William Roughead's crime writing is rich in detail about doctors, says Theodore Dalrymple, p 661

Public health reforms won't mitigate the cuts

PERSONAL VIEW **Tim Blackman**

Among the places least resilient in coping with the Conservative led coalition government's public spending cuts in England is the northern town of Middlesbrough, where 33% of jobs are in the public sector and 21% of the population of working age are claiming benefits because they are out of work. Previous Labour administrations used growth in public sector jobs to help tackle worklessness, bringing many women, in particular, into the workforce. Now women will bear the brunt of public sector job cuts. The scenario coincides with the latest life expectancy figures, which show a fall in female life expectancy in Middlesbrough.

How much will places like Middlesbrough be helped by this government's reinvention of public health with its own separate budget and a new home in local authorities rather than the NHS? Certainly, this budgetary transparency contrasts with the last Labour period, when it was impossible to establish how much was being spent on public health and tackling health inequalities. The last Labour period was also a time of growing medicalisation in public health, when the race to hit 2010 targets for reducing health inequalities saw efforts increasingly focus on finding the undiagnosed so called missing millions who need medical treatment. Social determinants are now to receive more attention.

Local authorities' ringfenced budgets, however, will be a fraction of their existing spending on public services such as housing and education, which are fundamental to good health—especially to the health of the poorest. Although directors of public health will be employed by local authorities, their influence over these large council budgets will be small and compromised by deep cuts and the continuing trend of handing budgets from multipurpose local authorities to single purpose housing companies, schools, and social enterprises. Public health will be one of many opposing priorities when making decisions about cuts to these services, and the devolution of budgets to single purpose and often competing organisations means that the public good may be trumped by organisational self interest.

Self interest, though, is something that the Conservative led coalition feels comfortable working with. Among a proliferation of so called nudge initiatives based on this rather dismal view of human nature are conditional payments. These incentivise healthier behaviour among those who otherwise cannot stop themselves eating junk food, smoking, and sitting in front of the television rather than jogging round the block. Paying people now for behaving better seems to work, for drug misuse and smoking at least, where the odds of success are raised by as much as 50%.

What better than to spend ringfenced public health funds on something that actually seems to work? But this is hardly public health coming home to its roots in major programmes of improvement, because these payments are far too low to change the material circumstances of the overwhelmingly poor people whose health would most benefit from a healthier lifestyle. Conditional payments just continue paying for the problem.

I have heard public health directors welcome secretary of state for health Andrew Lansley's emphasis on the social determinants of health inequalities. Housing, for instance, is back on the agenda. Yet this is largely about individualistic solutions, such as supposed innovatory schemes for repairs on prescription or fuel poverty referrals for home improvements. These too might be seen as good candidates for spending from local ringfenced budgets, but at population level are likely to have little impact.

A housing measure with a population impact, and on the industrial scale that we might expect from a public health initiative, is the last Labour government's Decent Homes programme. In all, £30bn ($48bn; €35bn) was spent on transforming material conditions in England's social housing estates. Compared with £30bn for a housing intervention alone, the total public health budget of an estimated £4bn will struggle to make a difference.

What that difference should be is now unclear as well. The last Labour government had explicit and measurable national targets for narrowing inequalities in life expectancy, infant mortality, smoking, and early deaths from circulatory disease and cancer. Under the coalition government's so called localism agenda there will be no national targets, only local outcomes that—if a local authority chooses to prioritise their delivery—will be rewarded with a small budget premium when achieved.

As the UK economy falteringly grows its way out of the financial crisis, public health professionals need to join in the argument about whether the speed and depth of the coalition's cuts to public spending are a necessary correction or a strategy to deliver a tax cut at the next general election. The latter will be at the cost of spending on public services important to the life expectancy of the people of Middlesbrough and other similar places likely to be many years behind economic recovery elsewhere.

