"Childhood obesity is the elephant in the room, and state intervention is an absolute priority"
Des Spence is back, p 374

Patients who discharge themselves need further thought

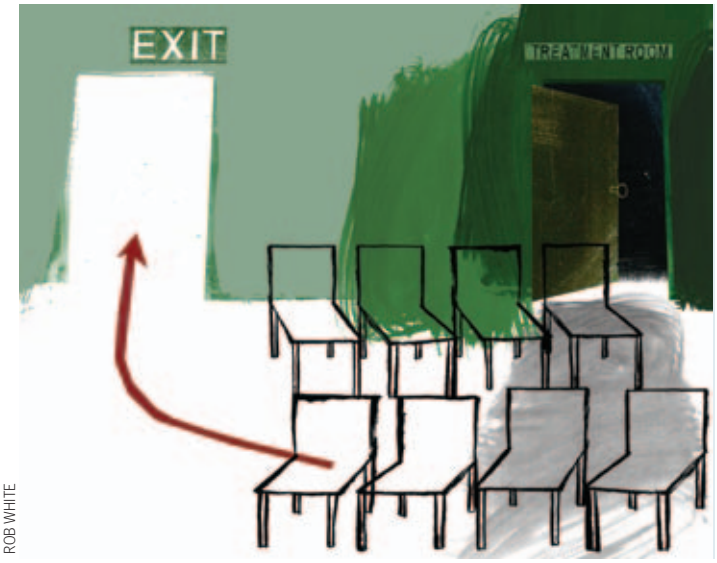
PERSONAL VIEW **David R Warriner**

A 24 year old man is admitted with a history of central crushing chest pain at 3 am on a Saturday. He has no drug or family medical history and despite denying illicit drug use is probably drunk and certainly disorderly. Unfortunately, despite his being referred within the four hour target from the emergency department, his wait in the medical assessment unit is considerable, so much so that he decides to discharge himself. After being given the necessary paperwork he is deemed to be taking responsibility for his actions, which is carefully documented in the medical and nursing notes, and he leaves, destination unknown.

Cynically, you could argue that cases such as this, termed "self discharge against medical advice," which makes up 1-2% of all admissions, is a win-win situation for patients and doctors. Firstly, the patient is happy because he can rapidly return home to a warm bed without delay and avoid the repetitive history and examination merry-go-round—and any painful and unnecessary procedures. Secondly, there is one less patient for the busy on-call night team to clerk and fewer investigations to chase. The nurses can devote more time to other patients, and the bed can be used by someone who is "really" ill. Thirdly, the patient is drunk and abusive, and privately, although we could not and would not admit this publicly, we are glad that he has left, because the nursing staff might not get verbally abused and the admitting doctor won't have to call security again. Fourthly, in this age of austerity, the financial benefits speak for themselves. After all, the patient wasn't unwell anyway, was he?

In our defence, we could argue that the patient has broken the unwritten contract between patients and physicians—that is, that they will concord with the process and treatment offered, regardless of timeframe, in the notion that it is in their best interests. The NHS, despite all its faults and failings, ensures that those with the greatest need will be seen and treated first, and so in this case the wait was unfortunate but necessary. Furthermore, the patient passed the acid test: if he was well enough to go home then clearly he didn't need to see a doctor in the first place. Of course, inpatients may choose to self discharge also.

When a patient discharges himself or herself it normally evokes one of two kinds of emotion from the hospital staff—delight or anger. I propose that it should evoke a further—regret



ROB WHITE

The counterargument is that it is a failure of ourselves that we allow these patients to discharge themselves. Many such patients don't necessarily need admission, but these patients are often disenfranchised and from hard to reach minority groups, and so this may represent a missed opportunity. Why do patients self discharge? Often, I think it is because we oversell in words. For example, we say, "Yes, the doctor will be along shortly to see you," to please and appease the patient in the absence of anything tangible happening; but we underdeliver in our actions, for example, "I'm sorry: contrary to what you were told the scan won't get done this weekend," rather than being honest with the patient from the outset. The numbers of patients discharging themselves reflects a change in the doctor-patient relationship, from compliance and paternalism through partnership and concordance to consumerism and autonomy. Just as when we see "did not attend" (DNA) in the hospital notes, our eyes may roll at the sight of such a self discharge form, yet rarely do we know the reasoning or background behind such a decision, and we should not jump to conclusions because we, like them, are far from perfect.

