, for despite its supposed sophistication marketing is fundamentally base, playing on fear, lust, and envy. But fear sells the most copies, from newspapers to toothpaste. Also, statistical numbers are easy to abuse through selection and misrepresentation because innumeracy is the norm, not the exception. But fear sells best with a human interest angle, because people connect with individuals not numbers—emotion always suffocates reason. One person's story can change national policy.

Are doctors any better? Not really. We constantly overestimate the risks of hypertension, osteoporosis, and cholesterol, and then compound this miscalculation by overestimating the benefit of intervention. If we are honest, many doctors even struggle to understand the basics, such as relative risk versus absolute risk. For all the hard simplicity of numbers, mathematical concepts are in fact abstract. Doctors too are lost to the emotion of experience and are taken in by medical marketing. But understanding risk and the probability of disease is a core professional duty. This allows us to accept clinical uncertainty and, in these over-anxious times, dispense the single greatest treatment of all—reassurance. Doctors need better training in numbers and marketing; perhaps the occasional night at the roulette wheel might help in the casino that is life.

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# A view from the beach

STARTING OUT
**Kinesh Patel**

I'm on honeymoon at the moment, sitting on an idyllic beach on an island off the coast of Thailand. Which, as I am sure you can imagine, makes writing my next column a bit more taxing than usual.

What do you suppose my greatest fear is (aside from the constant war of attrition I am losing with the local mosquitoes)? Being robbed? No—in fact it seems safer than parts of London here. Losing my luggage? Again, not too much of a concern. The bags are carried by hand from the aircraft into the airport, so there is not much scope for Heathrow Terminal 5 syndrome: "The wide jawed conveyor belt has lost your worldly possessions, sir."

In fact, my greatest fear is getting sick. Not just a little gastroenteritis, but really sick. Sick enough to need hospital. That's despite the fact that I'm insured and that any admission would be to the rather clean and efficient looking international hospital on the next island. Irrational maybe, but it's certainly my greatest fear.

The average salary here is a few dollars a day, which means that local people cannot afford most of the medical care we take for granted. The result is their own fear of becoming unwell. Even those who are insured usually have to make some form of copayment. It does give me a satisfying feeling that in the United Kingdom everyone, whether listed in Debrett's or not, is treated on an equal footing.

However, my views have been tempered by being away from the NHS for a couple of weeks. The real dilemma is reconciling the tremendous waste that we all see every day with the admittedly altruistic notion of universal coverage—waste in the NHS, through its tremendous management inefficiencies; but also waste by patients, who often do not appreciate the privileged position they find themselves in, even when the food may not be exactly to their liking or when they have to wait a little longer than they would like.

How often is an ambulance called out for a trivial ailment? How often do we see patients not attend their appointments? How often do we hear patients ready for discharge ask to stay in hospital for another day or two for no particular reason? How many of those patients would actually leave immediately if promised room and board at the Savoy (which would be cheaper for the NHS than an additional night in hospital)?

Too many. But then again any system that strips patients of any form of personal responsibility is bound to be profligate in its spending, with results that are not commensurate with the level of expenditure. And that sums up the NHS quite nicely.

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