Read the review on p 483 and join the discussion on doc2doc

Autopsies—why families count too

PERSONAL VIEW **Anonymous**

As a veterinary surgeon I am expected to communicate effectively with clients at all times when dealing with their pets and to be accountable to my clients for my actions. Informed consent is paramount in the way we operate. I was therefore horrified that there was no effective communication between doctors and myself when my partner died. Apart from notification of his death, I was faced with a wall of silence from the time of my partner's collapse to the reading of the postmortem report.

Nine months ago my partner collapsed at work and was subsequently pronounced dead at the local hospital. My request to accompany him in the ambulance to the hospital was turned down. I was given no information when I arrived at the hospital and was ushered into a side room to be sympathetically conveyed the news that he had died. I was told that a postmortem examination would be needed. Although I wasn't told this at the time, my partner was automatically classified as a coroner's case, as his death was sudden and unexpected and he hadn't seen a doctor in the two weeks beforehand.

Although I strongly objected on personal grounds to a postmortem examination, I was told I had no rights in this matter and that no consent was required. I was interviewed by the police and left the hospital. As I left, little did I realise that all avenues of communication would close down. My partner was now classified as a coroner's case—any contact with the staff involved with his death at the hospital was subsequently refused.

I contacted the coroner's office on two occasions asking to speak to him and was told this was not possible. On the second occasion, without warning, the results of the postmortem examination were read out to me over the phone by someone clearly unfamiliar with medical terminology. I was asked to make a prompt decision as to whether samples taken at the time of the examination could be retained.

Looking back, I have concerns about the insensitive way the situation was handled by most (but not all) of the professionals involved. Many questions remain unanswered, even though I have subsequently met hospital staff and eventually spoke to the coroner by phone.

GUY CROFT/ALAMY

Is there another way?

The hospital doctor and nurse involved were sympathetic and caring, but I was told that a sudden death leaves us with no rights. Surely my partner's history of oesophageal cancer and his witnessed collapse, surrounded by well qualified staff at work who administered cardiopulmonary resuscitation and who were aware of the most likely reason for his collapse (and were subsequently proved correct), dictated that common sense could have possibly prevailed? The police at the time admitted as much.

No effort or consideration was given to whether I wished to be with my partner in his last moments. I can appreciate that for many this would be too harrowing an experience, but for me it would have been a privilege. We expect accident and emergency staff to confront the unpredictable and unexpected with a well thought out plan of action. I would suggest that even if there is no legal obligation for the coroner's department to discuss with the family why a postmortem examination is required there should be at the very least an ethical and moral obligation to involve the family face to face. Although a postmortem examination may bring comfort to some, it should be appreciated that for others it is unacceptable. Perhaps pathologists by virtue of their profession are not suited to confront these issues with the living, but the situation surely should be addressed. There must be many sudden and natural deaths where the circumstances are not suspicious and could be dealt with in an acceptable manner.

Even if there is no legal obligation for the coroner's department to discuss with the family why a postmortem examination is required there should be at the very least an ethical and moral obligation to involve the family face to face

I was involved with my partner for 23 years of his life and his work, his cremation, and his memorial service. Would it have been too much to ask to have been there at his death and to have been consulted about the need for a postmortem examination? To those medical staff involved it will all have been part of a routine day's work. For me the painful memory of that day will last a lifetime. I believe it could have been handled so much better. We expect our medical colleagues to be adequately trained to deal with death in whatever form it takes. We rely on them to help us through this difficult event. We may not choose the manner of our dying, but death should not deny us our rights or our dignity. Could not communication, common sense, and, above all, compassion prevail?

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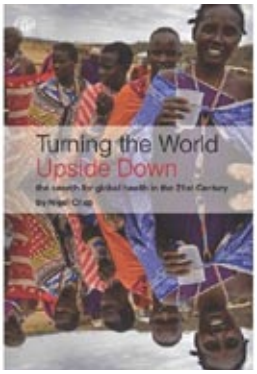
See OBSERVATIONS, p 454

REVIEW OF THE WEEK

Time to turn the world upside down

Are rich countries' aid programmes part of the problem, not the solution for improving health in the developing world? **Richard Smith** reviews a sceptical book by a former NHS chief executive



Turning the World Upside Down: The Search for Global Health in the 21st Century
Nigel Crisp
Royal Society of Medicine Press, £12.95, pp 256
ISBN: 978-1853159336
Rating: ★★★★

In 2006 the NHS in England was left with many of its parts in deficit after the biggest ever increases in funding, and Nigel Crisp, then the service's chief executive, was kicked upstairs to the House of Lords and offered what many saw as a face saving job to see how the United Kingdom could help with health care in developing countries. A year later he produced a report, *Global Health Partnerships*, much of which has been ignored; but in January he published a book on global health that is refreshingly radical.