Under the coalition government's so called localism agenda there will be no national targets, only local outcomes

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Cite this as: *BMJ* 2011;342:d1597

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REVIEW OF THE WEEK

Rocking the foundations of hospital architecture

The Architecture of Hope: Maggie's Cancer Caring Centres
V&A+RIBA Architecture Gallery, Victoria and Albert Museum, London SW7 2RL
Till 8 May 2011; free
www.vam.ac.uk
Rating: ★★☆☆

Maggie Jencks' spatial experience of cancer was poor. Just as for hundreds of thousands of others, the diagnosis of the cancer that would eventually kill her was revealed to her in a grim, strip lit room, sitting on plastic chairs amid the bustle and ennui of a general hospital. She became convinced that it didn't have to be this way, and, together with her husband, architecture critic and designer Charles Jencks, she founded the first of what would become Maggie's Cancer Caring Centres. This was an intimate, domestically scaled refuge in a stable block in the grounds of Edinburgh's Western General Hospital, a place for patients with cancer and their relatives to escape the relentless medicalised glare of the hospital building, to remove themselves to a humane setting of care, empathy, and humanity.

Maggie Jencks died in 1995, but Maggie's Centres have flourished and become a much studied and emulated model of a new type of hybrid medical building, one that is not a clinical centre but that nevertheless has a specialist nurse constantly available; one that is not institutional yet is allied to a neighbouring hospital; one in which a patient can be alone yet also can take solace in the company and experience of others. It has also become an environment in which architecture is brought to the foreground, challenging conventional propriety and the seeming consensus that the architecture of health should be as sterile and inoffensive as possible.

Charles Jencks has driven Maggie's programme with Laura Lee, chief executive of the centres and Maggie's cancer nurse during her illness. He has attempted to define a new kind of building, a hybrid that incorporates elements from a diffuse group of existing typologies. The centres are all based around a kitchen table, reinforcing a deliberately homely, domestic feel—the antithesis of the institutional impersonality of the general hospital. However, they are designed by world famous architects, so they begin, perhaps inevitably, to display elements of the blockbuster cultural building—the icon. You could argue that their role reflects something of what has become known as the Bilbao effect, after the regenerational boost attributed to Frank Gehry's Bilbao Guggenheim Museum. They effectively regenerate the architectural deserts that surround huge general hospitals.

Architecture is notoriously difficult to exhibit, relying for its effect on the space and the fabric itself, which is untranslatable

They also have something indefinable of the chapel or the church about them: these are places of solace and community but also perhaps of the transcendence of space in a secular era. Equally, though, they reflect a past in which the clinical was not ghettoised but a part of everyday life, in which the clinical was celebrated in wonderfully rich buildings, such as the Burgundian Hospices de Beaune; the first perfect Renaissance building, Brunelleschi's Ospedale degli Innocenti in Florence; to Wren's Royal Hospital Chelsea in London and the Invalides in Paris. This tension between the domestic and the monumental, the everyday and the uplifting, the billboarding of its services and the notion of quiet retreat makes for a fascinating new building type, rich with potential.

These are not clinical buildings: they are not required to house the awesome battery of services and equipment that define a modern hospital. Nevertheless they do offer enticing glimpses of an alternative to the relentless grimness and dimness of most healthcare design.

A small exhibition at London's Victoria and Albert Museum attempts to put Maggie's Centres into the context of an architecture gallery: a collection of models and photos, texts, and films. It fails, but for the best possible reasons. Architecture is notoriously difficult to exhibit, relying for its effect on the space and the fabric itself, which is untranslatable. Maggie's Centres in particular rely on their peculiar blend of what has become known as starchitecture (iconic buildings by globally lauded designers) and intimacy. A far better introduction is London's first Maggie's Centre at the nearby Charing Cross Hospital, by Rogers Stirk Harbour and Partners. The architects responsible for the futuristic vision of the Pompidou Centre and the vast transport hubs of Heathrow's Terminal 5 and Madrid's Barajas Airport prove remarkably adept at creating a space that is simultaneously uplifting and intimate, a piece of West Coast lightness in traffic jammed Hammersmith. Likewise, Frank Gehry's building in Dundee refines the sculptural inventiveness of his grander work into a humane house that seems to soak up the landscape and reflect it inside, where it sparkles in every corner.

