"Having an 8 year old boy translating in a consultation about his mother's mood is less than ideal"
Des Spence on translation services, p 51

PERSONAL VIEW **Kenneth G Taylor**

There's no evidence that 25% of hospital patients would be better off cared for out of hospital

The NHS Confederation recently said that one in four hospital patients would be better off being looked after in the community (*BMJ* 2011;343:d8336). The subject was covered on Radio 4's *Today* programme and was followed by an interview with Michael Farrar, chief executive of the confederation.

He repeated this controversial statement to the interviewer and I waited for the fundamentally important next question: "Where is the evidence?" But the question was never asked. Instead the statement was accepted as fact. I also waited to learn whether people better informed than Mr Farrar were to give their opinions. A statement without evidence is no more than an opinion, and if we are to have opinions then they should be grounded on a foundation of evidence or personal experience. Perhaps somebody from the Royal College of Physicians or the Royal College of General Practitioners would be invited to contribute? Sadly this was not the case.

Mr Farrar was treated as the only source of information and an expert on the subject—an exalted position for a health service manager. I suspect he was espousing current thinking from the Department of Health, which is cutting funding so severely that primary care is to be kept afloat by cutting secondary care, along classic Thatcherite lines. He did enlighten us about the nature of the 25% of patients who are apparently blocking hospital beds. From my experience they are likely to be frail elderly people with multiple pathology, previously living in social isolation, most likely in deprived communities, and with meagre financial resources. Successive governments have been aware of this problem for the 40 years that I have been involved with the NHS, and they have done spectacularly little about it. In fact the situation is set to become worse.

Mr Farrar may not have noticed that residential care homes have been closing down, and more may well follow. In 2011 the future of 750 care homes run by Southern Cross hung in the balance because of funding problems caused when private equity meets public service (*BMJ* 2011;343:d7964). The problem with Southern Cross stemmed from legislation brought in during the Thatcher years that was intended to bring the efficiencies of private enterprise into social care.

Frail elderly people with multiple health problems living with carers need a lot of care—medical, nursing, paramedical, and social. Living alone they need even more. Unfortunately central government continues to make things worse rather than better. It is no longer possible for a patient's own general practitioner to organise and take responsibility for an out of hours service. General practitioners voted to divest themselves of this responsibility, which now means we have second or third rate out of hours cover.

CHRIS ROUT/ALAMY

Community nurse posts have been drastically cut

Community nursing posts have been drastically cut as a result of the financial savings demanded by government. The funding for community nursing and healthcare assistants across 45 primary care organisations in the UK was £9m in 2010-11 and is due to fall to £8.5m in 2011-12 while the number of frail elderly grows. How will this improve care in the community? When this government and its acolytes at the NHS Confederation talk about care in the community they really mean care in your own home, out of sight. Out of sight so that nobody can see—not just bad care, but non-existent care. A national health service in which primary care is dominated by the burden of care imposed on the community is in fact the care advocated for third world countries with third world budgets. Just how low has the UK sunk under our incompetent politicians with their vested interests?

Politicians have grasped that people are living longer—they do not seem to appreciate that many of these elderly people are not fit and healthy. Often the elderly are frail with thin fragile bones, weak muscles, worn out joints, shrunken brains, and failing hearts. If we are to look after them properly they need good primary care, and good secondary care. In this situation you cannot fund primary care by cutting the funding of secondary care. This is what Mr Farrar is really saying, and I am sure the government is pleased he is saying it. When interviewed he went on to talk about better outcomes if some patients travel further for treatment—to centres of expertise, I presume. This would enable the closure of some hospitals, something which apparently we should all support. Certainly patients need treatments that offer the best outcomes, and I presume Mr Farrar was referring to primary coronary angioplasty, neurosurgery, vascular surgery, and major trauma. This still leaves a lot of medical problems that must be managed at the local hospital.