Crisp, as he compares and contrasts his experience running the world's largest healthcare system with working in poor countries, argues convincingly that our present systems are bust in rich and in poor countries alike and that it's time for something new to arise. His case for "turning the world upside down" might begin with the stark facts that Africa has 25% of the world's burden of disease but only 3% of its healthcare resources and 1% of health workers. North America, in contrast, has 3% of the disease burden but 25% of healthcare resources and 30% of health workers.

Clearly Africa's predicament is unacceptable, but so is that of North America: its doctor and hospital dominated healthcare system, designed largely for an age of acute care, is inappropriate and increasingly unaffordable. It's the same for other rich countries, and rich and poor need something different. Poor countries certainly don't need a dilute version of what rich countries have now; and ironically poor countries may have an easier time building a better system from little than rich countries will have countering the huge inertia and vested interests of their existing systems.

Rich countries like to think that they and their aid programmes are part of the solution for improving health in developing countries, but Crisp is less sure. Aid is minute, in comparison with investment and trade, both of which are unfairly dominated by rich countries. Rich countries are plundering health workers from poor countries, and one reason that's happening is that rich countries have exported their outdated health systems and ways of thinking—meaning that health workers in poor countries are trained inappropriately and feel more comfortable in rich settings.

Africa has 25% of the world's burden of disease but only 3% of its healthcare resources and 1% of health workers. North America has 3% of the disease burden but 25% of healthcare resources and 30% of health workers

Crisp sees an alignment of "medico-academic-commercial-governmental" interests that worked well in the 20th century but now may work against patients' interests. The professions, commerce, and technology are all incentivised to "do more, treat more patients, and increase overall costs." We, the public, are deceived into believing that "greater expenditure is a good thing and should always bring greater benefit"—hence political parties competing to promise more for the NHS. But strong professional groups and systems "disempower their patients and restrict their ability to make decisions about their own health."

The poor may have more to teach the rich than the other way round, and Crisp has a strong chapter on how the rich are learning from the poor. The rich world has come to believe that good health means doctors, hospitals, and technical treatments, but organisations such as BRAC (www.brac.net) in Bangladesh remind us of the importance of community, family, lifestyles, culture, and behavioural and social factors. Ethiopia is trying to build a system that is based on health not disease. Global health also emphasises the importance of public health and reverses what Crisp calls "the hegemony of clinical medicine." Another lesson is that people should be trained for the job they have to do rather than to meet the needs of professions.

Although trained as a philosopher, Crisp is a practical man, and he ends his book with three proposals for action to help us move from "the top down approach of western scientific medicine" to the "interdependence, independence, and rights of global health." Firstly, there should be a movement of local practitioners and communities that would enrich conversations on health currently dominated by the World Health Organization, the World Bank, government departments, Oxfam, and other bureaucracies. Secondly, the education and training of health workers should be fundamentally redesigned. Thirdly, we need to create African, Asian, and American alliances to train and educate health workers where they are needed—meeting WHO's estimate of a global shortage of over four million health workers.

I greatly enjoyed the book and was inspired by it, but I was also irritated by some of its defects. The chapter on science and systems seemed only half developed, and every medical student knows that John Snow removed the handle of the water pump not in Clapham but in Broad Street in Soho.

But despite these mostly minor defects this is a tremendous book of which Crisp should be proud. He has distilled his unique, considerable, and sometimes painful experience into a wise book full of provocative ideas that—and I hesitate to write such a cliche—everybody interested in health, and particularly students in health disciplines—would benefit from reading.

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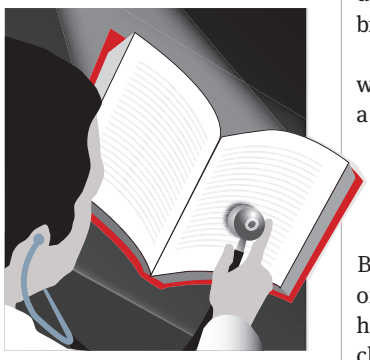
The draw of dusty tomes

BETWEEN THE LINES
Theodore Dalrymple



The French doctor J-B Descuret took up the gauntlet and ranked bibliomania among the perverted passions such as drunkenness, gluttony, anger, sloth, fear, and libertinism that led to madness

Not many people give a word to the language or a name to a disease, whether real or purported, but John Ferriar MD (1761-1815) did both. His poem, *The Bibliomania*, published in 1809, was addressed to Richard Heber, a book collector of such voracity that he needed eight houses and said that "no gentleman can be without three copies of a book, one for show, one for use and one for borrowers."