Rather than rushing to cover our backs, fill in worthless forms, and document that the back has been covered and the worthless form has been filled in, might it be better to use this time to speak to the patient, not to persuade them from leaving, but to explain why they are having to wait so long, perhaps even to apologise that you are not delivering the best service you would like. It might not change their minds but it will show that they are being taken seriously, that the delay in treatment is regrettable, and that their frustrations are understood. Empathy can be powerful.

Often patients don't truly understand the risks that they are taking by taking their own leave, and perhaps being complicit with them is eroding our relationship further. When a patient discharges himself or herself it normally evokes one of two kinds of emotion from the hospital staff—delight or anger. I propose that it should evoke a further—regret. Hospitals should have a weekly meeting where all such discharges are discussed and failings are identified and corrected where possible. Interviewing or following up such patients with a telephone call could help us to understand the decision they made and what intervention could prevent such a failing, and even check that they are alright. Yet there remains a paucity of evidence on how to do this.

Patient consent not needed (patient anonymised, dead, or hypothetical).

David R Warriner is clinical research fellow and honorary specialist registrar in cardiology, Sheffield
D.R.Warriner@sheffield.ac.uk

Cite this as: *BMJ* 2011;343:d5054

EXHIBITION REVIEW

The emergence of art-science

Although art inspired by medicine is nothing new, this exhibition prompts discussions about biomedical ethics, says **Sally Carter**

Art & Science: Merging Art & Science to Make a Revolutionary New Art Movement

GV Art Gallery, London W1U 6LY, until 24 September

Listen to two panel debates on the exhibition at www.artandscience.org.uk. A third debate will occur on 22 September at 7 pm

www.gvart.co.uk

Rating: ★★★☆

Don't let the long and rather pretentious title put you off—this exhibition is an adventure. Arthur Miller, emeritus professor of history and philosophy of science at University College London and co-curator , asks if the two disciplines can combine to form a third culture. He also chairs a series of debates held in the gallery around this theme. However, regardless of whether this is a "revolutionary new art movement," the exhibition has some interesting art done by some clever people.

The exhibition comprises pieces by 13 artists who work at the boundary of industry and nature, many making use of the latest technology, where dark and difficult ethical challenges often lie. They cover subjects from surgery and tissue engineering to photosynthesis and physics. Before you go, print out the catalogue from the gallery's website: you'll need it.

Some of the art is shocking, but other exhibits are subtle and take longer to appreciate. Many ask questions about death; how we view ourselves, our bodies, and nature; how we use the latest technology in areas such as plastic surgery; and who owns body tissues.

The first piece you see as you walk into the gallery is *The Physician* by David Marron, an artist and paramedic. Inspired by his day job, Marron has produced a striking life size sculpture of what seems to be a plague doctor made from wood and plaster and, as the exhibition list says, "adorned with symbolic found objects." The sculpture's head has a plague doctor's beak and the feather headdress of a shaman, but it also wears a stethoscope and surgical gown. The torso doubles as a medicine chest filled with jars of leeches, electric fish, paracetamol, laudanum, and honey. It takes some time to notice all the detail, but you can tell right away that this physician is all about death.

Susan Aldworth also explores a big subject—the self—in her work. She had a functional magnetic resonance scan done and a set of 20 digital prints from it are incorporated into her work, *Cogito Ergo Sum 3*. She altered each of the pictures, adding words and images to connect the scans to her life. It's what a set of images might look like if they could show what was going on in the imagination.

Among the pieces that shock is the performance artist Stelarc's *Stretched Skin*. It is a digital portrait of Stelarc's flattened face that hangs horizontal just above the floor. Stelarc also appears in Nina Sellars's *Oblique: Images from Stelarc's Extra Ear Surgery*, which comprises a series of giant unframed photographs that show Stelarc having an extra ear made from living tissue inserted under the skin of his arm. The pictures of the operation itself are fascinating, but it also makes you wonder who is the artist—Stelarc, as the patient; the surgeons; or the photographer.