People are generally pragmatic and practical. We want decent local medical services, both primary and secondary. Most people, including the elderly, would like their own general practitioner to oversee their care. They want good community services with enough community nurses to look after them at home when circumstances are appropriate. When they have a substantial health problem, acute or chronic, they want to go to a clean, well-run, competent, and caring local hospital for treatment. Is this too much to expect in a first world country in the 21st century? Most people accept that some circumstances may require them to travel, but this should be the exception rather than the rule.

Mr Farrar and the government are laying down a smoke screen of propaganda for 2012, the year of more Draconian cuts to the nation's most precious asset—the NHS.

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Competing interests: None declared.

Cite this as: *BMJ* 2012;344:e587

Let's talk about sex addiction: Michael Fassbender and Carey Mulligan in *Shame*

REVIEW OF THE WEEK

Showing the unspeakable

Despite the hype, *Shame* isn't really a film about sex at all, writes Sandy Goldbeck-Wood. Instead, in inviting its audience to look under the surface of behaviours, it is a powerful reminder of the consulting room

Shame
Directed by Steve McQueen
On general UK release
Rating: ★★★☆

Shame was trailed as a film about sex addiction. That made me curious: in around seven years as a practitioner of psychosexual medicine, latterly in a demographically diverse central London clinic, I couldn't recall a single patient I thought of by this diagnosis. I remembered people distressed by their own, or their partner's, use of pornography, or prostitutes (or work or alcohol) as an alternative to intimacy. I remember people struggling to connect with their partner sexually because of the specificity or unusualness of their preferences (so-called paraphilias). I remember fractious differences in libido between partners, often masking anger or pain; people unable to have sex in a loving relationship; people who viewed their genitals as dangerous or dirty; and people driven to harm themselves in grotesque ways. But none lives in my memory as a "sex addict." Rather, what lives on are individual stories that, once told, make sense of apparently bizarre behaviour: often stories involving trauma.

Shame is a film that denies us the real story. We get clues: insistent, needy messages on a man's answering machine from a woman you think must be his ex-lover, but turns out to be his sister—messages he ignores, with a distaste verging on violence, but leaves playing while he masturbates; a sister's chaotic invasion of her brother's apparently neat life; endless, emotionless, compulsive sex, just below the slick surface of the apparently successful life of lead character Brandon (Michael Fassbender), alone, with prostitutes or strangers, or with internet porn—sex smacking of power without intimacy, and sex you mostly don't get to see, because it doesn't matter. This isn't really a film about sex at all—it's certainly not "sexy." It's about prodromal anxiety-of-unknown-origin, and (after perfunctory, forgettable sex) temporary relief, recurring in miserable, unexplanatory cycles, like a narrative that cannot develop, or an unincised abscess. The sex might as well be gambling or alcohol or heroin, but the real strength of this film is how clearly you get to understand that what is being portrayed is not the point.

The soundtrack would be worth a review of its own. Repeating in the background at key moments like the soundtrack of a disembodied mind, Glenn Gould plays Bach. The introverted intensity of a performer who preferred the recording studio to live audiences fits Brandon's dissociated life beautifully; and the clash between Bach's serenity and the banality of Brandon's life underlines the split between his emotional and physical worlds. Here is a person palpably in bits. Sister Sissy, played by Carey Mulligan, is equally damaged, but has equally

The sex might as well be gambling or alcohol or heroin, but the real strength of this film is how clearly you get to understand that what is being portrayed is not the point

supernatural pulling power, best demonstrated in an outstanding, touching, and ruthlessly seductive performance of *New York New York*. "I'll make a brand new start of it in old New York . . . if I can make it there, I'll make it anywhere . . . ," she sings, hinting with unconscious irony at the futility of flight from inauspicious origins. Some of the most telling lines are given to Sissy. Occasionally she emerges from the chaos of her life to summarise the film's whole story and its wider implications: "We're not bad people, we just come from a bad place."