The poem inspired many subsequent books (Flaubert wrote a story of that title), including the Reverend Thomas Frognall Dibdin's *The Bibliomania, or Book Madness: History, Symptoms and Cure of This Fatal Disease*, 89 pages long when first published in 1811 and 618 pages long in its final edition of 1842. Somewhat in contradiction, Dibdin also wrote a tract called *Bibliophobia*, to lament the depressed state of the antiquarian book trade caused by his fellow countrymen's lack of bibliomania. Another book published at about the same time was titled *Bibliosophia*, suggesting that the love of books was the beginning of wisdom. The French doctor J-B Descuret (1754-1825) took up the gauntlet and ranked bibliomania among the perverted passions such as drunkenness, gluttony, anger, sloth, fear, and libertinism that led to madness.

Ferriar was a man of parts. A graduate of Edinburgh, he practised as a physician in Manchester and was among the pioneers of public health in that city, establishing an isolation ward for fever cases. He was among the first to adopt the use of digitalis, publishing *An Essay on the Medical Effects of the Digitalis Purpurea* in 1799. Among his many essays was *Of Popular Illusion and Particularly Medical Demonology*, and in 1813 he published a treatise entitled *An Essay Towards a Theory of Apparitions*, maintaining that reports of ghosts were the result of hallucinations caused by temporary or permanent, endogenous or exogenous derangement of the brain.

The preface to this work begins: "When a late ingenious Physician discovered the elastic fluid, which he termed his 'Gas of Paradise' [Thomas Beddoes and nitrous oxide], and which he hoped to render a cheap substitute for inebriating liquors, he claimed the honours due to the inventor of a new pleasure."

He continues: "How far mankind would have benefited, by the introduction of a fresh mode of intoxication, I leave it to the reflection of those sages, whose duty it would have become to appreciate its value, as an additional source of revenue to the state."

Ferriar's poem *The Bibliomania* begins: "What wild desires, what restless torments seize / The hapless man, who feels the book-disease . . ." He satirises the bibliomane's insistence on good condition: "The Bibliomane exclaims, with haggard eye, / 'No Margin!' turns in haste, and scorns to buy." The bibliomane loves what is rare and obscure: "English books, neglected and forgot, / Excite his wish in many a dusty lot . . ."

But his reward is great: "How pure the joy, when first his hands unfold / The small, rare volume, black with tarnish's gold!"

I know not whether Ferriar himself suffered from the bibliomania (not, as yet, recognised in the *International Classification of Diseases*), but he described my condition well enough.

Of course, with the new technology, the bibliomania may become as extinct as chlorosis, "the disease of maids occasioned by celibacy."

Theodore Dalrymple is a writer and retired doctor

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ROUND TABLE

A Short History of Tractors in Ukrainian

Marina Lewycka **Published 2006**

Elder abuse is a complex area of clinical practice and differs hugely from child abuse, as the older person consents to, and partners in, the assessment process. Even as older adults we have the right to behave in ways that may seem injudicious or foolish; and deciding at what point such situations might constitute elder abuse is one of the most complex areas of geriatric medicine. Artists can often handle complexity in a more approachable way than less articulate clinicians, and Marina Lewycka's debut novel provides thought provoking insights into elder abuse. Written with acerbic wit and humour, this short novel is a hugely entertaining comedy of colourful characters. It also succeeds as an unexpectedly moving account of vulnerability in later life.

It has valuable insights into the variety of presentations that elder abuse can take, the difficulty in highlighting cases of elder abuse, and the complexities of caring for an older relative who denies a need for help.

Lewycka weaves the tale of Kolya, an elderly Ukrainian widower who lives in Britain and who falls hopelessly for a 36 year old voluptuous Ukrainian divorcee, Valentina, who is in search of a visa and Western wealth. The lonely Kolya is easily persuaded by Valentina into using his pension to buy her three cars, while he remains blind to her blatant disregard for him. His two daughters put aside a lifelong sibling rivalry to join forces and break up the marriage, to free their infatuated father from the tirade of physical and psychological abuse that ensues.

Although the book is a comedy, the deep shame of elder abuse pervades the story. We feel Kolya's humiliation and his daughters' helplessness.

The loss of dignity is exposed in one vivid scene, where Valentina strikes Kolya with a wet tea towel and slaps him as he backs away from her, his glasses knocked from his face. Even more upsetting is the account of Valentina trying to lock him into his bedroom, dangling the keys out of his reach and taunting him as he feebly tries to jump up to get them. He is an "imbecile to be locked away," a "dried shrivelled relic of ancient goat turd." His lack of strength renders him helpless.