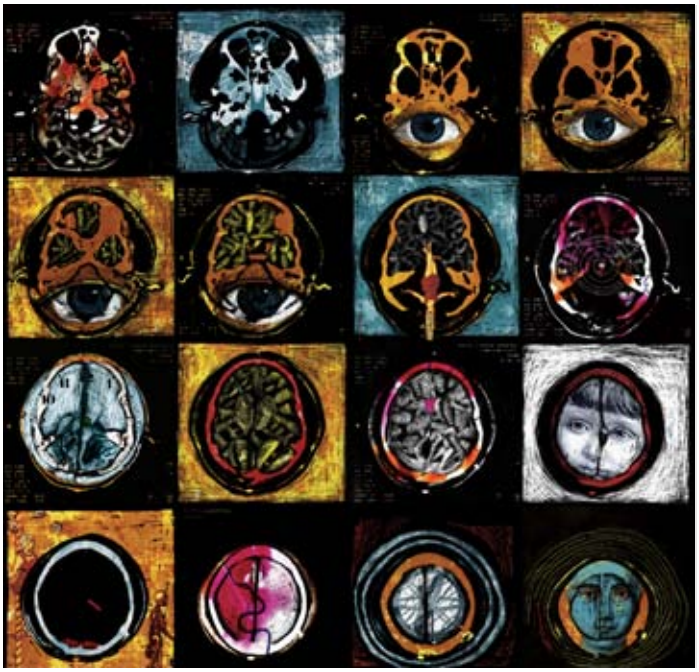
Less shocking but no less impressive pieces include *Pleasure/Pain*, an intricate sculpture by the artist Annie Cattrell working with the neuroscientist Morten Kringelbach. It looks as though it could be a vertebra, a coral, or a fungus. You need the gallery catalogue to know that it's a model of structural connections of the periaqueductal grey—an area of the brainstem that is involved in regulating pain. Cattrell tries to make a moving, active neurological process tangible using a type of "sculptural photocopying," and it turns out to be a beautiful object.

Oron Catts and Ionat Zurr are artists, researchers, and curators in biological arts. Their piece, *Pig Wings*, is a set of three framed wings formed from cultured pig mesenchymal cells grown over degradable polymer scaffolds. They developed it during a residency at the tissue engineering and organ fabrication laboratory at Massachusetts General Hospital, Harvard Medical School. If pigs could be designed to fly, what would their wings look like? These wings—in the form of angelic bird wings, satanic bat wings, and pterosaur wings—hint at potential futures in which we have semi-living objects and animal organs being transplanted into humans.

This exhibition is such a mixture of artists and subjects that it can't really answer the question of whether art and science can merge to make a third culture, and there's nothing new in artists being inspired by science. But the gallery showcases some excellent artists who might make us think, if not differently, then at least a little harder about some difficult areas of science and technology.

Sally Carter technical editor, *BMJ*
scarter@bmj.com

Cite this as: *BMJ* 2011;343:d5133



***Cogito Ergo Sum 3* by Susan Aldworth (detail)**

***The Physician* by David Marron**

BETWEEN THE LINES **Theodore Dalrymple**

The medical materialists

The belief that the theory of evolution and the neurosciences have something important to tell us about the inescapable problems of human existence has once again become fashionable. In my view, this is false and facile; a reading of the first chapter of William James's *The Varieties of Religious Experience* should explain why.

James (1842–1910) was one of three distinguished siblings. His brother Henry was the famous novelist, whom some find long winded and over-refined. His sister Alice became famous posthumously for the diary that she kept during her various breakdowns and the lung cancer that eventually killed her. William was one of those many distinguished doctors who never actually practised, though after he qualified at Harvard he did for a time teach anatomy and physiology.

The Varieties of Religious Experience was first published in 1902 and consisted of the text of the Gifford lectures in natural theology that he gave at the University of Edinburgh between 1900 and 1902. James said at the beginning of these lectures that they might mark the beginning of the reversal of the current of intellectual influence from East to West, and in this he was surely right. He called Edinburgh University hallowed ground for Americans, perhaps because one of its medical graduates, Benjamin Rush, had been a signer of the Declaration of Independence.

The first of his lectures was titled "Religion and neurology." At the time, it was fashionable for those he called medical materialists to explain, or explain away, religious experience and belief by reference to the bodily condition of those who had it, as if some derangement of physiology could invalidate the experience and belief: "Medical materialism finishes up St Paul by calling his vision on the road to Damascus a discharging lesion of the occipital cortex, he being an epileptic. It snuffs out St Teresa as an hysteric, St Francis of Assisi as an hereditary degenerate. George Fox's discontents with the shams of his age, and his pining for spiritual veracity, it treats as a symptom of a disordered colon . . . And medical materialism thinks that the spiritual authority of all such personages is successfully undermined."