There are some genuinely quirky buildings on display here, and the exhibition is best at explaining the buildings as yet uncompleted: Wilkinson Eyre's Oxford tree house and Piers Gough's weirdly friendly ceramic clad Nottingham vessel are the standouts. But if the show can encourage a questioning of the norms of clinical design, and raise the bar for the architecture that accommodates our most traumatic and moving moments, it will have done something worth while.

London's Maggie's Centre (above) and the architects model of the Cheltenham centre (above right)

Competing interests: EH is coauthor, with Charles Jencks, of *The Architecture of Hope: Maggie's Caring Centres*, published by Frances Lincoln in 2010.

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Cite this as: *BMJ* 2011;342:d1599
bmj.com Maggie's Centres (*BMJ* 2006;333:1304)

BETWEEN THE LINES **Theodore Dalrymple**

Murder, mystery, and medicine

William Roughead (1870–1952) was the doyen of British crime writers and might even be said to have invented the genre. The style of his essays was admired by Henry James; he was a friend of Joseph Conrad; and he knew JB Priestley. He also helped a famous doctor-writer, Arthur Conan Doyle, in his long campaign to exonerate Oscar Slater, wrongly imprisoned for a murder that he did not commit.

Roughead edited *Burke and Hare*, in the Notable British Trials series, providing in his introduction an excellent summary of the history of that pair who killed to furnish anatomy teachers with specimens to dissect. Occasionally, some of the criminals of whom he wrote were doctors themselves, such as Dr Dionysius Wielobycki MD, whose tomb in an Edinburgh graveyard intrigued him as a child. He later wrote an essay, *Physic and Forgery*, about him.

Wielobycki (1813–1882) was a Polish exile who studied medicine in Edinburgh and established a successful and lucrative homoeopathic practice there. However, he decided he would like a little extra money and forged a will in his own favour, supposedly written in an old woman's own hand. He was caught because although the old woman was all but illiterate, he wrote the will in the most arcane legal language, which immediately aroused suspicion of the canny lawyers who disputed its terms. He was found guilty and sentenced to 14 years' transportation "beyond the seas," but was released after five years' imprisonment in Wandsworth and Pentonville. He then married a Polish countess.

You can't write long about murder without mentioning doctors, and the famous forensic pathologists of his days bestride Roughead's pages: John Glaister, Sydney Smith, Bernard Spilsbury. In his essay *My First Murder* (and he is said to have attended every "important" murder trial in Scotland for half a century, though this raises the intriguing question of what an "unimportant" murder trial might be), he describes how in 1889 he played truant from the lawyer's office in which he was training to be a writer, that is to say a solicitor, to attend a trial for murder, and was thereafter addicted to attendance at such trials.

You can't write long about murder without mentioning doctors, and the famous forensic pathologists of his days bestride Roughead's pages: John Glaister, Sydney Smith, Bernard Spilsbury

Roughead: crime writing doyen

The case did not, as Sherlock Holmes might have said, present many difficulties. It was of a woman who accepted illegitimate babies for a small sum of money to pay for their keep and then killed them. At the trial three doctors gave evidence: Henry Littlejohn, later knighted when professor of forensic medicine in Edinburgh, Harvey Littlejohn, his son and also later professor of forensic medicine in Edinburgh, and Dr Joseph Bell, the prototype of Sherlock Holmes. Because of the condition of the dead babies, none of the doctors could swear to the cause of death, although the ligatures around their necks gave a clue.

I was reminded of my own first murder. A man had stabbed his wife and then put his head in the oven (in those days you could still gas yourself courtesy of the Gas Board). The defence counsel in his final address to the jury made much of the connection between the man's unhappy childhood and his decision to kill his wife.