The challenge of drawing attention to elder abuse is emphasised in the demoralising account of the visit from the local police at the request of Kolya's daughter. She finds him upset in his room, naked from the waist down, having soiled himself, while the policeman and Valentina sit at the kitchen table sharing a joke over coffee. The relentless efforts of Kolya's daughters to protect their father are impeded by his shame in admitting his situation. His desire for companionship is so great that he excuses the affairs, the insults, and the demands for money. Despite his realisation that she might eventually kill him, he would rather "die at the hands of someone he loves, than die alone." Original in style and subject matter, this absorbing narrative is a valuable addition to the reading lists of geriatricians in training.

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Admission of failure

FROM THE FRONTLINE
Des Spence

You have to queue for hours to be admitted then queue again for expensive but disappointing machines. Its fabled costumed characters walk the floors, and in the evening there are scary processions and fireworks, but you've no idea how to get out. Visiting hospital is even worse than visiting Euro Disney. So why are hospital admissions increasing at 6% a year? Is this even important?

It is fundamentally important—because hospitals consume the vast majority of NHS spending, and so any increase starves other areas of the NHS. Also, an increase of a few percentage points in admissions turns a barely coping system into a failing one. But this is not a matter of mere economics. Admission to hospital is a source of intense anxiety and concern to families. And almost every medical situation can be made worse by emergency admission. For even in these enlightened days the most junior doctors still provide acute care; inexperience, uncertainty, and a lack of insight generate the overinvestigation and overintervention that so define out of hours hospital care.

So why has the number of admissions risen? Our ageing population can't be an explanation; indeed, acute pathology is in steep decline. The reason is obvious. GPs once worked full time, in the same area, for at least 30 years and covered their own nights and weekends. They knew that patients' contact with doctors often had little to do with disease and much to do with health seeking behaviours. They knew the frequent callers and how to allay their anxiety by not responding to cues, ignoring unexplained symptoms, and offering reassurance. Referral to hospital was the surest way to compound these problems. Although medicine is a science, it is the art of its application that is the real gift. This was called continuity of care, but continuity was never valued or understood—and now it is broken.

Daytime continuity of care has been diminished through greater part time working and the breakdown in partnership working. But it is in out of hours care where continuity has been completely lost, as GPs relinquished the responsibility for weekend and night work in 2004, to be replaced by a faceless and increasingly algorithmic, bureaucratic, and risk averse NHS Direct and NHS24. And now many GPs who provide out of hours services are hired guns from outside the local area or are inexperienced, recently qualified doctors who take the easier option of referral to hospital.

All centralised initiatives to reduce admission rates are doomed to fail. The only solution is to re-establish local accountability in general practices. A simple first step might be for practices to return to telephone triaging of out of hours calls. GPs should once again be bound by the collectiveness of partnership; and, radically, medicine should acknowledge the importance of full time working.

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Survival of the fittest?

THE BIGGER PICTURE
Mary E Black

There is an assumption that when we are doctors, and especially when we are senior, we can and should take whatever is thrown our way: blood, bureaucracy, bullshit, and even bullying. There is an assumption that we are grown up enough, paid well enough, and mature enough to just take it, to weather the abuse and survive power struggles—to tend our wounds alone and live on, scarred but stronger, to fight another day. There is an assumption that such macho battles are a necessary part of proving our true worth and that any senior medic worth their salt will survive unscathed and stronger. But who wrote that script? Who set up the balance sheet in that way?

Right now I am the confidante of not one but three senior colleagues: three reasonable, hard working, and, to my mind, fair people who are entangled in local power games. Our every conversation is dominated by the machinations of their supervisors, senior colleagues, or trusts and the time consuming unfairness of it all. I am brought right back to my teenage years, listening to my own father, a senior public health doctor in Northern Ireland, as he was relentlessly harassed for 10 years. This ended only when one of his tormentors died and the other retired. We have more formal systems in the NHS these days to deal with these complex problems, but they do not always work. Bullying still happens, and we mostly turn our cheeks to avoid getting caught up in it all. Bullying is an attack on someone's dignity and self worth and has a destructive knock-on effect on the workplace, families, and friendships.

I do not think that surviving bullying is a necessary rite of passage, and neither do I think that those who get hurt or fall by the wayside are wimps. Medical leaders who are battle hardened, politically astute, vicious survivors are damaged. Survival of the fittest, if victory is measured by who can win a power battle at any price, will give us medical leaders and health service managers primed to continue patterns of abuse into the next generation. Being able to play politics at the highest level is a valuable skill—but not if integrity is sacrificed and justice does not prevail.

Perhaps I am naive; I hold medicine as a high calling, centred on trust. I want our senior doctors to be excellent at clinical care, to know how to make the NHS deliver in the best possible way, to lead teams humbly and yet with honour, and to inspire the next generation. I want wisdom, decency, and kindness. So, I suspect, do our ultimate bosses and paymasters: patients. Survival of the fittest? Darwin, get lost.

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