"In the natural sciences and industrial arts it never occurs to anyone to try to refute opinions by showing up their author's neurotic constitution"

BETTMAN/CORBIS

James: religion and neurology

However, this is illogical, he says. "In the natural sciences and industrial arts it never occurs to anyone to try to refute opinions by showing up their author's neurotic constitution. Opinions here are invariably tested by logic and by experiment, no matter what may be their author's neurological type."

The origins, psychological or otherwise, of an opinion (James makes reference to autointoxication, the fashionable theory that one's psyche might be adversely affected by the retained products of the digestive system) have nothing whatever to do with their truth or falsity: "Dogmatic philosophers have sought for tests for truth which might dispense us from appealing to the future [proof] . . . It is clear that the *origin* of the truth would be an admirable criterion of this sort, if only the various origins could be discriminated from one another . . . The medical materialists are therefore only so many belated dogmatists, neatly turning the tables on their predecessors."

In other words, humanity is stuck with the obligation to test the truth of its ideas, which no amount of reflection on their origins will ever do. The possession of self consciousness and propositional language means that naturalistic explanations will always remain insufficient and will never pluck out the heart of our mystery.

Theodore Dalrymple is a writer and retired doctor

Cite this as: *BMJ* 2011;343:d5017

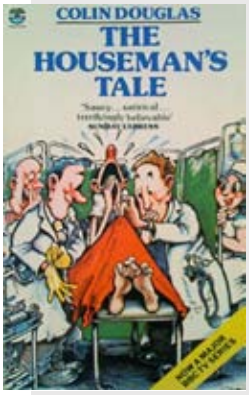
MEDICAL CLASSICS

The Houseman's Tale

A book by Colin Douglas; first published 1975

Currently out of print, *The Houseman's Tale*, by the doctor and former *BMJ* columnist Colin Douglas, is a bawdy, but often affecting, hospital romp. Set in an Edinburgh hospital in the mid 1970s, the novel exploits every comic opportunity, including the misadventures of young doctors and nurses in their free time as much as mishaps on the ward. But perhaps the book is ill served by the cartoon on the cover of some editions; for all its outlandish situations, *The Houseman's Tale* has the ring of authenticity, and rarely descends into outright spoof.

The book is fascinating for its evocations of the cosy institutions that have long since vanished—for example, traditions like sherry in sister's office, and a bustling residency ministered by a trusty steward. These are a couple of the pleasant rituals that I will not experience when I become a houseman (foundation year 1 doctor, in today's jargon) this August. Reading *The Houseman's Tale* also gave me the odd twinge of inadequacy. Douglas's medical student, for example, takes a bone marrow biopsy (albeit with amateurish consequences).



There are other aspects of this world less worthy of nostalgia. Careers imperilled by the whims of idiosyncratic consultants, the conspicuous absence of female medics, and crass racial insensitivity stand out as some of the less wholesome traits of the time.

Some things don't change. Douglas has a keen sense of the often absurd and sometimes fatal consequences of our presumption in meddling with physiology. Meanwhile, Campbell, the eponymous houseman, imagines himself an embattled soldier in a seemingly futile conflict with disease, commanded by officers of variable calibre.

Aside from Campbell there are few striking characters in the novel. Patients are a fairly homogeneous bunch of charming cap doffers and respectable elderly people. Nurses are discussed mainly in terms of their efficiency while on the ward and their promiscuity when off it. The housemen are a gang of hard drinking youngsters who relax by laughing about their conquests.

But this is missing the point. These people pale against the real story at the heart of this novel: a young man's initiation into the rites of medicine. By turns beneficent and monstrous, trivial and tragic, the vicissitudes of medical practice are wonderfully depicted. Although almost unknown by today's trainees, *The Houseman's Tale* remains an unparalleled account of the terror, hardships, and fun of becoming a doctor.