"I should have thought," the judge interrupted him, "that the fact that his wife attacked him first was sufficient explanation."

"Oh yes, milord, I was just coming to that," said the defence counsel, but he had obviously forgotten it. I learnt that it isn't only doctors who can be incompetent.

Theodore Dalrymple is a writer and retired doctor

Cite this as: *BMJ* 2011;342:d1620

MEDICAL CLASSICS

The Edwin Smith papyrus

An ancient Egyptian text dating from about 1600 BC

The ancient Egyptians were a primitive people whose approach to medicine was founded entirely on magic and superstition. Or so the Western world smugly believed until their illusions were shattered by the translation in 1930 of the Edwin Smith papyrus.

The US Egyptologist Edwin Smith (1822–1906) had acquired the 22 page scroll from a dealer in Luxor in 1862, but left it to gather dust while he concentrated on the more exciting business of opening tombs. On his death his daughter gave the unread text to the New York Historical Society, and it was 1920 before the society asked historian James Breasted to translate it. What Breasted discovered and published in 1930 turned the understanding of ancient Egyptian medicine on its head.

Whereas other medical papyruses consisted solely of spells and recipes, the Edwin Smith papyrus revealed a practical guide to management of wounds based on a rational and inductive process. The papyrus is dated to 1600 BC, but copied from a text several hundred years older, and is the world's oldest surgical text. It is written in hieratic script, the shorthand version of hieroglyphics, in neat columns of black text with red headings, and is anonymous. The papyrus begins without introduction and breaks off mid-sentence. But the 48 case studies of head and torso wounds it considers provide an astonishingly advanced approach to surgery and to science.

Evidently written as a practical guide to trauma wounds, perhaps for an army surgeon, the text starts with injuries to the head and works downwards to the torso. Each case begins with a single word, which translates as "knowledge gained from practical experience." Each case then describes a particular injury and explains how to diagnose the problem, probing with the fingers to assess the damage where necessary. But before rushing headlong into treatment, the text divides the cases into one of three categories: "an ailment I will handle" denotes a wound for which a known treatment existed; "an ailment I will fight with" indicates a problem for which treatment was uncertain; and "an ailment for which nothing is done" makes clear that no remedy was known.

The papyrus describes treatment, in simple steps, for the first two categories, and palliative care for the third. So a gaping head wound is considered eminently treatable by applying fresh meat and linen bandages coated in oil and honey. But if the wound has penetrated the brain, a watch and wait regimen is advised.

The papyrus contains the first known mention of the brain; the pulse; the role of the heart in circulating blood, though not complete circulation; and the brain in controlling the limbs. Treatment includes suturing, reducing dislocations, and splints. Although the papyrus also gives eight spells, including one for rejuvenation, its real magic lies in its pioneering approach to surgery as science.

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Cite this as: *BMJ* 2011;342:d1598

Review: Die like an Egyptian (*BMJ* 2010;341:c6478)

We need a Sunshine Act in the UK

FROM THE FRONTLINE

Des Spence

bmj.com

News: US drug manufacturers will have to disclose payments to doctors (*BMJ* 2010;340:c1648)

News: Drug industry weakens US bill about disclosure of gifts (*BMJ* 2008;336:1268)

Observations: Data sharing: let the sunshine in (*BMJ* 2010;340:c1896)

The United States is different. Its citizens have far too many horribly straight, white teeth. They wear checks, stripes, and bold colours all at the same time, all topped off with a baseball cap. They speak so loudly that you would swear they had a hearing impairment (probably caused by loud whooping as teenagers).