If a failure to come to the point sounds like a weakness in a film, that was not my experience. On the contrary, the missing story seemed all the more powerful for being subterranean, in exactly the way untold trauma is in the lives it wrecks. McQueen recreates in his audience a felt sense of unspeakable distress, in much the way a patient in therapy can make the practitioner feel his feelings, as a prelude, hopefully, to reflection. The film plays with its audience as skilfully and ruthlessly as its leading characters play with their selected objects of seduction.

If you went to this film expecting titillation, a conventionally graspable story, or even education about sex addiction, you might be disappointed. Artistically, it is all the more interesting for the way it undercuts expectations and withholds key information. By arousing your interest but denying you knowledge, the director keeps you in his power rather as Brandon tantalises strangers on the subway with seductive looks. Locked in pursuit of the almost visible explanation, you wonder: will he reveal abuse? incest? In the end all he shows you is that it is too painful to confront.

It was a relief to find this film "about sex addiction" wasn't a latter day freak show of bizarre pathology, or an "issues" film, offering overt messages at a purely conscious, emotionally superficial level. But it has a message all right. Sidestepping the controversy over whether sex addiction actually exists—on which the evidence is equivocal—it invites its audience to look beneath the surface. It is a powerful reminder of the consulting room. It says: what you see is not always what you get. Bizarre behaviours are sometimes the only way of telling unspeakable stories.

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Cite this as: *BMJ* 2012;344:e619

BETWEEN THE LINES **Theodore Dalrymple**

Medicolegal judgments

Even eminent people are soon forgotten, and I don't suppose that the name of Sir John Collie (1862-1935) will mean much to most readers, even though he was knighted twice, first for his medical services to the Metropolitan Water Board, and second for his medical services during the first world war.

The nature of his researches can perhaps best be grasped from the titles of a few of his books: *Fraud and its Detection in Accident Insurance Cases* (1912), *Malingering and Feigned Sickness* (1913—dedicated to "my friend the British Workman to whom I owe much"), and *Fraud in Medico-Legal Practice* (1932).

His obituary in the *BMJ* was not such as one might wish for oneself (*BMJ* 1935;1:807). Although he was really very kind, said the obituarist, some people sent to him for examination were so frightened that they were left almost paralysed, if not by the industrial accident that had brought them there, then by the prospect of the encounter.

The trouble is, of course, that fraud and malingering really do exist, and unless they be counted as diseases in themselves a doctor sometimes has to pass judgment on them. Collie's book, *Medico-legal Examinations and the Workmen's Compensation Act, 1906* (1912) elaborates on this at some length, in an excellent prose style.

That the prospect of compensation can play tricks on the human mind is surely within the experience of many doctors. Collie says: "Many a workman who would scorn to rob his employer of a penny is induced by the working of this Act to formulate an inflated, if not an unjust, claim for compensation . . . many of the abuses are the result of petty intrigues, and he is but the tool of unscrupulous agents . . ."

In short, of lawyers: for if you ask *cui bono*, the answer is obvious: "Several times working men have appealed to me, saying in effect that whilst the lawyers fight they starve."

Some people sent to him for examination were so frightened that they were left almost paralysed, if not by the industrial accident that had brought them there, then by the prospect of the encounter

NATIONAL PORTRAIT GALLERY

Sir John: scourge of malingerers

Some of Sir John's methods of uncovering fraud would perhaps not find approval today. In those days, it was a common or urban myth that low back injury caused insensibility of the skin over the area of the injury, and in one case Sir John, who suspected the man of malingering, applied his electric battery to the man's back.

"I applied the battery. The claimant said he did not feel it over the painful area. I made the current considerably stronger, and he tried to bear it manfully. At last, with a howl, he fell in a heap on the ground. I told him to get up and not make a fool of himself."