Stephen Bradley, final year medical student,
Hull York Medical School **stephen.bradley@hyms.ac.uk**

Cite this as: *BMJ* 2011;343:d4593

Inactivity and obesity

FROM THE FRONTLINE

Des Spence

The wine always disinhibits your inner voice: "Boring, boring, boring," you yell. Dinner parties can be dull affairs. Suggesting that private schools are "socially elitist and divisive" is social Semtex to liven things up. Concerned and liberal middle class parents are put on the rack and bleat in pain, their moral joints pulled out of sockets as they seek to justify why they educate their children privately. Finally they rasp a choked "I just want the best for my children." This position needs no defending.

The privately educated have a tight grip on all professional and academic institutions. It is obvious to everyone that the only way to reduce this influence is for the state sector to adopt the educationally conservative practices of private schools. And the difference is down to more than mere academic results, because private schools value sport and exercise. This is reflected in a doubling in childhood obesity rates across the socioeconomic classes (http://bit.ly/oy73RT). Obesity is a matter of socioeconomic class.

There has been a near doubling of obesity in adults since 1993 to 24%, with a doomsday projection that by 2050, 47% of men and 36% of women will be obese (http://bit.ly/oO1B3V). Obese children tend to become obese adults; childhood experience is the behavioural DNA of life. Childhood obesity is about more than just health. Both anecdote and evidence indicate that obesity blocks progress in public life and in the professions (*Obesity* 2008;16:654-8). Obesity reduces social mobility. So we are passively witnessing a widening and compounding of the class divide. Emotional and physical welfare are interwoven, so what impact does obesity have on self esteem and mental health in the long term? Childhood obesity is the elephant in the room, and state intervention is an absolute priority.

Obesity's cause and solutions are presented as complex, and fatalism prevails. One thing is certain though—activity can control weight. The Department of Health's current guidance to increase activity among children is to be welcomed, but the recommendation of an hour a day for teenagers is inadequate (http://bit.ly/r7KxXP).

The devil is in the implementation, however. Sport and activity are not priorities in state education, where the culture is hostile towards sporting competition. The widespread adoption of non-contested sports days and the demise of interschool leagues are a testimony to this. Private education places the challenge of sport and activity at its core, daily, compulsorily, and often after school. Medicine's lack of effective advocacy on activity is bad medicine and has led to a comprehensive failure to protect millions of our poorest children from a lifetime of inactivity, obesity, and social immobility.

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

Cite this as: *BMJ* 2011;343:d5093

Getting out more

OUTSIDE THE BOX

Trisha Greenhalgh

Epic vacations are all the rage. Unless you have small children or a certified disability, it is now considered something of a cop out to spend your hard earned holiday playing Frisbee on the beach or shopping for knick knacks in ethnic markets. Real men (and women) are expected to take off on as long a journey as their annual leave allowance permits, travelling by any bona fide method of self propulsion (without a spouse or tour company carrying their kit) while blogging the experience for relatives and other devotees. The only rule is that it has to hurt.

In this general spirit, I have just cycled the length of Great Britain, from the crashing surf of Land's End to the tiny harbour of John O'Groats in windswept Caithness, a stone's throw from the Orkney Isles. Apart from a personal surgical fascinoma (an egg sized ischial bursitis from a particularly unforgiving saddle), what have I gleaned from this trip that might be of interest to readers of this column?

I have learnt that this land consists mostly of countryside—that is, bog, burn, brae, dale, fen, forest, field, lake, loch, meadow, marsh, moor, and so on—dotted with occasional towns and rare cities. Rich in human history though it may be, Britain is primarily home to badgers, deer, red squirrels, wildcats, eagles, owls, bats, seals, dolphins, and basking sharks, who cohabit with thousands of species of toads, newts, spiders, snails, beetles, midges, and other creepy crawlies. Drill down and you will find a similar diversity in the earth itself. As the man in the pub put it, "Those of us who live above the Great Glen are, geologically speaking, part of Scandinavia."

But despite huge natural and physical diversity, and leaving aside regional accents, the human component of our sceptred isle has a striking sameness from sea to chilly sea. People commute vacantly to work (if they are lucky) or drift even more vacantly around town (if they are not). They spend most of their time indoors surrounded by technology. They eat, drink, smoke, push pieces of paper around their desks, and absorb hour upon hour of passive entertainment. And in their thousands and millions, they develop obesity, diabetes, hypertension, heart disease, constipation, depression, and . . . I'm sure you could complete the list as well as I could. Without wishing to decry the splendid achievements of medical science, perhaps we should just all try to get out more?

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

Cite this as: *BMJ* 2011;343:d5014