America's style of medicine is foreign to us, too. The dogma of free enterprise allows direct to consumer advertising, which has made drug names as well known as Coca-Cola. Costs have soared, and new drugs have been widely prescribed, often off label, leading to polypharmacy, medicalisation, disease creep, and potentially the deaths of tens of thousands. The drug industry is dragging doctors down through excessive hospitality and concealed payments, and its influence has been compared to that of the tobacco industry. But never underestimate the US: it is as hard as nails when it comes to white collar crime, sentencing the investment adviser Bernard Madoff to 150 years' imprisonment for financial fraud.

So the Obama administration introduced the Physician Payments Sunshine Act in 2009 to force the drug industry to release information about payments, gifts, travel, and education offered to doctors. We know that the industry pays key opinion leaders to act as advisers and "educators," but the scale of payments has always been a closely guarded secret. US investigative journalists at the ProPublica public interest news agency have disclosed that $320m (£200m; €230m) was given to 18 000 doctors in 2009-10, with the top 10 receiving more that $250 000 each ("A sugared pill," 8 March 2011, www.ft.com/cms/s/0/ae7099a0-49bc-11e0-acf0-00144feab49a.html#axzz1GZT6jkTd). These payments seem beyond excessive and poison the public professional standing of all doctors. They are rightly causing anger in the US and bringing about change through transparency.

Although the United Kingdom has been spared the worst of the free market zeal of the drug industry, we are more like our US cousins than we would like to admit. Leading experts in the UK receive direct payments from the industry as advisers and as "educators" in the marketing activity that passes as our greasy postgraduate medical education. And attempts to establish registers of payment at the trust level have failed. The General Medical Council seems incapable of tackling these important conflicts of interest. Voluntary attempts by doctors have also failed to deliver any transparency. The US has its flaws, but we should take a lesson from it in directness, openness, and grit. We need to protect the reputation and integrity of our profession from the actions of a few, so let there be sunshine in the UK too. The profession should demand that the drug industry release information about payments and hospitality paid to UK doctors.

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Cite this as: *BMJ* 2011;342:d1647

Working harder for longer

OUTSIDE THE BOX

Trisha Greenhalgh

bmj.com News: BMA warns of mass retirement after Hutton recommends end to final salary pensions (*BMJ* 2011;342:d1596)

Turning 50 brings invitations for a host of delights: cruise holidays, cheap car insurance, screening mammograms—and pre-retirement seminars at the BMA.

It didn't seem right to turn up to a retirement planning event on a mountain bike, so I went home from work to collect the car. On arrival at BMA House I was met by a picket line. Was my projected pension so high, I wondered, that people were protesting against it? No such luck. The placards were directed at the minister of health, who was allegedly already in the banqueting suite, preparing to defend the latest austerity cuts.

Two queues were forming in reception: one was young, sharp suited, and equipped with gold edged personal invitations; the other was in comfy cardigans, peering through bifocals, and wondering whether we recognised each other from medical school.

Reception had not been told to expect us. There was no pre-retirement seminar going on today. Were we sure we hadn't made a mistake? To everyone's relief someone produced a letter of confirmation—evidence that this was not some collective onset of Alzheimer's disease. The letter even offered "tea and cakes" for which some had deferred their supper. But we were past the age of violent protest. We sighed and realised that we'd been had, most probably by a mail merge error. The real seminar was scheduled for the next day, but it was full, and our names weren't listed.

Given that joining the picket would have brought out our chilblains, there was only one option: adjourn to the nearest pub for some small group work. A round of drinks later, we had the whole issue wrapped up. There was no undoing past mistakes: we were stuck with the shortfalls in our endowment mortgages and gaps in pension subscriptions caused by career breaks that had seemed like a good idea in our youth. We had all had too many children and invested in their education rather than buying added years. Our pooled knowledge suggested that there were only two options to maintain our standard of living in retirement: (a) work harder or (b) work for longer.

My husband was surprised to see me home so early. He asked how the seminar had gone. "It was great," I said. "I learnt a lot." And I picked up the pile of cruise holiday fliers and discreetly dropped them in the bin.

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Cite this as: *BMJ* 2011;342:d1616