The story, though, has a happy ending. "His wife, hearing the yell, came into the room, and I explained to her that I had cured him with the battery. I said I was very pleased; he said he was; and the wife agreed with both of us. He said he would go back to work forthwith, and he did so."

My copy of this book was inscribed by Sir John to none other than Lloyd George, the most important member of the government that passed the Workmen's Compensation Act. My copy of Sir John's *Fraud in Medico-Legal Practice* once belonged to Sydney Dernley, who was the last surviving hangman (or should it be hangperson?) of England.

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Cite this as: *BMJ* 2012;344:e572

MEDICAL CLASSICS

The Emperor of Ice-Cream

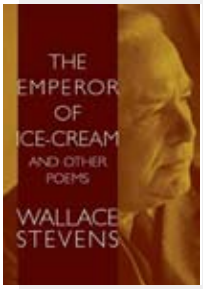
A poem by Wallace Stevens; first published 1922

Although death is a constant companion of medical practice, we are rarely well equipped for the juxtaposition of life and the living with death and the dying. From the chatter from the nurses' station and the hubbub of visiting families to the quiet of the side room, there is a constant and often uneasy sense of two parallel worlds jostling with each other.

The respectful stillness and calm in the company of the dying eventually segues into discussion and even laughter, with episodic, sometimes embarrassed, lapses back into solemnity and silence. An awareness of the awesome nature of what we are witnessing is constantly challenged by the surrounding human vitality and the mundane. Those dying almost certainly do not want life to stop, yet we are often at a loss as to how to negotiate these abrupt shifts of emotional climate.

Where prose falters, poetry steps up: *The Emperor of Ice-Cream*, arguably the most famous poem of the American poet Wallace Stevens, brings us skilfully to the heart of this everyday clinical conundrum. Two stanzas, each of eight short lines, draw us immediately into a world that makes sense of these conflicting emotions and experiences.

Stevens was a consistently fascinating poet, using an almost outrageously broad vocabulary with surgical precision to create an unrivalled marriage between the reality of the mundane and the possibilities of the imagination.



This poem describes a wake, the ice cream suggesting to me an African-American household: the first verse explodes with an effervescence of life in all its energy and normality. The imagery veers between the lustful and the tawdry; the maker of ice cream whips it into "concupiscent curds" and the sense of permission for the living to continue to live is expressed: "Let the wenches dawdle in such dress / As they are used to wear, and let the boys / Bring flowers in last month's newspapers."

The second verse portrays the desolation and mean reality of the corpse, taking from, "the dresser of deal, / Lacking the three glass knobs, that sheet / Upon which she embroidered fantails once / And spread it to cover her face." We may rebel at the poet seeming to denigrate the deceased in these terms: "If her horny feet protrude, they come / To show how cold she is, and dumb." Yet these lines serve as a foil to the reassertion of life in the person of the emperor of ice cream.

And who is the emperor? The genius of Stevens is that his masterly ambivalence allows each of us to come away with one or simultaneously several images of what the emperor might represent: life in all its vulgarity and power; a universal being; or those in the family whose role and reactions are central to celebrating the deceased and carrying his or her spirit into the future.

With this we are comforted by a duality that not only is death a part of living, but that life—and those who live on—are in turn equally entwined with our deaths.

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Cite this as: *BMJ* 2012;344:e562

FROM THE FRONTLINE **Des Spence**

Transforming translation

I am British linguistically, barely able to order coffee in three broken European languages. Is it laziness? The truth is that there is no pressing incentive to learn different languages—I don't live in Sweden. But I have travelled, getting by not badly with a phrase book and that internationally recognised lingo, exaggerated sign language.

Languages have become more of a concern in the past decade in the NHS, given the rise in immigration from around the world, even to inner city concrete tower blocks in Glasgow. Immigration highlights major cultural differences in medical care—different expectations, different international practices, and widely differing health beliefs. The internet has been a saviour, and my tip is to brush up using Wikipedia geography and history before consultations.

As for translation, to begin with this was an amateurish affair, using improvised sign language or friends or family members as ad hoc medical interpreters. But having an 8 year old boy translating in a consultation about his mother's mood is less than ideal. Recently professional translation has become the norm and a great advance. These services are not without problems. Translation services are expensive, especially in these straightened times. Sometimes the patients are late, the translators are late, or neither one turns up. Also translation is not always available in the emergency situations when we most need it. But there is a more fundamental problem—the presence of a third party in the consultation. It doesn't matter how professional the translators are, a third party changes the dynamic of a medical consultation. Therefore frank and open discussion can be difficult. Also, sometimes the translators unwittingly bring their own health beliefs into the consultation.

It doesn't matter how professional the translators are, a third party changes the dynamic of a medical consultation

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Often, like many clinicians (*BMJ* 2011;343:d721), I have been forced to use online translation services such as Google Translate. Surprisingly, perhaps, this has worked well, with good feedback from patients. The service is quick and seems accurate, especially when simple and short sentences are used. There is a problem with non-roman scripts, such as Arabic, but devices such as the iPad and iPhone allow you to switch electronically to a different keyboard. Google Translate automatically detects the change. In this way, the doctor can type a question on the desktop computer, and the patient can respond using their own alphabet on a mobile device. This allows a quick, real-time, two way conversation. Also, because this exchange uses two different internet provider addresses, it negates much of the concern about online confidentiality.

Should we explore offering this type of online translation as an alternative to traditional translation services? It is a viable option for use in unscheduled appointments, in addition to the usual sign language.

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Cite this as: *BMJ* 2012;344:e596

IN AND OUT OF HOSPITAL **James Owen Drife**

Saving Charlotte Brontë

With Dickens' 200th birthday only days away, Britain's love affair with 19th century novelists continues. The Brontë sisters have another film out, and it is only two years since Elizabeth Gaskell's work was last on television. What impresses me is how productive they all were in their short lives.

Emily and Anne Brontë died in their 20s, and Gaskell and Dickens in their 50s, but the death that still grieves me, as a Yorkshire obstetrician, is that of Charlotte Brontë. Newly married and pregnant at 38, she soon began vomiting. Her friend and biographer Mrs Gaskell later wrote that "a wren would have starved on what she ate during those last six weeks."

Today her hyperemesis would be treated with a routine drip, but sometimes cure can be elusive, particularly if the patient resents the pregnancy. When I was a student, before the Abortion Act of 1967, our textbooks pointed out that hyperemesis can lead to liver failure and it may be necessary to terminate the pregnancy.

This, I assumed, was not an option for Miss Brontë—sorry, Mrs Nicholls—in 1854. Recently, however, I was invited to write a review of the history of abortion. I was surprised when my online searches of the *BMJ* and the *Lancet* revealed that criminal abortion was available then in England's industrial cities. That and infanticide, as the millponds testified.

I wondered if Mrs Gaskell knew. She wrote about Manchester's slums but she was married to a Unitarian minister. Had she heard what women resorted to, long before contraception? Did she sympathise?

Coincidentally, another invitation arrived soon afterwards, to speak to the Gaskell Society. It meets in Knutsford (the real life Cranford of Gaskell's novel of the same name) in a Methodist chapel. I felt hesitant about raising this question but it was answered matter of factly, and I was sent a photocopy from Gaskell's collected letters: "How I wish I had known!" Gaskell wrote. "I do fancy that if I had come, I could have induced her,—even though they had all felt angry with me at first,—to do what was so absolutely necessary, for her very life. Poor poor creature!"

Had she heard what women resorted to, long before contraception? Did she sympathise?

But nobody had told Mrs Gaskell about Brontë's sickness. Charlotte was a parson's daughter, and in her poignant final letters she seems to accept God's will. Could her friend have persuaded her? If she had, would we ever have known?

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Cite this as: *BMJ* 2012;344:e567